I am very much aware that other individuals in this country have been involved with overseas doctors, and perhaps the time has come for the College to reconstitute its International Division to direct and co-ordinate our efforts in this direction.

J.J. FERGUSON
University of Edinburgh
Department of General Practice
Mackenzie Medical Centre
20 West Richmond Street
Edinburgh EH8 9DX.

The quality initiative

Sir,
The College's quality initiative has impressed me, but the policy statement, *Quality in general practice,* disturbs me. Our early endeavours to delineate 'quality' in no way qualifies us to deliver autocratic opinions on the way forward.

I would contest the assumption that a professional man's career should progress with a series of recognizable hurdles along its path. General practice is a discipline which has room for a great diversity of people. I worry about the effect that vocational training is having on the capacity of young doctors for original thought, and a more rigidly structured career pattern will further discourage originality.

If College examiners are finding that large numbers of candidates are inadequate then training needs to improve. It is probably a mistake to allow candidates to sit the membership examination at the time they complete their vocational training. Three years after obtaining the Joint Certificate on Postgraduate Training for General Practice would be a much more suitable time. By then doctors would have the benefit of a much greater breadth of experience. It is possible, of course, that if the examination were to cease to become a passport to a partnership, the number of candidates would go down. I can see nothing wrong with associate membership as a way of staying in touch with College activities. A further advantage might be that many enthusiastic doctors might find that large amounts of their time were no longer taken up with marking papers and conducting oral examinations.

The policy statement talks of teamwork and organization but says very little of the role of the patient. It also says very little about single-handed practices.

The idea of incentives for doctors seems so difficult that it can only be deeply divisive within the profession. The varying bodies which represent our concerns and interests need to work together and the present arrangement whereby the General Medical Services Committee deals with terms and conditions of service seems satisfactory. The College should not intrude in this area and should concentrate its efforts on defining quality in practice and encouraging its attainment. It is on this point that I feel that the document has gone off at a tangent to the central issue of what is good quality and how we can improve it.

VALERIE M.K. ARTHUR
21 Stockwell Road
Knaresborough
North Yorkshire HG5 0JY

Choosing a new partner

Sir,
I was intrigued to read Dr Thomson's letter (October *Journal* p.498) about his efforts to appoint a new partner. I would make two points:

1. He should not be disappointed or even surprised that so few applicants did not have the MRCGP, as many would still be in their training year and therefore not eligible to sit the examination.

2. Why has he excluded all the unmarried applicants? It would seem that many prospective senior partners feel that single applicants are unsuitable for general practice. Is he not aware that the late William Pickles, the founding president of the RCGP was a bachelor when he entered general practice — I am sure he is not the only one.

Thankfully I did not apply for Dr Thomson's post as I would not wish to work with such a short-sighted, senior partner — to exclude applicants solely on their marital status is to exclude some excellent prospective partners.

JAMES MOORE
33 Church Park Road
Yealmpton
Devon

Testicular torsion presenting with abdominal pain

Sir,
The danger of failing to recognize testicular torsion is well known. Late diagnosis is still common, and Williamson[1] in a large series showed that some 40% of testicles are not viable. Delay in diagnosis adversely affects the prognosis,[1] and it was recently brought to our attention that when the patient presents with abdominal pain only, and no scrotal pain, then delay and consequent orchidectomy are likely. It is essential that general practitioners and casualty officers know that patients with testicular torsion may have no scrotal pain at all, but only pain in the abdomen. Two case histories illustrate the problem and emphasize that the scrotum must always be examined in a patient with abdominal pain.

Case One. A 22-year-old man experienced sudden onset of abdominal pain and vomiting while playing hockey. Later he was visited by his general practitioner who found no signs of pain in the abdomen or scrotum. The practitioner was asked to visit again two days later because the pain was worse and had moved to the scrotum. There were now obvious signs in the scrotum, and torsion was confirmed at operation. The colour of the testicle improved after untwisting and applying hot packs so it was replaced and both testicles were fixed. The wound never healed, it discharged pus and three weeks later the necrotic testicle had to be excised.

Case Two. A four-year-old Indian boy was visited at home because of sore throat and abdominal pain. Examination showed inflammed fauces, tender cervical lymphadenopathy and a normal abdomen but the external genitalia were not examined. Mesenteric adenitis was diagnosed. A second visit was requested the next day because the child had developed testicular pain and this time a swollen tender testicle was noted. At operation the testicle was black and had to be excised. The right testicle was fixed.

These two cases illustrate the difficulty when there is no complaint of scrotal pain at first presentation. In both these patients the pain was abdominal and only moved to the scrotum after the initial presentation. Williamson reported that 11% of patients had no scrotal pain, 39% had some pain in the lower abdomen and 19% experienced inguinal pain. Cass[2] stated that 12.5% of 49 patients experienced only abdominal or inguinal pain and 52.5% had scrotal pain with some radiation to these regions. Pain initially confined to the abdomen was noted by Greaney[3] in 11% of 19 cases.

Moore[4] pointed out that the initial pain of torsion should not be felt in the scrotum at all, the extrascrotal pain representing the anatomy of testicular innervation. The testicle is innervated by spinal segments T10 and T11 but the scrotum is supplied by L1 anteriorly and by S2 and S3 in its posterior part.[5]

In the first two decades of life testicular torsion is encountered more often than epididymitis but nevertheless in this age