



but responsible for the everyday running of both the temporal and religious affairs of the community based on the teachings of the Quran, which is still available today in its original form. It provides guidance for all Muslims.

M A K Omar, *Durban*

G M Hoosen, *Durban*

M Tikly, *Durban*

S Wadee, *Cape Town*

M Solwa, *Durban*

H Tayob, *Johannesburg*

PO Box 701063

Overport

4067

1. Ncayiyana DJ. What Islam does not need is a pope! (Editorial). *S Afr Med J* 2004; 94: 385.

Cancer and the prediction of death by oncologists

To the Editor: The diagnosis that one has cancer comes as a great shock. Many people immediately accept it as a death sentence, while a few resolve to fight the disease. On top of this

traumatic situation, oncologists predict the death of the patient when their treatment fails.

When my late wife was diagnosed with cancer of the ovaries, both she and I went into shock. I urged her not to take the diagnosis as a death sentence. The first thing the oncologist asked us to do was to have an interview with the counsellor at the oncology department. One visit was all we could take. She started off by saying that people with cancer are lucky because cancer is a slow-developing disease and that it gives one time to prepare for death. That is not what we wanted to hear. We wanted to be given hope for life, not a lecture on how to prepare for death! The treatment my wife received was not successful. Instead of keeping the hope of life alive in her, the oncologist asked her to prepare for death within a month or two. My wife was devastated by the news. Once again we went to the counsellor who immediately started to prepare for the funeral. She contacted the hospice, and advised us on funeral undertakers. The very people to whom we turned to keep our hope alive wanted my wife dead. That is what their advice amounted to.

She gave up on life and almost fulfilled the oncologist's prediction. Fortunately we changed doctors. Our new doctor encouraged her to live and did everything possible to



strengthen her will to live. On our very first consultation he said 'Out there is somebody who has been cured of cancer of the ovaries. If somebody could be cured why not you also?' What a boost it was for her spirit.

I know of many cancer patients who died within the time specified by oncologists. Their predictions became reality for their patients.

Patients go to an oncologist for treatment in the hope of beating the disease so that they can live longer. Rather than keeping the hope of a patient alive, oncologists seem to be over-zealous to kill them off with their predictions of death.

F G Backman

26 Avenue D'Hermet
Glenhaven
Bellville, 7530

Straight thinking about the aetiology of endemic cancer of the oesophagus

To the Editor: Despite decades of research, no carcinogen has yet been identified as the cause of endemic squamous cancer of the oesophagus (SCO), yet there is still a view current that endemic SCO in South Africa may be caused by a single potent carcinogen. Logic does not support this view.

Smoking has been identified as having a very strong association with SCO in endemic areas.^{1,2} Tobacco has a proven association with SCO in non-endemic situations also. It is therefore extremely unlikely that its association with endemic disease is spurious. Tobacco is a proven carcinogen. It is therefore logical to assume that its action in promotion of SCO is as a carcinogen.

Conclusion: tobacco is a significant carcinogen for endemic SCO.

Tobacco may act as a carcinogen for the majority of those who have SCO, but it cannot be involved for the significant

minority of approximately 30% who do not smoke, 19% of whom have never smoked.^{1,2} After excluding all patients who smoke, the remaining number who have SCO in endemic areas and who do not smoke would still provide a grossly elevated prevalence of the disease.

Conclusion: in addition to tobacco, there is another carcinogen or other carcinogens at work.

Although the white population of South Africa smokes more than the black population it does not have the same incidence of SCO. Two possibilities exist. The white population may be protected from the effects of tobacco. This idea is unlikely enough to be eliminated — the incidence for whites in South Africa is as for similar population groups in Europe and North America. The alternative explanation is that the black population is predisposed to the effects of tobacco or is exposed to co-carcinogens that work with tobacco and other carcinogen(s).

Conclusion: the affected population is predisposed to the action of tobacco as a carcinogen, or is exposed to co-carcinogen(s) that can work with tobacco.

The presence of a single powerful carcinogen acting on its own as the cause of endemic SCO is not a credible possibility.

The molecular and genetic background to the disease, the focus of much research at the moment, may well reflect only the end stage of the disease and may not furnish tools for prevention.

Effort should therefore be directed to pursuing the two remaining possibilities — predisposition and co-carcinogenesis.

Alastair Sammon

Jehu Iputo

Department of Physiology
University of the Transkei
Umtata

1. Van Rensburg SJ, Bradshaw ES, Bradshaw D, Rose EF. Oesophageal cancer in Zulu men, South Africa: A case-control study. *Br J Cancer* 1985; **51**: 339-405.
2. Sammon AM. A case-control study of diet and social factors in cancer of the oesophagus in Transkei. *Cancer* 1992; **69**: 860-865.