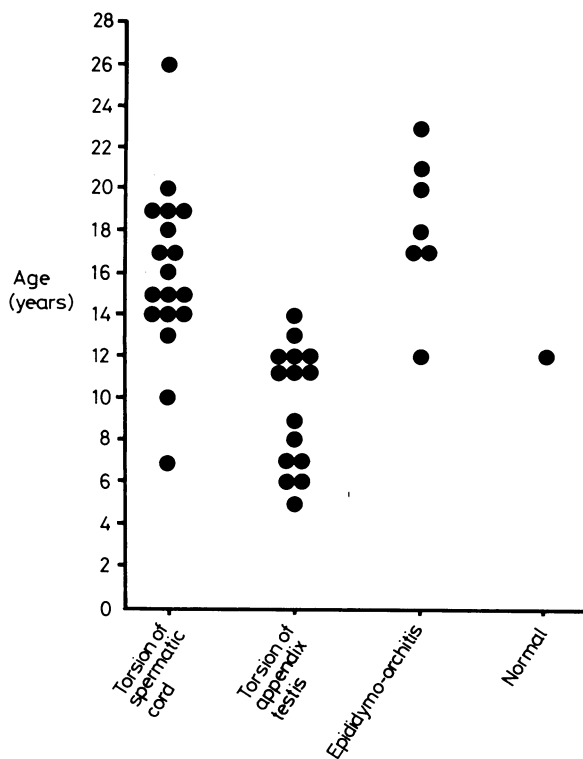


Comment

The results of this study re-emphasise that the cause of acute scrotal pain cannot be diagnosed on the basis of age. The clinical diagnosis is difficult and can be made with certainty only at operation. As the viability of the testis is measured in hours, any delay increases the risk of infarction and cannot be justified—even if diagnostic aids such as Doppler flow and scintigraphy occasionally prevent unnecessary operations. Torsion of the spermatic cord and the testicular appendages is often diagnosed as epididymo-orchitis and treated with antibiotics. There is no place for a therapeutic trial. In boys aged under 14 the diagnosis of epididymo-orchitis is so uncommon that it should not be entertained without exploration.



Diagnosis and age distributions of patients presenting with acute scrotal pain.

In our hospital all males under the age of 25 presenting with acute scrotal pain undergo surgery, unless a midstream urine specimen can be obtained immediately and organisms are found. Urgent surgery resulted in no appreciable morbidity, as shown by others,² a short hospital stay, accurate diagnosis, and rapid alleviation of symptoms. All these advantages were particularly true in torsion of the appendix testis, where symptoms are promptly relieved by surgery, and where failure to diagnose and treat correctly may lead to infertility.³

It is mandatory for all patients with acute scrotal pain to be explored. The alternative is castration by neglect.⁴

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¹ Whitaker RH. Benign disorders of the testicle. In: Blandy JP, ed. *Urology*. Oxford: Blackwell Scientific, 1976.

² Cranston DW, Maisey CE. Management of acute scrotum pain. *Br J Surg* 1983;70:505-6.

³ Fitzpatrick RJ. Torsion of the appendix testis. *J Urol* 1958;79:521-6.

⁴ Anonymous. Castration by neglect [Editorial]. *Br Med J* 1972;i:128.

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Assessment of gastric cancer by laparoscopy

In most countries gastric cancer has a poor prognosis with a crude five year survival of 4-15%.¹ Only about 21-58% of the cancers are resectable,¹ and it seems illogical to subject all patients to full exploratory laparotomy. Furthermore, laparotomy has a high incidence of complications² and appreciable mortality, ranging from 14% to 28%.^{2,3} Laparoscopy is a relatively minor procedure, which may have a role in the assessment of gastric cancer. It would seem to be particularly useful in patients with incurable lesions that are not causing obstruction.

We present our own experience with laparoscopy in patients with gastric cancer.

Patients, methods, and results

We studied 46 consecutive patients (33 men, 13 women) with histologically proved adenocarcinoma of the stomach. In two a mass suggested inoperable cancer and the examination was used to obtain objective proof. Laparoscopy was carried out under general anaesthesia. Both forward and side viewing techniques were used to obtain an optimum view of the peritoneal cavity. Biopsy specimens of metastases of the liver or peritoneum were taken under direct vision with a needle or biopsy forceps through a second puncture site. A tumour was deemed incurable if there were liver metastases or visible transperitoneal spread. No attempt was made to enter the lesser sac with the laparoscope as the degree of posterior fixation of a tumour is difficult to assess.

There were no deaths, and morbidity was minimal. A few patients developed subcutaneous emphysema. In one case the Verres needle penetrated the transverse colon. This was recognised immediately and was repaired without further complications.

No metastases were found in 19 patients, of whom 18 subsequently underwent laparotomy and one declined. Gastrectomy was undertaken in 16, but in two major posterior extension of the cancer prevented resection, and we performed palliative gastrojejunostomy.

Of the 27 patients with incurable disease, most had extensive lesions precluding palliative distal gastrectomy and were treated symptomatically. Seven were referred to a medical oncologist and given cytotoxic chemotherapy as part of a trial of new chemotherapeutic agents. Six underwent endo-oesophageal intubation using an endoscopic technique. Two patients subsequently developed gastric outlet obstruction and required palliative gastroenterostomy.

Comment

Although the laparoscope is often regarded as a gynaecological instrument, it is used increasingly by general surgeons. Unfruitful laparotomy was avoided in more than half our patients, who suffered little discomfort. Symptoms other than weakness were usually easily controlled. In patients with an obstructing lesion at the cardia laparoscopy was a convenient preliminary to endoscopic intubation under the same anaesthetic. Laparoscopy was surprisingly accurate. The false negative results were due to posterior extension of the tumour. In our opinion this can only be assessed at laparotomy, and even then it may be difficult to differentiate between inflammatory and malignant adherence to the pancreas.

We conclude that laparoscopy is a useful method for the assessment of gastric cancer and allows easy biopsy, particularly of peritoneal deposits. Unnecessary laparotomy is avoided and the morbidity of the procedure is minimal.

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³ Dupont JB Jr, Lee JR, Burton GR, Cohn I Jr. Adenocarcinoma of the stomach: review of 1497 cases. *Cancer* 1978;41:941-7.

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