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CORRESPONDENCE

Correspondents are asked to be brief

Disease in the Tropics

SIR,—Dr. W. Z. Conco (11 August, p. 331) has helped to restore the balance in the Western diseases argument since he speaks from a close personal knowledge of the African peasant, his language, and his culture. However, one hesitates to accept his diagnosis of ischaemic heart disease without special facilities.

One of the worst cases of acute appendicitis I have had was in a young herd boy who had probably never eaten even a slice of "Western" bread in his life. Nevertheless, at a hospital with 95 beds and two full surgical lists a week I have not removed a single appendix in the last two and a half years. I cannot believe I have been missing many patients with acute appendicitis who have either recovered, been cured by the witch doctor, or died at home, since many other patients in extremis are brought to us as a last resort.

One wishes that more of Dr. Conco's African colleagues would give the same attention to the problem as he has and help to open our eyes to the many clues we are missing because of language and cultural barriers.—I am, etc.,

IAN KENNEDY

Bamalete Lutheran Hospital,
Ramoutsa Village,
Botswana

SIR,—I was most interested in the paper by Dr. W. Z. Conco (11 August, p. 331). I have been engaged in rural hospital practice for the past 32 years in the West Nile District of Uganda and speak the language of the largest tribe and a smattering of others. The tendency to make epidemiological generalizations is common in trying to explain disease patterns in developing countries. There is also a temptation to pontificate in the light of one's own particular and localized knowledge and this needs to be resisted.

While noting that many of Dr. Conco's experiences correspond with my own, there are some clear disagreements. For instance, I do not find a high pain threshold here, though there are instances of stoicism. In regard to the hold of traditional medicine and beliefs in the attitude of local people towards disease, I have witnessed here a very great change from the position described by Dr. Conco to one of widespread confidence in Western-type medicine, especially since 1960. In this area medical facilities are reasonable, but many conditions are misdiagnosed by the lower echelons of medical workers who see most of the patients. But unusual conditions are by and large referred to medical practitioners. Unfortunately many of these are Western-trained, seldom long in any one area, and not experienced in diagnosing tropical conditions. For instance, I have seen many patients diagnosed by such practitioners on clinical grounds as having peptic ulcers who are later found to have intestinal infestations by stool examination, revealing the true cause of their unremitted symptoms. My experience in this area is that diabetes mellitus began to appear in the early 50s and has become increasingly common since. Refined sugar consumption began in the late 40s and now runs at an average of 100 g per person per day in tea alone. During the 60s I have noticed a gradual increase in the number of cases of hypertension, haemorrhoids, and varicose veins. I find that instructing my hypertensive patients to cut out refined sugar does in time produce a lowering of blood pressure to some degree.

But I want to emphasize that in my opinion it is not correct to look on Africa as a homogeneous whole from the point of view of disease patterns. I can illustrate this best from my own experience in cancer epidemiology. Since 1961 I have been watching for cases of cancer and now have 600 recorded with their home addresses. This total probably represents about half the total of cancer cases which have occurred here over the past 12 years. My series shows that generalizations which have been made on cancer patterns in Uganda do not necessarily apply in the local context. For instance, I have seen only eight cases of carcinoma of the penis in a population which does *not* practise circumcision. I have seen only five cases of bowel carcinoma, which supports Burkitt's contention[1] that this is rare in developing countries, at least in the local situation. I have seen four cases of carcinoma of the bronchus, three in heavy smokers of many years' duration, and there are few such as yet in this district. I have seen only two cases of carcinoma of the stomach, which is relatively common in some other areas of East and Central Africa. I have seen four cases of carcinoma of the oesophagus, which is the commonest neoplasm in some other localized areas. The commonest cancers here are Burkitt's lymphoma, hepatoma, and Kaposi's sarcoma, but in other parts of Africa these can be rare.

My feeling is that epidemiology in Africa has now exhausted the value of generalizations and that more attention should be paid to studying local disease patterns and the reasons for the differences.—I am, etc.,

E. H. WILLIAMS

Kuluva Hospital,
Arua, Uganda

1 Burkitt, D. P., *Lancet*, 1970, 2, 1237.