Agenesis of right lung with esophageal atresia and distal tracheoesophageal fistula

The author describes a neonate with agenesis of right lung with Esophageal Atresia (EA) and distal Tracheoesophageal Fistula (TEF).[1] (Repair of EA and TEF was carried out immediately after birth and the child is now alive and healthy more than 2 years and 6 months after surgery). The incidence of combined anomalies of unilateral agenesis of lung with EA and TEF is extremely rare and highly lethal for long term survival).[2] This is the first case to be reported from the Kingdom of Saudi Arabia.

Incidence of combined anomalies of unilateral agenesis of lung with EA and TEF is exceedingly rare and lethal association for long term survival. Only 19 infants with this combination of anomalies have been reported during the last 2 decades. Of these only 8 children are surviving at present. This is a report of a child with agenesis of right lung with EA and TEF treated in our hospital who is alive and healthy more than 2 years and 6 months after surgery.

A 2.36 kg baby girl SSM was born on 8-12-1416 (15-4-1996) by normal spontaneous vaginal delivery (NSVD) at home after 36 weeks gestation. Baby developed excessive salivation and respiratory distress immediately after birth and was admitted to the nearest hospital and then transferred to us. Examination of the baby revealed excessive salivation in the mouth, tachypnoea and moderate respiratory distress. Breath sounds were absent on the right side of chest and heart sounds were better heard on the right side. Abdomen was distended and tense. Anus was patent and passed meconium. An attempt to insert an naso gastric tube (NGT) into the stomach failed. A plain x-ray chest and abdomen showed complete opacification of the right hemithorax with mediastinal shift to the right and excessively aerated left lung (Figure 1a). An esophagogram with contrast showed a block at Th-3 level. The stomach and small bowel were distended with air. CT scan of the chest showed an absent right lung (Figure 1b). The findings were suggestive of unilateral agenesis of right lung with EA and distal TEF.[3] Baby was operated upon - a gastrostomy was fashioned first, followed immediately by right sided thoracotomy and repair of EA and TEF were carried out. (The operation was simple and there was complete absence of right lung). Baby did not require any ventilatory support post operatively and did well. An esophagogram on the 5th post-op day showed well formed esophagus pushed to the right side (Figure 1c). She was discharged home after 3 weeks and was being followed up in the clinic frequently. The girl is now more than 2 years and 6 months and doing fine.

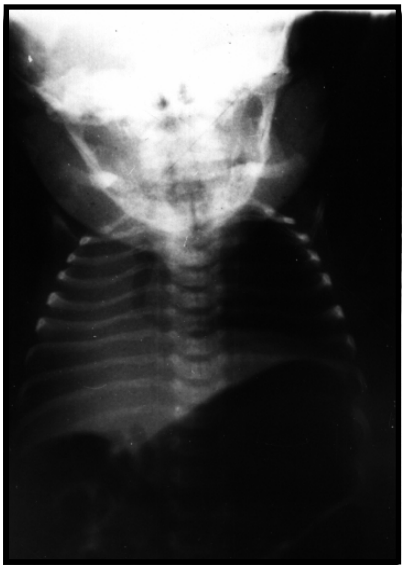

Figure 1a - Plain x-ray chest and abdomen. Complete opacification of right hemithorax and excessively aerated left lung with mediastinal shift to the right. Note: the stomach is hugely distended with air.

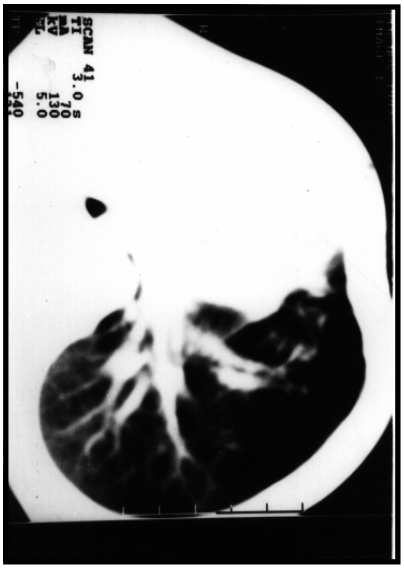

Figure 1b - CT scan chest: Absent right lung.

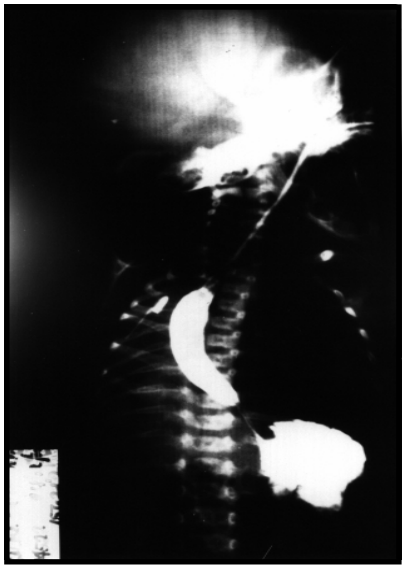

Figure 1c - Post-op Esophagogram with contrast: Dye is passing through and reaching the stomach. Note: Esophagus is pushed to the right.

Incidence of combined anomalies of unilateral agenesis of lung with EA is exceedingly rare and highly lethal association for long term survival. Children with isolated pulmonary agenesis have shorter life expectancy and usually did not survive into the second decade. Nineteen infants with the combination of unilateral pulmonary agenesis with EA and TEF have been reported during the last 2 decades.[4] Of these only 8 long term survivors have been reported. Among the 19 cases the agenesis was seen on the right side in 17 children and only one on the left and the other was bilateral. Almost all EA and TEF were the Gross type C except in one which was H-type. The sex distribution was almost equal.

The case presented here is a typical example of agenesis of right lung with EA and TEF (Gross type C) and with no other anomalies. She has undergone corrective surgery after birth and recovered completely. She is presently leading a normal life with left lung functioning alone. Since her life expectancy is short, she is being followed up in the clinic frequently.

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Admission patterns and outcomes of sick children: experience from a pediatric intensive care unit in Oman

Sir,

In developed countries, pediatric critical care medicine has matured dramatically during the last 2 decades, reflected by increase in pediatric intensive care units (PICU) from 59% to 76%.[1] However, in developing countries, the numbers of the PICUs are restricted, as the development of such units requires resources and financial support. In addition to that, data on the services of these PICUs are scanty. Recently, an audit was carried out to look at the performance of the PICU at the University Hospital in Oman. This report discusses the findings of the audit. The pattern of admissions and outcomes is described.

The PICU at Sultan Qaboos University Hospital (SQUH), Oman is a 3-beded unit. It functions as level II PICU in the region, as per the definition.[2] A retrospective review was carried out and the data was collected from the records kept in the PICU registers. The study period was February 1997 to January 1999. The variables looked at were age, sex, diagnosis, primary referral center and the outcome.

Total 131 children were admitted during the study period. We noted that about half of the admissions were below 1 year of age (Table 1). Out of 131 children, 73 (55%) were males. Most of the children were referred from our own wards (70%). Thirty-nine (30%) children were referral from the regional hospitals.

According to the diagnosis, respiratory illnesses were the major reason for admission to PICU (Table 2 and 3). Twenty children died in the PICU giving the mortality rate of 15%. Table 4 depicts the different variables in the group of non-survivors. Among the non-survivor, most of the children were under 1 year of age. Seventy percent of the cases were admitted with the diagnosis of sepsis or septic shock.

Our data revealed that our PICU had catered for sick children with a wide spectrum of disorders, and most of them were discharged in good health. As the study was the first audit of PICU, it will be difficult to comment on the efficiency or inefficiency or on the range of utilization of the PICU services. Pollack et al,[3] in a comparative analysis of 8 PICUs, found a wide range of utilization of PICU services, varying from very efficient to inefficient. A second audit will be needed for comparison.

The data presented in our study highlighted towards the amount of attention and improvement needed in the care of respiratory illness (pneumonia and asthma) and sepsis. Our data of 15% mortality, with most of the children having the diagnosis of sepsis and meningitis, suggested the need for earlier detection and intervention in the suspected cases. As noted that 65% of mortality was among children of less than 1 year of age, it further emphasized that the infections in infancy should be taken seriously. A prompt approach should be followed with early institution of broad-spectrum antibiotics.

The significance of the study was that it had provided some information on the spectrum and intensity of the problem of the sick children admitted to PICU on regional level. This will help in further developing and modifying the policies and guidelines

Table 1 - Distribution of patients in different age groups.

Age	Number of cases	Percentage of admission
>1months to < 1 year	64	48.8
>1 year to < 5 year	36	27.4
>5 year to < 12 year	29	22
> 12 years	2	1.5

Table 2 - Diagnostic groups of patients (more than one case).

Diagnosis	Number of cases (%)
Pneumonia	33 (25)
Sepsis/Septic shock	22 (16)
Status epilepticus/seizures	15 (11)
Asthma	10 (8)
Poisoning	5 (4)
Sickle cell disease	4 (3)
Meningitis	3 (2)
Cystic fibrosis	3 (2)
Failure to thrive	3 (2)
Guillain-Barre syndrome	3 (2)
Supraventricular tachycardia	2 (1.5)
Pleural effusion	2 (1.5)
DIC	2 (1.5)
Stridor	2 (1.5)
Thalassemia	2 (1.5)
Diarrhea	2 (1.5)
Leukemia	2 (1.5)
Myasthenia Gravis	2 (1.5)

Table 3 - Diagnostic groups of patients (one case each).

Diagnosis	Number of cases (%)
Aplastic anemia	1
Red cell aplasia	1
Nephrotic syndrome	1
Hepatic encephalopathy	1
Job syndrome	1
Hemiplegia	1
Cardiac failure	1
Near drowning	1
Cardiomyopathy	1
Short bowel syndrome	1
Breath holding spell	1
Bronchiolitis	1
For bronchoscopy	1
Palatal tumor	1
Total	14

Table 4 - Details of the non-survivors (20 cases out of 131 cases).

Age	No. of cases (%)
< 1 year	13 cases (65)
> 1 year to < 5 years	3 cases (15)
> 5 years to < 12years	4 cases (20)
Sex	
Male	11 (55)
Female	9 (45)
Referred Cases	3 (15)
In-hospital transfers	17 (85)
Diagnosis	
Sepsis	14 cases (70)
Meningitis	2 cases (10)
Stroke	1 case (5)
Syndrome	1 case (5)
Cardiomyopathy	1 case (5)
Hepatic-Encephalopathy	1 case (5)

for PICU at national level, as recommended in a recent report.[4]

In conclusion, our experience with the PICU suggested that improvement is needed in the care of respiratory illnesses and sepsis to decreases the number of admissions and mortality among the sick children. A follow up audit will be of great value to have a comparative analysis.

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Erratum

Due to an error in publishing, article "Thyroid function in cord blood" published in Saudi Medical Journal January 2000; Vol. 21: 1 should have the following authors:

Gerard Henry, *FRCPath,* ***Samia H. Sobki,*** *MRCPath,* ***Najla M. Al Beshara,*** *BSc,* ***Mimmi E. Harkonen,*** *BSc,* ***Helen R. Miller,*** *BSc.*

Letters to the Editor

The midstream muddle

Sir,

Is it any wonder that clinicians have lost confidence in the results of the microbiological examination of midstream urines in female patients? Outpatient collection facilities rarely have instructions for the patient posted in the cubicle providing a step-by-step procedure for collecting a proper sample. Even when they do many of the patients are unable to follow the instructions either because they themselves cannot read or because the instructions are poorly written and confusing. Also, the use of schematic diagrams are often condemned as indecent or immodest. The collection procedure itself is totally impractical for those unfortunate women who have to contend with layers of skirts and clothing, all-the-while attempting to control two or three writhing toddlers.

Once collected, the specimen must be promptly transported to the central processing laboratory. If vans with cooler-boxes are available specimen integrity is reasonably certain but if transport is delegated to the patient e.g. from the clinic to a distant laboratory then the urine sample may be subjected to a varying period of incubation with multiplication of the contained bacteria. Moreover, arrival in the laboratory is no guarantee of prompt processing as urine specimens may be batched to save technical time.

Most laboratories process urines in the time-honored quantitative fashion where counts of greater than 10^5/ml (10^8/l) are generally interpreted as indicating possible infection. At the same time, counts of less than 10^5/ml are often dismissed as "no infection" even when many of these specimens are heavily laced with antibiotics rendering the interpretation of the bacterial count absolute guesswork.[1] Additionally, no provisions are made in the quantitative system for the diagnosis of "low grade bacteruria"[2] where bacterial counts are indistinguishable from those due to contamination unless collection methods are meticulous.

In view of the above circumstances it is not unreasonable for clinicians to treat their female patients with lower urinary tract infection purely on symptomatic grounds (±dipstick)[3] and to eschew specimen referral to laboratories.

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Correspondence

Histiocytosis X and Caroli's disease

Sir,

We read with interest the above case report which was published in the Saudi Medical Journal.[1]

To us this is a case of Langerhan's cell histiocytosis (LCH) with a known complication called sclerosing cholangitis. LCH was present in this patient from the age of 7 months as the patient had cardinal signs of LCH including diabetes insipidus, skin rash and otorrhoea at that age. Sclerosing cholangitis was present early in the course of the disease as manifested by jaundice. Sclerosing cholangitis is a chronic cholestasis characterized by inflammation and obliteration of the intra and in most cases, extrahepatic bile ducts leading to cyst-like dilatation of bile ducts and biliary cirrhosis, and ultimately to liver failure. Its association with LCH is well known.[2,3]

Caroli's disease is a congenital dilation and ectasia of segmental intrahepatic bile ducts in the absence of other histological abnormalities or diagnoses. Some authors regard it as type 4 of choledochal cyst. Others refer to it as a separate entity with or without associated polycystic disease.[4] It is characterized by relapsing episodes of cholangitis mainly in young adults.[5,6] It is an autosomal recessive disease and the author's statement that it is not familial is not appropriate. While diagnosis mainly depends on

cholangiography, the author did not report cholangiography data in detail. He only mentioned the presence of three stones in the common bile ducts. The author stated that histopathology of the excised cyst supported the diagnosis of Caroli's disease. What histological features for Caroli's disease were present in the cyst? The liver biopsy was reported to suggest cholestasis which could be due to Caroli's disease or sclerosing cholangitis or other aetiology.

The author also mentioned that the liver biopsy was negative for LCH. Was S100 positivity, CD1 expression determined? Was study of ultrastructure by electron microscopy performed? What are the findings in the liver biopsy in this case? As LCH was confirmed histologically in this case, its association with sclerosing cholangitis speaks strongly against Caroli's disease.

We observed 2 cases in pediatrics with LCH who also had sclerosing cholangitis. In one case it was focal intrahepatic detected at presentation and in the other, it developed many years after presentation of LCH. diagnosis of sclerosing cholangitis in LCH is very important because of dismal outlook and the only available curative treatment is liver transplant.

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Reply from the Author

Sir,

My colleagues, Drs R Al-Asiri, M Al-Rashed and S Wali wrote a very good correspondence which will certainly add to the interest of my article published in the Journal.[1]

Starting from a point of agreement it is clear from the theme of their letter that there are controversies regarding Caroli's disease, this is due to its rare occurrence; their definition of Caroli's disease is not appropriate because it has an erroneous limitation which is I quote, "in the absence of other histological abnormalities or diagnosis".

There are two entities of the disease simple type and a peri-portal fibrosis type (congenital fibrosis); the usual complication of the first type includes recurrent cholangitis; intraductal lithiasis; and sepsis; in addition, the second type is complicated by portal hypertension and believed to be autosomal recessive disease, the first is not, which means that the autosomal recessive inheritance is of congenital fibrosis and ductal dilation and in some cases with renal abnormalities. The case reported is of the first type; if my colleagues think that it is for definite that Caroli's disease is on type and always inherited as autosomal recessive they should have told us at what gene location the abnormalities occur.

The diagnosis depends mainly on cholangiography but CT scan can also diagnose the disease with the advantage of telling the state a liver parenchyma; the case was diagnosed as Caroli's by CT scan, U/S and even by HIDA scan and they are all well documented modalities for the diagnosis of Caroli's disease.

I mentioned in my article that the histology support - (not confirm) the diagnosis; this space is not enough for details of histological appearance of the Caroli disease but it is well-documented in literature and our histopathology reports of the excised cyst support the diagnosis and confirmed the absence of hepatic cirrhosis or fibrous or inflammatory reaction that would suggest sclerosing cholangitis.

The liver biopsy mentioned in the article which was negative for (LCH) is the slides of original liver biopsy at the referring hospital, so it was not possible to do electron microscopy even if we intended to do so; the S100 positivity and CD1 expression were not carried out too; but we were sure that there was no cirrhosis; fibrosis or inflammatory reaction that would suggest sclerosing cholangitis.

Because diagnosis of sclerosing cholangitis is very important in LCH for the reasons mentioned by the colleagues, we made every possible effort to exclude it. We had no evidence by CT, U/S, HIDA, operative cholangiogram, post operative T-tube cholangiogram and histology from referring hospital or at our hospital to suggest its presence; with many thanks to the colleagues for their interest.

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AIDS NOT LOSING MOMENTUM
HIV HAS INFECTED 50 MILLION, KILLED 16 MILLION, SINCE EPIDEMIC BEGAN

In Africa HIV-positive women now outnumber infected men by 2 million Countries of former Soviet Union see infection rates double in just two years
Strong prevention efforts, care programmes, find success in certain regions

LONDON, 23 November - Since the beginning of the AIDS epidemic, 50 million individuals worldwide have been infected with HIV, of whom more than 33 million are still alive and over 16 million have died, according to a report issued today by the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The report, entitled AIDS Epidemic Update - December 1999, was released in advance of World AIDS Day, commemorated each year on 1 December. It shows that AIDS deaths reached a record 2.6 million this year and that new HIV infections continued unabated, with an estimated 5.6 million adults and children worldwide becoming infected in 1999.

With an epidemic of this scale, every new infection adds to the ripple effect, impacting families, communities, households and increasingly, businesses and economies. AIDS has emerged as the single greatest threat to development in many countries of the world," said Peter Piot, Executive Director of UNAIDS.

"We have to ensure that health systems are capable of handling the increasing numbers of HIV-positive people who develop AIDS. De-stigmatization, access to health care and low-cost measures such as the treatment of opportunistic infections become important. WHO is working with Ministries of Health across the world to ensure that adequate facilities and resources are made available to the millions of people likely to develop AIDS in the coming years," said Gro Harlem Brundtland, Director-General of WHO.

AIDS develops in an HIV-positive person after years of infection, as HIV steadily weakens the body's immune system and increases its vulnerability to pneumonia, tuberculosis, diarrhea, tumors and other illnesses. With the number of people infected with HIV continuing to rise, the number of people falling sick and dying of AIDS will multiply.

HIV-positive women now outnumber HIV-positive men in Africa. In sub-Saharan Africa - still the global epicentre of the epidemic - new evidence shows clearly for the first time that

women infected with HIV outnumber men. "Ten years ago, it was hard to make people listen when we were saying AIDS wasn't just a man's disease," said Dr. Piot. "Today, we see the evidence of the terrible burden women now carry in Africa's epidemic."

Fifty-five percent of infected adults in sub-Saharan Africa are women, which means more than six HIV-positive women for every five HIV-positive men. UNAIDS and WHO estimate that 12.2 million African women and 10.1 million African men aged 15-49 are living with HIV at the end of 1999.

Studies in several countries have found that African girls aged 15-19 are five to six times more likely to be HIV-positive than boys the same age. Ease of male-to-female sexual transmission, and sex with older, infected men appear to be contributing factors to girls' greater vulnerability to HIV.

According to the United Nations Development Programme (UNDP), a number of African nations suffered downward changes this year in the Human Development Index, a ranking based on levels of health, wealth and education. Almost all of the major changes in rank could be attributed to declining life expectancy as a result of AIDS.

Life expectancy at birth in Southern Africa, which climbed from 44 in the early 1950s to 59 in the early 1990s, is expected to drop back to 45 sometime between 2005 and 2010.

UNDP estimates that fewer than 50% of South Africans currently alive can expect to reach the age of 60, compared with an average of 70% for all developing countries and 90% for industrialized countries.

According to a survey of commercial farms in Kenya, illness and death have already replaced old-age retirement as the leading reason why employees leave service.

Yet there are reasons for optimism even in this most devastated region: a number of African countries have demonstrated a much stronger commitment to fighting AIDS than ever before. "I believe we are now at a turning point in the 20-year history of the AIDS epidemic in Africa. Everywhere I go, I hear the top African leaders speaking out about AIDS as the major threat to the continent's development," said Dr. Piot. "This gives me grounds for hope that in the coming years, we will see stronger, more effective responses to AIDS in many more sub-Saharan African nations - responses to complement the strong programmes that already exist."

Injecting drug use in former USSR fuels world's steepest HIV increases. The report further reveals that the world's steepest HIV curve in 1999 was recorded in the newly independent states of the former Soviet Union, where the proportion of the population living with HIV doubled between 1997 and 1999. In the larger region comprising these nations and the remainder of Central and Eastern Europe, the number of HIV- infected rose by more than a third in 1999 alone, to reach an estimated 360 000.

In the Russian Federation, nearly half of all reported cases of HIV infection since the start of the epidemic were recorded in the first nine months of 1999 alone.

In Moscow, three times as many cases were reported in the first nine months of 1999 as in all previous years combined. Towns around Moscow had even sharper rises in HIV, with over 5 times as many infections reported in the first nine months of 1999 as in all previous years combined.

Preliminary studies suggest that injecting drug use is becoming increasingly common among unemployed young people in many of the industrial cities of the Russian Federation and Ukraine. HIV is not limited to Russia's major metropolitan regions; in the Siberian city of Irkutsk, nearly 1300 infections have been reported, most of them in 1999.

Injecting drug use appears to be well established even among Russian schoolchildren. An outreach programme for drug injectors in St Petersburg reported that the caseload for clients under age 14 increased 20-fold between 1997 and the first quarter of 1999.

Strong prevention efforts, care programmes, find success in certain regions. In the report, UNAIDS and WHO also point to some countries and regions which are managing to keep down

the number of new infections or improve the well-being of those already infected. For example, evidence continues to mount that the strong prevention programmes of Thailand and the Philippines have had sustained success in reducing HIV risk and lowering or stabilizing HIV rates.

In India, major efforts to improve the tracking of the epidemic more than tripled the number of HIV surveillance sites in 1998. Estimates now place total HIV infections in the country at around 4 million - more than in any other country, but fewer than projected on the basis of earlier surveillance estimates. Consequently, the regional estimate of HIV infections in Asia has been revised downward by 800,000.

The AIDS Society in the Indian state of Tamil Nadu has enlisted the support of an advertising agency to encourage safer sexual behavior, airing television advertisements during major sporting events. Casual sex among factory workers in the state reportedly fell by half between 1996 and 1998, while condom use with casual partners rose from 17% to 50%.

Some Latin American countries have joined the ranks of those providing antiretroviral drugs to people infected with HIV. Brazil, for example, spent an estimated US $300 million to treat some 75 000 people in 1999. Brazilian health officials said the considerable expense was offset in part by savings in hospitalization and medical care; the country averted an estimated US $136 million in such costs between 1997 and 1998.

"Providing care to growing numbers of HIV-positive people when health systems are already overburdened is no straightforward task. But these examples show how countries around the world can make a difference in fighting the epidemic through both prevention and care. WHO has shown how relatively inexpensive modifications and additions to health-care systems can bring major benefits to people with HIV. Everyone, and every country, can learn and benefit from these examples," said Dr. Brundtland.

No room for complacency. Releasing the report, UNAIDS Executive Director Peter Piot also urged industrialized nations to put more emphasis on HIV prevention efforts. "There is no room for complacency in any discussion of this epidemic. The threat of HIV has not diminished in any country. We have even seen evidence from North America and Western Europe suggesting that availability of life-prolonging therapies may be contributing to an erosion of safer sexual behavior. This is tragic" Dr. Piot said.

"While antiretrovirals have brought hope to many people with HIV who are fortunate enough to have access to them, they are not a panacea, and they are not available in most of the world," Dr Piot said. "The key to fighting AIDS is preventing new infections. For this more resources are needed - to implement the prevention strategies we have today, and to develop new and better tools, such as microbicides and a vaccine."

Dr Brundtland added, "While prevention is the most promising strategy for managing the AIDS epidemic in the long term, we cannot lose sight of the fact that millions of people are infected today. For them, we must do a much better job of increasing access to health care and support, including inexpensive antibiotics that can add many months to the lives of people already sick with AIDS, to palliative therapies that can help increase comfort and reduce suffering, and to psychological and social support for patients and their families. WHO and UNAIDS will continue to engage the pharmaceutical industry to make new HIV-related drugs available at affordable prices for those in need."

Brain Imaging in Clinical Psychiatry

K RANGA RAMA KRISHNAN, PM DORAISWAMY 647pp. **Price:** ..... **Publisher:** Marcel Decker, Inc. **Date of Publication:** 1997. **ISBN:** 1-8247-9859-7

This book provides an extensive view of the role of brain imaging in understanding the relationship between the brain structures and functions and psychiatric disorders. The first 3 chapters provide a fruitful review of the principles of several brain imaging modalities. The limbic system (which is a hypothetical functional system representing a complicated interrelation between several brain structures), is believed to play a very important role in memory, emotion, behaviour and verbal processes. The sophisticated technology of brain imaging which has been developed through the last 2 decades, has led to more understanding of the biological basis of a variety of psychiatric disorder and psychological functions. This piece of evidence resulted in making psychiatry a division within neurosciences in several leading medical centres around the globe. Moreover, some eminent members in the World Psychiatric Organization are advocating changing the title of psychiatric practice to brainology, is discussed along with planum temporale - anatomically, physically and functionally in chapter 4. The remaining 19 chapters are devoted to review the findings of industrious studies of different types of brain imaging in a variety psychiatric disorders as well as normal brain development. Reading this book shows striking results of connection between brain structure, physiology and biochemistry on the one hand, and clinical psychiatry on the other hand. However, more research is needed to put the brain imaging as a clinical diagnostic or prognostic tool. The authors are optamistic that more solid information will be consolidated in the time lapse between this edition of the book and the forth-coming one. This book is very informative, and despite the difficult issues it is concerned with, it is written in a clear, step-by-step way.

This book is a great asset to psychiatrists, neurosciences professors, radiologists and researchers. I believe it should be available in all medical libraries.

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Herbal Medicinals - A clinican's guide

LUCINDA G. MILLER, WALLACE J. MURRAY, 382pp. **Price:** US$ 59.95. **Publishers:** Haworth Press, Inc. USA. **Date of Publication:** 1998. **ISBN:** 0-7890-0466-6.

By their own admission the authors state that this book is not an exhaustive account of herbal medicine. However they do highlight the magnitude of alternative medicine being used in the USA - nearly one-third Americans using it.

Considering the USA as an advanced country, one can imagine the state of use of alternative medicine in the under and less developed countries. Allopathic medicines are exorbitantly expensive and out of reach of most people there. Alternative medicine is therefore bound to excel in use. The only problem with alternative therapies has been the lack of evidence based medicine.

In this setting, scientific and semi-scientific books on alternative medicine are a welcomed break. Herbal medicine is probably the most ancient form of therapy used by mankind. The amount of herbs around the world are so innumerous and scientific work on them so scanty that even strive to give herbal medicine any respectability is near impossible.

Herbal medicinals is a brave effort to combine clinical situations and herbal therapeutics. It addresses common problems faced in the West and relevant therapy is suggested. The tables given at the end are very helpful. Perhaps the case study approach is a little excessive because it gives a rather narrow look into problems. Clinical conditions in life are not only more complex and diverse but also include multi organ involvement.

A random check of one of the references, page 116 and reference 8 showed a misinformation. Momordical charantia is said to cause hepatic and testicular lesions but reference 8 quoted for this has nothing to do with this information.

In the Middle East, lots of herbal medicine is related to Nigella sativa on which there are many publications which has been largely ignored in this book. Hopefully a later edition will mention herbal medicines abounding in the Middle East.

The last chapter is an excellent overview of the legal implications and responsibilities of both the industry and the regulatory authorities.

Overall Herbal Medicinals is a treasure of knowledge that should stimulate more scientific personnel to uncover and make use of the limitless source of medicine from herbs.

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Psychopharmacology of Antidepressants

STEPHEN M. STAHL, 114pp. **Price:** PS 12.95. **Publishers:** Martin Dunitz Publishers. UK. **Date of Publication:** 1999. **ISBN:** 1-85317-513-7.

This is a very clear and concise but informative book which is extracted from a comprehensive book by the author, Essential Psychopharmacology. It covers a very important area for all physicians which is the psychopharmacology of antidepressants. It simplifies the subject by well-presented figures but in a comprehensive scientific discussion. It is divided into three sections. The first discusses the monoamine hypothesis of depression and the main three neurotransmitters systems in the brain, namely noradrenoline, dopamine and serotomin. The second describes classes of antidepressants, the tricyclics, the MAOIs, the SSRIs and other newly developed ones. In section three, two issues for the expert were covered, combinations and augmentation strategies and antidepressant intractions in relation to cytochrome. I think it is a reasonable buy.

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Osteoporosis - Clinical & Commercial perspectives

JULIET E. COMPSTON, PHILIP WHITE. 144pp. **Price:** **Publisher:** FT Pharmaceuticals, UK. **Date of Publication:** 1998. **ISBN:** 1-86067-360-0.

This small book or pharmaceutical and healthcare management report of 141 pages is a product from the famous "Financial Times" healthcare, a division of Financial Times Professional Ltd. and healthcare publishing. It is written by a leading author in the area of osteoporosis (Dr J Comptson) and an independent healthcare marketing consultant (Dr G White). As expected, the report contains issues related to osteoporosis, both medical and commercial. The report contains 13 chapters as well as an executive summary. The medically oriented chapters cover areas related to the bone structure and it physiology, clinical aspects of osteoporosis, prevention and treatment as well as some molecular biological aspecs of bone metabolism. The report then covers all new preparations under current investigation for the treatment of osteoporosis. After discussing epidemiological aspects about osteoporosis, the report describes the current market for the different modalities of treatment of osteoporosis and the leading International Corporations in this regard. It finally ends by describing some commercial issues related to the economic impact of this disease and the diagnostic tests for screening.

This report is good and an up to date reference on osteoporosis from clinical and commercial perspectives. Being a "report" rather than a textbook, the material covered is quite wide but not in much depth. However, for quick reference it will serve the purpose. The commercial and pharmaceutical aspects covered are interesting and they are indeed, an excellent and up to date source which is very useful for epidemiologists, healthcare administrators, marketing consultants and pharmaceuticals experts.

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