by the lower take up of single payments. As one way of financing these benefits has been by not increasing child benefits for non-claimants in line with inflation the result may be merely that the poorest children do a little better at the expense of other children. This is important because there is no doubt that families with children have faced a steeper increase in poverty than others. For example, in 1985, 2·25 million children (18% of the total) were living at or below the poverty line,[3] an increase of 91% on the figure at the time of the Black report.[1]

The first target for Europe of the World Health Organisation's plan for health for all in the year 2000 is to reduce inequalities in health by a quarter.[9] The organisation has called for a research policy to back up its targets, and research into health inequalities should aim at understanding the mechanisms that create and maintain the inequalities.[10-12] This will demand research into the impact on poverty and health of social security policies. The Department of Health and Social Security has now been split into two departments. Social security has a larger budget than health but commissions far less research. The new Department of Social Security should surely be provided with a research budget that will allow it to discover whether what the government's critics say is true—that "over the past decade growing abundance for some has been accompanied by persistent poverty and hardship for a significant minority.[13] Or whether a more accurate statement is the one made by the Prime Minister when she told the House of Commons that "Everyone in the nation has benefited from the increased prosperity—everyone."[14]

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Germ cell tumours in men

Diagnosis of these cancers is often delayed

More than three quarters of men with germ cell tumours may now be cured with chemotherapy containing cisplatin.[1] Yet diagnosis is often delayed, sometimes with dire consequences.[2]

In 1984 there were 909 cases of testicular cancer in England and Wales,[3] representing at least an increase of a half in the past 20 years. The reasons for the increase are uncertain,[4] but this is by far the commonest malignancy in men aged 20-34—and the incidence is continuing to rise rapidly. The public know little about the disease, which is one reason for delayed diagnosis.[5]

In most patients diagnosis is straightforward. Usually the patient draws attention to an abnormal testis which may be painful with an area of induration or a mass. Occasional patients present with a hydrocele or a mass noted immediately after trauma to the testicle. Testicular neoplasms should always be considered in such cases, and the patient should be referred to a urologist.

Although testicular seminoma is commonly confined to the testis, metastases are present in at least half of all patients with teratoma. In many of these cases the presenting symptoms result from the metastases. A palpable testicular mass may be small, absent, or concealed by an embarrassed patient. Patients then present with symptoms caused by metastatic disease. Lumbar back pain,[2] which is often progressive and poorly controlled, and abdominal pain may be caused by cancer spreading to retroperitoneal lymph nodes. Progression of the disease may cause leg and genital oedema secondary to compression of the inferior vena cava, compression of the spinal cord, or obstruction of the ureters or small bowel.[6] Occasional patients notice an abdominal mass. Lung metastases are common, but they rarely cause symptoms. Patients may, however, present with cough, dyspnoea, chest pain, or haemoptysis. Patients with large mediastinal masses may present with dyspnoea, obstruction of the superior vena cava, or occasionally pericardial tamponade.[7] Some patients present with cervical adenopathy: the nodes are usually confined to the supraclavicular fossa or scalene area on the left, and the masses may occasionally be large. Occasional patients present with metastases in the central nervous system, liver, or bone, but such patients almost always have readily apparent metastatic disease at other sites, particularly in the chest. Finally, gynaecomastia in a young man in association with a testicular mass or lung metastases is virtually pathognomic of a metastatic germ cell tumour.

Young men presenting with any of these symptoms should have a full genital examination. If this gives normal results and there is any suspicion of a germ cell tumour then the testes should be examined with ultrasonography to exclude an impalpable primary tumour. In some patients (10% in Southampton) there is no tumour in the testes; these patients have the extragonadal germ cell syndrome and may present with retroperitoneal or mediastinal masses[8,9] or with lung metastases. In most patients the serum concentrations of α fetoprotein or the β subunit of human chorionic gonadotrophin are high, and large increases are common. When possible the diagnosis should be proved in such patients by biopsy. Biopsy of tumours with prominent elements of choriocarcinoma may, however, be dangerous because of haemorrhage.

Pathologists should be alert to the possibility of a germ cell tumour in any specimen of metastatic neoplasm obtained from a young man. Diagnosis may be difficult and histology atypical. In the absence of an obvious primary site, patients with a final diagnosis of poorly differentiated carcinoma (even in the presence of normal serum markers) may still be considered for treatment with cisplatin containing

combination chemotherapy as a proportion probably have germ cell tumours and may be cured.[10 11]

The main task of doctors is to recognise what is treatable. Germ cell tumours in men deserve a higher profile both with the public and with doctors in all specialties. The maxim "exclude lymphoma" should be supplemented by "Could this be a germ cell tumour?"

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Dissecting the NHS bonanza

It almost disappears

"£1·8 billion boost for health service" ran the headline to the Department of Health's press release issued on the day of the Chancellor's autumn statement. Such an increase for the English NHS does on first examination look generous: it is an increase of nearly 10% over this year's estimated expenditure —even allowing for the costs of the nurses' pay awards. Breaking down the increase shows, however, that first impressions may be deceptive. The table below shows how the £1·8 billion (in fact rounded up from £1787m) has been constituted.

Additional planned expenditure (£m) on the health service in England for 1989-90

	New cash	Savings	Total
Hospital and community services:			
Cash increase	861		
Cost improvement programmes		150	
Income generation schemes		25	
Superannuation savings		237	
Total	861	412	1273
Family practitioner services:			
Cash increase	280		
Superannuation savings		40	
Total	280	40	320
Central services and others:			
Cash increase	194		
Total	194		194
Total for NHS	1335	452	1787

The "new cash" column shows the literal cash increase in NHS budgets. By the end of this financial year the hospital and community health services in England are expected to spend £12 640m. The planned spending next year is £13 501m —a "new cash" increase of £861m, 6·8% more than this year's spending. Yet between 5% and 6% of this increase will be consumed by inflation leaving a real increase of between 0·8% and 1·8%.

The "savings" column details the government's estimates of how much money will be available out of the planned budget of £13 501m to be spent in other ways. In the case of cost improvement programmes this includes using existing resources more efficiently to release cash to develop services. A substantial portion of the savings comes from superannuation savings, which are in a sense fortuitous. Actuarial advice received by the government recommended a cut in employers' pension contributions from 7·5% to 4·0%, and the NHS has been allowed to keep these savings.

As in previous years it is savings like these that are crucial to health authority finances. How crucial may be judged by looking at the commitments next year on the cash increase of £861m for the hospital and community services. Inflation (estimated by the government at 5%) will require £632m; money earmarked for the treatment and prevention of AIDS will take £68m. Nurses' training will need £12m; central government initiatives (like the waiting list initiative of the past few years) will take some £30m; and correcting health authorities over commitments on their income and expenditure accounts (in a sense, a debt to be paid off) will require about £100m. This leaves £19m, an increase of just 0·15% on this year's spending.

The savings of £402m should boost this increase to 3·4%, but not only may the savings have been overestimated but also the financial commitments of the hospital and community services may have been underestimated. The government's estimate of savings from cost improvement programmes for next year is the same as the target this year—£150m. But the programmes are likely to fall short of their target by some £34m this year and are likely to fall at least as short next year.[1]

Another problem is that the government may have ignored the fact that inflation is higher in the health service than in the general economy.[1] It has been predicted to be 6% rather than 5% next year, swallowing up another £216m.[1] In addition, underfunding this year and last because of failure to allow for higher inflation rates will mean that the hospital and community services will effectively start next year £89m down. Taking these overestimates and underestimates together leaves the hospital and community services with £182m to develop services—real growth of 1·4%.

This is unlikely to be enough. The most recent estimates from the hospital and community services suggest that a 3·6% (£455m) increase will be needed next year to meet additional demands from elderly people, finance medical advances, and fund central government priorities for activities such as renal services and community care.[1] In addition, previous underfunding does not disappear at the start of each financial