

merely an honest clinician) the medical board still has to give unequivocal answers to impossible questions because of the financial benefits which depend on the answers.

The Industrial Injuries Act needs completely rethinking and redrafting. In its present form it encourages ill-founded claims and discourages proper clinical judgments.—I am, etc.,

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SIR,—Your leading article on occupational dermatitis (4 December, p. 1322) provides a welcome and refreshing approach to an old and difficult problem. Present legislation often militates against the best long-term interests of the patient not only in cases of occupational dermatitis but in many instances of industrial injury where the causes are multiple. In many cases of "back strain," for example, it is extremely difficult to decide whether such an injury originally started at work and was aggravated by digging the garden or vice versa. It seems illogical that a different scale of benefit should be awarded for industrial as opposed to non-industrial disease or injury. If a man is away from work his family's financial needs are the same regardless of the cause of his incapacity.

Now that many firms are paying absent employees' wages, less National Insurance benefit, it is the employer who gains from the higher rate, making the situation even more ridiculous. The employer is in effect being paid for causing his employee's injury.

The present situation, as Dr. F. Ray Bettley says in his paper (p. 1340), places the examining medical practitioner in a difficult position, and he is advised to give the patient the benefit of the doubt. It would be a brave man who had no doubts. Consequently patients are also tempted to have doubts about the origin of their backache, their skin irritation, or their inguinal hernia, and who is to blame those without sickness benefit schemes who give themselves the tangible financial benefit of that doubt?

More accurate aetiological diagnosis of occupational dermatitis is difficult enough even for a panel of practitioner, dermatologist, and industrial medical officer without adding the task of certification for different rates of benefit to the problem. The two main advantages of accurate identification of the primary cause are to ensure logical treatment, and to prevent further trouble to the patient or his workmates.

It would be better for patient, doctor, employer, and trade-union official alike if the problems of industrial disease and injury were removed from the certification arena. A positive approach to prevention could then replace the present obsession with compensation for events past.

Finally I must emphasize that industrial medical officers are not as yet "within the framework of the National Health Service." Perhaps if they were the group-approach you suggest might be made easier. In the meantime the Ministry of National Insurance might be persuaded to try such a scheme in one or two pilot areas, where industrial medicine is well established.—I am, etc.,

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### Undescended Testicle

SIR,—Mr. D. J. Tibbs (17 July, p. 169) requested and Dr. E. N. K. Wallace (28 August, p. 533) supplied further information on maldescent of the testicle, orchidopexy, and the risk of malignancy. To supplement these data the published figures for this clinic<sup>1</sup> have been brought up to date (Tables I–IV).

Since the incidence of orchidopexy prior to puberty is unknown it is not possible to be dogmatic about Mr. Tibbs's contention that this reduces the risk of malignancy to normal levels, but the combined incidence of such patients in Dr. Wallace's and the Peter MacCallum Clinic's series (4 of 353 tumours) suggests that this is the case, since it approaches the figures for cryptorchidism in the normal population. That the cryptorchid testis can function normally is suggested by the finding that the wife of one patient with bilateral maldescent had two children—presumably by him—prior to treatment. Hormonal influences would appear to be difficult to detect, as one with contralateral and one with ipsilateral cryptorchidism fathered offspring prior to treatment—one fathered two and a half years after and one had a normal sperm count before and after x-ray therapy.

TABLE I

Total cases, 1930–1964	261
Maldescented	27 (Incidence 10.2%)
Intra-abdominal	2
Inguinal	23
Retractile	2
Bilateral	3
Contralateral	2
Ipsilateral	22

TABLE II

	Alive	Dead
Orchidopexy		
Prior to puberty	2	0
At puberty	2	1
After puberty	1	0
	5	1
Orchidocoelioplasty	1	0

TABLE III

	Maldescented Cases	Total Series to 1962 (200 Cases) <sup>1</sup>
Seminoma	19 (70.5%)	128 (64.0%)
Teratoma	6 (22.0%)	63 (31.5%)
Choriocarcinoma	0	3 (1.5%)
Lymphosarcoma	0	1 (0.5%)
Bilateral tumours	1	6

TABLE IV

	Alive and Well	Dead of Other Causes	Dead of Tumour	Survival %
Maldescented cases	16	3	8	59
Total series up to 1962				61 (3 years)

Two recent cases, one included in the above figures and one too recently treated to be incorporated, illustrate a puzzling facet of orchidopexy, and because of their unusualness and their similarity appear worthy of reporting.

Case 1.—A 41-year-old man was referred to a surgeon with a lump in the groin present for seven weeks. Excision of this quite definitely inguinal node showed seminoma. Orchidectomy and block dissection of the groin failed to reveal further tumour, but the testicle was extensively hyalinized and calcified. He had had an orchidopexy at the age of 7.

Case 2.—At the age of 25 the patient came to laparotomy for a mass in the left iliac fossa which had caused pain and oedema of the whole left leg for four weeks. Although at first reported as retroperitoneal sarcoma, the presence of bilateral inguinal scars, an atrophic left testis, and an absent right testis led to the suspicion that a testicular tumour—albeit on the wrong side—might be the true diagnosis. Review of the section confirmed seminoma in the biopsy taken. The atrophic testis contained no clinical tumour and the question of whether exploration of this is warranted in the absence of the right testis is yet to be decided in the light of information from the original hospital in which he was operated on at the age of 5.

The question raised by both these cases is whether cells sown at the original orchidopexies could have been the origin of the presenting tumour 35 and 20 years later. An inguinal node in the absence of scrotal involvement and clinical and radiological evidence of blockage of higher nodes must be very unusual. Regression of primary testicular neoplasms while the metastases grow has been reported, but these have been in the more usual para-aortic region. If cases have occurred at other sites it would be interesting to know if there had been at any prior stage surgery in the environs of the testicular descent pathway.

Finally I would like to ask if anyone has an adequate explanation for the statistically significant frequency of neoplasia of the right testis as compared with the left. It is not sufficient to say that the right is more often retractile or later in descent, although I have no figures to back these statements. This harks back to the mechanism whereby maldescent influences the incidence of tumours. If hormones were the mediating factor contralateral testes would be equally affected, but it is much more common to find the malignancy in the maldescented side. A higher temperature closer to the trunk with an increased mutation rate might be entertained for the Scots, but in present-day clothing it is difficult to imagine any measurable difference.—I am, etc.,

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#### REFERENCE

- <sup>1</sup> Sandeman, T. F., *J. Coll. Radiol. Aust.*, 1964, 8, 134

### Natural History of Breast Cancer

SIR,—I have read with interest your leader on this subject (18 December, p. 1450). In a detailed analysis of the natural history of cancer I showed that patients with breast cancer treated almost immediately after they discover the tumour live longer on an average than do those who delay for several months; and more of them are still alive five years later. Up to about two years every month's delay tends to reduce the survival rate. But after that increasing delay improves the average chance of survival until, with delay beyond four years, the average length of life from onset may be twice that of the average patient treated immediately.

To explain these paradoxical findings I postulated that cancer consultations are either predominantly personality-determined or predominantly tumour-determined.<sup>1</sup> My inter-