HIV-infected infants born to women who tested HIV-negative during pregnancy

To the Editor: The prevention of mother-to-child transmission (PMTCT) programme in the Western Cape is said to have achieved 100% coverage.[1] This implies that all pregnant women who attend an antenatal health care facility in the public sector are offered voluntary counselling and testing (VCT). Uptake varies but has been reported to be as high as 90% in the Guguletu district.[1] Currently, women who test HIV-positive qualify for the nevirapine-based PMTCT programme. Transmission rates below 10% have been achieved in some health districts (Médecins sans Frontières — unpublished research).

Mothers of several perinatally infected infants recently diagnosed in our institution have indicated that they tested HIV-negative during their pregnancy. In some cases we have verified their statements with clinical and laboratory documentation. There is a need to determine the frequency of this phenonomen.

Pregnant women are encouraged to book at their nearest antenatal clinic before 5 months' gestation, although this frequently does not occur. We are concerned about women who *do* book early and test HIV-negative. Some may be in the 'window period' of the infection or become infected from a sexual partner during the latter stages of pregnancy. At present, there is no provision within the PMTCT programme for repeat HIV testing during pregnancy. Some women may, therefore, be denied the benefits of prevention measures including counselling on infant feeding options.

One possible solution is the use of rapid HIV testing in women presenting in labour. While this may detect women who previously tested HIV-negative for the reasons indicated above, labour is certainly not an optimal time to receive counselling and give informed consent for an HIV test. A less explored alternative would be to allow for repeat testing during the antenatal course. Repeat HIV testing at 34 - 36 weeks' gestation would detect those women who have seroconverted or acquired infection since undergoing initial HIV testing, and allow for timeous introduction of prevention measures. A third option is to consider selective re-testing on demand, following a high-risk exposure or a suspected seroconversion illness. Rapid testing of unbooked delivered mothers in the immediate postnatal period would allow for neonatal post-exposure prophylaxis.

The overall goal should be the reduction of vertical transmission to the absolute minimum. In this regard the Western Cape government is about to intensify the antiretroviral options within its programme. One hundred per cent PMTCT coverage should mean that all women who qualify for prevention and who are willing to accept the PMTCT programme are in fact included. Repeat HIV testing during late pregnancy will assist in making this a reality, and may make a small but important contribution to reducing vertical transmission. A study on the extent of the problem and additional resources in the form of midwives and counsellors are prerequisites to this being included in routine care.

James Nuttall
Brian Eley
School of Child and Adolescent Health
Red Cross Children's Hospital
Cape Town

Simone Honikman
Department of Obstetrics
Mowbray Maternity Hospital
Cape Town

1. Department of Health, South Africa. *Interim Findings on the National PMTCT Pilot Sites. Lessons and Recommendations*. Pretoria: DOH, 2002.

Dispensing — ironies and conflicts

To the Editor: How ironic to discover that some of the very colleagues who helped to take the dispensing issue to court were among the very first to do the dispensing course and apply for their own dispensing licences.

How equally ironic to observe that SAMA on the one hand opposed the dispensing licence issue but on the other let the SAMA-affiliated Foundation for Professional Development be one of the first three bodies to advertise a dispensing course at (of course) a substantial profit for themselves.

Yet again doctors couldn't succeed in uniting and in so doing make an end to this backstabbing from (primarily) our pharmacist 'friends'. Is it yet again doctors' greed and self-interest that caused these conflicting actions within our profession? Are we losing our self-respect as professionals that we accept being evaluated by another profession, the pharmacists, on something we are taking all the responsibility and accountability for? Would any other profession allow something like this to happen to it?

Yet again we as doctors sat back and hoped that the legal profession alone would be successful in fighting our case for us, while allowing ourselves to be divided and ruined. Shouldn't we have doomed this process to total failure by refusing to comply with unreasonable requirements — in unity? When will we ever learn, doctors? When will we ever learn . . .?

C J Brand
PO Box 101396
Moreleta Plaza
Pretoria

The efficacy-effectiveness gap in PMTCT

To the Editor: I wish to congratulate Sherman *et al*.[1] on having undertaken the challenge of assessing the efficacy of a prevention of mother-to-child transmission (PMTCT) programme in a routine setting. The findings of the study are groundbreaking in many ways. However, we feel that this study partially fails to envelop the entire reality of PMTCT, thus leading to a potentially misleading title and conclusion. Selection bias and drop-out of the study population in addition to the extrapolation of research setting rates to routine setting ones call for caution when interpreting the study findings.

The efficacy of the single-dose nevirapine regimen has been established by clinical trials.[2,3] A reality perspective implies assessment of the effectiveness of PMTCT for HIV-positive women accessing routine care, rather than only for women who gave consent for voluntary counselling and testing (VCT). Therefore the VCT acceptability rate should have been reported. In the Coronation Women and Children's Hospital (CWCH) area, with an estimated HIV prevalence rate in pregnant women similar to that of Gauteng, approximately 2 450 of 8 221 women who gave birth were HIV-positive (29.8%). Thus, 1 216 potential participants were never enrolled in the PMTCT programme. Neither these women nor their babies received nevirapine. Nor were counselling on infant feeding choices or free milk formula provided. Even if this 'forgotten group' was counselled on infant feeding choices, MTCT would occur in 20.7%, according to the findings of Coutsoudis *et al*.[4] on MTCT rate and infant feeding practices.[4]

Another concern is the assumption that drug compliance in the group without records of nevirapine status is similar to that of the group with properly recorded nevirapine status. Although there is no hard evidence for reduced compliance in the 'no record'group (25%), there is no proof of equal compliance in both groups either. It is not unthinkable that drug administration may also be missed in an environment in which registers are not kept properly, the latter owing to the less stable and controlled environment of the labour ward.

Similarly to the effectiveness of drug compliance, the authors jump to the conclusion that the women from the communities attending the routine PMTCT programme are able to abstain from breast-feeding. Even though this statement is confirmed in the 'research group', data on feeding practices are missing for 38% of the women in the 'routine setting'. Women participating in the infant diagnostic study may have felt more encouraged and supported to abstain from breast-feeding than their counterparts in the routine setting. In addition, the thought of having their babies tested for HIV at 6 weeks and 3 months of age may have been an extra stimulus to formula-feed exclusively. Acknowledging the fact that both follow-up infant visits and adherence to exclusive formula-feeding require a certain level of commitment, selection bias may be suspected with regard to the rates of reported feeding practices. In other words, among those 38% lost to follow-up, relatively more breast-feeding and mixed feeding may have occurred. Moreover, feelings of fear or guilt that go along with having breast-fed may have counteracted return for follow-up infant visits. For the above reasons, the overall rate of exclusive formula-feeding may be lower than assumed by Sherman *et al*.[1]

When considering the results of this study one should keep in mind that the findings are merely efficacy rates for the CWCH, so they do not necessarily reflect the real MTCT rate in the community. As much as this study is a big leap forward in the implementation of PMTCT, additional research is needed to translate high levels of efficacy into equally high levels of effectiveness in the community.

Wim Delva
Marleen Temmerman
Ghent University Hospital
De Pintelaan 185 2K3
9000 Ghent
Belgium

1. Sherman GG, Jones SA, Coovadia AH, Urban MF, Bolton KD. PMTCT from research to reality — results from a routine service. *S Afr Med J* 2004; **94:** 289-292.
2. Guay LA, Musoke P, Fleming T, *et al*. Intrapartum and neonatal single-dose nevirapine compared with zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda: HIVNET 012 randomised trial. *Lancet* 1999; **354:** 795-802.
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Louis Leipoldt

To the Editor: South Africa has a dearth of good biographers and Kay de Villiers[1] has produced an unsentimental and objective account of the luminary life of Louis Leipoldt, a medical renaissance man.

One issue is conspicuous by its absence in the article — Leipoldt's sexuality. Dr Peter Shields, in the introduction to the recent anthology,[2] left no doubt that Leipoldt was homosexual, although either inactive or highly discreet. I mention this not out of a sense of scurrilous sensationalism but because any account of Leipoldt that ignores it is lacking.

Consider the effect on someone who, by his own admission, did medicine to expiate a sense of guilt engendered by being the son of missionary. To what extent was his career choice driven by a deeper guilt about sexuality? Leipoldt was a remarkable doctor, but what would he have achieved if he had devoted himself to pursuits not driven by a sense of guilt and desire to care for others?

And, on a positive note, as a genuine polymath and sensualist, to what extent was his sensibility a reflection of a more subtle homosexual perception for which we are all the

better to be the recipients?

We should not be afraid of mentioning Leipoldt's sexuality; there is no one to hurt now, and why not celebrate an important aspect of his nature that contributes as much to his achievements as it did to his silent pain and despair?

Robert M Kaplan

The Liaison Clinic
Wollongong
New South Wales
Australia

1. De Villiers JC. C F L Leipoldt (1980 - 1947) — journalist doctor. *S Afr Med J* 2004; **94:** 552-556.
2. Emslie TS, Murray PL. *Leipoldt's Food and Wine*. Cape Town: Stonewall Books, 2003.

Psychoneuroimmunology — mind-brain-immune interactions

To the Editor: The authors are to be commended on the above article,[1] yet it does not go nearly far enough. The sequence of a subconscious thought leading to a negative emotion (anxiety, fear, guilt and anger) resulting in a negative behaviour has long been established. Perhaps the first published comment was by Breuer back in the 1880s! Be aware that a pathological disease process may well be a behaviour, whatever biological pathway is followed!

The references provided are scarce indeed — let no reader be misled. There are many hundreds of research articles confirming the clinical experience that early life experiences — pre-natal, birth and infancy — are responsible for many problems later in life. I have referred in published papers to diseases such as certain cancers and autoimmune disorders as 'malignant psychosomatic disease' — all treatable according to one of three goals depending on the patient's level of autonomy: palliation, facilitation of medical or surgical management, and cure.

Modern modalities of clinical hypnosis are extremely useful in uncovering the causative events, allowing a profound change in even 'catastrophic' negative outcomes. The largely blinkered vision of the healing professions in regarding medical hypnoanalysis and ego state therapy as oddities or 'not very useful' in general medicine is a tragedy for the public at large. The book I wrote and advertised through the *SAMJ* was purchased by just three doctors! So much for self-motivated CPD.

The South African Society of Clinical Hypnosis (SASCH) provides training recognised by the International Society of Hypnosis (ISH) — in fact it is the only ISH-affiliated society that offers training in all the modalities under one roof. The Society (a Division of PsySSA) may be contacted at (012) 365-3647 on weekdays between 08h00 and 12h00.

I would also caution against the global perception that alcoholism has a genetic background — the article by Professor Pienaar in the same issue of the *SAMJ*[2] says that it 'plainly occurs in certain families'. Professor Pienaar correctly points out that 'it may result' from such a source. We are mindful of the fact that these families are severely dysfunctional — this is the primary reason for learned behaviour such as using substances to alleviate the pain inherent in such families. A behaviour that is learned can be unlearned, and this is far more easily accomplished with early intervention.

Trevor Modlin

PO Box 29041
Sandringham
2131

1. Whitesman S, Booth R. Psychoneuroimmunology — mind-brain-immune interactions. *S Afr Med J* 2004; **94:** 259-261.
2. Pienaar W. The treatment of alcohol dependence — new horizons. *S Afr Med J* 2004; **94:** 264-266.

Drs Whitesman and Booth reply: The intention of this review was to provide a scientific rationale for the exploration and clinical application of the mind/body connection in medicine and health. At the request of the Editor of the *SAMJ* we limited the review in terms of both words and references; it was preferable to have an abridged article published with limited references rather than not having the topic in mainstream academic debate where it belongs. Given this situation, we carefully chose references that would be a springboard to the considerable amount of information available on this subject.

The field of psychoneuroimmunology no longer seems to be restricted to the exposition of interactions between mind, brain and immune systems (as we suggest in our conclusion), but 'ranges in topics from effects of psychosocial factors on the whole organisms to events taking place at the termini of the neuroendocrine-immune axis' (see New directions in psychoneuroimmunology: A critique. *Advances* 1996; **12:** 5-15). Elucidation of the degree of influence and clinical relevance of these factors on illness and health — including the effects of early childhood and unconscious mental processes — remain challenges in this field. Furthermore, consideration of the philosophical issues of an integrative, as opposed to a dualistic, view of the mind-body continuum is in its relative infancy. It was our hope that an article of this nature, while limited in content, might begin a more substantial debate on the relevance and implications of these data in the South African context.

What Islam does not need is a pope!

To the Editor: Your editorial in the June *SAMJ*[1] refers. I take strong exception to your simplistic arguments and views on Muslims and Islam. While you may be competent to write on matters medical, you are in no way qualified to be the self-appointed spokesman on 'what Islam needs'.

The immunisation fracas in Nigeria is well known and understood. But however important herd immunity may be, it is the constitutional right of every individual to refuse medical intervention they do not want.

However, this is not the crux of my objection. What disturbs me is that two-thirds of your editorial is focused on Islam and the augmentation of the negative stereotyping daily seen in most of the mainstream media. What on earth have the Taliban and their perceived past 'injustices' got to do with the current immunisation crisis in Nigeria? For your information, the current situation in Afghanistan is infinitely worse under the US puppet Kharzai than it was under the Taliban. Poppy production has increased some 600%; the abuse and rape of women has dramatically increased; law and order has deteriorated, with large no-go areas run by warlords; curfews are the order of the day. The common citizen is much worse off than at any time during the Taliban rule (during which poppy production declined dramatically). Women had more (yes, more!) rights and dignity than they have now — true rights granted to them in Islam, and not the superficial so- called democratic rights of the West. (Anyone who has made an unbiased study of Islam would be able to verify this.)

Your comments on terrorism and the despicable beheading of an American predictably point a finger at Islam, by simply restating what is presented as fact in the media without any proper critical evaluation, e.g.: (*i*) who truly stands to gain from these events? (*ii*) are the perpertrators really Muslim? (*iii*) have the many thousands arrested been convicted in an unbiased court of law? and (*iv*) are the repeated video tape releases really authentic? Note that the CIA has stated unequivocally that they are prepared to go to any lengths in their so-called war on terrorism, including media misinformation.

If it is *proven* that these acts, and others (e.g. 9/11), are perpetrated by Muslims in the name of Islam, than any true Muslim will condemn them in the strongest possible terms. You state that the Muslims known to you 'are all decent, gentle people' — surely this stereotyping, which is enhanced by your editorial, does not apply to them?

Finally I maintain that it is not your call to say that 'what Islam needs is a pope'. Leave this to the Muslims to decide for themselves. After all, the Christian Pope could not prevent the illegal and immoral killing of thousands of innocent men, women and children in Iraq, by the Christian fundamentalist president of the United States!

My view is that your editorials should stick mainly to medical matters, and if you do happen to venture into fields such as religion, you should make an informed and broad-based analysis of events, not confined purely to selected and unverified mainstream media reports.

S A S Haffejee
32 Berea Road
Durban
4001

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