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LUPUS ERYTHEMATOSUS

The treatment of lupus erythematosus with antimalarial drugs is not new, yet even today little is known about the mode of action of these drugs. The subject has been fully reviewed in a recent article which should be read for details as to the history, theories of the mechanisms involved, and the toxicity of the drugs that have been used.[1]

Quinine and pamaquin were first used, and in more recent years mepacrine and the 4-aminoquinolines (chloroquine, hydroxychloroquine, amodiaquin) have come to be used. In all these compounds the 4-aminoquinoline radicle appears to be the active moiety that suppresses lupus erythematosus. The mode of action is still unknown, but many possibilities have been suggested, as listed by Epstein.[2] These include (*a*) filtration of light, (*b*) inhibition of antibodies, and (*c*) an anti-inflammatory action through inhibition of enzymes, inhibition of adenosine, binding with nucleoprotein, an effect on the pituitary-adrenal system, or a local effect.

Antimalarial drugs are concentrated in the epidermis more than in the corium, and this may modify the reaction pattern in light-sensitive persons so as to suppress abnormal responses to ultraviolet rays. There are different opinions regarding the sun-screening effect of these drugs. The theory that adrenocortical stimulation is produced is also not accepted, and the concept that antibody inhibition occurs is not based on good evidence. Whatever their effect on the altered biochemical reactions in these patients, there is a high incidence of relapses when treatment is discontinued, and the action is temporary and suppressive. The dose of corticosteroids used in this disease can be much reduced by the concurrent administration of the antimalarial drugs, and this in itself is a valuable feature in the use of these drugs. The doses must be individually determined for each patient. After initial dosage lasting one to three weeks the dose is gradually reduced over a period of two to three weeks until an adequate minimal maintenance dose has been established.

The toxicity of all these agents requires careful attention. Large doses are likely to produce toxic reactions which may be severe. Too high a maintenance dose has been used in the past. Gastro-intestinal symptoms may be produced by the antimalarial drugs. Nervous effects also occur, for example dizziness and headache, but with mepacrine more serious features such as toxic psychosis, depression, anxiety, and polyneuritis also occur. Chloroquine and hydroxychloroquine are regarded as less toxic than mepacrine, but they may affect vision, as with mepacrine; and blurred vision, haloes around lights, deposits in the cornea, and retinopathy have all been observed. Cutaneous effects occur: with mepacrine not only yellow or brownish-grey pigmentation, but pruritis, eczematoid and other skin changes may be produced, and with chloroquine a variety of skin changes including bluish-grey pigmentation of the oral mucous membrane may occur. With amodiaquin, melanosis, and yellow, brown, or grey discolouration may be produced. Chloroquine may produce whiteness or blondness of the hair, and even loss of hair. The bone marrow may be affected by these agents, leucopenia and agranulocytosis having been observed, as well as other changes in the blood picture.

A number of other toxic effects have also been noted. Some of the effects may be related to dosage, but more data are required to evaluate these effects to the dose range required for the suppression of lupus erythematosus. In most cases the reduction or temporary discontinuation of dosage with these drugs is sufficient to produce allevation of the toxic reactions. Physicians must be aware of the pharmacological problems involved in the use of these drugs because the treatment must be continued for a long time.

The choice of a particular drug is based on a therapeutic trial. There is no simple way of determining how a particular patient will respond to the drug that has been chosen. Several drugs may need to be tried before the best one is found. Also, a drug that has been effective may become ineffective, and vice versa. The most effective drug is not necessarily the one that is best tolerated. That antimalarial drugs have a place in the suppressive treatment of lupus erythematosus is accepted, but it is obvious that careful supervision of the patient is necessary all the time.

1. Merwin, C. F. (1962): Proc. Mayo Clin., **37,** 253.
2. Epstein, J. H. (1960): Calif. Med., **92,** 135.

DIE VERSORGING VAN SWAKSINNIGE PERSONE

Gedurende die afgelope paar dekades het die basiese benadering tot sekere aspekte van welsynswerk radikaal verander. Vroeër was noodleniging die essensie van dié soort werk, maar vandag word dit algemeen aangeneem dat maatskaplike probleme op 'n meer dinamiese en konstruktiewe manier benader moet word.

In terme van hierdie benadering het spesifieke voorsiening in spesifieke probleem- en behoeftestoestande nou ontstaan. Ons het dus spesiale voorsiening vir, byvoorbeeld, normale oumense en seniele oumense, jeugoortreders, gebreklikes en ander liggaamlike ongeskiktes, epileptici, geestesversteurdes, ens., ens. En deur voorsiening te maak vir die versorging en behandeling van hierdie en ander soortgelyke probleemgroepe van persone, lewer ons 'n belangrike maatskaplike gesondheidsdiens.

Ons wil hier nou egter weer die aandag vestig op 'n groep persone in ons land wat as 'n ,verwaarloosde' groep beskou kan word, naamlik die groot groep van betreklike laegraad-swaksinniges. Daar word bereken dat daar in ons land nagenoeg 100,000 persone is wat in terme van die Wet op Geestesgebreke as swaksinnig beskou moet word. Dit sluit persone van alle rasse in.

Nou is dit wel nie nodig om vir spesiale versorging vir al 100,000 voorsiening te maak nie. Van een helfte tot 'n derde van dié persone is hoëgraad-swaksinniges — persone wat dus eintlik in die samelewing self versorg moet word. Hulle sal natuurlik altyd sekere probleme skep, maar as roetinewerkers en helpers behoort hulle darem opgeneem te kan word in die samelewing.

Die verstandvermoë van 'n groot deel van die res is egter op so 'n lae vlak dat spesiale voorsiening vir hulle gemaak *moet* word. Ouers met sulke kinders vind dit dikwels moeilik om hulle te behartig as daar ook ander kinders in die huis is. Swaksinnige persone is dikwels ook onderhewig aan groot emosionele onstabiliteit, sodat hulle om dié rede 'n probleem vorm. Hulle word maklik die prooi van psigopatiese persone met 'n gebrekkige sin vir waardes. En as hulle ouer word, word hul onbeheersde geslagsdrange dikwels 'n ernstige bron van bedreiging vir die samelewing.

Om al hierdie redes, en om baie ander ongenoemdes, is dit belangrik dat spesiale voorsiening gemaak moet word vir die hantering van laegraad-swaksinniges. En dit is juis op hierdie gebied dat ons in ons land tekortskiet. Daar is wel 'n aantal klein, private inrigtings in ons land waar laegraad-swaksinniges versorg word, maar eintlik is die voorsiening so min dat dit nie werklik die probleem verlig nie. Swaksinniges wat ook tegelykertyd geestesversteurd is, kan ook tot die inrigtings vir sielsiekes toegelaat word. Weer is dit egter maar net 'n druppel in die emmer.

Dan bestaan daar die drie groot staatsinrigtings waarin Blanke swaksinnige persone toegelaat kan word, naamlik die Alexandra Inrigting in Maitland, Kp., die Witrand Inrigting in Potchefstroom, en die Umgeni-Waterval Inrigting in Natal. Daar is egter altyd 'n lang waglys om persone toegelaat te kry, en in die behoeftes van nie-Blankes word so goed as geen voorsiening gemaak nie.

Dit is 'n interessante en ook betekenisvolle feit dat ouers van swaksinnige kinders dikwels besonder baie geheg aan dié kinders word — soms meer so as wat die geval met hul normale kinders is. En waar sulke ouers, sonder te veel skade vir hulself of vir hul ander normale kinders, hierdie swaksinnige kinders kan oppas, is dit 'n uitstekende ding. Maar baie werkende ouers, en dit geld veral vir die nie-Blankes, kan dikwels nie sulke versorging onderneem nie. Want waar daar 'n laegraad-swaksinnige in die huis is, moet iemand altyd spesiaal net op sy versorging aangewys wees. En in werkende gesinne is *dit* dikwels moeilik en soms onmoontlik.

In 'n gemeenskap waarin daar dus nie genoegsame fasiliteite bestaan vir die versorging van laegraad-swaksinniges nie, vorm hierdie gebrek aan fasiliteite 'n oorsaak van groot ontbering. Dit is dus goed dat individuele persone, welsynsorganisasies, sowel as die Staat gedurig van die bestaan van hierdie besondere probleem bewus bly. En as lede van 'n beskaafde gemeenskap kan ons nie toesien dat 'n groot onvervulde behoefte onbepaald bly voortbestaan nie.