



Youth — forever bad?

'Our youth loves luxury, has bad manners, disregards authority and has no respect whatsoever for age: our today's children are tyrants; they do not get up when an elderly man enters the room — they talk back to their parents — they are just very bad.'

'This youth is rotten from the very bottom of their hearts; the young people are malicious and lazy; they will never be as youth happened to be before; our today's youth will not be able to maintain our culture.'

These are two of four delightful quotes in the editorial by the ever-youthful Walkers and co-author Wadee (p. 125). All four quotes date back to the time of Socrates and earlier! The editorial considers various reports dealing with categories of health-risk behaviours among youth and young adults in the USA and concludes that 'the current practices of youth, in the contexts described, can scarcely fail to lessen subsequent years of healthy life expectancy'. What then are the practices?

A study in the USA on the young, aged 10 - 24 years, indicated that three-quarters of deaths were due to only four causes, namely motor vehicle crashes, other unintentional injuries, homicide and suicide. Many high-school students engaged in behaviours that increased the likelihood of death from these four causes, namely rarely or never wearing a seat belt, riding with a driver who had been drinking alcohol, carrying a weapon, drinking alcohol or using marijuana; 8.8% had attempted suicide. Morbidity and social problems resulted from unintended pregnancies and sexually transmitted diseases.

An increasing prevalence of smoking among the young is reported in the USA and in Europe and physical activity in this age group has markedly decreased — the prevalence of overweight among US schoolchildren between 1973 and 1991 increased from 15.4% to 25.61%.

The authors seem to lament the loss of another practice from the past: 'Corporal punishment at schools, which was previously an accepted form of discipline of scholars, is now forbidden.'

From our own largely rural community in KwaZulu-Natal Taylor and colleagues (p. 136) report patterns of substance use among high school pupils which echo those reported in the editorial.

Both papers suggest that health promotion interventions are needed. However Walker *et al.* question why avoiding action is not taken when the unhealthiness of the practices described is well understood. They conclude with another apt quote, this time from Confucius, who several millennia ago maintained that 'the essence of knowledge is, having acquired it, to apply it'.

Amoebic liver abscess — conservatism pays

When we saw a case of amoebic liver abscess in our student days, the size of the abscesses and where in the liver they were situated was largely a matter of speculation. Conventional X-rays, which were the only imaging techniques available to us, did not distinguish between the water-density of the liver and of the hepatic abscess. This is another reminder of the stunning

clinical advance of having ultrasound to demonstrate the site and size of such lesions.

McGarr *et al.* (p. 132) address one of the contentious aspects of managing amoebic liver abscess (ALA), namely whether and when they should be aspirated. When untreated and enlarging ALAs are at risk of rupturing into contiguous vital structures such as the chest, peritoneum and pericardium. This is the main reason for the development of management algorithms to aspirate abscesses perceived to be at increased risk of rupture.

The authors, who report on a large series of 178 patients (male/female ratio 5:1) with 203 abscesses, provide convincing reasons for their proposed conservative approach, according to which patients are initially treated with metronidazole 800 mg orally or 500 mg intravenously 3 times a day for 2 weeks. Indications for ultrasound-guided aspiration are clinical deterioration, failure to improve clinically within 48 - 72 hours, or suspicion of a secondarily infected abscess.

When this protocol was followed the majority (80%) of patients required only medical management, sparing many from invasive procedures and their potential complications. The major criterion for aspiration was lack of clinical improvement after 48 hours. Operative drainage should be reserved for intraperitoneal rupture.

Egg allergy and vaccination

Not all vaccines are grown in cultures of fibroblasts from chick embryos, though two of the locally available measles mumps rubella (MMR) vaccines are produced this way. However the amount of ovalbumin in the vaccines seems too small to cause an allergic reaction in the majority of individuals even considering the parenteral route of administration.

In their 'Clinical Practice' article (p. 113) Du Toit and Weinberg review this issue and conclude that 'Measles and MMR vaccines are as safe as any other vaccine, and can safely be given to the vast majority of children regardless of whether or not they are allergic to eggs.' They state, however, that adrenaline should be available, as for any other vaccination, and that the subgroup at increased risk should receive vaccination under medical supervision.

TB out of control

Local health care workers are taught that the Western Cape is the TB capital of the world. That there are other contenders for this dubious honour is not cause for rejoicing. Mwaba and colleagues (p. 149) review the spread of tuberculosis in our near neighbour, Zambia, over a period of 37 years. They reveal a frightening picture of an epidemic out of control and perhaps beyond control.

Much of the increase in TB reported is due to the HIV epidemic and the well-known factors influencing TB trends — poverty, malnutrition, and management failures in the treatment system.

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