VAN DIE REDAKSIE : EDITORIAL

LEWENDE VERSWAKTE POLIO-ENTSTOF

'n Grootskaalse poging om inenting teweeg te bring met die Sabin tipe I polio-entstof is van stapel gestuur in Suid-Afrika. Teen die einde van Oktober het die Departement van Gesondheid twee miljoen dosisse van hierdie entstof vrygestel vir gebruik in die grotere sentrums in die land. In April en Mei 1961 sal verdere besendings van al drie tipes van die entstof uitgereik word. Meer as 'n miljoen dosisse van die entstof wat vervaardig word in die laboratoriums van die ‚Stigting vir Poliomyelitisnavorsing' is reeds met goeie gevolge gebruik in Kenia en Mauritius.

Suid-Afrika staan dus hier saam met ander lande in 'n omvattende poging om poliomiëlitis geheel-en-al die hoof te bied. As die Sabin-stamme van polio-entstof werklik lewenslange immuniteit teweegbring soos verwag word, sal iets bereik word waarna baie lank uitgesien is. In 'n onlangse uitgawe van die *Tydskrif* het prof. R. Turner[1] 'n omvattende bespreking gegee van die navorsing en die uitgebreide toetse wat daartoe gelei het dat baie lande die Sabin-stamme van polio-entstof wat per mond gegee word, aangeneem het. Hy het aangetoon dat selfs voordat die verswakte entstof, wat deur Salk ontwikkel is, vervolmaak is, baie outoriteite as 'n saak van beginsel al geglo het dat die beste hoop vir 'n werklike doeltreffende profilaktiese middel teen poliomiëlitis geleë is in die vervaardiging van 'n lewende entstof.

Selfs die groot sukses van die verswakte polio-entstof van Salk het nie hierdie navorsers ontmoedig nie. Een van die belangrikste van hulle was Koprowski. Teen 1957 was verskillende stamme van lewende entstof al ontwikkel en gereed vir grootskaalse toetse. Drie verskillende stamme is gekies, naamlik die Koprowski-, die Cox- en die Sabin-stamme.

In sy artikel bespreek Turner die besonderhede van die resultate van toetse met hierdie stamme en hy stel dit baie duidelik dat al die beskikbare gegewens aantoon dat die Sabin-stamme die veiligste en ook die mees doeltreffende is. Dit is hierdie stamme wat gebruik is in nagenoeg sestig miljoen Russe en in miljoene ander persone sonder enige ongunstige uitwerking hoegenaamd. Turner glo nie dat daar reeds al genoegsame gegewens is waarop 'n finale mening oor die veiligheid en doeltreffendheid van die Koprowski-stamme gebaseer kan word nie (alhoewel hulle sover skynbaar veilig en doeltreffend is); hy voel ook dat 'n finale besluit oor die veiligheid van die Cox-stamme nog nie gemaak is nie, alhoewel hulle skynbaar doeltreffend is. Al die gegewens skyn dus aan te toon dat ons in hierdie land die veiligste en die mees doeltreffende lewende polio-entstof wat beskikbaar is, vervaardig.

Turner wys op 'n belangrike punt in verband met die openbare gesondheid in sy artikel. Hy sê, ‚As ons eers begin het met hierdie optrede (die toediening van lewende polio-entstof) kan ons nie weer daarmee ophou nie. As polio-virusse uit die omgewing verban word, sal geen kind in die toekoms 'n natuurlike immuniteit kan verwerf deur normale en toevallige infeksie nie. Gevolglik word dit dan noodsaaklik om lewende entstof so vroeg moontlik aan alle pasgebore kinders te gee, want as hulle moet groot word sonder hulle immuniteit, en indien die poliovirus weer opduik, kan dit nie anders nie as om tot 'n onvermydelike ramp te lei nie.'

Hierdie faset van die probleem moet in gedagte gehou word deur alle openbare gesondheidsoutoriteite. Op die oomblik ontwikkel 'n groot aantal van die bevolking 'n natuurlike immuniteit teen poliomiëlitis teen die tyd dat hulle volwassenheid bereik. Ons mag in staat wees om poliomiëlitis uit Suid-Afrika te verdryf, maar dit mag wel weer van 'n ander land af oorgedra word. Tensy alle kinders dus op 'n vroeë stadium teen poliomiëlitis ge-ent word, soos die geval is met pokkies, sal hulle blootgestel word aan groot gevare as wilde stamme van die poliovirus weer te voorskyn kom. Dit mag wel nodig wees dat verpligte inenting teen poliomiëlitis in die toekoms ingestel moet word om die moontlikheid van 'n katastrofe te voorkom.

1. Turner, R. (1960): S. Afr. T. Geneesk., **34**, 961.

PRESCRIPTIONS FOR POTENTIALLY HARMFUL DRUGS

In the *Journal* for 26 March 1960 a supplement was published in which the rules governing the issue of prescriptions for potentially harmful drugs were set out. This was drawn up jointly by the Medical Association of South Africa and the Pharmaceutical Society of South Africa for the guidance of doctors.

At the recent congress of the Pharmaceutical Society of South Africa mention was made of the fact that many doctors are still contravening the provisions of the Medical, Dental and Pharmacy Act in connection with the issuing of these prescriptions. We cannot urge doctors too strongly to put their house in order in this respect.

Section 61 *bis* of the Act lays down the requirements for these prescriptions extremely clearly. It states that they should include the following information: The date of issue of the prescription; the name and address of the patient; the name and quantity of the drug to be supplied, the number of times and the intervals at which the prescription should be dispensed and, except in the case of a preparation for external use, the amount and frequency of each dose to be taken; and the usual signature, address, and professional qualifications of the doctor who issued the prescription. The prescription should be in the doctor's own handwriting.

All too often these requirements are not met; one or other item of information is omitted. A particular omission

which causes pharmacists, and subsequently doctors, much trouble, is the strength of various ethical preparations. Often a drug is available in, e.g. 25, 50 or 100 mg. strengths. The doctor may simply prescribe '20 tablets'. The pharmacist then has to telephone the doctor (and often has difficulty in finding him) to correct this. Much time and trouble could be saved both by the doctor and the pharmacist if this point, especially, is borne in mind when writing prescriptions.

In general, a conscientious pharmacist, whose duty to refrain from dispensing drugs on an incorrectly completed prescription is clearly laid down, will ask the doctor to redraft the prescription in terms of the Act. Some doctors become irritated by such requests and refuse to alter their prescriptions; others are too occupied to do so at once, and the matter is left in abeyance, to be forgotten in the rush of a busy practice. All this does not create a happy doctor-pharmacist relationship, quite apart from the penalties (a fine not exceeding one hundred pounds or imprisonment for a period not exceeding six months without the option of a fine, or both such a fine and imprisonment) which hang over the heads of both doctor and pharmacist.

Another aspect of the same problem is the issuing of prescriptions for potentially harmful drugs following telephonic instructions. The Act lays down that, in an emergency, a pharmacist may supply these drugs on the telephoned instructions of a doctor who is personally known to him. However, a prescription in the prescribed form, covering such instructions, should be forwarded by the doctor within twenty-four hours to the pharmacist.

Unfortunately, while doctors frequently make use of the provision of the Act which permits of telephonic instructions, they seldom follow this with a written prescription. It is the opinion of the South African Pharmacy Board, which has the same statutory powers over pharmacists as the South African Medical and Dental Council has over doctors, that it is not the responsibility of the pharmacist to compel doctors to issue a prescription to cover a telephonic instruction. It is the duty of the doctor to see that this is done.

The Sixth Schedule of the Medical, Dental and Pharmacy Act contains a list of potentially harmful drugs. This list is amended from time to time, both by additions and deletions. For instance, antihistamine drugs, which were at one time on this list, have now been removed. However, the list still contains such drugs as sulphonamides and antibiotics, barbiturates (except when prescribed in very small quantities), hormones, rauwolfia derivatives, and anticoagulants. As can be seen, an extremely high proportion of modern prescriptions will contain one or other of the potentially harmful drugs.

The average doctor cannot be expected to keep up-to-date with the amendments which are frequently made to this list, apart from the fact that the names in the list are the pharmaceutical names of the drugs, with which most doctors are unfamiliar. It is suggested, therefore, that doctors make it a practice to complete all their prescriptions in the manner we have set out, that is, as though they were for potentially harmful drugs. (Of course, prescriptions for habit-forming drugs fall into a special class — they require all the information mentioned above, but on each prescription no more than one issue of the drug mentioned may be made.)

If doctors complete all prescriptions as required by Section 61 *bis* of the Act, the legal requirements will be fulfilled, much petty irritation will be avoided, and ill-feeling between doctors and pharmacists will be obviated. Doctors will be harassed far less by pharmacists who are trying to have prescriptions corrected, and they will be sure that they cannot fall foul of the Law.