EDITORIAL

THE DEATH OF BRENDA FASSIE

The recent tragic death of the celebrated South African pop diva, Brenda Fassie, at the early age of 39 years has been greeted with great sadness throughout the country and the African continent. Early reports suggested that she suffered a fatal asthma attack. Although later reports cast some doubt as to the exact cause of her death as she had recently battled with drug addiction, her passing has brought home to the public at large that asthma may be a fatal condition.

The death of Chris Barnard as a result of a fatal asthma attack while holidaying in Cyprus a few years ago made a deep impression on many South Africans and left no doubt that death may occur following a severe asthma attack.

It is appropriate that this issue of our journal with its focus on practical issues in allergology should carry the superb article by my co-editor, Heather Zar, on 'Fatal and near-fatal asthma in South Africa'. In the early 1980s a pivotal study by Solly Benatar and Gill Ansell1 in Cape Town revealed that there was an unacceptably high incidence of fatal asthma in the city. A significant number of deaths occurred in young people (under 40 years of age), most deaths occurred at night, there was under-use of inhaled corticosteroids and a lack of access to adequate asthma care and emergency facilities. This applied specially to people living in conditions of poverty and affected communities living on the Cape Flats in particular.

A subsequent study, also conducted in Cape Town, by Ehrlich and Bourne2 found that the majority of asthma deaths occurred in poor communities where there was inadequate access to health care facilities, inadequate transport and telephone services and frequent under-recognition of the severity of the fatal asthma episode.

More recently it appears that the incidence of fatal asthma in Cape Town is decreasing but the number of adult admissions to intensive-care units has remained unchanged. The good news is that the number of children requiring ICU admission for life-threatening asthma has declined significantly. The decline in asthma mortality reflects improved health care and access to this care. There is greater use of inhaled corticosteroids and an overall improvement in the diagnosis and treatment of asthma. Unfortunately, the disparity in asthma deaths among people living in conditions of poverty remains, and a lack of access to adequate health care in these areas remains an important factor.

The Cape Town studies will translate to the other urban areas of South Africa. Much research needs to be undertaken to determine the incidence of fatal asthma in other parts of this country. With the rising prevalence of asthma, an increase in morbidity and mortality will result if adequate health care facilities and asthma education are not made available in areas of the greatest need. It is unacceptable that asthma still carries the risk of death in young people when effective and affordable treatment should be readily available.

It is appropriate that Robin Green’s outstanding and thought-provoking article on the ‘Cost-effective management of asthma in children’ should follow. Robin proposes a two-prong approach to the thorny issue of cost-effective asthma care: the wider dissemination and application of asthma guidelines and the establishment of asthma clinics in general practice. An effective asthma education programme is an essential component in asthma management and results in significant cost savings in asthma therapy. This article deserves to be read with care and it is hoped that it will be brought to the attention of the authorities responsible for the planning of strategies for the management of this common condition.

Helen Fisher, a highly experienced allergy nurse at St Mary’s Hospital, London, has contributed an excellent article on the ‘Needs of parents with allergic children’. She convincingly demonstrates that parents may have an enormous struggle to adapt to a diagnosis of asthma in their children. They require support, education and adequate information. Disagreement among healthcare professionals as to the most appropriate approach to management of their child’s asthma generates anxiety and insecurity. These professionals should aim to achieve a partnership with their colleagues and with parents in order to address these issues.

George du Toit, previously Senior Registrar in Paediatric Allergy at the Red Cross Children’s Hospital and currently Consultant in Paediatric Allergy at St Mary’s Hospital, London, brings us up to date on the most effective diagnostic methods in peanut and tree nut allergy. A careful allergy history, physical examination, skin-prick tests and specific IgE assays may fail to diagnose nut allergy with confidence. What is often required is an oral nut challenge. The lack of access to oral food challenge tests is a disadvantage in most centres in South Africa. It is only once the use of oral food challenges becomes readily available that the use of skin-prick tests and specific IgE tests will be open to validation.

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may be overlooked if an adequate history is not taken. This article advises which diagnostic tests to employ in order to establish the diagnosis of allergic alveolitis as a result of exposure to pigeons and their droppings. This article is required reading for prospective Diploma in Allergology candidates.

I hope that readers will enjoy this issue and find much of practical value for their practice in the exciting and rewarding field of allergology.

Eugene Weinberg

Editor


Dr Adrian Morris was recently invited to address the Polish Allergy Society in Warsaw. He and Prof. Samolinski (right) are standing in front of a portrait of the last king of Poland.