Vuvuzelas: Ex Africa semper aliquid novis – again?

To the Editor: The vuvuzela, or lepata (Tsawa), or ‘stadium horn,’ has recently become an object of intense interest because of its prominence during the FIFA World Cup in South Africa. Its history has been well documented. We all now know what a vuvuzela is. Its monotonous sound, if produced simultaneously by, say, 40 000 soccer enthusiasts, can fill an entire stadium for hours on end, to the intense irritation of players, coaches, non-participating spectators, TV audiences, and many more (for miles around the stadium).

The impact of the vuvuzela on the human ear has recently been studied, and the recreational risk that vuvuzelas pose to spectators in a stadium is significant. It may also disseminate droplet-spread infections and be used as a weapon by soccer hooligans; among other things, it has been described as ‘an instrument from hell.’

Despite these negatives, Mr Sepp Blatter felt that ‘We should not try to Europeanize an African World Cup ... that is what African and South African football is all about – noise, excitement, dancing, shouting and enjoyment.’ Therefore, as a voice of moderation in favour of the accursed instrument, FIFA permitted the vuvuzela to be used in the 2010 WC stadia. And the 2010 FIFA WC went off well. A minimum of crime was reported, and no significant soccer hooliganism. There was even a respectful hush before each national anthem.

The system is also potentially labour-intensive, with the assessment of toxic granulated neutrophils requiring experienced clinical practice. However, there are some points of concern. Firstly, the assessment of toxic granulation must be based on experienced clinical microscopy; this might not be available in rural hospitals. Secondly, there are many confusing factors that can affect the CRP level, and this aspect was not totally controlled in the article.

Dr Van de Vyver replies: Laboratory confirmation of the presence of inflammation can be problematic in certain settings. This is a particular issue in settings where anti-inflammatory drugs – especially corticosteroids – are administered. In this setting, a combination of assays is usually employed to provide a cumulative impression of the presence or absence of infection or inflammation. C-reactive protein (CRP) is a widely utilised assay in the evaluation of inflammation. As with most immune assays, various factors can theoretically interfere with the final value reported. However, this seems to be a significant problem with highly sensitive assays (measuring levels below 10 mg/l) as opposed to assays measuring levels in excess of 10 mg/l.

We agree that assessment of toxic granulated neutrophils requires an experienced technologist, unfortunately not generally available in rural areas. The system is also potentially labour-intensive, with reproducibility highly dependent on the training of the examiners. Toxic granulation can only serve as an additional tool to assess the presence of infection if there is diagnostic uncertainty. As a single parameter, it is of limited diagnostic value and can serve purely as a contribution to other infective markers.