

In the evolution of the methods of treatment of any disease, there are three stages:

A. The identification of the problem: in this case, that testicular cancer kills and hence should be detected and treated early by orchidectomy.

B. The second phase, where the treatment is carried out enthusiastically and sometimes overenthusiastically, and where statements such as 'every intrascrotal mass should be treated as cancer till proved otherwise' become common.

C. The rational phase where diagnostic refinement occurs and treatment becomes sophisticated.

Witness the changes that have occurred in the treatment of appendicitis. Tissue review committees have condemned the surgeon who removed too few normal appendices (at least 20% were expected to be normal) only a decade ago. Today, the figure of 20% unnecessary misdiagnosed appendices is unacceptable. Today, in the West, doubtful testicular torsions are not subjected to exploration IF scintiscan or Doppler studies are possible without further compromising the testis (Time is of utmost importance here).

I agree that biopsy and frozen section adds to operating time. The risk of sympathetic orchioptia is mentioned in the article under discussion, and methods are suggested to overcome this obstacle, and one of these (ice slush cooling) is in practice in the States. The production of sympathetic orchioptia has been disputed recently¹. That facilities are not available today is no reason why

they should not be developed.

At the time of introduction of needle biopsy of the thyroid gland, its protagonists were often reviled for spreading cancer along the needle tract.

The fear of spread of cancer has not materialised. The same fear is justified in testicular cancer and careless manipulation is not justified nor is it acceptable. The testis needs to be isolated during surgery, and the instruments used in biopsy need to be discarded.

The treatment of tuberculous abscess is NOT orchidectomy. Tuberculosis is a generalised disease and the testis may be bilaterally involved.

When the patient is told that if there is still a doubt on exploration, that the lump may be malignant, the testis will be removed, the patients often delay surgery and start a round of visits to various physicians, surgeons and homeopaths, in the hope that they will find someone who will prescribe medication, at least in the first instance. This causes further delay, and noncompliance with the surgeons line of action.

The critical comment was not written as an expose of current practice, but rather as a thought provoking comment on what we should work towards achieving.

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1. Testicular torsion does not cause autoimmunisation in man, *British Journal of Surgery*, 1985, 72: 237-238.

Book Review

SYMPOSIUM : LIVER DISEASES

Edited by S.A.R. Hamdani, Professor of medicine at Quaid-e-Azam Medical College, Bahawalpur brings the college as much to the forefront as it does liver diseases in Pakistan. No less than nine out of eleven contributors are faculty members of that college. The review article on 'Drug Hepatitis' by Khurshid Ahmed, Professor of Pharmacology, is a valiant attempt at integrating basic sciences with a predominantly clinical symposium. The papers on hepatic coma (Sarwar Zuberi), haemolytic jaundice (Saeed Ahmed Malik), and on jaundice in paediatric (Sarwar Alam Sarwar) and in pregnancy (Tasleem Malik) provide epidemiological information which might become useful as the data base expands. The differences in renal function in coma between cirrhotics and those suffering from acute virous hepatitis provide interesting reading. Hamdani's Evaluation of indigenous drugs in

the treatment of jaundice has no pretensions of being a random controlled trial. The other papers are essentially neurological, although Dr. Muhammad Amir does make a fleeting reference to his own small series of patients with surgical jaundice.

Elegantly jacketed, this compact publication by Hamdard Foundation Press, is refreshingly free of advertisements. There are not too many typographical errors. Some of the tables are unnecessary and others unclear, the line drawings are amateurish and the histograms in Hamdani's paper defy comprehension. Some articles do not have references.

This booklet, more than anything else, proves that academic interest is alive at Quaid-e-Azam Medical College.

MUSHTAQ AHMED

specially as they have had a wealth of experience about their own professional experiences.

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Dear Sir,

Ref. Biopsy for Suspected Testicular Cancer Pakistan Journal of Surgery 1, 1-6.

I concur with Dr. Talati's concern about unnecessary orchidectomy for some of the rare benign lesions of the testis which can be cured by means other than surgery. However, the dictum "Always Biopsy before orchidectomy" is extremely deleterious and detrimental and, in majority of cases contraindicated in cases of Testicular Tumours.

A patient with intrascrotal mass who has even a slightest doubt of having a malignant lesion by means of clinical and/or laboratory examinations must undergo 'Transinguinal scrotal exploration'. Gentle intra-operative examination of scrotal contents will not in any way increase the risk of spreading cancer cells as compared to preoperative physical examination of scrotal mass by number of examiners as well as by patient himself. Henceforth, clamping of the spermatic cord prior to delivery and isolation of scrotal contents for inspection alone is not mandatory. If warranted one may use a bull dog or suitable noncrushing vascular clamp for soft occlusion of spermatic vessels at the level of internal inguinal ring. This will not produce any ischemic changes or necrosis if occlusion time is limited to minimum. The diagnosis can be made within seconds whether the scrotal mass is extra testicular or intra testicular in origin. If the lesion is confirmed to be intratesticular, one must proceed with the radical orchidectomy except under very rare circumstances for the following reasons.

1. 98 out of 100 times intra testicular mass will be malignant.

2. Most of the benign lesions of the testis reported in the literature occur in the age group 40 - 70 years old, while most of the malignant lesions occur in the age group 22-36. Most benign lesions of testis appear to be superficial, discrete and confined to tunical-

buginea. Only in such cases one may consider biopsy and frozen section.

3. Certain conditions like Tuberculous granuloma or Syphilitic gumma of testis which may be indistinguishable from a testicular tumor by palpation are also best treated by means of orchidectomy.

4. Biopsy and frozen section is time consuming which in itself defeats the purpose of saving a testis because of increased ischemia time. This sort of practice in every given case may also put a contralateral testis at risk because of sympathetic Orchioepithelia. Besides even in most modern urban hospitals in Pakistan frozen section report would not be totally reliable.

5. In some cases of testicular tumor like chorioncinoma the tumor may be so minute and it may be only diagnosed by removing the testis and take multiple serial sections. In such cases the removal of testis will be justified on the basis of laboratory and clinical findings.

6. The risk of spreading tumor cells and error in the diagnosis by means of biopsy and frozen section of the testis is much greater than the risk of occasional removal of testis for a benign lesion which could be treated without orchidectomy.

7. Patient and his relatives are always well informed that if there is any doubt about the lesion being malignant, it would be safer to remove the testis rather taking the risk of biopsy and spreading the tumor cells.

8. The procedure of systematic 'Transinguinal exploration and inspection of scrotal contents followed by orchidectomy for the reasons as stated above should not be labeled as 'blind orchidectomy'.

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Author's Reply:

The comments of the reader are valid and traditional, and applicable in practice today, in all our hospitals. The reasoning is very rational, and this approach has been the accepted one for many years. However, in practical terms, the policy of orchidectomy on suspicion will continually result in a number of unnecessary orchidectomies.

Letters to the Editor

Dear Sir,

Higher Surgical Training

What is a Surgeon and what are the training requirements of a Surgeon?

It is difficult to define a Surgeon, but generally he can be defined as a scientist and craftsman with a human touch. It is generally considered by leading world authorities that a Surgeon should have a sound knowledge of basic sciences in addition to his particular craft.

Practical training in this country is as hapazard as it used to be in the U.K. before Lord Pickering's report in 1965. There is no fixed period or routine to be followed for a particular field although the total time period of training has been fixed. It is also considered that a Surgeon should have a broad based practical experience preferably under quite a few trained Surgeons. There has been some suggestions that a trained Surgeon should spend a fixed period with a trained Surgeon and be certified at the end of that period. This will do nothing to improve the standard of Surgery in Pakistan.

There is also a lot of controversy about the time a trained registrar should spend with a particular Surgeon. Some have demanded two years, others have kept their registrar for ten years. When one talks to house surgeons one gets the impression that they are not quite sure about what they want to do; they leave it to fate. I believe that training of a Surgeon should be started only after the part I fellowship examination has been cleared.

I suggest that following measures to improve the training facilities.

1. Medical students in the later years of their clinical training should be encouraged to choose a speciality for training if they wish. A posting in a District Headquarter DHQ Hospital may enlighten them as to the lacunae in our present system and may help them choose a career.
2. A high power committee should be set up which should include Surgeons and Executives from the

planning department of the Government. This committee should thrash out the following points:-

- i. The number of Surgeons required.
- ii. Period of training. In this context, I must emphasise that during this period the trainee should rotate through a wide range of specialities.
- iii. A Surgeon in training should know in advance the overall plan of his training and the specialities in which he will be rotated.
- iv. A Surgeon in training (SIT) should get preferential treatment from the unit to which he is attached. He should not be forced to utilize his time for providing routine services. He should be given a day off in a week to look up literature. He should be motivated towards research work.
- v. Once a SIT completes his training programme, he should move out and not continue in the same post.
- vi. A Surgeon in training should spend sometime in the D.H.Q. Hospital.
- vii. The SIT should also be encouraged to spend part of his training period abroad for wider exposure as it is being done in U.K. where the trainee is sent to U.S.A. or Canada on an exchange basis.
- viii. After they have finished their training, the SIT should be reasonably sure about getting a job, otherwise it will be a colossal waste of national as well as individual talent.
- ix. Experienced retired surgeons should be requested from time to time to deliver guest lectures