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

in the postoperative period and bringing the profession of specialist surgeon into disrepute is provocative and laughable. I'm surprised that this hearing favoured the 'expertise' presented by a retired surgical academic, who by his own admission had done very little laparoscopic surgery, over that of a professor and a specialist intensivist currently at the top of their careers. Surely experienced medical personnel should be appointed to hear public grievances? Those of us who are members of the Medical Protection Society (MPS) are concerned that in a case like this the legal representatives failed dismally. This case should have won hands down.

There is a perception among the lay public and litigation lawyers that as most of us have some form of medical protection there's no harm in 'having a go'! MPS reports suggest that medicolegal claims in South Africa have escalated way above rates in the rest of the world. It is my impression that we in clinical medicine are seen as an easily milked cash cow. We are under continual pressure from medical aids, hospital groups and the media – and now our very own HPCSA.

I sincerely hope that the colleague in question has the stamina to exercise his rights and appeal against the findings of the HPCSA, and that his surgical association reacts strongly to this disgraceful decision.

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Well done, SAMA's Industrial Relations Unit!

To the Editor: It is reassuring to know that the South African Medical Association, through its Industrial Relations Unit, has the capacity to assist doctors, especially hospital doctors, should any have reason to believe that they have been subjected to unfair labour practices.

My own experience is that about 3 years after retirement I was phoned by the hospital concerned and told that I had received a salary increase some 2 or 3 years before retirement for which I had not been paid. I was told that if I supplied my bank details I would be paid. Having heard nothing for a year I made further enquiries, only to be told that the provincial health department concern had no money.

I had no recourse other than through the SAMA Industrial Labour Unit, which was entirely successful in obtaining my back pay.

I don't hesitate to recommend to all doctors that they should become SAMA members, for this and many other reasons!

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Selective serotonin reuptake inhibitors in children and adolescents

To the Editor: The introduction of the selective serotonin reuptake inhibitors (SSRIs) was widely viewed as an important advance in clinical psychopharmacology, not only because of their broad-spectrum efficacy but also because of their tolerability and safety advantages, particularly compared with the older tricyclic antidepressants (TCAs) and monoamine oxide inhibitors (MAOIs). Subsequently there has been considerable controversy about this class of agents, partly because of concerns about the extent to which they have been injudiciously prescribed for 'cosmetic' problems rather than for genuine psychopathology,[1] and partly because of concerns regarding their adverse effects. Most recently, attention has been paid to the appropriate use of SSRIs in children and adolescents.

The 'Drug Alert' published by the National Adverse Drug Event Monitoring Centre in the September 2005 SAMJ[2] is singularly unhelpful in this regard. The report takes a far more conservative stance than that taken by regulators in the USA, the UK and the EU; it may be misleading by implication and omission; and (if followed to the letter) it may cause child and adolescent psychiatric patients significant harm.

The 'Drug Alert' warns practitioners on four points. First, 'None of the SSRIs are currently approved in South Africa for any indication in children and adolescents.' It should be pointed out, however, that fluoxetine is registered with the US Food and Drug Administration (FDA) for child and adolescent depression and several of the SSRIs (fluvoxamine, sertraline, and fluoxetine) are also FDA-registered for child and adolescent obsessive-compulsive disorder (OCD).[3] Practitioners should also be aware that decisions about whether to submit pharmaceutical agents to the Medicines Control Council for registration of particular indications may often be made on the basis of cost rather than scientific or clinical considerations.

Second, 'SSRIs have been associated with an increase in the risk of suicidal thinking and behaviour (suicidality) in children and adolescents with MDD [major depressive disorder] and other psychiatric disorders.' However, as the drug alert also states, 'no suicides occurred' in the 24 trials involving over 4 400 patients. In addition, a systematic review[4] published recently found no significant difference in the risk of suicide in patients taking SSRIs compared with those taking TCAs. As several commentators have pointed out, patients with overt suicidal ideation are excluded from clinical trials and the heterogeneous nature of the trial designs employed (use of different definitions and assessments of self-harm in different study populations) further contributes to the difficulty of interpreting the data. The trials quoted were not designed to address the question of whether SSRIs increase suicidal ideation, and cannot in fact do so.[5]