Testing for allergy

Guidelines or standards in medicine provide useful beacons to show practitioners the way through often complex clinical situations. For many of us the diagnosis of allergic diseases and what diagnostic tests to use is just such a maze. To have authority, guidelines must be developed by experts on the subject and be approved by an authoritative body. The guideline on 'Diagnostic testing in allergy' by Motala and Hawarden[1] on behalf of the Allergy Society of South Africa provides a crisp set of definitions of atopy and of allergy and briefly outlines their diseases. The diagnostic approach is clearly outlined with the aid of algorithms.

Allergy diagnosis depends primarily on the clinical history; the history, aided by a physical examination, guides objective tests of IgE sensitivity. Either skin tests or allergen-specific serum IgE measurements (RAST) are used to focus on whether the patient is allergic, whether allergy contributes to the symptoms and what the relevant allergens are. A positive history and positive tests help in rationalising treatment, initiating specific allergen avoidance measures and selecting appropriate immunotherapy. Tests include skin-prick testing, blood tests, multi-allergen IgE antibody screening assays, mast cell tryptase and CAST testing.

Many of the allergy 'diagnostic' tests performed by ecologists and alternative practitioners are of unproven value, time consuming and expensive. These are not to be recommended. This list includes neutralisation provocation (Miller) tests, hair analysis, ALCAT and IgG measurements.

Deviance and medicines regulation

The widely publicised woes of the parastatals, Eskom, the SABC and South African Airways are mirrored in the health sector by poor delivery by the professional councils, the Medical Research Council and the Medicines Control Council (MCC). In his editorial Roy Jobson[2] draws attention to the normalisation of deviance in medicines regulation in South Africa.

Normalisation of deviance describes situations where an error or an omission has become standard practice, usually through unchecked repetition. The uncontrolled deluge of complementary medicines available in South Africa can be traced back to 2002 when the Medicines Regulatory Affairs cluster of the Department of Health continued to accept documentation for complementary medicines well after their 'call-up' date had expired.

The technical deviation contributing to the normalisation of deviance in the regulation of complementary medicines in South Africa is that none of these medicines has had to provide independent evidence of their quality. This essentially means that none of the unregistered complementary medicines on the market have had any independent South African validation of their quality. The MCC is the statutory body mandated to ensure that the availability of any and all medicines and related substances is in the public interest and meets satisfactory criteria of quality, safety and efficacy.

Resources and infrastructure are urgently required to commence the gargantuan task of assessing all the unregistered medicines on the market.

Rubella and a Greek tragedy

Rubella in children and adults is almost always a mild disease, with serious or long-term sequelae very rare. The main concern is the risk of congenital rubella syndrome (CRS) in early pregnancy. The risk of CRS in the first 8 - 10 weeks is up to 90%, after which it drops and is virtually absent after 16 weeks other than rare mild systemic illnesses. The current rubella vaccine is safe and effective and can be given in combination with measles (MR) or measles and mumps (MMR). Since it has a high cost-benefit ratio there is a great impetus to introduce routine rubella immunisation. However, Schoub and colleagues[3] warn of the possibility of a 'Greek tragedy' – after an outbreak of CRS in Greece following the introduction of such a campaign.

To prevent an upward age shift of infection, and therefore an upsurge in rubella and possibly an outbreak of CRS, the authors urge that precautionary measures must first be met before commencing with an immunisation campaign. These are a robust programme for selective immunisation of pre-pubertal/adolescent girls and strengthening of routine measles immunisation.

Fluid creep in major burns

Rogers *et al*.[4] warn that over-reliance on the Parkland formula in the resuscitation of patients with major burns may lead to over-hydration. If severe this may manifest as compartment syndromes in unburnt limbs and in the abdomen, with potentially lethal consequences. Over-resuscitation ('fluid creep') can result in pulmonary oedema, acute respiratory distress syndrome, pneumonia, multiple organ dysfunction, compartment syndromes and cerebral oedema.

The authors provide clear guidelines to optimise fluid resuscitation and prevent adverse complications. The first is that resuscitation should start immediately for all burns with body surface area involvement of >15%.

JPvN

1. Motala C, Hawarden D, on behalf of the Allergy Society of South Africa. Diagnostic testing in allergy. *S Afr Med J* 2009; 99: 531-535.
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3. Schoub BD, Harris BN, McAnerney J, Blumberg l. Rubella in South Africa: An impending Greek tragedy? *S Afr Med J* 2009; 99: 515-519.
4. Rogers AD, Karpelowsky JS, Argent A, Millar AJW, Rode HS. Resuscitation in major burns: The problem of fluid creep. *S Afr Med J* 2009; 99: 512-513.