GESONDHEIDSVOORLIGTING DEUR MIDDEL VAN OPENBARE SKEAKELWERK

Die vraagstuk van hoe om betroubare mediese inligting beskikkbaar te maak vir die algemene publiek, is al op verskillende vlakke en uit verskillende hoeke bespreek. Dit is 'n belangrike vraagstuk, aangesien die ingeligde deel van die algemene publiek hierdie soort leiding en inligting wil hê.

Die kanale waarin inligting van hierdie aard gewoonlik vloei, is hoofsaaklik die dagbladpers, die populaire tydskrifpers, die radio, en persoonlike praatjies en voorlesings. Laat ons kortlik na elkeen van dié media kyk.

Die dagbladpers stel hoofsaaklik belang in berigte wat van aktuele belang is en onmiddellijke nuswaarde het. En die bronne waaruit nuus van hierdie aard ontleen word, is mededelings deur geneesheere of verwante werkers en wetenskaplike publikasies. Omdat tegniese en hoogswetenskaplike materiaal dikwels inderhaas deur leke-joernaliste gehanteer moet word, vind onakurate en misleidende berigte soms hul weg tot die nuuskolomme. Die meeste, verantwoordelike koerante het wel verwante joernaliste om nuusberigte van hierdie aard hanteer. Nogtans sluit daar foute van ernstige aard in.

As ons oor hierdie saak skryf, het ons dit nie te doen om inperking van nuus nie. Trouens, ons wil net die teenoorgestelde bereik. Ons wil soveel mediese nuus as moontlik, huisvroue en bejaardes. Hierdie medium van inligting moet ten volle uitgebrei word. Dit is egter goed om daarop te wys dat daar in hierdie geval sekere tegniese en aanbiedingsmetodes is wat eie is aan dié soort medium. Genees-here moet hulle dus laat lei deur kennis op dié gebied. Oor die algemene is 'praatjies' waarskynlik minder doeltreffend as, bv. goed-uitgewerkte dramatiserings. In hierdie verband wil ons verwys na 'n onlangse, baie geslaagde, gedramatiseerde uitsending oor kindervering en die probleme van die verwagende moeder. Dit is hierdie soort uitsending wat ons wil aanmoedig, alhoewel daar gewaak moet word teen die aanprys van onbevestigde tegniese.

Onder persoonlike mededelings val daar te wys op individuele publikasies, waarvan daar baie goeie voorbeelde is, onder andere wat betref babasorg, voeding, die probleme van bejaardes, ens. En dan is daar die medium van praat- en openbare voordragte. Geneeshere was dikwels in dié verlede, na ons mening, ten versig om nie die gees en bedoeling van die Geneeskundige Raad se reël, wat waarsku teen advertensie, te oortree nie. Dié reël is nou so gewy dat dit aan die oordeel van elke geneesheer wat as publieke spreker optree, oorgelaat word om te besluit of hy die reël oortree of nie. Ons wil in hierdie verband 'n beroep doen op ons kollegas wat spreektalent het om, binne die reël wat ons genoem het, soveel as moontlik te doen om gesondheidsvoorligting te bevorder en die beeld van die mediese professie te versterk, wat net soos die verskillende Nasionale Rade vir die bekampings van siektes, sowel as verskeringmaatskappye, ens., verstreke van tyd tot tyd publikasies wat belangrike gesondheidsinligting bevat. Dit is 'n vertakking van die gesondheidsvoorligting in die algemeen, wat nie sterk genoeg aanbeveel kan word nie.

Die radio word al meer 'n belangrike medium van inligting—veral vir sekere groepe van luisteraars soos kinders, huisvroue en bejaardes. Hierdie medium van inligting moet ten volle uitgebrei word. Dit is egter goed om daarop te wys dat daar in hierdie geval sekere tegniese en aanbiedingsmetodes is wat eie is aan dié soort medium. Genees-here moet hulle dus laat lei deur kennis op dié gebied. Oor die algemene is 'praatjies' waarskynlik minder doeltreffend as, bv. goed-uitgewerkte dramatiserings. In hierdie verband wil ons verwys na 'n onlangse, baie geslaagde, gedramatiseerde uitsending oor kindervering en die probleme van die verwagende moeder. Dit is hierdie soort uitsending wat ons wil aanmoedig, alhoewel daar gewaak moet word teen die aanprys van onbevestigde tegniese.

Van dié redaksie: EDITORIAL
It is usual for European and American physicians to consider that diabetes is considerably more common in women than in men. The excess of the fair sex is due to a female preponderance of maturity-onset diabetes, seen after the age of 35-40. Pyke and Fitzgerald and his co-workers actually produced apparently unimpeachable figures and reasoning to show that, in Britain at least, the excess of middle-aged diabetic women could be explained by parity—each pregnancy adding a little more diabetogenicity until the fully blown disorder sprang from its latent bud. This nice theory, however, did not take into account the fact that in most of the non-Caucasian countries of the world there is no female preponderance among diabetics—in fact the evidence (unfortunately inconclusive) points to a male preponderance in many tropical countries.

There is more striking evidence—which suggests that this early 20th century Caucasian female diabetes ascendency was a purely transitory oddity even in White people themselves. In the last century there was probably more diabetes in men than in women in Britain and on the European continent. Thus Pavy, in figures from his private practice in London, treated 260 men between the ages of 40 and 49 and only 79 women. Standardized mortality rates for England and Wales from the records of the Registrar General also show a death rate from diabetes twice as high for men as for women in the 1860s.

From the beginning of this century there was a steady rise in the mortality rate from diabetes in women, as shown in the statistics from several European countries. Malins and his co-workers have published figures from their diabetes clinic showing the number of new cases in 5-year groups from 1930 to 1964. At the beginning of this period the preponderance of women was already well-marked and there was no significant change in the male/female ratio until 1955–59, when the growth of the female diabetic population eased while that of the males progressed steadily. Thus in 1945–49 the male/female ratio was 0.48 and in 1960–64 it was 0.90. Standardizing their figures against the appropriate census figures made virtually no difference to the ratios. As Malins et al. point out, there are certain possible errors. Where more than one hospital clinic exists in a city, practitioners may choose to refer young patients to one clinic and older patients with mild diabetes to another. Mild cases and the aged or severely disabled may never be referred to hospital. Men may be more reluctant to attend hospital because of the time and money lost from work. As far as is known none of these considerations applied to any significant extent to the diabetes clinic at the general hospital from which the material of Malins' enquiry was drawn. Even if they did, it is difficult to imagine that a change would have occurred in the last twenty years which would affect one sex rather than the other.

Further analysis of Malins' figures indicate that the change is due to a more rapid increase in the number of men developing diabetes since 1950, particularly between the ages of 35 and 64. This increase in male diabetes is probably not brought about by an increase in routine testing of the population, although this would be expected to lead to the discovery of more men than women diabetics between the ages of 50 and 69.

The explanation of this change is obscure. Malins considers the possibility that there has been a recent decline in the number of women presenting with diabetes, but there is no good evidence that this is occurring. If it were true it could not be explained either by a reduction in obesity or by changes in parity of the female community. Malins ends by warning that it is necessary to show considerable caution in applying formal genetical analysis to data collected in periods of comparatively rapid change.

The first South African issue of the booklet You and Your Baby, which was published last year by the Medical Association of South Africa in conjunction with the British Medical Association, proved to be a very great success. The booklet contained articles written by authorities (in English and Afrikaans) on practically every aspect of those problems on which expectant mothers would like to have information. Last year 80,000 copies of this booklet were printed and these copies were distributed to all general practitioners, obstetricians and gynaecologists, paediatricians and hospital administrators in the country. In addition to this, copies were distributed to approximately 500 hospitals and clinics all over the country where expectant mothers are being seen and treated, to the health departments of all our large towns and cities and to organizations like the National Council for Child Welfare and the various women's organizations and federations in all the provinces. The booklet is also being used in the training of maternity nurses.

The reception of the booklet was so overwhelming and requests from doctors and clinics for more copies so great, that we had to double the second edition which is to be published in September this year; 150,000 copies are therefore being printed and they will be distributed as indicated above.

This year's edition of You and Your Baby will be an improved and extended version of last year's issue and will contain the following articles: 'Baby on the way', 'How baby starts to grow', 'The confinement—where', 'Breast feeding', 'Financial support for the mother', 'Exercises', 'Immunization' and articles by a beauty specialist and by a qualified dietitian, etc. The advertisements have also been planned in such a way that each one contains information

SECOND SOUTH AFRICAN ISSUE—'YOU AND YOUR BABY'

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which will be important for the expectant mother.

A number of copies will be sent free of charge to all members of the Medical Association to whom this publication may be of use—for instance, to general practitioners, obstetricians and gynaecologists, paediatricians and hospital administrators; the Association looks upon it as a service rendered by the Medical Association to its members and to the public. The booklet will therefore be available for distribution to patients who are expecting babies, irrespective of whether they are private patients or hospital patients attending outpatient or antenatal clinics.

In view of the fact that no separate lists of addresses of colleagues in full-time employment are available, copies will be received by a number of colleagues who have no private patients of their own; it will be greatly appreciated if these colleagues would give the copies that will be sent to them to doctors whom they know are in private practice or to clinics where expectant mothers are being treated.

It will be greatly appreciated if colleagues would let the Association know in due course whether they find the booklet useful. They are also requested to inform the Association whether they need more copies than those sent to them, in which case a further free consignment will be forwarded to them for distribution to their patients.

ABNORMAL HAEMOGLOBINS IN CAPE TOWN*

(OCURRENCE AND SIGNIFICANCE)

M. C. Botha, M.B., Ch.B. (Capetown), D.Path. (R.C.S.P.E.), D.C.P. (Lond.), F.C. Path., with the assistance of L. J. Van Zyl, Senior Medical Technologist, Provincial Blood Grouping Laboratory, Cape Town

Abnormal forms of haemoglobin are known to occur in the Coloured population of Cape Town. The carrier rate of Hb. S was estimated by Esrachowitz et al. to be 0.58%; and homozygous Hb. S disease (sickle-cell anaemia) was described in two Coloured sisters by Wasser-mann and three members of a second Coloured family by Anstey. The Hb. C trait was found by Brain in 2 out of 219 Coloured women, giving a carrier rate of about 0.9%; and Brain and Budtz-Olsen reported Hb. E, associated with thalassaemia, in one member of a Cape Coloured family.

There are two reports of abnormal haemoglobin forms in the White South African population. A family with homozygous Hb. C disease in three members and Hb. C trait in a further three members, was studied by Lewis et al. Among the four earlier accounts of Hb. S disease in South Africa, is a report of sickle-cell anaemia in a White South African family, although the possibility of Coloured admixture in this instance was admitted on the grounds of physical appearance. In studying this report, it is also noted that there is an unexplained absence from the family pedigree of particulars relating to the mother of the proband. Moreover, in our opinion, there is doubt about the diagnosis in this very early report also. Sickling was not demonstrated in the parent available for study; and in the absence of present-day technical methods, Hb. S was not demonstrated. The fact that the patient had been accepted by the army in the category AI, is hardly in keeping with a diagnosis of sickle-cell anaemia.

In the remaining three South African reports of sickle-cell anaemia, at least one parent was from another country where the Hb. S trait is common, i.e. India and Liberia. Two of these families were pure Asiatic (Indian); the other patient was of mixed Xosa and Liberian origin. In addition to this demonstration of the Hb. S trait in a Bantu parent, there are two further accounts of abnormal haemoglobins among South African Bantu. Hb. S carrier rates of 1 in 403 and 2 in more than 600 have been reported.

In view of the high incidence of anaemia of pregnancy among certain population groups in Cape Town, an investigation was undertaken to determine the frequency of the carrier state of abnormal haemoglobin forms and of thalassaemia among pregnant women in the area. This report deals with abnormal haemoglobins; the occurrence of various forms of thalassaemia will be reported later.

MATERIAL AND METHODS

Blood is taken by venepuncture from all women attending for the first time during pregnancy at the antenatal clinics of the Cape Town City Health Department. Specimens, with the potassium salt of ethylene diamine acetic acid as anticoagulant, are submitted as a routine for determination of the Hb. value. A proportion of the antenatal specimens received in this laboratory was examined for abnormal haemoglobin. The population sample was not random, since blood specimens with a Hb. value below 10 G/100 ml. were selected in the first instance.

Haemoglobin samples were run on Whatman's No. 3 MM paper in a vertical tank, using barbital buffer at pH 8.6 and ionic strength 0.05, for 17 hours at 5 V/cm. and 0.3 mA/cm. After detection and primary classification, haemolysates containing abnormal haemoglobins were run similarly in TRIS buffer at pH 8.9, as well as in phosphate buffer pH 6-5, of ionic strength 0.1. Specimens containing an abnormal fraction were also separated on an ion exchange column; and specimens of intermediate mobility were examined by Itano's test, and by the alkali denaturation test for sickling.

At the beginning of the study, specimens with different mobilities were submitted to Dr. H. Lehmann for confirmation of identity. Blood from these individuals served as reference specimens throughout the later investigation.

RESULTS

Table I shows the occurrence of various abnormal haemoglobins among anaemic and non-anaemic antenatal patients in different population groups of Cape Town. Of the Coloured

TABLE I. OCCURRENCE OF VARIOUS ABNORMAL HAEMOGLOBINS AMONG PREGNANT WOMEN IN CAPE TOWN

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*C This paper was read in part at the meeting of the South African Society for Haematology, Johannesburg, 1965.

**Present address: MRC Abnormal Haemoglobin Research Unit, University of Cambridge, England.