about *Journal* policy. It is often suggested, in local faculty meetings and at central College gatherings, that the *Journal* should be the vehicle for promulgating College statements about clinical work and for publishing review articles. The College does indeed make statements from time to time, but has so far stuck to its academic role and has restricted itself almost entirely to pronouncements about educational matters (see, for instance, the document on training for obstetrics published recently with the RCOG in News and Views, pages 116-122, February *Journal*). As far as review articles go, we have also usually rejected these for several reasons: the chief one is that we prefer to remain a journal of report, recording the slow and painstaking addition of new information to the structure that is called the scientific basis of general practice medicine. This kind of information is not the statement of an authority made from the eminence of some institutional position; it is, rather, the raw data of research, the findings of general practitioner scientists in the consulting rooms and the domestic laboratories where we see our patients. As general practitioners, we will therefore both understand the basis of the research and be able to question it: we will not be satisfied with mere dogmatic assertions such as "all patients with proven urinary tract infection must receive appropriate antibiotics for one week". We know that patients do not wait for proof of infection before they ask for treatment; we know that antibiotics will be appropriate for reasons other than just bacteriological; we know that few patients (and few doctors) take antibiotics accurately. We therefore ask that a scientific article goes beyond directions, admonitions and exhortations; we ask for the evidence. Review articles, even though they may be hellishly difficult to write well, are very satisfying to read. They give the reader the feeling of having been able mentally to tick off the subject as 'done' for a while. They are usually produced by hospital specialists, and seeing them arouses, we suspect, ancient fears and feelings born out of an undergraduate anxiety to please our teachers. They tend to invite passive acceptance more than active questioning, disagreement and argument. They have their valued place in several other high-class medical journals, distinguished contemporaries whose efforts we salute but do not wish to copy.

If the place for review articles in this journal is therefore limited, what is the aim of the long editorials such as those on nutritional supplement in pregnancy (January) and on antibiotics (April)? One crucial factor lies in the authorship of these editorials, which, being firmly general practitioner, roots the conclusions in our own discipline. The second aim is to provide what amounts to an annotated bibliography. Thirdly, these editorials aim to provide an up-to-date statement of current thinking about the subject in question.

Journal policy will thus remain much as it has for many years: to record original research from and about general practice, to leave review articles mainly to those journals which already do them well, and to use the editorial columns for occasional review of major topics in general practice medicine.

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Delay in diagnosing testicular cancer

Of 335 patients with germ-cell testicular cancer, 87.5 per cent had symptoms related to the testis. Only 40 per cent of the patients saw a physician within two weeks. Similarly, testicular signs were present in more than 90 per cent of patients, but in only 61 per cent of patients was a correct diagnosis made within two weeks of the initial physician visit. The length of the patient-related and physician-related delay was directly related to the clinical stage of the cancer at diagnosis. The median patient-plus-physician delay for stage I was 75 days, for stage II, 134 days ($p = 0.017$).

Source: Bosl, G. J., Goldman, A., Lange, P. H. *et al.* (1981). Impact of delay in diagnosis of clinical stage of testicular cancer. *Lancet*, **2**, 970-972.

Words our patients use

'Slethering', or 'slothering'—dragging a bit, as of a paralyzed leg (South Yorkshire).

'Baith', 'beeling' or 'birling'—septic, as in finger (Scotland).

'Annoyed'—worried or anxious: "The family are very annoyed at the doctor's advice" (Shetland).

'Lisk'—groin (Tyneside).

'Pown'—to be worried or in a muddle (Lancashire).

'Wurch'—to ache (Lancashire).

'Gam'—a funny or humorous person (Lancashire).

'Gobbin'—a simple, silly person (Lancashire).

"I am hully out of repair" or "I am hully queer"—not well (East Anglia).

'Merry-go-wimbles'—borborygmi (East Anglia).