
BOOK REVIEWS

Manual of Definitive Surgical Trauma Care ed Kenneth D Boffard

This provides exactly what it says on the cover. It is a manual of surgical trauma care edited by one of the acknowledged world experts in the management of blunt and penetrating trauma. Not surprisingly the editorial board and contributors represent the leading body of world opinion on trauma care. As this presents itself as a manual, the style is didactic, but extremely well referenced. Every aspect of trauma is covered in a clear and concise manner, with logical management pathways outlined. In addition there is a most useful glossary of trauma scoring systems with indications of how each should be used. There is a carefully thought out chapter on operating in austere and military environments and useful guidelines on when to amputate severely injured limbs. This is the definitive text for all surgeons who deal with trauma whether in training or as experienced consultants. All military staff who intend to go to Johannesburg for trauma training will need to be familiar with the concepts within this manual, and all surgeons involved in emergency work would do well to have this readily to hand.

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The Complete MRCGP Study Guide. Sarah Gear. Radcliffe 2004. £24.95 PB Pp vi – 281 ISBN 1-85775-865-X.

This MRCGP preparation book is written by a General Practitioner who recently passed her exam. It is full of short notes on multiple aspects of General Practice that are easy to follow. There are also “hot topics” very likely to come up in the MRCGP. The helpful references include useful internet links. The introduction gives good advice on not to plough through the book but to use it as a reference and revision guide. I found the sections on the Government plans for General Practice, including NHS Practice management, particularly useful, as this is an area that military GPs are likely to be less familiar with.

The book is written in three parts that appear to me to be in the wrong order. Part 1 concentrates on “clinical areas” and Part 2 on the “latest policies and slightly more ambiguous topics”. Part 3 covers details of the MRCGP with advice on exam preparation. I would recommend that Part 3 is read first so that the reader begins to plan their exam preparation before being buried in the volume of reading required to pass the MRCGP. The personal tips on each module

of the MRCGP are most helpful for candidates preparing for their exam.

The author advises that MRCGP preparation courses are “not needed” to pass the MRCGP as long as candidates are “well read”. I can’t agree with this advice particularly for military GP Registrars who are less likely to have been exposed to NHS management topics. Furthermore the book misses out on some important areas such as “trans-cultural medicine” and communicating through interpreters.

I would recommend this book to any military GP preparing for their MRCGP. However, the book should be read in conjunction with attending one of the DMS MRCGP preparation courses.

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Rather A Mixed Crowd: Military Medicine in India and South East Asia 1944-1947. John Black. William Sessions Ltd 2003. £4.50. PB. Pp 68. ISBN 1-85072-309-5.

“Rather a Mixed Crowd” is the service record of a National Service medical officer in India and South East Asia during the Second World War. Although the title is defined as ‘a derogatory term for the Royal Army Medical Corps used by Regular Army Officers’, the implied inter-regimental angle is not really born out in the subsequent text. This short book is an affectionate string of light hearted autobiographical reminiscences of Black’s service, and as such, is an interesting personal record. Black gives amusing anecdotes of his three years service in the ‘enjoyable madhouse’, interspersed with nuggets of clinical cases. In addition there is an appendix on the origins and history of the Indian Medical Services and Indian Army Medical Corps.

Each chapter is self contained and deals with a specific ‘posting’. The tone is casual and conversational, with a touch of humour. The book does not reveal much about the author, although there are tantalizing flashes of individuality. Black makes fleeting references to events unfolding in the theatre of operations and does not delve deeply into the Campaign of Burma. He assumes that those interested in Wingate’s Chindits, Slim’s 14th Army or the history of British medical units in Asia will consult more authoritative sources.

“Rather a Mixed Crowd” is a welcome addition to the growing pool of personal recollections of past conflicts.

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A Guide To Laboratory Investigations 4th Edition. Michael McGhee. Radcliffe 2003. PB. £21.95. Pp v- 180. ISBN 1-85775-823-4.

Introduction

The fact that this book first appeared in 1989 and has run to a fourth edition suggests that it continues to fulfil a need. Any shortcomings should have been identified already by expert clinical pathologists and remedial action taken. Given these observations, the challenge was to find some points to criticize in order to improve this text.

Typographical errors

Typographical errors still persist (page 15 'evelaated' and 'obsesity', page 17 the Epstein-Barr virus became the 'Epstein-Han' virus, page 58 rtreponemes became 'treponemas', page 60 nitrite turned into 'nitrate', page 86 form became 'from', page 94 Dubin-Johnson became 'Dublin-Johnson', page 150 creatinine became 'creatine'.

Drug names

Consistency in naming drugs was absent. Approved (generic) names are to be preferred. 'Flagyl' was mentioned on several occasions (page 47,49,55,56) whilst metronidazole was mentioned only once (page 57). 'Zovirax' (page 53) was always mentioned in preference to aciclovir and 'Maxepa' (pages 143, 145) was preferred on many occasions to omega-3 marine triglycerides (although this term was used eventually on page 149). Most of the time, reference was made to the bile sequestrant, cholestyramine but 'Questran' did creep in on one occasion (page 144) as did 'Bezalip' in preference to bezafibrate (page 146). 'Tigason' (page 143) has long been replaced by 'Neotigason' but acitretin is preferable to both trade names. The inhibitory effect of metronidazole on acetaldehyde dehydrogenase which, like disulfiram (*Antabuse*), causes intolerance to alcohol is commonly referred to as the '*Antabuse*' effect. This should be printed in a fashion other than that currently used (page 56) so that the trade name origin is clear.

Haematology

In the haematology section, it would be more helpful to indicate the lower normal range for white cell count in dark-skinned races (not just afro-caribbeans) immediately after that for Caucasians. APTT mentioned on page 28 should have been referred to as the ratio (APTTTR) when describing the desirable (not 'normal') range for heparin based anticoagulation. Coagulation pathways are complex enough but reference to 'activated protein C2 (page 34) confuses activated protein C, which interacts with factor V with a new recombinant anticoagulant protein C2 which interacts with activated factor

V11/tissue factor complex.

Microbiological

The section on travel-related infections (page 52) was, perhaps of necessity, brief. However, given the importance of malaria diagnosis, a book published in 2003 does need to mention the highly sensitive and specific rapid tests for malaria, such as the '*Optimal*' test. These tests are probably more reliable than blood smear examinations, especially when the latter are conducted by the less experienced.

Biochemistry

It is agreed that methodology does result in some variation in the reference range for serum albumin but the quoted range (30-55g/l) on page 107 is somewhat wide and 35-50g/l would be more helpful. To avoid the trap of ascribing the combination of elevated bilirubin, gamma-glutamyl transpeptidase and alkaline phosphatase to surgical causes alone, the term 'cholestatic' is preferred to 'obstructive' jaundice on page 96, especially when non-surgical intra-hepatic causes of this combination are more common. In the first instance, protein electrophoresis (PE) is a simpler test than measuring alpha-1 antitrypsin (AAT, page 96) levels in suspected deficiency. AAT constitutes most of the alpha-1 globulin, a low level of which on PE would suggest deficiency to be present. This is a much more useful observation than finding low levels in nephritic syndrome (page 108), a condition which should be more easily suspected by the presence of dependent oedema and heavy proteinuria and diagnosed without laboratory tests.

Renal function

Owing to the many non-renal factors which can affect urea levels (a low protein diet needs to be included as a cause of low urea levels on page 111), a clear statement needs to be made that, as a basis for assessing renal function, creatinine is to be preferred to urea. Mention of monitoring the glomerular filtration rate (GFR) to detect toxic renal effects from age (yr), gender, weight (kg) and serum creatinine (mg/dl) is quoted (page 115), although not named as such. However, the form of the equation where serum creatinine was in $\mu\text{M/l}$ (mg/dl is no longer used routinely in the UK) would have been more helpful. This equation needs much more prominence and certainly more than the reference range for creatinine. It is possible for a small patient to lose half of their renal function yet for creatinine to remain within the reference range (60-120 $\mu\text{M/l}$). The false sense of security that an apparently normal creatinine can generate can now be avoided, permitting timely referral to a nephrologist before renal replacement treatment is inevitable. While on nephrology, non-steroidal anti-inflammatory drugs which can cause

interstitial nephritis are probably one of the commoner causes of sterile pyuria in the UK population. They need to be included in the list of causes of this on page 60, especially when dipstick urine tests may show no other abnormality.

Endocrinology

A normal serum calcium does occur with elevated alkaline phosphatase in *secondary* hyperparathyroidism and, hence, normal serum calcium does *not* exclude hyperparathyroidism (page 99). A raised alkaline phosphatase is commonly the sole abnormality in Paget's disease without any change in calcium levels (page 125). The concurrent finding of a raised calcium in this condition suggests the development of complicating osteosarcoma. Overtreatment with thyroxine does suppress thyroid stimulating hormone levels but usually thyroxine level is elevated on presentation by the overgenerous extrinsic supply rather than suppressed (page 133).

As a consequence of the advent of highly effective inhibition of gastric acid secretion for peptic ulceration, patients who have undergone gastrectomy are mercifully rare these days. To quote this (page 128) as a cause of hypoglycaemia is not incoherent but is somewhat misleading. However, rapid gastric emptying in the absence of previous surgery certainly does occur producing the so-called 'lag storage' blood glucose curve as a result of precipitate insulin secretion which can cause glucose to fall to abnormally low levels.

Cardiology

The section on 'Blood Tests in Heart Failure' was somewhat incongruously included at the end of the section on haematology (page 44).

Its better place is probably in the biochemistry section after 'Lactate Dehydrogenase', on page 132. Discussion of troponins needs to be included in the diagnostic tests for myocardial infarction rather than heart failure. Blood tests for heart failure should now include comment on brain natriuretic polypeptide (BNP).

Long sections

Some rather long and tedious sections were identified. The first was the section on blood lipids and treatment of related abnormalities (page 137-150). The Frederickson classification has little clinical value and could be eliminated. Tortuous discussions of risk assessment could be avoided by referring to, or reproducing, the Coronary Risk Prediction Charts in the back pages of the British National Formulary. Plasma exchange for elevated low density lipoprotein levels (page 144) has been superseded by plasma apheresis which removes apoprotein B-containing moieties from an extracorporeal blood circuit. The other long sections were those related to non-sexual and sexual endocrinology. Careful editing would reduce confusion.

Conclusion

Despite fourteen years of publication and the appearance of a fourth edition, there is still room for improvement in this otherwise helpful book. It is to be hoped that constructive criticisms such as those given above will be incorporated into a fifth edition. This aim could be best achieved by expert review of individual sections before publication.

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