

## LETTERS ♦ BRIEWE

Can we afford to call stating the truth as a first step to changing man's behaviour impractical idealism? Does sex education in this country promote anything to do with the restoration of God's order for sexual relationships (sex is in fact the smallest part of this huge and important subject) or is it just symptomatic in its treatment, promoting premarital or extramarital sex indirectly, through its focus on 'safer sex' and the prevention of pregnancy? You can hardly call playing Russian roulette practical.

No progress in halting the AIDS epidemic is likely

until we are prepared to recognise the need for the restoration of God's order for sexual relationships as laid down in the Bible. AIDS would be wiped off the face of the earth if we all followed these rules. If the truth is never said, it leaves us with no real hope, only delusions.

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## Botshabelo's vaccination survey

**To the Editor:** We wish to comment on the article by De Montigny *et al.*<sup>1</sup> Although we fully agree that vaccination coverage in Botshabelo needs urgent attention, we are perturbed that the authors specify under 'Methods' that the most disadvantaged sections of the community were selected for inclusion in the survey, whereas the title and summary imply a survey of the entire township. (In the summary the sample is referred to as 'a randomly selected sample of a black South African township'.) Surely by selecting the worst sectors the results can only reflect those sectors and not the entire township?

In December 1989 (4 months after the study conducted by De Montigny *et al.*), the community health services section of the Botshabelo health services conducted an immunisation coverage survey in Botshabelo as part of the urban Orange Free State pre-immunisation campaign baseline study. The survey (of children aged 12 - 23 months) consisted of a random Expanded Program for Immunization cluster sample (30 clusters of 7 children each). The results (Table I) reflect the vaccination coverage of Botshabelo. From De Montigny's article it is not clear what is referred to as fully vaccinated. Our definition was that all state-recommended vaccinations should have been given at state-recommended intervals. This definition led to an estimate of 31,8% compared with the 19% of De Montigny *et al.*

A mass immunisation campaign was launched in the OFS between January 1990 and July 1991. A follow-up immunisation coverage survey consisting of 120 urban and 120 rural clusters of 7 children each was done throughout the OFS in July - September 1991. Botshabelo contributed 21 clusters of the urban survey. The results of this sample are presented in the last column of Table I, which indicates that there was some improvement in immunisation coverage, but the level still leaves much to be desired. The percentage of children considered fully vaccinated because they had received all vaccinations at the state-recommen-

**TABLE I.**  
Immunisation coverage in Botshabelo

	De Montigny's survey (N = 99)	PAO/UOFS survey, 1989 (N = 211)	PAO/UOFS survey, 1991 (N = 143)
Immunisation card (%)	72,7	82,0	90,9
BCG*	72,7	78,2	86,0
Polio 1*	57,6	62,1	79,0
Polio 2*	43,4	51,7	72,7
Polio 3*	31,3	42,7	65,0
Measles*	30,3	40,3	55,6

\* Expressed as a percentage of all children studied, children without vaccination card taken to be not immunised.

PAO = Provincial Administration of the Orange Free State; UOFS = University of the Orange Free State.

ded intervals is now 42,0%, compared with 54,5% if fully vaccinated is taken to mean having received all vaccinations, regardless of the appropriateness of the timing.

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1. De Montigny S, Ferrinho P de L GM, Barron PM, Lozat R, Gear JSS. Botshabelo's vaccination survey. *S Afr Med J* 1991; 80: 582-584.

Both surveys reflect very low immunisation results, and even after a mass immunisation campaign was conducted, the measles immunisation rate of 55,6% was unacceptably low. What Botshabelo needs is a strengthening of primary health care services to ensure that immunisation services are available and accessible to all who need them.

## Chemotherapy, medical oncology and nomenclature

**To the Editor:** Recent letters in the *SAMJ* touch on several very important issues. Booyens openly thinks chemotherapy is quackery, but Smit,<sup>1</sup> Anderson<sup>2</sup> and Jordaan<sup>3</sup> pointed out that not *all* chemotherapy is as bad as Booyens<sup>4</sup> would have it. The impression of quackery in chemotherapy circles is strengthened by the nomenclature developed by medical oncologists. 'Complete response

rate' may perhaps reflect the clinical situation better if described as 'apparent disappearance of tumour' (ADT), with a qualifier to reflect the mean duration and in what percentage of patients the disappearance was observed. Thus ADT<sub>4/20</sub> will indicate to the reader that the tumour apparently disappeared for a median duration of 4 months in 20% of the patients. 'Partial responses rate' would have



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much more meaning if defined as 'marginal effect' (ME), and, as above,  $ME_{2/20}$  will mean some effect for a median of 2 months in 20% of patients. Scientific propriety would dictate that 'non-responders' be seen for what they are — those in whom there has been *complete failure* (CF) of treatment —  $CF_{60}$  will therefore indicate that in the above example 60% of the patients had no benefit and may have suffered detriment. The 'overall response rate' has little meaning if the ADT, ME and CF are not defined. Treatment-related mortality (TRM) should be expressed as a percentage of the number of patients receiving the particular treatment. This may be sobering, since the TRM can reach what are to me alarming proportions. 'Informed consent' should perhaps be replaced by consent after talking to the friend of the patient — a non-involved medic from another discipline who studied the clinical research plan (CRP). (Is CRP not better than 'protocol'?) 'Regimen', or worse, 'regime', could sensibly be replaced with 'schedule'. This will tend to highlight the TRMs better — the regal 'regime' seems to sanction toxicity and mortality due to the treatment, or to mesmerise the reader. What about a regular IOS (index of suffering) rather than QOL (quality of life) index?

Vorobiof<sup>5</sup> in his latest letter suggests that the problems identified by Booyens lie with professionals not qualified to give chemotherapy. He includes in this category radiotherapists, surgeons and general practitioners. I disagree strongly with this point of view.

'Cookbook chemotherapy', i.e. chemotherapy given according to well-proven recipes ('regimes') such as MOPP (and variations), BACOP, CYVADIC, CMF, etc., is well within the scope of the average medical officer under supervision in 'radiotherapy' departments. Radiotherapists are well versed in the basics of chemotherapy, which is part of their postgraduate training. Radiotherapists also know that a partial disappearance of a tumour is a complete failure in most instances, and prefer

to express results in terms of survival! With manpower shortages getting worse in academic hospitals, it makes sense to utilise radiotherapy staff to give the routine chemotherapy plus that of clinical trials based on standard effective schedules. It makes much more sense to train medical oncologists to work in one or two national units exclusively designed for *very intensive chemotherapy*, for example leukaemia and lymphoma where bone marrow grafting is needed, or where there is co-operation with Ph.D.s in well-equipped laboratories pursuing real experimental work on the lunatic fringe. Routine chemotherapy in paediatric patients with cancer is probably best left to the paediatricians, and should not be the domain of medical oncologists who are not paediatricians. Finally, it is questionable whether medical oncologists should be in private practice, unless they are restricted to give chemotherapy for the few acknowledged indications not requiring the back-up of one or two specialist academic units for intensive and experimental chemotherapy. To give chemotherapy in private practice to non-small-cell lung cancer, cancer of the pancreas or primary cancer of the liver, to name a few, will not be easy to justify.

It is just possible that Booyens catalysed a necessary discussion.

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1. Smit BJ. Can cancer be beaten? (Reply to letter). *S Afr Med J* 1991; **80**: 463.
2. Anderson JD. Can cancer be beaten? (Reply to letter). *S Afr Med J* 1991; **80**: 108.
3. Jordaan A. Can cancer be beaten? *S Afr Med J* 1992; **81**: 229.
4. Booyens J. Can cancer be beaten? (Letter). *S Afr Med J* 1992; **81**: 228-229.
5. Vorobiof DA. Can cancer be beaten? *S Afr Med J* 1992; **81**: 228.

**Thank you — words too easily forgotten**

**To the Editor:** It was the eminent American philosopher William James who once said: 'The deepest principle in human nature is the craving to be appreciated.'

The state of health care in South Africa is in crisis and the morale of persons involved at all levels remains low. Is it not time that we all went on an inward journey of self-examination of our daily interactions and relationships with everyone involved in the medical profession? While performing my daily duties as student intern I cannot help but notice the servants of the medical profession, who despite performing outstanding work in the most trying circumstances are not getting the gratitude they deserve. We all speak of improved finances and socio-economic upliftment as being the keys to improving the current difficulties we face. I say to you that unless we all start showing a little appreciation and gratitude to those around us, the reversal of the abovementioned factors will not appease the hearts of those many individuals who are running at an emotional low.

Stop and take time to think — when was the last time you thanked someone for something they did for you, or rewarded a job well done with a handshake and a warm smile? There are individuals out there crying out for us to show them that we really care. If we could only recognise and treat the soul void of appreciation as easily as we do the common diseases, then we could really call ourselves doctors.

Storm Jameson once said: 'It is an illusion to think that more comfort means more happiness. Happiness comes of the capacity to feel deeply, to think freely, to be needed.' If this letter has stimulated you to explore your current attitudes towards and relationships with others in the profession, it will have served its purpose.

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