Letter from . . . Africa

Do-it-yourself medicine

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The uncertainties in this investigation began at the beginning, for no one ever knew the name, or even the age, of the little girl who became the index case. She was admitted unconscious with no history and a couple of days later she died, but before she did a distended, tympanitic, silent abdomen gave the clue, and rectal examination showed total absence of the anterior wall. During the succeeding month two more toddlers died in the same manner.

To set the scene: the children’s medical ward at St Elizabeth’s Hospital, Lusikisiki, Transkei, has 15 cots in a floor space of about 24 x 18 ft (7 x 6 m). These cots usually contain 40-50 children, roughly arranged in a form of progressive care. Next to this main ward is a succession of smaller rooms, containing the “gastos,” a dozen or so, mainly on intravenous treatment; a variable number (but always far too many) of children severely ill with tuberculosis, all needing triple therapy; isolation cases; and, lastly, those with scabies. Ward rounds were a daily battle against time for at 1015 came the blessing of tea, and 15 minutes later the daily grind of OPD (outpatients department). Once imprisoned in the small concrete cell that represented the children’s clinic there was little chance to return to the ward, except to officiate at the only too frequent death beds. Death was indeed commonplace.

Enemas and herbs

But not such deaths. “Why?” “It is the Higginson syringes, there are boxes of them now in the stores.” “But why?” “For the enemas.”

The devastating results of this “do-it-yourself” treatment had been unceremoniously buried in plain wooden coffins when I started my “research.”

How many of the sick children that were ill enough to be admitted had had prior treatment? My splendid clinic staff, Anna and Clement, without whose patience and good humour the whole enterprise would have foundered on the first day, inquired, in neutral tones, and as part of the routine history taking; “When did he/she last have herbs/enema/coloured medicine?” The results were startling. Of 100 consecutive children, exactly half had had some treatment—herbs (22), enemas (33), coloured medicines (3). Of the enemas, 27 had been herbal, four blue soap, and four Dettol. (Keen observers will have noted the discrepancies. These accompanied the whole investigation and will be discussed later.)

Clearly, home treatment was widespread, and in many cases it seemed to predate by a week or more the onset of symptoms. So perhaps these remedies were given routinely, much in the manner of the old Victorian “brimstone and treacle.” A further 100 consecutive “well” children were recorded. (“Well” needs some qualification here. All were considered by an experienced clinic sister to need a doctor’s opinion but for conditions such as trauma, discharging ears, scabies, etc, that did not need admission. It would have been better to inquire of the really well children, but the volume and pace of the work was too great and it would have been impossible to control.) Surprisingly, the number recorded as having had home treatments was still large—roughly a third, herbs (6), enemas (23), and coloured medicines (5). A few individual cases were particularly interesting. One indigent mother complained bitterly that her toddler’s chronic diarrhoea had not been cured despite the fact that she had seen several doctors and paid quite large sums for private opinions. Only on direct questioning did she divulge that the child had had daily blue soap enemas. One day-old baby had been given an enema and one unfortunate child enemas three times a day. Most distressing were twins aged about 6 months. One was admitted only as a lodger as its sibling was poorly and mother was breast feeding both, yet in a couple of days it was the iller, with rapidly developing hepatomegaly and vomiting. The first twin’s illness followed the same course and both died within the week. This episode was disturbing for it left the query as to how many children with only minor symptoms were discharged only to succumb at home.

Indignation now became the dominant emotion. It is intolerable that young children, even neonates, should be subjected to such treatment. It must be stopped! The medical superintendent went to a meeting of the local community health council and the head men listened to her in amazement. “But,” they said, “we all had enemas.” And then they added, like any men anywhere, “Never did us any harm.”

The head men were indeed alive and vigorous, so perhaps not all home treatment was harmful. The next step was to trace the course of those previously treated children who had been admitted. Their names and ages had all been noted in the clinic. Reference to the ward book should show their fate, but one evening spent in this exercise produced only profound depression, for in fewer than 10 cases was the child identifiable. The Xhosa language has three clicks, conventionally written as C, K, and X, but this has no meaning for the bulk of the people who are illiterate and innumerate, so names are given phonetically and ages only as guesses. Clearly there was no possibility of tracing the outcome that way. The alternative was to extract the records of the past months and note the deaths and discharges and whether home treatment had been given. Time was now running out, and only 58 were isolated. Of these, 12 had died, two had no treatment, six had taken herbs and five coloured medicines, and three had multiple treatment.

What of the substances used? By now my interest in the whole subject was well known and, at the request of the local Roman Catholic priest the local herbalist made an unheralded visit one Sunday afternoon, sending my Franciscan colleague into a flurry of hospitality. We sat for a couple of hours on the stoep, gently probing each other’s knowledge. “Had I” he inquired “a cure...
for epilepsy?" "Alas, no." But could he let me know a little of his art? Like any senior member of a British royal college he inveighed against unlicensed practitioners, but the only secret that he would divulge was that onion juice was good for settling a fractious child, and he departed fortified by the convent's entire stock of biscuits. Much more helpful were those who were kind enough to answer my letters of inquiry, particularly Dr Elizabeth Rose from the toxicology department of the National Research Institute for Nutritional Diseases, East London, who told me that they have collected over 2000 herbal plants and are in the process of classifying them; Dr M V Gumede from the Department of Health; Kwa Zulu, who sent a list of plants with their medicinal and nutritional purposes; and Dr Bhoda, department of anatomical pathology, University of Natal, who sent a full toxicological account of Caffelepius laureola (impila in Zulu). This plant, the root of which produces profound hypoglycaemia, uraemia, hyperkalaemia, and death in a few days could well be the villain of the study.

Coloured medicine
Or one of them. So far only brief reference has been made to "coloured medicines." This term, very freely used, was thought at first to denote the appearance of the medicine, but in fact it referred to medicines made and sold by the Coloured people. The subtleties of South African racial discrimination are difficult for even the inhabitants to grasp, let alone to defend, but the Coloureds (people of mixed race) are a minority group in the Transkei and tend to keep themselves apart. At first it was difficult to obtain any information, staff and patients alike were evasive. Then one day someone tentatively mentioned the lady who lived on the hill opposite, and suddenly the floodgates opened. People crowded around with their stories. She came to the hospital often. She had hypertension and other things wrong with her, she demanded medicines, she mixed them all together and sold them, the same for babies as for their parents, 60 cents for a small bottle, sometimes more (more than they paid for outpatients). Remembering the babies with almost uncontrollable status epilepticus it was difficult not to be angry.

As has been made clear all along the whole project was dogged with inaccuracies. Children appeared with different names and inconsistent ages. Histories had to be amended when a child said he had had nothing but clear fluids produced a tell-tale stool or vomit resembling spinach water, or when the development of signs such as gastrointestinal bleeding or hepatomegaly led to renewed inquiries. (At no time was any pressure put on the mothers and the whole atmosphere was deliberately made as non-threatening as possible. Between the upper grindstone of hospital expectations and the lower one of tribal practice they already had enough to bear, without being made to feel the instrument of their child’s illness or death.)

Is there then any value in attempting to collect and then publish such suspect observations? I hope so, for several reasons. Firstly, they do indicate that a problem exists, and other measures may then be devised to measure it more accurately. Secondly, I hope it will encourage others to make their experience public, for I am sure that a vast amount of knowledge is at present locked up in the records of rural hospitals. More practically, the work of the toxicologists indicates that they have already gone some way towards isolating a few of the really poisonous plants, and widespread illustration of their appearance with a cautionary notice, especially in "under-5" clinics could be an important public health measure. Equally important is the help such information would give to the doctor. No one is going to start a lengthy search for the cause of gastrointestinal bleeding if it is known that a child has had a herb which produces that very effect. Finally, it might be possible to put a stop to the totally irresponsible practice of making and selling coloured medicines, of any type, anywhere.

And in the end the "proper" research will have to take into account the patient's whole experience, not just his contacts with European medicine. Statements about liver pathology and the causes of cirrhosis may be very misleading if a long exposure to hepatotoxic herbs (such as the West Indian bush tree) is ignored. As far as one can, I ask myself, really say that the Africans have such marvellous big bulky stools as a result of their diet if they are also taking aperients? I wonder.

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I understand that it is generally believed that Henry VIII suffered from syphilis and that in consequence Edward VI was a congenital syphilitic; but what is nowadays regarded as the explanation of Catherine of Aragon's failure to produce more viable children after Mary? Was this a rhesus problem rather than a spherocytial infection?

In 1888 A S Currie, an obstetrician, suggested that Henry VIII had suffered from syphilis. He based the theory largely on the obstetric history of Catherine of Aragon. In 1930 a gynaecologist, C MacLurin, came to the same conclusion (without apparently knowing of Currie's paper) partly on the obstetric history, but also on the history of the leg ulcer and the mental, moral, and physical degeneration of the King during his last 17 years. These papers seemed to establish, on rather a slender basis, the widespread belief that Henry VIII had syphilis. Later authors, however, have denied that diagnosis. Barrett,1 for instance, believed that Henry's leg ulcer was due to osteomyelitis secondary to injuries sustained in jousting; and he maintained that Henry's children who reached adult life did not have the stigmata of congenital syphilis. Shrewsbury,2 in a long and detailed paper published in 1952, made out a convincing case against the syphilitic theory. He maintained that syphilis was introduced into Europe in 1493 and it was, during Henry VIII's lifetime, a "new" disease of great virulence, causing a secondary rash of great ferocity; this explains why it was called the great pox while variola was by contrast the lesser disease, or smallpox. There is a history of Henry suffering a skin disorder from January to March 1514 (which was over four years after he had married Catherine of Aragon) but it is unlikely that it was syphilitic. The same author also shows that Catherine of Aragon's well-documented and complex obstetric history does not fit either with syphilis or with Rh factor. In fact, it seems that she was, for reasons now obscure, just not very good at "carrying babies." In 1958 Ove Brinch3 wrote another detailed account of the medical history of Henry and Catherine. He believes that Catherine may well have had syphilis, but, if she did, she may have acquired it from Diego Fernandez before she was married to Henry VIII. Fernandez was a Spanish confessor who was, reputedly, a dissolute monk and "a lusty and domineering man of low moral standards." But, to add to the complexity, Ove Brinch also believes that Henry VIII did have syphilis among other diseases; his final conclusion is that Henry's medical history included "malaria, adipsosis, abusus spirituosorum, polynuereitis alcoholica, syphilis III stadii (gummata multipla), osteomyelitis secundaria, dementia alcoholica and/or dementia paralytica and psychoparia." There is no real doubt that the King in his latter days was neither an easy patient to treat nor a pleasing companion. Many others have entered this difficult field of disputed diagnoses, and Brinch ends his paper with an impassioned plea for the disintering of the remains of Henry VIII so that "a scientific study of his bones would reveal the truth without any possible doubt." Meanwhile, there is no clear answer to the questions that have been asked here.—S L LOUDON, Wellcome Research Fellow, Oxford.

1 Barrett NR. Thoughts about Henry VIII. St Thomas's Hospital Gazette 1960; 58:3-4.