Management guidelines for common kidney disorders relevant to South Africa

To the Editor: World Kidney Day (WKD), an annual event, is celebrated on 8 March 2012. As a project for WKD, the National Kidney Foundation of South Africa (NKFSA) has arranged for a group of experienced senior nephrologists from around the country to contribute to a guideline booklet presenting the diagnosis and state-of-the-art management of renal disorders. Its main aim is to educate and update general practitioners, but it should also be useful for under- and postgraduate students, urologists and specialist physicians.

The guideline is being edited and will be sent to the South African Renal Society for their endorsement. We aim to publish the guideline as a supplement to the South African Medical Journal. We thank the contributors to and supporters of the project, and the National Lotteries Distribution Trust Fund for financial support towards the initial draft copy of the guideline.

A M Meyers
Chairman, National Kidney Foundation of South Africa

Fanie du Toit
Administrator, NKFSA
nkfsa@mweb.co.za

Correspondence


Health professionals should be speaking out about the victimisation of doctors in Bahrain

To the Editor: Doctors in Bahrain who treated people wounded during and after demonstrations have been arrested, tried by a military court and given sentences of up to 15 years’ imprisonment. A report by the Physicians for Human Rights recounts the result of an on-the-spot inquiry as follows: ‘Our investigators spoke to eyewitnesses of abducted physicians, some of whom were ripped from their homes in the middle of the night by masked security forces ... [the report] documents other violations of medical neutrality, including the beating, abuse and threatening of Shi’a physicians at Salmaniya Hospital; government security forces stealing ambulances and posing as medics; the militarisation of hospitals and clinics, thus obstructing medical care; and rampant fear that prevents patients from seeking urgent medical treatment.’ Most of the doctors are women, and there have been reports of torture, including electrocution and threats of rape while in detention.

These accounts are shocking and remind South Africans of a sorry history where human rights abuses at the hands of security forces were allowed to go unchecked and where the health sector was drawn willingly and unwittingly into violations of the rights of patients and professionals. Not surprisingly, there has been sustained outcry from the medical profession in other parts of the world. Following the exposé by Physicians for Human Rights for Human Rights, and pressure by the World Health Organization and the World Medical Association, it was announced by a civilian court that some charges against 20 health professionals would be dropped and that a new trial would begin to assess the allegations.

We ask why there has been so little outcry in South Africa, a country whose history should make it acutely aware of the consequences of the political abuse of doctors. The South African Medical Association released a Medigram reporting the resolution of the WMA, but has not taken any proactive steps to champion the cause of the persecuted doctors. Why has SAMA not been more active? Why have members of the medical profession not seen it as their ethical obligation to take action in solidarity with colleagues, if only to press our government, a member of the UN Security Council, to take diplomatic action? One of the consistent findings of research into complicity of health professionals in human rights abuses has been the effect of isolation and a failure to stand up for colleagues under threat, a finding echoed in the conclusions of the Truth and Reconciliation Commission. It appears that since the late 1970s we have not learnt sufficiently the importance of health professionals speaking truth to power. One of us (SS) wrote to the President of SAMA, urging SAMA to take action, to which there was not even an acknowledgement. South Africans deserve better.

Stuart Saunders
Emeritus Professor
University of Cape Town

Leslie London
School of Public Health and Family Medicine
University of Cape Town
leslie.london@uct.ac.za

Side-effect of acetazolamide in prevention of acute mountain sickness

To the Editor: The scientific letter by Firth et al.1 about the side-effect of acetazolamide on a hiker on Mt Kilimanjaro makes a rather hasty conclusion about the recommendation of acetazolamide to prevent acute mountain sickness (AMS), especially in a rapid ascent climb such as Kilimanjaro. It is difficult to disagree about the effect of acetazolamide on a hiker on Mt Kilimanjaro as a prophylactic of AMS; this effect (if indeed it is) in this report, it would not be justifiable to prevent AMS during the very rapid ascent profiles typical on Kilimanjaro to impairment of corneal endothelial function.1 Although we described complication, this appears to involve different mechanisms as induced myopia with low doses of sulphonamides is a rare but well-known effect of acetazolamide during gradual ascents be abandoned on the basis of this report; rather, the possible causes of a problem should be identified and removed if symptoms occur. Hence, we should continue using acetazolamide with caution for preventing AMS where there is rapid ascent profile.

Matiram Pun
Specialization Program in Mountain Medicine and High Altitude Physiology
Department of Medical Sciences
Faculty of Medicine
University of Calgary
Calgary, Canada
mpun@ucalgary.ca

---

Firth, Gray and Novis reply: We thank Dr Pun for his comments. The climber did not remember the dose she took, but thinks it was 250 mg daily by mouth, starting on the ascent. While painful drug-induced myopia with low doses of sulphonamides is a rare but well-described complication, this appears to involve different mechanisms to impairment of corneal endothelial function.1 Although we pointed out that a causal pathophysiology was not demonstrated,2 we therefore speculate that the interaction of drug effect with rapid ascent played a role.

Irrespective of the pathophysiology, it is prudent to discontinue a drug if adverse side-effects occur after dosing. Similarly, if symptoms occur following rapid ascent, it is sensible to remove the possible cause by rapid descent. The onset of visual disturbances should therefore prompt discontinuation of the possibly offending drug and to consider descending.

Although the effectiveness of acetazolamide in preventing AMS during the very rapid ascent profiles typical on Kilimanjaro is debatable,3 we do not suggest that the prophylactic use of acetazolamide during gradual ascents be abandoned on the basis of this report; rather, the possible causes of a problem should be identified and removed if symptoms occur.

---