phagus, the source of haemorrhage. He also had bilateral enlargement and caseation of the adrenal glands. Histology, however, suggested carcinoma of the suprarenal cortex, with lymphatic spread to the oesophagus. The patient also had bilateral silicosis and caseating tuberculosis.

Except for the normal blood pressure the patient had an Addisonian-like appearance, and this is of interest, considering the involvement of the adrenal cortex.—I am, etc.,

Glasgow. GILMOUR HARRIS.

Educating the Public about Cancer

SIR,—I have read with great interest Dr. N. E. McKinnon's pessimistic letter (March 8, p. 544) and his article in *Surgery, Gynecology and Obstetrics*, February, 1952 (p. 173).

Nearly everybody realizes that prognosis in cancer depends very largely on the degree of differentiation and power of the tumour to metastasize. I say nearly everybody, because some people still seem surprised to find that patients with a well-differentiated tumour can be "cured" in spite of delay in diagnosis and seem to forget that those which are undifferentiated may become inoperable in the same space of time. Dr. McKinnon, however, seems to assume that tumours can be classified into:

(*a*) those that are so undifferentiated and metastasize so soon that early diagnosis is impossible, or

(*b*) those that are so well differentiated that early diagnosis is unnecessary.

The evidence for such an assumption which he gives in his article quoted is not convincing. Surely experience, and indeed some experiments with corneal transplants, suggest that there are all degrees of differentiation, and even that some tumours may become less differentiated in the course of time. It is in such cases as these that early diagnosis will help.

In the case of cancer of the cervix uteri, Heyman's *Report* (Vol. VI), which includes records of 41,046 patients, shows that, between the publication of Volume IV in 1941 and Volume VI in 1949, the percentage of stage I and II cases has increased with a corresponding increase in the percentage of the five-year survival rate without symptoms or signs. This increase for *all* cases treated is shown to be 5.1%, and of this improvement Heyman suggests that 3.2% is due to the "quality of the material" and 1.7% due to improved treatment.

Dr. McKinnon in his article (*Surg. Gynec. Obstet.*) states that there has been no material reduction in cancer mortality during the last 20 to 30 years due to earlier or different treatment. If this is so, Nature is being kind and providing more differentiated tumours.

It is true that there is not nearly enough evidence to correlate time of diagnosis, stage of the disease, and the type of the tumour, and it is hoped that a critical experiment under the guidance of statisticians at every stage of the experiment will be undertaken in this country as soon as possible.—I am, etc.,

London, W.14. M. DONALDSON.

SIR,—Recent letters in the *British Medical Journal* have shown a pessimistic attitude towards the early treatment of breast cancer. It is advisable that the arguments adduced should be refuted.

The belief of the medical profession is that a certain number of cases of breast cancer, if seen early and radically treated, are cured; some are not cured but remain free from signs of "recurrence" for long periods, even up to nine or ten years of useful life. Unfortunately, others are very soon in a hopeless condition.

Dr. N. E. McKinnon (March 8, p. 544) bases his attack on these beliefs entirely on statistical evidence that the mortality rates from breast cancer remain unchanged, in spite of propaganda and early treatment. But he is dealing with two variables: one, the incidence of breast cancer in the female population; the other, the number of cases that get early and adequate treatment. If (as seems likely in an ageing population) the incidence of breast cancer is increasing, and concurrently the proportion of those who get early treatment by modern surgery and radiation with good results has also increased, then the mortality rates would not show much change.

The rather rare atrophic breast cancer can remain free from metastases, but is usually fatal in the end. However, Dr. McKinnon summarily dismisses all the (admittedly) large number of breast cancers that do well after treatment as belonging to a non-lethal and non-metastatic variety of cancer. Surely such an assertion would require evidence from the pathologists. If there is no evidence at all, we can continue in the more sensible and comforting belief that the fortunate women who do well have done so as the result of good treatment.—I am, etc.,

Hastings. HARRY GABB.

SIR,—Dr. N. E. McKinnon's letter to you on this subject (March 8, p. 544) does not appear to be helpful in the campaign against cancer. Whatever may be the statistical facts about breast cancer, the same does not apply to cancer in other parts of the body, especially the larynx and deep pharynx. It has been my painful experience over the last six years to see at least 10 cases of carcinoma in the cricoid region too far advanced for successful treatment. The causes are many, among which are fear on the part of the public of this disease, and their ignorance of the result of treatment. May I add that I disagree with the quoted words of Dr. James F. Brailsford: on the contrary, we have something solid to offer, and it should not be done quietly.—I am, etc.,

Liverpool. JOHN MCFARLAND.

Sexual Disorders in Women

SIR,—I do not agree with Dr. Joan Malleson (February 23, p. 437) that some women have their erotic sensation limited to the cervix. Deep penetration by touch and pressure will undoubtedly give rise to sensation in the pelvis interpreted by some women as an added emotional factor to the joy of sexual intercourse and by other women as dyspareunia. Even if erotic sensation were present in the cervix, it is doubtful whether the thin rubber of the occlusive cap could prevent stimulation of the cervix by the thrusting penis. It is true, however, that discarding the cap does occasionally lead to complete orgasm, but many years of experience of sexual disorders and contraception have convinced me that the basis of this is emotional. The lowest part of the anterior vaginal wall is of course erotic, because stimulation here is directly on the tissues of the vestibule and round the urethral orifice. The penetrating penis produces erotic sensations by friction at the upper two-thirds of the vaginal introitus, having practically direct contact with the tissues under discussion. A well-fitting cap cannot interfere with this contact except, as always, for psychogenic reasons, and once again discarding the cap does in a small percentage of women help to relieve varying types of emotional tension and may allow orgasm.—I am, etc.,

London, W.1. PHILIP M. BLOOM.

Male Infertility

SIR,—Your leading article (December 22, 1951, p. 1507) drew attention to work by Nelson and others, who have shown that big daily doses of testosterone given to men with defective spermatogenesis cause further inhibition of spermatogenesis. But if the testes are examined a year or two after treatment there is a regeneration of the seminiferous tubules and a normal sperm picture, in contrast to the defective spermatogenesis present before injection.

This result was interpreted as meaning that the testosterone originally suppressed the pituitary gonadotrophic hormone, but that a subsequent rebound effect occurred, stimulating the production of gonadotrophic hormone.

In 1938 I published a paper (*Lancet*, 1938, **2**, 1457) describing a comparable phenomenon. I showed that injection of large