pernicious anaemia. That was what was necessary. And the reward to the haematologist was a guinea a mile. Twenty six guineas to a young, recently married apprentice pathologist—I went. And the results were completely satisfactory. Could any different procedure have been equally effective?

As for Harley Street and its big fees Hugh was going to give up all that nonsense. Overnight sleepers: out on Friday night and back on Sunday night—it was not worth so much labour and stress for all that was left in his pocket after expenses and taxation. What was left? Well—about £100 for two exhausting days. [That, in 1936, would be the equivalent of £2000 today. Not really worth it for two days' work!]

Hugh's fees for consultations were arrived at empirically—often reasonable or even generous; at other times what the market would bear. He quoted one remarkable example.

"I was making out my bills and my wife was looking over my shoulder. 'Hughie,' she said, 'what's this £20 to that woman? You saved her life!' 'Maybe I did,' I replied, 'she was perhaps suicidal till I got her case cleared up. But that's nothing.' 'Nothing,' said my wife. 'Put on the nothing then!'"

Said Hugh, "I hesitated, but I put it in just to see what would happen. She had plenty of money. Back came my bill with the cheque for £200, a warm letter of thanks, and an invitation to take my wife with me on a Mediterranean cruise and send the bill to her."

I never underestimated Hugh Morton. I read of his death in office with sadness; but I never thought of following in his footsteps.

Lesson of the Week

Low back pain and testicular cancer

R P COLE

Testicular cancer accounts for only about 1% of cancers in male patients but is the commonest solid tumour in men aged 20-34; its incidence is increasing. It is potentially curable because of recent advances in chemotherapy.[1] With combination chemotherapy a three year survival of 75% can be achieved in metastatic non-seminomatous germ cell testicular tumours.[2] There is a significant association between an initial delay by the patient in seeking advice or by the doctor in making a diagnosis, or both, and the occurrence of advanced testicular cancer.[3] Delay between the first symptom and the start of treatment is a determinant of long term survival.[2] I report two cases in which delays of several months occurred in the diagnosis.

Low back pain may be the presenting complaint of young men with testicular cancer

Case 1

A 17 year old youth presented to his general practitioner with low back pain, which had been gradually increasing in severity and had stopped him working for one month. The pain was exacerbated by coughing and sneezing but did not radiate. He was told that he had a slipped disc that would settle. After a further month off work the pain became worse and radiated into the thighs. He developed weakness and numbness in the left thigh and was admitted for a two week course of traction. The symptoms worsened and signs of L2-3 compression became more pronounced. He was referred for a neurosurgical opinion and underwent myelography. This showed extradural compression of the cord at L2-4.

At this point his scrotum was examined; there was a hard mass at the lower pole of the left testis. The right testis was atrophic with an associated inguinal scar after orchidopexy at the age of 8 for an undescended testis. Blood was taken for assay of tumour marker concentrations, and a left orchidectomy was performed. Histological examination showed a non-seminomatous germ cell tumour. Because of small pulmonary metastases it was graded as stage IV.

Cyclical chemotherapy resulted in resolution of his symptoms and the return of the tumour marker concentrations to normal. Computed tomography showed only a residual nodule in the right lung, which was removed at thoracotomy and histologically was a necrotic, non-viable tumour. He was subsequently disease free.

Case 2

A 15 year old boy presented to his general practitioner with dragging low back pain, which had gradually become more severe. There were no neurological signs. The symptoms worsened over several weeks, and he developed lethargy and malaise. He was referred to an orthopaedic clinic. Radiographs of the lumbar spine did not show any abnormality. A non-steroidal anti-inflammatory drug was prescribed. The symptoms persisted, and at a follow up visit the erythrocyte sedimentation rate was noted to be raised. He was then referred to a rheumatologist, who diagnosed ankylosing spondylitis and prescribed a different non-steroidal anti-inflammatory drug.

The symptoms persisted and he began to lose weight, so he was admitted for bed rest, analgesia, and physiotherapy. At this point his scrotum was examined and a hard irregular mass in the left testicle found. Blood was taken for assay of tumour marker concentrations. Orchidectomy was performed, and histological examination confirmed a non-seminomatous germ cell tumour. Abdominal ultrasonography showed retroperitoneal lymphadenopathy and metastases in the liver. Chest radiography showed multiple cannon ball metastases; the tumour was therefore graded as stage IV. Despite intensive cyclical chemotherapy the patient died.

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Discussion

Advances in chemotherapy over the past 15 years have dramatically improved survival of patients with metastatic non-seminomatous germ cell testicular tumours. Patients with bulky abdominal nodes or small volume lung metastases may do well: up to 81% may achieve disease free remission with intensive chemotherapy.[4] Patients with bulky deposits in the lung or liver, however, fare poorly, with under 17% achieving complete remission.

The efficacy of treatment depends on the stage of the tumour and the bulk of metastases. Delay in diagnosis therefore affects the stage and ultimate prognosis.[2] Delay is usually attributable to the patient, who ignores his testicular swelling,[5] but may also be attributable to the doctor, as in the cases reported here. In both cases presented here the scrotum was not examined at the time of presentation or at subsequent outpatient clinics. Although the patient in case 1 gave a clear history of surgery for undescended testis, the diagnosis was not considered until after myelography. Up to 8% of biopsy specimens from patients previously treated for testicular maldescent show carcinoma in situ (ipsilateral testis).[6]

Recent improvements in chemotherapy, staging, and monitoring should be complemented with measures to encourage early diagnosis. Public health education should help to reduce the number of patients waiting before seeking medical advice.[7] High risk groups have been recognised, and in these patients screening tests such as testicular ultrasonography, magnetic resonance imaging, or biopsy may have an impact.[8] By maintaining a high index of suspicion medical staff of all specialties will help to achieve earlier diagnosis of this curable cancer.

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(Accepted 27 July 1987)

MATERIA NON MEDICA

Postscript

I was not often called to Spandau prison on a Saturday afternoon. As medical officer at the British Military Hospital Berlin in the spring of 1950, I paid a daily visit, seeing each of the seven prisoners condemned at Nuremberg and serving sentences ranging from 10 years (Döenitz) to life (Funk and Hess). The emergency call was for prisoner number seven, Rudolf Hess, who had collapsed with abdominal pain. The man who had been deputy Führer until he parachuted into wartime Britain with a set of self constructed peace proposals lay on a hard bunk in a cell. His knees were drawn up, his hands were clasped to his upper abdomen, and he stared out of eyes set deep in shadows—features familiar to every newspaper reader in those days.

We had a problem. My knowledge of German was rudimentary though I had a small stock of medical phrases. Hess, despite 10 years in captivity—five of them in Britain—spoke little English. At that time he hardly spoke at all. My daily visit consisted of a brief inquiry from me and a blank stare in return. On this occasion he cooperated grudgingly, indicated the site of his pains and described them as "schwer." This was no time for textbook medicine. I examined him and was relieved to find that no serious condition was present. Thank heavens he did not have a surgical abdomen—it would have taken a four power conference to get him to an operating theatre.

Just a simple gastric upset, I thought.

"Nur die Magenverstimmung," I told him, using up abut half my stock of German. "Did you ever have stomach trouble in the past?"

No answer.

"Before you came to England? . . . Scotland, rather?"

"You came down at Eaglesham not far from where I lived," I remarked aloud, trying for some response.

"I remember the sensation you caused."

I had touched the spring that opened the floodgates.

Hess was immensely proud of his exploit. It certainly took a brave man to fly an Me 109 past the point of no return, and Hess's previous flying experience consisted of training flights at the end of the first world war. It took a good—or lucky—navigator to get so close to his intended destination. What kind of man did it take to extricate himself and leap into the darkness over enemy territory?

The story was now pouring out in animated tones and gestures, and was not easy to follow. Willi Messerschmitt, the designer of the aircraft, had told the interested deputy Führer about the controls and flight characteristics. To ask how to get out in mid-air could have aroused suspicion and been fatal to his plans. Over the dark Renfrewshire hills Hess throttled back, put the plane into a gentle glide, threw back the canopy, and struggled in the slipstream to free himself. He was stuck half in and half out as the plane's nose dipped out of control. He regained the seat and levelled out. A second attempt was also unsuccessful. He rolled the aircraft and upside down tried to kick himself out.

At this point I could scarcely follow the narrative. History records that he did get out, that he landed safely apart from an ankle injury, and that he brought his grand peace plan. Was he also telling me, that afternoon in Spandau, that he also brought a stock of indigestion tablets?

Just enough to last for a week or so.

It is more than 40 years since he came to Britain and over 30 years since I saw him in Spandau. I had forgotten the incident until a few years ago, when I saw an elderly German tourist with indigestion. He congratulated me on my knowledge of the German for dyspepsia and antacid tablets. I did not tell him how I knew.—ROBERT BAIN, general practitioner, Ayr.

The show must . . .

Open air opera is quite the thing. Our choice of venue was the Roman amphitheatre in Verona, the city of Romeo and Juliet.

The locals could not have been more friendly, from the proprietor of the poultry shop in Corso Cavour who seemed to know each egg personally, to the ex-prisoner of the Eighth Army who gave us valuable directions and felt encouraged to reminisce. Being a POW of the British had suited him well, but he regretted ever since having given the camp's English classes a miss. It seemed that he had opted for football instead. At our residence perpetually smiling Sinhalese ("No, we're definitely not Tamils") were in attendance, ever keen to please.

Among the many ancient monuments was that of Dr Fracastoro. His stone effigy in the wall of San Fermo's ov[illegible]ks the street below. Once he was physician to Verona's powerful rulers. Now he badly needs a good dusting off. One of his patrons, Cangrande I, sits precariously on a horse atop his church entrance. "Don't worry," said a knowledgeable bystander," he's only a copy. The real Cangrande is in the museum."

Came the day of the opera. The heavens opened and it poured. Said my lady: "If there's too much water for *Aida* will there perhaps be enough water in the arena for a boat race?" But then the skies relented. On the huge stage there was frantic activity from the bucket brigade, reinforced with outsize vacuum cleaners. A case of "all hands on deck." The rain continued to hold off. No harm befell the charming ballerinas in the course of their gyrations. Only Aida's father came to grief. He slipped, arose again with dignity, dusted himself off, and carried on like any true professional. The audience of some 20 000 were unusually mellow, so pleased were they that the show was actually on. Not a solitary "boo" was to be heard. Such restraint is uncommon with discerning Italian audiences. Our final impression was one of a tremendous spectacle with music rather than a great musical experience. But we would not have missed it for worlds.—K G HEYMANN, London.