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.

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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.

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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.

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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

group epididymitis was reported to occur in 23% of patients,[6] as against 77% who had torsion of the testicle or torsion of an appendage. In subsequent decades epididymitis predominates over torsion.

A recent paper[6] advocated a computer programme available in the casualty department to improve the diagnosis of testicular pain. While this may be valuable it will be useless if the first clinician to see the patient has not considered torsion. Examination of the external genitalia is essential in any male with abdominal pain and the role of the general practitioner or casualty officer is crucial.

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Acknowledgement

We thank Mr W.J.D. Bradfield for allowing us to report a patient admitted under his care.

Why not a district policy for hypertension?

Sir,
When we were both postgraduate clinical tutors we decided to designate 1982 as 'The year to start blood pressure checks'.

On the hospital side a new space was printed on all discharge summaries for the blood pressure to be recorded. In general practice we held talks, discussions and distributed posters and other literature. We produced a policy document (available from C.B.-C.) for all doctors, with guidelines on how to screen for high blood pressure and how to act on the blood pressures found, and with suggestions for investigations and treatment. These guidelines were approved by other consultant physicians.

In 1983 and 1984 the policy document was revised and recirculated. We then reviewed the effect of the first year's programme by a questionnaire sent to all general practitioners.

One hundred and twenty questionnaires were posted to general practitioners and 101 (84%) were returned. Six doctors were new to the district since 1982 and these were excluded leaving 95 relevant answers. The results are shown in Table 1.

Table 1. Screening for high blood pressure — 95 responses from general practitioners to postal questionnaire.

	Number	(%)
GPs who were screening before 1982	37	*(39)*
GPs who started screening as a result of blood pressure check year	40	*(42)*
GPs who started screening for other reasons	2	*(2)*
GPs who were screening in 1984 (total)	79	*(83)*
GPs who remembered seeing policy document	83	*(87)*
GPs who found policy document helpful	74	*(78)*

Part of the increase in the numbers of doctors screening may be the result of nationwide changes, but the increase from 39% to 79% over two years indicates to us that the year was worthwhile. We are now in the process of producing guidelines sheets in other clinical areas.

Why not do something like this in your district?

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Assessment of time of death

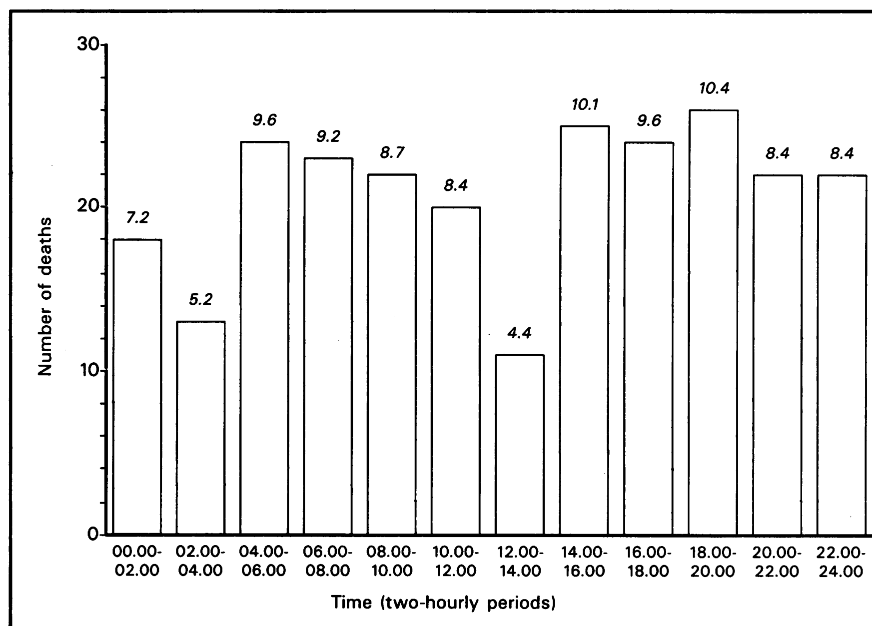

Figure 1. *Combined number of deaths in 1983 and 1984 by time of day in two-hourly periods. (Numbers over bars show percentages;* n = *251 deaths.)*

Sir,
We became aware during our work at the Macmillan Service that a number of calls from families at night were generated from an expectation that people die at night, especially just before the dawn when life forces are supposedly at their lowest ebb. A review of the literature[1,2] produced no information as to whether this supposition was based on fact or not. An attempt was made to investigate this using data obtained from patients cared for by the Macmillan Service. These patients, by definition, were terminally ill with a malignant disease and were cared for and died at home. The notes of all patients who died in 1983 and 1984 were reviewed and the times of death were noted to within half an hour.

We retrieved the notes of 162 patients who died in 1983 and 117 who died in 1984. The data were analysed using Edwards test for cyclic trend.[3] There was no evidence of a cyclical trend for time of death when the two years of data were