In this CPD issue:

This is the first issue of the SAFP journal for 2010 in which interesting articles have been put together for your reading pleasure. As South Africa prepares for the first FIFA World Cup on the African soil, we have decided to feature a relevant article on pain management in Sports Medicine, which will be discussed later in this editorial.

The first CPD article, which is the 9th in the series, focuses on "Healthy lifestyle interventions in general practice and HIV/AIDS" by *Schwellnus MP et al*. HIV/AIDS continues to be a major global health priority. Heterosexual spread is the main mode of transmission in sub-Saharan Africa and this article highlights the role of physical exercise in the management of this condition. Various meta-analyses suggest that constant or interval aerobic exercise at 60–80% of maximum heart rate or a combination of aerobic exercise and progressive resistance exercise for at least 20 minutes, three times a week for a minimum period of four weeks is beneficial and appears to be safe for adults living with HIV/AIDS. The article reviews the effects of physical exercise on various body systems and it is quite clear that physical exercise is beneficial in the HIV/AIDS affected individuals and should form part of their holistic management. In addition, the important roles of psychosocial interventions and dietary recommendations are concisely discussed.

The article on the revised national guidelines for first-line comprehensive management and control of sexually transmitted infections (STIs) by *Lewis DA and Marumo E* covers what is "new" based on evidence-based information following antibiotic resistance profiles that have emerged over time in the management of some of the syndromes. With the increasing prevalence of the quinolone resistance *Neisseria gonorrhoeae* to ciprofloxacin, the new recommended alternatives are cefixime and ceftriaxone. The changes in the management of the genital ulcer syndrome takes into cognisance that genital herpes now accounts for more than half of all genital ulcer cases, hence the addition of acyclovir to the regimen. The modifications to the vaginal discharge syndrome flowchart replace ciprofloxacin with an oral single 400 mg dose of cefixime, which may be given to both pregnant women and lactating mothers with safety. There are other modifications which change how we manage STIs in South Africa and I encourage the readers to familiarise themselves with these changes to improve compliance and cure rates in our patients at the primary care level. There should be a roll out of in-service training for all doctors and nurses in both public and private health services as a matter of urgency.

The article by *Derman EW and Schwellnus MP* on pain management in Sports Medicine is very easy to read and understand. The authors stress the fact that abuse of non-steroidal anti-inflammatory drugs (NSAIDs) is common at both FIFA World Cup and Olympic level athletes. The pathophysiology of pain is explained concisely including the differences between the isoforms of the cyclo-oxygenase enzymes (COX-1 and COX-2). They advocate that analgesics such as acetylsalicylic acid, paracetamol, codeine and tramadol should be used as the first line management for acute sports injuries and cautioned on the use of topical analgesics, the majority of which cause erythema, blood vessel dilatation and stimulate pain and temperature receptors. In the article, they discuss when NSAIDs should be used and their effects on the bone, skeletal muscles, ligaments and tendon in detail and conclude with recommendations for the use of analgesics and anti-inflammatories in sports medicine, which include rest, ice, compression and elevation in the first 48 hours following injury. After 48 hours post-injury, if there is evidence of inflammation, then an NSAID or COXIB should be used for a limited period of five days.

The last article by *Copley GJ and Friderichs NB* deals with an approach to hearing loss in children. They state that infant hearing loss is the most common congenital sensory birth defect with a prevalence of 4–6 per 1 000 live births in a developing country like South Africa. In terms of the aetiology, hearing loss associated with newborns is usually sensorineural in nature which may be due to a genetic defect or acquired from the environment. A number of conditions either in the mother or due to intrauterine infections have been implicated in this condition. Hearing loss in the older child is considered to be due to complications of upper respiratory tract infections with resultant chronic middle ear pathology. Identification of hearing loss is crucial to limit the sequelae of poor reading comprehension and language skills in the later life of the affected child. The solution lies in the screening of children suspected of hearing loss and the authors provide risk indicators for infants and children which primary care practitioners can use with ease.

As we anticipate the buzz of the FIFA World Cup on our shores in the next few weeks, let us show the rest of the world the warmth and hospitality of South Africans as we welcome them to our beautiful country.

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