Matters arising

Sexually transmitted diseases in South Africa: epidemic donovanosis in Durban?

In their review of sexually transmitted diseases in South Africa, Pham-Kanter and colleagues state that donovanosis may have disappeared only to reemerge in 1981 in Johannesburg, with subsequent case reports from other areas including Durban.¹ This scenario is exceedingly unlikely if the Annual reports of the Medical Officer of Health (MOH) for Durban of the Durban City Health Department are taken into account.

Throughout South Africa STD clinics are administered under the statutory authority of the local MOH. Returns from these clinics are published in the annual reports of the MOH which contain a wealth of information compiled from STD clinics throughout the country. In Durban cases of donovanosis are reported almost every year in the MOH's reports from 1959 onwards, when the current STD reporting classification system was introduced. Peaks of infection were reported in 1973 and 1988² but a dramatic increase in the numbers of donovanosis cases has apparently occurred in recent years. The most recent data show that 2385 cases (2225 men, 160 women) donovanosis cases were diagnosed in 1995 (table). If these figures reflect accurate diagnoses they represent a significant epidemic of donovanosis and the largest in recent times.

Despite this reported increase, the true nature of the current status of donovanosis is uncertain. Cases diagnosed in 1988 were usually confirmed by examination of tissue smears using a rapid technique. Subsequently the decision to decentralise STD services led to staff cuts and discontinuation of laboratory testing for the detection of Donovan bodies. Although the overall accuracy of specific clinical diagnosis in genital ulceration may be low, this is not necessarily so for donovanosis which can be predicted accurately on clinical grounds.³

Further investigation is urgently required to determine whether or not a true current epidemic of donovanosis exists. Genital ulcer disease and donovanosis in particular, are playing a major role in the rapid escalation of the HIV epidemic in Durban/KwaZulu/Natal⁴ and it is therefore vital to maintain and strengthen local STD surveillance so that STD/HIV prevention strategies can be targeted to have the maximum impact.

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Number of cases of donovanosis in Durban 1988-1995

Year	Numbers of donovanosis cases			Total
	Males (M)	Females (F)	M to F ratio	
1988	256	57	4.5	312
1989	569	95	6.0	664
1990	981	129	7.6	1110
1991	1306	138	9.5	1444
1992	1226	112	10.9	1338
1993	1060	78	13.6	1138
1994	2119	152	13.9	2271
1995	2225	160	13.9	2385

Source: Annual Reports of the MOH for Durban 1988-1995.

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Multidrug resistant tuberculosis: practical lesson for HIV units

Dr Easterbrook's timely editorial highlights the potential problems of nosocomial spread of tuberculosis and, in particular, multidrug resistant tuberculosis (MDR TB), with some useful practical points.¹ Published data suggest that chances of survival in patients with AIDS who acquire MDR TB are particularly poor, but, in line with more recently published data,³ our experience at St Mary's Hospital suggests that aggressive early treatment may prolong survival substantially. Of note, one patient who had had AIDS for a year before acquiring MDR TB nosocomially at another hospital is still alive and well 18 months after its acquisition. With patients' increased survival and the waxing and waning course of their tuberculosis significant practical and ethical dilemmas are raised, not least the dilemma of prolonged isolation of patients with a terminal disease in hospital. Dr Easterbrook suggests that MDR TB strains are no more infectious than drug susceptible ones and although this is true for a given time period, the protracted nature of the disease and its slow response to antituberculous therapies means that the overall infectiousness will be prolonged and isolation protracted.

Dr Easterbrook states that patients should only be discharged from hospital when they are no longer infectious. Unfortunately it is difficult to determine in patients with MDR TB when they are non-infectious and local guidelines based on national guidelines will need to be clear on this issue.

If compliance is poor in patients with tuberculosis, then directly observed therapy should be employed as Dr Easterbrook states. In addition, in any patient with MDR TB supervised or directly observed therapy is mandatory. Unfortunately, at present, a shortage of TB Clinical Nurse Specialists (and sometimes the resistance or inability of District Nurses to take on this service) means that it can falter. This area urgently needs to be addressed.

Lastly, as Dr Easterbrook states, in the UK the use of masks in the context of patients with