**Provinciale hospitale, staatshospitale en mediese skemas**

Aan die Redakteur: Ek verwys na twee berigre in *Die Burger* van 1 Mei 1990 onder die opsckrifte '[Provinciale] Hospitaalgelede styg skerp' en 'Strenger beheer oor privaat hospitale, toerusting kom'.

As die provinciale hospitale nou gaan 'siekefondsfoie' vra, beteken dit dat die provinciale hospitale besig is om te privateer en dat die Staat dus in direkte kompetisie met die privaatsektor tree. 'Strenger regenerheer be de oprigting van privaat hospitale en velur duur toerusting 'n terugwaartse stap vir privatiserings en demp private inisiatief. Uit hierdie twee berigre kan afgelei word dat staatshospitale geprivatiseer en privaat hospitale genasionaaliseer gaan word!

'Staatsgeriewe word ten volle benut'. Daarenteen moet ons dikwels hoor dat die privaatsektor personeel weglok van die openbare sektor, dat daar nie genoeg personeel is nie en dat sale gesluit moet word. As gevolg van die inisiatief van die privaatsektor is dit soms nodig dat pasiente van staatshospitale tydelik na privaat hospitale moet gaan vir sekere procedures.

As sake teen hierdie tempo ontwikkel, sal ons dit moeilik vind om pasiente te kry vir ons opleidingshospitale. Opleiding moet ook deur die privaatsektor onderneem word. Dit is die enigste oplasing vir ons huidige tekort aan opgeleide personeel. As dit gebeur, sal die koste egter nie so daardie betrokke word soos wat in die berigte voorsien word nie. Tweedens sal privaat- of siekefonds-pasiente net maar daar moet hulle beskikbaar moet wees vir kliniese materiaal waar nodig. Daar moet groter samewerking wees tussen die openbare en privaatsektore. Dit is noodsaaklik dat die antipatie, en soms moedigheid, wat dikwels tussen die twee sektore waargeneem word, aangespreek word en met positiewe benadering uitgeroei word.

Volgens *Die Burger* sal siekefonds 'n deurslaggwendel rol speel in die beheer van koste deur hul voordele aan lede te bepaal. Dis ou nuus — hulle doen dit alreeds. Die Wet op Mediese Skemas No. 72 van 1967 soos gewysig geneem by implikasie 'n vereniing (Verteenwoordigende Vereniging van Mediese Skemas) byna die selfde magte as die daarop 'n statutaire organisasie kan staanmaak. Hierdie situasie is mettertyd as 'n volgende feit aanvaar. Siekefonds word nopens die wettlike treg gegee om as monitor ('big brother') op te tree nie. Hulle is blyb enkies wat die werkgewer en werknemer moet probeer tevreden hou en in dié proses hul eie boeke laat klop. Die Wet oor Mediese Skemas is vandag uitgedien en is slegs 'n reliek wat sedert die depressie van die dertigerjare geskrap en is 'n strenger beheer oor privaat hospitale, toerusting kom'.

**Absence of cardiovascular disease in a rural community using soft water**

There are some apparently contradictory findings in the traditional-living rural community of Tshikundama Venda in Limpopo Province.

The Hans Snyckers Institute is involved in a long-term research project in this remote area in Venda in an effort to monitor the development of some diseases associated with a Western lifestyle in an isolated tribe, living very traditionally but being exposed gradually to a changing lifestyle. Their diet is very simple and contains very little in the way of salt, sugar, meat, milk and eggs, while extensive use is made of natural foods from the veld, and water, untreated, from natural sources.

The quality of the drinking water obtained from four different sources, namely the river, a spring, a mountain stream and a ravine, has been analysed and it has been found to be extremely soft, containing CaCO₃ levels of 21, 5, 5 and 13 mg/l respectively, compared with 87 mg/l for Pretoria. Jodine was undeterminably low in all the sources and fluoride extremely low (0,05 parts per million).

In spite of this apparently unhealthy drinking water, cardiovascular disease appears to be very uncommon in this population. Only 5% of 276 persons over the age of 40 years (median 59 years) examined in a house-to-house survey had a sitting blood pressure above 140/90 mmHg (Korotkoff phase 1 and 5). Taking age into account no person had real clinical hypertension. The absence of hypertension is not an ethnic feature among Venda people, since the condition occurs in other communities in the region.

ECGs were performed on a representative group of adults and found to be normal in 80% of subjects. The 20% of deviations did not represent ischaemia or lengthening of the Q-T interval but only those changes regarded as typical in blacks. No case of peripheral vascular disease was detected.

It would appear that soft drinking water, in contrast to the findings of other authors and as a single factor, is not a cause of hypertension or cardiovascular disease in a community where the other factors associated with westernisation are virtually absent.

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TABLE I. PERCENTAGE OF sIg-NEGATIVE PBMNCs EXPRESSING HLA-DR ANTIGEN

<table>
<thead>
<tr>
<th>Patient group</th>
<th>Unstimulated (uDR)</th>
<th>Stimulated (sDR)</th>
<th>Expression Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>(N = 10)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control group</td>
<td>6.1</td>
<td>13.4</td>
<td>1.2</td>
</tr>
<tr>
<td>(N = 10)</td>
<td>3.5</td>
<td>12.4</td>
<td>2.54</td>
</tr>
<tr>
<td>Patient 1</td>
<td>25</td>
<td>28</td>
<td>0.12</td>
</tr>
<tr>
<td>Control 1</td>
<td>2</td>
<td>14</td>
<td>6.0</td>
</tr>
<tr>
<td>Patient 2</td>
<td>7</td>
<td>6</td>
<td>-0.14</td>
</tr>
<tr>
<td>Control 2</td>
<td>2</td>
<td>10</td>
<td>4.0</td>
</tr>
<tr>
<td>Patient 3</td>
<td>4</td>
<td>3</td>
<td>-0.25</td>
</tr>
<tr>
<td>Control 3</td>
<td>5</td>
<td>13</td>
<td>1.6</td>
</tr>
</tbody>
</table>

On account of this observation and because an increase in the number of unstimulated peripheral lymphocytes expressing HLA-DR has been reported for CFS patients, we investigated the expression of HLA-DR on the non-B-lymphocyte PBMNCs of these patients before and after in vitro PHA stimulation.

We tested 10 patients referred to us with histories of unexplained chronic fatigue and conforming to the proposed criteria for the CFS. Controls, recruited from the hospital staff, were matched for age and sex. The tests were carried out blind and the laboratory had no knowledge of the origin of a particular sample.

PBMNCs were obtained by Ficoll-Hypaque density-gradient centrifugation of venous blood and were incubated in two groups for 24 hours in RPMI 1640 with 10% fetal calf serum, one group in medium only and the other group in medium and PHA at the final concentration of 4 μg/ml. The percentage of PBMNCs expressing HLA-DR antigen and surface immunoglobulin (sIg) was determined using monoclonal antibodies (Ortho Diagnostics) and indirect immunofluorescence microscopy or FITC-conjugated anti-human immunoglobulin antiserum (Cappel, Organon Technika) and direct microscopy respectively.

The percentages of sIg-negative PBMNCs expressing HLA-DR in the unstimulated (uDR) and stimulated (sDR) cultures were calculated by excluding the sIg-positive cells. An HLA-DR expression index was determined using the equation: index = (sDR - uDR) / uDR.

The mean expression index for the patient group was lower than that for the control group, but this difference was not statistically significant. However, 3 out of the 10 patients tested exhibited expression indices more than 10 times lower than the mean for the patient group (Table I). This was mainly due to the inability of PHA to induce a significant increase in HLA-DR expression (sDR - uDR), although a high background level of expression in uDR was a contributory factor in patient 1 and to a lesser extent in patient 2 (range of uDR for control group: 1.14 - 6.06%).

Larger studies will help to confirm or refute the above data, and because of the cyclical nature of the clinical disease longitudinal studies may define the proportion of patients involved more clearly.

The basis for the observed phenomenon is unknown, but investigating it may possibly help elucidate the role of the immune system in the pathogenesis of the syndrome. The exact phenotype of PBMNCs involved remains to be determined.

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**HIV and granuloma inguinale in Durban**

To the Editor: Dr Freinkel1 questions whether granuloma inguinale (donovanosis) disappeared from South Africa for half a century and re-emerged in the late 1970s or was present all the time but remained unrecognized. Following the introduction into routine use of a rapid test for the detection of Donovanov bodies in tissue smears,2 the numbers of cases of granuloma inguinale diagnosed at this clinic increased immediately; 313 new cases (256 men, 57 women) were seen in 1988, a caseload surpassed only in west New Guinea3 in modern times.

Freinkel cites a report of granuloma inguinale in 1939 and further cases are recorded in the annual reports of the Medical Officer of Health (MOH) for Durban from 1959, when the present sexually transmitted diseases (STD) classification was introduced. In these reports the numbers of new cases ranged from 195 in 1973 to zero in 1979, when old cases only were diagnosed. One explanation for this fluctuation in the recognition of granuloma inguinale may be confusion with lymphogranuloma venerum (LGV) caused by *Chlamydia trachomatis* L. serovars. The clinical lymphogranuloma inguinale and granuloma venerum are mentioned in the MOH's report of 1956, and in 1959 attenders with lymphogranuloma inguinale are reported as serving as a source of antigen for the Frei test at the South African Institute for Medical Research in Johannesburg. In 1964 Davis4 reported 5 patients with lymphogranuloma inguinale caused by *Donovara granulomatis* responding to streptomycin, the standard treatment for granuloma inguinale at that time. However, in all cases inguinal buboes were present and genital ulcers absent and it is more likely that LGV was the correct diagnosis.

Recently granuloma inguinale has been identified as a risk factor for HIV infection among local Zulu men with genito-urinary disease (GUD),5 who are a key core group in the spread of HIV-1 in Durban.6 Some countries have virtually eradicated granuloma inguinale, but its lack of recognition and poor control locally is probably a reflection of an overworked STD service with limited resources and an ever-increasing workload. A World Health Organisation consensus statement7 has stressed the importance of GUD and STD control in reducing HIV-1 transmission. The document also emphasises the need for increased support for programmes of STD prevention and research and clearly identifies an area to be addressed by the Advisory Group on AIDS.

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