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mortality rates and fluoride concentrations were averaged over magisterial districts. For all permutations of sex, race and cause no significant correlation ($P < 0,05$) with a non-zero slope was found between the SMRs of the various carcinomas and fluoride concentration.

The negative finding for South Africa is in accordance with the general conclusions of both the British¹ and the US² governments' reviews of the epidemiological evidence on the lack of a relation between fluoridation of water and cancer.

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Screening for breast cancer in South Africa

To the Editor: Dr Said's efforts to form a multidisciplinary breast society¹ should be supported by all breast cancer specialists. Breast cancer causes 1 - 3% of all deaths in women in developing countries, only slightly less than the 3 - 5% in developed countries.² According to available estimates 3,1% of South African women will develop breast cancer (1,8% of black, 3,3% of coloured and 6,3% of white women).³

From 1987 to 1992, 1 927 postoperative or untreated female breast cancer patients presented to the Breast Clinic at Groote Schuur Hospital; 34% had stage 3 or 4 disease (73% of black, 38% of coloured and 23% of white women). The overall 5-year mortality rates in the three groups in patients followed up for 5 years were 52%, 34% and 31% respectively. If our figures are representative of the country as a whole, roughly 1% of black and coloured women and a higher proportion of white women will die of breast cancer.

Professor Stjernsward⁴ of the World Health Organisation has recommended that to reduce mortality from breast cancer resources should be used to decrease the advanced disease pool and increase the early stage pool, rather than to investigate the treatment of advanced disease. Lack of medical facilities must be a major cause of delay in diagnosis. Patients may initially seek help from tribal healers and may refuse conventional Western treatment.⁵ Education is essential but cannot take the place of mammographic screening for those women whose medical needs have been neglected in previous health budgets.

Screening is reported to reduce breast cancer mortality by 25 - 40%.^{6,7} A screening programme for medically under-served women in Florida (where a similar proportion of black women presented with advanced disease as in Cape Town) produced an estimated 50% decrease in mortality and a significant decrease in costs.⁸

The calculated cost per year of life gained from screening for breast cancer in the USA varies greatly but appears to be comparable to costs per quality-adjusted life year gained from haemodialysis for end-stage renal disease, bone marrow transplantation for acute leukaemia and the treatment of three-vessel coronary artery disease and of hypertension.⁹ All these conditions are treated in South Africa. The question is whether we can justify the unavailability of a screening programme for breast cancer much longer. More patients are likely to demand screening and a national programme is essential for quality control.

All women are at risk of breast cancer. Early detection is the only way of reducing mortality from this disease at pre-

sent. Urgent attention should be paid to education in underprivileged groups, but at the same time we should investigate the development of a screening programme, since this must be our ultimate aim.

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Nutritional composition of South African eggs

To the Editor: We congratulate Van Niekerk and Van Heerden on their excellent study on the nutritional composition of South African eggs,¹ in which they show that the cholesterol content of South African eggs is 23,5% lower than the values listed in the *NRIND Food Composition Tables*. The article raises a number of important issues that should be addressed.

Food composition tables and databases are used extensively by, among others, epidemiologists, government agencies for planning national nutritional policy, the food industry, hospitals, and other institutions for menu planning. The goal of all these users is to work with reliable nutrient data. Undoubtedly the compilation of the *NRIND Food Composition Tables* was an important milestone in the field of nutrition in this country. However, because of the lack of local information, the tables are unfortunately based, by and large, on American and English data.² The practice of developers of food composition tables to 'borrow from each other' is not unique to South Africa, and is necessitated by insufficient information on nutrient analysis of locally produced foods. Nevertheless, it is often insufficiently appreciated that this limitation, together with those of differences in agricultural practices, soil composition, food processing, preparation methods and dietary methodology,³ make food composition tables guidelines at the very best. Certainly, nutritional status assessment by dietary data alone should be seen as very limiting. This publication highlights the urgent need for nutrient analysis data on the most commonly consumed foods in South Africa, and for those nutrients that are associated with the biggest health problems.

Although a reduction in the cholesterol content of eggs due to *improved analytical techniques* (as suggested by the authors¹) does not necessarily warrant a revision of dietary guidelines, the appropriateness of present guidelines regarding cholesterol intake should nevertheless be urgently updated. Of all the dietary factors believed to be linked with the incidence of coronary heart disease, cholesterol intake *per se* has the weakest evidence, the majority of people showing little or no benefit from a reduction in cholesterol intake.^{4,5} The 'prudent diet', which is advocated so widely, must therefore be seen in the correct perspective in relation to egg intake. While moderation is of paramount importance and should be encouraged strongly,⁶ one must question the appropriateness and relevance of restricting the

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intake of good, wholesome, and relatively cheap food — especially in the low socio-economic segments of the population — on account of cholesterol content.

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To the Editor: The authors of the article on the nutritional composition of eggs¹ unfortunately compared their values to those used in the 2nd revision (1986) of the *NRIND Food Composition Tables*.² American values were used in these tables owing to a lack of South African data.

These tables were, however, updated at the end of 1991, and the South African values, which were kindly made available by the Egg Board, were published in the 3rd revision of the tables.³ This 3rd revision replaces all previous editions, and copies are readily available from the Medical Research Council.

Data on the nutrient composition of South African foods are scarce, and the initiative the (ex) Egg Board took in providing information on the nutrient composition of South African eggs, and the financial investment they made, are to be commended.

The American values were also revised in 1989,⁴ on the basis of newer methodology (e.g. 425 mg cholesterol per 100 g egg) and are comparable to the current South African values.

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Egg supplementation to combat undernutrition

To the Editor: We agree with Van Niekerk and Van Heerden¹ that eggs are valuable and inexpensive sources of nutrients that should be included in the diets of young children. Eggs may be used to supplement the diets of undernourished rural black children who have low intakes of animal protein² and a dietary imbalance (unpublished data) of n-6/n-3 fatty acids (FAs). Such children have an adequate intake of total protein, which is mainly of plant origin, and a high intake of n-6 FAs according to the Canadian Nutrition Recommendations.³ This may result in a relative deficiency of n-3 FAs in populations at risk for undernutrition.⁴ Present knowledge suggests that n-3 FAs are essential for the normal growth and development of children. A diet with a high n-6/n-3 FAs ratio can potentially damage the developing nervous system of undernourished children.⁵

Using the *MRC Food Composition Tables*⁶ it can be calculated from Table I that a large chicken egg (\pm 50 g) contains 3,52 g saturated FAs, 5,15 g monounsaturated FAs and 1,63 g polyunsaturated FAs (PUFAs). PUFAs comprise 1,24 g n-6 FAs and 0,39 g n-3 FAs. However, 1 - 3-year-old children should consume 4,0 g n-6 FAs and 0,7 g n-3 FAs daily.

TABLE I.
The fatty acid composition of chicken eggs

FA	Composition (%)
C16:0	25,58 \pm 1,87
C16:1n-7	2,82 \pm 0,35
C18:0	8,63 \pm 0,92
C18:1n-9	47,14 \pm 2,40
C18:2n-6	10,92 \pm 0,63
C20:4n-6	1,16 \pm 0,25
C22:6n-3	3,76 \pm 0,30
Saturated FAs	34,21 \pm 2,29
Monounsaturated FAs	49,96 \pm 2,68
PUFAs	15,84 \pm 0,85
n-6/n-3 FAs	3,21

Because such undernourished children have low cholesterol intakes with a very low percentage energy intake from fat,² one egg per day may serve as the ideal supplement not only to increase the n-3 FA intake in order to combat undernutrition, but also to improve the protein quality of the diet since one egg supplies an average of 64% of the required essential amino acids for a 2-year-old.

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Factors associated with airway colonisation and invasion due to *Klebsiella* spp.

To the Editor: The paper by Feldman *et al.*¹ requires a response, since although the contents are interesting, the conclusions cannot be justified by the information provided.

This is a purely descriptive report of a group of patients, both hospitalised and from the community, in whom *Klebsiella* spp. were isolated from the sputum. The significance of the finding is very different in these two groups of patients, since *Klebsiella* is a common hospital pathogen, but uncommon in the community. It is therefore not helpful for nosocomial and community-acquired infections to be analysed as a single group, and they should be considered separately. Culture of an organism may represent infection, colonisation or contamination and no clear differentiation between these states has been provided, which further detracts from the significance of Feldman *et al.*'s findings.²