and limited surgery reduces the need for radical surgery in patients with genitourinary rhabdomyosarcoma.

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Orchidopexy before age of 10 is best for undescended testes

EDITOR,—Chris Dawson and Hugh Whitfield's article on common paediatric problems in urology suggests that an intra-abdominal testis diagnosed after the age of 2 should be left in situ to preserve hormonal function until after puberty, when orchidectomy could then be performed.¹ We are aware of the need for brevity in ABC series, but we think that this suggestion is unusual and open to debate.

The authors make no distinction between unilateral and bilateral cases of undescended testis. The policy that they advocate confers no obvious endocrine advantage in unilateral cases. In bilateral cases orchidectomy after puberty will necessitate long term hormone replacement treatment, whereas orchidopexy performed at the time of diagnosis and before the age of 10 years will obviate the need for such treatment while mitigating the potential for malignant degeneration.^{2,3} Recent studies with long term follow up have shown that even for the impalpable testis, high success rates are achievable with a variety of techniques, including microvascular techniques.^{4,5}

We assume that the advice in the flowchart for orchidopexy to be performed after puberty in those diagnosed after the age of 2 years is a typographical error as it is at variance with the advice given in the text.

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Laparoscopy has much to offer

EDITOR,—Chris Dawson and Hugh Whitfield's article on common paediatric problems in urology suggests that there is no difference between the management of non-palpable

unilateral and bilateral undescended testes.¹ The authors advocate laparoscopy as the method of choice for investigating the presence or absence of testes and recommend orchidectomy for children presenting after the age of 2, because their testes are likely to be sterile, though they say that this should be done only after puberty to avoid any problems with a low concentration of testosterone. This policy will lead to a large number of unnecessary orchidectomies.

For unilateral non-palpable undescended testis many surgeons still explore the groin. If a testis or a blind ending vas and vessels are found then the problem is solved. If not then extending the incision and opening the peritoneum may help. Laparoscopy is gaining wider acceptance as the investigation of choice to avoid negative findings and unnecessary extensive explorations of the groin. As most intra-abdominal testes are present near the deep ring, single stage laparoscopic orchidopexy is the operation of choice if a good quality testis is found.² For high testes a two stage laparoscopic Fowler-Stephens orchidopexy or microsurgical autotransplantation³ should be considered. All these operations should preferably be done before the age of 2 years to decrease the likelihood of sterile testes, but children presenting after the age of 2 should be offered the operation. Age is not a limitation, especially if good quality testes are present at the deep ring or peeping in and out of the inguinal canal.⁴

Children with bilateral non-palpable undescended testes should undergo XY karyotyping and human chorionic gonadotrophin and luteinising hormone releasing hormone stimulation tests. High concentrations of gonadotrophins with no increase in the testosterone concentration mean that no testicular tissue is present and operation can be avoided.⁵ If testicular tissue is present then laparoscopic orchidopexy for low testes and a two stage laparoscopic Fowler-Stephens or autotransplantation for high testes can be done. These operations should ideally be done in centres with a special interest in undescended testes. Age should be less of a consideration in these cases, and older children should be offered the treatment.⁴

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Authors' reply

EDITOR,—Sue J Vernon and colleagues question our comments about the management of urinary tract infection in children. The detail that can be supplied in an ABC article is limited, but we recognise that age has an important bearing on the investigation of children presenting with urinary tract infection.

Michael Hehir and Lawrence Walker's comments about staging of prostate cancer and the errors in the figure are correct. The diagram showing stage T3 disease should have been labelled T4 disease, and T3 prostate cancer should have been represented by a figure showing extension of cancer beyond the prostatic capsule.

Our article on common paediatric problems was aimed at doctors who are not specialists in paediatric oncology, and we therefore kept details to a minimum. Nevertheless, C R Pinkerton and colleagues' points are valid, and paediatric tumours are best dealt with by specialists.

G Humphrey and B R Squire criticise our comments about the treatment of rhabdomyosarcoma. Our short paragraph on this subject reflected the importance of this rare tumour to general urologists. We recognise that chemotherapy has a pivotal role.

J A Jibril and colleagues' comments about undescended testes are pertinent, and our article has given rise to confusion. All patients with bilateral undescended testes should undergo XY karyotyping. The presence of hormonally active testicular tissue can be confirmed by luteinising hormone releasing hormone and human chorionic gonadotrophin stimulation tests, although these are not useful in unilateral cases with a normally situated contralateral testis.

For children aged under 2 (regardless of whether one or both testes are undescended) the management is the same—that is, orchidopexy should be performed before the age of 2 if possible. If both testes are undescended then an orchidopexy should be performed on the second testis only after survival of the first testis has been assured. In prepubertal children over the age of 2 the undescended testis is likely to be sterile and early orchidopexy is not essential. Some urologists believe that operation should be deferred until after puberty as there is a risk of atrophy and loss of endogenous hormones from orchidopexy before this time, especially in bilateral cases. After puberty there is no possibility of an undescended testis being fertile. Orchidectomy is probably advisable in unilateral cases, and the decision to insert a prosthesis for cosmetic reasons can be made after counselling. The role of orchidectomy for bilateral undescended testes is less clear, but the testes must at least be moved to a position where they can be regularly and easily examined.

Finally, with regard to Sherif E Habib's letter, there was a typographical error in the text of our article, and orchidectomy should have read orchidopexy. We suggested that as undescended testes in children presenting after the age of 2 are likely to be sterile, orchidopexy is less urgent. Because orchidopexy by the Fowler-Stephens method is associated with atrophy rates in excess of 50%, loss of endogenous testosterone is an important complication, particularly in bilateral cases. Some authors have therefore suggested that orchidopexy in such cases be deferred until after puberty.

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Adjuvant treatment with tamoxifen

Care is necessary

EDITOR,—Michael Baum and Jack Cuzick¹ object to my comments about a clinical announcement by the National Cancer Institute that a trial comparing five years of adjuvant treatment with tamoxifen for breast cancer with a longer period of such treatment has been stopped.² They say that the announcement is a "dubious and previously discredited process" (why?) and is based on