BCG and HIV: To give or not to give?

The World Health Organization has revised its earlier recommendations and since 2007 has made HIV infection a full contraindication to BCG vaccination. Hesseling and colleagues[1] examine the evidence and reach a contradictory conclusion.

BCG induces protective efficacy against tuberculous meningitis of 73% and against military disease of 77% in HIV-uninfected children. BCG is a safe vaccine in immunocompetent infants, and severe vaccine adverse events in the HIV-uninfected occur only with rare primary immune deficiencies. South African HIV-infected infants receiving BCG vaccination at birth are at increased risk of developing BCG adverse events. BCG adenitis has been recorded in up to 6% of children enrolled in a public access HIV treatment programme; confirmed BCG dissemination has only been recorded in infants with rapid HIV disease progression in the first year of life.

There are potential risks of non-BCG vaccination in HIV-exposed infants. South African children have a high risk of exposure of tuberculosis early in life. Apart from reducing the considerable risk of BCG vaccination in a small proportion of HIV-infected infants, there is a potentially greater risk that the much larger proportion of HIV-exposed yet uninfected infants will inadvertently not receive BCG if vaccination is selectively deferred.

Successful implementation of a selective delayed BCG vaccination policy in HIV-exposed infants requires that all of several conditions are met. These include a high uptake of maternal HIV testing coupled with more effective PMTCT strategies including maternal HAART and early institution of HAART in HIV-infected infants.

The authors conclude that universal BCG immunisation of infants should continue in South Africa and other countries with high burdens of HIV and tuberculosis until all programmes are in place for preventing maternal tuberculosis and HIV infection and for safely implementing selective deferred vaccination of HIV-exposed infants.

Tube thoracostomy complications

Trauma, social or otherwise, ranks high on South Africa's list of problems. The rapid development of emergency medicine as a separate discipline owes much to this scourge. Chest injury requiring the insertion of intercostal drains is a commonly used procedure in emergency centres. Maritz, Wallis and Hardcastle[2] investigated the insertional and positional complications encountered by the placement of intercostal chest drains.

Of their patients with complications the majority (92%) had been referred with an ICD *in situ*. Insertional complications numbered 27% with 73% positional complications. The most common errors encountered were insertion at the incorrect anatomical site, extrathoracic placement, and placement that was too shallow (side portal of the ICD lying outside the chest cavity).

Consistently identified as an independent risk factor for the development of complications was insertion of an ICD by a non-surgical operator. The authors provide a quick review of the appropriate technique.

Child Support Grant myths

Some reporters and the public have had a field day in the newspapers and radio talk-shows alleging abuse by women of the Child Support Grant. Marlise Richter[3] provides a timely editorial that debunks this viewpoint.

A Human Sciences Research Council study showed that there was no association between teenage fertility and the grant. Research has consistently found a correlation between social grants and positive childhood development. Studies on the Child Support Grant have shown that this grant is often the only source of income for the child's primary caregiver and that it is spent on food and clothing – not on Lotto tickets or cosmetics.

HIV and surgeons' attitudes

With the HIV/AIDS pandemic the initial focus of risk in the medical setting was on health care workers (HCWs) (and surgeons in particular), but the emergence of HIV-positive HCWs resulted in concerns that also included patient safety. Szabo and colleagues[4] explored the views of practising surgeons in South Africa regarding aspects of HIV and its impact on surgeons.

The perceived risk to patients appeared to have been overstated, especially in view of the advent of antiretrovirals that reduce viral load and infectivity.

Most surgeons were against informing patients or colleagues of HIV status. Such attitudes appear to be contrary to a patient-centred approach whereby such information could be deemed to be in the best interests of the patient. However, patient knowledge of surgeon HIV status could deter the patient from undergoing a procedure by a surgeon who may be uniquely skilled. Therefore it seems that such information should not be shared, and to do so would probably do more harm than good.

In the absence of comparable local or international data, this study provides clinicians' views with implications for the development of locally relevant policies and guidelines.

JPvN

1. Hesseling AC, Caldwell J, Cotton MF, *et al*. BCG vaccination in South African HIV-exposed infants – risks and benefits. *S Afr Med J* 2009; 99: 88-91.
2. Maritz D, Wallis L, Hardcastle T. Complications of tube thoracostomy for chest trauma. *S Afr Med J* 2009; 99: 114-117.
3. Richter M. Bread, baby shoes or blusher? Myths about social grants and 'lazy' young mothers. *S Afr Med J* 2009; 99: 94.
4. Szabo CP, Dhai A, Veller M, Kleinsmidt A. Surgeons and HIV: South African attitudes. *S Afr Med* J 2009; 99: 110-113.