



Haemorrhoids – what op?

Our tutors told us medical students that having painful piles was helpful in becoming a successful doctor as it ensured having that necessary serious look about one. For such a common affliction (and one that is the butt of many jokes and a source of personal embarrassment) one would have thought that the treatment would be cut and dried, but not so! Madiba, Esterhuizen and Thomson¹ provide a systematic review and meta-analysis comparing 'procedure for prolapse and haemorrhoids' (PPH) with 'excisional haemorrhoidectomy' (EH).

First- and second-degree haemorrhoids and relatively small third-degree haemorrhoids can be treated non-operatively. Surgery is generally reserved for patients with large third- or fourth-degree haemorrhoids, haemorrhoids with an extensive and symptomatic external component, or patients who have undergone less aggressive therapy with poor results.

Whereas EH removes the prolapsed haemorrhoids, it does not address the underlying cause of both mucosal and haemorrhoidal prolapse; conversely PPH, by 'lifting' the prolapsed haemorrhoids and mucosa, re-places the haemorrhoidal cushions high in the anal canal, thus establishing the topographical relationship between the anal cushions and the rectal muscle layer.

Compared with EH, PPH is associated with less postoperative pain, reduced operative time and hospital stay and earlier return to normal activity, and a trend to improved patient satisfaction. The rate of recurrence appears higher with PPH. But there are compelling reasons for EH which cannot be met by PPH, including acutely incarcerated and thrombosed haemorrhoids, presence of gangrene, the need for limited haemorrhoidectomy and the presence of numerous skin tags. It is therefore advisable that all surgeons learn both techniques and decide which to use in case each specific case after full discussion with the patient.

Importance of rural-origin students

Rural areas globally experience shortages of health care professionals, and South Africa is no exception. Tumbo, Couper and Hugo² studied the proportions of rural-origin students at all medical schools in South Africa. Why should there be an interest in whether or not students are of rural origin?

Internationally the disproportionate distribution of health care professionals has been shown to be influenced by factors such as domestic origin of the professionals, career choice, social amenities in urban areas, and the availability of specialist support services. Evidence from various countries that rural background is strongly associated with practice has been confirmed in South Africa.

Tumbo and colleagues found that the average proportion of rural-origin health science students nationally over the 4-year period studied was 26%. In the four disciplines that

they included the average proportion of rural-origin students ranged between 22.3% and 27.5% compared with the rural population of 46%. The lower proportion of rural-origin students may partly be attributed to poor education in rural areas and the absence of a policy on preferential admission. Educational institutions therefore need to uplift the educational standards of rural schools, and incentives, guidelines and quotas to increase the proportion of rural-origin students at medical schools are also required.

Hypoalbuminaemia plays a minor role in oedema

Seriously ill patients often suffer from disorders of salt and water balance and present with clinical signs of either dehydration or oedema. The concept that hypoalbuminaemia directly causes oedema due to fluid extravasation is challenged in a study by Steyl and Van Zyl-Smit.³

Fifty patients admitted to medical wards were evaluated. Significant hypoalbuminaemia was present in many of their patients, yet oedema was detected infrequently and generally had an easily identifiable cause not related to low albumin levels. Most patients with hypoalbuminaemia presented with normal or positive water balance. The authors conclude that their study supports the notion that hypoalbuminaemia is infrequently associated with oedema and plays a minor role in its formation.

Compulsory HIV testing of sex offenders

Alleged sex offenders may be compelled to be tested for HIV at state expense without their consent. David McQuoid-Mason examines the legal implications of the Sexual Offences Act⁴ that allows victims of sexual offences, interested persons on their behalf, and investigating officers of the South African Police Service to apply for such a court order. To protect the alleged offender's constitutional right to privacy, special procedures exist to protect the confidentiality of the court application and the HIV test results.

A person's constitutional right to bodily integrity and privacy is violated if their blood is tested for HIV without their informed consent, except where this is allowed by reasonable and justifiable legislation. Given the high incidence of sexual violence and HIV in South Africa, the compulsory testing of alleged sex offenders for HIV without their consent is reasonable and justifiable, provided that constitutional safeguards regarding confidentiality are maintained.

1. Madiba TE, Esterhuizen TM, Thomson SR. Procedure for prolapsed haemorrhoids versus excisional haemorrhoidectomy – a systematic review and meta-analysis. *S Afr Med J* 2009; 99: 43-53.
2. Tumbo JM, Couper ID, Hugo JFM. Rural-origin health science students at South African universities. *S Afr Med J* 2009; 99: 54-56.
3. Steyl C, Van Zyl-Smit R. Mechanisms of oedema formation: The minor role of hypoalbuminaemia. *S Afr Med J* 2009; 99: 57-59.
4. McQuoid-Mason D. Compulsory HIV testing of alleged sex offenders. *S Afr Med J* 2009; 99: 26-28.