



IN MEMORIAM

Bruce Merton McIntosh (1919 - 2005)

Dr Bruce McIntosh ('Dr Mac') died on 16 April 2005 at the age of 86. Bruce was born on 23 February 1919 in Durban, KwaZulu-Natal. He spent his childhood and youth on the family farm near Harding on the southern KwaZulu-Natal coast. It was here that he developed his love for natural history, particularly ornithology, which would prove so useful in his subsequent career. He matriculated at Maritzburg College, Pietermaritzburg and in 1942 he graduated as a veterinarian at the University of Pretoria. In the same year he married Virginie (Veenie) Forder. During World War II he served as a lieutenant in the South African Veterinary Corps and saw active service in the Indian Ocean and the Far East. After demobilisation he joined the Government Veterinary Service in Port Shepstone but later joined the Veterinary Research Institute at Onderstepoort in Pretoria as a virologist. There he identified the various serotypes of African horse sickness (AHS) virus, and was awarded a D VSc degree by the University of Pretoria in 1955. In 1955/56 he was a postdoctoral researcher at the Animal Virus Research Institute, Pirbright, England, where he undertook further work on the AHS virus. His work still stands as the basis for the classification of AHS viral strains today.

In July 1960 the last Rockefeller staff members returned to the USA from Johannesburg where they had established an Arbovirus Research Unit jointly with the South African Institute for Medical Research (SAIMR) at the laboratories of the Poliomyelitis Research Foundation (PRF). Bruce had been taken on as a virologist in this unit in 1957 and was made head of the unit in 1960. He and his colleagues did pioneering work isolating many new arboviruses, especially from mosquitoes collected in the Ndumu Game Reserve in northern KwaZulu-Natal. From 1960 until his retirement in February 1982, he led the unit in research focused on the ecology and epidemiology of particular arboviruses that had been shown as important causes of medical and/or veterinary disease. These included West Nile, Sindbis, chikungunya, Wesselsbron and Rift Valley viruses. During this period the Department of National Health took over the PRF laboratories, so that the Arbovirus Unit became part of the National Institute for Virology. Bruce also served as an honorary senior lecturer in tropical medicine at the University of the Witwatersrand and published numerous original papers in a variety of scientific journals.

Bruce and his colleagues did field studies throughout southern Africa and these were combined with the relevant laboratory work to determine the natural transmission cycles of the arboviruses concerned. Although primarily a virologist, he also took a keen interest in the entomological aspects of arboviral research and became a competent mosquito taxonomist. Before retiring in 1982, Pretoria University awarded Bruce a DSc degree for a thesis entitled 'The epidemiology of arthropod-borne viruses in southern Africa'.

On his retirement Bruce returned to Port Shepstone, where he became enthusiastically involved in nature conservation. He was able to devote more time to his two great interests: bird watching and wildlife. He made a major contribution to the bird atlas project for southern KwaZulu-Natal.

It is a tribute to his congenial nature that there were always staff members of other units who wanted to transfer to the Arbovirus Unit! Bruce will be fondly remembered by his colleagues in arbovirology, entomology and veterinary science. He leaves behind three children Judy, David and Peter, eight grandchildren and one great-grandchild.

Peter G Jupp

Formerly Entomologist to the Arbovirus Research Unit

Robert Godfrey (Bob) Saner



Bob Saner died at the age of 85, after a lifetime devoted to the care of his patients. In all, he was in practice for 57 years, most of the time as physician.

He was educated at Potchefstroom Boys High and later studied medicine at the University of the Witwatersrand Medical School. His studies were interrupted by army service in the

Medical Corps (Mobile Laboratory Section) but he returned to the Medical School to complete his degree (MB BCh) before joining the South African Defence Force. While serving in the army, Bob worked under Professor James Gear and produced scientific papers on the production of various vaccines.

He also acted as a volunteer in a study to find ways of alleviating thirst in survivors of the many ships sunk by enemy action. As a result, he received a special commendation from the Director of Medical Services. On discharge from the army he trained as a medical registrar at Baragwanath Hospital, which had been reopened as a civilian hospital and he received an MD (Wits) in 1952. He then spent a year in Edinburgh and was elected a Member of the Royal College of Physicians (1954) and later a Fellow (1971). On his return to South Africa, he joined Dr Fred Reid and Dr Alf Tinker in their specialist practice, an association that was to continue for 37 years.

In addition to his private practice, Bob was a member of the part-time staff of the Department of Medicine for many years and with Dr Ray Dando took the initiative of setting up a chemotherapy service, a prescient forerunner of the department's large oncology division that was developed in later years. Bob's approach was, as always, a holistic one and he became a staunch advocate and supporter of the Hospice movement in South Africa.

Bob was a founder member of the College of Medicine of South Africa, and was actively involved in Medical Association





affairs, serving as Chairman of the Southern Transvaal Branch and as a member of the Federal Council. He was also involved in the modernisation of ambulance services and spent many hours lecturing to aspirant paramedics. Another interest was the Johannesburg Clinical and Pathological Club, started by his father and later called the John Saner Club. In due course, Bob became its chairman.

While this brief résumé gives some idea of the range of Bob Saner's interests, it does little to define the special nature of his contribution. In an environment increasingly dominated by technology and material considerations, Bob practised old-fashioned medicine, totally in tune with the proud traditions of the past. His compassion and commitment, coupled with considerable clinical abilities and absolute professionalism, endeared him to his patients and earned the deep respect and affection of his colleagues and friends.

Bob's family life was a happy one. He was an avid sea and trout fisherman and loved nothing more than a good red wine and an after-dinner tawny port in the company of friends. He also spent many rewarding hours as an oil painter and exhibited his pictures on several occasions. He is survived by his beloved wife, Jane, and three children.

TH Bothwell

MIXED BAG

Treating asthma

Asthma is an increasingly common disease and one that most GPs and specialist physicians will have plenty of experience of. But, as an asthmatic myself, I know that often, both the doctor's expectation of what constitutes good asthma treatment and the patient's expectations of what life is like with asthma, fall far short of what can actually be achieved. For most asthmatics, a completely normal life should be possible, with the correct medication. Recent studies of patients' priorities for asthma care showed a recurrent theme – the importance of the doctor-patient relationship. According to an article in a recent edition of the *Medical Journal of Australia*, improving the implementation of the asthma guidelines requires not only insights into the perspectives of those living with asthma, but also an understanding of what GPs priorities are for achieving optimal outcomes in people with asthma and the barriers they feel they face in delivering this care.

Diane Goeman and her colleagues set out to answer the question, 'What do you think is needed to achieve best outcomes in people with asthma?' They used something called the nominal group technique, a highly structured meeting that is used to gain information from experts about a particular issue. The study was carried out between August 2002 and September 2003. Forty-nine GPs, 34 from urban areas and 15 from rural areas, split into 6 groups, were asked to participate. All the groups nominated asthma education for patients and continuing professional education for GPs as major priorities.

They also described problems with meeting these priorities. Other priorities were adherence to medication, facilitating regular patient review, negotiated treatment/management plans, making the correct diagnosis, being paid more for asthma care and having more consultation time and safer asthma medications and access to these. Health promotion initiatives and increased public awareness were also cited as priorities. Most GPs admitted being uncomfortable using spirometry and written asthma action plans were not a high priority.

This study identified gaps between current asthma guidelines and Australian GPs' priorities for optimal asthma care. The top priorities identified by GPs are not given the same prominence in local asthma guidelines. The authors suggest that, to deliver asthma care according to GPs' priorities, broader issues such as facilitating relationships with patients, making an accurate diagnosis, establishing a patient recall system and finding the time to provide asthma education, need to be addressed. Although there was broad support for asthma management plans, GPs did not see written asthma action plans to deal with severe exacerbations as a priority. This is consistent with studies from Britain that show a decline in the use of these management plans in the UK.

Spirometry is recommended to improve diagnosis and also to help patients to comply with treatment. However, many GPs thought that spirometers were too expensive to have in their practices and were also underconfident in using them, particularly those from rural areas, where spirometers might be even more useful because of lack of easy access to specialists.

The bottom line appeared to be that GPs were delivering asthma care in the way that they found easiest and not necessarily according to the asthma treatment guidelines. This may be fine, if most GPs are managing to control their asthmatic patients so that the patients seldom have exacerbations. However, my experience of treating asthma in primary care, both here in the state system and in Britain, is that asthma patients are generally treated suboptimally and suffer unnecessary exacerbations. Asthma is, to me, a poorly understood disease. Some years ago I heard a specialist respiratory physician speak almost disparagingly of the long-acting bronchodilators that I have been using for the past decade and which have transformed my life as an asthmatic. Hopefully, increasing experience of their use has changed his mind. But herein lies the problem. Asthma treatment has improved beyond all recognition in the past decade. All but the most brittle asthmatics should now be able to live a completely normal life, with no exacerbations at all if they are on the correct medication and with completely normal effort tolerance. My experience is that few doctors, let alone the asthmatics themselves, expect this as the main outcome of treatment. Symptoms are expected and regarded as normal. I would have been very interested to have taken part in the group discussions to see exactly where it was that the GPs felt they and their patients lacked information and understanding.

Goeman DP, et al. *MJA* 2005; 183: 457.

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Sedatives and the elderly

An elderly acquaintance of mine has found it increasingly difficult to sleep through the night over the years. I am sure that there is a treatable component to his insomnia, such as depression, but, not being his doctor, I have not had the chance to do anything about this. What has happened, however, is that he has become increasingly dependent on sedative hypnotics, although these drugs are becoming less effective as he continues to use them. This pattern of poor sleep and drug use is, I'm sure, familiar to many of you reading this. Some of you may have prescribed sedative hypnotics to your elderly patients and have no doubt found them to be of variable efficacy. We know that their use is common. Between 5% and 33% of elderly people in the USA and Britain are prescribed a benzodiazepine or a benzodiazepine receptor agonist for sleep problems. However, there is also evidence of adverse effects associated with sedative use such as ataxia, falls, and memory loss and these have the potential for being particularly problematic for older people. A recent paper in the *British Medical Journal* reports that, although there is widespread use of sedative hypnotics in older people, we have no idea whether they are actually doing any good and whether they may, in fact, be doing harm.

Jennifer Glass and her colleagues set out to quantify and compare the potential benefits, in the form of subjective reports of sleep benefits and risks, of adverse events and morning-after psychomotor impairment, of short-term treatment with sedative hypnotics in older people with insomnia. Using Medline, Embase, the Cochrane clinical trials database, PubMed and PsychLit from 1966 to 2003, they examined randomised controlled trials of any pharmacological treatment for insomnia for at least 5 consecutive nights in people aged 60 or over who had insomnia, but no other psychiatric or psychosocial disorder.

They looked at 24 studies that involved 2 417 people. These studies showed that sleep quality improved, total sleep time increased and the number of night time awakenings decreased in those who were using sedatives compared with those who were using placebo. However, the studies also showed that adverse effects were more common in those using sedatives compared with those using placebo. Adverse cognitive effects were 4.78 times more common, adverse psychomotor effects were 2.61 times more common and reports of daytime tiredness were 3.82 times more common in people using a sedative hypnotic compared with those using placebo.

The authors concluded that, while improvements in sleep in those using sedative hypnotics were statistically significant, the magnitude of the effect is small. Furthermore, the increased risk of adverse events is statistically significant and potentially clinically relevant in older people, who may be at risk of falls and cognitive impairment. So, in people over the age of 60

the benefits of these drugs may not justify the increased risks associated with their use. It is worth pointing out that the studies that were examined looked at relatively short-term use of benzodiazepines. We are all familiar with the patient who has been using 'sleeping pills' for many years. There is an all too easy acceptance of cognitive decline, unsteadiness and daytime tiredness as simply being part of 'old age'. Perhaps we should look more closely at a person's medication before making subjective judgements about what causes this apparent steady decline.

Glass J, et al. *BMJ* 2005; 331: 1169.

Bridget Farham

BOOK REVIEW

Genetic Disorders of the Indian Subcontinent

Edited by Dhavendra Kumar. Pp. xv + 579, Illustrated. £145. Kluwer Academic Publishers. 2004. ISBN 1-4020-1215-2.

In this excellent monograph, Dhavendra Kumar and forty expert contributors have provided a comprehensive overview of genetic conditions that have been identified in persons with origins of the Indian subcontinent.

The first section of this 607-page book contains accounts of the historical, social and demographic factors that underlie the rich ethnic and cultural diversity of the population of India. In the second section, specific genetic conditions or categories of heritable disorders which are of special importance are reviewed. The third and last section is devoted to the implications and management of genetic disorders in India and Sri Lanka.

The wide range of academic interests of the contributors is reflected in the content of the individual chapters. The overall standard is high, although inevitably, there is a certain amount of overlap and repetition. The quality of the printing and presentation of this hardback book is good, while the illustrations and tables are informative. The references are extensive and relevant and the idea is well formulated.

Immigrant communities in many parts of the world have ancestral links with the Indian subcontinent, and their current genetic endowment reflects these origins. For this reason, this magisterial book is relevant at an international level. The time is ripe for similar works focused on specific immigrant Indian communities; Southern Africa has a pressing need in this respect.

Peter Beighton

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