The efficacy-effectiveness gap in PMTCT

To the Editor: I wish to congratulate Sherman *et al*.[1] on having undertaken the challenge of assessing the efficacy of a prevention of mother-to-child transmission (PMTCT) programme in a routine setting. The findings of the study are groundbreaking in many ways. However, we feel that this study partially fails to envelop the entire reality of PMTCT, thus leading to a potentially misleading title and conclusion. Selection bias and drop-out of the study population in addition to the extrapolation of research setting rates to routine setting ones call for caution when interpreting the study findings.

The efficacy of the single-dose nevirapine regimen has been established by clinical trials.[2,3] A reality perspective implies assessment of the effectiveness of PMTCT for HIV-positive women accessing routine care, rather than only for women who gave consent for voluntary counselling and testing (VCT). Therefore the VCT acceptability rate should have been reported. In the Coronation Women and Children's Hospital (CWCH) area, with an estimated HIV prevalence rate in pregnant women similar to that of Gauteng, approximately 2 450 of 8 221 women who gave birth were HIV-positive (29.8%). Thus, 1 216 potential participants were never enrolled in the PMTCT programme. Neither these women nor their babies received nevirapine. Nor were counselling on infant feeding choices or free milk formula provided. Even if this 'forgotten group' was counselled on infant feeding choices, MTCT would occur in 20.7%, according to the findings of Coutsoudis *et al*.[4] on MTCT rate and infant feeding practices.[4]

Another concern is the assumption that drug compliance in the group without records of nevirapine status is similar to that of the group with properly recorded nevirapine status. Although there is no hard evidence for reduced compliance in the 'no record'group (25%), there is no proof of equal compliance in both groups either. It is not unthinkable that drug administration may also be missed in an environment in which registers are not kept properly, the latter owing to the less stable and controlled environment of the labour ward.

Similarly to the effectiveness of drug compliance, the authors jump to the conclusion that the women from the communities attending the routine PMTCT programme are able to abstain from breast-feeding. Even though this statement is confirmed in the 'research group', data on feeding practices are missing for 38% of the women in the 'routine setting'. Women participating in the infant diagnostic study may have felt more encouraged and supported to abstain from breast-feeding than their counterparts in the routine setting. In addition, the thought of having their babies tested for HIV at 6 weeks and 3 months of age may have been an extra stimulus to formula-feed exclusively. Acknowledging the fact that both follow-up infant visits and adherence to exclusive formula-feeding require a certain level of commitment, selection bias may be suspected with regard to the rates of reported feeding practices. In other words, among those 38% lost to follow-up, relatively more breast-feeding and mixed feeding may have occurred. Moreover, feelings of fear or guilt that go along with having breast-fed may have counteracted return for follow-up infant visits. For the above reasons, the overall rate of exclusive formula-feeding may be lower than assumed by Sherman *et al*.[1]

When considering the results of this study one should keep in mind that the findings are merely efficacy rates for the CWCH, so they do not necessarily reflect the real MTCT rate in the community. As much as this study is a big leap forward in the implementation of PMTCT, additional research is needed to translate high levels of efficacy into equally high levels of effectiveness in the community.

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Louis Leipoldt

To the Editor: South Africa has a dearth of good biographers and Kay de Villiers[1] has produced an unsentimental and objective account of the luminary life of Louis Leipoldt, a medical renaissance man.

One issue is conspicuous by its absence in the article — Leipoldt's sexuality. Dr Peter Shields, in the introduction to the recent anthology,[2] left no doubt that Leipoldt was homosexual, although either inactive or highly discreet. I mention this not out of a sense of scurrilous sensationalism but because any account of Leipoldt that ignores it is lacking.

Consider the effect on someone who, by his own admission, did medicine to expiate a sense of guilt engendered by being the son of missionary. To what extent was his career choice driven by a deeper guilt about sexuality? Leipoldt was a remarkable doctor, but what would he have achieved if he had devoted himself to pursuits not driven by a sense of guilt and desire to care for others?

And, on a positive note, as a genuine polymath and sensualist, to what extent was his sensibility a reflection of a more subtle homosexual perception for which we are all the

better to be the recipients?

We should not be afraid of mentioning Leipoldt's sexuality; there is no one to hurt now, and why not celebrate an important aspect of his nature that contributes as much to his achievements as it did to his silent pain and despair?

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Psychoneuroimmunology — mind-brain-immune interactions

To the Editor: The authors are to be commended on the above article,[1] yet it does not go nearly far enough. The sequence of a subconscious thought leading to a negative emotion (anxiety, fear, guilt and anger) resulting in a negative behaviour has long been established. Perhaps the first published comment was by Breuer back in the 1880s! Be aware that a pathological disease process may well be a behaviour, whatever biological pathway is followed!

The references provided are scarce indeed — let no reader be misled. There are many hundreds of research articles confirming the clinical experience that early life experiences — pre-natal, birth and infancy — are responsible for many problems later in life. I have referred in published papers to diseases such as certain cancers and autoimmune disorders as 'malignant psychosomatic disease' — all treatable according to one of three goals depending on the patient's level of autonomy: palliation, facilitation of medical or surgical management, and cure.

Modern modalities of clinical hypnosis are extremely useful in uncovering the causative events, allowing a profound change in even 'catastrophic' negative outcomes. The largely blinkered vision of the healing professions in regarding medical hypnoanalysis and ego state therapy as oddities or 'not very useful' in general medicine is a tragedy for the public at large. The book I wrote and advertised through the *SAMJ* was purchased by just three doctors! So much for self-motivated CPD.

The South African Society of Clinical Hypnosis (SASCH) provides training recognised by the International Society of Hypnosis (ISH) — in fact it is the only ISH-affiliated society that offers training in all the modalities under one roof. The Society (a Division of PsySSA) may be contacted at (012) 365-3647 on weekdays between 08h00 and 12h00.

I would also caution against the global perception that alcoholism has a genetic background — the article by Professor Pienaar in the same issue of the *SAMJ*[2] says that it 'plainly occurs in certain families'. Professor Pienaar correctly points out that 'it may result' from such a source. We are mindful of the fact that these families are severely dysfunctional — this is the primary reason for learned behaviour such as using substances to alleviate the pain inherent in such families. A behaviour that is learned can be unlearned, and this is far more easily accomplished with early intervention.

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