methods or the very considerable competence of its practitioners — it will need to undertake a major scale shift in its view of disease and health. One of the difficulties, for which orthodox medicine cannot be blamed, is that its philosophy is derived largely from a pervasive and invasive surrounding set of values. Recent comments from within the profession[2] none the less give grounds for some cautious hope, but the message will have to spread quickly if the patient's regenerative systems are not to be destroyed, or damaged beyond its ability to support higher life forms.

S. Robertson

School of Pharmacy
Rhodes University
Grahamstown, CP

1. Walker ARP, Davies JCA. 'Doomsday' — chimera or reality? (Opinion). *S Afr Med J* 1991; **79**: 121-122.
2. Editorial. Nothing is unthinkable. *Lancet* 1990; **336**: 659-661.

Dr Walker and Professor Davies reply: The letter by Dr Robertson, and the issues raised, are extremely important. The future of the human race is a vast and profound subject, and it is sobering that what we are doing now, in both First- and Third-World countries, will have tremendous future ramifications, for good or for ill.

Our article was written principally because the word 'Doomsday' has been coming to the fore, in various papers and in the media. The presentation was not exhaustive; we simply drew attention to what *could* happen, regarding outcomes from AIDS, nuclear war, and the falling birth rate in prosperous populations.

There are of course other tremendous issues, which are associated in measure — the world's expanding population, with limited food production land, and our improvident utilisation or attrition of the world's resources. These are mentioned by Dr Robertson, and are discussed in some detail in a recent editorial in the *Lancet*,[1] cited above, entitled 'Nothing is unthinkable'. This is a review, of first importance, of a paper by Dr Maurice King,[2] in which he concluded that 'runaway growth is so serious that "such measures as oral rehydration should not be introduced on a public health scale, since they increase the man-years of human misery, ultimately from starvation"'. The editorial cites Bangladesh, 'where the social marketing programme stops births by distributing 130 million condoms a year, and stops infant deaths by selling oral rehydration sachets'. Yet 'the population is almost bound to double at least one more time before it stabilises, when a population of the same size as that of the contemporary USA will be crammed in one tiny country, the same size as the single US state of Wisconsin'.

The editorial continues, 'ultimately our world must arrive at a biologically sustainable economy or cease to exist'. Hence, 'are ecology and compassion incommensurate? . . . If we go on as at present the answer . . . will be "no". If politicians and health planners make realistic, appropriately funded family planning services available, it might still be "yes". The cost would be trivial — a penny a day from each Western taxpayer could meet the global need for family planning.'

Some populations are meeting the challenges with do-or-die philosophy. In China, in the 1950s, Mao Zedong's population policy was 'more people, more power'. It is now 'one child one family', still likely to yield a total population of 1,2 billion by the year 2000.[3]

As for the huge subject of our attrition of material and other resources, this is being increasingly appreciated, and hence need not be enlarged upon, save for one telling comparison. A baby born in the West will impose over a hundred times more stress on the world's resources and environment than will a baby born in the Third World.[4]

If we are to succeed in population control and conserving resources, herculean discipline will be required by all populations.

1. Editorial. Nothing is unthinkable. *Lancet* 1990; **336**: 659-661.
2. King M. Health is a sustainable state. *Lancet* 1990; **336**: 664-667.
3. Ma E. One child, one family. *JAMA* 1989; **261**: 1735-1736.
4. Qureshi SJ. The population bomb has already exploded. *Br Med J* 1990; **301**: 1050.

Fluoriednavorsing

Aan die Redakteur: Gedurende September 1990 het die MNR 'n werkskursus oor fluoriednavorsing geborg. Die doel van die kursus was om 'n geheelbeeld van fluoriednavorsing in Suid-Afrika te kry, raakpunte te soek vir gesamentlike projekte en om aanbevelings te maak oor fluoriednavorsing in Suid-Afrika.

'n Komitee is aangewys om 'n verslag op te stel en aanbevelings te maak. Hier volg die verslag:

1. Die Komitee het kennis geneem van en aanvaar die feit dat uitgebreide inligting reeds oor die voordele en nadele van fluoried op tande bestaan.
2. Die Komitee aanvaar dat huidige inligting daarop dui dat waterfluoridasie die goedkoopste, die veiligste en die mees effektiewe vorm van voorkoming van tandbederf is.
3. Die Komitee is egter van mening dat gedifferensieerde, gemonitorde en gestruktureerde fluoried-voorkomingsprogramme so gou doenlik ingestel moet word, aangesien waterfluoridasie op landswye vlak nog jare sal neem en dat die instelling daarvan nie vir almal aanvaarbaar is nie en ook nie almal in die land sal bereik nie.
4. Die implementering van sulke voorkomingsprogramme behoort in samewerking met die Departement van Nasionale Gesondheid en Bevolkingsontwikkeling (NGBO) en die private sektor plaas te vind met die MNR as 'n sentrale koördineringsliggaam.
5. Die Komitee beskou fundamentele navorsing oor fluoried as van definitiewe belang. Die volgende aspekte behoort nagevors te word: *(i)* sistemiese effekte van fluoried; *(ii)* die metabolisme, die meganisme en die sellulêre uitwerking van fluoried in die mens en dier; en *(iii)* die terapeutiese gebruik van fluoried (bv. in osteoporose).
6. Finansiering van voorkomingsprogramme sal sterk staatmaak op die Departement NGBO en die private sektor terwyl die MNR vir die fundamentele navorsing verantwoordelik moet wees.
7. Aangesien fluoriednavorsing (toegepas sowel as fundamenteel) so 'n unieke en belangrike plek in die mediese wetenskap inneem, voel die Komitee dat dit gestimuleer en, waar doenlik, gekoördineer moet word.

In die lig van bogenoemde aanbevelings sou dit tog van nut wees as navorsers opnuut kyk na hierdie gebied van navorsing.

C. W. van Wyk

Navorsingsinstituut van Mond- en Tandheelkunde
Fakulteit van Tandheelkunde
Universiteit van Stellenbosch
Parowvallei, KP

Oesophageal cancer study group report

To the Editor: The South African National Study Group for Oesophageal Cancer (SANSGOC) was founded in 1984 by a group of concerned clinicians and research workers aware of the ever-increasing incidence of oesophageal cancer in southern Africa and the poor survival statistics achieved in the management of this condition. SANSGOC is a small closed society with limited membership that has an annual meeting once a year for informal discussion of oesophageal topics. Visitors are welcome but have to be introduced by a member.

Over the years, this Group has attempted to collate data from all the major teaching institutions in the country on aetiological factors, incidence and procedures of investigation and management relevant to oesophageal cancer. A national programme has now been devised to optimise the investigation of patients referred with dysphagia and suspected to have oesophageal cancer, and national clinical trials have been formulated to evaluate different treatment options for all stages of this disease.

The first national study for treatment of stages I and II disease, which was implemented in 1989, has now been closed owing to poor patient accrual. A prerequisite for entry to this study was the obtaining of informed written consent for the investigations and treatment options under review. This was not possible in the majority of patients who would otherwise have been eligible for inclusion, because of problems of language and/or tribal beliefs.

The majority of patients registered with this Group present with stage III disease (a lesion > 5 cm in length on barium study, cir-