KWASHIORKOR

NOW A NOTIFIABLE DISEASE

At the request of the Secretary for Health we are publishing the following abstract from a questionnaire on the incidence of nutritional diseases circulated by the National Nutrition Research Institute of the South African Council for Scientific and Industrial Research, which gives the salient points concerning the nature and diagnosis of kwashiorkor. This is being done to help to familiarize all doctors with this condition which, as stated in Government Notice No. 1481 in the *Government Gazette* of 14 September 1962, is now a notifiable disease throughout the Republic of South Africa:

Kwashiorkor usually occurs between the ages of one and two years, or in the immediate post-weaning stage. It is rare before the age of six months.

The disease is always associated with an arrest of growth. The decrease in body weight may, however, be masked by the presence of oedema, and may only become evident when the oedema has disappeared after treatment.

The mental changes are important features of the disease and are the best clinical guide to its severity. The severely ill child is apathetic and miserable, shows no interest in his surroundings and resents any disturbance. The face is dull and expressionless. In the terminal stages the child may be almost comatose. Even those children who are not severely ill are remarkably silent and still. 'A renewal of interest is one of the most obvious signs of improvement and the child who smiles is well on the way to recovery'.

Oedema is one of the distinctive features of kwashiorkor. It is usually a sign of transition from mild to severe kwashiorkor and it may be precipitated by other conditions, e.g. infections or diarrhoea. It usually appears first on the lower parts of the legs and the dorsum of the foot. The oedema pits readily and the pressure of the thumb or finger seldom appears to cause pain. The face is usually involved; the cheeks are characteristically chubby and appear to droop owing to the accumulation of fluid. Oedema of the genitalia is usually present. The hands and the arms may also be affected, but generalized oedema is uncommon and effusions into the serous cavities are rarely found unless a complicating condition, e.g. tuberculosis, is present.

Changes in the hair are typical of most children with kwashiorkor. Instead of the stiff, curly appearance, the hair of the Bantu child becomes softer and straighter than normal. A reddish or brownish discoloration of the hair is usually present. The hair in the temporal regions and over the ears is usually affected first, but later the whole of the scalp may be involved. The hair tends to fall out and become very thin, and in severe cases can be pulled out very easily.

A characteristic dermatosis usually develops in kwashiorkor. The lesions first appear as purplish or black pigmented plaques sharply demarcated from and raised above the surrounding skin. These initial changes usually occur in areas subjected to pressure or moistened by sweat or any secretions. Areas exposed to sunlight are not affected to the same degree. The distribution therefore differs from pellagrous dermatosis. In later stages the plaques enlarge, coalesce and desquamate. The desquamation may be severe, and large areas of erosion and ulceration may appear. Secondary infection seldom occurs in these erosions.

Other skin lesions which are typical of kwashiorkor are linear fissures or 'flexural fissures' which extend into the subcutaneous tissue and which usually occur around the pinna of the ear, at the back of the knee, in front of the elbow, in the axilla, between the toes, at the edge of the foreskin, and in the centre of the lips.

In mild cases of kwashiorkor the skin is usually dry and shows a fine desquamation and a tendency to crack along the natural lines of flexion. Skin lesions suggestive of vitamin deficiencies may also be found in a large percentage of kwashiorkor patients, e.g. angular stomatitis and cheilosis.

It is also typical of advanced kwashiorkor that the skin is much more easily damaged than normal skin. This is especially evident over bony points where the skin may break down and raw, eroded areas may be formed.

Signs and symptoms referable to the digestive system usually consist of loss of appetite and diarrhoea. The abdomen is usually prominent, tense and distended. Enlargement of the liver is not a constant finding. Even if enlarged, the liver is never tender.

PASSING EVENTS : IN DIE VERBYGAAN

Mr. Ivan Coll, surgeon, of Durban, is commencing practice on 1 October at 22 Medical Centre, Field Street, Durban. Telephones: Rooms 6-9574, residence 83-6484. (N.B.: These numbers do not appear in the current *Telephone Directory*.)

Dr. Ivan Coll, chirurg, van Durban, sal vanaf 1 Oktober begin praktiseer te Mediese Sentrum 22, Fieldstraat, Durban. Telefone: Kamers 6-9574, woning 83-6484. (L.W.: Hierdie nommers verskyn nie in die 1962 *Telefoongids* nie.)

* * *

Dr. G. C. C. Burger, diagnostiese radioloog, van Pretoria, praktiseer vanaf 1 September in vennootskap met dr. W. W. Fontanive te Robert Koch Mediese Gebou 335, Pretoria. Telefoon: Kamers 3-3645.

Dr. G. C. C. Burger, diagnostic radiologist, of Pretoria, is practising in partnership with Dr. W. W. Fontanive, as from 1 September, at 335 Robert Koch Medical Building, Pretoria. Telephone: Rooms 3-3645.

* * *

Klinies-patologiese Besprekings, Karl Bremer-hospitaal. Die volgende vergadering in hierdie reeks word gehou op Dinsdagmiddag 2 Oktober om 4.30 nm. in Lesingkamer 2, Farmakologiegebou, Karl Bremer-hospitaal, Bellville. Prof. H. W. Weber sal as spreker optree oor ‚Begrippe van inflammasie'. Alle dokters wat belang stel, word uitgenooi om die vergadering by te woon.

The South African Institute for Medical Research, Johannesburg, Staff Scientific Meeting. The next meeting will be held on Monday 1 October 1962 at 5.10 p.m. in the Institute Lecture Theatre. Mr. G. MacNab will speak on 'Recent methods for immunochemical investigations'.

* * *

University of Cape Town and Association of Surgeons of South Africa (M.A.S.A.), Joint Lectures. The next lecture in this series will be held on Wednesday 3 October at 5.30 p.m. in the E-floor Lecture Theatre, Groote Schuur Hospital, Observatory, Cape. Mr. G. W. Muller Botha will speak on 'The significance of the small hiatal hernia'. All members of the Medical Association are welcome to attend this lecture.

* * *

Mr. David A. Muskat, surgeon, of Johannesburg, has changed his address from 504 Medical Arts Building, to Suite 706 Lancet Hall, Jeppe Street, Johannesburg, as from 1 September 1962. The telephone number remains unchanged — 22-9208.

Dr. David A. Muskat, chirurg, van Johannesburg, het vanaf 1 September sy adres verander na Suite 706 Lancet Hall, Jeppestraat, Johannesburg, voorheen 504 Medical Arts-gebou. Die telefoonnommer bly onveranderd — 22-9208.