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METRIEKE RESEPTERING

Stadig maar seker is ons besig om op alle gebiede oor te skakel na die metrieke stelsel en oor die algemeen gaan dit makliker as wat aanvanklik verwag is. Hier en daar is daar nog 'n paar haakplekke, maar hulle sal mettertyd vanself verdwyn. Die huisvrouens sukkel nog met ou koekresepte wat die bestanddele in onse aangee en hier en daar is daar 'n optimis te vinde wat dink dat die nuwe spoedgrens op ons hoofpaaie opgeskuif is na 120 mpu instede van kilometer per uur. Nou moet die medici sorg dra dat hulle nie agterbly en ook een van die vertragingsfaktore blyk te wees nie.

Veral vir die ouer kollegas sal dit nie maklik wees om na jare van dink in terme van onse en grein, oor te skakel na die meer praktiese milliliter en milligram nie, maar dit moet gedoen word en op die ou end sal almal wel saamstem dat dit die moeite werd was. Daar het nou weer 'n beroep van die Metriseringsadviesraad gekom dat ons tog asseblief skouer aan die wiel moet sit en die oorskakeling so vlug as moontlik laat verloop.

Die *Tydskrif* het reeds in alle opsigte tot die metrieke stelsel oorgegaan. Advertensiekoste, drukkersinstruksies en al die ander kleinighede waarvoor mate nodig is, word reeds in millimeter gedoen, en waar doenlik word ook die gegewens in artikels omskep na metrieke mate. In dié opsig wil ons graag 'n beroep op ons skrywers doen om die redaksie se taak te vergemaklik deur die manuskripte uit wans uit in die nuwe stelsel aan te bied. Dit is natuurlik die beste beleid om die navorsing self op 'n metrieke lees te skoei, liefs as om dit later te probeer omskep.

In meeste opsigte is dit aan te beveel dat dit nie soseer 'n omrekening moet wees nie, maar liefs 'n nuwe denke in metrieke eenhede. Dit is veel makliker vir die huisvrou wat inkopies doen om te weet dat 'n kilogram vis of maalvleis so min of meer haar honger familie sal voed, liewer as om telkens te probeer onthou dat 1 kg gelyk is aan 2·2 lb. Met ander woorde, die gewig van dinge in alledaagse gebruik moet in kilogram geskat word om sodoende 'n nuwe benadering te skep. Omrekeningstabelle sal ongetwyfeld nog 'n tydlank nodig bly, want soos reeds genoem, is ingewikkelde kookresepte nog in ponde en onse, maar 'n groot deel van die aktiwiteite in die daaglikse lewe kan sumier op metrieke eenhede verrig word.

Nou en dan sien mens sinnelose omskakelings wat net bydra om die hele saak te vertroebel. Koerantberigte wat fratsongelukke rapporteer is geneig om te konstateer dat sus en so 'n motor 30 vt (11·62 meter) geval het. Dit is miskien lofwaardige akkuraatheid aan die kant van die verslaggewer om die hoogte tot die naaste millimeter aan te gee, maar mens twyfel darem aan die geloofwaardigheid van sy feite. Hier en daar sal daar nostalgiese verliese moet voorkom. Ons wonder byvoorbeeld of die welbekende 'Lady's mile' nou omskep sal word tot 'gentleman's kilometer'.

Die groot knoop lê egter by die medisyne voorskrifte, veral wat betref resepte wat deur die apteker aangemaak moet word. Tablette en ampules word reeds lankal feitlik uniform in metrieke eenhede aangebied, sodat daar nie veel probleme sal voorkom nie. Dit is egter die ou familiedokter wat sal swaarkry om sy geliefkooste hoesmiddel nou in metrieke eenhede uit te skryf. Seer seker sal daar van tyd tot tyd klagtes gehoor word van pasiënte wat sê: 'Dokter, maar die goed smaak dan nou anders'. Sulke effense verskille sal nie saak maak nie, ons moet net versigtig wees om nie 1/100 gr met 100 mg te verwar nie. Sulke foute het reeds voorgekom en ons moet voordurend op ons hoede wees.

Een van die dae kondig die Metriseringsadviesraad die oorskakelingsdatums vir die farmaseutiese wêreld en die aptekers aan en dan moet alle dokters sorg dat hulle voldoende gekonfyt is om nie klei te trap nie.

THE SOUTH AFRICAN HAEMOPHILIA FOUNDATION

The South African Haemophilia Foundation was formed in April 1970 at the South African Institute for Medical Research, under the auspices of the Southern African Society for Haematology. The aims of the Foundation are, firstly, to provide a fellowship for sufferers of haemophilia and similar bleeding disorders, for their families and those concerned in their health and welfare and secondly, to promote the interests of such patients by whatever legal means available. Mr Frank Schnabel, Chairman of the World Federation of Haemophilia (WFH) and himself a haemophiliac, visited South Africa in May 1970, to help inaugurate the Foundation. The Foundation has established regional branches in Johannesburg, Cape Town, Durban, Pretoria and Bloemfontein. Their initial tasks are to register all patients, to issue haemophilia identity cards and bracelets, to organize prompt and efficient outpatient and inpatient treatment for acute bleeding episodes, and to establish haemophilia clinics for therapy, rehabilitation and genetic counselling. The activities of the Foundation will extend to social and community matters as well, such as the education of parents and schoolteachers, and the question of life-insurance policies.

In July 1970, the S.A. Haemophilia Foundation was elected a member of the WFH in Baden, Austria. This is at present a federation of haemophilia societies of 34 countries.

The lag between advances in knowledge of a disease, and the application of such understanding to the treat-

ment of the individual patient suffering from that disease, is often very great. This is particularly true in the case of the rare deficiency diseases such as haemophilia.

Until fairly recently, haemophilia had been thought to be a congenital deficiency disease lacking a specific clotting factor termed factor VIII (the antihaemophilic globulin), resulting in the disease haemophilia 'A'; or lacking factor IX (the Christmas factor) in the case of haemophilia 'B' (Christmas disease). With improved techniques for demonstrating antigenic structure, however, several workers[1-6] have demonstrated antigenically cross-reacting protein to specific factor VIII or IX antibodies in several cases of haemophilia 'A' and 'B' respectively. This cross-reacting material (CRM) has been demonstrated in a small number of typically "deficient" haemophilic patients, i.e. patients with deficient *functional* clotting-factor activity who have the fully expressed clinical syndrome.

Great strides, too, have been made in the therapy of these conditions. The severity of the disease has been shown to correlate well with the circulating level of functional clotting-factor activity in patients' plasma.[7] Three clinical groups of patients have been described; the severely affected group, who show no functional clotting activity (<1%); the moderately severely affected group of patients with 1 - 5% factor VIII or IX in their plasma; and a mildly affected group with 5 - 30% of the clotting factor in their plasma. The commonest haemorrhagic lesion experienced by the haemophiliac (bleeding into joints or muscles unassociated with trauma—the so-called spontaneous bleed), is prevented by a minimum plasma level of 5% of the clotting factor. Surgical haemostasis, however, requires a circulating clotting-factor level of at least 30%. Therefore, to prevent the 'spontaneous' haemorrhage, it is necessary to raise the plasma level of the deficient factor to at least 5%, but to effect 'surgical' haemostasis, the plasma factor level would need to be raised to at least 30%. The only practical therapeutic agents that are able to effect this rise in clotting factors in the circulation are plasma itself or plasma products rich in the appropriate factor.

It soon became evident that because of the short half-life of factor VIII, plasma needed to be fresh to retain its factor VIII activity. Freezing plasma while it is still fresh, however, retains 80 - 90% of its activity. Frozen fresh plasma (FFP) thus became the main therapeutic agent available for the treatment of haemophilia. FFP can effect a rise of 15 - 20% of factor VIII in the circulation which is adequate to stop the spontaneous haemorrhage into joints.[8] Infusing greater volumes of FFP to give rises higher than 20% may cause circulatory overload. As a result efforts over the last 15 - 20 years have been directed into producing plasma concentrates containing the required factor in a smaller volume. Such products have been produced at great expense of donor blood material and with a considerable loss of factor VIII activity during production.

A major breakthrough was achieved with the production of cryoprecipitate. This is the precipitate that remains when FFP is allowed to thaw at 4°C, which is the temperature of the average household refrigerator. The precipitate (i.e. cold or cryoprecipitate) is rich in fibrinogen and factor VIII, and can be produced by any transfusion service capable of making FFP, as elaborate fractionation equipment is not required. Unfortunately, factor VIII loss may be significant during production of the cryoprecipitate and attention to technical details during production is vital. One of the variables difficult to control is the difference in factor VIII levels of donor blood. For clinical use, individual cryoprecipitate units should be pooled immediately before use. Cryoprecipitate has insufficient factor IX for its use as a factor IX concentrate. The production of factor IX concentrates is complex. Happily, though, such concentrates are now available commercially, although at great expense. They are rich, too, in factors II, VII and X and are thus useful for conditions requiring the 'prothrombin complex' in high concentration, such as coumarin overdosage.

The experience of most haemophiliacs in their efforts to obtain treatment is one of frustration and mismanagement. They are labelled troublesome, hostile, ungrateful and demanding patients. Yet they suffer a succession of delays in casualty departments, repeated X-rays, inadequate or incorrect treatment, crippling deformities, missing of school or work, and a deluge of hospital bills. Like all sufferers they will clamour for any suggestion offering help and relief—and will try peanuts, EACA, oral contraceptives, steroids, hypnotism and faith-healing.

It is hoped that doctors in the Republic who have haemophilic patients or other 'bleeders' in their practice will avail themselves of the facilities of the Foundation and of the specialized treatment centres that it helps to establish.

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INSTRUCTIONS TO AUTHORS : INSTRUKSIES VIR SKRYWERS

The attention of authors is drawn to the revised 'Instructions for Authors' which appear regularly in the *Journal*. The most recent example will be found on p. xiv of the issue of 10 April 1971. Publication of papers can be expedited considerably if they are prepared in accordance with these instructions.

Die aandag van skrywers word vriendelik gevestig op die nuwe hersiene 'Instruksies vir Skrywers' wat gereeld gepubliseer word. Die jongste voorbeeld verskyn op bl. xxvi van die *Tydskrif* van 3 April 1971. Publikasie van bydraes kan aansienlik bespoedig word as hulle voorberei is in ooreenstemming met hierdie instruksies.