heads not more than 30° above the horizontal when feeding or during evacuations, but otherwise keeping them completely recumbent, though they could move as much as they liked in the horizontal plane.

It was found by means of gamma-ray absorptiometry that the mineral loss affected mainly the weight-bearing bones, especially the calcaneus, whereas the radius and ulna were not affected at all. Without treatment the rate of calcium loss from the body was about 0.5% of the whole body store per month, the mean rate being 190 mg per day, while the diet contained 1.0 g of calcium and 1.6 g of phosphorus per day. When the man got up again, the calcaneus recovered its mineral content slightly faster than the previous rate of loss.

Six methods of treatment were tried to prevent the mineral loss. Conventional exercises for a total of 80 minutes per day were found to have no effect. Longitudinal static compression between the soles of the feet and the iliac crest, with a special "gravitation simulating" suit applying 80% of the compression which gravity would cause, was tried for four hours a day continuously on some of the men and on others intermittently 45 times a minute for four to six hours a day with 80 to 100% of gravitational compression. But this simulation of gravity, the authors state, "provided at best a limited degree of protection."

As to supplementing the diet, calcitonin was tried but had no beneficial effect. Phosphate, given as the neutral potassium salt at the rate of 1.3 g of phosphorus per day, prevented hypercalcuria but did not reduce the overall mineral loss. But this dose of phosphorus combined with calcium lactate giving 0.8 or 1.3 g of calcium per day maintained the mineral balance and prevented loss of mineral from the calcaneus for the first 10 weeks—but not, apparently, during the fourth and final month of bed rest. The authors therefore recommend a high intake of calcium and phosphorus for prolonged space flights.

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**Trends for Scientific Journals**

Doctors who try to "keep up with the literature" may take some comfort from findings reported last week to a conference of scientific editors at the Royal Society. Full-time research workers, it appears, can stay abreast of their subject by taking on average no more than 12 of the hundreds of journals in that field, and even in the case of these "core" journals they look at only between 4% and 17% of the pages. This selection of the small proportion of relevant material from the mass of published work is accepted as inevitable by scientists, so the practising clinician should not be surprised if many of the original articles in medical journals are not applicable to his day-to-day work. This must be so since in any one clinical discipline important research findings are relatively rare events. The biological, earth, and physical sciences were all represented at the meeting, and there was little dissent from the findings of Dr. K. L. Blaxter that in any given field of interest 90% of important original work is published in a handful of journals; that this core of journals is also the starting point for searches of literature (rather than abstracting journals or indexing services); and that at least in western countries photocopying is rapidly making the reprint obsolete.

The steady growth in numbers of scientific journals—doubling about every 25 years—may seem less alarming in the light of this assessment, but there was no doubt that it worried the meeting. There was strong criticism of the mushroom growth of trivial new journals. One reason for their proliferation, according to Sir Harold Thompson, was that "commercial publishers offer young men financial inducements to act as editors or to sit on editorial boards." Professor H. L. Kornberg revived the idea that journals should publish only extended abstracts of scientific work and that the full text should be deposited in a central library, which could provide photocopies on request. There was little enthusiasm for this scheme, though it seems to be widely used in the U.S.S.R. and in Eastern Europe. Several speakers with experience of systems in Britain for the deposit of detailed basic data not published with a paper reported that such data were hardly ever consulted; but publication of essential data is mandatory if the paper is to be critically assessed and commented on in subsequent correspondence. Certainly no collection of extended abstracts can make attractive reading—surely one of the best features of scientific journals is their browsing potential?

Long-term trends are difficult to forecast in the field of scientific publications. In retrospect no one is surprised that prepublication clubs have burned themselves out and that publication of verbatim conference proceedings has virtually ceased, though neither event seemed certain even three years ago. But it does seem unlikely that the present growth rate...

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**Inquiry into G.M.C.**

The Government's announcement last week that it will set up a committee of inquiry into the structure and functions of the G.M.C. was inevitable once it was clear that the profession no longer was likely to reach agreement within itself. The decision must now be seen as providing an opportunity to look at the question in a fresh spirit. Presumably the report of the Brymner Jones Committee on the G.M.C.'s structure will be high on the agenda for the new committee of inquiry to consider. Doctors will note with satisfaction the assurance that Sir Keith Joseph gave when announcing the inquiry that it was not contemplated that the profession should be regulated otherwise than by a predominantly professional body.

Though it is occasional doctor's follies or delinquencies that bring the G.M.C. most dramatically before the public eye, its responsibility for educational standards is the real basis of its existence. It is the training he has undergone to the satisfaction of his teachers that distinguishes a registered doctor from a quack, and it was to make this distinction for the public benefit that the Government of the day established the G.M.C. under the Act of 1858—to the cheers of the medical profession. Now that the hazards as well as the benefits of medicine have multiplied 10 times over the control of educational standards must be the primary duty of the G.M.C. or its successor. From this starting point the committee of inquiry can have a fruitful examination of how the G.M.C. can best be composed to command the respect of the medical profession and to serve the interests of its patients.
of journals will continue. Neither potential readers nor actual libraries are multiplying at anything like the rate that journals have increased in number in the last decade. The rising costs of production are now forcing libraries to be more selective, and librarians are assessing the quality of journals and the amount they are used.

Professor Henry Harris made some useful comments on the features that maintain quality in scientific journals. The scope of the journal—in both subject matter and potential authors—had to be large enough to ensure that enough papers were submitted for the poor ones to be rejected. The referees should be young and energetic rather than old, distinguished, and too busy; and the editors should know enough about the subject to recognize capricious refereeing. Perhaps, as one speaker suggested, referees' names should be printed alongside the papers they recommended. Professor Harris was also unimpressed by the emphasis given to speed of publication by some journals. "If there is that much of a scramble for priority," he observed, "then the work can't have any real originality."

### Torsion of the Testicle Again

Earlier this year a paper by R. H. Chapman and A. J. Walton1 and a leading article2 drew attention to torsion of the testicle as a remediable condition often missed by doctors who would be ashamed to miss an acute appendix or a perforated peptic ulcer. The ensuing correspondence showed the persistence of the old notion that torsion is rare or discounted the existence of the underlying anomaly in the construction of the tunica vaginalis which permits the testicle to spin round on its mesentery. Acute torsion is sometimes missed, sometimes treated as if it were epididymitis, and sometimes not offered the chance of manipulative reduction, which in the early stages may save the testicle.

Attacks of pain in the lower abdomen3 or testicle and swelling in the testicle, the warning episodes which so frequently precede the last twist, are apt to be disregarded,4 though if these warnings are heeded many testicles can be saved. J. A. Burton5 has recently drawn attention to the problem from the experience of the Sheffield Student Health Service, in which as medical officer he saw 17 examples of torsion within the short span of 3½ years. Unfortunately six of these were too late for anything to be done: the men had an atrophied testicle on one side. But in the same space of time he came across the same number in whom prompt manipulation followed by surgical fixation saved the gonad, thus confirming J. P. Sparks's similar experience at Rugby School.6 Confronted with a possible example of testicular torsion, any doctor can make an attempt to untwist it there and then. In general the right testis should be "unscrewed" and the left one "screwed up" to undo the twist. If one forgets this in the heat of the moment, the simple mnemonic of "open the doors" may remind one which way the testicles should go. Or, if rotation of the testicle in one direction makes the pain worse, one may twist the other way. The manoeuvre is simple and worth trying.

Misconceptions about the rarity of torsion should be forgotten once and for all. M. Etienne and M. Vialas7 in a recent review of the subject show that torsion may occur rather commonly and at any age. In the newborn boy it consists of extra-vaginalis torsion of the whole cord, and only this condition may be regarded as really uncommon. Later on in childhood it is the same kind of intra-vaginalis torsion as found in the adult, and unfortunately shares the same fate of being generally misdiagnosed and mismanaged. As in the adult, so in the infant; if there is any question of torsion, the testicle must be explored.

What is the risk of performing an unnecessary operation? Idiopathic oedema of the scrotum8 may at first glance be confused with torsion, but the testicle itself feels normal in this strange condition; only the scrotal skin and fat are oedematous. Mumps orchitis is rare before puberty. Epididymitis does occur, but like epididymitis in the adult it usually begins by being limited to the epididymis and generally accompanies other evidence of urinary or urethral infection. If the testicle is undescended, there is less risk of the condition going unnoticed, since the tender lump will be diagnosed as a strangulated hernia and an operation performed without delay. The underlying anomaly which predisposes to torsion is often bilateral. Both testicles must be fixed if one has undergone torsion.

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### Candida Infection

The unstable host-parasite relationship between man and _Candida_ species, notably _Candida albicans_, is incompletely understood even by those who devote much of their time to the study of this increasingly important problem. Patients who are symptom-free healthy carriers of _C. albicans_ in its non-pathogenic yeast phase frequently receive prolonged and unnecessary treatment. The development of acute candidiasis is favoured by certain antibiotics, corticosteroids, and perhaps by the contraceptive pill, and is now familiar to general practitioners.

The association of chronic candidiasis with diabetes mellitus has long been recognized, and the increased susceptibility to candidiasis of patients with some other endocrine disorders has also been known for many years.1 Chronic candidiasis may also occur in patients with a wide variety of defects in the immune response.

In 1970 R. S. Wells2 described a genetically determined syndrome in which susceptibility to chronic candidiasis occurs in the absence of other clinical abnormality. Wells and his colleagues3 have recently reported the results of their investigation of 46 patients, most of them referred at their request by dermatologists throughout England and Wales. All these patients had chronic oral candidiasis, some had candidiasis in other sites, but none had other clinically evident disease.

The 46 patients were provisionally classified in four groups. Twenty-two patients were placed in group 1; all had developed oral candidiasis early in life, often before the age of 2, and some had candidiasis of nails or other sites. Pedigrees suggested that the susceptibility to candidiasis was probably determined by an autosomal recessive gene. Wells at present