

## Specialist shortage and RWOPS – a potent mix

Re-building trust for workable relationships that can address complex problems in the healthcare sector has never been more vital than in the ugly, potentially debilitating Remuneration for Work Outside the Public Service (RWOPS) controversy, currently raging across academic and regional hospitals countrywide. By early May, irreconcilable differences had caused the divorce of 17 specialists from the academic hospitals of Charlotte Maxeke (anaesthetists) and Chris Hani/Baragwanath (radiologists). In *Izindaba*, Chris Bateman singles out just two provinces (Free State and Gauteng), interviewing a wide range of consultants, medical officers and departmental heads to elicit their grievances – while reflecting the attitudes and frustrations of provincial and national health officials.<sup>[1]</sup> What emerges is a toxic mix of historical neglect of specialists overworked by the state, huge skills shortages, dysfunctional and inept management – and an obviously significant minority of consultants abusing RWOPS to short-change public sector patients.<sup>[2]</sup> As Chris Hani/Baragwanath surgical chief Professor Martin Smith observes, 'we have to find middle ground very quickly' to avoid a protracted fall-out with huge implications for service delivery, training and a workable National Health Insurance. Also, how will private/public partnerships ever help overcome our quadruple burden of disease when the mere removal of RWOPS can potentially implode two major private hospitals?

## AIDS-related progressive leukoencephalopathy (PML)

Given our leading position in the HIV/AIDS stakes, it is surprising that PML has been seen so seldom in SA. One obvious reason is that we fail to recognise what can be subtle changes of motor or cognitive function in patients who are battling more acute illnesses (such as disseminated tuberculosis). Another reason may be that the clade C HI viruses that infect people in sub-Saharan Africa interact with the JC virus that causes PML in a different way to clade B viruses (common in Europe).

The paucity of reports may also reflect Africa's lack of the sophisticated technology needed to confirm a diagnosis of PML. South Africa does have this technology, involving a polymerase chain reaction method to probe the presence of the JC virus in the cerebrospinal fluid, and in the past 2 years the Department of Neurology at Steve Biko Academic Hospital in Pretoria has seen a rising number of patients with PML.<sup>[3]</sup>

## Acute kidney injury risk factors

A paper from Ethiopia from collaborating nephrologists (through an International Society of Nephrology's Sister Centre Programme established in 2010) based in Cardiff, Wales, and Addis Ababa highlights how easily a patient's quiet slip into renal failure, from which only dialysis – all too frequently unavailable, even in SA – can rescue them, can be overlooked on the wards.<sup>[4]</sup> It doesn't help that many patients have pre-existing renal dysfunction, linked to hypertension, diabetes or age (>65), and that the blood chemistry, if measured, is normal until 50% of renal function is lost. Medical ward personnel were more aware than those on the obstetric or surgical wards. Drugs such as the angiotensin-converting inhibitors and non-steroidal anti-inflammatory drugs (NSAIDs) often 'set the stage' by preventing adaptive haemodynamic changes in face of dehydration/blood loss. Aminoglycoside antibiotics are direct renal toxins: in the surgical wards they, in combination with NSAIDs, proved particularly injurious. Key to recognising potential trouble is diligent and complete documentation of past medical history and co-morbidities. It is imperative that a diagnosis of any 'co-morbidity' should prompt renal function testing and regular monitoring, with monitoring mandatory if potentially nephrotoxic drugs are prescribed. Though the risk of

developing nephrotoxicity following NSAID use is reportedly low, the extensive prescription of NSAIDs for analgesia, when alternative agents are available, puts many patients at unnecessary risk.

The following bears noting: 'The recent National Confidential Enquiry into Perioperative Deaths (NCEPOD) report on AKI in the UK suggested that 29% of patients did not have adequate assessment or documentation of the most important risk factors for AKI.' As in the Ethiopian study, medication and co-morbidity were among the most common risk factors not assessed!

## Pharmacokinetics of anti-TB drugs

About 1 in 10 patients with tuberculosis develops respiratory failure severe enough to warrant ICU admission and ventilator support. We assume that the fixed-dose four-drug anti-TB tablet, crushed and administered nasogastrically, will achieve optimal systemic drug levels; we are wrong, as a paper<sup>[5]</sup> from the pulmonology and pharmacology services at Stellenbosch University shows. A therapeutic maximum plasma concentration ( $C_{max}$ ) was frequently not achieved for rifampicin, isoniazid, pyrazinamide and ethambutol.

There are many reasons for distorted drug pharmacokinetics in ICU patients, but the key message is that while rifampicin and isoniazid remain the cornerstone drugs in the treatment of TB and combination treatment is essential to reduce drug resistance, it is wise to administer intravenous rifampicin in addition to the combination tablet(s) of anti-TB drugs in the critically ill TB patient.

## Chronic rhinitis in SA – 2013 update

The South African Allergic Rhinitis Working Group reminds us that not all patients with rhinitis have allergic rhinitis. Where ongoing rhinitic symptoms present for many months (as for persistent allergic rhinitis), but with no IgE basis, it suggests chronic rhinitis (CR). CR is common and becoming more so, and results in significant co-morbidity.<sup>[6]</sup> The increase is attributed to several factors, among which is worsening urban pollution – one has only to look down onto our large conurbations (from a plane or a mountain pass) to witness this. The trick for the clinician is not to ascribe symptoms to infection or allergy, but successful treatment isn't easy, and is fraught with the risk of violating the anti-doping codes when treating sportspeople.

## Latex allergy

A paper<sup>[7]</sup> and accompanying editorial<sup>[8]</sup> aptly capture the 'plight, rights and fights' of latex-allergic healthcare workers. New opportunities exist for both prevention and treatment of latex allergy for health professionals, of which hospital administrators need to be aware. Latex allergy is a notifiable occupational disease, and it is the employer's responsibility to provide a latex-safe environment for atopic individuals.

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