earth is made to swallow the putrefaction of their deeds in the name of civilisation and progress. It is men like you who play the fiddle and those who follow you dance to the tune only to please and entertain your masters while you remain enslaved.

Islam is diametrically opposed to your idea, because a Muslim lives to promote peace and justice and to eradicate oppression, thereby satisfying his duty and conscience and ultimate accountability only to his Creator.

A greater public health hazard could be a avoided because in Islam the Bounty of the most Merciful God transcends over all its creatures, but lack of wisdom seldom prevails to illuminate the path of those in drunken stupor.

*He it is who sent His Messenger (Muhammed SAW) with the guidance and the Religion of Truth, that He may cause it to prevail over all religion (way of life), however much the idolaters (infidels, pagans, polytheists) may hate it*. (*Quraan* 9: 33).

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1. Ncayiyana D. What Islam needs is a pope (Editorial). *S Afr Med J* 2004; **94:** 385.

**To the Editor:** Our beloved continent of Africa has had the misfortune of harbouring both immunisation and AIDS dissidents, which has undoubtedly encouraged the spread of both polio and HIV/AIDS.

The Papal institution in all its pomp and glory indeed exists as a guide to Catholic Christians.[1] But it has failed to control the priests who have sexually abused boys and young men in many Catholic communities. The Pope's silence was deafening during the reigns of terror of Hitler and Mussolini, and he has been silent again over the massacre of both Christians and Muslims in Palestine, Iraq and Bosnia. A pope-like authority is patently not the solution to the world's problems.

As fellow black South Africans, you and I both know the reason for the high crime rate in our country. What hope do our youth have if the hopelessness and grinding poverty of the rural areas and squatter camps is not relieved by prioritising job creation as opposed to arms purchases?

As you have so astutely understood 'the profound political and socio-economic underpinnings to the Islamist fundamentalist carnage, not least the politics of oil', you must fully appreciate the plight of refugees in squalid camps in Palestine, the daily Israeli state-sponsored terrorism on Palestinian sub-humans and the civilised American torture at Guantanamo Bay (Blair appealed to Bush to stop the torture of British prisoners there).

Sadly, I do not hear the Pope imploring Bush and Blair (good WASPs) to halt this carnage. Islam does not have a monopoly on terrorism. So-called terrorists (remember that our own ex-president Nelson Mandela was honoured with this title) are products of Israeli, American and British terrorism. Have you seen the innocent old men, women and children of Shabra, Chatilla, Baghdad, Nablus, Jenin, Nicaragua and our own Soweto and Sharpeville?

Muslims are unlikely to regard the Christian Pope as much of an example to emulate when they see the havoc wreaked behind the facade of democracy by so-called good Christians like Bush and Blair, who use despots and self-appointed kings to uphold their new world order and to secure oil. The rape of Afghanistan and Vietnam, Iraq and Bosnia and support of Ariel Sharon are ample proof of their tyranny. The 'scientific desert' was created by Western-sponsored destabilisation, so that the Muslim scientists of today are found working in research programmes in the USA, the UK and Europe, having been forced to flee from their homelands.

Women's rights in Islam are entrenched in the Holy Quraan. If they are not applied, it is because of human transgression.

The khalifat in Islam had its appropriate lifespan, and its authority passed on to eminent scholars of jurisprudence. Like all scholars, including those battling HIV/AIDS, their voices are hoarse, because who listens to them?

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1. Ncayiyana DJ. What Islam needs is a pope (Editorial). *S Afr Med J* 2004; **94:** 386.

## Psychopathology and coping in recently diagnosed HIV/AIDS patients

**To the Editor:** We thank Dr Singh for raising several issues for discussion in his letter[1] in response to our paper.[2] He states that there is no evidence to support the hypothesis that women with HIV/AIDS may face greater stigmatisation than men, emphasises rather social inequality and poverty as risk factors for HIV infection in women, and recommends the inclusion of a particular stigma scale. Stigmatisation may well have been interesting to include, but it was not a primary object of study in this work, and the validity of the scale recommended by Singh has not yet been demonstrated in developing world contexts. Furthermore, we would point out that HIV/AIDS stigma and gender discrimination are constructs that appear to have considerable overlap.[3]

Dr Singh also questions the reliability of assessing sexual risk behaviour in a single interview, queries the assertion that men

'exchange sex for drugs and money', and seems to suggest that the use of quantitative scales was inappropriate in this study. We agree with the truism that quantitative research has its limitations, and that behavioural scales should be used with due caution. We would, however, emphasise that given that HIV/AIDS is currently the most important contributor to South Africa's burden of disease, quantitative research to ascertain its behavioral antecedents, associations, and consequences is of paramount importance. Such antecedents undoubtedly include transactional sex between men and women.[4] The instruments used in our study were appropriate for its focused objectives, although future work to provide additional information on their psychometrics in the local context would certainly be valuable.

This is an opportune time to correct an error in the paper — the Brief Cope was described as a 12-scale measure, but is in fact a 14-scale instrument.

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## Ventricular fibrillation in a clinically normal heart

**To the Editor:** The recent scientific letter by Stanley[1] reports on an interesting case of idiopathic electrical cardiac disorder — ventricular fibrillation — in a patient with normal heart anatomy and haemodynamic functions. Idiopathic (or 'primary') ventricular fibrillation remains an enigma although over the last decades significant advances have been made in understanding the causes and mechanisms in some subgroups of patients.[2]

Brugada syndrome is one of the conditions recently recognised and defined at clinical and cellular levels. Polymorphic ventricular tachycardia or fibrillation in patients with Brugada syndrome who have normal heart anatomy is initiated by so-called phase 2 (of monophasic action potential) re-entry among different layers of myocardium (epi-, mid-, and endocardial), which occurs due to an abnormal function of cellular membrane sodium channel SNCA5.[3]

Unfortunately, the diagnosis of Brugada syndrome in the reported patient is based solely on surface ECG patterns that are equivocal. There is no real ST-segment elevation in right precordial leads and the partial right bundle-branch block has a narrow r' wave while the typical r' wave should be wider and part of a saddle-back pattern (www.crtia.be). The surface electrocardiogram in Brugada syndrome can be variable; therefore, pharmacological testing using class I antiarrhythmic drugs is recommended to uncover or highlight abnormal patterns. In the presented case, neither pharmacological nor genetic testing was performed. The easy induction of ventricular fibrillation during electrophysiological study was also a nonspecific finding possibly suggesting an electrical vulnerability but not confirming the diagnosis of Brugada syndrome.

In conclusion, Stanley presents an interesting case of idiopathic ventricular fibrillation that was appropriately managed by implantation of a cardioverter/defibrillator, and that underlines the significance of ICD for secondary prevention in cardiac arrest survivors and in patients with symptomatic ventricular tachycardias.[4]

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## Traditional formulary?

**To the Editor:** I see the HPCSA wants to register traditional healers, thereby ensuring better control and that medical aids will then also pay for their services. I wonder, will they be able to dispense traditional medicines as they have done for many years, and will these medicines be specified in a formulary? If they are allowed to dispense medicines, why is this different from Western-trained doctors?

I would be interested to hear what other doctors think. By the way, I am not a dispensing doctor.

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