Letters to the Editor

We welcome any brief comments on articles published in the Journal or other information of interest to readers. Letters selected for publication that comment on published articles will be forwarded to the original authors of those articles. Final approval of letters to be published remains with the Editor. Please note that only letters of 300 words or less will be considered for publication. Please send your letter to: pjtdv@sun.ac.za or P.O. Box 19063, Tygerberg, 7505

Congratulations on new journal

To the Editor: I wish to congratulate you and the Editorial Board on a really fine Journal.

Twenty odd years ago I enjoyed the old SAFP as a junior G.P. Because of an increasing interest in Aviation and Diving medicine I lost touch with SAFP. When your new journal landed on my desk recently, I browsed through it and found myself reading it cover to cover. (and the same with the March and April issues.)

Good luck!

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Tuberculosis

To the Editor: The Clinical Review article "Tuberculosis: Current issues on diagnosis and management" (SA Fam Pract 2003;45(2):38-43) was disappointing, especially appearing in a clinicians' journal ("the only one you need to read").

It is good top-down declamatory stuff, nearly all of which has been around for several years.

Instead of packing material from the Department of Health's *The South African Tuberculosis Control Programme: Practical Guidelines 2000* into dense column-inches it would have been better to recommend the Guidelines' more accessible format and how to get them.

Hands-on clinical "challenges and problems" that deserve up to date discussion include:

- Definition of Contacts for management purposes (Anxious patient says I visited my brother last week and he is being treated for PTB. Is he *ipso facto* a contact?).
- Quantitative interpretation of sputum reports (eg. scanty smears and 2-colony cultures).
- Precautions for outpatients who cough (separate waiting?) and hospitalised PTB patients beginning treatment (isolation wards?)
- Practical advice on sputum disposal (eg for patients who don't have tissues or toilets).
- Definition of non-adherence for management purposes. (eg 3 times a week, say, instead of 5?)
- How to improve adherence (patient-centredness?).

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Authors' response:

We value Dr. Ingle's criticisms and comments on our article. The aim of the review was to highlight important issues in tuberculosis, and to complement the national guidelines, and we feel these aims were achieved. The subject of tuberculosis is huge and we were constrained by the need to limit the length of the article. He posed a number of questions regarding tuberculosis and we would like to respond to these. A **contact** is someone who lives in the same household with a TB patient who is smear sputum positive for acid fast bacilli usually reported quantitatively e.g. 1+, 2+, 3+. If less than 10 bacilli per 100 immersion fields are seen, the actual number of bacilli is reported. This would be equivalent to the term *'scanty'*, which is being phased out. It is advisable to repeat the sputum smear, and submit the sputum for culture in patients whose sputa are reported to contain less than 10 bacilli per 100 fields since occasionally this may result from laboratory contamination. Quantification of sputa is performed so that one can compare sequential sputa and assess response to treatment. In practice the results may be highly variable, and not always reliable.

Ideally, patients with suspected or confirmed TB should be in a separate area in the waiting room, and those who are smear positive should be isolated in hospital for about 14 days. If resources are limited, patients can be cohorted into those with susceptible TB or those with drug-resistant TB. Patients with fully susceptible TB who comply with appropriate treatment respond rapidly to treatment. Regarding the issue of sputum disposal in the absence of tissues or toilets. Perhaps a piece of newspaper could be used, closed and simply thrown away. Although, the TB bacilli may remain viable for some time, they are spread by aerosols, and would not pose a risk. **Treatment interruption** occurs in a patient whose treatment was interrupted for two months or more. It becomes a bit more difficult to categorize defaulters based on different permutations and variations. However when considering Dr Ingle's example of 3 times a week versus 5 times a week of the same dosage, perhaps one would again use the 2-month or more cut-off. Patient adherence to TB management is critical, plus individual patient treatment and cure. Dr. Ingle correctly identifies the importance of patient centeredness in TB management and this we agree with. Additional factors will include easy access to medication, patient's understanding of the need to complete six months of treatment, and management of adverse drug reactions.

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