

The Emergency Medicine Consultation: Revisited

To the Editor: Emergency Medicine is a broad discipline. "It may be regarded as a multidisciplinary resuscitation, stabilization and appropriate disposition' speciality."¹

Emergency units are often characterized by large amounts of patients and few medical staff; leading to the health care professional not being able to spend enough time with a patient. Many consultations are rushed, simply to clear the queue. Patients tend to be dissatisfied with the quality of service received, often not knowing how to use medication and present with frequent exacerbations of many common chronic conditions. One such comment follows: "I'd rather be treated at the SPCA than come to hospital."²

This letter addresses the holistic management of patients presenting to Emergency units. The proposal is that the word "prevention" be added to the above definition of Emergency Medicine and that patients be managed using the "Educate – Bio – Psychosocial" approach that is often taught in Family Medicine and Psychiatry.

For Example, a 55 year old male presents with polyuria and polydipsia. He is a known diabetic on oral hypoglycaemics. His glucose is 24.

Bio: Resuscitate, correct glucose and electrolyte abnormalities.

Educate: Spend some time educating him about his illness, medications, diet and dangers of poorly controlled diabetes. Book him for follow up at OPD.

Psychosocial: His wife just died. He is at high risk for depression. Book him to see the psychologist. This need not be done immediately but should be part of a holistic approach to patient care.

Hospitals have allied health professionals that are enthusiastic and willing to assist. The dieticians, social worker, OT, Physiotherapist, and Psychologist are just a few to name and all have a role in Emergency Medicine.

It seems futile to see 40 patients, claim to have cleared a queue, doing no justice to the medical profession and patients alike. Maybe, by following the "Educate – Bio – Psychosocial" approach; we will have fewer patients visiting the SPCA.

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References

1. Balfour, C. Emergency Medicine – a new era in South African medicine. SAMJ; Jan 2006, Vol.96, p47
2. Patient's Complaint Register at Polokwane Hospital.

Misoprostol alone for the termination of Pregnancy

To the Editor: I find it reprehensible and unworthy of a supposedly scientific magazine to publish an article about the unlawful use of Misoprostol.¹ It's package insert and manufacturer doesn't state as its use the killing off of human life. Publishing such stuff is unscientific and unethical and lowers you in our estimation. Maybe, in your next edition you'll tell us how many failures you had with intra-vaginal bamboo sticks.

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Reference

1. Cuellar T, Lang B, Joubert G, Duma MP, Metula M. Misoprostol alone for the termination of Pregnancy. SA Fam Pract 2007; 49(3): 16-17

Comment by the Editor: The article of Cuellar et al does not report on any unlawful use of Misoprostol. The use of Misoprostol for termination of pregnancy has been approved by the Medicines Control Council of South Africa. It is part of the approved protocol for termination of pregnancy in public sector facilities in the Western Cape.¹

Reference

1. Provincial Administration: Western Cape: Termination of Pregnancy (Top): Policy, Guidelines and Protocols. Circular Number: H97/2000

Mifepristone in termination of pregnancy

To the Editor: I read with interest Cuellar et al.'s paper.¹ It is an important topic, especially in view of the lack of availability of mifepristone. There is wide consensus that mifepristone improves the outcome of "medical abortion". Currently, the dosage has been reduced from 600 to 200 mg. Mifepristone has been registered by the South African Medicine Control Council and is listed as an essential drug by the World Health Organization.² Unfortunately, mifepristone is still not available in the public sector. Hence, we have to do without, albeit with lesser success.

There is still no agreement on the best route of administration (sublingual, buccal, vaginal, or rectal), the dosage, and the maximum number of repeat administration and time interval between repeat administrations. There is some indication that the oral route is less effective than the vaginal.³ This might be due to the difference in speed to reach a high plasma level and how long that level is sustained. The vaginal route provides a faster high plasma level, which is sustained for a longer period of time than the buccal route.⁴

The originality of this research is to have compared the vaginal with a combined oral-vaginal administration of misoprostol for first and second trimester termination. Although the authors recognise that larger studies are needed (especially in view of the high rate of loss to follow-up), I think that their conclusion does not reflect the findings. They write (cautiously): "The combination of the two modes in the use of misoprostol *seems* better for producing an abortion" (emphasis added). In fact, the comparison between the two modes for first and second trimester termination yields respectively a chi-square of 0.15 ($P = 0.70$) and 0.16 ($P = 0.90$). The comparison between the vaginal and combined mode for both trimesters yields a chi-square of 0.06 ($P = 0.80$). Hence, it has not been shown convincingly that the combined approach *is* better.

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1. Cuellar T, Lang B, Joubert G, Duma MP, Metula M. Misoprostol alone for the termination of Pregnancy. SA Fam Pract 2007; 49: 16.
2. Cooper D, Dickson K, Blanchard K, Brown H, Mavimbela N, von Mollingdorf, van Bogaert LJ, Winikoff B. Medical abortion: The possibilities for introduction in the Public Sector in South Africa. Reproductive Health Matters 2005; 13: 35-43.
3. Katz AI, Cremer M. Misoprostol alone for early abortion: an evaluation of seven potential regimens. Contraception 2006; 74: 176.
4. Gemzell Danielson K, Marions L, Rodriguez A, Spur BW, Wong PYK. Comparison between oral and vaginal administration of misoprostol on uterine contractility. Obstet Gynecol 1999; 93: 275-280.

Reply from the authors

Thank you for the interest shown in our paper¹. Our study reports on the results found with the medication available for use in local facilities. We tried to find the most suitable regimen in our environment. As can be seen from the references listed in our paper, these medications are also in use and researched elsewhere. Due to the small sample size one cannot deduce from the p-values that there are indeed no differences between regimens: the percentage failed procedures were twice as high in the vaginal only administration as in the vaginal and oral administration.

M Cuellar Torriente G Joubert

Reference

1. Cuellar Torriente M, Lang Ballona F, Joubert G, Duma MP, Metula M. Misoprostol alone for the termination of pregnancy. SA Fam Pract 2007; 49(3): 16-17.