

Wanted: anti-corruption torchbearers in health

The ongoing corruption clean-up in the Eastern Cape health department, led by its director-general Dr Siva Pillay, is an excellent example of what can be done when leadership comes to grips with this monster in our midst.¹

That Pillay's life and the lives of his family are under threat is an excellent indicator that he's winning, roughing up syndicates who've had it too easy for too long. It is disturbing that these syndicates, with robust roots in the top echelons of health departments, have grown so arrogant as to threaten anyone disturbing the status quo. Health corruption busters have yet to emerge publicly elsewhere – in spite of plentiful evidence of skulduggery pushing mismanaged provincial budgets way further into deficit. As one provincial health service monitoring NGO veteran observed to Chris Bateman: 'crooked tender practices require complicity at or near the top – look at provinces where it's still going on and you wonder'. Contrast with Eastern Cape Health! Fired: the chief financial officer (along with seven other senior officials), all facing fraud and corruption charges. Fired: a director in the Infrastructure Department, in connection with crooked tender procedures (and irregularly increasing his job contract from three to five years). Go figure.

Immediate HIV treatment saves costs

One can only guess the reasons for the denial of HIV treatment for HIV-infected patients in the era when Mbeki was President of South Africa. Perhaps it was economic considerations for the perceived costs of such treatment? Since that time scientific sense has prevailed, costs of antiretroviral drugs have come down, and treatment programmes are being rolled out vigorously.

A recent report commissioned by the South African government examines alternative long-term scenarios for the costs and benefits of HIV prevention and treatment, and care for orphans and others affected by AIDS in South Africa. The report did not consider 'treatment-centred prevention' (TCP) – a combination of regular testing for HIV, immediate highly active antiretroviral treatment (HAART) offered to all infected individuals, and other proven methods. Such an approach could dramatically reduce infectiousness of HIV-positive people, leading to critical reductions in the rate of new infections.

The costs and consequences of delayed versus immediate HIV treatment are considered by Welte and colleagues.² They conclude that if the indirect costs to society of HIV-related morbidity and mortality are taken into account as well, deferred HAART initiation becomes more expensive than the cheaper option. The current policy does little to reduce the rate of new infection, but does ensure that people are sicker, and require more medical attention and expenditure, when they start treatment. The choice is not about spending much more or considerably less money on HIV treatment – it is about attempting to eradicate HIV over the next two generations, or accepting endemic levels of HIV infection, quite probably for many more generations.

Dilated cardiomyopathy

Two papers^{3,4} and an accompanying editorial⁵ by Lionel Opie provide insights into the nature and management of dilated cardiomyopathy (DCM) in South Africa.

DCM is defined by the presence of left ventricular systolic dysfunction and dilatation in the absence of abnormal loading conditions (e.g. hypertension or valve disease) or coronary artery disease sufficient to cause global systolic impairment. DCM is an important cause of heart failure and a common indication for heart transplantation. Most cases of DCM are thought to be sporadic or acquired. Familial (inherited) DCM may account for 20 - 50% of DCM in Western populations.

The studies found that familial DCM affects at least a quarter of African patients with DCM, presents at a young age, is associated with peripartum cardiomyopathy, and follows an autosomal dominant pattern of inheritance in the majority of families. Family screening for familial DCM is indicated in all cases of unexplained DCM, including patients with peripartum cardiomyopathy.

While DCM occurs at any age, it is most common in the 3rd and 4th decades of life. Two-thirds of patients with DCM, especially those over 55 years of age, have persistently low arterial pressure, ventricular arrhythmias and/or atrioventricular valve incompetence and die within 5 years of their first symptom. The authors confirm that DCM occurs twice as commonly in men as women.

The results of the retrospective analysis suggest that clinicians should refrain from blanket prescription of digoxin for all DCM patients without monitoring digoxin levels. Opie notes that the therapeutic-toxic window of digoxin is narrow and that it is not considered safe as a last-minute measure in patients with advanced heart failure referred for transplant therapy. After discussing the digoxin cautions before use and its contraindications, Opie concludes that 'before using digoxin, be fully convinced that this potentially lethal drug is essential'.

Increasing proportion of MRSA in Botswana

The epidemiology and changes of antimicrobial susceptibility of *Staphylococcus aureus* were studied in skin and soft-tissue infections (SSTIs) at a tertiary hospital in Botswana by Truong and colleagues.⁶ Their study revealed an increasing proportion of methicillin-resistant *S. aureus* (MRSA) and high levels of MRSA resistance to commonly used antibiotics. It resulted in the revision of Botswana's national antibiotic guidelines. The authors also recommend trimethoprim-sulfamethoxazole (TMP-SMX) susceptibility testing of all *S. aureus* SSTI isolates, improved hospital infection control practices, and vancomycin availability in district hospitals.

JPvN

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3. Ntusi NBA, Wonkam A, Shaboodien G, Badri M, Mayosi BM. Frequency and clinical genetics of familial dilated cardiomyopathy in Cape Town: Implications for the evaluation of patients with unexplained cardiomyopathy. *S Afr Med J* 2011;101:394-398.
4. Ntusi NBA, Badri M, Gumedze F, Wonkam A, Mayosi BM. Clinical characteristics and outcomes of familial and idiopathic dilated cardiomyopathy in Cape Town: A comparative study of 120 cases followed up over 14 years. *S Afr Med J* 2011;101:399-404.
5. Opie LH. Dilated cardiomyopathy and potentially deadly digoxin. *S Afr Med J* 2011;101:388-390.
6. Truong H, Shah SS, Ludmir J, et al. *Staphylococcus aureus* skin and soft-tissue infections at a tertiary hospital in Botswana. *S Afr Med J* 2011;101:413-416.