

**LETTERS / BRIEVE**

If induction fails, I repeat the procedure the following day, this time using 10 mg PGF<sub>2</sub>α in 40 ml 0,9% saline solution with oxytocin augmentation if contractions are not adequate.

In over 200 terminations using this technique I have observed minor complications (nausea, vomiting, skin rash and transient dyspnoea) in only 7 women. I have never observed any serious complications despite using the technique to terminate pregnancy in women with intra-uterine deaths after 2 previous caesarean sections!

As long as better drugs are not available locally, extra-amniotic infusion of PGF<sub>2</sub>α seems to be the best and safest method of termination of pregnancy complicated by intra-uterine death in the third, as well as the second, trimester.

**A. KROLIKOWSKI**

Eshowe Hospital  
Eshowe  
Natal

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*This letter was referred for review and comment to a consultant in the Department of Obstetrics and Gynaecology at the University of Cape Town, who expressed concern about the 'very high dose' of PGF<sub>2</sub>α cited in Dr Krolikowski's letter. The practice at UCT is to use a dose of 0,5 - 1 mg/h, and not a stat dose. The concern here is the possibility of inadvertent intravascular injection, which at this dose 'could indeed be lethal', according to the consultant. Finally, concern was expressed about possible uterine rupture. On the other hand, Dr Krolikowski has used this method on more than 200 patients over a period of 6 years, with no serious adverse effects. The SAMJ would be glad to receive an account of the experience of others in this country and/or abroad. — Editor*

**A sincere thank-you**

**To the Editor:** On Saturday 11 December, crossing the road at the entrance to the Cape Town Waterfront, I softly banged the top of my head on the bottom part of a metal sign.

I felt something hot — and, to my astonishment, it was blood! It poured out like water from a tap. I became very hysterical.

Luckily, in the first car that stopped was a doctor (Dr Kwinana, 17 Buller Street, Cambridge, East London). He got out of his car with his fiancée and put lots of toilet paper onto my head, then took me to Somerset Hospital. These were the only people who came to my aid.

The young doctor at Somerset Hospital and his staff of three also did me a wonderful service.

Thanks to the MASA for its high-quality medical personnel!

**A. GAFFAR BEGG**

29 Coleridge Road  
Salt River  
Cape Town

**Prevention of measles**

**To the Editor:** The results of the 1990 national measles campaign and the possible reasons for the subsequent measles epidemic have recently been discussed.<sup>1,3</sup>

During the 12-month period 1 July 1991 - 30 June 1992, 80 patients with measles (6 per month) were admitted to a rural hospital in northern Zululand. Three children died (case-fatality rate 3,75%). The age distribution is

shown in Fig. 1. Fifteen children (19%) had proven immunisation, 42 (52%) had definitely not been immunised, and the remaining 23 (29%) had no record of immunisation.

Measles immunisation coverage for 1991 was estimated at 68%, using an estimated target population calculated from available birth data.<sup>4</sup> These findings suggested the need to improve immunisation coverage and to strengthen existing services, and this was attempted through the identification of a senior nurse with responsibility for immunisation services, the holding of update workshops and the provision of extra mobile clinic services.

In the second half of 1992 and early 1993 the measles epidemic continued and, as a follow-up evaluation, between 6 April and 6 September 1993, 62 consecutive measles admissions (12,5 per month) were studied. The age range was similar to the previous study. Three children died (case-fatality rate 4,8%). Ten (16%) had proven immunisation, 30 (48%) had definitely not been immunised, and the remaining 22 (36%) had no record of immunisation (there was no significant difference between the two study periods,  $\chi^2$  for linear trend). Measles immunisation coverage for 1992, using the same method of calculation as above, was estimated at 78%.

In 1992 only 30% of measles vaccine issued from the hospital could be accounted for from statistical returns for immunisations. Only 40% of issued measles vaccine for all KwaZulu institutions could be accounted for in 1991 (M. Short — personal communication). Although our policy is to immunise any child who requires it, at any time, regardless of waste, these figures suggest fundamental operational weaknesses (not least administrative).

Our results confirm that the measles epidemic also occurred in this health ward, despite some success in increasing vaccination coverage. We believe that although 'vaccination days' or 'weeks'<sup>5</sup> may play a role, the most appropriate and sustainable approach to achieving consistently high levels of immunisation coverage is through the strengthening and extension of existing primary health care services.<sup>1</sup> Our experience suggests that this may be a long and difficult process. The issue of 'missed opportunities' for immunisation is of fundamental importance.<sup>3</sup>

We acknowledge the assistance of David Eaton, a medical student from the UK, who carried out the first study as an elective project.

**D. WILKINSON**

**J. KENDELL**

Hlabisa Hospital  
Hlabisa, Natal/KwaZulu

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**Prevalence and management of childhood diarrhoea**

**To the Editor:** Acute diarrhoea is one of the world's leading causes of childhood morbidity and mortality.<sup>1</sup> Its greatest impact is felt in underdeveloped countries, where diarrhoeal diseases (DDs) are also major contributors to childhood malnutrition.<sup>2</sup>

Although South Africa is a middle-income country, its political policies have resulted in socio-economically deprived communities with poor access to the basic commodities of life (water supplies, sanitation, health care). Not surprisingly, DDs contribute significantly to childhood mortality.<sup>3</sup>