SOUTH AFRICAN MEDICAL JOURNAL SUID-AFRIKAANSE TYDSKRIF VIR GENEESKUNDE

Cape Town, 9 July 1966 Volume 40 No. 25 Deel 40 Kaapstad, 9 Julie 1966

EDITORIAL : VAN DIE REDAKSIE

THE ADOLESCENT

In spite of the fact that it has often been said that special health services for the adolescent would constitute 'a fragmentation of medicine', most people will agree that the needs of this age-group are neither fully understood nor dealt with adequately.

The adolescent is in a stage of transition and is not fully developed either physically or emotionally. Parents of adolescents know full well that their children are experiencing physical urges, states of restlessness, ambivalence and even open rebellion against those who have nurtured them. These disturbances of adjustment occur because of the unequal character of physical and emotional growth, since the degree and type of maladjustment varies between boys and girls.

As it is a period of concomitant physical growth, biological change and social adjustment, it is generally conceded to be one of the most difficult stages in the life of the average individual in our society.[1] Authorities differ as to the exact duration of adolescence, but in the United States where adolescent clinics exist the age range is taken to be from 12 to 21. There is a continuum from childhood to adulthood, but, broadly, adolescence has been defined as the period extending from the onset of puberty to the attainment of full physical maturity.

At the Children's Medical Centre in Boston an Adolescent Unit has been established since 1952 which operates as an outpatient facility for those between the ages of 12 - 21, and it offers traineeship courses in adolescent medicine. Such a clinic is well patronized indicating the need for a treatment and possibly a research centre. The adolescent requires the help of doctors and specialists who are interested in the physical and mental care of this age-group, and in addition that of psychologists, social workers and other paramedical personnel, whose multidisciplined approaches, combined into a team, would be of enormous benefit to such patients and of great interest to those who work with them.

Initially one thinks primarily of emotional disturbances and psychiatric care, but there is a great deal of physical illness that would also be detected. In a survey of 750 patients at the Children's Medical Centre in Boston, Williams[2] has analysed two broad diagnostic categories, one in which physical conditions are the primary diagnoses and the other which comprises emotional, adjustment and academic problems in which the 'functional' element is paramount. The analysis is worth recording:

TABLE I. PRIMARY PHYSICAL CONDITIONS

	No. of patients		
Diagnosis	*Girls*	*Boys*	*Total*
Seizures	22	52	74
Mental retardation	16	45	61
No abnormality	13	48	61
Growth and development problems	19	33	52
Cardiac conditions	11	29	40
Miscellaneous conditions	9	22	31
Orthopaedic problems	5	24	29
ENT and respiratory problems	9	15	24
Skin disorders	11	14	25
Brain damage	0	13	13
Speech disorders	1	8	9
Gynaecological conditions	8	—	8
Total	124	303	427

TABLE II. PRIMARY FUNCTIONAL CONDITIONS

	No. of patients		
Diagnosis	*Girls*	*Boys*	*Total*
Adjustment reactions of adolescence	22	92	114
Neuroses	25	39	64
Behaviour problems	14	44	58
School problems	3	50	53
Psychoses	3	20	23
Enuresis	2	9	11
Total	69	254	323

It will be noticed that chronic problems are the ones mainly presented and that boys outnumber girls in both physical and mental ill-health by about 3 : 1. Further, one cannot but remark that with some of the physical and primarily functional conditions, treatment could possibly have been instituted earlier if diagnosis had been made when the patient was younger. Orthopaedic problems, deafness or brain damage, on the physical side, and neuroses and behaviour problems may be given as examples, since these had probably been present for some time. Mental retardation had most likely been detected early and help sought elsewhere.

Some universities in our country have a student health service which caters for the needs of the relatively few who are fortunate enough to be able to attend university. A good deal of work goes into such a facility. Most often acute illness of a physical nature is treated, but many students, particularly the younger ones, have 'functional' problems which are as yet not fully catered for and may result in breakdown when stress, such as impending examinations, has to be borne.

Adolescent university students form a special group of young people, and there may be a number who should not be at university at all if factors other than school examination results were taken into account.

Busy hospital outpatient departments may see small numbers of people in this age-group, but is the time available and the atmosphere suitable for the adolescent as a person? Poor school achievement may indicate early that something is wrong. 'School is often the battleground upon which are fought out the adolescent's conflicts with himself, his family and his environment, and authority in general bears the brunt of his hostility.'[3] Careful physical examination with particular attention to vision, hearing, and neurological symptoms, assessment of intelligence and emotional problems should be sought for by the school medical officer, and are often detected when a teacher refers the child to the school doctor as a 'poor-achiever'.

The intention of this article is to stimulate colleagues to take a closer look at *adolescence* as a period in the growth of the individual where the emergent problems may warrant the establishment of special clinics for adolescents, if it is believed that this age-group is insufficiently catered for by our existing medical services.

1. Elliot, M. A. and Merrill, F. E. (1950): *Social Disorganization*, 3rd ed., p. 52. New York: Harper and Brothers.
2. Williams, M. (1952): Med. J. Aust., **2**, 201.
3. Liss, E. (1955): Psychoanal. Stud. Child., **10**, 100.

ASPEKTE VAN IATROGENIESE SIEKTE

Baie aandag is gedurende die laaste aantal jare gegee aan iatrogeniese siekte—veral die liggaamlike aspekte daarvan wat gewoonlik ontstaan as gevolg van die newe-uitwerking van die toediening van mediese middels. Aspekte van hierdie mens-, en veral geneesheer-gemaakte toestande wat gewoonlik minder beklemtoon word, is daardie iatrogeniese toestande wat 'n psigogene oorsprong het. By geleentheid van die Konferensie oor Gesondheidsvoorligting wat onlangs in Pretoria gehou is, het prof. G. A. Elliott, van die Universiteit van die Witwatersrand, spesiale aandag aan hierdie aspekte van die saak gegee.

Hy het onder meer daarop gewys dat spanning en bekommernis en veral neurotiese siektetoestande maklik kan onstaaan by 'n pasiënt as gevolg van 'n ondersoek deur sy geneesheer, sonder dat die geneesheer iets van dié aard vermoed. Die geneesheer mag byvoorbeeld as gevolg van vermoeienis of oorwerk, of bloot omdat hy haastig mag wees om by 'n noodgeval te kom, 'n verkeerde of onverstandige woord laat val wat dan tot morbiede introspeksie by die pasiënt ly. Ook is dit bekend dat 'n foutiewe diagnose, bv. die toeskryf van organiese implikasies aan 'n onskuldige hartgeruis, al dikwels tot ernstige hartneurose gely het.

Ook moet die geneesheer in staat wees om die pasiënt te hanteer wat hom bewus en onbewus mislei. Onbewuste misleiding kom dikwels voor omdat pasiënte dié soort antwoorde gee wat hulle dink hul geneeshere graag wil ontvang. Veral waar die toestand hoofsaaklik op die aard van die geskiedenis wat die pasiënt gee, gediagnoseer word, is sulke onopsetlike misleiding van groot belang.

Omrede van ernstige, half-verdronge vrese, steek die pasiënt dikwels 'n belangrike simptoom weg. 'n Pasiënt wat ongeveer 50 jaar oud is en vir die eerste keer dispeptiese ongerief beleef, mag alle moontlike ander simptome behalwe hierdie een noem. As hy dan op 'n angstige manier vir sy geneesheer aan die einde van die onderhoud vra: ‚Is dit kanker', of ‚is dit my hart', moet die geneesheer dadelik insien dat daar hier, afgesien, van 'n moontlike fisieke ongesteldheid, ook 'n aanduiding van vrees en angsneurose is—toestande wat versigtig en oordeelkundig gehanteer moet word.

Omdat hulle wat siektetoestande betref gewoonlik leke is, interpreteer pasiënte die woorde van hul geneeshere dikwels op 'n baie letterlike manier. Daarom is nie net *wat* die geneesheer bedoel om te sê van belang nie, maar sy spesifieke woordgebruik is van belang sowel as die manier waarop hy met die pasiënt praat. Aanmoediging en gerusstelling word dus van die grootste belang. Sover as moontlik moet die geneesheer enige negatiewe twyfel oor die redelike prognose, of ook oor die differensiële diagnose van 'n toestand, eers in sy eie gedagtes verwerk voordat hy 'n hele reeks van negatiewe suggesties aan 'n pasiënt oordra. As die geneesheer seker van sy saak is, kan hy sê wat die diagnose is. As hy nie seker is nie, kan hy sê: ‚ek dink jy het dít, of dát, maar ek wil net nog 'n slag seker maak.' As hy egter 'n hele reeks van toestande in die differensiële diagnose opnoem, mag die vrugbare aarde voorberei word vir ernstige neurotiese ongesteldhede.

Spesiale aandag moet ook gegee word aan sogenaamde roetine-ondersoeke en -prosedures. Baie pasiënte is byvoorbeeld geleer om hul urine gereeld te toets en hul inspuitings van insulien self te gee. Dit lei nie meer tot onnodige angste nie, omdat hulle *opgevoed* is om dié prosedures te verstaan en te hanteer. In gevalle waar pasiënte gereelde bloeddruk-ondersoeke moet ondergaan, omdat hulle byvoorbeeld hipotensiewe middels gebruik, mag dit gerade wees om hulle ook op te lei om hul bloeddruk-lesings self te neem en dan periodiek aan die geneesheer voor te lê. Dit mag miskien 'n goeie manier wees om betroubare, rustende oggend- en aandlesings in gevalle van intelligente pasiënte te verkry. Dié hele saak bly egter onderhewig aan die diskressie van die geneesheer, aangesien daar gevalle is van pasiënte met bv. maligne hipertensie, wat liewers nie moet weet wat hulle bloeddruk is nie.

Die oorwegings en voorbeelde hierbo genoem dien maar net as indikasies van moontlike iatrogeniese toestande wat voorkom kan word deur die bewuste en versigtige optrede van 'n geneesheer wat in die hele persoonlikheid van sy pasiënt belang stel.

POISONOUS SNAKES OF SOUTHERN AFRICA

The last book dealing exclusively with poisonous snakes and the treatment of snakebite in Southern Africa was Fitzsimons' *Snakes and the Treatment of Snakebite* which was published in 1919. This book has now been out of print for many years. Furthermore, our knowledge of the indigenous snakes has increased immensely, and both the first-aid and medical treatment of snakebite have undergone phenomenal changes during the past forty-five years.

In order to fill the long-felt need for an authoritative review of this subject, the Cape of Good Hope Faculty of the College of General Practitioners invited Mr. John Visser, who is well-known to museums and universities both in South Africa and overseas through his own herpetological work, to undertake the task of compiling such a review.

The result has been the publication of a splendid volume *Poisonous Snakes in Southern Africa*,[1] written by Mr. John Visser and sponsored by the College of General Practitioners. The book is a balanced and integrated account which fills the needs of physicians, first-aid organizations and the public. In addition to its other qualities, it is the first book in which all the South African poisonous snakes are illustrated in colour. These splendid illustrations are produced on art paper and will serve as an invaluable guide for identification of the snakes involved in possible snakebites, and therefore also for the institution of the correct treatment.

The publication of the book was not only sponsored by the College of General Practitioners but also checked at all stages by the author's colleagues and by various medical specialists. It can therefore, in fact, be regarded as a truly authoritative guide in this field. The following chapters give an indication of the range of the publication:

1. Poisonous snakes of Southern Africa and the effects of their venoms
2. Factors affecting the severity of snakebite
3. Antivenoms—specificity, indications and precautions
4. Treatment of snakebite—First-aid and medical
5. Appendix 1—First-aid measures
   Appendix 2—Illustrative case-histories
   Appendix 3—About snakes in general—questions and answers

Glossary, Bibliography, Index

The acquisition of this book is strongly recommended to doctors as well as to youth and first-aid organizations, mountaineering clubs and members of the public who are interested in this subject.

1. Visser, J. (1966): *Poisonous Snakes of Southern Africa*. Cape Town: Howard Timmins (R4.50).