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CHOLERA

For the first time in 75 years cholera has appeared in Africa south of the Sahara. Official WHO reports have confirmed cholera in Guinea, Ghana, the Ivory Coast, Liberia, Sierra Leone, Libya and Tunisia. Press reports and other unofficial sources have reported outbreaks of a cholera-like disease in the United Arab Republic, Ethiopia, Malawi, Senegal, Sudan and Togo. On several occasions recently the official organ of the WHO, the *Weekly Epidemiological Record,* has drawn attention to the fact that it has become evident that some countries are not notifying the disease and the Director General of the Organization has taken the unusual step of stating that, in the absence of notification, the presence of cholera should be disclosed when reliable technical evidence is available.[1]

South Africa, in spite of its geographical situation and climatic circumstances, must be considered to be at risk to the introduction of cholera during the progress of the current pandemic. During the hot and humid summer months ahead, particularly at the sea-ports, the possibility of a case appearing or a small outbreak occurring is not remote. While vaccination against cholera confers a degree of protection on the majority of immunized individuals for a period of 3 - 6 months, it does not prevent those vaccinated from becoming infected, excreting cholera vibrios and so infecting others either directly or through a common source vehicle such as water or food. This is particularly so in groups living in close association, sharing feeding facilities and with indifferent standards of personal and environmental hygiene. Accordingly, while cholera is unlikely to establish itself in an endemic focus in Southern Africa, if introduced into overcrowded communities with low standards of environmental sanitation and scanty, restricted or unprotected water supplies, outbreaks of some severity could be expected. The nature of cholera is such that an infected person capable of infecting others can readily and unwittingly breach quarantine defences, however sophisticated, and thus introduce the disease into a susceptible community.

Cholera has also been introduced into countries in Europe and the Middle East, notably Israel and most recently Turkey. In June 1970 the health authorities in Israel, realizing that the country was at particular risk of the introduction of cholera, introduced a programme of diarrhoeal disease surveillance. The first case of cholera was diagnosed clinically on 20 August and confirmed next day.[2] Since then there have been 249 cases of cholera, of which over one-third have been detected only as a result of the surveillance programme.

This example is illustrative of the risk even to communities which are exercising vigilance through comprehensive health and laboratory services. Consequently, during the hot humid months ahead Southern Africa is undoubtedly at risk, particularly in coastal areas where traffic from cholera-infected local areas makes use of the ports. Quite apart from the risk of cholera being introduced through the chance infection of an air traveller, groups of seamen living in close association in crew's quarters of merchant ships probably pose a greater risk.

It is almost certain that a clinical case of cholera will be the first indication of infection. Therefore clinical vigilance and an active laboratory surveillance of diarrhoeal diseases are the main safeguards against widespread dissemination and sharp outbreaks of cholera. This is particularly so in small groups living under conditions of overcrowding, with poor standards of hygiene, scanty water supplies and with considerable interchange between urban and rural areas. In this connection it is as well to remember that for each case of cholera with 'rice-water' stools there may be 100 other cholera infections in the community at large with either minimal or no symptoms of gastro-intestinal upset manifest in the individuals concerned.[3,4]

Given early and adequate treatment cholera is no longer a highly lethal disease. However, in an article in this issue of the *Journal,* it is stressed that it is necessary to deal equally urgently with the contacts and the immediate environment of the index case if the situation is to be kept under control. This presupposes not only vigilance by clinicians and laboratory personnel but planning ahead by the local authority health services responsible for infectious disease control and environmental sanitation. It may not be possible to prevent the introduction of cholera but it is possible to control an outbreak quickly and to mitigate the impact on the daily life and economy of the community.

While mass immunization with cholera vaccine may be expected to reduce the number of clinical cases by between 45% and 80%, the protection offered is limited and of short duration. Provided that the community responds adequately and mass campaigns can be held every 6 months this may be worth while. However, in a country with a well-developed network of health services, early recognition of the infection with good public information regarding treatment centres and control measures is a much more effective way of controlling the disease. There are, however, certain groups which should be given vaccine. In terms of the International Sanitary Regulations all travellers from a notified cholera-infected area should be in possession of a valid certificate of vaccination against cholera in the internationally accepted form. In view of the fact that some countries are not notifying the disease when it does occur, cholera vaccination is in any case a prudent protective measure for all individuals travelling outside the Republic. In South Africa itself for doctors, health officials, laboratory workers and those likely to be in contact with imported cholera, immunization is also a personal safeguard.

Cholera may appear in Southern Africa and to avoid panic measures and public apprehension it is wise for all

health authorities at all levels in the Republic to have ready plans for control and prevention with which their officials are fully familiar. The gearing of laboratory units to diarrhoeal disease surveillance and to the support of hospital and quarantine emergency service needs is vital to early recognition of the disease. Similarly the vigilance necessary to ensure adequate environmental measures, particularly at ports of entry by sea and air, will not only stimulate public confidence in the face of the current threat of the introduction of *Vibrio cholerae* into the community but will ensure prompt and constructive action if it does appear.

1. World Health Organization (1970): Wkly Epidem. Rec., **45**, 377.
2. *Idem* (1970): *Ibid.*, **45**, 403.
3. Leading Article (1970): Brit. Med. J., **4**, 2.
4. Van de Linde, P. A. and Forbes, G. I. (1965): Bull. Wld Hlth Org., **32**, 515.

DIE NUWE JAAR

Now the New Year reviving old Desires,
The thoughtful Soul to Solitude retires.
Fitzgerald: *Omar Khayýam*

Die vooruitsigte is goed. Daar lê 'n seereis voor; ons het 'n nuwe groep spesiaal opgeleide huisartse; heelparty afgestudeerdes begin hul professionele loopbaan en die nuwe mediese skool te Bloemfontein is in volle swang—wat meer kan mens vra? Daar is nie veel meer wat ons hoef te vra nie, behalwe dat iedere kollega sy deel bydra soos nog altyd in die verlede die geval was.

Nuwejaarsvoornemens is maar selde suksesvol en hoe ingewikkelder en belangriker hulle is, hoe minder kans is daar skynbaar dat hulle end-uit gaan hou. Om 'n hele rits van idealistiese besluite te neem in die vae hoop dat ten minste 'n paar van hulle 'n rukkie lank mens se lewenspatroon gaan beïnvloed, het min waarde. Dit is veel beter om slegs een of uiters twee aspekte uit te sonder en werklik voet by stuk te hou. Daar kan selfs geargumenteer word dat iedere dag 'n nuwe begin moet of kan wees en dat dit nie nodig is om vir 'n nuwe jaartal te wag voordat verbeterings aangebring word nie. Dit is miskien wel so, maar die mens is nou maar eenmaal 'n wese wat daarvan hou om aanknopingspunte te soek, soos ons vele feeste en verjaardagvierings klinkklaar bewys. 'n Datumsverandering bo aan die kalender is 'n lekker aansporing om weer opnuut te probeer om daardie klein verbeterinkies aan te bring wat reeds so lank nodig was.

Iedere dokter sal sy eie dingetjies hê wat opknapping vereis en een kan nie vir die ander besluit nie. Daar is iedergeval niks so vervelig en irriterend as om deur ander voorgeskryf te word hoe jy jou lewe moet inrig nie. As 'n karringkous van 'n familielid daarop aandring dat pa moet ophou rook of dat ma eens en vir altyd moet leer om die sitplekgordel vas te maak voor sy die motor aanskakel, is die stryd sommer uit die staanspoor halfpad verlore. Mens wil self besluit en op eie houdjie die verantwoordelikheid dra om toe te sien dat die goeie voorneme altans vir 'n rukkie stand hou—dan kan niemand sê wê as die stukrag so teen Februarie bietjie ingee nie.

Dit is vandag Tweede Nuwejaar in die Kaap—tog te 'n lekker instelling en as ons hier by die redaksie ons sin kon kry hou ons sommer gesellig Nuwejaar tot doer diep in Maart in. Maar dit kan ongelukkig nie want die kersgeskenke en die vakansie moet betaal word en die werk hoop op. Veral die kollegas wat hul plek onder die pasiënte moet volstaan is terdeë bewus daarvan dat daar nie tyd is vir te lank rus nie. Trouens, diegene wat in ongevalle departemente werk sal seker nou 'n sug van verligting gee en met dankbaarheid weer die normale roetine tegemoet gaan.

Ons het gesê ons wil nie voorskryf nie, en dit is ook nie nodig nie; maar mens hoop darem dat daar hier en daar iemand gaan wees wat die haas onmoontlike Nuwejaarsvoorneme gaan aanvaar; naamlik om in die komende jaar elke enkele pasiënt wat teëgekom word, hetsy in die hospitaal, in 'n buitekliniek of in die privaatpraktyk, die volle onverdeelde aandag te gee waarop hy geregtig is. Dit klink maklik en daar is moontlik enkeles onder ons lesers wat so 'n praktykspatroon dag in en dag uit volhou. Vir hulle wil ons hoed afhaal en sê 'pragtig—hou so aan'. Maar aan die gemiddeldes en selfs die ander uitstekendes wat gewillig is om rondborstig te erken dat dit bykans bowemenslike inspanning vereis om iedere pasiënt met dieselfde volkome toegewyde aandag te konsulteer, wil ons vra of daar nie enkeles gaan wees wat dit op die proef wil stel nie.

As die wagkamer op 'n Saterdagmôre kant en wal vol sit en daar wag 'n hele paar lang distriksritte, kos dit heldemoed en selfdissipline om na afloop van die spreekuur met eerlikheid te kan sê dat nie een enkele pasiënt gevra is om Maandag te kom vir 'n urine-ondersoek of wat ook al net om bietjie blaaskans te skep nie, miskien in die hoop dat Maandagoggend minder blou sal blyk te wees. Miskien gaan 1971 die paar dokters oplewer wat selfs aan die gemoedelike tannie wat so lekker voor die lessenaar regskuif en sê: 'Dokter, waar sal ek begin?' hul onverdeelde aandag gaan skenk en wat nie eens in hulle eie gedagtes vir haar gaan sê waar sy ten minste behoort op te hou nie.

Wat ook al die Nuwejaarsvoornemens gaan wees, kennende ons kollegas het ons min twyfel dat dit op een of ander wyse tot voordeel van die pasiënte sal strek, en al sypel die Nuwejaarstroompie dan maar so teen April in die droë sandjies weg, het mens ten minste die vertroosting dat die eerste paar maande van die jaar vir 'n hele aantal pasiënte iets goeds gebring het.

Mediese praktyk in Suid-Afrika is goed en op 'n veilige koers—al wat ons te doen staan is om te verseker dat ons nooit in 'n waas van selftevredenheid toelaat dat ons pogings om dit nog verder te verbeter enigsins verslap nie. Met blymoedige vertroue tree ons die Nuwejaar toe.