

### CME: Peripheral vascular disease

This month's education component deals with peripheral vascular disease. A review article presents the evidence for and against novel anticoagulants,<sup>[1]</sup> the use of which was detailed in 'Venous thromboembolism: Prophylactic and therapeutic practice guideline.'<sup>[2]</sup> We include summaries of full articles (available online), which consider:

- the clinical screening for peripheral arterial disease,<sup>[3]</sup> important because its presence signals future cerebrovascular complications and premature mortality
- the spectrum of chronic venous disorders – which, with a prevalence of 5 - 30% in adults, impact significantly on health and wellbeing – and its clinical and radiological diagnosis.<sup>[4]</sup>

### Palliative care needs in South Africa

Two articles<sup>[5,6]</sup> and two editorials<sup>[7,8]</sup> address the palliative care needs in South Africa (SA), and Africa more widely.

Van Niekerk and Raubenheimer<sup>[5]</sup> address the particular needs of patients with severe chronic medical illness ... 'the greatest burden of disease was found in the general medical wards'. Their survey found that the inpatient mortality of medical patients admitted to the general medical service was 11%, with a 12-month post-discharge mortality of 35%. In many cases this was predictable on discharge, reflecting the burden of patients requiring palliative care in the acute medical service.

Farrant *et al.*<sup>[6]</sup> describe palliative care needs in HIV-positive patients receiving highly active antiretroviral therapy (HAART). The authors found a high symptom burden despite patients receiving treatment, and recommend that detailed symptom assessment and control should be part of HIV care to address palliative care in HIV alongside HAART, as is well established in the UK.

A notable finding regarding medical patients was their much younger average age compared with international samples reflecting the burden of disease in patients with non-communicable diseases, cancer and HIV/AIDS.<sup>[5]</sup> In addition, resource constraints result in patients requiring palliative care for conditions (e.g. end-stage renal failure) that would be treatable in better-resourced settings.

The need for palliative care is increasing globally, but is especially critical in developing countries. Of the 58 million annual deaths in 2008, 45 million occurred in developing countries, with the World Health Organization (WHO) estimating that approximately 10 million people are in need of palliative care across Africa.

Providing palliative care to patients not only relieves symptoms and improves patient satisfaction, but may also reduce admission rates and length of hospital stay and decrease the overall cost of care.

### Failing to numb the pain: The untreated epidemic

An editorial by Powell *et al.*<sup>[7]</sup> highlights the consensus statement arising out of the first session of the African Ministers of Health on palliative care, held in September 2013 at the joint conference

of the African Palliative Care Association/Hospice and Palliative Care Association of South Africa in Johannesburg, that proposed '... the use of the already established global and regional frameworks provided by the African Union and WHO, to ensure availability of, and access to, essential medicines and technologies for the treatment of pain and other symptoms being experienced by so many in Africa, including children. This includes the procurement and distribution of morphine, to ensure greater availability and access of this main opioid for the management of moderate to severe pain'. This was in response to the reality that no one African country has all seven of the formulations considered essential for the relief of cancer pain (i.e. codeine, immediate and slow-release oral morphine, injectable morphine, oral oxycodone, oral methadone and transdermal fentanyl).

### Hidden costs of alcohol-related harms

Matzopoulos *et al.*<sup>[9]</sup> unpack, in impressive detail, the economic, social and health costs associated with alcohol-related harms to inform alcohol management policies and laws. The combined total tangible and intangible costs of alcohol harm to the economy were estimated at 10 - 12% of (the 2009) gross domestic product. The impact on health is huge: alcohol is the third-largest contributor to death and disability after unsafe sex/sexually-transmitted infections and interpersonal violence, both of which are themselves influenced by alcohol consumption.

The pros and cons of alcohol advertising have been much in the news. Given the prevalence and magnitude of drinking in SA, companies on the supply side of the alcohol market are powerful and their economic influence means that the existing frameworks that guide the regulation and distribution of alcohol are founded on claims of their contributions to the local economy. The authors assert that these industry claims must be assessed against the economic, social and health costs associated with the end use of their products. Furthermore, consideration should be given to who is benefiting from the industry and who is paying its costs.

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