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June 2023 Edition

QualiCare

The Qualicare Team after the successful open day in Cape Town

Address from the audience by Tony Behrman to the closing session of the Board of Healthcare Funders Cape Town May 2023

Special points of interest

- Address from the audience by Tony Behrman....
- Garden Route Open Day Invitation
- Engineering Micro Robots
- Obstetric Ultrasound: NOTICE

Colleagues, the end point of the BHF conference this year has not changed over the past 12 years.

Funders and administrators continue to operate in silos with a marked absence of representation by provider organizations such as doctors, nurses, paramedics, pharmacists etc. Furthermore there is no representation by any consumer organizations of health on behalf of the very patients who consume health care.

Yet again this year we talk about "Patient centricity" but the absence of both consumers and suppliers of healthcare, this suggests that the participants to the conference have not moved away from paternalism, devising solutions for individuals who are not in the room and then attempting to implement them in a top down, out-dated, "kragdadig" fashion.

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OPEN DAY 2023

Garden Route

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Yvette Du Bruyn
061 528 6741

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BHF Cape Town .... Continue from page 1

Here today, I represent 3,000 General Practitioners in the IPA Foundation and state publicly today that we are still awaiting a final decision from the Competition Commission (who have just addressed us), on the IPAF's application for the right to collective bargaining on price for the General Practitioners of RSA. Currently, as a result of the current dispensation, family doctors are going out of business as rapidly as did the small pharmacists some years ago.

My members agree that Universal Healthcare and Social Health Insurance is an honorable goal but have repeatedly cautioned, many times, that NHI in its currently envisioned format is merely an unaffordable whiteboard exercise and is light years away from meaningful implementation.

It is based on a myth that 80% of South African citizens have no access to good quality health care when in fact there is (and always was) a highly developed, but since 1994 and currently, a poorly run and badly administered public sector, which is supposed to look after the healthcare of all South Africans paid for through general taxation.

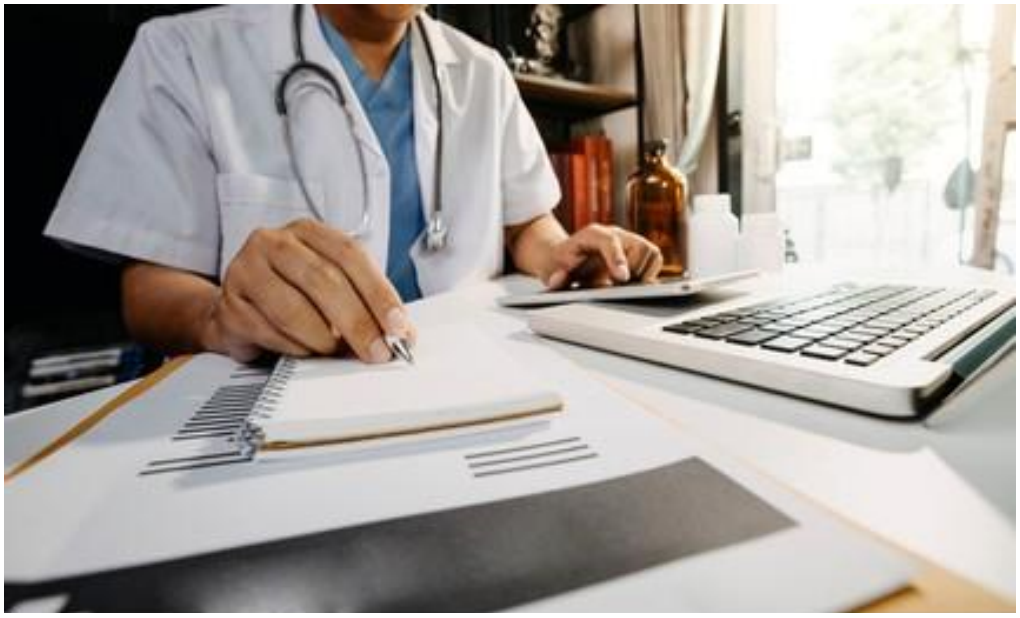
The private sector burgeoned as result of the abrogation of this responsibility by the state. The fault for this cannot be placed solely at the door of the private sector nor can it be that, by pooling all health funds of the two sectors into one, this will suddenly result in the correction in the course of the public sector, and eliminate endemic corruption.

It is now more than ever time for a meeting of all parties, State and Private in a healthcare CODESA to explore real meaningful pragmatic cooperation between healthcare in the private and public sectors.

Remove health care from the political arena once and for all, and urgently appoint a CEO to overarch the sharing of the strengths of both private and public sectors as well as the exploration and correction of their collective weaknesses.

Failing this, we will all be back next year, and just continue talking.

Dr Tony Behrman CEO CPC Qualicare. Director of the IPA Foundation of RSA



Litigation clouds gather over NHI Bill

- ***Healthcare industry disappointed little of new public input taken into account in latest version.***

Parliament portfolio commit on health has formally adopted its amendment to the National Health Insurance (NHI) Bill, marketing a key milestone in the ANC-led government's plans for achieving universal health coverage.

The committee has made only minor changes to the bill, prompting a warning from SA's biggest medical scheme administrator, Discovery Health, that the legislation will be open to constitutional challenges, and eliciting an immediate thread of legal action from trade union.

Solidarity. The ANC-dominated committee has been considering the NHI Bill for the past four years, and has made no substantive amendments to the bill despite the concerns raised by parliament's legal advisers, the issues raised by opposition parties and the input received from stakeholders ranging from private healthcare providers to patient advocacy groups.

Th "B-Version" of the bill was adopted by the committee on Wednesday, with six ANC MPs voting in favour, versus two DA MPs and one MP each from the Freedom Front Plus (FF+) and EFF voting against it.

The bill will now go to the National Assembly where it is expected to be passed.

It will then be sent to the National Council of Provinces for concurrence, a process that is likely to take at least a year.

The bill is the first piece of enabling legislation for NHI and proposes establishing a central NHI fund that will purchase services from accredited public and private sector providers.

These services will be free at the point of delivery for SA citizens, regardless of their income.

While government has said it intends the fund to be based on social solidarity principles, with the rich and healthy subsiding the poor and the sick, it has yet to indicate how it will be financed.

Discovery Health CEO Ryan Noach said he was disappointed that the amended version of the bill varied little form the original.

Discovery Health did not support the single funder model proposed by the bill, nor its proposal to restrict medical schemes to only offer cover for services not included under NHI.

" The portfolio committee elected not to take the opportunity to make amendments to the NHI Bill that would enhance both the feasibility and effectiveness of the NHI Fund, despite detailed and constructive inputs from multiple stakeholders."

"As a result, it is highly likely that this bill will be challenged through various legal avenues, including probably being contested on constitutional grounds, "he said.

Noach said the financing of NHI remains unclear as there has been no input from the National Treasury.

"It is absolutely critical to understand the affordability and economic strategy for supporting the bill's proposals, as well as the financial system and controls required to ensure effective oversight of the monies in the fund.

"(Without) substantial financial support, the necessary health system improvements and the sustainability of this approach will be impossible," he said.

Trade Union Solidarity said it would take the government to court if the bill is accepted.

In the run-up to next year's election, and in order to canvass cheap votes, the ANC government insist on pushing through this law while they are fully aware that their own system cannot support it," Solidarity's medical network co-ordinator, Peirru Marx, said.

The department of health's deputy director-general for NHI, Nicholas Crisp, said the government was ready to defend the legislation.

"Plenty of people say they will challenge some or all the bill. "

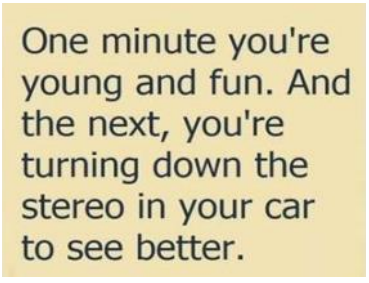
"Millions of people say they will fight to ensure it happens"

"We'll allow our court and constitutional processes to unfold," he said.

FF+ MP Phillip van Staden said the health committee's approval of the bill on Wednesday marked a "very dark day forr health care SA", also sounding a warning about prospective legal challenges to the legislation.

Hospital Association of SA spokesperson Mark Peach urged legislators to engage with the matters raised in various forums including parliamentary hearings.

"What we do now will remain with us for generations," he said.



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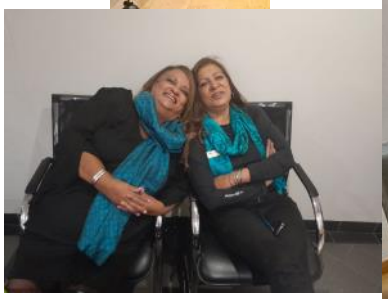
Thank you

to all the team members for working hard and not giving up till the end



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Engineering micro robots for targeted cancer therapies from a medical perspective

CLINICAL LABORATORIES

Cancer is a complex disease that affects millions of people worldwide. Despite significant advances in cancer treatment, many patients still suffer from side effects associated with traditional therapies, such as chemotherapy and radiation therapy. Moreover, these treatments are often unable to target cancer cells specifically, leading to damage to healthy cells and tissues. The development of micro-robots for targeted cancer therapies has emerged as a promising approach to overcome these limitations.

Design and Fabrication of Micro-Robots for Targeted Cancer Therapies

The design and fabrication of micro-robots for targeted cancer therapies are complex processes that require multidisciplinary expertise. The first step in designing a micro-robot is to identify the cancer cells that need to be targeted. Biosensors can be used to detect cancer biomarkers or changes in pH levels that are characteristic of cancer cells. Once a cancer cell is detected, the micro-robot can be programmed to deliver a specific therapy or drug to the targeted cell.

One of the main challenges in designing micro-robots for cancer therapies is their small size. Micro-robots are typically smaller than a millimeter in size, which allows them to move through the bloodstream and navigate through the body to reach their target. The shape of the robot can also be designed to optimize its movement and increase its ability to penetrate tissues. For example, micro-robots can be designed to have a cylindrical shape with a tapered end, which allows them to move through small blood vessels.

The materials used to construct the micro-robots are also important. The materials need to be biocompatible, meaning they do not cause an adverse reaction when introduced into the body. The micro-robot must also be able to withstand the harsh conditions of the body, including high temperatures and pressures. Materials such as silicon and biodegradable polymers are commonly used to fabricate micro-robots.

One of the challenges in fabricating micro-robots is the need for precision manufacturing. Micro-robots are typically fabricated using microfabrication techniques, which involve the use of photolithography, etching, and deposition processes. These techniques require high precision and accuracy, as errors can result in the failure of the robot to reach its target or cause harm to healthy cells.

Applications of Micro-Robots in Targeted Cancer Therapies

Micro-robots can be used for a variety of applications in targeted cancer therapies. One of the most promising applications is drug delivery. Micro-robots can be designed to deliver drugs directly to cancer cells, thereby reducing the side effects associated with traditional therapies. The drugs can be encapsulated within the micro-robot or attached to its surface.

Micro-robots can also be used for photo thermal therapy, a technique that involves the use of light to heat cancer cells and destroy them. Micro-robots can be designed to absorb light and convert it into heat, which can be used to destroy cancer cells. This technique has the advantage of being non-invasive and can be used to target cancer cells deep within the body.

In addition to delivering drugs and therapies, micro-robots can also be used for diagnostic purposes. For example, they can be designed to collect tissue samples from specific locations in the body for analysis. This can help in early cancer detection and enable more targeted treatment.

Another potential application of micro-robots is in the detection of cancer metastasis. Metastasis is the spread of cancer cells from the original tumor to other parts of the body. It is a major cause of cancer-related deaths, as it makes treatment more difficult. Micro-robots can be designed to detect cancer cells that have spread to other parts of the body and deliver therapies to these cells.

One of the most exciting applications of micro-robots in cancer therapies is their potential to overcome the blood-brain barrier. The blood-brain barrier is a protective barrier that prevents many drugs from reaching the brain. This makes it difficult to treat brain tumors and other neurological conditions. Micro-robots can be designed to cross the blood-brain barrier and deliver drugs directly to the brain, opening up new possibilities for the treatment of brain tumors and other neurological conditions.

Challenges and Future Directions

While the potential of micro-robots in cancer therapies is significant, there are still many challenges that need to be addressed. One of the main challenges is the development of more sophisticated biosensors that can detect cancer cells with high accuracy and specificity. Current biosensors are limited in their ability to distinguish between cancer cells and healthy cells, which can lead to false positives and false negatives.

Another challenge is improving the navigation capabilities of micro-robots. Micro-robots need to be able to navigate through complex environments, such as blood vessels and tissues, to reach their target. This requires advanced control systems and sensors that can guide the robot to the desired location.

Safety is another important consideration in the development of micro-robots for cancer therapies. The materials used to construct the micro-robots must be biocompatible and non-toxic, and the robots must be able to withstand the harsh conditions of the body without causing harm to healthy cells and tissues.

Finally, cost is an important consideration in the development of micro-robots for cancer therapies. Fabrication techniques such as photolithography can be expensive, and the cost of producing micro-robots in large quantities can be prohibitive. As such, the development of cost-effective fabrication methods is an important area of research.

The engineering of micro-robots for targeted cancer therapies holds immense promise for improving cancer treatment outcomes. Micro-robots have the potential to deliver therapies directly to cancer cells, reducing the side effects associated with traditional therapies and improving treatment efficacy. They can also be used for diagnostic purposes and to overcome the blood-brain barrier, opening up new possibilities for the treatment of brain tumors and other neurological conditions. While there are still many challenges that need to be addressed, the potential of micro-robots in cancer therapies is becoming increasingly clear, and continued research in this field holds great promise for the future of cancer treatment.

https://www.nature.com/articles/s41467-020-19322-7


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SA's HIV testing formula to change

For years, South Africa has used **HIV Rapid Diagnostic Tests** (finger prick – same-day testing), but the **National Department of Health** has now decided to align with the **World Health Organisation**'s recommendation of a three-test algorithm to ensure even more accuracy of test results.

There are several reasons why the country has stuck to the Rapid Diagnostic Tests: they are cheap, reliable, and can be used in any setting, with fewer requirements than blood collection.

Also, writes René Sparks for ***Spotlight***, they provide same-day results to clients, meaning people can be started on treatment earlier if they test positive, and preventative services such as PrEP can be provided if they test negative.

During HIV testing, the healthcare worker follows a standardised step-by-step HIV testing algorithm process, guiding them to diagnose HIV negativity or positivity with the approved test kits. These kits change every three years, with the aid of the **National Health Laboratory Service**, which tests their quality and ability to accurately detect HIV positivity (referred to as specificity) and HIV negativity (referred to as sensitivity).

Since implementation, South Africa has adopted a serial algorithm, involving first offering people a finger prick test using a screening test with high specificity. This means the risk of a false negative is extremely low, and if the person tests negative no further test is required.

SA's HIV testing .... Continue to page 11

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SA's HIV testing .... Continue from page 9

If, however, there is a reaction, people would be offered another finger prick test. This confirmatory test has higher sensitivity than the first and is less likely to yield false positives.

From two to three

Now, as South Africa approaches the amendment of our HIV Testing Policy, the Quality Improvement of HIV Rapid Testing Policy, and undertakes a new rapid test tender, the National Department of Health is opting for WHO's recommendation of a three-test algorithm for better accuracy of test results.

With this change, probably from later this year, people will be offered an additional, second finger prick confirmatory test.

Why is this important?

UNAIDS has set targets referred to as the **95-95-95 Strategy**, also part of SA's **National Strategic Plan for HIV, TB, and STIs 2023-2028**. This means 95% of people living with HIV should know their status, 95% of those who know their status should be on treatment, and 95% of those on ARVs should be virally suppressed. This is a critical HIV prevention strategy to get to zero HIV infections by 2030.

Reaching 'saturation'

The WHO recommends the three-test algorithm to ensure the accuracy of results as we reach 'saturation' (nearing the target of 95% of people living with HIV knowing their status).

Although the recommendation was made in 2019, South Africa did not meet the eligibility criteria to implement it as there was still a high yield (HIV positivity rate) at that time. However, a decrease is being seen in the test positivity, and experts say it is getting harder to find people living with HIV, so adding a second confirmatory test is an obvious way to add that additional specificity.

The two-test algorithm has served the country well to date, but it is in the public's interest to recalibrate the testing algorithm.

How this will affect the health system

Some critical aspects will require immediate attention to mitigate risk and support a smooth transition from the existing testing algorithm to the new formula

The drafting and finalisation of roll-out and implementation plans for all the changes need to be shared before the launch of the HIV rapid test kits, HTS registers, HIV consent forms, and the policies and guidelines. This will require each province/district to agree to training and the cascading of these changes in a timely manner.

The HIV Rapid Diagnostic Test kit tender and job aids (a desktop guide for testers which includes the testing process, the HIV testing algorithm, and Health & Safety aspects of testing) need to be finalised as well, for seamless transition.

-END-

Expired Covid vaccines will not be destroyed, Health Department says

Millions of doses of the **Pfizer-BioNtech** Covid-19 vaccine have expired, and the shot is largely unavailable, despite an announcement in February that South Africa's **National Health Department** was sitting on a stockpile of almost 30m doses.

At the time, writes Adele Baleta for ***Spotlight***, in explaining the huge number of unused jabs, the department said vaccine uptake had been low due to decreasing cases, people's erroneous perception that the pandemic was over, and hesitancy affected by vaccine disinformation.

National Department of Health spokesperson Foster Mohale confirmed that 7m Pfizer doses had expired but said they would not be disposed of. Instead, the manufacturers would test the vaccines to ensure continued safety and efficacy.

The **South African Health Products Regulatory Authority** (Sahpra) will review the test results and, if satisfied that the vaccine will still work as well as data showed before, they will approve an extended shelf life.

The remaining estimated 23m **Johnson and Johnson** (J&J) vaccine doses are due to expire in 2024 and 2025.

"The expiry of a vaccine is not the same as the expiry date of food, which cannot be extended," Mohale said, adding that the Pfizer vaccine had a short shelf life and that its expiry date had already been extended twice in the past. He said the testing should be done by June and the Pfizer shots should become available in July.

Responding to questions on the Department of Health's hotline, an intern told an anxious caller: "Many people have phoned in stressing about travelling, emigrating, or getting vaccinated for the first time. We have been told there are very few sites that still have some stock. If people have had two Pfizer doses, they can boost with a J&J dose. However, if they have only had one Pfizer, they will have to wait."

Frustration on social media regarding the issue also relates to the Health Department's vaccination website being outdated and it being hard to find places to get vaccinated.

Health Department says…. Continue to page 13

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Health Department says…. Continue to page 12

Risk ever present

On the WHO lifting the Covid-19 Public Health Emergency of International Concern (PHEIC) earlier this month, Caprisa director Professor Salim Abdool Karim, writing in his updates blog, said: "We are still living in the midst of a pandemic with thousands of cases each day. Since SARS-CoV-2 is going to be with us for a long time, a pragmatic decision was needed as the pandemic emergency has been steadily receding and a new variant of concern has not emerged in 17 months.

"But the risk of a new variant of concern is ever-present, even if it is getting progressively smaller with time. The public is also tired of the pandemic and many have simply put it out of sight and out of mind."

Kariem wrote that globally there were currently far more Covid-19 cases, hospitalisations, and deaths each day than on the day (30 January 2020) that Covid-19 was initially declared a PHEIC.

"So, it (the WHO decision) was not based on the situation getting to a point pre-PHEIC. Waiting to reach that point may take many years or may never happen and so ending the PHEIC is a judgment call, taking many factors into consideration."

'Still with us'

Speaking at a recent webinar hosted by ***Internews***, science writer David Quammen, who wrote a book called *Breathless: The Scientific Race to Defeat a Deadly Virus*, and before that, *Spillover*, said: "The coronavirus is still with us, it's circulating worldwide among humans, and circulating also among whitetail deer, feral mink, and probably other wild mammals."

He said efforts should be directed to approaching Covid-19 as a long-term cause of human illness, suffering, and death, not "a short-term catastrophe".

He said laboratory techniques needed to be improved as well as manufacturing capacity for updated vaccines. Inequitable access to vaccines would also need to be solved. "We will need to dissolve vaccine reluctance and refusal – among the privileged but obdurate, and also among those historically ill-served by Western medicine – with better communication and education."

Diagnostic testing needed to be maintained and not reduced, as well as the sequencing of genomes from patient samples to detect and trace new and immune-evasive variants, he said.

"We will need to prepare, not just for the next coming of SARS-CoV-2 … but also for the next coronavirus or influenza virus (more than likely H1N1) or other highly adaptive animal-borne virus that appears in humans, seemingly out of nowhere," he said. "But they don't come out of nowhere. They come from nature."

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The Diagnostic Words We Use Can Be Harmful

We are living in an era of increasing sensitivity to our diversity and the ways we interact, but also an era of growing resistance to change and accommodation. As clinicians, we hope to be among the sensitive and the progressive, open to improving our views and interactions. And as part of our respect for those we treat, we seek to speak clearly with them about our assessment of what is disrupting their lives and about their options.

Using the right words is crucial in that work. Well-chosen words can be heard and understood. Poorly chosen words can be confusing or off-putting; they may miscommunicate or be offensive. Maintaining the quality of clinician-patient communication requires special care, because one party is expert and the other may not be, and because only one party is identified as ill. Careful choice of words is also important among colleagues, who may not always mean the same things when using the same words.

In psychiatry, consumer knowledge and access are growing. There are effective standard treatments and promising new ones. But our terminology is often antique and obscure. This is so despite a recognition that some terms we use may communicate poorly and some are deprecating.

A notable example is “schizophrenia.” Originally referring to cognitive phenomena that were not adequately coherent with reality or one another, it has gone through periods of describing most psychosis to particular subsets of psychoses. Debates persist on specific criteria for key symptoms and typical course. Even two clinicians trained in the same site may not agree on the defining criteria, and the public, mostly informed by books, movies, and newspapers, is even more confused, often believing schizophrenia is multiple -personality disorder. In addition, the press and public often associate schizophrenia with violent behavior and uniformly bad outcomes, and for those reasons, a diagnosis is not only frightening but also stigmatizing.[1]

Many papers have presented the case for retiring “schizophrenia.”[2] And practical efforts to rename schizophrenia have been made. These efforts have occurred in countries in which English is not the primary language.[3] In Japan, schizophrenia was replaced by “integration disorder.” In Hong Kong, “disorder of thought and perception” was implemented. Korea chose “attunement disorder.” A recent large survey of stakeholders, including clinicians, researchers, and consumers in the United States, explored alternatives in English.[4] Terms receiving approval included: “psychosis spectrum syndrome,” “altered perception syndrome,” and “neuro-emotional integration disorder.”

Despite these recommendations, the standard manuals of diagnosis, the ICD and DSM, have maintained the century-old term “schizophrenia” in their most recent editions, released in 2022. Aside from the inertia commonly associated with long-standing practic-es, it has been noted that many of the alternatives suggested or, in some places, implemented, are complex, somewhat vague, or too inclusive to distinguish different clinical presentations requiring different treatment approaches. They might not be compelling for use or optimal to guide caregiving.

Diagnostic Words .... Continue to page 16

Perhaps more concerning than "schizophrenia" are terms used to describe personality disorders. [5] "Personality disorder" itself is problematic, implying a core and possibly unalterable fault in an individual. And among the personality disorders, words for the related group of disorders called "Cluster B" in the DSM raise issues. This includes the terms narcissistic, antisocial, histrionic, and borderline in DSM-5-TR. The first three terms are clearly pejorative. The last is unclear: What is the border between? Originally, it was bordering on psychosis, but as explained in DSM and ICD, borderline disorder is much more closely related to other personality disorders.

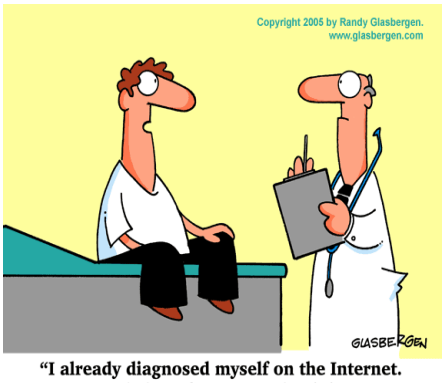
Notably, the "Cluster B" disorders run together in families, but men are more likely to be called antisocial and women borderline, even though the overlap in signs and symptoms is profound, suggesting marginally different manifestations of the same condition. The ICD has made changes to address the problems associated with some of these terms. ICD proposes personality "difficulty" to replace personality "disorder"; a modest change but less offensive. And it proposes seeing all, or at least most, personality disorders as being related to one another. Most share features of disturbances in sense-of-self and relationships with others. As descriptors, ICD kept "borderline pattern," but replaced "antisocial" with "dissocial," in an effort to be accurate but less demeaning. Other descriptors it proposes are negative affectivity, detachment, disinhibition, and anankastia, the last referring to compulsions.

These are notable advances. Can the field find even better terms to communicate hard to hear information, with words that are less problematic? In search of options, we surveyed clinicians at academic centers about the terms they preferred to avoid and the ones they prefer to use in talking with patients.[6] Their practices may be informative.

Briefly summarized, these clinicians preferred not to use "schizophrenia" and very few used "antisocial," "histrionic," or "narcissistic." Most avoided using "borderline" as well. Instead, they recommended discussing specific symptoms and manifestations of illness or dysfunctional behavior and relationships with their patients. They employed terms including "psychosis," "hallucination," "delusion," "thinking disorder," and "mood disorder." They explained these terms, as needed, and found that patients understood them.

For Cluster B personality disorders, they spoke of personality traits and styles and specifically about "conduct," "rule breaking," "coping," "self-focus," "emotionality," and "reactivity." Those choices are not perfect, of course. Medical terms are often not standard words used in a conversational way. But the words chosen by these clinicians are generally straightforward and may communicate in a clear and acceptable fashion. It is also notable that the terms match how the clinicians assess and treat their patients, as observed in a separate study of their practices.[7] That is, the clinicians advised that they look for and suggest treatments for the specific symptoms they see that most disrupt an individual's life, such as delusions or mood instability. They are not much guided by diagnoses, like schizophrenia or borderline disorder. That makes the chosen terms not only less confusing or off-putting but also more practical.

Changing terminology in any field is difficult. We are trained to use standard terms. Clearly, however, many clinicians avoid some terms and use alternatives in their work. Asked why, they responded that they did so precisely to communicate more effectively and more respectfully. That is key to their treatment goals. Perhaps others will consider these choices useful in their work. And perhaps both the DSM and the ICD will not only continue to consider but will decide to implement alternatives for problematic terms in the years ahead, as they discuss their next revisions.



"I already diagnosed myself on the Internet. I'm only here for a second opinion."

-END-

Marijuana Linked to Higher PAD Risk

PHOENIX — Marijuana users have an almost four times greater risk of developing peripheral artery disease, compared with nonusers, results of a study of more than 600,000 marijuana users suggest, although there was no greater risk of death from myocardial infarction or other cardiac causes or need for revascularization.

The researchers noted, however, that the study population was young, with an average age of 37.4 years, and that the study period, from 2016 to 2019, predates the legalization of recreational marijuana in a number of states.

Nonetheless, even in this young study population, marijuana users' risk of developing peripheral artery disease (PAD) was 3.68 times greater (P < .001) than that of nonusers. PAD at a young age could precede worse outcomes later in life, the study authors said.

"Basically, marijuana users were at increased risk of being diagnosed with peripheral artery disease, but there was no increased risk for them requiring any intervention, such as a peripheral vascular intervention, nor were they at increased risk of death from what we found," said Hirva Vyas, DO, an internal medicine resident at Hackensack University Medical Center in New Jersey, who presented the results at the Society for Cardiovascular Angiography & Interventions annual scientific sessions.

The study used data on 623,768 marijuana users from the National Inpatient Sample, a nationwide database of inpatient visits covered by all public and commercial payers, then extracted a diagnosis for PAD from all 30 million–plus patient encounters to compare PAD rates between marijuana users and nonusers. Marijuana users were more likely to be White and to have elective rather than emergency admissions (P < .001). The researchers used diagnostic codes to identify marijuana users and PAD patients.

Recreational marijuana is legal in 22 states and the District of Columbia, according to ProCon.org. Since 2019, the last year of the study, 11 states have legalized marijuana for recreational use. "It's a data point that we studied at one point in time, only from 2016 to 2019," Dr. Vyas said in an interview.

"As we've seen over the past 4-5 years, legalization has skyrocketed and recreational use has become more and more favorable not only among younger folks but older folks," study coauthor Harsh Jain, MD, a second-year internal medicine resident at Montefiore Medical Center in New York, said in the interview. "It would be really refreshing to see how these data change as we look at endpoints from 2019 to 2023."

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Because of the young age of the study population, Dr. Jain said, these findings may not accurately represent the true cardiovascular risks of marijuana use, especially later in life.

"One of the biggest secondary endpoints that we wanted to study was the development of chronic conditions that lead to multiple rehospitalizations, the most significant one of which would be the development of heart failure," Dr. Jain said. "However, it was difficult to stratify because, again, many of these patients were very young and so they did not carry the diagnosis for heart failure, so we couldn't complete that subset analysis."

The goal is to extend the study period out to 2023, Dr. Jain said. "We know that these are very crude and rudimentary data findings that we presented so far, but we're hoping that the final paper gives us a chance to flesh out all the details of our study and also gives us a chance to expand going forward," he said.

The findings are in line with other research into the effects of marijuana and cardiovascular disease, said Carl "Chip" Lavie, MD, medical director for cardiac rehabilitation and prevention at the John Ochsner Heart and Vascular Institute in New Orleans who's published a number of studies on PAD and substance use, including marijuana.

"It is known that cannabis is associated with more vasoconstriction, has sympathomimetic effects, causes endothelial dysfunction and increased platelet aggregation, and is known to increase the risk of acute myocardial infarction, especially in the hour or so after use," he said in written comments sent to this news organization.

"It is also well known to be a cause of thromboangiitis obliterans, which is in the PAD family," he added. "Based on these mechanisms, one would expect an increased PAD and, especially, PAD events. The 3.7-fold increased risk is supportive of this increased PAD."

One study strength, Dr. Lavie pointed out, is that it's one of the few studies that found an association between marijuana and PAD, which hasn't been studied as well as other cardiovascular endpoints. "However," he said, "the limitation is this is just an inpatient sample, and it is all based on coding — e.g., a patient could have PAD and it may not have been coded."

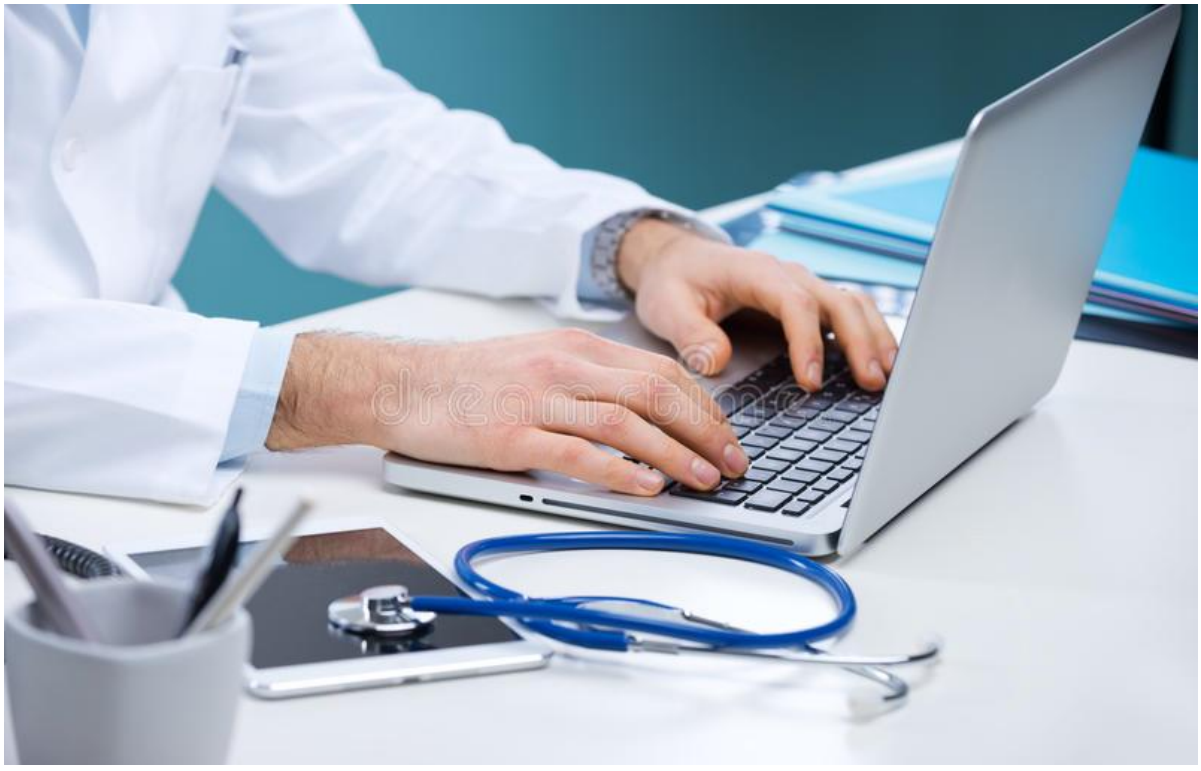
-END-

Obstetric Ultrasound: (Reporting and Documentation)

Writing or printing an ultrasound report is an important and essential part of the examination and you need to include the following details. Ask yourself these questions.

1. Do you do obstetric ultrasounds after 12 weeks? Do you know that Indemnity companies place you in a different risk category when you perform any obstetric scan over 12 weeks gestation?
2. What is the serial number of your machine?
3. When was it last serviced or calibrated?
4. Do you take a photograph or print the screen to keep the record?
5. Do you write or print a report on the Ultrasound and place it in record?

QC team



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Private doctors concerned about NHI Bill given government's history of financial mismanagement

Image: *GALLO IMAGES*

The KwaZulu-Natal Doctors Healthcare Coalition (KZNDHC) is concerned about entrusting the lives and wellbeing of citizens to a government with a history of financial mismanagement, it said on Wednesday.

The organisation voiced its concerns on the National Health Insurance (NHI) Bill, which was approved by the parliamentary portfolio committee on health on Friday before it goes to the National Assembly.

It said the failures of the current public health systems cannot be ignored.

KZNDHC CEO Dr Neven Govender said the independent practitioners' association, representing 1,200 doctors in the private sector, believes that any reform, including the implementation of the NHI, must address the fundamental issues that "plague our public health system.

"These issues include a lack of sufficient resources, infrastructure deficiencies and workforce shortages. The failure to adequately address these challenges has resulted in compromised healthcare services and hindered access to quality care for many South Africans.

"We cannot ignore the issues of abuse and mismanagement of funds that have plagued our public health system. Instances of financial misconduct and misappropriation of funds within various state-owned entities have eroded trust in the government's ability to efficiently manage healthcare budgets.

Not in jail, not in a mental hospital, not in a grave - I say I'm having a very good day.

NHI Bill .... Continue to page 21

NHI Bill .... Continue from page 20

“The NHI Bill, in its current form, does not provide sufficient reassurances or mechanisms to address these concerns adequately. As representatives of the healthcare community, we believe it is essential to prioritise strengthening our public health system, ensuring transparency, accountability, and responsible management of resources, before implementing reforms such as the NHI,” he said.

Govender said one of the main issues raised was the development of the bill without due consideration for the legitimate concerns and recommendations of experts, particularly regarding the introduction of contracting units for primary healthcare (CUPs).

“We believe that the implementation of CUPs may have implications for the delivery of primary healthcare services, including the quality, accessibility and continuity of care. It is vital that the voices of professionals and stakeholders in the healthcare industry are heard and incorporated into the development of the bill, particularly when it comes to the establishment and functioning of CUPs.”

He urged stakeholders to critically assess the proposed reforms, engage in open dialogue and collaborate to develop a healthcare system that “is truly comprehensive, equitable and sustainable for all South Africans.

“The KZNDHC will continue to closely monitor the developments around the bill, advocating for the urgent rectification of the existing failures in the public health system. We remain committed to working together with policymakers, experts and stakeholders to ensure the provision of high-quality healthcare services that our citizens deserve.”

- END -

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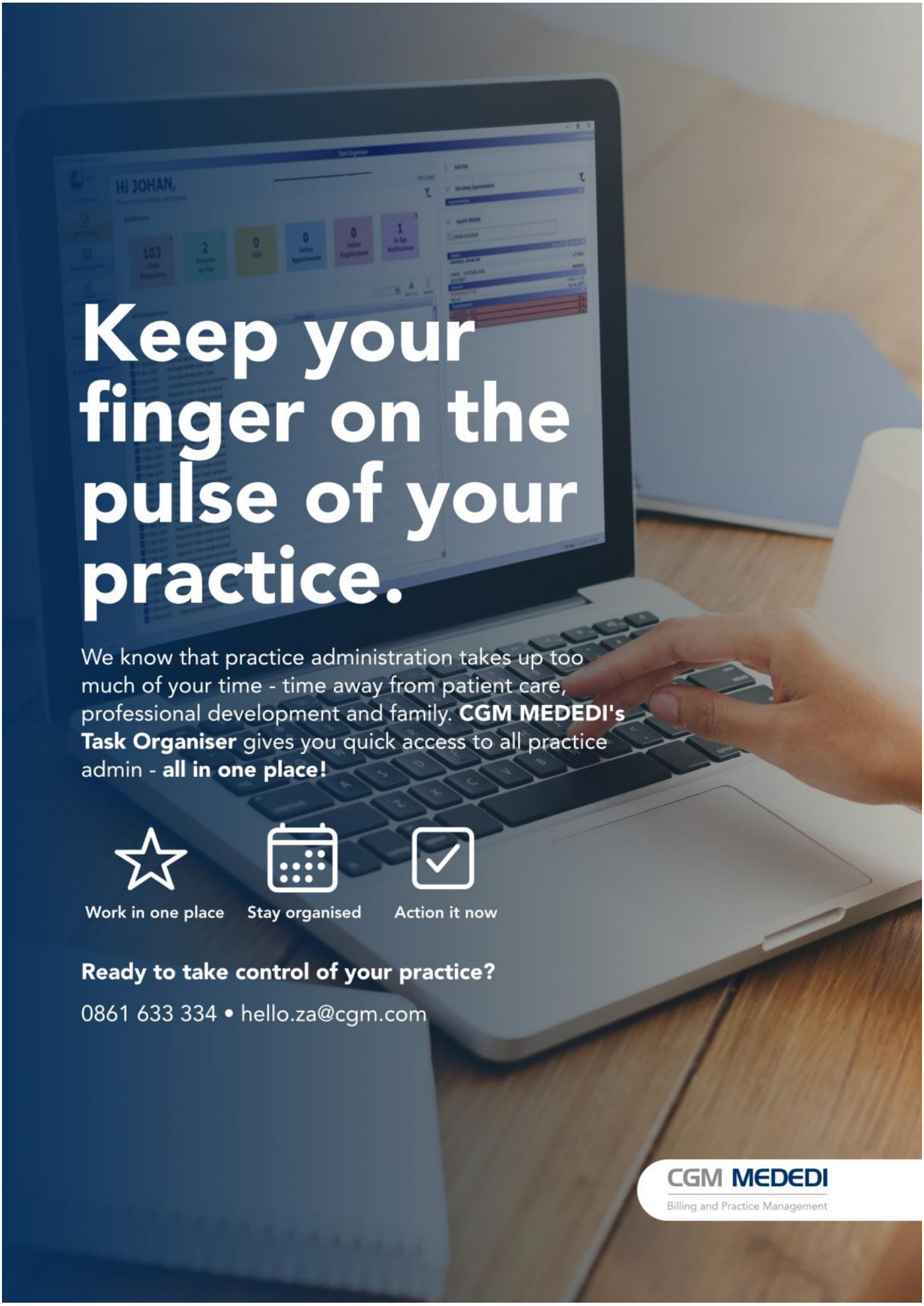

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Issue 5 of 2023
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Focus on Cholera

Cholera is an infectious diarrhoeal disease caused by a bacterium called Vibrio cholerae. The first cholera pandemic originated in India in 1817. In South Africa, cholera was first reported in 1974, and the outbreaks in the country have been associated with importation from neighbouring countries, especially Zimbabwe and Mozambique. The last cholera outbreak in South Africa was triggered by imported cases from an outbreak in Zimbabwe during 2008. Over the years, cholera outbreaks and pandemics have occurred in countries associated with poor water, sanitation, and hygiene infrastructures. Although cholera has been eliminated from the Global North more than 150 years ago, the disease still affects over 2.86 million people and kills an estimated 95 thousand people annually. Currently, several cases of cholera have been confirmed in Gauteng, Free State and Limpopo provinces in South Africa. There are also deaths reported due to the cholera outbreak.

Who is at risk of getting cholera?

The people most at risk of contracting cholera are those who are exposed to unsafe drinking water, contaminated rivers or dams, poor sanitation, and inadequate hygiene.

What are the signs and symptoms of cholera?

The period from which the person is infected to when they fall sick can be from a few hours to as long as 5 days. Most people infected experience very mild illness or do not feel ill at all. Mild cholera presents as a diarrhoeal illness which cannot easily be distinguished from other common causes of diarrhoea.

How is cholera spread?

Cholera can be transmitted in the following ways:

- Drinking water contaminated by the cholera bacteria.
- Eating contaminated food such as vegetables that have been fertilised with human excreta or watered with contaminated water.
- Soiled hands can contaminate clean drinking water and food.

Severe cholera can present as follows:

- Sudden onset of ill health.
- Profuse painless watery diarrhoea, with flecks of mucus in the stool or "rice water" stools.
- Vomiting may occur early in the illness.
- No fever in adults, but children may develop a fever.
- Dehydration occurs rapidly and can lead to death if untreated.

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How is cholera diagnosed?

A stool sample is the preferred specimen to confirm a diagnosis of cholera through laboratory analysis. If a stool sample cannot be collected, a rectal swab can still be taken to rule out cholera bacteria.

How is cholera treated?

Treatment depends on the severity of the condition. Mild cases can be managed at home, and an oral rehydration solution (ORS) can be taken to prevent dehydration. ORS can be prepared at home by boiling 1 litre of water, and then adding 8 level teaspoons of sugar and 1 level teaspoon of salt to the water. Individuals who are moderately or severely ill need to be admitted to the hospital for treatment.

How can you prevent the spread of cholera?

- Hand washing with soap and clean water before and after handling food and after using a toilet is necessary to reduce the risk of transmission of cholera as well as other diarrhoeal diseases. An alcohol-based hand sanitiser with at least 70% alcohol can be used if there is no soap and clean water.
- Food safety is important, and food must be thoroughly cooked to kill the bacteria. Cooking surfaces and items must be cleaned with soapy water.
- People are urged not to drink water from unsafe sources such as rivers, dams, and streams. In areas with unsafe water, water can be chlorinated using household bleach as follows:
  - Add one teaspoon (5 ml or one capful bleach bottle) of household bleach to 20 to 25 litres of water.
  - Thoroughly mix the bleach solution with the water and allow it to stand for at least two hours before use.
- Water can also be boiled, however, boiled water should be used within a day to avoid contamination of water when it is stored beyond 1 - 2 days.

What is covered as PMB level of care?

"Cholera" is a PMB condition under Diagnosis and Treatment Pair (DTP) code 338S. The treatment component specified for this DTP is "Medical management". The medical schemes must pay for in and out-of-hospital consultations, tests, medicines, follow-up consultations and treatment in full if the services were obtained from a designated service provider (DSP).

In case of an emergency, healthcare services must be paid in full, even if a non-DSP was used. The healthcare practitioner must assist the member in completing the forms to register for PMB benefits which must be funded by the medical scheme from the risk-benefit. Funding of PMB claims from the Medical Savings Account (MSA) contravenes the Medical Schemes Act.

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The Communications Unit would like to thank the Clinical Unit for assisting with this edition of CMScript

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UK & Ireland Clinical Guideline for Stroke

This summary of the updated 2023 stroke guideline covers prehospital care, long-term management, and secondary prevention strategies, such as blood pressure control, lipid modification, and improved nutrition.

This summary is intended for primary care practitioners. For recommendations on acute care, refer to the secondary care summary—click here

Organisation of stroke services

Transfer to Acute Stroke Services

- Community health services and ambulance services (including call handlers and primary care reception staff) should be trained to recognise people with symptoms indicating an acute stroke as an emergency requiring transfer to a hyperacute stroke centre with pre-alert notification to the stroke team
- People with an acute neurological presentation suspected to be a stroke should be admitted directly to a hyperacute stroke unit that cares predominantly for patients with stroke, with access to a designated thrombectomy centre 24 hours a day, 7 days a week for consideration of mechanical thrombectomy.

Organisation of Inpatient Stroke Services

- People with the sudden onset of focal neurological symptoms seen by community-based clinicians (for example, ambulance paramedics) should be screened forhypoglycaemia with a capillary blood glucose test, and for stroke or transient ischaemic attack (TIA) using a validated tool. Those people with persisting neurological symptoms who screen positive using a validated tool should be transferred to a hyperacute stroke unit as soon as possible with pre-alert notification to the admitting stroke team
- People with suspected acute stroke (including people already in hospital) should be admitted directly to a hyperacute stroke unit and be assessed for emergency stroke treatments by a specialist clinician without delay. Refer to the secondary care summary for further information.

Organisation of Inpatient Stroke Services

Hydration and Nutrition

- Patients with stroke who are at risk of malnutrition should be offered nutritional support
- This may include oral nutritional supplements, specialist dietary advice, and/or tube feeding in accordance with their expressed wishes or, if the patient lacks mental capacity, in their best interests
- Patients with stroke who are unable to maintain adequate nutrition and hydration orally should be referred to a dietitian for specialist nutritional assessment, advice, and monitoring
- People with stroke who require food or fluid of a modified consistency should:

* be referred to a dietitian for specialist nutritional assessment, advice, and monitoring
* have the texture of modified food or fluids prescribed using internationally agreed descriptors
* be referred to a pharmacist to review the formulation and administration of medication

- People with difficulties self-feeding after stroke should be assessed and provided with the appropriate equipment and assistance including physical help and encouragement, environmental considerations, and postural support to promote independent and safe feeding.

Continence

- People with stroke with continued loss of urinary continence should be offered behavioural nterventions and adaptations prior to considering pharmaceutical and long-term catheter options, such as:

* timed toileting
* prompted voiding
* review of caffeine intake

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* bladder retraining
* pelvic floor exercises
* external equipment

- People with stroke with constipation should be offered :

* advice on diet, fluid intake, and exercise
* a regulated routine of toileting
* a prescribed medication review to minimise use of constipating medication
* oral laxatives
* a structured bowel management programme which includes nurse-led bowel care interventions
* education and information for the person with stroke and their family/carers
* rectal laxatives if severe problems persist

- People with continued continence problems on transfer of care from hospital should receive follow up with specialist continence services in the community.

Driving

- People with stroke who wish to drive should :

* be advised of the exclusion period from driving and their responsibility to notify the Driver & Vehicle Licensing Agency, Driver & Vehicle Agency, or National Driver Licence Service if they have any persisting disability which may affect their eligibility
* be asked about or examined for any absolute bars to driving for example, epileptic seizure (excluding seizure within 24 hours of stroke onset), significant visual field defects, reduced visual acuity, or double vision
* be offered an assessment of the impairments that may affect their eligibility, including their cognitive, visual, and physical abilities
* receive a written record of the findings and conclusions, copied to their general practitioner

- People with persisting cognitive, language, or motor disability after stroke who wish to return to driving should be referred for on-road screening and evaluation
- People who wish to drive after a stroke should be informed about eligibility for disabled concessions (for example, Motability, the Blue Badge scheme).

Return to Work

- People with stroke should be asked about their work at the earliest opportunity, irrespective of whether they plan to return. This will enable staff to have a better understanding of their role before having a stroke, and offer the person an opportunity to discuss their thoughts and feelings
- People who need or wish to return to any type of work after stroke should:

* be provided with information regarding rights, financial support, and vocational rehabilitation. This should include information regarding driving, where appropriate (for example, in the work role or travelling to work)
* be supported to understand the consequences of their stroke in relation to work

- Healthcare professionals who work with people following stroke should have knowledge and skills about supporting them to return to work, appropriate to the nature and level of service they provide
- Authorised healthcare professionals should provide a statement of fitness to work (for example, 'fit note' to support people to return to work, including recommended alterations to work patterns, tasks undertaken, or environment).

Motor Recovery and Physical Effect of Stroke

Falls and Fear of Falling

- People with stroke should be offered a falls risk assessment and management as part of their stroke rehabilitation, including training for them and their family/carers in how to get up after a fall. Assessment should include physical, sensory, psychological, pharmacological, and environmental factors
- People with stroke should be offered an assessment of fear of falling as part of their falls risk assessment and receive psychological support if identified
- People at high risk of falls after stroke should be offered a standardised assessment of fragility fracture risk as part of their stroke rehabilitation

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Guideline for Stroke…. Continue from page 27

- People with stroke with symptoms of vitamin D deficiency, or those who are considered to be at high risk (for example, housebound) should be offered calcium and vitamin D supplements
- People at high risk of falls after stroke should be advised to participate in physical activity/exercise which incorporates balance and co-ordination at least twice per week
- People with stroke and limitations of dorsiflexion or ankle instability causing impaired balance and risk or fear of falling should be considered for referral to orthotics for an ankle–foot orthosis and/or functional electrical stimulation. The person with stroke, their family/carers, and clinicians in all settings should be trained in the safe use and application of orthoses and electrical stimulation devices.

Walking

- People with limited mobility after stroke should be assessed for, provided with, and trained to use appropriate mobility aids, including a wheelchair, to enable safe independent mobility
- People with stroke, including those who use wheelchairs or have poor mobility, should be advised to participate in exercise with the aim of improving aerobic fitness and muscle strength unless there are contraindications
- People with impaired mobility after stroke should be offered repetitive task practice as the principal rehabilitation approach, in preference to other therapy approaches including Bobath therapy
- People who cannot walk independently after stroke should be considered for electromechanical-assisted gait training including body weight support.

Musculoskeletal Pain

- People with musculoskeletal pain after stroke should be assessed to ensure that movement, posture, and moving and handling techniques are optimised to reduce pain
- People who continue to experience musculoskeletal pain should be offered pharmacological treatment with simple analgesic medication. Paracetamol, topical nonsteroidal anti-inflammatory drugs, or transcutaneous electrical nerve stimulation should be offered before considering the addition of opioid analgesics.

Fatigue

- Healthcare professionals should anticipate post-stroke fatigue, and ask people with stroke (or their family/carers) if they experience fatigue and how it impacts on their life
- Healthcare professionals should use a validated measure in their assessment of post-stroke fatigue, with a clear rationale for its selection, and should also consider physical and psychological fatigue, personality style, context demands, and coping styles
- People with stroke should be assessed and periodically reviewed for post-stroke fatigue, including for factors that might precipitate or exacerbate fatigue (for example, depression and anxiety, sleep disorders, pain), and these factors should be addressed accordingly. Appropriate time points for review are at discharge from hospital and then at regular intervals, including at 6 months and annually thereafter
- People with stroke should be provided with information and education regarding fatigue being a common post-stroke problem, and with reassurance and support as early as possible, including how to prevent and manage it, and signposting to peer support and voluntary sector organisations. Information should be provided in appropriate and accessible formats
- People with post-stroke fatigue should be involved in decision making about strategies to prevent and manage it that are tailored to their individual needs, goals, and circumstances

Guideline for Stroke…. Continue to page 29

Guideline for Stroke…. Continue from page 28

- People with post-stroke fatigue should be referred to appropriately skilled and experienced clinicians as required, and should be considered for the following approaches, whilst being aware that no single measure will be effective for everyone:

* building acceptance and adjustment to post-stroke fatigue and recognising the need to manage it
* education on post-stroke fatigue for the person with stroke, and their family/carers
* using a diary to record activities and fatigue
* predicting situations that may precipitate or exacerbate fatigue
* pacing and prioritising activities
* relaxation and meditation
* rest
* setting small goals and gradually expanding activities
* changing diet and/or exercise (applied with caution and tailored to individual needs)
* seeking peer support and/or professional advice
* coping methods including compensatory techniques, equipment, and environmental adaptations

- Healthcare professionals working with people affected by post-stroke fatigue should be provided with education and training on post-stroke fatigue, including its multi-factorial nature and impact, potential causes and triggers, validated assessment tools, and the importance of involving people affected by post-stroke fatigue in designing strategies to prevent and manage it
- Healthcare professionals working with people with post-stroke fatigue should consider the impact of fatigue on their day-to-day ability to engage with assessment and rehabilitation, and tailor the scheduling and length of such activities accordingly.

Anxiety, Depression and Psychological Distress:

- Healthcare professionals should be aware of the psychological needs of people with stroke and their family/carers, and routinely provide education, advice, and emotional support for them. Multidisciplinary teams should embed measures that promote physical and mental wellbeing within the wider rehabilitation package, and collaborate with other statutory and voluntary services to deliver them, such as:
- Where people with depression or anxiety after stroke are being treated within primary care mental health services (such as Improving Access to Psychological Therapies) or secondary care mental health services, advice, consultation, and training should be available from the stroke service. Guidance for the management of people with significant language and cognitive impairment should be agreed between services and joint working offered where appropriate.

Long-term management and secondary prevention

A Comprehensive and Personalised Approach

- People with stroke or TIA should receive a comprehensive and personalised strategy for vascular prevention including medication and lifestyle factors, which should be implemented as soon as possible and should continue long term
- People with stroke or TIA should receive information, advice, and treatment for stroke, TIA, and vascular risk factors which is:

* given first in the hospital or clinic setting
* reinforced by all health professionals involved in their care
* provided in an appropriate format

- People with stroke or TIA should have their risk factors and secondary prevention reviewed and monitored at least once a year in primary care

Guideline for Stroke…. Continue to page 31

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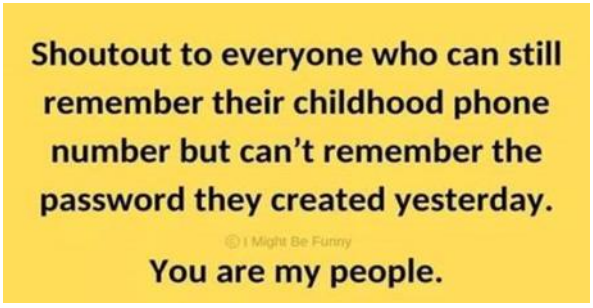
Guideline for Stroke…. Continue from page 29

- People with stroke or TIA who are receiving medication for secondary prevention should:

* receive information about the reason for the medication, how and when to take it, and common side effects
* receive verbal and written information about their medicines in an appropriate format
* be offered compliance aids such as large-print labels, non-childproof tops, and dosette boxes according to their level of manual dexterity, cognitive impairment, personal preference, and compatibility with safety in the home

Blood Pressure

- People with stroke or TIA should have their blood pressure (BP) checked, and treatment should be initiated or increased as tolerated to consistently achieve a clinic systolic BP below 130 mmHg, equivalent to a home systolic BP below 125 mmHg. The exception is for people with severe bilateral carotid artery stenosis, for whom a systolic BP target of 140–150 mmHg is appropriate. Concern about potential adverse effects should not impede the initiation of treatment that prevents stroke, major cardiovascular events, or mortality
- For people with stroke or TIA aged 55 or over, or of African or Caribbean origin at any age, antihypertensive treatment should be initiated with a long-acting dihydropyridine calcium-channel blocker or a thiazide-like diuretic. If target BP is not achieved, an angiotensin-converting enzyme inhibitor or angiotensin II receptor blocker should be added
- For people with stroke or TIA not of African or Caribbean origin and younger than 55 years, antihypertensive treatment should be initiated with an angiotensin-converting enzyme inhibitor or an angiotensin II receptor blocker
- People with stroke or TIA should have BP-lowering treatment initiated prior to the transfer of care out of hospital or at 2 weeks, whichever is the soonest, or at the first clinic visit for people not admitted
- People with stroke or TIA should have their BP-lowering treatment monitored frequently in primary care and increased to achieve target BP as quickly and safely as tolerated. People whose BP remains above target despite treatment should be checked for medication adherence at each visit before escalation of treatment, and people who do not achieve their target BP despite escalated treatment should be referred for a specialist opinion. Once BP is controlled to target, people taking antihypertensive treatment should be reviewed at least annually
- In people with stroke being treated with antihypertensive agents to reduce recurrent stroke risk, management guided by home or ambulatory BP monitoring should be considered, in order to improve treatment compliance and BP control
- People with stroke using home BP monitoring should use a validated device with an appropriate measurement cuff and a standardised method. They (or where appropriate, their family/carer) should receive education on how to use the device, the implications of readings for management, and be provided with ongoing support, particularly if they have anxiety or cognitive and physical disability after stroke.



Guideline for Stroke…. Continue to page 33

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Guideline for Stroke…. Continue from page 31

Lipid Modification

- People with ischaemic stroke or TIA should be offered personalised advice and support on lifestyle factors to reduce cardiovascular risk, including diet, physical activity, weight reduction, alcohol moderation, and smoking cessation
- People with ischaemic stroke or TIA should be offered treatment with a statin unless contraindicated or investigation of their stroke or TIA confirms no evidence of atherosclerosis. Treatment should:

* begin with a high-intensity statin such as atorvastatin 80 mg daily. A lower dose should be used if there is the potential for medication interactions or a high risk of adverse effects
* be with an alternative statin at the maximum tolerated dose if a high-intensity statin is unsuitable or not tolerated

- Lipid-lowering treatment for people with ischaemic stroke or TIA and evidence of atherosclerosis should aim to reduce fasting LDL-cholesterol to below 1.8 mmol/L (equivalent to a non-HDL-cholesterol of below 2.5 mmol/L in a non -fasting sample). If this is not achieved at first review at 4–6 weeks, the prescriber should:

* discuss adherence and tolerability
* optimise dietary and lifestyle measures through personalised advice and support
* consider increasing to a higher dose of statin if this was not prescribed from the outset
* consider adding ezetimibe 10 mg daily
* consider the use of additional agents such as injectables (inclisiran or monoclonal antibodies to proprotein convertase subtilisin/kexin type 9) or bempedoic acid (for statin-intolerant people taking ezetimibe monotherapy)
* continue to escalate lipid-lowering therapy (in combination if necessary) at regular intervals in order to reduce LDL-cholesterol to below 1.8 mmol/L

- People with ischaemic stroke or TIA in whom investigation confirms no evidence of atherosclerosis should be assessed for lipid-lowering therapy on the basis of their overall cardiovascular risk
- People with intracerebral haemorrhage should be assessed for lipid-lowering therapy on the basis of their overall cardiovascular risk and the underlying cause of the haemorrhage
- In people with ischaemic stroke or TIA below 60 years of age with very high cholesterol (below 30 years with total cholesterol above 7.5 mmol/L or 30 years or older with total cholesterol concentration above 9.0 mmol/L) consider a diagnosis of familial hypercholesterolaemia
- In people with ischaemic stroke or TIA of presumed atherosclerotic cause below 60 years of age, consider the measurement of lipoprotein(a) and specialist referral if raised above 200 nmol/L.

Antiplatelet Treatment

- For long-term prevention of vascular events in people with ischaemic stroke or TIA without paroxysmal or permanent atrial fibrillation (AF):

* clopidogrel 75 mg daily should be the standard antithrombotic treatment
* aspirin 75 mg daily should be used for those who are unable to tolerate clopidogrel
* if a patient has a recurrent cardiovascular event on clopidogrel, clopidogrel resistance may be considered

- The combination of aspirin and clopidogrel is not recommended for long-term prevention of vascular events unless there is another indication, for example, acute coronary syndrome, recent coronary stent
- For more details on antiplatelet treatment, please refer to the secondary care summary.

Anticoagulation

* For people with ischaemic stroke or TIA and paroxysmal, persistent, or permanent atrial fibrillation

Guideline for Stroke…. Continue to page 34

- AF (valvular or non-valvular) or atrial flutter, oral anticoagulation should be the standard long-term treatment for stroke prevention. For further information, please refer to the secondary care summary
- People with cardioembolic TIA or stroke for whom treatment with anticoagulation is considered inappropriate for reasons other than the risk of bleeding may be considered for antiplatelet treatment to reduce the risk of recurrent vaso-occlusive disease.

Physical Activity

- People with stroke or TIA should participate in physical activity for fitness unless there are contraindications. Exercise prescription should be individualised, and reflect treatment goals and activity recommendations
- People with stroke or TIA should aim to be active every day and minimise the amount of time spent sitting for long periods
- People with stroke should be offered cardiorespiratory training or mixed training regardless of age, time since having the stroke, and severity of impairment

* facilities and equipment to support high-intensity (greater than 70% peak heart rate) cardiorespiratory fitness training (such as bodyweight support treadmills, or static or recumbent cycles) should be available
* the dose of training should be at least 30–40 minutes, three to five times a week for 10–20 weeks
* programmes of mixed training (medium intensity cardiorespiratory [40–60% of heart rate reserve] and strength training [50–70% of one-repetition maximum]) such as circuit training classes should also be available at least 3 days per week for 20 weeks
* the choice of programme should be guided by patients' goals and preferences and delivery of the programme individualised to their level of impairment and goals

- People with stroke or TIA who are at risk of falls should engage in additional physical activity which incorporates balance and co-ordination, at least twice per week
- Physical activity programmes for people with stroke or TIA should be tailored to the individual after appropriate assessment, starting with low-intensity physical activity and gradually increasing to moderate levels.

Smoking Cessation

- People with stroke or TIA who smoke should be advised to stop immediately. Smoking cessation should be promoted in an individualised prevention plan using interventions which may include pharmacotherapy, psychosocial support, and referral to statutory stop smoking services.

Nutrition (Secondary Prevention)

- People with stroke or TIA should be advised to eat an optimum diet that includes:

* five or more portions of fruit and vegetables per day from a variety of sources
* two portions of oily fish per week (salmon, trout, herring, pilchards, sardines, fresh tuna)

- People with stroke or TIA should be advised to reduce and replace saturated fats in their diet with polyunsaturated or monounsaturated fats by:

* using low-fat dairy products
* replacing butter, ghee, and lard with products based on vegetable and plant oils
* limiting red meat intake, especially fatty cuts and processed meat

- People with stroke or TIA who are overweight or obese should be offered advice and support to aid weight loss including adopting a healthy diet, limiting alcohol intake to 2 units a day or less, and taking regular exercise. Targeting weight reduction in isolation is not recommended

Guideline for Stroke…. Continue to page 35

- People with stroke or TIA should be advised to reduce their salt intake by:

* not adding salt to food at the table
* using little or no salt in cooking
* avoiding high-salt foods, for example, processed meat such as ham and salami, cheese, stock cubes, pre-prepared soups, and savoury snacks such as crisps and salted nuts

- People with stroke or TIA who drink alcohol should be advised to limit their intake to 14 units a week, spread over at least 3 days
- Unless advised to do so for other medical conditions, people with stroke or TIA should not routinely supplement their diet with:

* B vitamins or folate
* vitamins A, C, E, or selenium
* calcium with or without vitamin D.

Further Rehabilitation

- People with stroke, including those living in a care home, should be offered a structured, holistic review of their individual needs by a healthcare professional with appropriate knowledge and skills, using an appropriate mode of communication (for example, face to face, by telephone, or online)

* this review should cover physical, neuropsychological, and social needs, seek to identify what matters most to the person, and be undertaken at 6 months after stroke, or earlier if requested by the person with stroke
* at this 6-month review, the reviewer should discuss with the person with stroke who would be best placed to undertake the next review at 1 year post-stroke (or at another point in time, depending on the person's needs), as well as the agreed mode of communication
* this review should be offered annually thereafter (or at another point in time, if requested by the person with stroke), for as long as a need for ongoing review continues and on request thereafter

- People with stroke should be provided with the contact details of a named healthcare professional (for example, a stroke co-ordinator or key worker) who can provide further information, support, and advice, as and when needed
- People with stroke should be supported to develop their own self-management plan, based on their individual needs, goals, preferences, and circumstances
- People with stroke who are unable to undertake their own self-management should be referred in a timely manner to appropriate health, social care, or other voluntary or statutory services depending on their needs.

- END -

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Aspirin Use Tied to Lower Risk for Early Colorectal Cancer

CHICAGO – The regular use of aspirin or other nonsteroidal anti-inflammatory drugs was found to be associated with a lower risk of early-onset conventional and advanced adenomas. The authors say that aspirin could prove to be an effective strategy in preventing early-onset colorectal cancer cases.

"What we have here is a 15% reduction for all adenomas and 33% for those with advanced histology, which to us is quite substantial. We have not seen that much [33%] in previous studies so I would think it definitely needs more study," said Cassandra D. Fritz, MD, MPHS, a gastroenterologist with Washington University, St. Louis, in an oral presentation given at the annual Digestive Disease Week®.

"This finding is important given the alarming rise in the incidence and mortality of early-onset colorectal cancer (age < 50 years), and our limited understanding of the underlying drivers to direct prevention efforts," Dr. Fritz said. Early-onset colorectal cancer cases have doubled since 1995, she said.

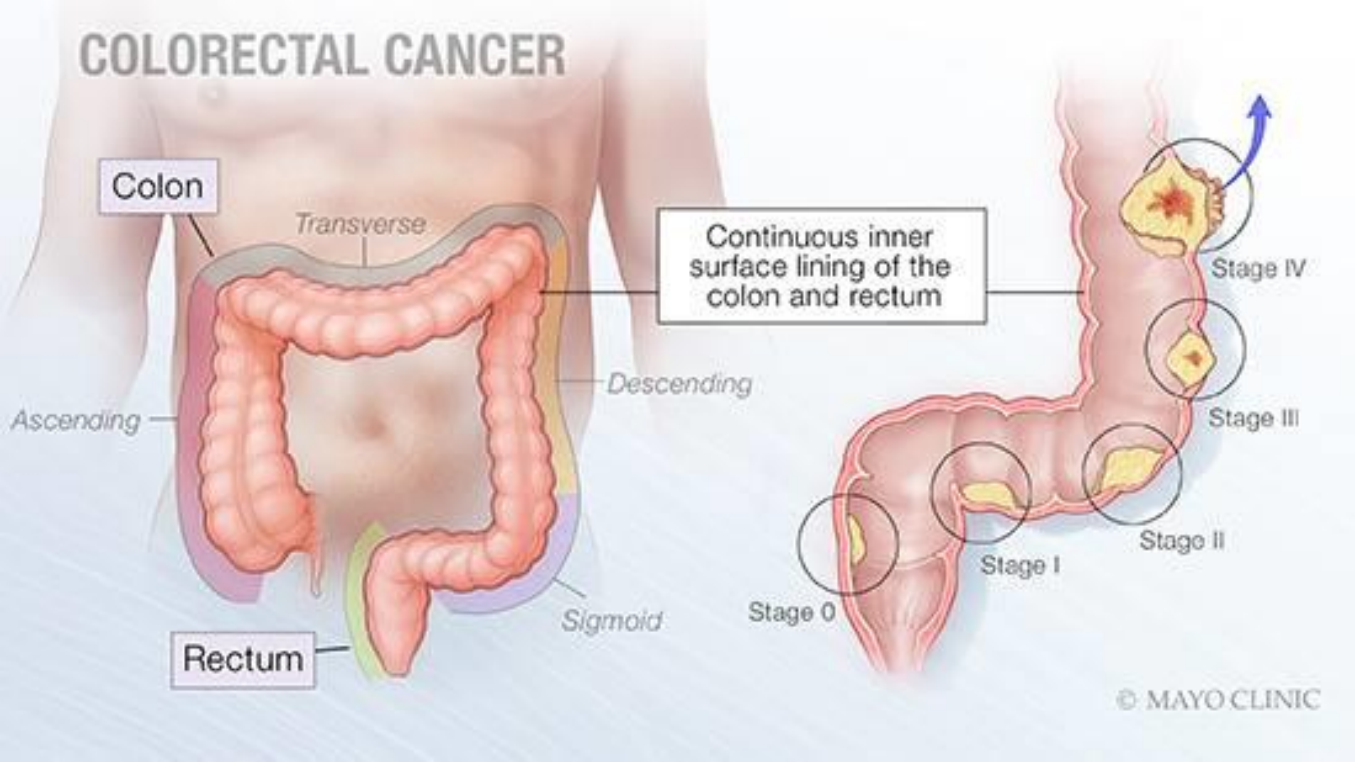
The study confirms evidence from 30 years of research that suggests regular aspirin use reduces cancer risk. In patients with Lynch syndrome, the CAPP2 study showed that aspirin has a protective effect against colorectal cancer at 20 years follow-up.

While emerging data have suggested that aspirin use may reduce later-onset colorectal cancer, it was not known if regular aspirin and NSAID use are associated with diminished risk of early-onset conventional adenomas, and especially the high-risk adenomas conferring greater malignant potential known to be the major precursor of early-onset colorectal cancer. An unpublished analysis of molecular markers by the study's senior author, Yin Cao, ScD, MPH, also of Washington University, found that at least 57% of early-onset colorectal cancers developed from the conventional adenoma-carcinoma pathway.

The objective of the new study was to assess the association between regular aspirin or NSAID use at least twice weekly, with the risk of developing early-onset adenoma. The analysis is based on an evaluation of data from the Nurses' Health Study II of 32,058 women who had at least one colonoscopy before age 50 (1991-2015). High-risk adenomas included those that were at least 1 cm with tubulovillous/villous histology or high-grade dysplasia, or the presence of at least three adenomas.

Aspirin Use Tied .... Continue to page 38

Aspirin Use Tied .... Continue from page 37



There were 1,247 early-onset adenomas, among which 290 were considered high risk. The risk of adenomas among patients who took aspirin or NSAIDs regularly for cardiovascular protection or for inflammatory conditions, was lower than in those who did not take aspirin and/or NSAIDs regularly. While the association was similar for high-risk vs. low-risk adenomas, the benefit was more pronounced for adenomas of tubulovillous/villous histology or with high-grade dysplasia (odds ratio, 0.67; 95% confidence interval, 0.51-0.89), a 33% reduction, compared with tubular adenomas (OR, 0.90; 95% CI, 0.79-1.0; P for heterogeneity = .02).

With later-onset adenomas, risk reduction was confined primarily to large (OR, 0.76; 95% CI, 0.62-0.93) or multiple adenomas (OR, 0.57; 95% CI, 0.40-0.83), but not adenomas of advanced histology (OR, 0.92; 95% CI, 0.73-1.17).

"With colorectal cancer rates increasing, we still don't have any preventative strategies beyond screening. With this 15% reduction with aspirin/NSAIDS in early-onset adenoma – and particularly for the quite substantial 33% benefit in advanced adenoma with advanced histology, we need to think about a precision-based chemoprevention strategy for early-onset precursors of colorectal cancer," Dr. Cao said.

The U.S. Preventive Services Task Force issued a new recommendation in 2021 stating that colorectal cancer screening for people with average risk should start 5 years sooner at age 45. "As we know," Dr. Yin said, "many younger adults are not screened. That's why we're looking into potential early-onset colorectal cancer chemopreventative agents."

DDW is sponsored by the American Association for the Study of Liver Diseases, the American Gastroenterological Association, the American Society for Gastrointestinal Endoscopy, and the Society for Surgery of the Alimentary Tract.

Dr. Fritz had no disclosures and Dr. Cao listed consulting for Geneoscopy.

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KwaZulu-Natal Doctors' Healthcare Coalition Advises Doctors to Deregister from WhatsApp/up Doc Program

The KwaZulu-Natal Doctors' Healthcare Coalition (KZNDHC), representing doctors across the region, has issued a strong advisory urging doctors to deregister from the controversial WhatsApp Doc program. The advisory comes in response to the recent incident involving a private GP who is registered with the HPCSA and is the founder of WhatsApp Doc which intercepts blood results ordered by doctors, without patient consent or consultation with their primary physicians and disrupts the doctor-patient relationship and erodes trust in the healthcare system.

The program appears to promote touting, which involves the solicitation of patients and the promotion of specific medical practitioners for personal gain. This practice undermines the impartiality and integrity of medical decision-making, ultimately compromising patient care and well-being. Furthermore, it interferes with existing doctor-patient relationships, introduces confusion and potential harm to patients.

In light of these ethical concerns, the KZNDHC strongly advises doctors across the region to immediately deregister from the WhatsApp Doc program. By taking this action, doctors demonstrate their commitment to maintaining patient-centered care, upholding the principles of professionalism, and preserving the sanctity of the doctor-patient relationship.

"We believe that patient care and ethical conduct should be the cornerstones of our medical practice," stated Dr Neven Govender, CEO for the KZNDHC. "It is our responsibility as healthcare professionals to prioritize the well-being of our patients and maintain the trust they place in us. Deregistering from the WhatsApp Doc program is an important step in upholding these values and ensuring the integrity of our profession."

The KZNDHC encourages doctors who have concerns or questions about the WhatsApp Doc program or ethical implications to engage in open discussions within their professional networks and seek guidance from their respective medical associations. Together, doctors can work collectively to protect patient interests and uphold the principles that underpin the medical profession.

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For full prescribing information please refer to the professional information approved by SAHPRA (South African Health Products Regulatory Authority).

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Qualicare EDN … Continue to page 44

Qualicare EDN … Continue from page 43

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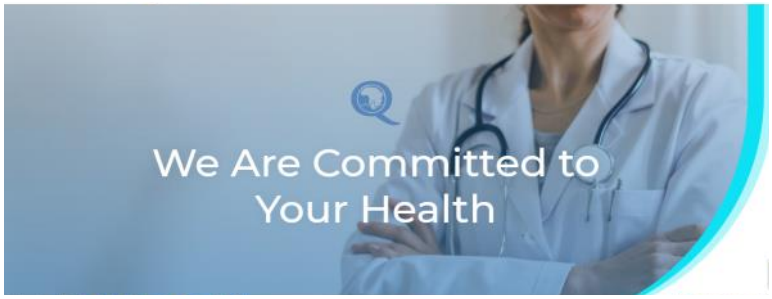

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