me that SAMA membership is not worth it. and I'm afraid they may be right. The medical aid industry should be made aware that they exist solely because of us, and not the other way around (arrogant but true), and SAMA should be at the forefront of this battle, because a battle it is.

P W L Groenveld

1 Castanea Place
Florida Glen
1709

1. Caldwell RI. My number is up (Forum). *S Afr Med J* 2003; **93:** 909.
2. Lee NC. To the barricades comrades! (sorry — colleagues) (Briewe). *S Afr Med J* 2004; **94:** 8.

Practice number furore

To the Editor: Medical practitioners are obliged by the Medical Schemes Act (Government Gazette No. 20556/20, October 1999) to incorporate into their accounts a practice code number 'issued by the registering authorities'. Such numbers have been in use for some years. The Act does not anticipate that there should be a cost to providing the number, and it is highly improbable that the Act anticipated that it would be used to create a profit-making monopoly. Nevertheless, over the last few years the Board of Health Care Funders (BHF) have attempted to levy a fee for the use of these practice numbers.

The practice number has an administrative benefit to the medical aids, but no obvious benefit to the medical practitioner. There is therefore no reason why the medical practitioner should pay a fee for this service.

The overall cost to the medical profession, at R100 per practitioner (the current fee) is over R3 million per annum, likely to increase in the future if the BHF succeeds in this ruse.

The BHF have exerted pressure on medical practitioners to pay this fee. If the BHF feel they have a legitimate claim against medical practitioners, they have available to them the conventional relief of civil litigation, i.e. to approach the dispute through the Magistrates Court.

Instead, the BHF have elected to intimidate medical practitioners by:

1. Spreading the rumour that any medical practitioner who has not paid the BHF has an 'inactive practice'. This is malicious defamation for which the BHF should be called to account.

2. Instructing individual medical aids to not make payment to either the practitioner or their member. By attempting to interfere with the flow of income to the medical practitioner to ensure their demands are met, the BHF are engaging in the criminal act of extortion.

The medical aids seem to have become unwilling intermediaries in this power struggle and only a few have attempted to enforce the directive from the BHF to withhold fees. At least a few have buckled and 're-instated the practice numbers'. Well they might, since to withhold these fees for their own use is an illegitimate diversion of funds. One might well ask to whom the benefit of accrued interest falls.

There are strong reasons why medical practitioners should resist these threats by the BHF, not the least of which is to distance the profession from this distasteful and illegal ploy. Since the medical aids are now more reluctant to become involved as intermediaries (and might well consider their own legal position) it is unlikely that the BHF will withstand their bluff being called.

It is to be hoped that all medical practitioners will refuse to pay any fee for the use of a practice number in the future.

I have forwarded this document to the Board of Health Care Funders for comment, but no response has been received.

J P Driver-Jowitt

3 Norfolk Road
Newlands
Cape Town

Kruisiging artikel — bravo!

Aan die Redakteur: Soos die publikasie van die uitstekende histories-geneeskundige artikel oor die kruisiging[1] vir professor C F van der Merwe[2] dronkgeslaan het, so slaan sy beswaar my totaal dronk, aangesien dit 'n uiters deeglik nagevorsde, tydige en hoogs interessante artikel oor 'n hoogs paslike onderwerp is.

Die artikel is duidelik onder die afdeling 'History of Medicine' geplaas en ook ongetwyfeld met dieselfde doel nagevors en gepubliseer. Dit is vanselfsprekend nie bedoel vir die gruheid daaraan verbonde nie, maar vir die histories-medies wetenskaplike inkleding van 'n onomstootlike historiese feit wat vir baie mense en selfs sommige geneeshere met 'n kulturele aanvoeling lig werp op 'n hoogs emotiewe en persoonlike geloofservaring. Hiervoor loof ek die skrywers — ook vir die tydigheid, die deeglikheid en die aanvoeling waarmee die feite aangebied word.

As wedergebore Christen het dit my aan die hart geraak om van die haas onmenslike lyding te lees wat my Verlosser ook vir my sondes en verlossing moes deurstaan. Die grafiese beskrywing van die intense lyding verbonde aan hierdie allerverskriklikste teregstelling kan 'n Christen se geloof net versterk, sy dankbaarheid teenoor sy Verlosser verdiep, en hom insig gee in die werklik onbeskryflike en onverklaarbare liefde wat Jesus Christus vir sondaars het.

In 'n era waartydens die akademiese post-modernisme die geloofsgronde van die Christendom bevraagteken en die

'historiese Jesus' soos vals profete aan ons wil verkwansel, vind ek Retief en Cilliers se artikel hoogs stimulerend, feitlik korrek, inhoudelik onverbeterlik en kultureel uiters bevredigend — bravo!

Die lees van enige artikel in enige tydskrif is uiteraard opsioneel en die inhoud daarvan kan onmoontlik alle smake bevredig. Byvoorbeeld, die persoon wat moontlik 'vrekgeskiet' is of die 'verkragte vrou' wat 'keelafgesny' is in professor Van der Merwe se brief vervul my met weersin, maar dit toon weereens dat smaak genadiglik verskil, en dat ons ons in ons kritiek kan laat temper deur verdraagsaamheid, aangesien daar vele ander stimulerende artikels oor VIGS en drakoniese wette rakende geneeshere in dieselfde *SAMJ* uitgawe verskyn in wat Van der Merwe liefderyk 'ons' joernaal noem.

Baie dankie aan die skrywers en ook veral aan die redakteur vir die plasing van 'n artikel wat poog om ook die kulturele visie van geneeshere te verruim.

Johann P Myburgh

Posbus 224
Kroonstad
9500

1. Retief FP, Cilliers L. The history and pathology of crucifixion. *SAMJ* 2003; **93:** 938-941.
2. Van der Merwe CF. Kruisinging beswaar (Briewe). *S Afr Med J* 2004; **94:** 8.

Read the label — blue may have become red

To the Editor: Drug errors, specifically injecting the wrong drug, remain cause for concern in anaesthetic practice.[1] In addition to coloured labelling, it was recently suggested that prefilled, bar-coded syringes be used to decrease the risk.[2] Computerised anaesthetic records will be required to be able to implement this facility. Unfortunately thousands of hospitals will not be able to afford this for decades to come.

In the meantime careful reading of the labels and colour coding of syringes will be the most reliable safety mechanisms.[3] Unfortunately the UK has been using a different colour code until recently and has only now started introducing the international system, to which South Africa also subscribes. This is a potential minefield for South African anaesthetists doing locums or short periods of duty in the UK. One can see the potential for disaster if theatre staff run out of coloured labels and replace them with the wrong type, or if staff are called to the accident and emergency department, the radiology department or any area where anaesthetic support is occasionally required and not stocked with the new labels.

The message to visiting colleagues is — do not rely on the colour code only, READ THE LABEL.

Pieter Bothma
Stef Oosthuysen

James Paget Hospital
Great Yarmouth
NR31 6LA
UK

1 Currie M, Mackay P, Morgan C, *et al*. The 'wrong drug' problem in anaesthesia: an analysis of 2000 incident reports. *Anaesth Intensive Care* 1993; **21:** 596-601.
2. Merry AF, Webster CS, Mathew DJ. A new, safety-oriented, integrated drug administration and automated anesthesia record system. *Anesthesia and Analgesia* 2001; **93:** 385-390.
3. Orser BA, Chen RJB, Yee DA. Medication errors in anesthetic practice: a survey of 687 practitioners. *Can J Anesth* 2001; **48:** 139-146.

Unusual endometrioma

To the Editor: On 26 May 2003 a 31-year-old woman who had had two normal vaginal deliveries presented with severe menorrhagia. This had failed to respond to conservative treatment, including an endometrial ablation in 1999.

On clinical examination no specific abnormalities were found other than a bulky adenomyotic uterus.

In view of the failed conservative treatment, laparoscopic assisted vaginal hysterectomy was performed on 24 June 2003. The operation and postoperative course were uneventful.

On 30 September 2003 the patient reported that she was once again having periods. She was examined carefully; the vault had healed well. There was no granulation, and absolutely no reason for the vaginal bleeding could be found. She was asked to return at the time that the bleeding was present. On 24 October 2003 she presented again complaining of a period and on this occasion a small bleeding area was noted at the site of her previous episotomy scar. An excision biopsy of this area was performed under general anaesthetic and a biopsy confirmed the clinical suspicion of endometriosis.

It is not that uncommon to find endometriomas at the site of caesarean section wounds but this is the first time that I have encountered an endometrioma at the site of a previous episotomy. It is also the first time in my experience that cyclical bleeding has been associated with such an endometrioma.

P C Koll

Sandton Clinic
Johannesburg