

number of patients pursuing this therapy at great financial cost and with high expectations. Regarding this technology, we would like to emphasise the following:

1. There is a complete absence of sound clinical evidence for the efficacy of stem cell therapy for ALS and neurodegenerative diseases in general. No randomised controlled studies or even open-label studies with long-term follow-up exist. Furthermore, a prospective case series in the Netherlands showed no benefit from treatment with olfactory ensheathing cells in patients with ALS.¹
2. Long-term safety data on the use of stem cell therapy in neurological disorders are lacking.
3. Currently, the main utility for stem cell technology in neurological disorders is the ability to offer human *in vitro* models for understanding disease mechanisms and facilitating drug discovery. Although the potential for cell-based therapy exists, current claims of efficacy in ALS and other neurodegenerative disorders are premature and unsubstantiated.

We have strong scientific, ethical and economic objections to clinics offering stem cell therapy on a commercial basis, as well as medical practitioners recommending (or not advising against) this modality for neurological disorders. Patients with incurable diseases such as ALS are desperate and emotionally vulnerable to the claims of institutions allegedly being able to heal a number of diseases that modern medicine is unable to. Although we respect their autonomy and right to self-determination, patients are seldom equipped to assess the evidence for or against different treatment modalities, and are therefore reliant on medical professionals in decision-making. Moreover, regulations guiding stem cell research and therapy are sorely lacking in South Africa.² It is therefore the healthcare professional's moral duty to present patients and their families with relevant information in an understandable manner. In the case of stem cell therapy, this involves a thorough discussion about the absence of scientific evidence and the likelihood that substantial sums will be paid by patients for no discernible benefit. Failing to do so, in our view, is unethical and not in the best interests of the patient.

Franco Henning

Jonathan Carr

Division of Neurology

Tygerberg Academic Hospital/Faculty of Health Sciences, Stellenbosch University

jhenning@sun.ac.za

1. Piepers S, van den Berg LH. No benefits from experimental treatment with olfactory ensheathing cells in patients with ALS. *Amyotroph Lateral Scler* 2010;11(3):328-330 [PMID: 20433414].

2. Pepper M. The stem cell regulatory environment in South Africa: cause for concern. *S Afr Med J* 2009;99(7):505-507 [PMID: 20460017].

Hydatid cysts of the breast and parotid gland

To the Editor: We report 2 interesting cases of hydatid cysts in unusual sites: in the breast and the deep lobe of the parotid gland.

Hydatid cysts are an infectious disease caused by the larval stage of the cestode *Echinococcus*. Humans are mostly affected by *E. granulosus* as incidental intermediate hosts. The liver (70%) and lungs (25%) are most commonly affected, with the spleen, heart, kidneys, bone, nervous system and soft tissue less frequently affected.¹ Even

in endemic areas, hydatid disease of the head, neck and breast is extremely rare. The incidence of hydatid cyst in the breast has been reported as 0.27%.² No parotid gland incidence figures are available.

A 24-year-old woman from Van Wyksvlei was referred to the surgical clinic with a lump in the superolateral quadrant of the left breast. Fine-needle aspiration was performed at a local clinic before referral to the surgical clinic; parasitic hooklets were observed, diagnosing an *Echinococcus* cyst. Chest X-ray (CXR) and abdominal sonar showed no other cysts. Pre-operative albendazole was administered and the cyst was removed by excision biopsy (Fig. 1). There were no postoperative complications.

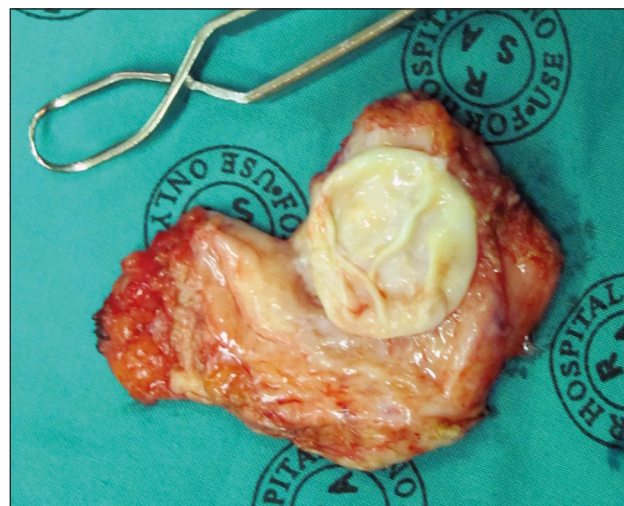


Fig. 1. Hydatid cyst excised from the breast.

In the second case, an HIV-negative 20-year-old man from Britstown was referred with a cystic mass in the right parotid area. The cyst, present for about 2 years, had fluctuated in size. It appeared superficial on examination. In the absence of a radiologist at the facility, informed consent was obtained for excision of the cyst with or without superficial parotidectomy. On excision, the cyst appeared to extend into the deep lobe of the parotid gland. Superficial parotidectomy and excision of the cyst was performed without injury to the facial nerve. Histology confirmed normal superficial parotid tissue and an *Echinococcus* cyst. CXR and abdominal sonar showed no other cysts. The patient was given albendazole and discharged; he returned once for follow-up.

Hydatid disease is a prevalent parasitic infection in sheep-rearing areas such as the Northern Cape. Although hydatid cysts in the head, neck and breast are extremely rare, *Echinococcus* infection should be considered as a differential diagnosis in patients from endemic areas.

Johlene du Plessis

Central Karoo Hospital

De Aar

Northern Cape

johlene_dup@yahoo.com

1. Ahmad S, Jalil S, Saleem Y, Suleman BA, Chughtai N. Hydatid cysts at unusual sites: reports of two cases in the neck and breast. *J Pak Med Assoc* 2010;60(3):232-234.

2. Epstein NA. Hydatid cyst of the breast: diagnosis using cytological techniques. *Acta Cytol* 1969;13(7):420-421.

Correction

We regret that an error occurred in the March 2012 issue of *SAMJ*. The citation in the abstract of the article 'Dyer SJ, Kruger TF. Assisted reproductive technology in South Africa: First results generated from the South African Register of Assisted Reproductive Techniques' should have read 'S Afr Med J 2012;102:167-170'. The online version was corrected on 11 May 2012.