

brain and oral cavity. This has led to their widespread use in evidence-based patient management. Radiation oncologists in SA, as elsewhere, will seek to participate in clinical research based on these and other novel approaches.

Raymond Abratt

*Radiation Oncology
Groote Schuur Hospital and University of Cape Town
raymond.abratt@uct.ac.za*

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Neutron radiotherapy: Society comments

To the Editor: The radiation oncology community in South Africa can no longer support the continuation of neutron therapy. The lack of new phase III data to support this treatment modality and the fact that patients numbers never really materialised resulted in very inefficient utilisation of available resources that could have been better spent. Progress in clinical and radiation oncology during the past 20 years with new technologies readily available in this country resulted in even fewer reasons to continue this programme. The logistics involved in trying to utilise this as a national resource – which would be the same if one were to try and argue for this to be used as a resource for the continent of Africa – would result in even less benefit to society as a whole.

South Africa can no longer afford to fund such programmes given the many competing priorities in oncology and health in general. To do so would border on being socially irresponsible.

Samuel Fourie

*Chairman of the South African Society of Clinical and Radiation Oncology
sfourie@sascro.org*

Raymond Abratt

Michiel Botha

Robbie De Muellenaere

Leon Gouws

Greg Hart

Amo Jordaan

Waldek Szpak

Committee members: South African Society of Clinical and Radiation Oncology

Neutron radiotherapy: Abratt supported

To the Editor: We write, with some unease, given that much of this matter is internal to the medical affairs of South Africa (SA), to lend support to the stance of Prof Abratt,^{1,2} regarding closure of the neutron facility in SA.

We recognise clearly the limitations of participating in this debate when we are not South African and do not practise medicine in the African continent. That said, there are points of illogic in the criticisms of Prof Abratt's stand that must be challenged.

Firstly, the rhetoric supporting the purported importance of recent research on neutron therapy, and the charge that Prof Abratt's

view of neutron therapy is outdated, are simply unreasonable. The whole issue of the utility of neutron therapy remains highly controversial internationally after more than 25 years of research and clinical practice. The issues remain unchanged: lack of proven benefit, narrow spectrum of clinical indications, offset by excessive toxicity demonstrated in the majority of published studies. While we recognise the difficulty of completing randomised clinical trials in this setting, it is important to note the absence of high-quality data to support this expensive technology.

Despite the claims of the proponents of such research on the topic of neutron therapy, we note a paucity of well-structured published research on the role of this treatment modality. It appears that the majority of use of available equipment has been for routine clinical practice, despite the absence of significant, recent published data to support such therapy; one might have hoped that investigational equipment might have been used to produce new data.

Perhaps of more importance, in a continent that is challenged by a shortage of costly medical resources, it seems importune to make a case for maintenance of an expensive, controversial, unproven therapy with so few indications, and to criticise an earnest and honest attempt to bring reason to the debate. We support Prof Abratt's view, based on logic, fiscal pragmatism, and recognise his presence as a leader in academic radiation oncology with several decades of carefully structured published data.

Derek Raghavan

*Levine Cancer Institute, Carolinas HealthCare System
Charlotte, NC, USA*

Michael Steinberg

*Radiation Oncology, David Geffen School of Medicine
UCLA, USA*

Howard Sandler

*Radiation Oncology, Cedars-Sinai Medical Center
Los Angeles, CA, USA*

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Traumatic rhabdomyolysis (crush syndrome) in the rural setting

To the Editor: I read with interest the article entitled "Traumatic rhabdomyolysis (crush syndrome) in the rural setting."¹ Crush syndrome from sjambok injury is a uniquely southern African experience.² It is unfortunately commonplace, making treatment guidelines essential to prevent the progression of acute kidney injury (AKI) and subsequent need for renal replacement therapy. The advent of the RIFLE and AKIN criteria in the description and risk stratification of AKI provides a framework from which strategies to prevent ongoing injury can be implemented.³ Their use has become commonplace in critical care and should be implemented in the emergency department.

Careful monitoring of fluid balance is essential, and a paper discussing the ATN and RENAL trial results shows that avoiding a positive fluid balance improves renal recovery times.⁴ Therefore I urge caution in trying to force a diuresis with resuscitation fluids if patients present with anuria/oliguria and do not respond to initial fluid therapy as they can be pushed into fluid overload with subsequent need for ventilatory support.

Alkalinisation of the urine with bicarbonate has been challenged as the standard of care. Evidence for this practice is weak; in 2 083 trauma ICU admissions, Velmahos' group failed to show improvement in outcomes despite urinary alkalinisation.⁵