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Shortage of doctors in rural areas

The article by Dr Bruno Mascarenhas 1 on overcoming the shortage of doctors in rural areas highlighted the success story of the Tamil Nadu government in this area. It is acknowledged that the health parameters in Tamil Nadu are better than those in most of India, but are they good? For example, the maternal mortality ratio in Tamil Nadu for 2007–09 was 97 per 100 000 live-births (the latest period for which official figures are available; data from the website of the National Rural Health Mission). 2 This compares with 39 for Sri Lanka, as highlighted by Dr Srinath Reddy in an editorial in the same issue. 3 The inference is that the mere availability of doctors is not enough to bring health indicators to world-class levels. What is required is an entire package of measures, as detailed in the report of the High-Level Expert Group of the Planning Commission.

REFERENCES

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Rabies after corneal transplantation: Non-canine rabies and eye banking

I read with interest the case report 1 of a blind patient who contracted rabies following a corneal transplant. I would like to congratulate the authors for maintaining a high degree of clinical suspicion of this rare entity, and acting swiftly and successfully to save the life of the second graft recipient. The treating team’s move to give rabies prophylaxis to 35 members of the hospital staff, along with the attendants of the first recipient, is an example of good occupational health practice. I would like to add that the changing epidemiology of rabies, characterized by a surge in non-canine transmission in many nations, requires a change in focus. The transmission of non-canine rabies is often neglected by clinicians as well as public health experts. Most cases of rabies due to bat bites go unnoticed and are not reported by patients or clinicians. 2 The dynamics of the transmission of rabies is complicated by the fact that the exact nature of rabies virus transmission by ‘vampire bats’ is not known—aerosols, bites and even intermediate animal hosts are being implicated. 2 The presence of ‘vampire bats’, which are expected to expand their habitat beyond Latin America as a result of climatic change, 3 has not been reported in this part of the world. However, we need to keep in mind the possibility of the expansion of their habitat and the local bat population needs to be examined for further evidence.

I would also like to highlight that going by the Standard of Eye Banking in India 2009, 4 the transplant tissue should have been rejected in the first place by the eye bank concerned. From the history given by the authors, it is clear that the cause of death was ‘suspected myocardial infarction’. However, no investigations or autopsy were carried out to confirm the cause of death and hence, the case should have been deemed as a ‘death of unknown cause’. The donor tissue would thus have had to be rejected. It is important to establish a confirmed cause of death before carrying out any transplantation. The fact that the donor had no history of animal bite or neurological manifestations is redundant. Cases like these demonstrate the need for more stringent compliance with existing norms. I hope that eye banks make suitable and systematic improvements in this regard to avoid such incidents.

REFERENCES

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Author’s reply

I read with interest Dr Bhaumik’s comments on our report, ‘Rabies in a blind patient: Confusion after corneal transplantation’, published in the Journal. 1 I completely agree with him that there is a need to establish and follow stringent criteria for collecting cornea or other organs from donors after their death. As already discussed in the report, such incidents have occurred even in the USA and Germany, though canine rabies was eradicated there several decades ago. In these countries, bat rabies poses a definite threat to humans. However, as bat bites are often ignored or not even felt as they cause little pain and no visible wound, those bitten are often not given post-exposure prophylaxis.

To the best of my knowledge, there is only one report of bat rabies in India, 2 a case which came to light several years ago. India and other Asian countries have never adopted a systematic approach to investigating the possibility of bat rabies. Recent reports from Thailand and China suggest that antibodies to Lyssavirus are found in bats. 3,4 This should alert us to investigate further and come to a definite conclusion.

Rabies is nearly 100% fatal in humans. Cornea donation has increased considerably in recent times and the cause of death should
be authentically documented at least by clinical investigations, if not an autopsy. In our case, the main concern was to save the other recipient from developing rabies. We instituted state-of-the-art prophylactic treatment procedures and the woman is alive after a year of follow-up. Our main aim in reporting this rare event was to alert physicians to be more vigilant when establishing the cause of death before accepting corneas for transplantation.

REFERENCES


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**Breastfeeding: Need for better communication**

Every year, globally, the first week of August is observed as Breastfeeding Awareness Week. It is surprising that there should be a need to market a natural product (breast milk) and publicize a natural phenomenon (breastfeeding). Breastfeeding is the best intervention to decrease mortality among children under 5 years of age by one-tenth. Therefore, we must strive to ensure that all babies are exclusively breastfed during the first six months. Adequate antenatal counselling of the mother, combined with support for postnatal lactation, are essential for the achievement of this goal. The 2011 Breastfeeding Awareness Week emphasized communication as the third dimension of the promotion of breastfeeding.

The increased incidence of mastitis and breast abscesses due to poor postnatal support has been highlighted by the Breastfeeding Promotion Network of India. Mastitis is experienced by 15%–20% of women who are breastfeeding. Mastitis is distressing, both physically and emotionally. It may be caused by an infection or may be due to poor drainage of milk and may not require antibiotics. The attending obstetrician, paediatrician or nurse can prevent it by providing timely counselling. It is natural for mothers with postnatal breast problems to switch over to breast milk substitutes, but this deprives their babies of the benefits of exclusive breastfeeding. Emphasis should be placed on skill-based education of the mothers before they are discharged from the healthcare facility and during their follow-up visits. Women’s knowledge and skills related to correct positioning and attachment to the breast should be strengthened under the Baby-Friendly Hospital Initiative (BFHI).

REFERENCES


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**Health and media: Should there be an internal check mechanism in and by media?**

The mass media (print, television, internet, etc.) has become an immensely popular mode of sharing information and knowledge. However, the risk of the dissemination of incomplete or incorrect information or information that is out of context, and of the media putting forward a one-sided viewpoint, especially in an environment full of lobbyists/propagandists, activists with an agenda and religious groups, is considerable when there is a tendency among people with vested interests to use incorrect information to oppose interventions. While a negative message often gets all the attention, incorrect reporting and the subsequent corrigendum are rarely given equal attention or importance in the newspapers and electronic media. The controversial reporting on the MMR (measles, mumps and rubella) vaccination and autism and the subsequent media hype led to outbreaks of measles in many European countries.

Incorrect or one-sided reporting on matters of health can have a long-lasting and damaging effect on ongoing programmes and interventions. Therefore, utmost caution must be exercised when reporting health-related matters. This becomes all the more important when the report is a lead story, prime-time report or cover story. Even if the incorrect reporting or bias is inadvertent, the impact may be negative. A negative message about an adverse event following immunization may reduce the coverage of immunization and lead to an outbreak of the disease. It may take months for the coverage to reach the same level as earlier. Many times, a journalist covering health has only a limited understanding of complex health matters. This often results in deficiencies in the reports filed by her/him.

A Delhi High Court decision on reporting matters concerning judicial proceedings could provide us with a solution to misreporting. The court suggested that guidelines be framed on reporting of judicial proceedings, whereby only a journalist with a law degree would be allowed to cover important proceedings of the high courts or Supreme Court. The argument was that misinterpretation of court judgments and their subsequent publication in the media may be detrimental to the judiciary and also to the parties concerned. The same argument could be used in the case of reporting on health-related matters.

Globally, there are practices whereby qualified medical doctors are on the editorial board of newspapers, journals, television channels and so on. They go through health-related news before it is printed or aired. Unfortunately, this is not the practice in India. The closest equivalent of such practices in India is the assignment of a specialist correspondent to health-related matters, but she/he does not necessarily have a medical qualification. The practice of having a special
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correspondent for health has helped improve the quality of the special or weekly sections on health in newspapers in India, but the routine reporting on health matters still leaves much to be desired.

An educated society deserves correct information from any source it accesses. Thus, it would not be too ambitious to suggest that media channels and publications covering health matters should have a medical doctor on their panel. Such self-accountability in reporting would not only enhance the credibility of the media, but would also encourage the public to use the media as a reliable tool to obtain information on health.

REFERENCES

6 Kankel N. Tighter norms: Journalists may soon need law degree to report on Supreme Court. Mint New Delhi; 2011 August 24, p. 3.

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Malignancies in persons with haemophilia: 25-year data from India

As the life expectancy of persons with haemophilia (PWH) is increasing, it is expected that malignancies whose prevalence tends to increase with age will increase in this population as well. PWH could be more vulnerable to certain types of cancer, particularly in developing countries, due to the higher prevalence of transfusion-transmitted diseases such as hepatitis B (HBV), hepatitis C (HCV) and HIV, as well as exposure to excessive foreign antigen load leading to transfusion-mediated immunomodulation. This could result in an increase in the prevalence of malignancies, particularly of lymphoid tissues, i.e. non-Hodgkin (NHL) or Hodgkin lymphoma (HD).

Very few large studies on malignancies in PWH are available, there being just a few anecdotal case reports.⁴⁻⁶ We present a retrospective analysis of the prevalence of malignancies in PWH registered under various chapters of the Haemophilia Federation of India (HFI) during the past 25 years (1986–2011). The HFI is a National Member Organization of the World Federation of Haemophilia. About 13 470 patients are registered in its 70 chapters across India. The data on malignancies were sought from the local chapters through a questionnaire. The diagnosis of different malignancies was verified from doctors’ reports or cases already reported in the literature, and documentation through tissue biopsy and other reports. In addition, data were obtained from relevant articles available on PubMed.

Eighteen different malignancies were described in the past 25 years (110 070 patient-years of follow-up). Two patients each had acute myeloid leukaemia (AML), carcinoma larynx and carcinoma lung. One each had acute lymphoid leukaemia (ALL), chronic myeloid leukaemia (CML), carcinoma oesophagus, Burkitt lymphoma, low-grade NHL, carcinoma stomach, multifocal hepatocellular

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Type of haemophilia/Factor level</th>
<th>Malignancy</th>
<th>Treatment</th>
<th>Survival after diagnosis (months)</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>4</td>
<td>Haemophilia A/F VIII &lt;1%</td>
<td>Acute myeloid leukaemia</td>
<td>Chemotherapy, cryoprecipitate</td>
<td>12</td>
<td>Died</td>
</tr>
<tr>
<td>28</td>
<td>Haemophilia A/F VIII &lt;1%</td>
<td>Chronic myeloid leukaemia</td>
<td>Hydroxyurea</td>
<td>30</td>
<td>Died</td>
</tr>
<tr>
<td>52*</td>
<td>Haemophilia B/F VIII &lt;1%</td>
<td>Hepatomatous carcinoma with multiple metastases</td>
<td>Palliative</td>
<td>3</td>
<td>Died</td>
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<td>8</td>
<td>F VIII &lt;1%/with inhibitors to von Willebrand factor</td>
<td>Burkitt lymphoma</td>
<td>Surgery</td>
<td>1</td>
<td>Died</td>
</tr>
<tr>
<td>62</td>
<td>Haemophilia A/F VIII &lt;1%</td>
<td>Mixed cellularity Hodgkin disease</td>
<td>Chemotherapy</td>
<td>48</td>
<td>Alive</td>
</tr>
<tr>
<td>58</td>
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<td>Large-cell carcinoma bronchus</td>
<td>Surgery, chemotherapy, factor replacement</td>
<td>2</td>
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<tr>
<td>40</td>
<td>Haemophilia A/F VIII &lt;1%</td>
<td>Carcinoma, lower third of oesophagus</td>
<td>Radiotherapy, chemotherapy</td>
<td>18</td>
<td>Alive</td>
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<tr>
<td>48</td>
<td>Type 1 von Willebrand disease</td>
<td>Angiosarcoma of cervical lymph node, multiple metastasis</td>
<td>Palliative</td>
<td>2</td>
<td>Died</td>
</tr>
<tr>
<td>40</td>
<td>Haemophilia A/F VIII &lt;1%</td>
<td>Carcinoma larynx</td>
<td>Radiotherapy</td>
<td>24</td>
<td>Died</td>
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<td>46</td>
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<td>Carcinoma larynx</td>
<td>Radiotherapy</td>
<td>36</td>
<td>Died</td>
</tr>
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<td>Treatment not started yet</td>
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<tr>
<td>67*</td>
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<td>Carcinoma prostate with bone secondaries</td>
<td>Orchiectomy, chemotherapy, bicalutides</td>
<td>24</td>
<td>Alive</td>
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<tr>
<td>57</td>
<td>Haemophilia A/F VIII &lt;1%</td>
<td>Non-Hodgkin lymphoma (low-grade)</td>
<td>Radiotherapy, chemotherapy</td>
<td>36</td>
<td>Died</td>
</tr>
<tr>
<td>56</td>
<td>Haemophilia A/F VIII &lt;1%</td>
<td>Acute lymphatic leukaemia</td>
<td>CCG protocol</td>
<td>24</td>
<td>Died</td>
</tr>
</tbody>
</table>

*hepatitis C virus positive  CCG Children’s cancer group
carcinoma, HD with mixed cellularity, large-cell carcinoma bronchus, myeloma and carcinoma prostate with secondaries in the vertebrae. One patient with von Willebrand disease (VWD) developed angiosarcoma of the cervical lymph node. Two patients were HCV-positive, but none was hepatitis B surface antigen-positive or HIV-positive. Standard protocols, with or without factor replacement, were used to treat all the patients with malignancies. Wherever radiotherapy and surgery produced equivalent results, radiotherapy was preferred over surgery. Except for 4 patients (carcinoma stomach, oesophageal carcinoma, HD with mixed cellularity and carcinoma prostate), all the patients died within a month to 3 years of the diagnosis of cancer (Table I).

An increased prevalence of malignancies related to HIV and HCV has been reported among patients with haemophilia.5,6 Though HIV infection is known to cause damage to the immune system, resulting in immunosuppression/immunomodulation, none of the 18 patients was HIV-positive. Also, even though there were 172 HIV-positive patients in this cohort, none had malignancies. What is noteworthy is that a majority of the malignancies were not associated with infection. The prevalence of malignancies among haemophiliacs is 0.13%, which is twice as high as that in the general population, i.e. 55.2 per 100 000 for men and 47.7 per 100 000 for women.7 All the patients with carcinoma bronchus and carcinoma larynx were chronic smokers who were middle-aged.

One of the drawbacks of these data is that in India, a large number of patients remain undiagnosed. However, as malignant disorders are reasonably well investigated, it is unlikely that patients with severe haemophilia together with malignant disorders were missed.

ACKNOWLEDGEMENTS
We are grateful to the HFI, all the local haemophilia chapters and the doctors affiliated to the society for providing us the clinical data of the patients.

REFERENCES