

Adenocarcinoma of the Esophagus in Switzerland

To the Editor.—Blot et al¹ provide comprehensive data on an increasing incidence of adenocarcinomas of the esophagus and gastric cardia, confirming previous clinical and epidemiologic observations.

The Cancer Registry of the Canton Vaud (covering approximately 530 000 inhabitants in the French-speaking part of Switzerland) has had a specific interest in esophageal adenocarcinomas derived from a privileged situation in terms of traditional attention and careful endoscopic and histopathologic examinations of esophageal lesions.² Average annual age-adjusted (on the world standard population) incidence rates for various histological types of esophageal cancers in two separate calendar periods (1976 through 1981 and 1982 through 1987) are given in the Table.

In men, there was a decline for squamous cell carcinomas (from 7.2 to 5.2 per 100 000) but a significant rise for adenocarcinomas (from 0.4 to 1.6 per 100 000; $P < .01$). Rates for other or unspecified cancers also are increasing. No significant trend was observed in women, possibly due to small absolute numbers. Over the same periods, gastric adenocarcinoma rates, including the cardia, were unchanged.³

These data in a European population confirm the observations made in North America. Since access to endoscopic and other diagnostic procedures has long been available in this population, we are not inclined to explain the rise totally in terms of improved diagnosis, as confirmed by the absence of decline for "other and unspecified" neoplasms.

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Esophageal Cancer, Vaud Cancer Registry, Switzerland, 1976 Through 1987*

Type	Men, Calendar Period		Women, Calendar Period	
	1976- 1981	1982- 1987	1976- 1981	1982- 1987
Squamous cell carcinoma	7.2 (163)	5.2 (120)	1.5 (51)	2.0 (61)
Adenocarcinoma	0.4 (11)	1.6 (37)	0.2 (5)	0.1 (4)
Other or unspecified	1.0 (29)	1.5 (37)	0.2 (11)	0.3 (16)
Total	8.6 (203)	8.3 (194)	1.9 (67)	2.4 (81)

*Absolute number of cases are given in parentheses. Values are per 100 000.

1. Blot WJ, Devesa SS, Kneller RW, Frammeni JF Jr. Rising incidence of adenocarcinoma of the esophagus and gastric cardia. *JAMA*. 1991;265:1287-1289.
2. Levi F, Olivo JB, La Vecchia C, Boyle P, Momnier P, Savary M. The consumption of tobacco, alcohol and the risk of adenocarcinoma in Barrett's oesophagus. *Int J Cancer*. 1990;45:852-854.
3. Levi F, La Vecchia C, Te VC. Descriptive epidemiology of adenocarcinomas of the cardia and distal stomach in the Swiss Canton of Vaud. *Tumori*. 1990;76:167-171.

The South Inflamed! The Case of Henry Wirz

To the Editor.—Although I have recently resigned myself to an open season on the Confederacy following the biased public broadcasting series "The Civil War," I take exception to the comments made by Skolnick¹ in his article. The linking of Major (erroneously called Captain) Henry Wirz, MD, with the "German war criminals" is inappropriate and uncalled for. These historical facts were ignored: (1) Major Wirz, although a German-trained physician, was a Confederate line infantry officer, not a medical corps officer²; (2) the death rate at Andersonville, Ga, was no worse, and by some accounts better,³ than that at comparable Union prisoner of war (POW) camps; (3) General Grant's decision to cancel the long-standing prisoner exchanges directly caused the overcrowded conditions; (4) the Yankee blockade and General Sherman's scorched earth policies on his march to the sea caused the decreased food supply, which prisoners and guards shared equally⁴; (5) his defense was not "superior orders"—he recognized the overcrowding and disease, repeatedly asked for help, and did the best he could with what resources he had. Major Wirz was a scapegoat who was used and executed to try to implicate President Jefferson Davis in a nonexistent conspiracy. Even modern Yankee historians admit that Major Wirz was illegally and unfairly put to death. The author should do both his medical and historical homework before drawing such a spurious and wrongful comparison.

Though this is not stated in the earlier part of the article, before the 1864 Geneva convention declaring medical personnel noncombatants, General Thomas J. "Stonewall" Jackson, CSA, and his medical director, Surgeon (Major) Hunter Holmes McGuire, MD, MC, CSA, established the practice of immediately releasing Union medical personnel whom they had captured. Federal forces soon reciprocated with similar actions. This first attempt in the world to demonstrate the neutral status of military medics⁵ should have been included in the article.

JAMA's view of Confederate medicine has not always been so unfavorably

biased. I refer you to your own editorial of February 4, 1961.⁶

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1. Skolnick A. Medicine and war: recognizing common vulnerability of friend and foe. *JAMA*. 1991;265:834-837.
2. Jackson D. Doctors afield: Henry Wirz (1822-1865). *N Engl J Med*. 1960;262:31-33.
3. Breeden JO. Andersonville: a southern surgeon's story. *Bull Hist Med*. 1973;47:317-343.
4. Cunningham HH. *Doctors in Gray: The Confederate Medical Service*. Gloucester, Mass: Peter Smith; 1970: 103-105.
5. Weaver GH. Surgeons as prisoners of war: agreement providing for their unconditional release during the American Civil War. *Bull Soc Med Hist Chicago*. 1933;4:249-261.
6. Confederate military medicine. *JAMA*. 1961;175:394-396. Editorial.

To the Editor.—In his article, Skolnick¹ stated that perhaps the first physician to be convicted of war crimes was Confederate Captain Henry Wirz, MD, commandant of the infamous Confederate prison at Andersonville. I wish to take issue with Skolnick's comments regarding this individual, for it would appear that Skolnick is a poor historian and has not taken the opportunity to investigate the facts that are readily available in the literature. Captain Wirz was, in fact, Major Henry Wirz. Confering on him the degree of doctor of medicine is a gross inaccuracy. Although in his youth he was interested in medicine, he arrived in this country in 1849 from his native Switzerland. He was employed as a physician's assistant around Kentucky for a brief period of time, and subsequently offered some medical assistance on a plantation in Louisiana.

After entering the service as an infantry officer, he was wounded, sustaining the loss of use of the right arm, and ultimately was appointed commandant of Andersonville prison camp. He was never a doctor of medicine or a medical officer as was stated.

Early in the war it was the practice to exchange the prisoners on both sides under a parole arrangement. However, General Grant discontinued this policy, leading to the overcrowding of the prison camps in the South. Medical officers were the exception to this rule.

If we are to place blame as to the cause of the overcrowding of the camps, then this is the responsibility of General Grant. Facts show that the Union POWs received a daily food ration that was identical to the rations received by the Confederate soldiers. As the fortunes of the South deteriorated, so did the rations that the Confederate soldier and the Union POW received. Medical equipment and medicines were considered contraband by the North, leading to the meager supplies that could be brought in by blockade runners. However, the Union POWs received the same medicines and medical care that were afforded the Confederate soldiers. All