



IV phenobarbitone shock

To the Editor: It has been brought to the attention of the Executive Committee of the South African Paediatric Association that the intravenous form of phenobarbitone is no longer available in South Africa.

In August 2004 Aventis informed all provincial authorities that the worldwide production of sodium gardenal would be stopped and that it would no longer be available once stocks had been depleted.

This is a matter of great concern in terms of treating children in South Africa, especially those who present with epilepsy, in particular status epilepticus. In general, as far as developing countries are concerned, the action of Aventis cannot be defended. It would have been far better had they made sure that alternative arrangements were available in Africa before unilaterally withdrawing sodium gardenal.

Intravenous phenobarbitone has proved to be highly effective, it is safe and cheap, it can be given in repeated doses by rapid push-in, and it is currently recommended on all the international APLS guidelines for the treatment of status epilepticus. We have been informed that intravenous phenytoin or lorazepam are proposed alternatives. These drugs would not pose a problem in tertiary settings, but at primary and secondary level intravenous phenobarbitone is easy to administer with relatively few complications, and needs to be available.

The decision by the World Health Organization (WHO) to remove intravenous phenobarbitone extensively without consultation in developing countries, especially in Africa, is also disconcerting. It is strongly advised that this matter be reconsidered and that dialogue be initiated with the WHO on this issue.

Phenytoin and lorazepam have been suggested as alternatives. Intravenous phenytoin has to be administered over a long period of time via a syringe driver and requires an intravenous line, which may not always be possible in rural settings. Cardiac monitoring is recommended because of cardiac arrhythmias. It cannot be repeated once given and it may not be as affective as phenobarbitone.

Lorazepam, on the other hand, is dangerous as a follow-up after 2 doses of short-acting benzodiazepine because respiratory depression is very likely. Again, this would be a problem in primary and secondary settings where there are no facilities to ventilate children. It is also markedly expensive compared with intravenous phenobarbitone.

It is therefore clear that intravenous phenobarbitone remains the mainstay of first-line treatment for status epilepticus, especially in the primary and secondary health care settings, where the majority of children in South Africa are managed. Phenobarbitone is still manufactured by alternative companies internationally and we would support efforts to have these

products registered and distributed in South Africa as soon as possible.

Currently intravenous phenobarbitone is available as a Section 21 medication, but this is not effective or useful for the future use of intravenous phenobarbitone for the children at risk.

We urge the Department of Health to take cognisance of the problem, and we would support any initiative from the Central Department of Health to address this medical crisis in the management of status epilepticus in children.

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'Found guilty' – an unjust outcome?

To the Editor: A well-respected surgical colleague was recently found guilty by the Health Professions Council of South Africa (HPCSA) on 5 of 8 charges after complications arose from a laparoscopic procedure for gastric reflux. Sentence was delivered on Friday 14 October, where he was cautioned and discharged.

As an anaesthesiologist I have witnessed many of these procedures by a wide variety of surgeons and my comments are based on personal experience. Looking at those who made up the bench for this hearing (a general practitioner, a community medicine doctor and a retired surgeon), I'm surprised that they did not include a surgeon *actively* involved in this type of surgery.

Together with all my colleagues currently engaged in laparoscopic surgery in Cape Town, I am devastated by the outcome of the hearing. Knowing what happened, and the steps taken to manage events, we can only assume that inexperienced people are, unfairly to themselves, being appointed to sit at these hearings.

The complications that arose in this case are well known to those involved in laparoscopic surgery. There is nothing disgraceful about a wrong clinical decision ... it is human. The unfortunate surgeon, who is highly experienced in laparoscopic surgery and well respected by colleagues, both academic and private, acted in the best interests of the patient. He sought advice and the problem was eventually resolved. The patient had a traumatic postoperative course but fortunately survived the ordeal and I believe is now fit and healthy. I have a sneaking suspicion that this case represents an attack on laparoscopic surgery by those who seem to have very little insight into the specialty.

A surgeon's decision may not always be correct, but to be found guilty of unprofessional conduct and to be accused of belated surgical action, failing to recognise the clinical course