



## AIDS in Africa

The tragedy of HIV and AIDS in Africa, mentioned in the article "Ottawa students mark '5 wonderful years' in Malawi" (*CMAJ* 1997; 157[9]:1191), by Dr. Kevin Chan, is beyond the comprehension of physicians whose experience of medicine is limited to the developed world. The World Health Organization has just revised its estimates of HIV infection worldwide, and more than 20 million Africans are now believed to be seropositive. I have worked in large hospitals in Africa where the medical wards were primarily "palliative care centres" with, in fact, very little palliation to offer.

But however bad the situation is in countries such as Malawi, it is hardly likely that between 30% and 40% of Malawians are infected with HIV. Such misinformation only reinforces the perception of hopelessness among physicians of goodwill, whom we must mobilize to provide help. I am not aware of the most recent estimates for Malawi, but in general the seropositivity rate for adults is rarely above 20% in the African countries most severely affected — a figure that is nevertheless stunning.

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### [The author responds:]

After rereading my original article, I agree that I insinuated that the seropositivity rates for HIV are 30% to 40% in Malawi. It is difficult to do an effective population analysis of HIV rates in many parts of Africa. A seropositivity rate of 36% was put forward by a physician at St. John's Hospital in Mzuzu, Malawi, who ar-

rived at the figure by using a sample of outpatient adults arriving at the hospital in 1995 (St. John's Hospital, 1995 statistics, unpublished data). This rate is thus biased toward the sickest and the weakest.

I do think that the rates of HIV and AIDS are too high in Africa, but, like Dr. Tectonidis, I agree that there is hope and a light at the end of the tunnel. For example, the incidence of HIV and AIDS is falling in Uganda because of good public health interventions, improved knowledge and changes in public attitudes. Increasing awareness leads to changes in public policy, and promotion of healthy sexual practices may help us win the battle. That is something we can hope and dream will one day occur.

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## A side effect of protease inhibitors

The article "Guidelines for anti-retroviral therapy for HIV infection" (*CMAJ* 1998;158(4):496-505), by Dr. Anita R. Rachlis and colleagues, was timely, informative and well written, but it did not mention an adverse effect of the protease

inhibitor class of drugs. Some patients with hemophilia have experienced increased frequency or severity (or both) of bleeding episodes while taking these drugs.<sup>1-3</sup> This adverse effect has been associated with all of the protease inhibitors currently available. The bleeding is spontaneous and tends to occur early in the course of treatment. The frequency of this reaction has not yet been established, because these drugs have been introduced only relatively recently; furthermore, patients and their care givers are accustomed to the unpredictable and episodic nature of bleeding in severe hemophilia, so the association with the drug may not be immediately obvious. The bleeding can be severe and can occur in the usual locations (joints and muscles) or at atypical sites. In my experience, the exaggerated bleeding tendency persists until the protease inhibitor is discontinued, at which time the problem resolves rapidly.

The pathophysiology of this adverse effect is unknown; it is not accompanied by laboratory abnormalities in addition to the patient's congenital deficiency of factor VIII or IX. Reports of bleeding in non-hemophilic patients have most commonly consisted of hematuria accompanying nephrolithiasis, which can complicate the use of indinavir.<sup>3</sup> Because it is difficult to envision a bio-



chemical basis for the preferential impairment of hemostasis in hemophilic patients, we might anticipate that patients with acquired bleeding disorders will experience a similar hemorrhagic tendency. Among those infected with HIV, such disorders could include idiopathic thrombocytopenia, chemotherapy-induced thrombocytopenia or the hemostatic deficiencies associated with liver disease.

Hemophilic patients should be closely questioned for any change in their usual bleeding pattern while they are receiving protease inhibitors, as should any patients with other congenital or acquired hemostatic disorders.

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### Applause for Dr. Romalis

Dr. Garson Romalis, whose story is told in the article "7:10 am, Nov. 8, 1994" (*CMAJ* 1998;158[4]:528-31), by Anne Mullens, deserves applause. His courage in defending his beliefs and his vision for the future of abortion in Canada can at the very least be described as commendable but is probably more suitably characterized as inspirational. As an idealistic young man on the brink of his medical

career, I too am drawn to obstetrics and gynecology. However, Romalis's ordeal leaves me asking why I should bother. When there are so many other ways to help my fellow human beings, why put my life on the line? For me the answer is clear: I hope I never have to practise medicine in a Canada where abortion is illegal.

The rewards of bringing a healthy, wanted child into the world are mirrored by the satisfaction of providing an essential and safe service to desperate young women. I have never assisted in more than the evacuation of an incomplete spontaneous abortion, and this means that I have not yet personally grappled with the emotional impact of the procedure. However, I have looked into the eyes of a distressed patient and seen the need. I may soon follow in the footsteps of "our greying abortion providers" and will actively support an educational symposium at McGill that is similar to the one described in this article.

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### Advance directives for insulin-using diabetic patients

Advance directives are instructional comments written by a patient to guide health care professionals in the future health care of that patient and to designate proxy decision-makers should the patient become incompetent. The increasing use of advance directives is now governed by legislation in both Canada and the US.<sup>1,2</sup> Although most end-of-life treatment planning has been done in hospital, it seems that the outpatient setting provides a calmer atmosphere for this activity.<sup>3</sup>

Little has been written about the use of advance directives by patients with diabetes. We asked 27 insulin-using diabetic outpatients of both sexes (aged 18 to 70 [mean 49] years) to complete a questionnaire on demographic characteristics and their current knowledge of, attitudes about and behaviours regarding advance directives. The patients and their physicians also rated the patients' quality of life using Cantril's Self-Anchoring Striving Scale<sup>4</sup> and the patients' state of health on a numeric scale ranging from 1 (excellent) to 5 (poor). Half of the participants were then randomly assigned to participate in an education program on advance directives, which included a discussion and question period with a health care professional, an information pamphlet and a video entitled *My Health Care — I Decide*.<sup>5</sup> Four to 6 weeks later the patients were asked to complete a follow-up questionnaire.

All of the patients indicated that it was either extremely important or very important that they have a say in what type of health care they received. Eighty-nine percent of the patients believed that the best time to discuss their wishes was when they were well, during a routine visit. Thirteen percent of the patients reported at the outset of the program that they already had a directive. Those who participated in the education program showed increased knowledge of advance directives and reported increased discussion of their wishes with their family members and physicians. When patients were contacted 2 years later, 30% had actually completed an advance directive.

This small group of diabetic patients demonstrated a readiness to discuss advance directives with health care professionals *in the outpatient setting*, an approach that has been advocated as sensible and potentially cost effective.<sup>1</sup> Given that diabetic patients have significant and often predictable illness, specialist caregivers should be