Kaapstad, 19 Desember 1964 Deel 38 No. 41 Volume 38 Cape Town, 19 December 1964

VAN DIE REDAKSIE : EDITORIAL

DIAGNOSE VAN BORSKANKER DEUR MAMMOGRAFIE

Ondanks die vordering van die moderne terapie het die erns van borskanker nog geensins afgeneem nie. Dit is 'n groter doder as kanker van die liggaam en die serviks van die baarmoeder tesame.[1] Alle metodes wat tot vroeër diagnosering van die toestand kan lei, verdien oorweging. Op die oomblik bestaan hierdie metodes uit: selfondersoek deur die pasiënt, roetine mediese ondersoeke, en mammografie. Veral laasgenoemde metode geniet op die oomblik baie aandag, en die roetine-gebruik daarvan is onlangs op die Kankerkongres van die Amerikaanse Mediese Vereniging aanbeveel.[2]

'n Geskiedkundige oorsig van die gebruik van röntgenstrale vir diagnostiese doeleindes in die vrouebors is in 1961 op skrif gestel.[3] Dit kom kortliks op die volgende neer: In 1913 het 'n Duitse chirurg, Salamon, 3,000 borste wat met mastektomie verwyder is, met röntgenstrale ondersoek. Hy het aangetoon dat die grootte en grens van tumore op hierdie wyse bepaal kon word. Hy kon ook skirrose van nodulêre tumore onderskei. Belangstelling in hierdie soort ondersoek is eers weer na die Eerste Wêreldoorlog gewek. Daar is toe ingegaan op die pasiënt se posisie gedurende 'n ondersoek, die beskrywing van tumore *in situ*, verskillende röntgenologiese tegnieke en die fisiologiese veranderinge in die bors gedurende die maandelikse siklus en die swangerskap.

In 1938 het Gerson-Cohen reeds die moontlikhede van hierdie soort ondersoek vir borskanker ingesien. In 1953 het Le Borgne se klassieke verhandeling *The Breast in Roentgen Diagnosis* verskyn.[4] Hy het berig dat kollietjierige-verkalking op vroeë karsinoom gedui het. In Amerika het Gerson-Cohen en sy medewerkers die vuur van geesdrif steeds hoog geblaas en in Europa het die belangstelling toegeneem, hoewel Engelse röntgenoloë nog nooit entoesiasties geraak het nie.

Die besef het deurgedring dat die oorlewingstydperk moes toeneem indien 'n karsinoom röntgenologies gediagnoseer kon word voordat dit tasbaar is. Ons sal nie hier ingaan op die fyner puntjies wat die tegniek van die ondersoek behels nie—genoeg om te let op die diagnostiese vingerwysings:[4] Die tumor is kleiner op die skiagram as wat dit met betasting voorkom; dit is rond of gelobuleer; die rante lyk ongereeld, grof en spitspuntig—of meer selde glad en duidelik omskrewe; dit is ondeurskynend en maklik sigbaar in vetterige of postmenopousale borste; die perifokale gebied mag helder wees, en baie klein areas van verkalking mag gesien word. Bykomstige tekens is instulping van die tepels, verdikking van die vel oor die tumor, veranderde trabekulasie, verhoogde bloedvatrykheid en proliferasie van fibreuse weefsel en aangetaste okselkliere. Dit gebeur selde dat al hierdie aanduidings in dieselfde pasiënt voorkom, dog 'n kombinasie van enige daarvan moet die vermoede wek dat daar 'n borskanker aanwesig is.

Kanker kan as volg van ander patologiese kondisies in die bors onderskei word: Fibrosisteuse siekte, fibroadenoom of 'n sist voel net so groot of groter as die beeld op die film, en eenvoudige siste is radiodeurskynend, terwyl fibroadenome gekenmerk word deur hul eweredigheid, verkalking en hul beperkende kapsel. Mastitis word gekenmerk deur deinserigheid, verhoogde bloedvatrykheid, subkutane edeem, pyn, koors en die feit dat dit gewoonlik gedurende laktasie voorkom. Papillome is gewoonlik in 'n melkbuisie, gaan dikwels gepaard met 'n bloederige afskeiding en kan, indien nodig, aangetoon word deur inspuiting van die buise. In 'n subareolare abses strek die skaduwee tot teen die vel. 'n Galaktoseel kom voor in 'n lakterende bors, is goed omskryf en deursigtig, en bevat soms kalk. 'n Lipoom is deursigtig. Troumatiese vetnekrose kom blasie-agtig voor en is deursigtig.

Hoewel daar nog nie volle rekenskap gegee kan word van die waarde van mammografie nie, dien daarop gelet te word dat selfdiagnose 'n baie feilbare metode is om borskanker *betyds* te ontdek. Ten eerste hang dit af van die pasiënt se oplettendheid en begripsvermoë; tweedens, is tasbare tumore reeds 2 cm. in deursnee groot, of groter, wanneer hulle ontdek word; derdens kan die versuim om chirurgiese behandeling te soek van 2 tot 12 maande duur; en vierdens, wanneer diagnostiese reseksie uiteindelik gedoen word, is daar reeds 'n hoë voorkoms van aangetaste kliere in die oksel. Wat ons van selfdiagnose gesê het, is ook in 'n mindere mate waar van roetine spreekkamerondersoeke om kanker van die bors te probeer uitskakel.

Teen hierdie agtergrond moet die nut van mammografie as 'n diagnostiese hulpmiddel in *vroeë* borskanker na waarde geskat word. As belanghebbende geneeshere wag ons op 'n waardeskatting van hierdie tegniek deur ons radiologiese kollegas.

1. Dalgarno, M. (1964): J. Coll. Radiol. Aust., **8**, 152.
2. Muller, C. J. B. (1964): S. Afr. T. Radiol., **2**, 44.
3. Gerson-Cohen, J. (1961): J. Amer. Med. Assoc., **178**, 1108.
4. Le Borgne, P. (1953): *The Breast in Roentgen Diagnosis*. Montevideo: Impresora Urugeraya

PROFESSIONAL PROVIDENT SOCIETY OF SOUTH AFRICA*

Almost immediately after its establishment by the Dental Profession in 1941, the Professional Provident Society of South Africa, at the request of the Medical Association, extended its facilities to the members of the Medical Association.

The Medical Association, as one of the sponsoring professional Associations, has supported the Society over the years, and approximately one-third of its members are now

*Abstracted from a report by Dr. J. I. H. Frootko to Federal Council on 13 - 15 October 1964.

members of the Society. The Association has, however, possibly never fully appreciated the value of the services provided by this Society. Although its benefits are not as yet completely comprehensive, it provides the basic essentials for the security and protection of the professional man, and the Association should ensure that the members take full advantage of the protection afforded by it.

The Professional Provident Society plays an extremely important part in the lives of many members of the Medical Association and should, in fact, play an important part in the lives of *all* members of the Association. Illness is often a serious hazard, particularly to the self-employed professional person, and with this in view the basic purpose of the Society is to protect the income of the professional man in the event of illness. This protection of income is most essential, since it is only when his income is assured that the professional man can afford to maintain the other essential forms of insurance he needs for his own and his family's security. In addition to this all-important protection offered by the Society throughout the practising life of the professional man, it also protects him against the hardships resulting from permanent incapacity, secures his position on retirement, and protects his family in the event of his death. The Society also assists him in meeting most of the hospitalization for himself and his family.

A recent issue of our *Journal* (30 May 1964) carried a résumé of the Annual Report of the Society which reflects the remarkable progress this organization has made in the 22 years of its existence. At present its membership exceeds 3,500, of whom some 1,760 are members of the Medical Association. Over and above cover in the event of illness, these members carry some R24m. in life assurance and are contributing over R½m. a year towards their retirement through the medium of the Society's Retirement Annuity (Pension) Fund. The total assets of the Society to date exceed R4m. and are at present increasing at the rate of approximately R¾m. a year. The annual income in contributions and earnings on investments now exceeds R1½m. These figures clearly illustrate the success achieved by the Society and are a guarantee to prospective members that the benefits to which they will be subscribing are backed by an organization of considerable strength. It should be clearly understood that this organization is controlled and run entirely by the professions for the benefit of the professions.

The Professional Provident Society will not accept as a member any member of the medical profession who is not a member of the Medical Association, and has in fact advanced the interests of the Association by insisting that such membership should be sought before joining the Society. The Medical Association as a sponsoring body should in turn do everything in its power to ensure that this important organization, operating for the benefit of its members, is given the maximum possible support.

COMPLICATIONS OF MEASLES

The 'need or desire' for large-scale vaccination against measles is subject to debate. One of the major sources of doubt about the need for immunization stems from the belief among many parents and doctors that measles is a rare disease in which complications are rare and almost never fatal in normal children. A recently published survey[1] indicates that measles is often complicated by serious sequelae.

A postal inquiry into the frequency of complications in 55,589 notified cases of measles in 47 large boroughs in England and Wales was carried out during the first four months of 1963. Information was obtained on 53,008 (95%) of the cases. About 1 in every 15 persons with measles suffered from a potentially serious complication and 12 patients died. The incidence of complications was highest in infants and adults. Severe bronchitis or pneumonia was reported in 38/1,000 cases; the rate in infants was nearly twice that in older children. Otitis media, the second most common complication, occurred in 25/1,000 cases and shows very little variation with age or sex. Neurological disturbances occurred in approximately 4/1,000 cases and 1 of the 4 had encephalitis or impaired consciousness. Fits and other motor disturbances were commoner in males than in females. Other complications were few.

EEG-studies of 16 children reported to have had encephalitis or impaired consciousness with measles up to 6 months earlier, showed mild but definite abnormalities in all but 2 cases.

1. Miller, D. L. (1964): Brit. Med. J., 2, 75.

Die Sekretaris van die Mediese Vereniging van Suid-Afrika, die Redakteur van die Suid-Afrikaanse Tydskrif vir Geneeskunde, en die ander lede van die hoofkantoorpersoneel van die Vereniging, stuur hartlike Kersgroete aan alle lede van die Vereniging, en alle lesers en ondersteuners van die Tydskrif, en wens hulle 'n gelukkige en geseënde Nuwe Jaar toe.

The Secretary of the Medical Association of South Africa, the Editor of the South African Medical Journal, and the other members of the head office staff of the Association, extend hearty Christmas greetings to all members of the Association and all readers and supporters of the Journal, and wish them a happy and prosperous New Year.

THE TWELVE PRINCIPLES OF SOCIAL SECURITY. SEE PAGE 960