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**Dr Chin replies:** The pharmacodynamic interaction between the NSAIDs and aspirin is poorly understood. In the study by Catella-Lawson *et al.*,<sup>1</sup> the concomitant administration of ibuprofen but not rofecoxib, paracetamol or diclofenac antagonised the irreversible platelet inhibition induced by aspirin. Thus, in the limited evidence available, treatment with ibuprofen has been shown in an experimental trial to limit the cardioprotective effects of aspirin in patients with increased cardiovascular risk.<sup>1</sup> Currently the US Food and Drug Administration recommends that ibuprofen be given at least 30 minutes after aspirin or at least 8 hours before aspirin to limit this interaction.<sup>2</sup> No data exist for definitive conclusions to be drawn about the interactions between celecoxib, indomethacin, other traditional NSAIDs and aspirin. Clearly the mechanism of cardiovascular hazard and the use of NSAIDs is complex. Although limited trial evidence suggests that the pharmacodynamic interaction between aspirin and NSAIDs may be a potential mechanism, a substantial body of evidence indicates that suppression of COX-2-dependent prostacyclin formation initiates and accelerates atherogenesis.<sup>3</sup>

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## Chris Barnard

**To the Editor:** With regard to John Terblanche's tribute to Barnard in the August *SAMJ*,<sup>1</sup> your readership might be interested in the following correspondence.

On 3 July 2006, I wrote to the Hunterian Museums at the Royal College of Surgeons, Lincoln's Inn Fields, London:

### Open Heart Surgery

Primarily, I would like to congratulate you on your magnificent museums. Any person who has studied medicine, or has contemplated its study, or indeed has an interest in biological sciences, should strive for the privilege of a visit.

The other purpose of this letter is as follows. In December 2005 I enjoyed a lengthy first sojourn in the Hunterian

Museum and noted in the *Open Heart Surgery* section:

*'In 1967 the first heart transplant was carried out' (full stop, paragraph).*

A separate preceding panel, containing a photograph of Cooley operating, stated: *'Denton Cooley is one of the pioneers of open heart surgery' – further paragraph, then: 'In 1968 Cooley performed the first successful heart transplant in the United States and in 1969 became the first heart surgeon to implant an artificial heart in a human patient.'*

One was a little puzzled that no mention was made of the surgeon who performed the first heart transplant nor of where the operation took place. I thought no more of it at the time, but was reminded of the omission when I watched a short documentary on the life of Christiaan Barnard on the plane back to South Africa a few days later. Since then I have discussed both the excellence of the museum and this observation with friends and medical colleagues at home and in the UK, and have been surprised at the almost uniform response. Most felt that one had a duty to query this historical/scientific/ethical anomaly.

Therefore I paid a brief second visit to the Royal College of Surgeons on Wednesday 28th June 2006 to confirm my facts and to establish via your most helpful information desk the appropriate recipient of this letter.

I look forward to your response and would be most grateful for comments on this small but possibly important issue.

Simon Chaplin, Senior Curator, replied on 6 July 2006:

Thank you for your email. I am glad you enjoyed your visit to the museum. Writing text for museum displays is always tricky: covering a broad topic (such as post-war heart surgery) in fewer than 160 words is something of a challenge. The decision I took as Curator was to try to avoid mentioning individual surgeons by name – I feared that otherwise the panels would become simply lists of names and dates. The addition of the separate panel on Denton Cooley's work was undertaken at the behest of our Trustees who felt that his overall contributions to the field of cardiac surgery (including, but certainly not limited to, his work in heart transplantation) were deserving of particular mention. This additional panel was added after the main text (with its brief reference to the 1967 breakthrough) had been installed, otherwise I would have added in Barnard's name to avoid any suggestion that his exclusion was in any way deliberate. Hopefully this is something that we will be able to correct in future, but for the meantime please be assured that our representation was not intended as any kind of slight towards Christiaan Barnard's work!



Perhaps the exclusion has since been attended to. Failing that: should not eminent South African surgeons take up the cudgels/scalpels on Barnard's and Groote Schuur Hospital's behalf?

**Robert-Ian Caldwell**

PO Box 893  
Hilton  
3245  
ric@caldwells.co.za

1. Terblanche J, Chris Barnard – a personal tribute to a gifted heart surgeon and a great intellect (Letter). *S Afr Med J* 2007; 97: 550.

## Gaucher disease in South Africa

**To the Editor:** I refer to the abstract by Govender and Newton in the August *SAMJ*.<sup>1</sup>

Gaucher disease is a relentless progressive multi-systemic disorder caused by deficiency or inadequate function of

lysosomal  $\beta$ -glucocerebrosidase. The resultant accumulation of the substrate glucocerebroside causes the organ damage. The classic clinical picture of organomegaly, cytopenia and bone pain or disease should always alert the practitioner and place Gaucher disease into the differential diagnosis. This will result in earlier intervention and minimise the risk of irreversible complications of the disease.

While initially Gaucher disease was thought to be more prevalent in the Jewish Ashkenazi population, it is now regarded as being pan-ethnic with a specific genotype, the N370S mutation being more prevalent in that group. There are now some 300 mutations causing the disease.

The Gaucher Clinic at Johannesburg Hospital has been in existence for some 14 years, and 30% of the patients are black Africans. It is interesting to note that there does appear to be a novel mutation for our black population. There are about 50 known patients in South Africa. The treatment of choice is

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