

VAN DIE REDAKSIE

EDITORIAL

Hondsdolheid

Medici moet nie paniek saai nie, maar hulle moet ook nie 'n gevaarlike traak-my-nie-agtige houding aanslaan nie. Die goue middeweg bly steeds die beste, maar dit is nie altyd so maklik om dit te vind nie.

Die huidige toename in die aantal aangemelde gevalle van hondsdolheid is onrusbarend, maar dit is ook nie so 'n ernstige epidemie as wat mens uit sommige koerantberigte sou kon aflei nie. Hondsdolheid is altyd endemies in Suid-Afrika en die algemeenste vektor is die meerkat, hoewel feitlik enige warmbloedige dier die siekte kan oordra. In Kaapland moet ons die gevaar van eekhorinkies nie geringskat nie en die Kapenaars moet nie toelaat dat hul sentimentaliteit oor hierdie aanvallige diertjies hul oordeel verdoesel nie.

Ongelukkig is daar geen klinklare simptome of tekens wat dit vir die dokter maklik maak om die diagnose in 'n oogwenk te maak nie. Dit is nou

noodsaaklik dat iedere geneesheer seker is dat hy of sy ten volle op hoogte is met al die nuutste kennis in verband met die gevreesde siekte en presies weet hoe om op te tree in gevalle van vermeende rabies.

Die spektrum van paramediese samewerking is feitlik daagliks besig om te verbreed en hier is weer 'n voorbeeld van die noodsaaklikheid van spanwerk. In die geval van hondsdolheid is dit die veearts en die neuroloog wat hand-in-hand die stryd moet stry—'n ongewone kameraadskap. Daarbenewens moet ook die Suid-Afrikaanse polisie se hulp ingeroep word want die kontrole van die siekte is so belangrik dat dit nie sonder die toetrede van ons geregsdienaars hanteer kan word nie. Die kwartet van huisarts, veearts, neuroloog en polisieman moet nie as koddig beskou te word nie; dit is 'n toonbeeld van pragmatiese samewerking.

Coronary Disease and the G P

There is no doubt about the magnitude of the problem of myocardial infarction as a leading cause of death. In America it is estimated that there are 1 500 000 episodes of myocardial infarction a year and 500 000 people die of coronary heart disease over the same period.

In South Africa the increasing trend to higher death rates from heart disease has been commented upon.¹ During the period 1959-61, heart disease accounted for 2 in every 9 deaths in the age group 35-39 years for White South African males. In 1966, this increased to 1 in 4 deaths.¹

The socio-economic effects of the high death rate, particularly in young people, have received much attention. The Framingham Report showed that over a period of 10 years, 1 in 10 men and 1 in 25 women between the age groups of 30 and 59 years are threatened by coronary heart disease.²

In the wake of these facts the last decade has seen the emergence of the Intensive Coronary Care Unit in the management of myocardial infarction. From this, much has been learnt about the behaviour of the heart after a myocardial infarction. It has been comprehensively documented that sudden deaths from myocardial infarction are almost always due to a deranged heart rhythm and that minor arrhythmias usually precede the major death-causing arrhythmias. Also it has been ascertained that 60% of the deaths from myocardial infarction occur in the first hour and 80% in the first 4 hours of the condition. It is obvious that treatment must take place promptly at the patient's bedside since time is the most important factor involved.

The article 'The Role of the General Practitioner in the Early Management of Acute Myocardial Infarction' appearing in this issue of the *Journal* is an attempt to use the knowledge gained from continuous cardiac monitoring at the bedside. Therefore emphasis should be placed on a number of important points:

1. Prompt attention by the general practitioner in view of high early death rate in a suspected case of myocardial infarction.

2. Reassuring the patient is not only psychologically important; it also prevents the release of catecholamines which may trigger off life-threatening arrhythmias.

3. The importance of and preference for the intravenous administration of drugs is stressed.

4. The value of prompt treatment and prophylaxis of the 'harbingers of death', the minor dysrhythmias, with the safe and relatively efficacious drugs lignocaine and atropine should be stressed; because this can prevent sudden death or further damage to the heart.

5. A lower dosage of morphine is important in view of its stimulation of vagal activity which increases the likelihood of higher morbidity and mortality later on in the disease process.

The author, in this case, places the responsibility on the first doctor contacted, usually the general practitioner, whose role he emphasizes in this important disease.

It is interesting to note that the Faculty of General Practice (Cape of Good Hope Region) of the College of Physicians, Surgeons and Gynaecologists of South Africa, are undertaking a research programme on the basis of the principles of this article. This could turn out to be an exciting, novel and educative exercise which may help to save many lives and increase our knowledge—knowledge which could facilitate the early management of acute myocardial infarction.

1. South African Life Tables (1959-1961): *Med. Proc.*, 17, 96.

2. Framingham Report (1968): *Study of Epidemiological Investigation of Cardiovascular Disease*, sect. 6-8.