million women screened in the British breast cancer screening programme in 1991-2 and that 1465 of the cancers were invasive and <10 mm in diameter.¹ Subsequently Yeoman *et al* reported that 39% of the cancers were palpable, leading to the conclusion that the balance, 39% (100-39-22), were non-invasive and impalpable.² Now Joan Austoker reports that ductal carcinoma in situ made up 17.6% of the cancers.³ In view of its rarity, lobular carcinoma in situ seems unlikely to have accounted for the other 21.4% of minimal lesions. We are left wondering where the discrepancy lies. In any event, such a large number of non-invasive cancers presents a practical and ethical problem since there is no consensus among surgeons about how to treat them.⁴ It is recognised that an appreciable proportion do not become life threatening.

We also note that figure 3 of Austoker's paper shows reduced mortality, with a relative risk of 0.5 among women aged 40-49 screened in the Malmö trial. This scarcely equates to a 29% increase in mortality among women under 55 screened in that trial⁵; this error would also affect the size of the cumulative reduction in mortality among the seven trials cited.

Austoker reports that "primary care teams have an important part to play in encouraging women to attend for screening and in providing information and advice, and reassurance at all stages of the screening process." She subsequently lists the benefits (three) and disadvantages (seven). It is not clear whether the women are shown this list and, in relation to overdiagnosis, told what Fentiman advises: that "for many borderline lesions there cannot be any clear guidelines at present, and the only appropriate treatment will be to enter the patient into well-designed national clinical trials."⁶

Skrabanek's argument for the need to obtain signed informed consent from the invited women at the outset of screening⁷ is underlined by the reported outcome measures.¹⁻³

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Screening for testicular cancer

Familial predisposition ignored

EDITOR,—Joan Austoker clearly evaluates the advantages and disadvantages of population screening for testicular cancer.¹ We agree that screening of the general population cannot be justified on present evidence and that greater awareness of this tumour in the general population and among the medical profession should be encouraged. Austoker does not, however, discuss the now substantial evidence concerning familial predisposition to testicular cancer.

Forman *et al* showed that sons of men with the disease had a relative risk of developing it them-

selves of 4.0 and that brothers of men with the disease had a relative risk of 9.8.² Thus siblings of patients with testicular cancer have a lifetime risk of developing the disease of over 2% and form a high risk population with a greater risk of developing the disease than patients with cryptorchidism. We believe that this risk is sufficient in brothers and sons of patients for them to be actively encouraged to undertake self examination and that self examination should be considered mandatory for males in families with two or more cases of testicular cancer.

In July this year the five groups involved in family studies of testicular cancer met to form a consortium to localise the predisposing gene(s) by linkage analysis in families of patients with the disease. If the gene is found it may help to select very high risk patients for more intensive screening as well as give insight into the mechanism of development of testicular cancer. To succeed we will need to examine a large number of families. Sixty families have been identified in Britain, but more are needed, and we would encourage oncologists and surgeons aware of such families to enter them into our research programme by contacting us or Dr David Forman at the Yorkshire Cancer Registry, Yorkshire Cancer Organisation, University of Leeds, Cookridge Hospital, Leeds LS16 6QB (from 1 October).

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Self examination of testes is of value

EDITOR,—As Joan Austoker states, 120 deaths from testicular cancer a year do not justify population screening for this disease.¹ The question of education of young men about testicular cancer in general, and about self examination of the testes in particular, raises some different questions; it will indeed be difficult to evaluate education about self examination of the testes in terms of its effect on mortality from the disease and the proportion of patients requiring chemotherapy.

I take issue, however, with Austoker's statement, based on anecdotal reports, that widespread application "might lead to a substantial increase in investigation of non-malignant conditions with its associated anxiety." Colleagues and I have reported the effect of distributing a leaflet about self examination of the testes. A study of a population of male students indicated that around 500 saw a copy of the leaflet.² Shortly after they did so there were seven consultations at the student health service for scrotal complaints. After the interviews that were conducted to evaluate the effect of the leaflet a further six consultations took place. Such consultations were monitored throughout the investigation, which lasted seven months. From this it seems that publicity about self examination of the testes will, over a short period, provoke inquiries from around 1% of the people who are affected by the publicity. There is no evidence of any longer term anxiety that would appreciably affect the demand on health services.

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Screening for toxoplasmosis

EDITOR,—The Toxoplasmosis Trust's finding that only just over half of British antenatal clinics give advice and information on toxoplasmosis¹ broadly agrees with the finding of a similar study by the Public Health Laboratory Service.² The trust's survey, however, raises more questions than it provides answers.

Both the table and the text misuse the term "screening" and therefore misleadingly imply that almost all the respondents (89% of British antenatal clinics) are, contrary to current recommendations,³ engaged in a category of this activity. Investigating subjects for acute toxoplasmosis on request and when flu-like symptoms are reported is diagnosis, not screening. Failure to distinguish between these two activities can only add confusion to the "ad hoc nature of current screening policy" deplored by Christine Asbury.¹ The activities carry completely different ethical and resource implications, although they both require backing by well informed professionals if patients are to benefit. The survey's finding that ignorance was common among midwives is therefore worrying, although unsurprising.

This ignorance was also reflected in the finding that 51 (>20%) clinics investigated women if they owned a cat. Although this is not commented on by Asbury, no scientific basis exists for doing this. The study's confirmation of professional ignorance also lends weight to earlier concerns about the ethics of media campaigns for screening for toxoplasmosis when expectations cannot be met in practice by the health service.⁴

The chief medical officer recently stated that purchasers should not start new screening programmes unless the programmes have been recommended after research and appraisal.⁵ Such appraisal led to the current recommendations about screening for toxoplasmosis,³ and it would be interesting to know why the purchasers responsible for the five clinics that reported routine screening disagreed with this conclusion.

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Mammography after treatment for breast cancer

EDITOR,—The National Breast Screening Programme's guidelines on follow up of women after treatment for breast cancer recommend regular mammographic surveillance of both the treated and contralateral breast.¹ This surveillance is the responsibility of the clinician providing follow up. Local screening units will continue to recall women with treated breast cancer aged 50 to 64 at the normal screening interval as part of the national programme. Women over the age of 64 will not be recalled but will be screened on request at the normal interval. But for women under 50, or women whose clinicians recommend surveillance

at more frequent intervals, organisation of mammography occurs within the hospital system.

Recently, during preliminary pilot work for a randomised trial of different approaches to follow up, we reviewed the medical records of 145 women who were being followed up after treatment for breast cancer at two district general hospitals. The results caused us some concern and merit wider discussion. We audited the interval between the date that the last mammogram was due, according to the clinician's stated policy for the patient, and the date it was done (or the audit date if it had never been done). In 35% (50 patients) the delay was six months or more, and in 21% (30 patients) it was 12 months or more.

Although the audit was restricted to two hospitals, and we cannot say for certain that we have identified a more widespread problem, we believe these findings raise three important issues. Firstly, there is no reason why quality control in a follow up surveillance programme should be less rigorous than in a primary screening programme—the same organisational principles should apply. Secondly, patients who have had one breast cancer are at approximately sixfold increased risk of a second primary cancer² and are less likely to comply readily with surveillance mammograms, even if aged over 64. Thirdly, and most importantly, many clinicians request mammographic surveillance of breast cancer patients more frequently than the national programme on the basis of evidence that mammography leads to earlier diagnosis of second primary cancers³ or local recurrence.⁴ However, debate remains about the appropriate surveillance interval for this purpose, as well as the overall effect of earlier diagnosis on disease control, quality of life, and survival.⁵

We feel that there is a need to clarify the objectives of mammographic surveillance in women with breast cancer in remission and to decide on the most appropriate screening interval. This would be best done by a randomised trial. Furthermore, there is a need to ensure that whatever surveillance policy is adopted, it is carried out effectively. It may be that screening units, which are already equipped to offer a high quality mammography service with a recall system, are best placed to take on this role—but they must be adequately resourced to do so.

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When to do orchidopexy

EDITOR,—Grant Williams' has misunderstood the recent paper from the United Kingdom Testicular Cancer Study Group.² His assertion that our paper implies that orchidopexy before the age of 10 is not necessary to diminish the risk of malignancy is the exact opposite to our conclusion. We present substantive evidence to suggest that early orchidopexy eliminates the excess risk of testicular cancer associated with undescended testes, and this was clearly stated in the clinical implications box in the paper. In agreement with Williams we stated that "the recent trend to reduce the age at which correction is carried out should be encouraged." We noted that, in our data, nearly all "early" corrections occurred in boys aged 5-9 and thus orchidopexy at younger ages was apparently not necessary to reduce the risk of cancer. This should not be taken to mean that orchidopexy ought to be delayed until the age of 5.

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Chinese medical journals

Include summaries of key articles

EDITOR,—We agree with Richard Smith that a wealth of medical science is being published in China but is getting no exposure in English speaking countries.¹ But his suggestion that individuals should contact the appropriate directors in Beijing for information, although helpful, is unwieldy and unlikely to be followed up by those without specific professional interests. General medical readers need to be more easily kept informed, and one way of helping them in this is for English language journals to carry short summaries of key work from the current Chinese medical literature. The June 1994 edition of the *Journal of Dermatological Treatment*, for example, devoted two pages to summarising eight articles selected by eminent Chinese dermatologists.² We encourage other editors to follow this example.

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English is a barrier

EDITOR,—Richard Smith highlights the wealth of material in Chinese medical journals.¹ During an attachment to the head and neck unit of Beijing Cancer Hospital I realised both the high quality and the large quantity of clinical work practised by Chinese surgeons. Many clinicians in this academic institute were participating in clinical research and also collating material from their wide experience for publication. This was all destined

for the Chinese literature. The main reason for these clinicians not submitting papers to Western medical journals was their perceived inability to express themselves clearly and correctly in English. I found it a straightforward task to adjust the text of two papers for submission to an English language Chinese medical journal.

The Chinese medical fraternity is eager to improve and expand professional contact with the West. This could be helped by doctors with personal medical contacts in China offering to correct the text of material written by these colleagues for publication. In addition, editors of Western medical journals could be generous with the time they invest in editing articles submitted from China that come close to the required standard of English.

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Have much to offer

EDITOR,—I agree with Richard Smith that doctors and researchers from outside China may have much to learn by reading medical journals published in China.¹ It is quite cheap to subscribe to Chinese journals: the cost of one issue of a typical Western journal may cover at least a year's subscription fee for a Chinese journal. Apart from providing a useful cross cultural perspective, Chinese studies frequently have sample sizes that are astounding by Western standards.

Because of the proximity of China and Hong Kong, Chinese journals in the major medical specialties are commonly available in our medical libraries in Hong Kong. In the case of psychiatry, the two main journals are the *Chinese Journal of Neurology and Psychiatry* and the *Chinese Journal of Nervous and Mental Diseases*. Containing English abstracts for most original articles, both of them have become an increasingly important source of information about the theory and practice of psychiatry in China today. In a review article on psychiatric nosology, to be published in *Transcultural Psychiatric Research Review*, as many as one fifth of the references cited are from Chinese sources.²

The Chinese make up about a quarter of human-kind. As well as suggesting that Western doctors should get in touch with Chinese medical journals Smith should also have suggested that Western medical knowledge should be made not only accessible but also comprehensible to Chinese doctors, most of whom do not read English readily. One way in which Western academics can bridge this gap is to review a useful topic, have their article translated into Chinese, and then submit it to a major Chinese journal for peer review and possible publication. Some Chinese postgraduate students studying outside China could help in this regard. Such students could even help to write the article and so make it more relevant for clinical practice in China. This would probably be a learning experience for the non-Chinese writer. The extent of dissemination of medical knowledge to Chinese readers would then be multiplied substantially.

The question of money arises, as medical departments in China may not be able to afford to subscribe to Western medical journals. Though a tiny subgroup of business people are becoming rich in China, academics are still poor: clinical professors generally earn about \$100 a month. The psychiatric department of one well known medical school in China recently stopped its subscription to a leading British psychiatric journal for financial reasons. I wonder whether special subscription