Oesophageal carcinoma

Third-World modification of a First-World treatment programme

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Summary

A 59-year-old man completed a course of cytotoxic treatment and palliative radiotherapy for stage III oesophageal carcinoma and then sought the aid of a traditional healer.

Carcinoma of the oesophagus is endemic in certain areas of South Africa. The population of Transkei is particularly prone to this disease,1,2 and in some areas its incidence has reached epidemic proportions.3,4 Cultural differences and tribal indoctrination make it difficult for these people to accept the tenets of First-World treatment. The patient is aware that 'the swallowing sickness', recognised by his tribal kinsmen, portends imminent death. He is often unable to understand the full significance of the disease, but is aware that dysphagia is the forerunner of a debilitating disease which will ultimately cause his death.

In many instances, the patient will seek advice and treatment from his tribal doctor. As a last resort, he will seek medical assistance, and will then travel long distances to the better known treatment centres in the RSA. Patients undergo modern treatment in conjunction with traditional medicine, and in many cases the hospital is used as a diagnostic centre to confirm the diagnosis of the tribal doctor.

The case reported here is unusual in that the traditional healer was a trained nurse who had returned home to practise tribal medicine.

Case report

A 59-year-old Transkeian contract worker was found in December 1986 to have stage III squamous carcinoma involving the middle and lower thirds of the intrathoracic oesophagus. Barium study examination demonstrated a lesion over 9 cm in length. Cytological examination of a transcarinal needle aspiration biopsy specimen confirmed extra-oesophageal spread.5

He was treated with 3 weekly methotrexate infusions (100 mg/m² body surface) followed by a split course of mediastinal irradiation (2000 rad central dose in 5 fractions over 5 days, followed 21 days later by 3360 rad central dose over 23 days).6 Radiation therapy was delivered through two opposing parallel mediastinal portals, 27 x 8 cm in size. The treatment programme began on 22 December 1986 and was completed on 27 February 1987. At this stage the patient returned to Transkei to seek advice from his tribal doctor.

He returned to hospital on 13 April 1987 looking fit and well, asymptomatic and able to swallow all types of food. He claimed to have no dysphagia. When examined, he was found to have a crude bandage of torn sheeting around his midriff. This held in place a sheet of polythene wrapped around his body next to the skin. When this was removed, the underlying skin was found to be escharified, and was excoriated and pigmented. This was bilateral and in the distribution of T12, L1 and L2 nerve roots. The involved area was thickly coated with powdered charcoal, from which emanated a strong odour of Jeyes fluid, a homogeneous solution of coal-tar acids with hydrocarbons and an emulsifying agent.7 Tar acids are generally very irritant and corrosive to the skin, even when dilute in a concentration used for disinfection.

Discussion

The patient told us of the alternative medicine which had effected a cure. He was most grateful to the modern doctors...
the treatment his traditional healer administered caused him a lot of pain, which resulted in his becoming very ill and weak, he firmly believed that his cancer was cured.

It was clear that the traditional healer was aware of the skin changes which occur after radiation therapy, since she had instructed the patient not to apply her embrocation to the skin areas we had treated.

Figs 1 and 2 show the two parallel opposed mediastinal fields clearly as well as the skin reaction following the treatment of the tribal healer, who obviously had knowledge of nerve root distribution and referred pain, since the areas of escharification followed the nerve roots of the 12th thoracic and 1st and 2nd lumbar vertebrae.

In subsequent conversation with the patient, it was discovered that he went to seek his tribal doctor because on completion of the radiation therapy, his dysphagia had become quite acute. This may have been caused by oedema resulting from his treatment but since the patient did not consult us it is impossible to assess whether resolution of the dysphagia was a natural process or whether it was enhanced by other medication. When seen in July, 8 months after initial referral, he was well and asymptomatic and none the worse following his tribal medication.

This, we feel, is an enlightening example of Third-World modification of a well-established First-World treatment programme.

REFERENCES


