

Co-operation between traditional healers and medical personnel

To the Editor: It is my opinion that meaningful co-operation between traditional healers and scientific medical practice is impossible, because of the fundamental difference in the concept of disease causation that underlies the practice of both sides. The articles in the insert to the *SAMJ* of December 1994 ('Bridging the gap') provided a welcome explanation of the way in which the traditional healers and their practices form an integral part of the culture and beliefs of the African people. Many practices, including the holistic approach to disease, should serve as examples to us. However, the non-scientific basis for the treatment of disease is to the ultimate disadvantage of the ill individual, and application of traditional practices is in many instances directly harmful, in addition to delaying or denying access to scientific medicine.

No one doubts the pharmacological activity contained in many plant species: a raffle through Watt and Breyer-Brandwijk provides ample proof of this. The same reference provides proof that these properties are not unknown to science, and are not the sole preserve of herbalists with their prolonged, intensive apprenticeship. Moreover, the scientific knowledge is free of the magical connotations which are an integral part of the *inyanga's* ethos, and were also an integral part of the practice of medicine in the pre-scientific days. One has only to read references in Culpepper's work to realise that many of the properties attributed to herbals were magical.

Apart from an oblique reference to the *abathakathi*, there is little mention of the darker side of traditional healing. The myriad stories of bewitchment, ritual murder and infant stealing are part and parcel of the practice; one cannot separate them. Permitting divination, for instance, to flourish, tacitly acknowledges the right of witchcraft to continue, and one cannot readily proscribe the one and not the other.

The major advantage quoted by many of the role of the traditional healer is in the realm of psychiatry. To the extent that mental illness is a product of a society, it is agreed that the logical person to treat these disorders is the traditional healer. The same arguments about herbals can be advanced against traditional healers by psychiatrists — the fact that the understanding and delivery of psychiatric care to the black African is imperfect does not mean that we must allow him sub-standard care.

The only way to overcome the 'problem' of the traditional healer is through provision of improved scientific health care, both in availability and quality. These include expanded local health care personnel, improved access at entry level, readily understood referral practices, greater involvement in preventive care, and acknowledgement that the individual is responsible for staying well.

It makes little sense to train a person whose entire being is bound up in one philosophy to administer a totally different one — better to start with a person who does not have the same emotional and ideological investment.

I feel that better provision of medical care at all levels will ultimately be to the benefit of individuals and the community, and that the authorities must accept that aspects of traditional culture are going to come under

pressure. At the same time, I do not think that there should be any regulatory effort made to curtail the activities of the traditional healers: rather permit the community ultimately to choose the better alternative.

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Dirty jobs

To the Editor: The account of the Thor Chemicals incident (*SAMJ* May 1995, pp. 311-315) was, quite correctly from the medical point of view, critical of the company.

Nevertheless this issue should be discussed in the wider context of the national economy. Given the socio-economic plight of many developing and Eastern European countries, is a dirty job better than no job?

I do not pretend to know the answer (if there is one). But I do recall several years ago, while practising in a country to the north, being told by a locally recruited personnel manager that labourers are cheaper than safety precautions.

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Malignant hyperthermia — still around

To the Editor: An apyrexial 4 kg 8-month-old child with a diagnosis of cerebral palsy with resultant spastic quadriplegia and dysmorphism was scheduled for bilateral inguinal herniotomies.

On admission the pulse rate was 120/min and the blood pressure 80/40 mmHg. The child received an appropriate dose of atropine (which increased the heart rate to 140/min) and induction with halothane and an air/oxygen gas mixture. A successful caudal epidural block was then performed. The pulse rate and blood pressure remained constant and the expiratory CO₂ and peripheral oxygen saturation were normal throughout the procedure, which took 40 minutes. Anaesthesia was terminated, and the child woke up and was extubated on the table and taken to the postoperative recovery ward.

Forty-five minutes after extubation the patient developed tachypnoea (50 breaths per minute) with laboured breathing and substernal retraction. Upper airway obstruction was suspected. The airway was cleared under direct vision and breathing was assisted with an Ambubag and mask with 100% oxygen. Because the obstruction was only partially relieved, suxamethonium (5 mg) was administered and an endotracheal tube inserted. The pulse rate was 195/min and the blood pressure 140/100 mmHg. After the capnograph was connected, the *P_eCO₂* read 7.7% in the presence of cyanosis. We were unable to lower the *P_eCO₂* with hyperventilation. When the suxamethonium reversed the patient was moving about violently, and although the spastic

quadriplegia polluted the clinical picture, clear tetanic contractions of the calf muscles were noted. The patient now also felt warm, and the temperature (measured rectally) was 39,5°C.

A diagnosis of malignant hyperpyrexia was made and dantrolene was given intravenously (2,5 mg/kg). This resulted in an immediate and dramatic fall in the P_{eCO_2} to 4,5% and in the temperature to 37,8°C, within 7 - 10 minutes.

The blood gases measured at the peak of the event were P_{aO_2} 6,4 kPa, pH 6,99 and P_{aCO_2} 9,8 kPa. The patient was ventilated in the paediatric intensive care ward for the next 22 hours, needed no further dantrolene, and had an uneventful recovery.

This case again demonstrated the effectiveness of dantrolene in managing this potentially lethal disorder. This is the second case reported in Tygerberg Hospital over a 15-year period, giving an approximate incidence for the disorder of 0,04/10 000 cases.

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Infantile onset of HTLV-I-associated myelopathy (HAM/TSP)

To the Editor: Vertical transmission of HTLV-I occurs via breast-milk.¹ Intra-uterine transmission is considered not to be important.² We report on a 3-year-old girl who possibly acquired the infection *in utero* or at delivery. She came to our attention when her mother presented with HAM/TSP. The mother had first developed symptoms while pregnant with the patient. The child had 5 older siblings, who are all well but had a different biological father. Three of these siblings were available for testing. They all tested negative for HTLV-I antibodies. The father of the sick infant declined testing.

The mother observed that fetal movements had been delayed. The infant, born by normal vaginal delivery, would not 'step' at 4 months, crawled at 16 months and walked at 30 months. She had frequent falls. Her mental state was normal and she had no physical stigmata of pseudohypoparathyroidism.³ Spastic paraparesis was present. Pinprick sensation was intact. A computed tomography (CT) scan of the brain and CT-myelogram were normal. Antibodies to HTLV-I were present in the serum (ELISA with Western blot confirmation). The CSF was not tested. PCR was used to amplify a portion of *pol* viral gene from peripheral blood lymphocyte DNA using the SK110 and SK111 primers.⁴ These primers amplify both HTLV-I and HTLV-II *pol* genes. The 195 bp amplicon was then identified with a specific HTLV-I (SK112) probe using the digoxigenin detection system (Boehringer Mannheim). Routine biochemical values, including calcium and phosphate, were normal.

HTLV-I IgG antibodies are commonly present in the cord blood of infants born to seropositive mothers.¹ These, however, rapidly disappear, confirming the maternal origin. Maternal antibodies are also believed to protect the infant from infection.^{1,5} Further, the detection of proviral DNA in

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