and I hope that we see them collaborating in the future!

Health warning—this book could seriously affect your future approach to paediatric neurological investigation and hopefully for the better.

B M MACARDLE
Consultant paediatrician

The Hereditary Hemolytic Anemias. Edited by William C Mentzer, Gail M Wagner. (Pp 476; £52·50, hardback.) Churchill Livingstone, 1989. ISBN 0–443–08242–1.

When the nineteenth century investigators first squinted down the microscope at blood cells and identified diseases they had no idea of the explosion of knowledge that would follow. A blood specimen is so easily obtained that the red cells have been studied in enormous detail, and a vast amount is known about their diseases, some of great rarity. Professor Mentzner is a paediatric haematologist and Dr Wagner is an adult haematologist. Their book is a comprehensive review by a selection of authors from the San Francisco Bay area of the hereditary red cell disorders which lead to haemolysis. After an introductory chapter by the editors, there are chapters on diagnostic strategy, and subsequent chapters on the thalassaemia syndromes, sickle cell disorders and unstable haemoglobins, membrane disorders, metabolic disorders, haemolytic disease of the newborn, mechanisms of red cell destruction, and a final chapter, which is the shortest in the book, on treatment.

The book is not written specifically for paediatricians. It is strong on pathophysiology and weak on management. The chapter on haemolytic disease of the newborn is an exception, so although the subject is not really hereditary, it is well worth reading. The other chapters are useful for reference. The need to be comprehensive means that a page and a half of table is given to classifying the 29 variants of glucose phosphate isomerase associated with haemolytic anaemia. Fortunately the editors have resisted the temptation to include the 150 variants of glucose-6-phosphate dehydrogenase. This is a problem with the haemolytic anaemias: all this information has to be recorded, but its relevance to the day to day management of the haemolytic anaemias that make up the day to day business of a paediatric clinic is slender in the extreme. Nevertheless, this is a good book for looking up the rare disease, for help with an unusual problem, and for throwing light on the dark mystery of the unsolved cases of haemolytic anaemia which puzzle every haematology department.

D I K EVANS
Consultant haematologist

Paediatric Clinical Examination. By Denis Gill, Niall O'Brien (Pp 188; paperback.) Churchill Livingstone, 1988. ISBN 0–433–03956–9.

'Learn to see things' is one of many quotes included in this book, and it is sound advice by Leonardo de Vinci, applicable to the field of paediatrics as well as to art. It can be remarkably difficult to 'learn to see things' in children without adequate guidance and practice, and yet little has been written on the subject. Denis Gill and Niall O'Brien aimed to fill this gap with an entertaining, concise and readable handbook that provides a simple approach to clinical examination of children.

The book is aimed at undergraduate medical students taking their paediatric course and also at postgraduate doctors commencing their first post in paediatrics. It provides a simple and thoughtful approach to history taking and examination at different ages, particularly in the newborn, infant, and preschool child. The text is written in a very humorous way which makes it easy to read as well as instructive. The authors' prime objective is to put the principles into practice by examining as many children as possible. If they fail to do this in some cases, I think it suggests that the student would be better suited to another specialty, rather than reflecting badly on the text.

In conclusion, I think that this book fills an important gap in the literature, and that students in paediatrics will find it an invaluable guide to the art of approaching children.

C SMITH
Senior registrar in paediatrics

Linear Growth Retardation in Less Developed Countries. Edited by J C Waterlow. Nestle Nutrition Workshop Series, Vol 14. (Pp 295; $50 hardback.) Raven Press, 1988. ISBN 0–88167–378–1.

This book contains a wealth of interesting information about human growth and nutrition. Unfortunately it cannot give a definite answer to the key question 'Is stunting accompanied by biological functional impairment?'

The size of the problem is not in doubt; 39% of preschool children in developing countries are stunted, less than −2 standard deviations below the most widely used reference figure for height for age (National Center for Health Statistics). This compares with only 12% who are wasted, with a weight for height less than −2 standard deviations (Kellar, chapter 2). The importance of stunting is less clear. Studies from Zaire (Van Lerberghe, chapter 14) do not confirm earlier findings from Bangladesh that there is an increased risk of death in children who are stunted. Most authorities accept that stunting has a definite association with poverty, poor living standards, and incomplete recuperation in adverse environments. Waterlow declares that 'both physiological and political aspects of stunting are important', but Tanner, the high priest of auxology, considers that 'height is only important as a proxy for social deprivation between groups'.

All who are interested in child growth should read this book, and no paediatrician can deny a concern about a process so fundamental to our specialty. Here are a few points, not all related to linear growth, to whet the appetite. Many are not new but some are based on recent research.

In malnutrition the growth related hormonal systems that are most affected are those of growth hormone – somatomedin (Rappaport, chapter 7). After malnutrition there is little catch up in height until there has been an increase in weight so that the weight for height ratio exceeds 85% of the reference values (Golden, chapter 9 and Nabarro, chapter 10). Zinc deficiency does cause decreased linear growth and supplementation increases growth rates in stunted male but not stunted female infants (Golden, chapter 9). Zinc increases the metabolic efficiency of dietary energy utilisation (Tomkins, discussion after chapter 9). Growth is very seasonal in Nepal, stunting is maximal in August to November but the peak weight gain occurs within the same period, mid August to mid October, followed by the peak height gains from mid December to mid April. Children between 12 and 24 months of age grow 1·5–2 cm in three months, but show no growth in height the rest of the year (Nabarro, chapter 10). There is no causal link between stunting and developmental delay or impaired intellect, both are associated with the effects of poverty and deprivation. Mental development is highly dependent on biological and environmental influences in the first two years of life. There is evidence that early stimulation can to some extent compensate for the negative effects of early malnutrition. 'The family environment . . . is a fundamental determinant' (Colombe, chapter 12). Physical work capacity, as measured by maximal oxygen consumption, is largely dependent on muscle mass which correlates with nutritional state. There are implications that undernourished children will become adults with a reduced physical work capacity (Spurr, chapter 13).

In the final chapter on the significance and implications of the findings of the symposium for health policy, Gopalan introduces some interesting unpublished data from India about the associations between birth weight, nutritional state, and family income. He also makes a few inaccurate over simplifications, 'stunting is . . . invariably associated with poverty'. However, in the context of a scientific meeting supported by the largest infant food multinational corporation he speaks out courageously about the abuses of commercial baby foods by the urban poor. He has data to show that 22–30% of the poorest mothers in Indian cities are using commercial milk substitutes with 'results that can only be described as disastrous'.

W A M CUTTING
Senior lecturer

The Baby Under 1000 g. Edited by David Harvey, Richard W I Cooke, Gillian A Levitt. (Pp 353; £65 hardback.) Butterworth Scientific Ltd, 1989. ISBN 0–7236–0952–7.

This book concerns the management of babies under 1000 g. It has been rather extravagantly claimed (not in this book) that a full term baby has more in common with a teenager than with a baby of 24 weeks' gestation. Certainly very preterm babies are different. Hence this book.

Some aspects of management are not that different, however, and despite valiant efforts by the contributors some chapters read much the same as they would have done had the title of the book been 'The Ill Baby under 2000 g'. Some such chapters, for example the one on ventilator care, are nevertheless very enjoyable. The authors of the chapters on the skin, calcium and phosphorus metabolism, and renal function have an easier time of it. Other stimulating chapters include those on monitoring and neurological abnormalities.

The 32 contributors to this book between them work in 18 different centres—all but three of which are in the United Kingdom. As well as 17 chapters on different aspects of the medical care of the baby under 1000 g there are eight chapters on the subjects of epidemiology, obstetric management, nursing care, emotional needs of the family, cost of care, and outcome. Most subjects are covered clearly and practically with remarkably little repetition. A lot of references are cited.

I would have liked more discussion of the