Pagophagia when ice is not available – drink cold water

To the Editor: Louw *et al*.[1] reported in the November issue of *SAMJ* that pagophagia (pica for ice) was present in 9 out of 16 patients with iron deficiency and some form of pica. In the adult haematology service at Universitas Tertiary Hospital, I have made the anecdotal observation that indigent patients with iron deficiency often have a variant of pagophagia: if they do not have access to freezers and ice, they often drink copious volumes of the coldest water they can obtain. Aristotle and Hippocrates as well as authors from more recent centuries warned against the excessive intake of cold water and ice.[2] They probably associated pagophagia with manifestations of iron deficiency.

Nojilana *et al*.[3] estimated that iron deficiency anaemia is responsible for a loss of as much as 0.9 - 1.3% disability-adjusted life-years in South Africa. Only 65.6% of South African households have a refrigerator, according to the All Media and Products Survey (AMPS), commissioned by the South African Advertising Research Foundation in 2004.[4] Therefore, only 65.6% of households have ready access to ice. It is possible that excessive consumption of cold water is a common form of pagophagia in South Africa.

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What did it cost to get you here?

To the Editor: J is a 29-year-old rural Zulu man, tall and muscular, intelligent and stoical. In July 2007, he developed difficulty in walking, which progressed over the next few weeks. His family gathered the funds to pay for him to go to the nearest district hospital in Pietermaritzburg, where he was found to have a neurological defect in his legs, and to be HIV-positive. An appointment was made for an MRI scan in the nearby tertiary unit, and he was also given an appointment to return to the hospital with the result. He was sent home because of the pressure on beds.

He kept his MRI scan appointment, but the family had used up all their money by then, partly because his sister had stopped work to nurse him (she was the main breadwinner), so he could not keep his follow-up appointment. They managed to gather the funds together by the end of November. J now had a flaccid paraplegia with no sensation below his T6 dermatome, large pressure sores, and clinical signs of pulmonary tuberculosis. When his MRI scan was retrieved, it showed multiple subdural abscesses and a psoas abscess. His paraplegia is now probably irreversible.

Were J and his family stupid? It is true that he did not properly understand the explanation of his probable pathology given at his first visit, but he was willing to co-operate nonetheless. I submit that it was not J who was stupid, but carers and a system of care that does not listen to patients and has never taken the trouble to find out what it means to be poor and sick in a rural environment. No one asked him: 'How far away do you live? What did it cost to get you here?' – not at the first visit, or when the scan showed pathology requiring urgent intervention. Assumptions were made based on the conveniences of city life. So a management plan that would have been acceptable in a city failed utterly.

Rural poor often live with such limited resources that carers are given just one opportunity to hit the target. Miss that at the first visit through a failure to listen and empathise, and the result can be catastrophic; which, as in this case, can pull a whole family yet deeper into poverty.

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What is the incidence of paediatric hypertension in South Africa?

To the Editor: In 2006, I wanted to find out the prevalence of hypertension in the paediatric population at my satellite practice in Alexandra, Johannesburg. I examined 49 children (12 males and 37 females), aged between 7 and 16. I measured their blood pressure (BP) with a validated electronic BP machine, after each patient had rested for at least 5 minutes. This BP was then compared with the US normative BP tables. Patients with a BP above the 95th percentile for age, height and gender were regarded as hypertensive. Eight patients were found to be hypertensive, which gave a worrying prevalence of 16%.

Literature searches revealed prevalences of 3.3% in Poland,[1] 4.2% in Italy[2] and 9.1% in Seychelles.[3] These results were from much larger numbers of patients, and most were based on multiple BP readings. The authors all used the same criteria to determine hypertension.

There is a low level of routine BP monitoring of children worldwide, and the prevalence of hypertension in this age group varies. We need a study of the paediatric population

of South Africa to determine the true prevalence of paediatric hypertension in this country, and to determine its correlation with increased body mass index. Until one is published, I believe it is critically important to educate GPs on the US normative BP tables, and encourage doctors and families to be on the lookout for this controllable condition.

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Am I just an old-fashioned GP?

To the Editor: Reflecting on my last three decades in general/family practice, I realised that I am an old-fashioned GP and expect too much from my colleagues. Over the Christmas/New Year period, when many of them were away, some of their patients requested me to fax their pharmacy for a new prescription. I usually respond to such requests: 'My name is Furman, not Faxman!'

The *Cape Times* recently published a notice that a patient, whom I have looked after since birth, had given birth. The gynaecologist did not ask me to assist at the caesarean section, I was not informed of the birth, and I won't get a letter from the paediatrician.

Mossie Silbert and Sid Kiel, whom I joined in Sea Point in 1975, made me call and introduce myself to the other doctors and pharmacists in the area and inform other GPs if I saw their patients. I once called Gresha Edelstein to tell him that a patient whom he had seen recently had consulted me. He responded, 'If my patients don't want to see me, it's OK by me!'

Another well-known physician would call me and ask my permission to see Mr X or Mrs Y who had come to see him without a referral letter.

I have watched the fragmentation and now the defragmentation of general/family practice. Patients self-refer to private clinics, and their medical aid benefits are often depleted by expensive special investigations and treatment. Examples are clinics for headache, sports medicine and women's wellness.

Nursing sisters at many pharmacies give flu vaccines and anti-inflammatory injections, and perform cholesterol and glucose tests. Guess who gets called out when there is an anaphalactoid reaction? Lately, I've been receiving patients requesting inappropriate HIV tests and other screening tests to earn points for their medical aid to fund cheaper movie tickets, plane tickets, car hire and other perks/benefits!

Primary care has changed with the mushrooming of the private trauma/casualty units that are housed at the biggest 'primary care centres'. As long as patients have cash or credit cards, they are seen for any urgent ailment, from nappy rash to rhinitis. These units have an important role in the community, if used appropriately for MVAs, myocardial infarcts, acute surgery and other true emergencies. However, they are being abused by arranging repeat visits instead of returning patients for continuing care to their primary caregiver.

I am now forced to do a dispensing course to continue to perform clinical trials that I have been doing since 1979. My medical training did not include the complex ICD10 codes, Nappi codes or how to manage managed health care. The attempts by the Department of Health to implement a 'Certificate of Need' would result in me not being able to treat whoever, with whatever, and now even wherever I want to treat!

A patient called me out at 07h30 on Christmas Day. He had had several recent hospital admissions after self-referring to a specialist and was on a host of medications of which I was unaware. He asked me, 'Knowing what you do now: if you had your life over, would you still choose medicine as a career?' Without hesitating, I replied, 'Yes'. Driving home for a delayed breakfast, Frank Sinatra was singing 'I did it my way', and I thought that there is no way in the current climate that I am able to practise *my way*!!!

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