



Fig. 1. Renal biopsy Masson trichrome x 400: collapsing focal and segmental glomerulosclerosis. Note the collapse of the glomerular tuft (1) and the intense vacuolisation of the podocytes (2).

to us likely. Indeed vacuoles in tubules, known to be related to VPA toxicity,¹ were also found in the glomeruli. These vacuoles might have originated the collapse of the glomeruli. Furthermore VPA toxicity is related to time exposure but not to blood level and occurs through lipid peroxidation,⁴ and our patient had been using VPA for several years. Chronic renal failure could have also magnified VPA toxicity through production of peroxides. Acute pancreatitis occurring at the time of oedema suggests renal damage by VPA as pancreatitis can occur after VPA.⁵ In conclusion, long-term use of VPA could lead to CFSGS. Assessment of renal function in this setting must be mandatory. When renal dysfunction is present, preferring another antiseizure drug is highly advisable.

Clement Ackoundou-N'guessan

Nephrology Unit
Yopougon Teaching Hospital
Abidjan
Ivory Coast
cnaackoundoun@hotmail.com

**Bernard Canaud
Hélène Leray-Moragues**

Nephrology Unit
Lapeyronie Hospital
Montpellier
France

Dominique Droz

Pathology Unit
Saint Louis Hospital
Paris

Pierre Baldet

Pathology Department
Lapeyronie Hospital
Montpellier
France

Michael Pages

Neurology Unit
Lapeyronie Hospital
Montpellier
France

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Mosvold Hospital ARV programme

To the Editor: Mosvold Hospital is a 250-bed government district hospital in northern KwaZulu-Natal. It has a catchment area of 110 000. The HIV-positivity rate for the area, as determined by prevention of mother-to-child transmission (PMTCT) statistics, is 28%.

The antiretroviral (ARV) programme at Mosvold Hospital began on 16 September 2004. By 7 December the first 100 patients had commenced treatment and by 30 October 2006, 1 400 had been started on ARVs.

The programme has gone through many changes. It started as a hospital-based programme, but after 3 months it was changed to a decentralised, clinic-based programme. A new ARV prescription card was developed allowing easy follow-up of patients, results and side-effects. Initially we only allowed a certain number of patients to start each month, but this was changed to a 'no waiting list' policy after a few months. A HAST committee was developed and continues to meet on a monthly basis, a new database was developed, and an ARV policy manual was developed and distributed to clinics.

Of the first 100 patients started on ARVs, 89 are still on the programme and in the district. Of those who left the programme, 8 died, 1 defaulted medication, and 2 transferred out of the district to return to work.

Of the 8 patients who died, 5 were identified as at high risk at the time of commencing medication according to one or more of the following criteria: (i) CD4 count < 50 cells/ul; (ii) World Health Organization stage 4 disease; (iii) new opportunistic infection in the month before starting ARVs; (iv) haemoglobin level < 8 g/dl; and (v) on intensive-phase tuberculosis treatment.

Of the 3 lower-risk patients, 1 died as a result of suicide, 1 as a result of clinically diagnosed lactic acidosis (at that time we were unable to measure lactate levels), and 1 as a result of immune reconstitution syndrome.

Of the remaining 89 patients, 76/89 (85%) have viral loads < 400 on their 18 - 24-month blood work; 5/89 (5.6%) have viral loads 400 - 5 000 (3 of these are children who are thriving); 5/89 (5.6%) have levels that would allow them to be considered for regimen 2; (one has changed and is doing well; the others have



adherence and alcohol issues); and 3/13 have not had their bloods done.

We believe that these results are encouraging and represent what is possible at a rural public hospital.

Jane Fleet

CMO, Mosvold Hospital
Private Bag X 2211
Ingwavuma, KwaZulu-Natal
janefleet@hotmail.com

Health and social scientists need to weigh in

To the Editor: In South Africa, a substantial segment of the population is overweight.¹ In 2000, non-communicable diseases (NCDs) accounted for 37% of deaths among adults² and this figure is rising alongside expanding waistlines. Overweight children are twice as likely to have elevated blood pressure, 13 times more likely to have elevated insulin levels, and 7 times more likely to have higher triglyceride levels.³ This noxious cocktail of risk factors predisposes overweight young people to develop NCDs as adults.

The Birth to Twenty (Bt20) cohort⁴ found that more than 70% of black female caregivers were overweight, and a staggering two-thirds of these adults were obese. Also, 9% of black female adolescents at age 13 were overweight and an additional 6% were obese.

We need evidence-based research that tackles the social epidemiology of obesity. There is no published South African research incorporating joint insights from both social and health science theory. We need to move towards a more comprehensive local model of obesity causation – properties of food (portion size, energy density, sugar-sweetened beverage intake); socio-economic factors (transportation, food pricing and availability of food choices, sedentary work, child care arrangements); home-environmental influences (parental role modelling, family meals, crèche, school meals, TV viewing); and eating behaviours (snacking).

Consider this Bt20 scenario: an adolescent living in Soweto uses public transport to school as her mother can't afford a bicycle and it's not safe or 'cool' to ride. She has R10 for lunch, which she spends on a sweetened beverage and a packet of potato chips. There are few sports facilities at school and physical education is not promoted, and consequently she doesn't participate in any school sport. At home she watches the afternoon 'soaps' and snacks on sandwiches. She strolls down the street to meet up with her friends, but engages in little other home-based physical activity. Her mother, who is obese and has high blood pressure, gets little exercise other than walking to and from the taxi rank and local grocery store. With her modest

income she prepares a usual dinner – stiff maize-meal with fatty bones fried in oil and made into gravy. After dinner she has her fourth cup of coffee for the day with 3 teaspoons of sugar and watches some television while doing the ironing.

This may seem over-simplistic, but this daily scenario is commonplace and is placing young urban adolescents, especially girls, at high risk of developing obesity-related diseases. If social and health scientists do not work together to understand and combat the complex aetiology of obesity by imparting information to health professionals, educators and parents, then the South African NCD burden will increase unabated.

Nina S Lewin

Birth to Twenty Research Programme
Department of Paediatrics
University of the Witwatersrand
Johannesburg
lewinn@medicine.wits.ac.za

Shane A Norris

Birth to Twenty Research Programme
Department of Paediatrics, and
MRC Mineral Metabolism Research Unit
University of the Witwatersrand
Johannesburg

Linda M Richter

Child, Youth, Family and Social Development
Human Sciences Research Council
Durban/Pretoria

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Surprise 'social status' finding in rape study

To the Editor: The recent Izindaba report entitled above refers.¹ The link between higher levels of maternal education and the perpetration of rape by these women's sons in the rural Eastern Cape is worth comment. The explanation given by the members of the community advisory board was that the reported situation is due to the higher social status of the mothers in a society that has relatively few men because of premature death and migratory labour.

This begs the question as to why young men from families of higher social status would engage more frequently than their peers in violent crime against women and girls in their own community. After all, young men from poorer families suffer from the same absence of father figures in the