Taking our journals in tablet form

The long-promised ability to take our medical journals in tablet form is now a reality. The *SAMJ* and all other journals in the stable have been, and will continue to be, accessible online; but this is more suited for researchers who wish to find specific articles than for general readers. The *SAMJ* is now available in a much more user-friendly format, on the Ipad initially and shortly on Android devices. This model also allows inclusion of active visual material that can, for instance, demonstrate a particular medical technique. Want yours? The app is in the App Store on the iPad (search for 'SA Medical Journal' to get a direct hit). The address via iTunes, on a web browser, is:
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Eastern Cape doctors still facing the ghost of Biko?

Dual loyalties. The words still send a chill tremor up the spines of several doctors approaching and past middle-age who lived through some of the worst years of apartheid. Security police and the government bullied many of them into silently selling out on their Hippocratic Oath when it came to the care of activist patients. Who would have thought that senior specialists today in several tertiary hospitals across the country would be facing a similar dilemma: staying silent about the lack of now constitutionally-obliged official support for patient care (critical clinical posts frozen, dysfunctional administrations, equipment failure and lack of maintenance, underlying corruption … the list is endless); or speaking out and face possible censure via a raft of regulations on media contact? The issue remains the same – dual loyalties. Earn yourself a name as a rebel, and it can be career-limiting. Politicians hate being embarrassed. In *Izindaba*,[1] Chris Bateman looks at three 'rebel' specialists in the Port Elizabeth Hospital Complex who're threatened with disciplinary action for holding a press conference about adapting their practices to optimise patient care within hugely constrained contexts. We ask: Why is a more pragmatic patient-centred balance not possible within a primary healthcare-favouring budget policy?

Diets, weight loss and obesity

Bookshelves are always filled with fads and fancies about weight-loss diets and what we're supposed to eat for optimum health. Worldwide, the 'diabesity' epidemic has resulted in an upsurge in public interest and debate on the matter. Three contributions in this issue[2-4] provide a balanced approach to different aspects of dietary issues that are often more influenced by beliefs than by empirical facts.

Cardiovascular health and diet

In his editorial, Derick Raal[2] re-affirms that excessive carbohydrate intake (particularly the refined carbohydrates in sugary drinks and energy snacks) is behind the epidemic of overweight, obesity and type 2 diabetes mellitus (T2DM). However, he states that it is wrong to conclude that high carbohydrate intake is the major cause of atherosclerosis. He cites that patients with familial hypercholesterolaemia – who if untreated develop severe atherosclerosis and often die prematurely from cardiovascular disease (CVD) – would have marked insulin resistance, which they do not. Small dense low-density lipoprotein cholesterol (LDL-C) particles, typical of the metabolic syndrome or T2DM, are thought to be more atherogenic. And many studies have shown that the more LDL-C is lowered, the lower the coronary artery disease risk.

Raal urges us not to 'throw out the baby with the bathwater'. Statins are safe and have shown benefits in lowering LDL-C levels, and high-risk patients should not be denied their undoubted benefit. A sedentary lifestyle, plus excess calorie intake – whether in the form of protein, carbohydrate or fat – is the major cause of the 'diabesity' epidemic contributing to, but not causing, atherosclerosis. Restricting refined carbohydrate assists in short-term weight reduction. However, it is incorrect, and potentially harmful, to advocate substituting refined carbohydrates with fats – particularly saturated fats.

Weight loss and avoiding obesity

Obesity is a multifactorial condition caused by overconsumption of food and complex interactions of biological, social, economic, environmental and psychological factors. In her contribution, Maria Catsicas[3] crisply outlines current knowledge on the subject. In achieving weight loss, long-term studies have shown that diet adherence, length of intervention and level of calorie restriction were far more important than adherence to a very low-carbohydrate regimen. Food variety, individual lifestyle constraints and social and cultural aspects must be addressed in weight-loss strategies.

The substitution of saturated and trans-fats with unsaturated fats rather than carbohydrates is recommended, as this contributes to a reduction in small dense LDL-C. Lower-fat and consequently higher-carbohydrate diets raise triglycerides and reduce HDL-C. Weight loss improves the atherogenic dyslipidaemia and insulin resistance that occurs concomitantly with abdominal adiposity. Low-carbohydrate diets can lead to short-term weight and metabolic improvements but offer no additional benefits to blood-lipid changes independent of weight loss. Further advice is to avoid processed meats, include nuts in the diet, and a higher consumption of fish.

Reducing sodium and high-salt foods

The high intake of salt by South Africans (8.1 g/day v. 4 - 6 g/day recommended by the WHO) contributes to an increasing burden of hypertension and cardiovascular disease. Bertram and colleagues[4] aimed to provide South African-specific information on the number of fatal cardiovascular events (stroke, ischaemic heart disease and hypertensive heart disease) that could be prevented each year by reducing the sodium content of bread, soup mix, seasoning and margarine. They found that population-wide strategies have great potential to achieve public health gains as they do not rely on individual behaviour or a well-functioning health system.

Need for a graduated driving licence

Road traffic injuries cause the death of more people aged 5 - 29 years than does HIV/AIDS. Chokotho and colleagues[5] showed a relationship between driver's mortality risk and younger age, and argue persuasively for the need to introduce a graduated driving licence programme in South Africa. The GDL is a three-phase licensing system for novice drivers consisting of a learner's permit, a provisional licence, and a full licence.

1. Bateman C. Port Elizabeth's tertiary care reaches crisis point. S Afr Med J 2012;102(9):720-722. DOI:10.7196/SAMJ.6173
2. Raal FJ. The cardiovascular health of the nation – should we be advocating a low-carbohydrate high-fat diet? S Afr Med J 2012;102(9):740. DOI:10.7196/SAMJ.6049
3. Catsicas ME. Achieving weight loss and avoiding obesity. S Afr Med J 2012;102(9):730-732. DOI:10.7196/SAMJ.6054
4. Bertram MY, Steyn K, Wentzel-Viljoen E, Tollman S, Hofman KJ. Reducing the sodium content of high-salt foods: Effect on cardiovascular disease in South Africa. S Afr Med J 2012;102(9):743-745. DOI:10.7196.SAMJ.5832
5. Chokotho LC, Matzopoulos R, Myers JE. Driver's risk profile indicates the need for a graduated driving licence in South Africa. S Afr Med J 2012;102(9):749-751. DOI:10.7196.SAMJ.5986