I would like to conclude with a testimony by G W H Tayler, one of Maxwell's close colleagues: 'We, his contemporaries at college, have seen in him high powers of mind and great capacity and original views, conjoined with deep humility before his God, reverent submission to His will, and hearty belief in the love and atonement of that divine Saviour, who was his portion and Comforter in trouble and sickness.'[5]

May many postmodern men and women rediscover and cast themselves again on the hope that inspired James Clerk Maxwell and many others.

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Dr St Clair Gibson replies: The author provides an interesting viewpoint in his letter. As described previously, it is impossible to prove or disprove the presence of a deity or higher being, and in the best spirit of postmodernism, every viewpoint is correct, but only to those individuals who believe in their own particular viewpoint.

RECOMBINANT HUMAN ERYTHROPOIETIN IN END-STAGE RENAL DISEASE

To the Editor: Provincial administrations in South Africa are encouraged to promote cost-effective health care from meagre health budgets stretched to the limit by highly prevalent diseases such as tuberculosis and HIV/AIDS. Although therapy of such treatable conditions is truly warranted this should not be at the cost of forgoing proven and cost-effective therapies for other chronic illnesses, such as the anaemia of end-stage renal disease. Anaemia has a major impact on the quality of life of such patients where fatigue, reduced exercise tolerance, dyspnoea, and cognitive, sexual and sleep dysfunctions abound. Therapy of the anaemia of end-stage renal disease using recombinant human erythropoietin (rhEPO) and iron supplementation (ideally intravenously) has been supported by substantial research evidence (level 1) and effectively reverses or improves most of the aforementioned symptoms. Furthermore there is increasing awareness that the use of rhEPO in pre-end-stage renal disease slows progression, improves co-morbidities and reduces hospital admissions (as it does in end-stage patients). Such treated patients therefore function better in their communities, are often able to continue with employment and spend less time in hospital, to the benefit of themselves and of course the administrative bodies. Blood transfusion temporarily improves anaemia in such patients although at the risk of viral and other infections, allosensitisation, iron overload and a not insignificant cost. The cost factor of such therapy is often forgotten when prescribing blood transfusions and if lymphocyte-depleted packed cells are used this can amount to over R900 per unit.

Unfortunately it is undeniable that rhEPO is also expensive (and likely to remain so). This economic fact of life, coupled with the aforementioned administrative concerns about escalating health care costs, has allowed decisions regarding the use of rhEPO to be made on political or economic grounds rather than clinical need or expectation of benefit. Regrettably in South African state hospitals renal replacement therapy (dialysis and transplantation) is only available to a highly selected few. Unfortunately these few are denied rhEPO (and intravenous iron for that matter), which is in reality inadequate therapy for their end-stage renal disease. However, rhEPO is available to these indigent patients in some provinces (Gauteng and the Free State) and not in others. This discrepancy is unconstitutional and requires immediate and aggressive action and correction from medical, political, and most importantly, patient organisations.

As this expensive form of therapy may easily deplete even the most generous of budgets it requires vigilant control, prescription by adequately trained personnel, and aggressive monitoring of clinical benefit and cost effectiveness. Ideally the use of rhEPO should adhere to strict guidelines adequately representing the South African perspective. Until such guidelines are available international guidelines should suffice (as detailed by the United States-based Dialysis Outcomes Quality Initiative and the European Best Practice Guidelines).

I am of the opinion that if the prescription of rhEPO is adequately guarded through an understanding between attending medical personnel and provincial administrators then patients suffering from end-stage renal disease should experience a dramatic improvement in their quality of life and long-term survival together with a reduction in expense to the provincial budgets charged with treating them.

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ALCOHOL AND YOUR HEALTH

To the Editor: Much has been written in the *Journal* on the health consequences of alcohol misuse. Articles have covered topics such as the negative effect of alcohol use on iron overload, coronary heart disease (CHD), cirrhosis of the liver, chronic digestive disease, pancreatitis, brain damage, fetal alcohol syndrome, and trauma.

Over the last decade there has been increasing discussion on the positive health effects of moderate consumption of alcohol.[1] This debate has been largely absent in South Africa. A recently published article in the *South African Journal of Clinical Nutrition* entitled 'If you drink alcohol, drink sensibly'[2] has addressed this issue as part of the Food-Based Dietary Guidelines (FBDG).

The FBDG on alcohol recommend that South African alcohol consumers should engage in 'low-risk' drinking, defined as no more that four standard units of alcohol per day for men and no more that two units for women, with at least two alcohol-free days per week. A standard unit is defined as one 340 ml can of beer containing 12 g of alcohol, a 120 ml glass of wine, or a 25 ml tot of spirits.[3] However, people are not encouraged to start drinking or to drink more to gain any claimed health benefit. Various categories of persons are advised not to consume alcohol: children, individuals who are not able to restrict their drinking to moderate levels, pregnant women, persons operating machinery, persons taking prescription medicines, and persons with a genetic tendency to alcohol dependence.

Regarding the protective effects of alcohol consumption for CHD, benefits may occur for some older individuals (e.g. men over 35 years and postmenopausal women[4]), with drinking levels as low as one drink every 2 days.[5] However, these benefits are replicable through other means such as ceasing to smoke, eating a balanced low-fat diet, and taking aspirin.[6] Drinking to the point of intoxication, which is fairly common among many drinkers in South Africa over weekends,[7] is likely to negate any health benefits. For younger persons alcohol is likely to have a net detrimental effect on mortality due to its role in violence and other forms of injury.

Public health experts are now questioning the 20 standard drinks for men and 10 for women as weekly 'low-risk' maximums (set out above). New Canadian guidelines are 14 standard drinks (of 13.6 g alcohol) per week for men and nine for women, with no more than two drinks per day.[8] This is a topic requiring further debate in this country.

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COMPLETE CONGENITAL HEART BLOCK DIAGNOSED IN LABOUR

To the Editor: Complete congenital heart block is a relatively rare disorder (incidence 1:20 000 - 25 000) almost always associated with the presence of passively acquired auto-antibodies, usually anti-Ro (SSA) and anti-La (SSB).[1] Several therapeutic options, including maternal immunosuppression and anti-arrhythmic drugs, are available if the diagnosis is made antenatally. We recently successfully managed a vaginal delivery in a patient with fetal heart block diagnosed during labour.

The patient, 21 years old, gravida 2, para 1, attended the antenatal clinic for the first time at 33 weeks' gestation. She had previously had an uncomplicated vaginal delivery at term. All the routine antenatal laboratory tests were within normal limits. She did not return for the scheduled follow-up visit, but presented 3 weeks later at the midwife obstetric unit in active labour. The attending midwife registered a fetal bradycardia on auscultation and the patient was transferred to Tygerberg Hospital.

After the patient was admitted to the labour ward, an internal scalp electrode was applied which showed a non-reactive cardiotocogram pattern with a constant heart rate of 55/min. The fetus was immediately examined with ultrasound. There were no obvious congenital abnormalities. The atria contracted normally at 140/min on an adequate four-chamber view of the heart, but the ventricular response rate was about 55/min. To exclude fetal distress, a scalp pH was attempted but the patient's cervix was fully dilated and she subsequently delivered.

A male infant was born, weighing 2 794 g and with good Apgar scores. An ECG tracing on the infant confirmed a complete heart block with a pulse rate of 55/min. The post-delivery course of both mother and baby was uncomplicated. Tests for the anti-Ro and anti-La antibodies were positive in the mother, with antinuclear antibodies negative. Both anti-Ro and anti-La antibodies were present in the infant, with the antinuclear factor positive with a titre of 320. The infant is still well 1 year later and did not require a pacemaker.

Complete heart block renders traditional cardiotocographic monitoring useless. The available options to monitor fetal wellbeing during labour are ultrasound and frequent scalp

blood gas analysis. This condition must always be part of the differential diagnosis of a fetal bradycardia on cardiotocography tracing and demonstrates that a good outcome is possible even in the absence of sophisticated and expensive antenatal and intrapartum care.

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CME AND RECERTIFICATION

To the Editor: All who are currently registered with the Health Professions Council of South Africa need to submit evidence of having participated in continuing medical education, designated as CPD points. This is also applicable to those who practise outside the boundaries of South Africa and continue to maintain registration in this country.

Continuing medical education is important and takes many forms, including conference attendance, participation in teaching activities, journal clubs and above all the self-discipline of regularly reading the medical literature, such as the *SAMJ*. As members of the medical profession, we have a duty to remain abreast of recent advances. This is not easy in a fast and changing world. Some doctors remain reluctant to attend meetings or conferences, usually using the age-old excuse of being too busy, or asking 'what are they going to teach me?' There is a burden on both the individual and the organisers of conferences; individuals must be motivated and desire to improve their knowledge, while on the other hand the organisers must put together attractive and balanced programmes, with good and knowledgeable speakers. Registrant involvement at conferences is desirable, as is the opportunity to be kept abreast of regulatory changes. In an ideal world all mesh, with satisfaction all around. Our patients are the ultimate beneficiaries and we get our CPD points!

The controversial question of recertification remains a very touchy issue with doctors, and in the USA it has been required by most, if not all, specialties. A colleague of mine was travelling by air in the US, and the person sitting next to him was a uniformed airline pilot going for his annual recertification. During their discussion, he mentioned that most of the pilots pass their recertification examinations on the first go. My colleague was appalled by the high pass rate and felt that this was a sham. After further explanation, my colleague realised that the purpose of pilot recertification was to ensure that pilots maintained essential skills and judgement.[1]

We all expect the pilots who fly us around the world to pass their recertification examination. Shouldn't we expect the same from all our doctors?

In 1993, I passed the recertification examination set by the American Board of Anesthesiology.

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