to colleagues; not accept more than reasonable costs of travel and accommodation when invited to speak at a meeting… (and) be cautious when giving personal endorsement of new medical techniques or therapeutic goods.’ Most physicians are happy to receive these recommendations because they clarify what has, for many, been a murky area.

In many developing countries, rational drug use is something to be aspired to and fought for. Reports from Indonesia describe a widespread practice, mainly in private clinics that serve the middle class, of prescribing powders that contain a cocktail of drugs for treating childhood illnesses. One mother of a child (9 months old) provided a prescription for a powder containing no less than 23 different drugs. A survey reported in the Jakarta Post on 27 January 2006 showed that 70% of Indonesian parents gave their young children more than 4 drugs at once to treat common illnesses and in 35% of cases, 5–7 drugs were given. Eighty-five per cent of powders examined contained antibiotics and many contained antituberculous drugs, antihistamines, bronchodilators, even corticosteroids. Attempts by concerned doctors to warn the public of risks such as the spread of antibiotic-resistant organisms in the community not only fall largely on deaf ears, but attract fierce criticism from other doctors whose income depends on being able to service a large clientele. Needless to say, research studies to document the adverse effects of irrational drug use in Indonesia are few and far between, but awareness of the problem is growing, thanks largely to the efforts of Jakarta-based paediatrician, Dr Purnamawati Pujianto. Dr Purnamawati has been supported by WHO to develop the Health Education for Parents Program (HEPP), which aims to empower consumers of healthcare. It has, so far, been very successful. It is interesting that in Indonesia, the group most at risk from irrational drug use is the middle class. The poor, who attend government-run community health centres known as puskesmas, receive evidence-based treatment according to protocols.

It was most heartening to hear that the Indonesian Paediatric Society has taken a brave stance to reduce the involvement of drug companies at scientific conferences. All promotional material displayed will, from now on, have to be evidence-based and displays will only be allowed in the exhibition hall. A selective approach to which drugs and products can be promoted will be practised and only those whose use is supported by strong evidence will be admitted. The promotion of infant formulas will be banned. Sessions debating controversial subjects will be encouraged and conference organizers will defend their independence, even if it means holding meetings in less luxurious venues than before.

GARRY WARNE

Letter from Sri Lanka

WORLD'S FIRST REPORTED OUTBREAK OF IATROGENIC FUNGAL MENINGITIS

Five women who underwent a caesarean section under spinal anaesthesia between 21 June and 17 July 2005 in two maternity hospitals of Colombo’s premier teaching hospital complex developed Aspergillus fumigatus meningitis. Surgery and spinal anaesthesia had been performed by different teams in several operating theatre locations by personnel who were all properly qualified and adhered to internationally accepted guidelines for sterility and surgical procedure. They had used bupivacaine and fentanyl as the spinal anaesthetic agents. Three infected women died; the fourth one recovered completely, and the fifth woman left the hospital with hearing and visual impairment after 60 days of intensive care.

The average incubation period of the infection was 11 days. Remittent fever persisting in spite of empirical broad-spectrum intravenous antibiotics, exacerbating headache, nuchal rigidity, papilloedema, lateral rectus palsy and cerebral infarction were the main clinical features. The cerebrospinal fluid showed pleocytosis (neutrophils and lymphocytes), and the detailed microbiological, clinical and epidemiological investigations of the outbreak have now been reported.

After examining over 200 operating theatre staff and environment samples, and over 1000 samples of ampoules, disposable needles, plastic syringes, cannulas, spinal needles, etc. in their supposedly sterile and visually intact packing, 43 syringes and two pairs of gloves were found to be positive for Aspergillus fumigatus. The authors found that the three well maintained warehouses of the Ministry of Health were full of tsunami donations, and regular Ministry procurements were consigned—most inadvisedly, as things turned out—to an old, dusty, musty and humid warehouse with leaky roofs. They opine that these dreadful storage conditions lasting for over 6 months was the most plausible explanation for minute cracks in the packaging and fungal contamination. Some unavoidable delay in diagnosing the fungal aetiology and in obtaining the specific antifungal drugs probably led to the death of 3 patients.

Sri Lanka suffered its worst natural disaster in recorded history on 26 December 2004 from the tsunami, which caused over 40 000 deaths, left at least 300 000 homeless or displaced, along with destruction of buildings and roads on a massive scale. Donations of uncatalogued medical supplies and devices then poured into the country over the next several months, the vast majority of them unnecessary or inappropriate, and a significant proportion, frankly unconscionable ‘dumping’. Regular storage facilities were completely overwhelmed, and this outbreak of fungal meningitis in 5 previously healthy women was probably the most tragic consequence of an uncontrolled deluge of medical supplies. The well known adverse effects of permitting the unplanned entry of donated medical supplies during natural or man-made disasters were blithely disregarded in the chaotic aftermath of the tsunami.
An epidemic of chikungunya fever (CF) swept across the island starting around mid-October 2006. Up to the end of January 2007, the Health Ministry Epidemiology Unit received over 37,000 reports of suspected cases. Only about 1050 blood samples were tested during this period, and a positive serological diagnosis was reported in 680 of them.

The reports of suspected cases were only from admissions to allopathic hospitals, so the vast numbers who had mild disease and took outpatient treatment from hospitals, general practitioners or traditional medical (e.g. Ayurveda) practitioners, or relied on home remedies, were not included. Nearly all major hospitals in the public and private sectors were overflowing with CF patients, and many had to be content with accommodation on trolleys and beds placed in hospital corridors and all available nooks and corners. The local population was largely non-immune, having experienced the last epidemic of CF in the late 1960s. Although the symptoms of CF are often disabling, and some sequelae such as myalgia, arthralgia and joint swelling may last for several weeks after the fever subsides, mortality from CF is extremely low. As of now, the epidemic is on the wane.

REFERENCES

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