Still dancing to the tune of the invisible piper: Failures in the PMTCT programme are costly

In the current economic climate, with cost-containment being key, the World Health Organization (WHO) recommends that resource allocation be guided by the three principles: efficiency (to maximise population health), fairness (to minimise the health differences) and utility (to provide the greatest good for the greatest number).[1] It is well-known that the paediatric intensive care unit (PICU) environment is highly costly and ethically challenging, particularly in the resource-constrained environment.

The original paper by Jeena PM *et al.*[2] addresses this very important area in the management of critically ill children with lower respiratory tract infections, who are admitted to PICU. They explored the impact of antiretroviral treatment (ART) and cytomegalovirus (CMV) infection on children requiring respiratory support. Interestingly, 19% of children were HIV-positive and of these, half had CMV co-infection. CMV infection was associated with a higher need for high-frequency oscillation, which in their study was used as rescue therapy for those with more severe acute respiratory distress syndrome. The mean duration prior to commencement of ganciclovir was 4 days after confirmation of a positive CMV viral load. This duration, however, did not impact the survival. The differences in survival rates between the groups (HIV-positive and -negative and -exposed), were not statistically significant. This could perhaps partly be explained by the fact that 42% of HIV-positive children were already on ART prior to admission, although the viral loads reported were still high. They also elegantly showed that a combination of high frequency oscillatory ventilation (HFOV), ganciclovir and ART improved survival rates to 90%. Although these are excellent results and a far cry from the dismal survival rates in the early 2000s, HFOV availability is still limited to tertiary centres in South Africa.[3,4]

Therefore, as the authors propose, we should possibly be more concerned that almost 60% of children in this study had no prevention of mother-to-child transmission (PMTCT) measures in place. Preventive measures would logically be more cost-effective and prevent long-term morbidity, which may be associated with being a PICU graduate. As critical care specialists, we need to stop dancing to the tune of the invisible piper, and assume our role in advocating for PMTCT.

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