Chorio-amnionitis following cervical cerclage in the second trimester

To the Editor: The outcome of 3 cases of chorio-amnionitis after emergency cervical cerclage late in the second trimester, shows clearly that cerclage performed under such conditions is contraindicated.

A 26-year-old woman, para 0, gravida 1, was referred from a peripheral hospital after a hysterecomy. She had been admitted at 17 weeks' gestation with a threatened abortion, and treated conservatively with bed rest and hexoprenaline. A McDonald suture was inserted 3 days later when the os did not dilate. After a further 2 days, signs of chorio-amnionitis developed, the suture was removed and a normal yet offensively smelling 400 g fetus was aborted. Uterine evacuation was followed by a total abdominal hysterectomy. She had not responded to conservative treatment and chronic renal failure. She refused further hospital treatment and was lost to follow-up.

A 37-year-old woman, para 1, gravida 2, had presented elsewhere with a 25-week threatened abortion. She was treated conservatively. One week later the cervix was 60% effaced and 5 cm dilated. A McDonald stitch was inserted but removed 2 days later when the membranes ruptured. She was delivered of a normal but offensively smelling 800 g fetus. Septicaemia developed (at this stage she was referred to us), which responded to appropriate therapy.

A 22-year-old woman, para 1, gravida 2, had presented elsewhere at 20 weeks' gestation with lower abdominal pain and a 3 cm dilated cervix. She had not responded to conservative treatment, and a McDonald suture was inserted. When pyrexia developed, the suture was removed and 500 g fetus was aborted. Septicaemia ensued, but responded to appropriate therapy.

These 3 cases depict the poor and potentially dangerous outcome to both mother and fetus when cerclage is performed late in the second trimester. This is particularly so with regard to chorio-amnionitis which has even resulted in a maternal death.1 The gestational age at the time of cervical cerclage has an important effect on the incidence of chorio-amnionitis. Charles and Edwards2 found that when cerclage was performed after 18 weeks' gestation, it was associated with a higher incidence of: (i) chorio-amnionitis; (ii) shorter gestation; (iii) subsequent caesarean section; and (iv) perinatal mortality (Table I).

<table>
<thead>
<tr>
<th>Gestational age at cerclage</th>
<th>14 - 18 weeks (elective)</th>
<th>19 - 26 weeks (therapeutic)</th>
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<tbody>
<tr>
<td>Chorio-amnionitis (%)</td>
<td>14,9</td>
<td>39,1</td>
</tr>
<tr>
<td>Pregnancies lasting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>more than 36 weeks (%)</td>
<td>78,3</td>
<td>8,7</td>
</tr>
<tr>
<td>Healthy infants (%)</td>
<td>86,9</td>
<td>60,8</td>
</tr>
<tr>
<td>Incidence of caesarean section (%)</td>
<td>14,5</td>
<td>39,1</td>
</tr>
</tbody>
</table>

Thus, significantly more favourable results will be achieved if cerclage is performed early, that is before 18 weeks' gestation. Other authors2-4 have also concluded that the success rate is higher if cerclage is performed early in the second trimester. Schwartz,5 however, found no statistically significant difference in success rates with cerclage before or after 20 weeks' gestation (P > 0,02), in a study of only 74 patients.

In contrast, two independently conducted trials on the benefits of cervical cerclage by Rush et al.6 and Lazar et al.7 reflected different conclusions. Rush et al. found: (i) a higher incidence of preterm deliveries (although not statistically significant); (ii) a lower overall gestational age (P < 0,01), although it must be stressed that this was mostly due to a difference which occurred after 37 weeks' gestation; (iii) more days spent in hospital (even after excluding hospitalisation for the initial procedure); and (iv) a higher incidence of low-birth-weight babies (< 2 500 g), although this too was not statistically significant.

Both Rush et al.6 and Lazar et al.7 showed that under elective conditions, while there may not always be a statistically significant difference between the two groups, there seems to be no advantage in performing cervical cerclage. If this is the case for an elective procedure, then according to Charles and Edwards2 it must apply even more strongly to emergency procedures. 

Elective cervical cerclage in early second trimester may be of benefit. We feel strongly, however, that emergency cervical cerclage done late in the second trimester, as illustrated by these cases, is hazardous and totally contraindicated.

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Z. Graubard
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Johannesburg


Please be brief. Letters longer than 400 words may be returned for shortening. All named authors must give signed consent to publication. Letters should be typewritten in tripe spacing and should be sent in duplicate. References, which must be complete, should be in the Vancouver style and should not exceed 10 in number. We may send letters critical of other authors to them so that their comments may appear in the same issue.

The views expressed in the Correspondence published in the SAMJ are not necessarily those of the Medical Association of South Africa.

Wees asb. saaklik. Briewe wat langer as 400 woordes is, kan vir verkorting teruggestuur word. Alle genoemde skrywers moet hul gekendek stembetragende aan die publikasie verskaf. Brieve moet in drieballe spasiëring getik en in dupliaat wees. Verwyshings moet volgens die Vancouver-styl gedoen word en mag nie meer as 10 beloop nie. Ons mag briewe waarin kritiek teen ander auteurs uitgespreek word aan Ig. stuur vir kommentaar, wat dan in dieselfde uitgawe sal verskyn.

Die mening is dat die Brieuberibiek van die SAMT is nie noodwendig die van die Mediese Vereniging van Suid-Afrika nie.
An interesting sign of pneumothorax

To the Editor: A healthy, fit, 35-year-old white man developed sudden left-sided chest pain, worse on breathing, and dyspnoea. He did not see his doctor but his wife noticed that from the onset of the pain she could hear his heart beating. Over the next 2–3 days his symptoms gradually disappeared and as this happened his audible heart beat softened and disappeared. When the man eventually saw his doctor he had no physical signs and a chest radiograph showed a 2 cm thick crescent of air over the apex of his left lung.

One can postulate that his pneumothorax had created a drum-like state in his left hemithorax and the cardiac pulsation was acting as the drumstick. With the resolution of his pneumothorax the sounds disappeared. At least his wife was able to monitor one of his vital signs during his recovery!

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Crossroads

To the Editor: In their appeal on Crossroads, 95 doctors from UCT medical school say: 'As doctors it is our fundamental ethic to save, heal and nurture life, to improve the condition under which man strives, and in so far as it lies within our power, to enable him to live in peace and harmony. We should never be silent when any of these objectives are threatened.' They also say they are 'dedicated to the maintenance and preservation of health and the well-being of the community [and] are appalled at the current situation at Crossroads'. If one studies the pattern of moral protest by UCT’s senior administrators and academics over the years, one notices that it has never been contrary to a particular political direction. They have always been silent in the face of man-made suffering when protest against it would have been contrary to this political direction.

Here are some examples of medical relevance out of many hundreds in the media. The 18-year-old son of a black town councillor was abducted, tortured for 13 hours, pushed inside three tyres, doused with petrol and set alight while still 'half-alive'. His hands had been tied with wire so tight that bone showed through. Blood-covered bottle-necks, stones and half-bricks were scattered around the mutilated and burnt body. A 15-year-old black girl was repeatedly raped by seven men, one at least being a member of Cosas, for 3 days for 'collaborating with civil servants' and because 'she had had people killed by her uncle, who is a policeman'. A 24-year-old black mother of a 5-year-old boy, accused of being a police informer, was kicked, beaten and burnt to death. She was shown on TV, surrounded by a crowd of men and struggling to get up from the ground while large areas of her skin were alight with a low, flickering flame. Four men entered the home of a black student nurse (who had re-applied to Baragwanath Hospital after going on strike), sprinkled inflammable powder on the floor and set it alight. She was ‘burned beyond recognition’ and died in hospital some days later, as did her mother, sister and a friend. A black man and his six sons, aged between 13 and 22, were thrown into their burning undertaker's complex after the following injuries had been inflicted: some arms and legs amputated by axe; all ribs fractured; intestines spilling out of a massive stomach wound; 25% of the head missing; sexual organs mutilated; and the handle of a 20 cm knife protruding from the mouth with its blade lodged in the throat. At a UDF people's court, four black men were handcuffed to a chain hanging from the roof and 'comrades' took turns in beating their backs to a pulp. The charred body of one victim was later found.

Although research of the press may reveal instances where UCT administrators and academics have issued the usual defensive-diplomatic formula, 'we deplore violence from all sides', they have

SONDER BEWEGING IS DAAR GEEN

Solphyllex help om dik brongiale slym uit te dryf en bied vinnige verligting van hoes wat geassosieer met asemhalingsinfeksies, asma en griep.
otherwise maintained a stony silence in the face of acts such as those described above. The incessant churning out of moral principles (as quoted for example in the first paragraph of this letter) is self-righteous, and the failure to match up to them in practice is hypocrisy. Self-righteous hypocrisy may not be a harmless failing, especially in our present circumstances.

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Fruit consumption and dental caries

To the Editor: Dental erosion, the chemical dissolution of tooth substance without the influence of microbiota, is well known to dentists. Abrasion, the reduction of tooth material by extraneous physical forces, is facilitated and accelerated by anything causing softening of the teeth. Attrition occurs physiologically with age and reduces vertical height and mesiodistal lengths of teeth, but may occur pathologically from anything mediating tooth softening. Decay occurs with tooth decalcification followed by bacterial invasion and cavitation. Ravages (attrition, abrasion, erosion and decay) caused by excessive consumption of fresh fruit and/or fresh fruit juice (F/FFJ) manifest simultaneously, separately, or in characteristic combinations. Grobler and Blignaut correctly state that fresh fruit causes tooth erosion but incorrectly assume that decay follows erosion.

In erosion, loss of softened, decalcified tooth occurs too rapidly to allow bacterial invasion, but stagnant decalcified areas permit bacterial destruction and cavitation, i.e. decay. Also it is not generally accepted that intake of different types of fruit is essential to general health. Living on vegetables and any source of first-class protein (and avoiding all fruit) suffices for health, longevity and reproduction. Grapes contain mainly glucose and tartaric acid, apples mainly glucose, sucrose, fructose and malic acid, while both fruits also contain some ascorbic acid. The F/FFJ of both apples and grapes have a pH low enough to dissolve tooth enamel, which is at a pH below 5.5. Certainly, consumption of F/FFJ of apples and grapes has been implicated in all the above ravages, and there is circumstantial evidence that caries prevalence is very high in the Cape fruit-growing districts. However, there are many confounding factors to be considered. These include, for example, the type of bacterial ecosystems in the mouth, the fluoride intake during tooth development, frequency of F/FFJ consumption, other sources of fermentable sugars and acids in the diet, the time of consumption, the method of drinking FFJ, oral hygiene habits, the intrinsic buffering capacities of saliva and the different F/FFJs. All these must be taken into account and cast serious doubt on the conclusion that ‘apples predispose to a higher incidence of caries than grapes’.

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**Business-training questionnaire**

To the Editor: Please may I through the correspondence columns of the SATM thank all medical practitioners who responded to the business-training questionnaire I mailed during August and September last year. The information that was sent to me was a great help in the preparation of my technical report which I am pleased to say was accepted by the University of Cape Town in partial fulfilment of an M.B.A. degree.

I would also like to use this opportunity to advise that I have established a practice-management and financial consulting practice to assist dentists, medical practitioners and veterinarians. The need for such a service became apparent both from the replies to the questionnaire and from my own experience and observations.

J. W. E. Adams
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Durban North

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**AIDS — what are the symptoms?**

To the Editor: Acquired immunodeficiency syndrome has become a very real threat to millions of people. I have read numerous reports and articles on the subject in both the medical and the lay Press. All these stress that an emergency exists and this is of course very correct. We are told how to control the spread, what action should be taken, which people are at risk of infection, and of the practically 100% mortality rate. We are also given details of highly sophisticated blood tests to be used.

There seems to be one glaring deficiency in this campaign in which we, as general practitioners, are bound to be in the forefront. Nowhere have I yet seen any comprehensive account of the symptomatology of the condition, and it is obvious that from the medical practitioner's and the patient's standpoint, such a list is mandatory. The only symptom to which I have so far found any reference, is that of debility and susceptibility to many infections. Is this the only symptom? Are there any physical signs for which we should search?

It would seem that if this is all we have, then the chance of us ever getting the better of the disease, even if a cure were to be found, is nil. I would welcome any suggestions on this matter from any source.

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**Antihypertensive therapy**

To the Editor: Dr Burman's suggestions for antihypertensive therapy deserve comment. Although cost is an important consideration in long-term therapy, treatment should be individualised with due attention paid to efficacy and safety. Low-dose reserpine appears to be gaining wider acceptance, but it is not customary to start with this agent when optimal intellectual activity is important.

The tendency is still to start with a diuretic or \( \beta \)-blocker, depending on the patient's age, race and diagnosis. Low-dose thiazides are preferable, but optimal antihypertensive effect may only be obtained with 12.5 - 25 mg hydrochlorothiazide per day, combined with a potassium-sparing diuretic in patients who lose potassium. There is also a trend towards using \( \alpha \)-blockers, angiotensin-converting enzyme inhibitors and calcium antagonists as first-line therapy.

All of these agents may have adverse effects, but angiotensin-converting inhibitors have now been very well tested against methyldopa and propranolol for their 'quality of life'. Careful psychometric testing has not been performed in patients given reserpine, but the experience with methyldopa should lead to some reserve about the use of centrally active agents when preservation of the quality of life is important.

Hydralazine is indeed a cost-effective vasodilator, but it should be remembered that lupus can occur with doses as low as 50 mg/d and it causes tachycardia (which would be offset by the adrenergic blockade of additional reserpine or a \( \beta \)-blocker), angina and fluid retention, which may not be offset by only 6 mg of hydrochlorothiazide. For these reasons hydralazine as a vasodilator has generally been superseded by calcium antagonists, especially in patients with ischaemic heart disease. Where cost is critical, hydralazine is cheaper than the calcium antagonists. Minoxidil, unsuitable for women because of frequent hypertrichosis, is usually reserved for resistant or severe hypertension. Like hydralazine, minoxidil causes tachycardia and fluid retention, unless combined with an adrenergic blocker and a diuretic.

While Dr Burman's conservatism has much merit, we do not see any particular reason to regard \( \beta \)-blockers as high-risk drugs. Instead of cutting down on smoking, we suggest no smoking at all. We are not sure of the value of 'milch of magnesia, calcium carbonate, amitriptyline, oestrogen-progesterone, nitrates and thorophylline'. Thorophylline is potentially dangerous to patients with ischaemic heart disease because of the build-up of arrhythmogenic concentrations of cyclic adenosine monophosphate in the myocardium.

In summary, we believe there is no simplified approach to hypertension. Many drugs may be used as first-line therapy. Even placebo therapy is sometimes remarkably successful. The drug used should be tailored to the needs of the patient and carefully selected rather than being automatically prescribed.

P. I. Pillans
L. H. Opie
Heart Research Unit and Hypertension Clinic
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**Medical listing in the telephone directory**

To the Editor: In a recent epidemiological survey of inflammatory bowel disease in Cape Town, it was necessary to contact all private physicians, surgeons, paediatricians, dermatologists and general practitioners in the greater Cape Town area. A list of 731 private practitioners was compiled from the medical list in the current Post Office telephone directory.

The doctors were initially contacted by post. If they failed to reply to three successive letters, they were telephoned. In this way, 97% of doctors in practice were contacted. However, it was found that 223 doctors were no longer in practice, 35 had retired, 14 were deceased, 42 were no longer in private practice, at least 9 had emigrated and 120 had moved without trace.

Instead of cutting down on smoking, we suggest no smoking at all. While Dr Burman's conservatism has much merit, we do not see any particular reason to regard \( \beta \)-blockers as high-risk drugs.

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This correspondence is now closed. — Editor

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Behavioural effects of writing a paper for a professional journal

To the Editor: During the past year I attempted for the first time to write an article for a professional journal. Its preparation changed my medical practice to such an extent that I thought I should report what has happened.

The activities upon which the exercise had most impact, and the way each was affected, are listed in Table I. The results reflected in the Table speak for themselves. One additional point needs to be made: drafting an article is a very useful, mostly enjoyable and relatively painless way of improving one's skill in the correct use of language. Indeed, I now find myself championing the cause that such an exercise constitutes a prerequisite for a complete medical education.

The article mentioned above was written in collaboration with Professor R. F. Gledhill, whose idea it was that I should report these observations.

P. Dessein
Department of Internal Medicine
University of Pretoria

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<table>
<thead>
<tr>
<th>TABLE I. BEHAVIOURAL EFFECTS OF WRITING A PAPER FOR A PROFESSIONAL JOURNAL</th>
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<tr>
<td><strong>Teaching</strong></td>
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<tr>
<td>Aim</td>
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<td>A-to-Z review</td>
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<td><strong>Self-education</strong></td>
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<td>Acquisition of knowledge</td>
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<td>Encyclopaedic</td>
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<td><strong>Clinical practice</strong></td>
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<td>Evaluating patients</td>
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<td>Aim</td>
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<tr>
<td>Determine diagnosis</td>
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<tr>
<td>Treating patients</td>
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<tr>
<td>Drug interactions and side-effects</td>
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<tr>
<td>React</td>
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<tr>
<td>Nursing staff notes</td>
</tr>
</tbody>
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The Transvaal Medical Journal

To the Editor: Perhaps a postscript to Dr R. E. Bernstein's account of the Transvaal Medical Journal in the form of a comment by C. L. Leipoldt when he was editor of Guy's Hospital Gazette, would be of interest to some of your readers. Leipoldt said: 1 We have to acknowledge the receipt of a new contemporary — the Transvaal Medical Journal — a venture with which, it is pleasant to record, several old Guy's men (and, if we mistake not, an old collaborator of this Gazette) are associated. It is a neatly-got-up monthly, containing much interesting clinical and local information, and it is the first issue of a medical paper in the new colonies. In the issue before us Dr Rogers, an old Guy's man, contributes an interesting paper on two cases of intestinal obstruction and among other principal articles are papers on "Six cases of accidental vaccination of the conjunctiva", "Hydatid cyst of the orbit", and "Melaena neonatorum". It possesses an excellent review of current literature and has a well-filled correspondence column. We wish our contemporary a long and successful career and are glad to see that it is already established — and evidently read — in the Library.

Theodore James
16 Spring Gardens
Pinelands, CP

Conversion from cyclosporin to azathioprine 3 months after renal transplantation — is it safe?

To the Editor: We read the article by Cassidy et al. 1 with interest. They conclude that withdrawal of cyclosporin A (CyA) 3 months after renal transplantation is safe.

However, we would like to pose a further question: withdrawal of CyA at 3 months is safer than what? It is safe compared with continuing with CyA? Immunosuppression induction with CyA and low-dose steroids has improved the results of renal transplantation world-wide. The reason for conversion has been concern over the possible long-term toxicity of CyA, but another concern that needs to be addressed is: would more grafts not be lost in the long term by rejection because of conversion and other complications associated with the use of azathioprine, than would be lost by attrition because of toxicity of CyA?

If we allow all the possible consequences of conversion to azathioprine in Cassidy et al.'s article, we note that 3 patients died at 6, 7 and 9 months respectively, all from sepsis. Although the data are not given, one must assume that the sepsis was related to the need for higher doses of steroids during and after conversion. Two further patients were put back on to CyA because of azathioprine leucopenia.

One patient developed rejection after conversion that could be controlled only after recommencement of CyA. One must presume that this patient was vigorously treated with intravenous boluses of methylprednisolone and consequently placed at risk of high-dose steroids. Before concluding that withdrawal of CyA at 3 months is safe, one would like to compare with a control group continuing on CyA.

In a similarly small group of patients treated with CyA and low-dose prednisone for 3 months, we prospectively and randomly converted 11 of 22 patients to azathioprine after 1 week of overlap with CyA. One graft was lost during conversion and 2 more from irreversible rejection over the next 2 years of follow-up. Only 1 graft was lost in the group continuing on CyA during the next 2 years.

The mean creatinine levels were 153 mmol/l at 1 year and 151 mmol/l at 2 years in the CyA group, thus showing no deterioration of kidney function. In the conventional immunosuppression group the levels were 151 mmol/l at 1 year and 118 mmol/l at 2 years. Although creatinine levels were significantly lower in the converted group, kidney function was excellent in the CyA group and more grafts survived in this group.

In the Canadian prospective trial, 2 graft survival rates were 69% with CyA and 58% on conventional immunosuppression at 3 years (P > 0.05). Admittedly in the conventional group immunosuppression was not induced for 3 months with CyA. But again, although creatinine levels were higher in the CyA group, kidney function did not deteriorate between 6 months and 3 years.

In another report on long-term renal function in CyA-treated patients after transplantation of a kidney from a living related HLA-mismatched donor, there was no deterioration of function in patients followed up for 4½ years. 3

It would therefore seem to us that long-term therapy with CyA improves results of renal transplantation. Any association with decreased creatinine clearance is offset by increased graft survival, and the impaired renal function does not appear to be progressive, at least in a 4½-year follow-up.

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P. J. Nel
J. H. R. Becker
J. P. Pretorius
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Drs Cassidy and Jacobson reply: We appreciate the interest expressed by Mieny et al. in our article. While we were writing our article, Strom and Loertscher 1 suggested that transplant groups would, in future, have to choose from protocols that included switching patients from cyclosporin to azathioprine after 'safe' engraftment in an attempt to reduce the risks of cyclosporin-induced nephrotoxicity. A further cogent reason for switching at 3 months which we did not allude to in our article was an economic one, cyclosporin being very expensive. In view of these concerns we reported our experience with 26 of the first 50 patients treated after renal transplantation in this manner. Our study was not a controlled trial. At the time we pointed out that experience of other groups that practised the switch from cyclosporin to azathioprine was not uniform.2,3

We doubt that an increase in dose of oral methylprednisolone from 24 mg to 32 mg at the time of stopping cyclosporin was directly responsible for the 3 deaths reported at 6, 7 and 9 months, although we do agree that the incidence of sepsis following renal transplantation is related in part to steroid dosage. None of these patients received additional boluses of methylprednisolone after stopping cyclosporin.

Continuing experience with cyclosporin suggests that stopping it at 3 months may be associated with significant hazard. We have therefore revised our earlier policy. As pointed out by Mieny et al. the long-term results of using cyclosporin have subsequently proved encouraging and previous fears of graft loss related to the long-term use of cyclosporin have to a certain extent been allayed.