Tuberculosis – an epidemic of injustice

Editor – At a time when the HIV pandemic has again taken over the headlines with predictions of even greater numbers of cases world-wide, Grange and Zumla have highlighted the continuing importance of a disease which has been with us for much longer and which still causes many more deaths each year (November/December 1996, pp 637–9). The HIV pandemic has increased both the numbers of cases of tuberculosis and also the world-wide attention paid to the disease because of the substantial overlap between the two infections. It is extremely difficult to obtain good estimates of the incidence and prevalence and therefore of the disease burden of both infections but undoubtedly they are a major cause of morbidity and mortality world-wide particularly in the developing countries which are least able to deal with them.

Although we have had highly effective therapy for tuberculosis for many years it was only in the early 1980s that short course regimens developed by the MRC group under the direction of Professors Fox and Mitchison and its many international collaborators were beginning to be introduced into developing countries. The National Tuberculosis and Leprosy Programmes – which the International Union Against Tuberculosis and Lung Diseases (IUATLD) was instrumental in setting up – led to improvements in cure rates but these have been threatened by the substantial increases in the numbers of cases due to HIV.

The importance of supervising tuberculosis chemotherapy and the need to achieve this with the minimal interruption of the patient’s life was recognised even before short course regimens had been developed. The report of the WHO ninth Expert Committee on Tuberculosis in 1974 stressed the need for fully supervised therapy. The Chest Service in Hong Kong successfully tackled this problem with a high prevalence of initial drug resistance, (due at least in part to inadequate therapy prescribed in private practice), by the introduction of fully supervised intermittent short course regimens which had been developed in Hong Kong; but different approaches are needed for most developing countries. An understanding of the individual social structures of the populations and innovative approaches to treatment supervision are needed for rural communities. These were shown to be effective in Algerian nomads in the 1980s.

Everyone with an interest in tuberculosis is aware of the need for better diagnostic tools and for new drugs. However, the use of existing technologies and drugs can make a major impact on tuberculosis incidence, as the events of the last decade in New York have demonstrated.

The renewed interest in tuberculosis in the US and Europe has undoubtedly had an impact in stimulating both research and the WHO initiatives to introduce DOTS on a global scale. However, without adequate resources and a flexible approach to supervision of therapy, these initiatives may fail. We can only hope that the improvements in both HIV and tuberculosis prevention and treatment in resource rich countries does not result in a loss of interest so that they both become ‘tropical’ diseases and the small advances which have been made in tuberculosis control will disappear. Tuberculosis declined in the West long before the introduction of the first drugs, and this was attributed to improved socio-economic conditions – a goal which seems even less likely to be achieved in many of the countries most affected by tuberculosis.

Those who have spent many years in tuberculosis research and clinical care and who saw interest in tuberculosis wane before, as it was no longer considered an important problem in the developed world, may be forgiven for being pessimistic.

References
1 WHO Expert Committee on Tuberculosis. Report of the ninth Expert Committee on Tuberculosis. Geneva: WHO, 1974.
2 Algerian Working Group and the British Medical Research Council. Controlled clinical trial comparing a 6-month and a 12-month regimen in the treatment of pulmonary tuberculosis in the Algerian Sahara. Am Rev Respir Dis 1984; 129:921–8.

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Electrocardiogram interpretation

Editor – It is a cause for concern that, in patients with suspected acute myocardial infarction (AMI), consultant physicians are less willing than consultant cardiologists to offer thrombolysis when there is coexisting left bundle branch block (LBBB) (November/December 1997, pp 536–40) given the 23.6% 30-day mortality risk associated with absence of thrombolytic therapy in bundle branch block (BBB). The point at issue is, perhaps, whether the survival benefit reported for thrombolysis in AMI-related BBB outweighs the mortality risk of inappropriate thrombolysis, given the scope for misdiagnosis when the differentiation between AMI and non-AMI, in these instances of BBB, rests solely on clinical criteria. This dilemma is more acute in the context of suspected AMI in the presence of previously documented LBBB. In that