SASPREN MAKES ITS MARK IN SOUTH AFRICA

Second research project underway

SASPREN — the Southern African Sentinel Practitioner Research Network — has finally made its mark in South Africa. It now has completed 18 months of surveillance of 13 diseases/events in primary care. The second research project started in September.

SASPREN is now ready to enter into a more mature phase as a sentinel network, for which it will need the financial support from the public health authorities. This will enable the network to get access to enough resources to fulfil its rightful role in providing much-needed public health information.

Membership update

The membership has grown from 70 to 76 during this quarter. Many thanks to Dr Ragavan in the Northern Province who is acting as regional co-ordinator. The steering committee has decided to launch a new membership drive at the end of this year, in order to improve the membership in certain provinces for the next cycle during 1998.

Surveillance update — Second quarter 1997

During the period April to June 1997, a total of 90 058 consultations were covered. A total of 8 196 events were notified (9%). The national notification rates for the various events are depicted in Table II.

Some events demonstrated a clear increasing trend: notably asthma, diabetes mellitus, PAP smears, suspected tuberculosis and underweight in children under six years. Likewise, a clear downward trend occurred in gastro-enteritis, measles and violence at home. The downward trend of measles is noted for the second consecutive quarter. It is interesting to note that measles and acute myocardial infarction now have the same incidence in these samples of family practices.

Focus on asthma

This quarter we focus on acute asthma. There seems to be an increase of 38% in the notification rate, when the second quarters of 1996 and 1997 are compared.

Looking at the graph of the trend during the first six months (Figure 1), it can be seen that the increase was mainly in the winter months. It is too early to make any definite conclusions, but it may have been due to an increase in the number of upper respiratory viral infections during the winter of 1997.

Report on European visit

The project leader of the surveillance system, Prof Pierre de Villiers, recently visited five European surveillance networks during July of this year. The purpose of this visit, which was funded by the University of Stellenbosch, was to learn from these networks and to make international contacts with a view to future collaboration.

The following networks were visited: the Dutch (GP network of the Netherlands Institute of Primary Health Care, NIVEL), the Belgian (Huisartspeilenpraktijken of the Louis Pasteur Institute), the French (Sentinells of INSERM) the Portuguese (Medicos Sentinels of the Department of Health) and the British (Weekly Returns Service of the Royal College of General Practitioners).

The highlight of the tour was undoubtedly the visit to the very technologically advanced French network in Paris. The following important lessons learnt will have to be considered for possible adoption by SASPREN in the near future:

Ownership: All the networks have very close ties with the Department of Health or a research institute funded by the department. This generally gives the network access to the resources of such department/institute.

Pierre de Villiers
Research Co-ordinator

Province	Members 1997	Sentinels 1996	Sentinels 1997
Eastern Cape	25	18	9
Free State	16	10	8
Gauteng	28	20	7
KwaZulu-Natal	26	12	11
Mpumalanga	21	13	5
Northern Cape	17	7	7
Northern Province	8	2	4
North West	8	7	4
Western Cape	42	31	21
Totals	**191**	**120**	**76**

Table I. Membership Status — June 1997

	1996	1997	Change (%)
Asthma	4,39	6,07	+38
Depression	5,80	5,66	-2
Diabetes Mellitus	1,68	2,32	+38
Gastro-enteritis < 6 years	17,26	13,6	-21
HIV tested	4,02	3,85	-4
Hypertension	8,45	8,84	+5
Measles	1,21	0,49	-60
Myocardial Infarction	0,43	0,46	+7
PAP smear	6,78	8,46	+25
STD Syndrome	31,62	29,46	-7
Tuberculosis	5,46	6,66	+22
Underweight < 6 years	1,80	2,39	+33
Violence at home	4,98	2,74	-45

Table II. Comparison of notification rates (number notified per 1 000 consultations) for the second quarter, 1996 vs 1997

Management: The manager of the network spends at least 50% of his/her time on the management of the network. Most have fulltime managers/co-ordinators.

Funding: All the networks are funded by their respective governments, directly or indirectly by means of a grant. This enables the network to employ enough fulltime staff.

Selection of events: The Department of Health has a meaningful say in the decision-making process selecting the events for surveillance. Most networks tend to focus on infectious diseases of which influenza seems to be the most important.

Data collection: All the networks make use of a more comprehensive report sheet, compared to the report card currently in use by SASPREN. This way they can collect much more information about every reported case.

Data transmission: The French and British networks are making use of electronic data transmission, over the telephone line. This requires each sentinel practitioner to have access to a personal computer with a modem.

Data analysis: All the networks have at least a part-time statistician and epidemiologist. This enables them to make use of very sophisticated statistical techniques and displaying methods.

Reporting and feedback: Reporting to the public health authorities is a very important component of the surveillance system. Some of the networks also make their information available on the Internet.

THE OUTGOING CHAIRMAN'S REPORT...

Members of council present, members-elect of the new council, ladies and gentlemen, it gives me pleasure to present the chairman's report for the financial year ending 31 March 1996, but also to report on the activities up to today. As the outgoing chairman, I would also beg your indulgence to permit me to reflect on some aspects of the organisation which was to consume many of my waking, sleeping and nightmare hours for the seventeen years since its formation in Cape Town in 1980.

The Academy was formed out of necessity seventeen years ago, following secret meetings in a house in Johannesburg's northern suburbs. There was considerable opposition to its formation, mainly from those who had driven us to form an organisation, independent from the College of Medicine and free of specialist domination and control, which could cater to the needs of all primary care doctors and not only those who had obtained a membership of the College. Our opponents in the College even threatened to expel our new executive from the College for having formed a new organisation, and spread rumours of an imminent split in the Academy between the south, led by Joe Levenstein and Basil Jaffe, and the north, led by myself! There was a desperate need for a separate voice for family doctors who wished to develop the academic discipline of family medicine.

We were supported in those early years by the NGPG of MASA, with whom we had a clearly defined agreement not to delve in medico-political matters and they would stay out of academic and CME activities. Apart from the Faculty of General Practice, the Academy and Transvaal Study Circle there was no other CME being offered within the community. The Division of Continuing Education at Wits offered some courses, but soon they stopped as the Academy grew.

In this new field of activity the organisation went from strength to strength in the early days under the leadership of some giants such as Basil Jaffe, Joe and Stan Levenstein, Mossie Silbert, Attie Baard, Abdul Barday and Saville Furman from Cape Town; Bozzie Fehler, Roly Meyer, Gus Clennar, Essop Jassat, Jane Bewsay, Willie Sacks, Abdul Nana, Des Sonnenfeld, Mike Perlman, Naomi Arnheim from Johannesburg; Howard Botha, Sam Fehrsen, Dries van den Berg, George Davie, from Pretoria; Garth Brink, Neethia Naidoo, Julia Blitz, Russel Kirkby and Syd Mobbs from Natal; Elliott Murray, Kaya Mfenyana and Basil Michaelides from the Eastern Cape and Gawie Pistorius from the Free State. Many of them are in retirement. I salute them all and thank them for the insight and perseverance that got us where we are.

In those days the rand was good value, and although our ministers of health were mainly gynaecologists, and dispensing was expected of GPs, the drug companies knew nothing about CME, so we were sought after in all quarters, and attending educational activities and congresses specially organised for GPs was a novelty. It was also safe to travel the streets at night and the siege mentality was not heard of. The only perceived threat in SA was from the international sanctions applied to the Nationalist Government.

When I took over from Joe Levenstein as Chairman in 1990 we had been through many ups and downs financially but we were holding our own with a successful journal and national coverage, with CME programmes being well attended. There was a need for more autonomy for the regions, and after successful national congresses in major centres the regional offices grew and flourished.

Prior to the unbanning of the ANC, the pharmaceutical companies expressed insecurity and we noticed a diminishing support for educational activities and for the journal. Unfortunately this uncertainty and insecurity has never really been allayed as far as they are concerned, with threats even now of parallel importing, price demands and so on.

This change in the milieu was coupled with a general increased societal insecurity and threat of violence. More doctors attended our lunch-time meetings than evening meetings. Venue changes were made to try and meet the needs of doctors. GPs sought attendance at meetings closer to home, often forming their own small groups. IPAs and PPAs began to flourish as the concept of managed care became more popular. The cake of marketing funds available from pharmaceutical companies for education and publications was now being cut into ever-decreasing slices. A plethora of overseas-owned journals with massive amounts of specialist-written editorial flew across our desks, and the marketing managers began to cut advertising in thinner family practice academic journals. (This phenomenon also occurred overseas.)

Coupled with these changes were the perceived inroads being made into our activities by the primary care nurses, the pharma-

New Council members elected

The Academy has a new Council, the members being elected on a Provincial basis. The new Council members are:

National chairman	Dr Marietjie de Villiers
National treasurer	Dr Garth Brink
Eastern Cape	Prof K Mfenyana
Gauteng	Dr L Shein
KwaZulu-Natal	Dr N Naidoo
Mpumalanga	Dr R Lombard
Northern Province	Dr M Kruger
North West Province	Prof J Hugo
Orange Free State	Dr W Seidel
Western Cape	Dr S Mazaza

The provincial chairmen will be responsible for the setting up of branches in the provinces.

Annual General Meeting

The Academy AGM was held on Tuesday, 14 October, at the College of Medicine. Professor Sparks, the outgoing chairman, paid tribute to those who had been involved in Academy initiatives, and welcomed Marietjie de Villiers as the new chairman. Dr de Villiers thanked Prof Sparks for his unfailing dedication to the Academy over a period of 18 years.

Council Meeting

The new Council met on 15 and 16 October at the Academy Head Office, Rivonia, and discussed a number of issues that affect the family practitioner. Items discussed included the National Rural Health Initiative, recertification for family practitioners, and the role of the Academy in the 21st Century, in particular by addressing members' needs.

Professors Hugo and Mfenyana and Dr Naidoo were appointed trustees for the Rural Health Initiative. Penny Bryce was appointed as the Consultant National Marketing Manager of the Academy, and Fundraising and Donor Managing Consultant of the RHI, with effect from 1 November 1997. She has been involved in the Rural Health Initiative since its inception, and has played an integral part in obtaining funds for the Initiative.

The Council resolved that the Academy should assist in the professional development of the family practitioner, and will explore methods in order to achieve this aim.

The new Academy structure and the enthusiasm of the Council will facilitate the growth of our organisation.

Members are reminded about the 11th Family Practitioners' Congress and the 15th World Congress of Family Doctors, details of which appear in this issue.

cists, alternative healers - also demanding a slice from the funders.

Our Journal then faced further calamity when our senior trained staff were drawn away by opposition forces. Training new marketing staff proved extremely expensive and difficult. We were now in a huge, very competitive market with journals owned by huge multinational organisations with incredible backing. We, together with MASA, were the only medical organisations that owned our own journals. All others are generating income for their holding companies and not the individual organisations.

The net result for the Academy was a decrease in revenues, associated with a diminishing desire on the part of cash-strapped GPs to pay for their own education. Attendance at meetings diminished (unless they related to financial matters), reinforcing to the industry the need to hold more expensive but better attended weekend "university" programmes and "Astra Days" etc., independent of any organisation. You see, we had taught them how to do it!

Dr Peter Cusins joined us as CEO in March 1995. He brought about many changes, including the suggestions for the new structure of the Academy which comes into effect with the new Council. I would like to thank him for the new directions and challenges he set for us. Unfortunately he chose not to reconsider his contract after the first year and has now gone to Ireland. His departure left an enormous gap, which due to financial constraints we were unable to fill. The tasks which he had initiated were taken over by myself and Garth Brink, ably supported by Mrs Mary Otte in the Rivonia office and Claire de Jongh in Garth's rooms. They have been absolute stars in keeping the functions of the Academy going after Peter left. Thanks too to Marie Jonker and Joan Strachan for taking a lot of the load off my back.

Despite these financial losses and stresses, which by the way, were handled most ably and with much personal sacrifice by Garth Brink and the executive committee, we were able to achieve considerable success in other fields.

The Academy continues to be an active member in government and other statutory organisations, and is continually consulted by them on matters pertaining to education, the affairs of family practitioners, compulsory community service and "vocational training", human resources development, recertification, HIV and AIDS, essential primary health care research, rural health matters, local government, primary health care services, and dispensing. The Academy has made presentations to the portfolio committee on health on vocational training and dispensing and also made submissions to the Truth and Reconciliation Committee.

It continues to fulfil its role as an educational body with numerous mini congresses, workshops and other activities. New regions have been established in Eastern Cape (Transkei) and Eastern Transvaal (now Mpumalanga). The Northern Transvaal region has also flourished and grown into an extremely active region.

The Academy has seen the flourishing of its research arm, SASPREN, which has shown itself to be a significant force in surveillance and community-based research, especially in the Western Cape. Recent years has also seen the formation of working parties on quality assurance, HIV and AIDS, women's health, examinations, CME and rural health.

The most recent WONCA World Rural Health Congress organised by the Rural Health Care Working Party in Durban was an enormous success. Out of it has come the Durban Declaration, a document of global significance, which calls on the nations of the world to urgently address the plight of the rural practitioner. I wish to formally congratulate Garth on his tremendous organisation and leadership in making it the success it was. Thanks Garth!

Claire de Jongh once again deserves our thanks for her hard work and dedication. Thank you too to Steve Reid, Neethia Naidoo and others for their dedication and hard work.

The most recent exciting development is the Rural Health Initiative which has been very successful in raising funds for Rural Practitioner Educational Programmes using communication technology. Sites have been established nationally and there is considerable interest from Government structures and WHO.

At last the Academy is able to meet the needs of its rural members. Thank you to Penny Bryce for her incredible assistance to me in this venture.

The Academy continues to enjoy international ties through WONCA and as you will know the Academy has been chosen to host the World Congress in 2001 in Durban.

The Academy is not a body which does things! It is the people within the organisation which give it its life and meaning. Its Mission is "to raise the standards of health of the individuals, families, and the communities of South Africa by developing primary health care personnel and the discipline of family medicine". I believe that it has done so and will continue to do so but at an even higher plane and level of activity under the leadership of Dr Marietjie de Villiers and her new council. I would like to thank all members of the "old" council and executive for their tremendous support for the Academy and for me personally. Thank you too to the regional committees, directors of committees and working parties, and of course the administrative staff, without whom we would have never got here — Marie Jonker, Mary Otte, Claire de Jongh, Jane Russel, Linda Howard, Joan Strachan — thanks to all of you.

I would also like to personally thank all my good friends in the Academy for putting up with me. I know I have not been the greatest communicator and delegator — but thanks. To Garth, Sam, Naomi — thank you! And a special thanks to my wife, who has put up with the Academy for seventeen years, and who has rescued me from my worst sleepless nights.

Marietjie, congratulations and good luck! May the force be with you!

— Prof Bruce Sparks

...AND A MESSAGE FROM THE NEW CHAIRMAN

The South African Academy of Family Practice/Primary Care has a new National Council. In addition to the national chairman and treasurer, each province is represented by a provincial chairman. Congratulations to our councillors-elect! This new structure facilitates direct input from members in the national body.

I want to invite all members to use the new Council to their advantage. Any organisation exists primarily to serve the needs of its members. The Council will endeavour to provide a clear flow of communication.

Family practice faces many challenges. Maintenance of standards, recertification and managed health care have become everyday realities. Medical education is changing from traditional methods to problem-based learning and community-based teaching. Family doctors are no longer satisfied to listen to didactic lectures by specialists. The task of the Academy is to facilitate the professional development of its members through quality continuing medical education. We know best what our needs are, and how we can address them.

The support and development of rural and underprivileged communities is a global priority. Through our Rural Health Initiative the Academy assists health professionals serving these communities. The rural doctors and the members of the Academy have a similar aim — to provide quality patient-centred care. We must work together towards this. Also, family doctors in the public sector are increasingly aware of their continuing education needs. The Academy has the experience and ability to play a role in the provision of continuing medical education to these doctors, and I urge them to join our organisation.

Afrikaanssprekende geneeshere vorm 'n groot deel van die huisartspopulasie van Suid-Afrika. Dit is vir my belangrik dat die Akademie vir Huisartspraktyk/Primêre Sorg ook kan voorsien in die spesifieke opvoedkundige behoeftes van hierdie beduidende groep dokters. Ons sal werk aan stratigieë en geleenthede waardeur u deelname aan hierdie organisasie aangemoedig sal word.

We are living in the technology age. Telemedicine brings new opportunities to all corners of the earth. Many innovative ideas are used to disseminate information. It is, however, important that

technology is utilised to serve our needs, and not only for the sake of technology. We are planning, amongst others, to establish a website for general organisational information and tailored continuing medical education. We welcome your contributions to this.

Almost 50% of medical students are female. Female doctors are increasingly pursuing family practice as a career. International research shows that female medical practitioners face specific challenges. Gender insensitivities, sexual harassment, unjust leave and maternity benefits and the ever-present glass ceiling are but a few. Male as well as female colleagues need to be sensitised about these issues. We are indeed different, but definitely equal.

At the recent World Rural Health Congress in Durban a resolution was passed to strengthen the participation of women. The resolution proposes the inclusion of women's issues and female speakers in plenary sessions, the availability of child care at conferences and a much larger involvement of women in the chairing of sessions. The South African Academy of Family Practice will work towards achieving this and other goals in the attainment of equality for our women.

Lastly, the growth of a discipline is dependant on its ability to generate new knowledge and question the existing. Family medicine in South Africa needs a solid body of research. The Academy encouraged research through various activities. SASPREN (SA Sentinel Practitioners' Network) is a national surveillance network which looks at certain common conditions in primary care. Also, the South African Family Practice Journal has been accredited as an official research journal, providing a platform for the publication of our research. We need your support and participation in all these activities.

A final word on my vision as national chairman. Participating management, transparency and communication are my priorities. An organisation is as strong as its membership. The Academy has many talented and dedicated members. The role of the chairman is to encourage and facilitate the involvement of the members to the benefit of the organisation as a whole. Together we can make it work.

— Dr Marietjie de Villiers

SA FAMILY PRACTICE: INSTRUCTIONS FOR AUTHORS

- The *South African Family Practice* accepts manuscripts prepared in accordance with the Vancouver Style[1] and any papers that conform to that style will be considered.
- All material submitted for publication is assumed to be submitted exclusively for the *South African Family Practice* unless otherwise stated.
- All authors must give signed consent to publication. Manuscripts should bear the name and the address of the author to whom proofs and correspondence should be sent.

Language policy

Articles in all eleven official languages will be considered for publication. All articles not written in English must be accompanied by an English summary.

- Manuscripts will be acknowledged; letters will not be, unless a stamped addressed envelope is enclosed.
- The Editor retains the right to stylise and, if necessary, shorten material accepted for publication.
- Any article may be submitted to outside peer-review, statistical assessment and evaluation by the Editorial committee. This should take six weeks but may take up to ten weeks.

Manuscript preparation

Copy should be neatly typewritten with double spacing and wide margins. Pages should be numbered.

- The manuscript must be submitted in triplicate. If the paper is rejected these will not be returned. Authors should keep one copy of their manuscript for reference.
- Scientific articles should conform to the conventional structure of abstract, introduction, methods, results, discussion and references.
- The abstract should be no longer than 150 words and should set out what was done, the main findings and their implications.
- Original articles should be 2000 words or less with no more than six tables or illustrations.
- Letters should normally be no more than 400 words.
- Abbreviations should preferably not be used. When used, they should be spelt out when first used in the text and thereafter used consistently.
- Tables and illustrations should be submitted separately from the text of the paper and legends to illustrations should be typed on a separate sheet.
- Tables should be simple and should not duplicate information in the text of the article.
- Tables should carry Roman numerals, thus: I, II, III etc. and illustrations Arabic numerals, thus: 1, 2, 3, etc.
- Photographs (in duplicate) should be glossy, unmounted prints.
- When identification of a patient is possible from a photograph, the patient must submit signed consent to publication.

References

References should be numbered in the order in which they appear in the text. The full list of references should give the names and initials of all authors (unless there are more than six, in which case only the first three should be given followed by *et al*).

The authors' names should be followed by the title of the article; the title of the journal, abbreviated according to the style of *Index Medicus* (consult the January issue of *Index Medicus* (No. 1 Part 1) for these details); the year of publication; the volume number; and the first and last page numbers. Titles of books should be followed by place of publication, publisher, and the year of publication:

Stott NCH, Davis RH. *The exceptional potential in each primary care consultation.* J.Roy Coll Gen Pract 1979;29:201-5.

Stott NCH. *Primary Health Care: Bridging the Gap Between Theory and Practice.* Berlin: Springer-Verlag, 1983:43-7.

Authors must verify references against the original documents before submitting the article. Scientific measurements should be given in SI units with two exceptions: Blood pressure should be given in mm Hg and Haemoglobin in g/dl.

Editorial address

The Editor,
South African Family Practice,
P.O. Box 459,
Umhlanga Rocks, 4320

[1] International Committee of Medical Journal Editors. *Uniform requirements for manuscripts submitted to biomedical journals.* Br. Med J 19X2; 2X4: 1766-70.

Polio surveillance network expands

In a crucial step toward achieving global polio eradication, the American Association for World Health (AAWH) announced recently that it will support the expansion of the World Health Organisation's polio surveillance network in Southern Africa, where the disease is still a major threat. The network and other AAWH activities aimed at polio eradication are being funded by a $1-million grant from Wyeth-Lederle Vaccines and Pediatrics.

"This expanded polio surveillance network in Southern Africa is crucial because it will enable us to quickly pinpoint locations of wild poliovirus outbreaks, alert local organisations to conduct massive immunisation campaigns and verify areas where polio has been eradicated," said Richard L Wittenberg, President and Chief Executive Officer of AAWH, which serves as the US Committee to the World Health Organisation. "With the help of Wyeth-Lederle, we are moving one step closer to global polio eradication."

In 1988, the World Health Assembly established a goal of globally eradicating polio by the year 2000. Since then, dramatic progress has been made in efforts to eradicate the disease, including the elimination of polio in the Western Hemisphere. However, Africa continues to be a key focus of eradication efforts, with more than 2 000 cases of polio reported in 1995.

Last year, the African Regional Office of the World Health Organisation, which will co-ordinate the expanded polio surveillance network, initiated the *Kick Polio Out of Africa* campaign, a three-year program to establish polio eradication immunisation campaigns in 45 African countries. So far, the WHO campaign has achieved substantial reductions in the number of polio cases occurring in the region. However, as the incidence of polio declines and eradication nears, it will become increasingly important to closely monitor new outbreaks of the disease, and to confirm that the disease has been eliminated.

Over a three-year period, the grant will provide technical assistance and support training programs at the National Institute of Virology (NIV) in Johannesburg, which will become the regional reference laboratory of the network. The grant will also be used for the procurement of needed laboratory equipment, reagents and supplies, and the accreditation of national laboratories.

At the Congressional briefing, Dr Ralph H Henderson, Assistant Director-General of the World Health Organisation, and the Honorable Franklin Sonn, South African Ambassador to the United States, highlighted progress in global efforts to eradicate polo, and called for new public-private sector initiatives to achieve this objective.

"This grant is an important example of effective collaboration between industry and humanitarian organisations for global immunisation and polio eradication," said Dr Henderson.

"Although this grant initially will be used to support the worldwide polio eradication effort, the laboratory network could also play an integral role in the surveillance of other life-threatening diseases such as measles and rotavirus diarrhoea," said Dr Ronald J Saldarini, President of Wyeth-Lederle Vaccines and Pediatrics.

"As other vaccines such as those to protect against hepatitis B, Haemophilus influenza and rotavirus disease are introduced into immunisation programs in Africa, extensive laboratory networks will be needed to monitor disease progression and elimination. Establishing a strong network of virology laboratories is the most efficient and sustainable way of ensuring that disease surveillance in this region will continue in the future."

The American Association for World Health (AAWH) was founded in 1953 as a private, non-profit, charitable and educational organisation and serves as the US Committee to the World Health Organisation (WHO) and the Pan American Health Organisation (PAHO). Its purposes are to inform the American public about major health challenges that affect people both at home and abroad, and to promote co-operative solutions that emphasise grassroots involvement. In carrying out its mission, AAWH works with a variety of public and private health-related organisations. ●

New agreement for cancer vaccines

Bristol-Myers Squibb, together with Progenics Pharmaceuticals (USA), have announced a licensing agreement under which Bristol-Myers Squibb will obtain the exclusive rights to GMK and MGV cancer vaccines.

GMK is a vaccine for the treatment of malignant melanoma, the deadliest form of skin cancer. MGV is a vaccine being developed to treat a variety of other tumour types.

Bristol-Myers Squibb will support the clinical development and the marketing of the vaccines and are delighted to have the opportunity to provide new hope for patients diagnosed with cancer.

The GMK and MGV vaccines are designed to stimulate a patient's immune system to control or eradicate residual cancer cells. GMK incorporates the GM2 ganglioside, a cancer antigen present in approximately 95 percent of melanoma cells. Phase II studies have shown that vaccination of melanoma patients with the GMK vaccine resulted in the formation of antibodies against GM2, which killed melanoma cells with no significant side effects to the patient. It has been demonstrated that patients with stage III melanoma who have developed antibodies against GM2 remain disease-free for significantly longer periods and had longer overall survival.

GMK is currently in National Cancer Institute (NCI)-sponsored pivotal Phase III clinical trials for patients with stage III melanoma, which involve several co-operative groups in the US and Canada. A second pivotal Phase III trial, also for stage III melanoma patients, will be initiated in Europe, Australia and New Zealand. In addition, the European Organisation for the Research and Treatment of Cancer (EORTC) will be conducting a Phase III study in patients with stage II melanoma, an earlier stage of the disease.

The MGV vaccine incorporates the gangliosides GD2 and GM2, antigens found on the surface of tumour cells such as colorectal and gastric cancer, small-cell lung cancer and sarcoma. MGV is currently in Phase I clinical trials.

Melanoma accounts for six out of seven skin cancer deaths, and its incidence is growing at the fastest rate of any cancer in the industrialised world. The American Cancer Society (ACS) estimates that in the United States alone approximately 43 000 patients will be diagnosed with melanoma this year, a 12 percent increase from 1996. ●

Physical rehab group gets underway

For the first time in South Africa, a therapy unit specialising in the physical rehabilitation of patients has become affiliated to an international network of 1 200 rehabilitation hospitals in 18 countries.

The Physical Rehab Group uses an internationally accepted outcomes management system in treating patients disabled by strokes, or injury to the brain or spinal cord, for example. Staffed by functional care specialists, it has its South African academic base at the University of Cape Town, headed by Prof Stephen Louw.

Prior to treatment, each patient's functional ability is assessed on 18 different measurements. With the use of sophisticated information technology the unit is able to predict the optimum degree of improvement in areas such as self-care, mobility and mental abilities.

"We offer employers, families of disabled victims, and the patients themselves, hope in their darkest hour by maximising their chances of recovery through the use of a co-ordinated rehabilitation programme. This programme is supported by an information technology system which predicts the duration of treatment, costs and expected results even before we begin treatment," comments Prof Louw. "The fact that our treatment is predictable and measurable is invaluable to insurers and medical aid schemes."

Prof Louw explains that although relatively undeveloped in South Africa, the science of physical medicine and rehabilitation is well established overseas. "This is currently the only unit in South Africa using the internationally accepted Functional Independence Measure, which provides a common language and uniform approach for assessing patient disability and the efficiency of rehabilitation efforts.

"We are able to compare a patient's admission assessment with an international database of over three million patient records. This comparison gives us an expected length of treatment, potential costs and improvement. By providing excellent post-acute therapy, we work with the patient's surgeon or doctor to enable the disabled patient to be reintegrated into his community."