TRANSACTIONS

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Admission Ceremony October 2015

TRANSACTIONS

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Contents

In support of contemporary Zulu telephone wire baskets

Instructions to Authors

1. Manuscripts

1.1 All copies should be typewritten using double spacing with wide margins.

1.2 In addition to the hard copy, material should also, if possible, be sent on disk (in text only format) to facilitate and expedite the setting of the manuscript.

1.3 Abbreviations should be spelt out when first used in the text. Scientific measurements should be expressed in SI units throughout, with two exceptions; blood pressure should be given in mmHg and haemoglobin as g/dl.

1.4 All numerals should be written as such (i.e. not spelt out) except at the beginning of a sentence.

1.5 Tables, references and legends for illustrations should be typed on separate sheets and should be clearly identified. Tables should carry Roman numerals, thus: I, II, III, etc. and illustrations should have Arabic numerals, thus 1,2,3, etc.

1.6 The author's contact details should be given on the title page, i.e. telephone, cellphone, fax numbers and e-mail address.

2. Figures

2.1 Figures consist of all material which cannot be set in type, such as photographs, line drawings, etc. (Tables are not included in this classification and should not be submitted as photographs).

Photographs should be glossy prints, not mounted, untrimmed and unmarked. Where possible, all illustrations should be of the same size, using the same scale.

2.2 Figures' numbers should be clearly marked with a sticker on the back and the top of the illustration should be indicated.

2.3 Where identification of a patient is possible from a photograph the author must submit consent to publication signed by the patient, or the parent or guardian in the case of a minor.

3. References

3.1 References should be inserted in the text as superior numbers and should be listed at the end of the article in numerical order.

3.2 References should be set out in the Vancouver style and the abbreviations of journals should conform to those used in Index Medicus. Names and initials of all authors should be given unless there are more than six, in which case the first three names should be given followed by 'et al'. First and last page num¬bers should be given.

3.3 'Unpublished observations' and 'personal communications' may be cited in the text, but not as references.

Article references:

- Price NC. Importance of asking about glaucoma. BMJ 1983; 286: 349-350.

Book references:

- Jeffcoate N. Principles of Gynaecology. 4th ed. London: Butterworths, 1975: 96.
- Weinstein L, Swartz MN. Pathogenic properties of inva-ding micro-organisms. In: Sodeman WA jun, Sodeman WA, eds. Pathologic Physiology: Mechanisms of Disease. Philadelphia: WB Saunders, 1974: 457-472.

Zika Virus Disease (ZVD): Another viral disease outbreak

Prof Gboyega A Ogunbanjo

Just when we emerged from the Ebola virus disease outbreak in West Africa, we are inundated by another viral disease outbreak with possible global spread. This time, it is not from Africa but from South America and specifically from two countries namely Brazil and Colombia. The Zika virus is a mosquito-borne virus disease first discovered in 1947 among rhesus monkeys from the Zika forest of Uganda, through a monitoring network of sylvatic yellow fever.[1]

The first human cases were confirmed in 1952 from Uganda and Tanzania respectively. Since then, there have been outbreaks in various parts of Africa, the Americas, Asia and the Pacific that did not attract much attention as the current outbreak in South America. In 2013, there was a large outbreak of Zika in French Polynesia. In 2015, Brazil and Columbia (South America) and Cape Verde (West Africa) reported outbreaks. Then on 1 Feb 2016, the World Health Organisation (WHO), declared Zika virus a public health emergency of international concern.[2] Available data on 2 March, 2016, indicate that Brazil confirmed 641 cases of microcephaly and 139 babies with the birth defect have died since the Zika virus outbreak started in October 2015.[3]

What makes the current outbreak in South America unique has been the increase in Guillain-Barré syndrome, which coincided with the increase in Zika virus infections in the general population, as well as the increase in babies born with microcephaly in north east Brazil.[1] It is still early days in terms of increasing body of evidence on the possible link between the Zika virus infection in pregnant mothers and babies born with microcephaly. However, it is known that the Aedes species mosquitoes (A. aegypti and A. albopictus) transmit the disease, which usually bite during the mornings and late afternoons. Researchers are still trying to determine the incubation period of the disease. It is postulated that the incubation period is probably a few days. The symptoms are similar to other arbovirus infections, such as dengue fever, chikungunya and yellow fever. It presents with mild fever headaches, skin rashes, muscle/joint pains and conjunctivitis. It appears that the "conjunctivitis" may be a distinguishing feature of this disease when compared with other arbovirus infections. The symptoms are short-lived and last 2-7 days with patients fully recovering.

Zika virus is transmitted from an infected mother to her foetus in utero and during birth. To date, there is no reported case of infants infected through breast-feeding. However, the virus spreads by unprotected heterosexual sexual contact from men who have Zika virus symptoms as the virus persists longer in semen than in blood. Between 1 Jan 2015 and 24 February 2016, the United States of America recorded 107 travel-related Zika virus diseases in twenty-six states. The three states with the highest cases were Florida (28), New York (17) and Texas (13).[4] Obviously, the Zika virus outbreaks has introduced a new dimension to the spread of the disease beyond the mosquito bite, that is, via unprotected sexual intercourse with infected persons. On 20 February 2016, South Africa reported its first travel-related case of Zika virus disease in a Columbian businessman who visited the country.[5]

The disease is diagnosed in the serum of suspected infected patients through reverse transcriptase-polymerase chain reaction (RT-PCR). The treatment is symptomatic comprising of bed rest, adequate fluid intake and analgesics. Currently, there is no vaccine against the disease. Prevention follows the same precautions against the mosquito bite including the use of repellents and insecticides. Should travel be restricted between South Africa and Brazil or Columbia? ZVD is a mild disease and no death has been reported. However, pregnant women are advised against travelling to these countries and men with flulike symptoms should be tested for malaria and Zika virus on return from these countries. If they test positive for ZVD, they should use condoms during sexual intercourse for a reasonable period to prevent the possible transmission of the disease. These are common sense approaches until we are fully aware of the impact of this outbreak in Brazil and Columbia.

Prof. Gboyega A Ogunbanjo

Originally published in South African Family Practice (Vol 58(1)).

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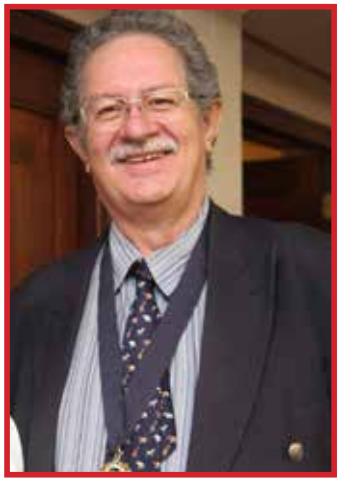
1. World Health Organisation. Zika virus 03 March 2016. Available at http://www.who.int/mediacentre/factsheets/zika/en
2. Centers for Disease Control and Prevention. About Zika Virus Disease. 03 March 2016. Available at http://www.cdc.gov/zika/about/index.html
3. The News International. Brazil confirms641 cases of microcephaly amid Zika outbreak. 04 March 2016. Available at http://thenews.com.pk/latest/102329-Brazilconfirms-641-cases-of-microcephaly-amid-Zika-outbreak
4. Centers for Disease Control and Prevention. Zika virus disease in the United States, 2015-2016. 03 March 2016. Available at http://www.cdc.gov/zika/geo/united-states.html
5. The Citizen. Columbian man diagnosed with Zika virus in Joburg. 20 February 2016. Available at http://www.citizen.co.za/1000448/columbian-man-diagnosedwith-zika-virus-in-joburg/

Presidential Message



Prof Gerhard Lindeque

Dear Colleagues and members of The Colleges of Medicine of South Africa

Our Colleges experience constant growth at all levels. The candidate numbers for our examinations are increasing all the time. Our structure has undergone growth and maturity. Our staff numbers have increased accordingly. We are governed by a Board of Directors that report to our Senate.

As we emerged from the CMSA of old where we offered examinations and qualifications to those who were interested in taking that up, that unilaterally was left far behind. The agreement with the HPCSA, where the CMSA was recognised as the body in South Africa responsible for exit examinations for the specialties in Medicine and most of Dentistry and all the subspecialties, led the CMSA into the "bilaterally" phase. The required detailed analysis of our examination outcomes has resulted in an amazing database that CMSA management is using to improve all the many aspects of CMSA work.

It was not unexpected that we are rapidly moving to trilaterally. This time the agreement is to be with the Committee of Medical Deans of South Africa and a suitable Memorandum of Understanding (and hopefully Agreement) was drawn up and accepted by the CMSA Board of Directors. It will serve before the SACMD in the last days of March 2016. The basic premise is not only the research component that the universities are responsible for in all our graduates, but includes amongst other aspects the importance of excellence at the training sites, the co-utilisation of teaching staff by the Universities as well as the CMSA, and the limitations of certain facilities in a generally resource poor health system in our country.

The next level will have to be an agreement with the national as well as provincial departments of Health, the employing bodies of our registrars and consultants, and the responsible bodies for the training facilities of the Health system. The first meeting in this regard took place in Pretoria recently where all Heads of Health of the nine provinces and the DG and DDGs of National Health during their meeting made time available for a presentation by the CMSA. The incoming president Professor Mike Sathekge gave a very good presentation illustrating the various areas and levels of contribution by the CMSA. From that meeting resulted the formation of a small task team where Dr Terence Carter, DDG of Health, will work together with CMSA leadership to identify the common areas of concern, cooperation and support from both sides. This development is very important as much of the context of CMSA work and impact will be seen within the framework of the various health departments.

One should ask what the most important values are that CMSA brings to the table. In my opinion, it is the standards of our disciplines that we guard as well as the standardisation of our examinations that we must achieve and protect. This last aspect is the topic of an on-going initiative under care of the E&C Committee of the CMSA.

The CMSA is well on its way towards playing a full role in a multilateral team of responsible bodies with regards to training and examining the target population of our candidates. As always, these efforts will absolutely require support and participation of the members of the CMSA. We count on you for your continuing work, support and ideas.

All good wishes go from me as outgoing President to Professor Mike Sathekge as incoming President, and to every member of CMSA at all levels of participation in our activities. Thank you for the great togetherness of the past term. It was a huge privilege.

Prof BG Lindeque
President

Admission Ceremony
22 October 2015

The admission ceremony was held in the Glenridge Church Hall, Durban. This was the largest admission ceremony that the CMSA has ever hosted. There were problems with a shortage of gowns and candidates are applauded for sharing so willingly with their colleagues so that all graduates were suitably gowned for their actual Admission to the CMSA.

At the opening of the ceremony the President, Professor Gerhard Lindeque asked the audience to observe a moment's silence for prayer and meditation.

Dr Albert van Jaarsveld, Vice-Chancellor and Principal of the University of KwaZulu-Natal delivered the oration.

Fellowship ad Eundem was presented to Professor Miriam Adhikari by the College of Paediatricians of South Africa. The citation for Professor Adhikari was written and read by Prof Sharon Kling.

Seven medallists were congratulated by the President on their outstanding performance in the CMSA examinations. Medals were awarded in the following fellowship disciplines, Anaesthetics, Dermatologists, Obstetrics and Gynaecology and Ophthalmology. A medal was also awarded in the following diplomate discipline, Primary Emergency Care.

The President announced that he would proceed with the admission to the CMSA of the new certificants, fellows and diplomates.

The new Certificants were announced and congratulated.

The Honorary Registrar - Examinations and Credentials, Professor Jeanine Vellema announced the candidates, in order, to be congratulated by the President. The Honorary Registrar – Education, Professor Jay Bagratee individually hooded the new Fellows. The Honorary Registrar – Finance and General Purposes, Professor Johan Fagan handed each graduate a scroll containing the Credo of the CMSA.

The new Diplomates were announced and congratulated.

All in all the President admitted 54 Certificants, 324 Fellows and 380 Diplomates.

At the end of the ceremony the National Anthem was sung, where after the President led the recent graduates out of the hall. Refreshments were served to the graduates and their families.

CMSA Membership Privileges

Life Membership

Members who have remained in good standing with the CMSA for 30 years since registration and who have reached the age of 65 years qualify for life membership, but must apply to the CMSA office in Rondebosch.

They can also become life members by paying a sum equal to twenty annual subscriptions at the rate that is applicable at the date of such payment, less an amount equal to five annual subscriptions if they have already paid for five years or longer.

Retirement Options

The names of members who have retired from active practice will, upon receipt of notification by the CMSA office in Rondebosch, be transferred to the list of "retired members".

The CMSA offers two options in this category:

First Option

The payment of a small subscription which will entitle the member to all privileges, including voting rights at Senate or constituent College elections. If they continue to pay this small subscription they will, most importantly, qualify for life membership when this is due.

Second Option

No further financial obligations to the CMSA, no voting rights and unfortunately no life membership in years to come.

Members in either of the "retired membership" categories continue to have electronic access to the journal, Transactions, and other important Collegiate matter.

Waiving of Annual Subscriptions

Payment of annual subscriptions are waived in respect of those who have attained the age of 70 years. Members in this category retain their voting rights.

Those who have reached the age of 70 years must advise the CMSA Office in Rondebosch accordingly as subscriptions are not waived automatically.

Oration: Dr A van Jaarsveld's Address at the Colleges of Medicine of South Africa Graduation Ceremony

22 October 2015, Durban

Dr A van Jaarsveld

Dear Professor Lindeque (President of the Colleges of Medicine of South Africa) and Prof Ogunbanjo (Vice-President of the Colleges), past presidents present, members of the Board of Directors, honoured guests, and last but not least, the new graduates of the Colleges of Medicine of South Africa.

Thank you for this opportunity to address you this evening. In agreeing to do this talk, I had to think a little bit about what someone who is a scientist by training, more specifically an evolutionary biologist, and who landed up working in the area of conservation planning, can possibly share with seasoned medical professionals like yourselves. And hopefully something that you may find thoughtful.

My first instinct was to turn to someone who was trained as a zoologist but made his biggest scientific contributions in the area of immune tolerance, and was eventually awarded the Nobel prize in Physiology and Medicine in 1960. This person, who is today regarded as "the father of transplantation" is Sir Peter Medawar. Richard Dawkins – the selfish gene guy - considers Sir Peter "the wittiest of all scientific writers", and Steven Jay Gould – a renowned evolutionary biologist, said he was the cleverest man he had ever known. Sir Peter's extraordinary works are all widely available, and I will encourage everyone, when you are looking for delightful summer reading, to read them, especially his autobiography – Memoirs of a Thinking Radish.

As practicing clinicians and medical professionals, all of you engage in that grey and difficult area of science and human nature on a daily basis. Some patients respond positively to treatment regimes and or medical advice, others are less responsive and some simply do not respond at all. This variability can be perplexing and sometimes deeply disturbing and distressing to people that are committed to improve the fate of their patients. A natural response from most of us would be that we need to improve the depth of our scientific understanding to that we can better and more comprehensively deal with the human condition.

However, it was Sir Peter himself who stated that "there is no quicker way for a scientist to bring discredit on himself and his profession… than to declare that science knows or will know the answers to all questions worth asking" – this in his Limits of Science book. He also added that questions that do not admit a scientific answer should not be assumed to be non-questions, sometimes, "we must turn to imaginative literature and religion for suitable answers!" When Steven Gould, was himself diagnosed with cancer he asked his physician about the best technical literature on abdominal mesotheliomas. This is what any scientist worth his/her salt would do. Surprisingly, she replied that the medical literature contained nothing worth reading. After visiting his closest library at Harvard, he realised this was humane advice, as the literature indicated – no cure with a median mortality of 8 months. When he subsequently enquired from Sir Peter Medawar about what the best prescription for success against cancer might be, Sir Peter replied – an "optimistic or positive personality". Receiving this diagnosis and reading the current scientific literature could have been devastating and debilitating. However. Steven Gould, under these circumstances found the time and resolve to reflect upon his situation in terms of his personal scientific training and proceeded to rationalise his path forward in a strict statistical sense.

First, the notion of a "median mortality of eight months" does not mean that he would likely pass away in 8 months – while also recognising that the mere mental acceptance of this statistic or giving up, would probably mean that he may very well pass away soon. As a trained evolutionary biologists, Gould realised that statistical measures of central tendencies, such as means and medians are not "hard realities" in biology, and that a biological variance reflects much more than an imperfect measurement of some hidden central essence. All evolutionary biologists, and medical practitioners, should know that biological variation itself is nature's and life's only irreducible essence. That variation is the hard reality and measures such as means and medians are the abstractions in biological systems. Here, Gould could also mentally place himself in the upper part of that variation curve, simply based on his positive personality type, early diagnosis, access to best medical treatment etc. This phenomenon is well established in the medical professions.

The second point Gould realised was that the mortality distribution of the disease was clearly and strongly right skewed, stretched out to the right, so that, once being in the upper half of the distribution, some patients in this area could potentially live for many years. This meant that he probably had time to deal with the disease and any personal matters, and was not personally overcome by despair.

The final conclusion Gould reminded himself about the nature of statistical distributions was that they only apply to a prescribed set of circumstances – in this case, the likelihood of survival using conventional modes of treatment. Things change and the distribution may alter – new treatments may emerge, new approaches that may fundamentally alter his survival probability. Steven Gould survived

a further 20 years before he succumbed to a completely unrelated cancer and continued to be one of the most influential evolutionary biologists of his time – e.g. his theory of punctuated equilibria with Niles Eldrige – that evolution is not simply a smooth progression over time, but that major evolutionary changes seem to happen in fits and starts.

To summarise, the central message from Gould, was that the reality of biological systems is variance, not the mean or median – and that this not the correct message to communicate to patients, that survival statistics are usually right skewed, as they are intrinsically anchored on the left by zero, and that statistical survival distributions may change when circumstances do. Keeping these three principles in mind as medical practitioners can assist you in dealing with the interpretation of data, when having to communicate diagnoses with patients and dealing with that complex science-human interphase as part of your every-day task.

But as you all know better than most professionals, those that rage mightily against the dying of the light will probably endure and that a sense of humour is often key to moving things forward. I for one, still get very nervous when I read on the door that my physician is "practicing", on whom and for what? I have heard people refer to medical practitioners as body mechanics, after all, automobile mechanics also change valves, grind them, replace spare parts to ensure that their babies run like kittens when their work is done. But, as a close medical friend of mine once said, try and do that with the engine running! Consequently, I salute you for your efforts and wish you well with taking your profession forward. We at UKZN stand ready to work hand in hand with the medical professions to advance medical science in this country.

Finally, I would like to take this opportunity to congratulate all the graduates of the Colleges of Medicine of South Africa for 2015. May your careers prosper and contribute significantly to the well-being of this nation that is so dear to us all, hopefully without too severe a wealth tax.

Thank you for listening to me!

Citation:
Professor Miriam Adhikari

Prof Miriam Adhikari

Miriam Adhikari was born in Cape Town and obtained her M.B., Ch.B. from the University of Cape Town in 1969. She obtained the FCP in Paediatrics from the Colleges of Medicine of South Africa in 1974, and her MD from the University of Natal in 1982 on "The Nephrotic Syndrome in African and Indian Children in South Africa". She was the Head of the Department of Paediatrics and Child Health at the University of KwaZulu Natal from 2001 until her retirement in 2010. She is currently Emeritus Professor in the Department of Paediatrics and Child Health and Associate Dean in the Postgraduate Office at the University of KwaZulu Natal.

Miriam Adhikari has served the College of Paediatricians and the Colleges of Medicine with distinction throughout her career spanning many years. She has examined countless times in many different examinations of our College, including the FC Paed parts 1 and 2 and the Certificate in Neonatology. She also served as a Councillor of the College of Paediatricians from 2005 - 2008.

However, apart from these distinctions Miriam Adhikari has been a pioneer in children's health and has served the children of South Africa, Africa and the world through her research (mostly in the fields of neonatology and paediatric renal disease), teaching and clinical service. She has been the recipient of many national and international awards, supervised many postgraduate students in medicine and the allied health professions, and a member of many committees at university and national level. She has been research intensive even now after her retirement in 2010, having authored or co-authored many publications, books and book chapters. During her later career she developed interest and expertise in ethical issues in paediatrics. Her CV bears testimony to her outstanding contributions in South Africa and internationally.

Professor Adhikari was instrumental in ensuring that paediatric care in KwaZulu Natal reached every child, through her many outreach programmes.

The College of Paediatricians unreservedly supports this nomination to Fellowship Ad Eundum for Prof Miriam Adhikari. She is truly loved by her students and colleagues. She is affectionately known as 'Mamma' by her Registrars.

Prof S Kling

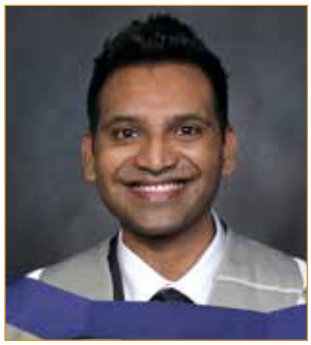
MEDALLISTS

JANSSEN RESEARCH FOUNDATION MEDAL;
ABBOTT MEDAL &
GLAXOSMITHKLINE MEDAL:
GARTH HORSTEN
FCA(SA) Part I

PETER GORDON-SMITH AWARD:
LEVASHNI NAIDOO
FC Derm(SA) Part II

NEVILLE WELSH MEDAL:
NEERAN NARAINSWAMI
FC Ophth(SA) Primary IA

DAUBENTON MEDAL:
KASANDRI GOVENDER
FCOG(SA) Part II



EUGENE WEINBERG MEDAL:
ASHLEY CLEMENT JEEVARATHNUM
Dip Allerg(SA)

LIST OF MEDALLISTS: 2015

Janssen Research Foundation Medal:
Dr Jonathan Jocum (May 2015)
FCA(SA) Part I

Abbott Medal:
Dr Jonathan Jocum (May 2015)
FCA(SA) Part I

Hymie Samson Medal:
Dr Jonathan Jocum (May 2015)
FCA(SA) Part I

Glaxosmithkline Medal:
Dr Jonathan Jocum (May 2015)
FCA(SA) Part I

Crest Healthcare Technology Medal:
Dr Neil David Hauser (May 2015)
FCA(SA) Part II

Jack Abelsohn Medal & Book Prize:
Dr Neil David Hauser (May 2015)
FCA(SA) Part II

Peter Gordon-Smith Award:
Dr Mercedes Morrison
(October 2015)
Dr Silindile Ayanda Sibisi
(October 2015)
FC Derm(SA) Part II

Resuscitation Council of Southern Africa Medal:
Dr Lucy Hindle (October 2015)
FCEM(SA) Part II

The Kloeck Family Medal:
Dr Lucy HINDLE (October 2015)
FCEM(SA) Part II

The Tim Quan Medal:
Dr Wiaan Francois Bedeker
(May 2015)
FCFP(SA)

Sigo Nielsen Memorial Prize:
Dr Saiesha Arti Dindayal (May 2015)
FC Neurol(SA) Part I

Novartis Medal:
Dr Izanne Craill Roos (May 2015)
FC Neurol(SA) Part II

Rowland A Krynauw Medal:
Dr Sudhir Dookie (October 2015)
FC Neurosurg(SA) Final

GP Charlewood Medal:
Dr Chané Paulsen (October 2015)
FCOG(SA) Part I

Daubenton Medal:
Dr Anneen Bianca Venter
(October 2015)
FCOG(SA) Part II

Neville Welsh Medal:
Dr Faheema Abdoola
(October 2015)
FC Ophth(SA) Primary IA

Ophthalmological Society Medal:
Dr Irfaan Hasrod (May 2015)
FC Ophth(SA) Intermediate IB

Justin van Selm Medal:
Dr Schalk du Toit (May 2015)
FC Ophth(SA) Final

JM Edelstein Medal:
Dr Andrew Strydom (May 2015)
FC Orth(SA) Final

SA Society of Otorhinolaryngology Medal:
Dr Michael Andrew Molyneaux
(October 2015)
FCORL(SA) Final

Leslie Rabinowitz Medal:
Dr Meera Chandrakant Nathoo Ooka
(October 2015)
FC Paed(SA) Part I

Robert McDonald Medal:
Dr Shehnaaz Akhalwaya
(October 2015)
FC Paed(SA) Part II

Coulter Medal:
Dr Kathy-Anne Strydom (May 2015)
FC Path(SA) Micro

AM Meyers Medal:
Dr Claire Keene (October 2015)
FCP(SA) Part I

Suzman Medal:
Dr Arthur Kaggwe Mutyaba
(May 2015)
FCP(SA) Part II

Novartis Medal:
Dr Tessa Christine Roos (May 2015)
FC Psych(SA) Part II

Henry Gluckman Medal:
Dr Kate Rees (May 2015)
FCPHM(SA)

Rhône-Poulenc Rorer Medal:
Dr Dashnee Govender
(October 2015)
Dr Vishesh Sood (October 2015)
FC Rad Diag(SA) Part I

Anatomy - Frederich Luvuno Medal:
Dr Sean Andrew Tromp (May 2015)
FCS(SA) Primary

Trubshaw Medal:
Dr Sean Andrew Tromp (May 2015)
FCS(SA) Primary

Brebner Award:
Dr Imraan Ismail Sardiwalla
(May 2015)
FCS(SA) Intermediate

Douglas Award:
Dr Brooke Puttergill (October 2015)
FCS(SA) Final

Eugene Weinberg Medal:
Dr Muhammed Moolla
(October 2015)
Dip Allerg(SA)

SASA John Couper Medal:
Dr Imraan Ismail Asmal
(October 2015)
DA(SA)

The HIV Clinicians Society Medal:
Dr David Andrew Biles (May 2015)
Dr Michael Terence Boswell
(October 2015)
Dip HIV Man(SA)

YK Seedat Medal:
Dr Simon Brett (October 2015)
Dr Kudakwashe Simba
(October 2015)
Dip Int Med(SA)

Walter G Kloeck Medal:
Dr Pieter Barend Kotze
(October 2015)
Dip PEC(SA)

Campbell Macfarlane Medal:
Dr Pieter Barend Kotze
(October 2015)
Dip PEC(SA)

Congratulations!

List Of Successful Candidates: September 2015

Fellowships

Fellowship of the College of Anaesthetists of South Africa - FCA(SA)

DASS Deshandra
GARDINER Caroline
GOKAL Nishen
GORDON Katherine Georgina
GOVENDER Pooveshni
HORSTEN Garth
HURRI Hemal
INVERNIZZI Jonathan
JOHNSON Marianne
JOUBERT Danielle
KABAMBI Kasandji Freddy
LENHARD Bernd Georg
MAHARAJ Dyuti
PORTER Angela
RAIMAN Mohamed
SETHUSA Phelisa
TARLOFF Deborah
VAN DER WALT Adele
VAN TONDER Willem Theodorus

Fellowship of the College of Cardiothoracic Surgeons of South Africa - FC Cardio(SA)

MUREKO Alfred Uriapehe

Fellowship of the College of Dermatologists of South Africa - FC Derm(SA)

LIMBA Babalwa Phindiswa Zinziswa
MARUMA Frans
MAZIBUKO Mthobisi Neliswa
MOGALE Patricia Lebogang
MOLOABI Claudia Boitshoko
MORRISON Mercedes
QWESHA Welcome Mfihlakalo
SIBISI Silindile Ayanda

Fellowship of the College of Emergency Medicine of South Africa - FCEM(SA)

BANDA Grace Wit
DHLAMINI Masikhanyise Elizabeth
EVANS Katya
GIHWALA Radha
HINDLE Lucy
JAFFAL Amer Mansour Rhoma
MOODLEY Pravani
NAICKER Bavani
XAFIS Paul

Fellowship of the College of Family Physicians of South Africa - FCFP(SA)

AWOLOLA Adeleye Makanjuola
BHEBHE Lesley Thembelani
KLEINHANS Shaun Frederik
MABELANE Tshegofatso
MOOLLA Salma Abdulkadir
NWANGWU Chinedu Onyebuchi
RAMLALL Rajiev
SAIDIYA Nasibu Sisa Christian
SAIMEN Amashnee
VAN COPPENHAGEN Brett
VAN ZYL Tanya Bernice

Fellowship of the College of Forensic Pathologists of South Africa - FC For Path(SA)

MAKHOBA Musa Aubrey

Fellowship of the College of Maxillo-Facial and Oral Surgeons of South Africa - FCMFOS(SA)

NUSRAT Aymen Arabi

Fellowship of the College of Medical Geneticists of South Africa - FCMG(SA)

KRZESINSKI Emma Iva

Fellowship of the College of Neurologists of South Africa - FC Neurol(SA)

BHOLA Sudika
NICHOL Rowan
SKOSANA Seawaba Eulenda
SMITH Marcelle Raye Dolores

Fellowship of the College of Neurosurgeons of South Africa - FC Neurosurg(SA)

CHULA Nakedi Duncan
DOOKIE Sudhir
MAMO Dereje Gebrehiwot
NAIDOO Sachindrin Ramurthi
STEYN Corlize
TIMAKIA Kritish
WEGOYE Emmanuel

Fellowship of the College of Nuclear Physicians of South Africa - FCNP(SA)

HADEBE Bawinile
LAWAL Abubakar K-Bai
MAFTAH Tausi Kassim
MBAKAZA Olwethu Natash
MORKEL Marguerite
YUNUSA Garba Haruna

Fellowship of the College of Obstetricians and Gynaecologists of South Africa - FCOG(SA)

AYOB Rizwana
BABAWALE Musiliu
BARNARD Annelize
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Certificate in Cardiology of the College of Paediatricians of South Africa - Cert Cardiology(SA) Paed

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Certificate in Cardiology of the College of Physicians of South Africa - Cert Cardiology(SA) Phys

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Certificate in Child and Adolescent Psychiatry of the College of Psychiatrists of South Africa - Cert Child and Adolescent Psychiatry(SA)

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Certificate in Clinical Haematology of the College of Paediatricians of South Africa - Cert Clin Haematology(SA) Paed

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Certificate in Critical Care of the College of Paediatricians of South Africa - Cert Critical Care(SA) Paed

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Certificate in Critical Care of the College of Surgeons of South Africa - Cert Critical Care(SA) Surg

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Certificate in Developmental Paediatrics of the College of Paediatricians of South Africa - Cert Dev Paed(SA)

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Certificate in Endocrinology and Metabolism of the College of Physicians of South Africa - Cert Endocrinology and Metabolism(SA) Phys

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Certificate in Gastroenterology of the College of Physicians of South Africa - Cert Gastroenterology(SA) Phys

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Certificate in Geriatric Medicine of the College of Physicians of South Africa - Cert Geriatric Medicine(SA)

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Part I, Primary and Intermediate Examinations

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COLLING Jennifer
DE JONGH Ruan
DE VASCONCELOS Sandra
DIAKAKIS Alexander Nikolas-John
DLAMINI Sanelisiwe Hlob'sile
DLOMO Nhloso
DYASI Luvuyo
ELFALLAH Balgeis Ali Omar
ELFIRGANI Mohamed F Farag Elfirgani
ELMISHAT Faraj Abduallah
FOSTER Matthew
GERAFA Muaad Munir Soliman Gerafa
GOGA Nabila
GORRY David Laurence Ashwyn
GROBLER Gerard
HANNINGTON Matthew
HARTFORD Leila Nompelo
HENNING Jandre
HYNES Alana Stacey
HIDDEMA Jan Siebrand
HOFFMANN Carolise
HOLFORD Etienne Brian
HUMAN Mathys Johannes
JOOMA Uzair
JUGNUNDAN Yashna
KANSILEMBO Kisubi
KAPLAN Nathan
KASILEMBO Riziki Odette
KEKEZWA Dideka Licher
KGOPANE Tshenolo Trobisch
KHALIFA-ALMABRUK Tareg Hussein. M
KHEDZI Lutendo
KISTEN Serisha
KLOPPERS Frederik Jacobus
KOCK Frans Willem
KRIEL Renier
LAKSHMANAN Aarti Komal
LANDMAN Ivan
LEECH Nicholas Bradley
LEEUW Phemelo Macdonald
LUTHULI Lulama
LUTHULI Vuyo
MABOKE Tshepo Sylvester
MAHARAJ Nishen
MAHARAJ Yasteel Rajendra Mohanpersadh
MAILA Solomon Aubrey
MAKWELA Jan Tshediso
MALIAKEL Athena George
MALIEPAARD Madelein
MANNEL Annelaide Shumay
MAPUNDA Patience Cynthia
MARAIS Dieter
MAUNICK Yash Shakti
MBONISWENI Akhona
MERCURE Christopher Ian-Anthony
METUSE Nombulelo Patricia
MINKOWITZ Shaul Yosef
MLOTSHWA Ncamiso Wiseman
MOLOSIWA Jonathan Motseotsile
MORDI Chukwunweike Victor
MOROATSHEHLA Sydney Mankale
MORULANA Takalani Gidion
MOSASI Tebo Cyril
MOTLOUNG Sipho
MOUTON Mariette Cordelia
MPIKASHE Mvuyisi
MTSHALI Thomas
MUNOO Nirov
MUSHUNJE Sithandweyinkosi
MUVHANGO Mpho Respect
MUZENDA Tanaka
MYINT Paing Phyo
NANSOOK Adisha
NDINDWA Bayanda Buphelo
NEL Paul
NGEMA Siphumelele Sydwell
NICOLAOU Caterina
NKADIMENG Lerato Shirley Lekgala
NKUNA Cry Sello
NTOLA Vuyolwethu Comfort
OPPEL Cleve Desmore
PARTHAB Shaheev
PHAKATHI Oatile
PHILLIAS Stanley Comfort
PIETERS Raymond Peter
PILLAY Nivashen
PILLAY Tristan
POWANE Shadrack Herman
PSWARAYI Rudo Mutsa Vanessa
PULE Mosimanegape Cecil
RAGUNANDAN Shiksha
RAJKUMAR Sarisha
RAMOKONOPI Samuel Besabakhe
RAMSAMMY Merash
REDDY Nicolas
ROTHMAN Sarel
RUGNATH Kapil
SERITSANE Joseph Tlakale
SESHIBE Matome Desmond
SILOLO Siseko
SINGH Ashvir Sidarta
SINGH Roxanne
SKOSANA Nonhlanhla
SOSIBO Sijabulile Cassius
SRIDARAN Vaishali
SWART Magrietha
TERREBLANCHE Michael Harland
THIKHATHALI Ndivhoniswani David
THOBEJANE Michael Lionel
TONI Asanda
TSOLO Gladwell Kekeletso
UDATINYA Daniel
VAN DER WALT Ruan
VAN DER WATT Nicolaas Pieter
WHITE Matthew Craig
WILLEMSE Donovan Steven
WILSON Stephen Peter
YAGAN Calvin

Primary of the Fellowship of the College of Urologists of South Africa - FC Urol(SA) Primary

ZONDO Mfundiso

Intermediate of the Fellowship of the College of Neurosurgeons of South Africa - FC Neurosurg(SA) Intermediate

ANYIKWA Anderson Chinedu
ARNOLD Christel
BOUNGOU-POATI Prince Darsi
CROOK Byron Martin
HARRINGTON Bradley Mcconville
HLAHLA Stevens Kgomotso
KAMAT Ameya Shrikant
MATHOLE Andrew Chiften
MPANZA Morena Nthuse
MPANZA Phila Martin
MSOMI Mduduzi Brian
ODUNTAN Akinola Olumide

Intermediate of the Fellowship of the College of Ophthalmologists of South Africa - FC Ophth(SA) Intermediate IB

ALLY Naseer
ANDREAE Corinna Doris
ERASMUS Clayton
GANI Aboobaker
KRIEK Jozef Albertus
KRITZINGER Anine
MASEKO Ntopi Joseph
MBELWA Samkelo Leon
MELANI Mahlatse Nancy
MTHETHWA Sibongile Constance
NAUDÉ Malcolm
NDLOVU Lungile Thandeka
NIEDER-HEITMANN Norman
SMITH Suzanne Mari
STEYN Anna
VAN DER MERWE Ernst Baard
VAN DER WESTHUIZEN Dean Andre
VAN ECK Elizabeth Catharina

Intermediate of the Fellowship of the College of Orthopaedic Surgeons of South Africa - FC Orth(SA) Intermediate

DAVIS Graeme Anthony
DESAI Yussuf Mohammed
GRUNDILL Michael Lancaster
HADEBE Nhlakanipho Christian
JADA Prince Masibulele

KUBICEK Juraj
MAINA Anne Wanjiru
MASEMOLA Mmakomane Godfrey
MKHWANAZI Uluthando
MOLEPO Matome Albert
MOTLOLISI Prince-Stoffel Elias Thabiso
Mosiuoa
MUGLA Walid
MUKABETA Takura Darlington Maumbe
NAKALE Ngenomeulu Tufikifa
NCUBE Thando
NEVONDO Lindelani
NTOMBELA Philani Ian
ORJIAKO Livinus Obiora
PHIRI Tshepang Edison
RACHUENE Pududu Archie
SEKEITTO Allan Roy
STEWART Andrew
VAN DER MERWE Wian
VAN STADEN Gideon Francois
ZONDO Zwelibanzi William

Intermediate of the Fellowship of the College of Surgeons of South Africa - FCS(SA) Intermediate

ABORKIS Ismail
ADZATIA Etornam Kwame
AIKMAN Johan George
ALHADAD Abdulrauf Ibrheem Alhadad
ALMGLA Naser
BALASUBRAMANIAN Ashok
BARA Memory
BAROUNI Elyas
BOGGENPOEL Ashton Richard
CHUNG Seo-Hwa
DE BRUYN Gerard Herman Matthys
DU TOIT Nina
ELS Timothy
GAUTAM Siddharth Ranjan
GWILIZA Luntu Lungile
HABIBI Reza
HAMUNYELA Kondjela
HBISH Mnier A.M. Hbish
KENOSHI Boitumelo
KESHAV Nerisha
KHAN Muddaseer
KIRPICHNIKOV Andriy
LEITCH Ailsa Marjorie
LENGTON Anel
LUTCHMINARIAN Kajal Anandkumar
MABOGOANE Tumiso BM
MAGAGANE Cleopatra Nomhle
MAKGOFA Nothabo
MAKGOKA Malose
MAKHOBA Sizwe
MAKOFANE Robert Moketi Philly
MALEFAHLO Thabiso
MARITZ Jan Paul Barnard
MASHAVA Rirhandzu Brighton
MATIMBA Abongile
MAZIBUKO Sifiso
MBAMBO Thandanani
MBANJE Chenesa
MISTRY Heeral Jayantilal
MONGWE Kenny Nyiko
MOTLOUNG Elliot
MUNGUL Sheetal
NAIDOO Sashelin
OMAR Mahad
PICKARD Henri Du Plessis
RAMABULANA Mpho Maano
RAMPAI Thabo Johnson
SALUKAZANA Azola Samkele
SINGH Avikar
STEENKAMP Andries
STEVENSON Nico
THOKAN Nishat
TRUTER Marilize
TSHIMANGA Kadima
VAN DER VYVER Marieta
VAN ZIJL Nicholas
WAGENER Mark

Higher Diplomas

Higher Diploma in Orthopaedics of the College of Orthopaedic Surgeons of South Africa - H Dip Orth(SA)

MOHAMMEDALI Shamshudin
MTHETHWA Phakamani Goodman

Diploma

Diploma in Allergology of the College of Family Physicians of South Africa - Dip Allerg(SA)

CHAYA Shaakira
COLIA Natasha Angela
AHER Abdullah Ebrahim
MOOLLA Muhammed
PARRIS Denise Chevonne
TRIKAMJEE Thulja

Diploma in Anaesthetics of the College of Anaesthetists of South Africa - DA(SA)

ABBAS Nafisa
ADAM Irfaan
ADELEKE Olukayode Ademola
AISINDI Annaliisa Kapango
AMADO Leandra Anastasia
ARANGIES Rebecca Anne
ASMAL Imraan Ismail
ASPELING Chrizanne
BAUMGARTEN Johanna Alida
BESTER Helen
BISMILLA Nisaa
BLOMEYER Melissa Caroline
BLUMENTHAL Trevor Martin
BRYANS Taryn
CHINDOVE Tsivai Mirriam
CURTIS Tatum Tamara
DE WET Darien
DICKS Leanne
DU PREEZ Liezl
DU TOIT Michiel Adriaan
EAVE Dylan
ELLIS Marli
ENOCH Leanthea Christine
FAKU Nomana Valencia
FOURIE Johan Benjamin
FRIDEY Wayne Ryan
GANGEN Sogendrin Balan
GAOSIWE Keabecwe
GAYAPARSAD Avika
GERBER Carmen
GILES Daniel
GOVENDER Shamandree
GREEFF Nicole
GUNGAPURSAD Jothika
HARGOVAN Karisha
JADHUNANDAN Kajal
JAGANATH Ushir Vijay
JAINSON Neenu
JEGGO Tahlia Ann
JONES Gareth Andrew Russell
JOUBERT Daniel Johannes
KGANANE Mpho Tryphosa
KIFT Etienne Fourie
KOUVARELLIS Alison
LATAKGOMO Dineo Bontle
LEBEPE Mmakoma Doreen
LIWANI Malibongwe Momboisse
LOGGIE Laura-Jane
MAHARAJ Arusha
MAKAN Vikash
MAKHUBELA Nkateko Leonard
MANDEBVU Takudzwa Richard
MANYOHA Hulisani Albertinah
MARAIS Eugene
MASELA Mathibela Janky
MASVIKWA Hilda
MASWANGANYI Goodwill
MATLHATSI Thabang Kate
MCCRINDLE Lorna Young
MEHLAPE Sello Francis
MERRIFIELD Belinda
MONCHWE Tebogo
MOOSA Mariam
NAICKER Kumeshnee
NAIK Kajal
NCOMANZI Bekinkosi
NOVEMBER Vuyokazi Joy
NYATELA-AKINRINMADE Zizikazi
OGUNJIOFOR Asinobi Cyril
PILLAY Fulton
PILLAY Sunthurie
PRETORIUS Marthinus Wessel
RAGIE Mahmood
RAMABULANA Matamela
RAMBURUTH Marsha

RAS Willem Abraham Prinsloo
ROOPNARAIN Bronwyn Sunitha
RUGBEER Alishea
RWASOKA Nyasha Brian
SAN PEDRO Karyll Mae
SEBEI Mmapula Pertunia
SEHLAPELO Mathabe
SHER Yonina Michel
SITHOLE Benedict
SMITH Sheena Diedre
STAATS Jurgens Staats
STRYDOM Magdel
SWART Reinier
TALJAARD Maritza Isabel
THABETHE Thulani Hamilton
THEUNISSEN Melissa Maria
THORNLEY Sean Peter
TSHABALALA Mabatho Roseline
TSHAKAYA Manasse Tshipama
TSHITANGANO Rofhiwa
UGWU Onyebuchi Henry
VAN DER MERWE Anchene Beatrix
VAN DER MERWE Freliza
VERMEULEN Dewald
VERMEULEN Petrus Jacobus
VERMEULEN Sonja Louise
WITT Jonathan
YOUNG Bronwyn

Diploma in Child Health of the College of Paediatricians of South Africa - DCH(SA)

ALEXANDER Nicole Anne
CASTELYN Claire
CHONAN Vaneshan
CREMONA Elena
CROUCAMP Rolanda
CUMMINS Tracy Robyn
DUBA Sithembiso Eric
DUBE-PULE Anele Sicebile
DUVENHAGE Joanie
FERREIRINHA Andrew Edward
GOBETZ Charlé
GOOLAB Deepika
GRACE Gaynor Helen
GREYLING Donna May
HARRIS Natasha Jade
HENDRICKS Simone Lara
HONGER Kate Isabella
JIRI Samantha Tsitsi
KIRSTEIN Irma
LEVETAN Candice Sara
MAHMOOD Shahid Mahmood
MARAIS Sumari
MASHILE Koki Octovia
MATHURE Muhammad Wakeel
MINNE Suzanne
MOHALE Ngoako Jafter
MOKOTO Tshepang
MOODLEY Mark
MOTHI Hemasha
MURRAY Sadia
NDHLOVU Lesego
NTANJANA Boyboy Tshiamo
PILLAI Sajal
PILLAY Larisha
PROP Serge
RAMJEE Natasha
RAMSUNDER Sheethal
RONGE Lena
SAIB Muhammad Zubayr
SHAH Candice
SHANGE Nolwazi Bonakele
SINGH Sarieta
STEYN Kristi Marguerite
TSHIPENG Jean Paul Mulang
VAN DER WESTHUIZEN Joh-Nell
VILLET John De Mornet

Diploma in Forensic Medicine of the College of Forensic Pathologists of South Africa - Clin - Dip For Med(SA) Clin

NAGAR Rajesh

Diploma in Forensic Medicine of the College of Forensic Pathologists of South Africa - Clin/Path - Dip For Med(SA) Clin/Path

PULE Motsoaleli Joel

Diploma in Forensic Medicine of the College of Forensic Pathologists of South Africa - Path - Dip For Med(SA) Path

DHLOMO Sibongiseni Maxwell
PEDDLE Laura Dawn

Diploma in Geriatric Medicine of the College of Physicians of South Africa - DGM(SA)

ADEBUSOYE Lawrence Adekunle

Diploma in HIV Management of the College of Family Physicians of South Africa - Dip HIV Man(SA)

ANAFI Ivy Yaa Gyamaa
BABU Neethu Esther
BAHEMIA Imtiaz Ahmad Farouk Issop
BLOCH Jolene
BOER Etienne Herbert
BOSWELL Michael Terence
BRAITHWAITE Kate
BUCHMANN Eckhart
BUTLER Thomas Alexander Gugile
CHILI Zandile Adelaide
COMINS Kyla Louise
CORNELLISSEN Garth
DALASILE Patiswa
DAVIDS Ashraf
DELPORT Johannes Eduard
DORSE Gillian Lorna
DU PLESSIS Michelle
DUDLEY Meagan Taryn
DUMA Siyanda
DUNWOODY Ian
ENGEL Willika Pernilla
EVANS Shannon Lee
FAKUDZE Sandile Vusumuzi
FLACK Katherine
FORRESTER Jane
FOX Darren Joshua
GRABE Rita Hamman
HIRI Onkarabile
HOLZ Guillaume Erich
IRWIN Natalie Elizabeth Anne
JACKSON Christi
JACOB Jose
JONES Deborah Marie
KANNIE Samantha Jess
KOTZE Suzanne
KUNYUZA Sithandiwe
LEE-JONES Scott Gareth
LETEBELE Arabang
LEVIN Gerald
LINDE Amy Ruth
MADIKIZELA Namhla
MALULEKE Vongane Louisa
MANGWAYANA PAZORORA Judith Tsitsi
MASEMOLA Kgaogelo Rangoakoana
MASEMOLA Queen Nhlanhla
MATOLE Sanelisiwe M
MAVETERA Justice Kudakwashe
MAYET Azraa
MBELLE Mzamo Ntsikelelo
MEMEH Uloma Gloria
MEYER Tabitha Nadishani
MIRI Anisa
MOGANO Sekolo Dinah
MOODLEY Vedanthi
MORGAN Nicole
MOSAM Saber Hoosen
MPHAHLELE Ramaite Matilda
MRUBATA Sikelelwa Lovedalia
MUDALY Vanessa
NAIDOO Maynolia
NAIDOO Nerissa Sanrisha
NEMUTUDI Thendo
NKUNA Tercia Tsakani
NNAMBALIRWA Maria Tegulifa
NTATAMALA Itumeleng Mmoko Theophelus
OPPERMAN Jacobus Benjamin
OVERMEYER Amanda Julia
PETERS Remco Petrus Hendricus
RAILTON Jean Pamela
RAYMOND Meriel Elizabeth
REYNEKE Izane
ROOD Jacques Wynand
SAYED Sumaya
SHALI Wanis Mohamad
SHELEMBE Zamazamela Precious
SHEPHERD Danielle Courtney
SINGH Yashna

SMIT Liani
SOBAZILE Loyiso
STUART Kelsey Vernon
SWARTBOOI Siyambonga Zintle
TAPIWANASHE Kusotera
TEW Catherine Louise
THACKWRAY Nicolas John
THUSI Mthunzi
TITUS Gideon John
VAN DEN BERG Liudmyla
VAN DER BIJL Chantelle Canada
VHEMBO Tichaona
VILJOEN Jacobus Abraham
WOODS Joana Francisca
YAKOOB Feroz Ismail
YALALA Mbakaniaki
ZAMPARINI Jarrod Mario

Diploma in Internal Medicine of the College of Physicians of South Africa - Dip Int Med(SA)

BRETT Simon
CHILIZA Nondumiso Nompumelelo
DRMESH Mustfy N M
DURAO Henrique
EMHEMED Mohamed Omar El Mehdi
KANYIK Jean-Paul Muzemb
KHOURY Justine Charmaine
PIETERSE Justin Sven
SHUUYA Rebekka Ndapewa
SIMBA Kudakwashe

Diploma in Mental Health of the College of Psychiatrists of South Africa - DMH(SA)

CHETTY Shren
DANIELS Michelle Veronica
HANSLO Gregory Raymond John
LETSELI Kabo
MAJIET Shakeera
NAIDU Kaveshin
NEFF Rhiyaaz
PHUNGULA Thabisile Nozuko
RAJU Anne Sheena
RITTER Ilze
ROUX Coritha
SCHULTZ Megan
VAN DER MERWE Nicolaas Jacobus
VAN ZYL Da-Niel Petrus

Diploma in Obstetrics of the College of Obstetricians and Gynaecologists of South Africa - Dip Obst(SA)

ABRAHAMS Tracey-Leigh
ALAM Sharmeen Sultana Alam
AUGUSTINE Leon
BAGUET Eveline Marie Amandine
CHIKWIRI Christopher
FERREIRA Bjorn
FINGER-MOTSEPE Kelebogile Lorraine
GERARDO Ronia H
GODWIN Claire Melanie
HORN Melanie
IKWEGBUE Joseph Nnaemeka
JOBARTEH Kinneh
KALWIBA Kita Christian
LE GRANGE Marinda
LOMBARD Gerrit Petrus
LOUW Corne
LUNUMBE Kondjo
LYELL Daphne
MAMUSHIANA Ndiitwani
MANGANYI Nkateko Shirley
MATHOSE Tabitha Tasunungurwa
MONGALO Klaas Nakedi
MORAPEDI Motlhokomedi
MOYO Mbongeni
MPHAHLELE Malefu Pearl Makadiso
ONAFUWA Adebisi Hakeem
ORABI Mokhamed
PIETERSE Marike
RAMSUNDER Nivadh
RYKLIEF Zulfa
SAYED Khaleda
SHEEHAMA Ilona Ndapewa
STANDER Elmien Elizabeth
STEWART Wayne William Dennis
SWANEPOEL Marco Clint
TIMEYIN Oluwaseun Temitope
TSHINETISE-MALIGANA Phathutshedzo
VAWDA Bibi Fathima
WALUGEMBE Edward

Diploma in Ophthalmology of the College of Ophthalmologists of South Africa - Dip Ophth(SA)

ANTWI-ANYIMADU Florence
GANGAI-SINGH Manisharani
KHUMALO Sphiwe Fabian
MAJOLA Nonhlanhla
MANYERUKE Stephen
MURUDKER Zahier
PRETORIUS Willem Sternberg
VAN DER COLFF Fredrich James

Diploma in Oral Surgery of the College of Maxillofacial and Oral Surgeons of South Africa - Dip Oral Surg(SA)

DE LANGE Johny

Diploma in Primary Emergency Care of the College of Emergency Medicine of South Africa - Dip PEC(SA)

AFRIKA Nomsa Lilly
ANAMEGE Declan Iheanyi
BESTER Petrus Jakobus
BOTES Chantel
BUNTTING George-Cornelius
CARVALHAL Diana Silva
DE BUYS Brian Michael
DE JAGER Nolene
DE VILLIERS Matheo Kock
DICKS Heather Nolene
EKSTEEN Aidan Andrew
ERASMUS Laura Jean
GUFFAR Sumaya
HAGEMEIJER Nikita Sophia Theresia
HANEKOM Lynn Reze
HARMSE Leani
HART Jedd Craig
HEUGH Remo Ricardo
HOFFE Mary Elizabeth
KAJEE Muhammad Shaheen Farouk
KAY Sharon Lynne
KOTZE Pieter Barend
KUMANDAN Fayaad
LAUDIN Garrick Edouard
LEIGHTON Patricia Susan
LEWIS Carolyn Mary
LOCHNER Phyllis Jesswin
MABUSELA Mfundo
MAJANGARA Munyaradzi Blessing Mhini
MAKI Lwando
MALAN Jan Johannes
MBALO Qhamisa Babalwa
MOOLLA Raeesa
MORROW James John
MULDER Shannon
NAICKER Tesham
PATEL Yousuf
PETERS Carryn
PILLAY Prenolan
PLATT Timothy Simon
PULE Marwala Simon
REDDY Deen Reddy
REED Kenneth Anthony
RETIEF Andre
RODRIGUES Janine Bianca Lira
SAYED Farzana Sayed
SINGH Mika
SINGH Navesh
STEENKAMP Yolandi Janelda
STEYN Johannes Hermanus
SUKNUNAN Jerome Jonathan
SWANEPOEL Adam Johannes
UHRICH Robert Klaus
VAN DER WESTHUIZEN Clinton
WARNICH Ilonka
ZAAYMAN Heinri

By Peer Review

SMIT Francis Edwin
College of Cardiothoracic Surgeons
BROWN Robin Alexander
College of Paediatric Surgeons

CMSA Minutes: The Sixtieth Annual General Meeting of the Colleges of Medicine of South Africa (CMSA)

Held At 11:00 on Friday, 23 October 2015

in DHS 1 & 2, Garden Court Marine Parade, Durban

PRESENT

Prof B G Lindeque (President) in the Chair

Prof G A Ogunbanjo (Vice President)

Prof M M Sathekge (Chairman: ECC)

Dr S M Aiyer (Chairman: EC)

Prof R N Dunn (Honorary Treasurer)

Prof J J Fagan (Honorary Registrar: FGPC)

Prof J Vellema (Honorary Registrar: ECC)

Prof J S Bagratee (Honorary Registrar: EC)

Prof J G Brink

Prof R Dickerson

Dr H I Geduld

Dr P D Gopalan

Prof D Govender

Prof A B R Janse van Rensburg

Dr C M Kgokolo

Prof S Kling

Prof M Z Koto

Prof L London

Prof D S Magazi

Prof J N Mahlangu

Dr F Mahomed

Prof M H Motswaledi

Mr M Munasur

Prof E Ndobe

Prof M V Ngcelwane

Prof E Osuch

Dr J R N Ouma

Prof T Parbhoo

Prof R D Pitcher

Dr D P Ramaema

Prof H Saloojee

Dr F Senkubuge

Dr A Sherriff

Prof L C Snyman

Prof L M Sykes

Prof M I Tshifularo

Dr L M Tucker

Prof M G Veller

Dr L Visser

Prof J M Warwick

Dr M J Young

CEO/COMPANY SECRETARY:

Mrs L Trollip

IN ATTENDANCE

Mrs A L Vorster (Academic Registrar)

Mrs M R Pollock (Finance Director)

Mrs S S Jagger-Smith (Minute Secretary)

APOLOGIES

Prof B Cassim

Prof B J S Diedericks

Prof A M P Harris

Prof D Hellenberg

Prof G Kariem

Dr W G Kleintjes

Prof A Krause

Prof F J Jacobs

Dr L A Lambie

Prof A Madaree

Prof A J W Millar

Prof S B A Mutambirwa

Dr W J Neuhoff

Prof S Seedat

Prof P L Semple

Prof A S Shaik

Dr T Stephens

Prof A Walubo

Prof S W Wentzel

WELCOME

The Chairman thanked everyone for attending the 60th Annual General Meeting.

REGISTRATION OF PROXIES

The CEO duly registered 18 proxies. A quorum was present.

MINUTES OF THE FIFTY NINETH ANNUAL GENERAL MEETING HELD ON 17 OCTOBER 2014

The minutes were adopted and signed.

MATTERS ARISING FROM THE MINUTES OF THE LAST ANNUAL GENERAL MEETING

The matters were included in the agenda.

ANNUAL REPORT OF THE CEO ON BEHALF OF SENATE FOR THE PERIOD JUNE 2014 TO MAY 2015

The CEO stated that the Annual Report of Senate appeared on pages 22 to 35 of Transactions and reflected the activities of the last financial year. The reports of the various constituent Colleges appeared on pages 36 to 47.

Progress for the year included the ratification of election results, the celebration of the CMSA's Diamond Jubilee, and the signing of the MoU and SLA with the HPCSA.

Dr Tucker pointed out that the report of the College of Radiologists was not included. Their report included practicalities of the JN and WLS Jacobson Lecture, where they were looking for flexibility in the model of that lectureship, which took place at the annual ENT conference and not at the breast congress.

Prof Ogunbanjo responded that this would be corrected.

ACCLAMATION

The annual report was adopted.

FINANCIAL REPORT OF HONORARY TREASURER: PROF R DUNN

Audited financial statements were attached.

Prof Dunn reported that the CMSA's assets were valued at R107 million, which included properties at R51 million, longer term investments at approximately R40 million and shorter term investments at R15 million. Liabilities were R12 million, which were largely trust funds administered. Income for the last financial year was R30 million, due to increased examination activity. Costs had increased in parallel. There was a surplus of R2.43 million.

The CMSA had accepted SARS' ruling that it was no longer VAT exempt. Prof Dunn and the CEO would be meeting with SARS on 28 October 2015.

The Auditors had confirmed that there were no issues to correct in the accounts. Prof Veller added that in the last Risk Committee meeting, they had met with the Auditors, who had testified that they had no concerns regarding the CMSA's accounts, and that to some degree the CMSA was actually over-audited.

THE ANNUAL FINANCIAL STATEMENTS WERE APPROVED.

The Honorary Treasurer's Report was adopted.

REPORT OF THE PRESIDENT: PROF B G LINDEQUE

Prof Lindeque indicated that his report was on page 4 of Transactions.

Prof Lindeque's report reflected on the targets set for the triennium. He stated that it had been a great honour to serve as President, and he appreciated the support he received from Senate, the CEO and staff.

He commented that the CMSA had grown in the previous three years, and a lot more emphasis had been placed on the CMSA's role as a values based organisation than before, and that there had been national recognition of the CMSA's work due to the MoU and SLA with the HPCSA.

Prof Lindeque added that the CMSA should build up its core of Examiners as one of its targets for the next three years.

The triennium target had been to have a clean administration, better communication, stakeholder identification and transparency in all the CMSA's operations. On reflection, it had been a very good and very clean crystal clear administration. There were good methods in place for different committees, and for the finances. The CMSA also met with the South African Committee of Medical Deans, the Department of Higher Education and Training and the Department of the Health. Many of the people in the current and previous Senate were instrumental in getting these meetings set up. Prof Lindeque expressed his sincere appreciation to all.

Prof Lindeque commented that the CMSA was to become VAT liable, the details of which would be sorted out at the meeting on 28 October 2015.

He spoke about the staggering of examinations and stated that it was a critical component of the CMSA survival strategy.

Prof Lindeque felt that communication with existing members should be done with greater intensity.

He stated that on reflection, the CMSA was in a good position, and was well respected. Prof Lindeque thanked everyone for their input, hard work and fantastic attitude.

ACCLAMATION

The President's report was adopted.

REPORT OF CHAIRMAN, EXAMINATIONS AND CREDENTIALS COMMITTEE (ECC): PROF M SATHEKGE

Prof Sathekge reported that the ECC and its Manco were very committed to dealing with matters as they occurred, such as issues of potential litigation as recommended by the Risk Committee. On 12 November 2015, the ECC Manco would meet about matters raised in the examination and meetings.

The CMSA were continuing to engage with the HPCSA, which had ratified some of the sub-specialties, but had omitted some. The ECC were working on this.

Prof Sathekge thanked the committees that functioned tirelessly, one of them being the policy committee run by Prof Mahlangu.

He committed to submitting a proposal for the staggered examination to the Board meeting in February 2016.

With regards to the SLA with the HPCSA, Prof Sathekge reported that the HPCSA had written to the CMSA with a note from Registrars complaining that the appeals process was not fair, as remarks had yielded no results. This was a miscommunication and misperception that the ECC would address.

ACCLAMATION

Prof Sathekge thanked the Honorary Registrar, Mrs Vorster and staff, the ECC and the ECC Manco for their work.

ACCLAMATION

The ECC's report was adopted.

REPORT ON ACTIVITIES OF THE EDUCATION COMMITTEE (EC): DR SM AIYER

Dr Aiyer reported that the EC consisted of 7 Senators and 4 co-opted members, which included the Dean of the Faculty of Medicine at UKZN. The ECC met regularly and attendance was excellent.

The EC accredited applications of CPD activity, which was run by Dr Clive Daniel. Dr Daniel was training Dr T Kisten, who was assisting him with this. Both attended the National Accreditors Forum meeting hosted by the HPCSA, which gave guidelines on how to improve CPD activity.

Dr Aiyer added that the Durban offices had relocated to the Westridge Medical Centre.

Additional activities of the EC were syllabi and regulations. Presidents were requested to look at documents sent to them and update accordingly.

ACCLAMATION

Dr Aiyer thanked the staff in the Durban office for diligent work in the past year.

ACCLAMATION

The EC's report was adopted.

REPORT OF CHAIRMAN, FINANCE AND GENERAL PURPOSES COMMITTEE: PROF G KARIEM

Prof Dunn reported on the FGPC activities, on behalf of Prof Kariem.

Prof Dunn explained the status of the VAT issue.

The Board of Directors agreed on 17 September 2015 to instruct Mr Ernie Lai King to take the following course of action:

- Accept SARS' position that the CMSA was not a Section 30 PBO, but a Section 30B organisation.
- The CMSA would still enjoy income tax exemption as a Section 30B organisation, in terms of Section 10(1)(d)(iv)(bb) of the Income Tax Act. However, it would be required to account for VAT.
- The CMSA would engage with SARS to negotiate that VAT would only be levied prospectively and not retrospectively. The CEO and Prof Dunn would be meeting with SARS in Pretoria on Wednesday, 28 October 2015.

Prof Dunn reported that the Durban properties had been sold for R2.3 million, and that offices would be rented until a suitable property could be found.

Colleges were encouraged to spend their levy accounts on examiner education, increasing the examiner pool and the facilitation of the examination process. It had been decided that Colleges with more than R250,000 in their levy accounts would not receive the annual R25,000 allowance, and the sliding scale was adapted to build up smaller colleges.

The CMSA's investment strategy was changed to increase equity exposure, and R5 million was in the process of being moved into equities.

A mechanism to deal with outstanding membership fees would be instituted.

ACCLAMATION

Prof Dunn thanked the CEO and all staff for meticulous and hard work.

ACCLAMATION

The FGPC's report was adopted.

REPORT OF CHAIRMAN, SOCIAL AND ETHICS COMMITTEE: PROF P SEMPLE

Prof Dunn reported on behalf of Prof Semple.

Prof Dunn reported that the Social and Ethics Committee met twice a year, and its activities were based around the ten principles of cognizance, which included human rights, labour standards, the environment and anti-corruption. No issues were reported to consider.

Prof Veller commented that it was good governance to have a Social and Ethics Committee. However, the CMSA SEC was not being used as it should be. Issues from other committees should be brought to the SEC.

Prof London asked about the role of committee in an educational context, with regards to graduates engaging with the market in private practice. He asked how the assessment process measured how specialists engaged with the market.

Prof Fagan suggested a generic question in examinations with regards to ethics.

ACCLAMATION

The SEC's report was adopted.

REPORT OF EDITOR OF TRANSACTIONS: PROF G A OGUNBANJO

Prof Ogunbanjo reported that since going digital, the number of hard copies printed had been reduced to 700 per issue. There had been a delay in the release of Apple and Android apps for Transactions.

Prof Ogunbanjo stated that more eponymous lectures should be published.

Prof Ogunbanjo called for a volunteer to serve at Deputy Editor. Prof Sykes volunteered.

ACCLAMATION

The Editor's report was adopted.

ANNUAL APPOINTMENT OF AUDITORS

The CEO reported that C2M were appointed as the Auditors. Prof Veller confirmed that the Risk Committee had interrogated them on the last audit, and were happy with their work. He also pointed out that their rates were a lot cheaper than other organisations.

AGREED

The re-appointment of C2M as the auditors.

CORRESPONDENCE

None received.

The business of the meeting concluded at 11:40.

ROBERT McDONALD RURAL PAEDIATRICS PROGRAMME

The late Prof Robert McDonald founded the above programme in 1974 for "The propagation of Paediatrics in the more remote and underprivileged parts of South Africa, by an occasional lecture or visit by someone in the field of the care of children".

Requests for funding are invited from teams of medical practitioners and senior nursing staff to travel to remote centres and areas to promote Paediatrics and child health, and the better care of children, and to disseminate knowledge in that field, especially in underprivileged communities. This can also include visits by medical practitioners or nurses working in remote areas to larger centres or centres of excellence.

The closing dates for applications are 15 July and 15 January of each year. Guidelines pertaining to the award can be requested from Mrs Sharleen Stone, tel: +27 (31) 261 8213/8518, e-mail: stone@ukzn.ac.za

SOUTH AFRICAN SIMS FELLOWSHIP SUB-SAHARAN AFRICA

Nominations are invited from Presidents of eligible Colleges for the above fellowship. The objective of the Fellowship is to establish and maintain educational development programmes in sub-Saharan Africa.

The disciplines of medicine eligible for the South African Sims Fellowship are the same as those eligible for the Sir Arthur Sims Commonwealth Professorship, i.e. Anaesthesia, Cardiothoracic Surgery, Medicine, Neurology, Neurosurgery, Ophthalmology, Orthopaedics, Otorhinolaryngology, Paediatrics, Plastic Surgery, Surgery (General) and Urology.

The nomination must be submitted with the curriculum vitae of the nominee, a motivation from the President of the College, as above, and an outline of the proposed visit.

Further information regarding the fellowship can also be obtained from Mrs Sharleen Stone, tel: +27 (31) 261 8213/8518, e-mail: stone@ukzn.ac.za

Report Back Eponymous 2015

MTHATHA EDUCATIONAL DEVELOPMENT PROGRAMME 2016

MPS WORKSHOP SPONSORED BY SPESNET

Date: Monday 28 February 2016

Speaker/s: Speakers to follow

Venue: Mthatha Health Resource Centre Auditorium

UPDATE ON MENOPAUSE AND HEALTHY AGEING

Date: Thursday 07 April 2016 – Saturday 09 April 2016

Speaker/s: Prof Franco Guidozzi – Menopause

Second speaker to follow – Healthy Ageing

Venue: Mthatha Health Resource Centre Auditorium

UPDATE ON PSYCHIATRY AND NEUROLOGY

Date: Thursday 21 July 2016 – Saturday 23 July 2016

Speaker/s: Prof Solly Rataemane

Venue: Mthatha Health Resource Centre Auditorium

UPDATE ON ONCOLOGY AND PALLIATIVE CARE

Date: Thursday 06 October 2016 – Saturday 08 October 2016

Speaker/s: Speakers to follow

Venue: Mthatha Health Resource Centre Auditorium

AWARDS 2016

MAURICE WEINBREN AWARD 2016

Submissions received are as follows:

- Dr Joseph Kabonga
- Dr Zakariya Vawda
- Dr Jacqueline du Toit
- Dr Ewoudt van der Linde

LECTURESHIPS 2016

ARTHUR LANDAU LECTURESHIP 2016

Professor Pravin Manga will present his lecture at the Medicine Update at Nelson Mandela Medical School UKZN on the 04 September 2016.

FP FOUCHE LECTURESHIP 2016

SAOA Orthopaedic Congress 2016 will take place in September 2016 at Spier Estate Cape Town.

JN AND WLS JACOBSON LECTURESHIP 2016

Dr Jacques Janse Van Rensburg presented his lecture at the National Radiology Congress 2016.

MARGARET ORFORD MEMORIAL LECTURESHIP 2016

Professor Van der Spuy will present her lecture at the SASOG Congress that will take place on 01 May 2016 – 04 May 2016 at Sun City.

REGULATIONS 2016

Updating of syllabi and referencing is on-going and undertaken by the Education Office.

All input and changes are sent to the examinations and credentials office for changes, updates / other.

Major changes are forwarded to Senate by the Academic Registrar.

CONTINUOUS PROFESSIONAL DEVELOPMENT 2016

THE CPD LINK HAS BEEN PUBLISHED ON THE COLLEGES OF MEDICINE OF SOUTH AFRICA WEBSITE AS OF FEBRUARY 2016.

CPD SUB-COMMITTEE MEETINGS ARE RECORDED AND GOOD MINUTE KEEPING IS IN PLACE.

THE HPCSA HAS SET SPECIFIC CRITERIA REGARDING ADMINISTRATIVE INFRASTRUCTURE FOR ALL ACCREDITING BODIES TO ADHERE TO:

- Computerised database that will be used for record keeping of all CPD activities. This has been implemented.

- Accreditors will be subject to an audit of CPD accreditation processes and record keeping.

THE CMSA WILL NEED TO APPLY TO BE AN APPROVED ACCREDITED SERVICE PROVIDER

The benefit if approved, the CMSA can then approve own activities however with a different accreditation number.

Lost Members

The CMSA office in Rondebosch is keen to establish the whereabouts of the following "lost members", some of whom may be deceased. Any information that can be of assistance must please be e-mailed to Bianca van der Westhuizen at memberdata@colmedsa.co.za or Tel: 021 689 9533.

Azam, Muhammed (College of Paediatricians)

Barry, Michael Emmett (College of Family Physicians)

Benatar, Victor (College of Obstetricians and Gynaecologists)

Binnewald, Bertram Ralph Arnim (College of Plastic Surgeons)

Blair, Ronald McAllister (College of Anaesthetists)

Bleloch, John Andrew (College of Urologists)

Chatora, Tsitsi Vimbayi (College of Family Physicians)

Hirschson, Herman (College of Radiologists)

Kok, Hendrik Willem Lindley (College of Neurologists)

Kuther, Annamarie (College of Emergency Medicine)

Manicum, Brent Nolan (College of Anaesthetists)

Megafu, Onyechi Sylvester (College of Anaesthetists)

Meyer, Julius (College of Psychiatrists)

Molepo, Shirley Sejabaledi Delina (College of Anaesthetists)

Moodley, Thavendree (College of Anaesthetists)

Mphaphuli, Aripfani Veronica (College of Paediatricians)

Ndimande, Benjamin Gregory Paschalis (College of Anaesthetists)

Onyebukwa, Chukwuma Victor (College of Paediatricians)

Ospovat, Norman Theodore (College of Physicians)

Raubenheimer, Arthur Arnold (College of Obstetricians and Gynaecologists)

Segal, Dennis Selwyn (College of Family Physicians)

Van Greunen, Johannes Petrus (College of Obstetricians and Gynaecologists)

The prevalence and associations of erectile dysfunction in a South African male diabetic urban population

T Kemp[a]* and P Rheeder[a]

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Background: Erectile dysfunction (ED) is a common condition in patients with type 1 or type 2 diabetes mellitus. The prevalence and predictors in our patient population are unknown since minimal data exist for this condition in South Africa.
Method: An observational, cross-sectional study was performed on 150 consecutive male patients aged ≥ 50 years, with either type 1 or type 2 diabetes mellitus, attending the Steve Biko Academic Hospital Diabetes Clinic. These patients were evaluated for diabetes mellitus control and medical complications, and for the presence of ED. Morning serum testosterone levels were determined.
Results: Some degree of ED was reported in 95% of the patients, with 51% reporting serious dysfunction. Using multivariate logistic regression, it was determined that the significant factors associated with ED were age, body mass index, the peripheral neuropathy score and diuretic therapy. Differences in quality-of-life scores were seen in some ED subgroups.
Conclusion: This study confirms the high prevalence of ED in diabetic male patients in a tertiary setting. It is suggested that universal screening should be performed for this population group. Multiple predictors of ED were identified in this study. ED negatively affected quality of life, but not in a statistically significant way.

Keywords: cardiovascular disease, diabetes mellitus, diuretic therapy, erectile dysfunction, glycaemic control, peripheral neuropathy

Introduction

Erectile dysfunction (ED) is a common problem in men with type 1 or type 2 diabetes mellitus, but it is often missed by treating physicians.[1–3] It occurs at a younger age and with greater frequency in men with diabetes mellitus compared to non-diabetic men.[1–3] The prevalence of erectile dysfunction in the general adult population in the USA was found to be between 18% and 31%, with up to 78% of men ≥ 75 years being affected.[4,5]

A prevalence of 35% ED was found in a study as early as 1980 in patients with diabetes mellitus.[1] The prevalence of ED was found to be 49% in men aged 40–88 years in a Canadian study,[6] while severe ED was found in 30% of men in a large study in Israel.[7] A prevalence of ED of as high as 71% was also demonstrated in another study in France.[3]

In South Africa, minimal data exist in this regard. De Klerk et al. reported a prevalence of 77% of ED in users of primary care in a black and mixed race urban population in the Western Cape.[8] Diabetes mellitus was one of the significant associated diseases, with a crude odds ratio of 3.35 (p 0.001). Webb and Rheeder found some degree of ED in 88% of men with type 1 or type 2 diabetes mellitus screened for complications at primary healthcare clinics in Tshwane.[9] Thirty-six per cent of these patients had severe ED.[9]

Multiple modifiable risk factors were found to be independently associated with ED in several trials, including diabetes mellitus, obesity, current smoking and hypertension.[5,6] The prevalence of ED increased progressively with age. Other important associations were treatment with insulin or oral hypoglycaemic agents, retinopathy, and symptomatic autonomic and peripheral neuropathy.[1] The duration of diabetes mellitus, the presence of ischaemic heart disease, nephropathy and poor glycaemic control may also be associated with ED.[1]

Men with ED are also more likely to have hypertension and diabetes mellitus, or to have undiagnosed hyperglycaemia.[6,10] ED severity seems to increase with age, diabetes mellitus duration, poor glycaemic control, the presence of microvascular complications, diuretic therapy and cardiovascular disease.[7] The consumption of small amounts of alcohol and physical activity might be protective.

ED is often related to organic causes, such as vasculogenic and neurological abnormalities.[3,11] The medical therapy on which these patients are placed can also contribute to ED.[7] An underlying cause is often found after extensive evaluation in patients with ED, including conditions such as hypogonadism.[12–14] Owing to insufficient evidence, it is unclear whether routine hormonal blood tests, such as the determination of serum testosterone levels, should be undertaken in all patients with ED.[15,16]

ED and atherosclerosis share similar risk factors, such as smoking, diabetes mellitus, dyslipidaemia, hypertension and obesity. There seems to be a strong link between ED and atherosclerotic vascular disease.[6,10,17,18] Endothelial dysfunction is the common underlying factor linking ED with cardiovascular disease.[19–21] This plays an important role in the development of atherosclerosis and systemic vascular diseases, such as diabetes mellitus, hypertension, dyslipidaemia, ischaemic heart disease, strokes and claudication.[20]

The symptoms of ED probably precede cardiovascular events.[21,22] ED can be an early marker for atherosclerosis, cardiovascular risk and subclinical vascular pathology.[17,19,20,23] It can also be predictive of the presence and extent of subclinical atherosclerosis, independent of traditional risk factors.[21] The overall ED prevalence in men with coronary artery disease seems to be high.[17,22] ED prevalence in acute coronary syndrome was found to differ

according to the extent of coronary artery disease, with a higher prevalence in patients with worse atherosclerosis. Coronary atherosclerosis seems to be more severe in patients with ED.[17,23] It has also been demonstrated in several prospective studies that ED can be predictive of coronary heart disease, cardiovascular events and death in patients with diabetes mellitus specifically.[7,8,24]

Since it has been suggested that ED might be an early symptom of generalised cardiovascular disease, patients should probably be systematically screened for ED as part of periodic examination programmes.[23,25,26] This could lead to early detection and treatment of modifiable vascular risk factors, or existing vascular disease.[22,25,26]

Men with diabetes mellitus who develop ED experience a significant decline in quality of life, and an increase in depressive symptoms.[2,27] Depression is also an important factor in the development of ED in patients with diabetes mellitus. The prognosis for ED in men with diabetes mellitus is poor. It was found that only 9% of these men regained erectile function over a five-year period in one prospective study. The development of ED was also significantly associated with poor glycaemic control and the appearance of neuropathic symptoms in the intervening five years.[28]

Method

Setting

This study was performed in an academic centre (Steve Biko Academic Hospital Diabetes Clinic, University of Pretoria).This is a tertiary diabetes mellitus clinic in a state hospital. The University of Pretoria Ethics Committee approved the study (213/2011).

Subject selection

One hundred and fifty consecutive convenience sampled male patients aged ≥ 50 years, with either type 1 or type 2 diabetes mellitus, were included. This study formed part of a larger study on late-onset hypogonadism, so men aged < 50 years were not included.

Research procedures

Information was obtained from the patients themselves, their hospital and clinic files, the hospital laboratory system, and from questionnaires which the patients completed.

Demographic variables, such as age, race, smoking history and employment status pertaining to the patients were recorded.

Clinical variables, including the type of diabetes mellitus, as well as the presence of hypertension and time since diagnosis, were recorded. A previous history of stroke, myocardial infarction, amputation, foot ulcerations, cataracts, revascularisation, nephropathy or retinopathy requiring laser therapy was obtained. Blood pressure was taken, body mass index (BMI) was calculated, and waist circumference (WC) measured. The medications used by patients at the time of the study were recorded.

The Sexual Health Inventory for Men (SHIM) questionnaire was completed by the patients.[29] This is a basic five-point questionnaire on ED. Each answer is graded from 0 (no sexual activity or attempt at intercourse) to 5 (very good sexual function). The maximum score that patients could obtain was 25 and the minimum was 1. Based on the SHIM questionnaire, the patients were divided into groups:

- *Severe ED (grade 4):* 1–7.
- *Moderate ED (grade 3):* 8–11.
- *Mild to moderate ED (grade 2):* 12–16.
- *Mild ED (grade 1):* 17–21.
- *No ED (grade 0):* ≥ 22.

This questionnaire was completed by the study participants, with assistance from a trained medical professional, where needed.

A basic health-related, quality-of-life questionnaire, i.e the EuroQol (EQ-5D) health questionnaire, was completed by the patients.[30] This questionnaire evaluates five different aspects, namely mobility, self-care, usual activities, pain and discomfort, and anxiety and depression. Patients scored 0 if they had no impairment, 1 if they had moderate problems, and 2 if they had severe impairment, adding up to a maximum of 10 points.

The World Health Organisation Rose angina questionnaire was used to diagnose intermittent claudication.[31] It consists of nine questions, and based on the patients' choice (out of two possible answers), intermittent claudication was either diagnosed or ruled out. A peripheral neuropathy questionnaire, i.e the modified Neuropathy Symptom Score, was also completed.[32] This questionnaire contains five questions on the symptoms of peripheral neuropathy. Patients could answer "no" or "yes", and grade the peripheral neuropathy by answering "worse at night".

All four questionnaires were chosen for their simplicity and brevity. Although none of them were validated in a South African population, they have been used and validated in other international institutions.

Laboratory measurements

Biochemical variables included routine tests, such as a serum creatinine, serum low-density lipoprotein (LDL) cholesterol and the haemoglobin A_{1c} (HbA_{1c}) value. After the exclusion of a possible urinary tract infection with a spot urine dipstick, a spot urine specimen was collected to measure the albumin to creatinine ratio. Total testosterone was the only non-routine test that was performed.

Fasting blood tests were carried out between 7h00 and 10h00 and were immediately refrigerated. They were transported to the Dr WJH Vermaak laboratory for analysis on the same day. The laboratory-specific normal reference range at this laboratory for total testosterone in males aged ≥ 50 years is 9.9–27.8 nmol/l.

Data analysis

Data were analysed with Stata® 12.[33] Exposure between cases and non-cases was compared using appropriate tests for continuous and categorical data. Logistic regression was utilised to determine predictors of outcome with tests of calibration and validation, as required. To determine which variables to use in the multivariate model, univariate logistic regression was performed to evaluate the relationship between demographic, clinical and biochemical variables, and the different health-related questionnaires.

Variables with a *p*-value < 0.250 were entered into a multivariate model, with manual backward elimination based on the *p*-values in the model. Non-significant variables were dropped based on the *p*-value. Sensitivity, specificity, positive and negative predictive values were calculated. To determine the calibration of the final model, receiver operating characteristic (ROC) curve analysis was performed with calculation of the c-statistic. Tenfold cross-validation of the area under the ROC curve was used for validation.

Table 1: The baseline characteristics of the study patients (clinical and biochemical variables)

Variable	*n* (%)	Mean (SD)**	Median (IQR)***
Type of diabetes mellitus			
Type 1	13 (8.7)		
Type 2	137 (91.3)		
Race			
White	79 (52.7)		
Black	45 (30.0)		
Coloured	15 (10.0)		
Asian	11 (7.3)		
Co-morbidities and medical complications			
Hypertension	142 (94.7)		
Past or present cardiovascular disease*	61 (40.7)		
Proliferative diabetic retinopathy	38 (25.3)		
Peripheral neuropathy	64 (43.2)		
Intermittent claudication	10 (6.7)		
Present or past cataracts	86 (58.5)		
Microalbuminuria	72 (48.0)		
Other			
Age		62 (7.9)	
Diabetes mellitus duration (years)		15 (8.7)	
Hypertension	142 (94.7)		
Hypertension duration (years)			12 (7–22)
Systolic blood pressure (mmHg)		134 (15.5)	
Diastolic blood pressure (mmHg)		77 (9.3)	
Current smoker	24 (16.0)		
Past smoker	42 (28.0)		
Body mass index (kg/m^2)		30.7 (5.37)	
Waist circumference (cm)		112 (16.4)	
Medications			
On insulin	127 (84.7)		
On metformin	96 (64.0)		
On statin	140 (93.3)		
On diuretics	123 (82.0)		
On fibrates	22 (14.7)		
On beta blockers	68 (45.3)		
Laboratory tests			
Serum creatinine (µmol/l)			96 (79–133)
HbA_{1c} (%)			7.9 (6.8–9.3)
Serum total testosterone (nmol/l)			9.88 (7.04–14.13)
Low total testosterone (nmol/l)	75 (50.0)		
Total cholesterol (mmol/l)		4.09 (0.97)	
TGs (mmol/l)			1.90 (1.20–2.50)
HDL (mmol/l)		0.99 (0.32)	
LDL (mmol/l)		2.33 (0.70)	

Note: HbA_{1c}: haemoglobin A_{1c}, HDL: high-density lipoprotein, IQR: interquartile range, LDL: low-density lipoprotein, SD: standard deviation, TGs: triglycerides
*:Cardiovascular disease defined as any of the following: previous myocardial infarction; typical angina; ECG evidence of past myocardial infarction; angiographic or MIBI or stress ECG evidence of ischaemic heart disease
**:SD = Standard deviation
***:IQR = Interquartile range

Table 2: The prevalence of erectile dysfunction

Erectile dysfunction (grades)*	*n* (%)
Grade 0	7 (4.7)
Grade 1	17 (11.3)
Grade 2	28 (18.7)
Grade 3	21 (14.0)
Grade 4	77 (51.3)
Total	**150 (100.0)**

*:According to the Sexual Health Inventory for Men questionnaire, a total score of 22–25 meant no erectile dysfunction (grade 0); 17–21, mild erectile dysfunction (grade 1); 12–16, mild to moderate erectile dysfunction (grade 2); 8–11, moderate erectile dysfunction (grade 3); and 1–7, severe erectile dysfunction (grade 4)

Results

Ninety-one per cent of the patients had type 2 diabetes mellitus. The mean age was 62 years [standard deviation (SD) 7.9]. Just over half of the patients were white (53%) and 30% were black. The mean duration of diabetes mellitus was 15 years (SD 8.7). Ninety-five per cent of the patients were previously diagnosed with hypertension, but this was relatively well controlled, with a mean systolic blood pressure (SBP) of 134 mmHg (SD 15.5) and mean diastolic blood pressure of 77 mmHg (SD 9.3). The patients were obese, with a mean BMI of 30.7 kg/m^2 (SD 5.4), and a mean WC of 112 cm (SD 16.4). Sixty-six per cent of the patients were current (24%) or past (42%) smokers.

The median serum creatinine was 96 µmol/l [interquartile range (IQR) 79–133]. The patients' diabetes mellitus was better controlled

Table 3: Total testosterone in the different erectile dysfunction categories

Erectile dysfunction	Normal total testosterone*	Low total testosterone**	Total (%)
	n (%)	*n* (%)	*n* (%)
Grade 0	3 (42.7)	4 (57.1)	7 (100.0)
Grade 1	11 (64.7)	6 (35.3)	17 (100.0)
Grade 2	10 (35.7)	18 (64.3)	28 (100.0)
Grade 3	12 (57.1)	9 (42.9)	21 (100.0)
Grade 4	39 (50.7)	38 (49.4)	77 (100.0)
Total	**75 (50.0)**	**75 (50.0)**	**150 (100.0)**

*:Normal total testosterone: 9.9–27.8 nmol/l
**:Low total testosterone: < 9.9 nmol/l

Table 4: Summary of univariate analysis of multiple statistically significant variables with erectile dysfunction (grade 0–2 versus grade 3–4 erectile dysfunction)

Variable	ED grades 0–2	ED grades 3–4	*p*-value
Age [mean (SD)]	59 (6.6)	64 (8.0)	< 0.001
Race			
White, *n* (%)	21 (40.4)	58 (59.2)	0.033
Black, *n* (%)	16 (30.8)	29 (29.6)	
Coloured, *n* (%)	8 (15.4)	7 (7.1)	
Asian, *n* (%)	7 (13.5)	4 (4.1)	
Smoker			
Never, *n* (%)	30 (57.7)	54 (55.1)	0.026
Current, *n* (%)	13 (25)	11 (11.2)	
Past, *n* (%)	9 (17.3)	33(33.7)	
Systolic blood pressure [mean (SD)]	130 (14.7)	136 (15.6)	0.034
Body mass index [mean (SD)]	29 (5.0)	31.6 (5.4)	0.006
Waist circumference [mean (SD)]	108 (15.7)	115 (16.4)	0.021
Serum creatinine [median (IQR)]	85 (76–106)	99 (83–146)	0.008
Peripheral neuropathy score [mean (SD)]	1.9 (2.2)	3.3 (3.0)	0.005
On a diuretic, *n* (%)	33 (63.5)	90 (91.8)	< 0.001

Note: ED: erectile dysfunction, IQR: interquartile range, SD: standard deviation

Table 5: Multivariate associations for erectile dysfunction (grades 0–2 versus grades 3–4)

Associations	OR	SE	95% CI (lower limit)	95% CI (upper limit)	*p*-value
Age	1.11	0.03	1.05	1.17	< 0.001
Body mass index	1.09	0.05	1.00	1.18	0.050
Peripheral neuropathy score	1.22	0.10	1.04	1.45	0.018
On diuretics	5.26	2.75	1.89	14.68	0.002

Note: CI: confidence interval, OR: odds ratio, SE: standard error

Table 6: Summary of the tenfold cross-validation of the area under the receiver operating characteristic curve

Model	Tenfold cross-validation	ROC area	SE	95% CI	
				Lower limit	Upper limit
ED	Before	0.770	0.041	0.690	0.850
	After	0.720	0.045	0.632	0.807

Note: CI: confidence interval, ED: erectile dysfunction, ROC: receiver operating characteristic SE: standard error

Table 7: Erectile dysfunction and quality-of-life score (EQ-5D]

Erectile dysfunction category	*n*	Quality-of-life score		
		Median*	Interquartile range	
			25th Percentile	75th Percentile
Grades 0–1	24	1	0	2
Grades 2–3	49	1	0	3
Grade 4	77	2	0	3

Note: EQ-5D: EuroQol
*Kruskal-Wallis test: $p < 0.0513$

than expected, with a median HbA_{1c} of 7.9% (IQR 6.8–9.3). The mean LDL was above target at 2.33 mmol/l (SD 0.7). The median triglycerides was 1.90 mmol/l (IQR 1.20–2.50). The median serum total testosterone was 9.88 nmol/l (IQR 7.04–14.13).

The baseline characteristics of patients' therapy and their diabetic complications are shown in Table 1. Forty-one per cent of patients were known to have cardiovascular disease, and less than 7% had intermittent claudication, as defined by the Rose questionnaire. Microvascular complications were common. Symptoms of significant peripheral neuropathy were present in 43% of the study population, microalbuminuria in 48% of patients, and proliferative diabetic retinopathy in 25%. Fifty-nine per cent of the study participants had cataracts at some point.

Eighty-five per cent of the patients had to be managed on insulin therapy. Metformin was prescribed to 64% of them. Statin usage was high at 93%, but fibrate use was low at 15%. Diuretics were prescribed to 82% of the study population, and 45% of the patients were on beta blockers.

The prevalence of erectile dysfunction

The prevalence of ED is shown in Table 2. Less than 5% of patients had no ED (grade 0), and 51% of patients had severe ED (grade 4). Forty-four per cent had milder degrees of ED.

Total testosterone levels in patients with erectile dysfunction

The distribution of low and normal total testosterone in the different ED categories is demonstrated in Table 3. The Fisher's exact result of 0.369 was non-significant ($p > 0.05$), which implied that there was no association in this study between the two variables of total testosterone and ED.

Associations of erectile dysfunction

The statistically significant univariate associations of ED are summarised in Table 4. These variables were age, race, smoking status, SBP, BMI, WC, serum creatinine, the peripheral neuropathy score and diuretic usage. To simplify the statistical analysis, and because of the low numbers in some of the ED categories, ED was regrouped into two groups, i.e grades 0–2 and grades 3– 4, and then compared.

Age, BMI, the peripheral neuropathy score and diuretic therapy were significant multivariate associations of ED (grades 0–2 versus grades 3–4) (Table 5).

The area under the ROC curve was 0.797 for this model in predicting ED. The sensitivity was 90%, the specificity was 55%, the positive predictive value was 80%, the negative predictive value was 73%, and 78% was correctly classified. Table 6 summarises the the tenfold cross-validation of the area under the ROC curve.

Erectile dysfunction and quality of life

When ED was regrouped into three categories to ensure adequate numbers in each group, i.e. grades 0–1, grades 2–3, or grade 4, an association was demonstrated with quality of life, especially between the grades 0–1 and grade 4 ED groups. This test approached, but did not reach, statistical significance. (Table 7)

Although the EQ-5D has not been validated in a South African population, the Cronbach's alpha reliability coefficient internal consistency was 0.7610, which meant that it was acceptable to use in our setting.

Discussion

ED was found in 95% of this group of patients with type 1 and type 2 diabetes mellitus. Fifty-one per cent reported serious ED. The prevalence in our study was higher than that described in the literature.[1,3,4,6–9] This may be because of patients' advanced medical complications, co-morbid diseases and numerous drug therapies.[34,35] There was also an exceptionally high number of current or ex-smokers (44%) in our patient population. The higher prevalence in this study could also be explained by the exclusion of younger patients with diabetes mellitus, compared to other studies.[1–3]

Univariate associations were age, race, smoking status, SBP, BMI, WC, serum creatinine, the peripheral neuropathy score and diuretic therapy. After multivariate logistic regression, remaining significant factors were age, BMI, the peripheral neuropathy score and diuretic therapy. Statistically significant associations with ED were not demonstrated with other drug classes, such as beta

blockers and fibrates. Predictors of ED were very similar to those reported in the literature.[1,5–7,10]

Using these variables in a model to predict ED, the area under the ROC curve was 0.797, which implied good discrimination. This model performed well on most of the statistical measures. Although the specificity was poor at 55%, the sensitivity was 90%, which means that this model could be used for screening for this condition. Seventy-eight per cent of cases were correctly classified.

Distinct and independent sets of observations are used in cross-validation to estimate the model and to evaluate prediction error. The estimate of the area under the ROC curve for the aforementioned model was larger than the cross-validated estimate. However, the difference was relatively small, suggesting the absence of over-fitting in the logistic model for ED. It could be expected that the area under the ROC curve would probably not be much higher than 0.80 in a new group of patients.

The testosterone levels did not differ significantly between the different ED groups. The different ED subgroups differed regarding quality of life, and this nearly reached statistical significance. This difference in quality of life was especially demonstrated between the grades 0–1 and grade 4 ED groups. Poorer quality of life was experienced by the latter group. ED's negative effect on quality of life has been described in the literature.[2]

There were several limitations to this study. It was conducted in a tertiary outpatient diabetes mellitus clinic, where most of the patients had medical complications and numerous co-morbid conditions. Therefore, the results cannot be generalised to the majority of diabetes mellitus patients who follow-up at primary healthcare facilities. The number of patients with type 1 diabetes mellitus is small, and should probably be studied separately. The pathogenesis may be different, with some overlapping factors.

By enrolling 150 consecutive patients in the study, selection bias was to some degree minimised, but not entirely eliminated. A limited number of Asian and mixed ancestry patients were included, which would make the results more difficult to interpret in these population groups. Some of the information was subjectively obtained from patients without outside corroboration, such as a history of ischaemic heart disease. Owing to the use of multiple examiners with different levels of expertise, only proliferative diabetic retinopathy (either objectively observed, documented in the ophthalmology notes, or based on a history of laser therapy or haemorrhage by the patients) was reported.

Performing a repeat confirmatory testosterone level test, a serum albumin test to calculate the bioavailable testosterone, or a serum luteinising hormone (LH) test to distinguish primary from secondary hypogonadism was not possible because of funding issues. Patients with low testosterone levels were referred to their relevant doctor for further workup, which would have included a serum LH level test, and further relevant investigations, dependent on that result. The questionnaires were also selected for their simplicity and brevity, not necessarily because of superior accuracy, owing to time constraints.

ED is associated with cardiovascular disease, as described in the literature.[6,10,17,18] It is uncertain how many of the patients in our study with ED had subclinical cardiovascular disease, and if they should have been screened for cardiovascular disease.

Testosterone therapy may be useful for improving vasculogenic ED in men with low or low to normal testosterone levels, especially with serum testosterone levels below 12 nmol/l.[36] It can moderately improve the number of nocturnal erections, sexual thoughts, number of occasions of successful intercourse and erectile function, but it has no effect on erectile function in eugonadal men.[36] This effect tends to decline over time, and the risks and benefits, as well as long-term safety data, are not available, especially regarding prostatic disease and cardiovascular health.[36,37]

While effective therapies are not available in the South African public health sector, the prevention of ED is important. A period of intensive glycaemic therapy significantly reduced the prevalence of ED 10 years later in men with type 1 diabetes mellitus who had some target organ damage at baseline in the Diabetes Control and Complications Trial.[38] The risk of ED was directly associated with mean HbA_{1c} during the trial duration.

Conclusion

This study confirmed the high prevalence of ED in a tertiary diabetic clinic setting, and that it may negatively affect quality of life. The high prevalence of ED should prompt all male patients aged ≥ 50 years with diabetes mellitus to be screened at tertiary clinics for this condition. Moreover, the clear association that is well described in the literature between ED and cardiovascular disease should prompt the screening of patients with ED for ischaemic heart disease.

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