The bulk of the book contains over 100 colour plates of children's genitalia and anuses supported by details of each child's age and sex, examination method, and a brief clinical history. The introduction illustrates examination techniques and the three sections then show normal findings, findings that 'commonly result from non-sexual or indeterminate etiology' and findings resulting from sexual abuse. This last section includes some dozen plates illustrating the clinical manifestations of selected sexually transmitted diseases.

Despite the comprehensive nature of the illustrations, one is left with feelings of incompleteness and unease about the use of this book by generalist 'health care professionals' to whom it is directed. Clearly detailed discussion of multidisciplinary assessment and management are outside the book's scope. However, important omissions are a diagrammatic key to the anatomical terms used in describing various physical signs and illustrations of any penile injuries. The plates showing lichen sclerosis atrophicus are also disappointing. On the positive side, the sequential illustrations showing healing are helpful, as are those showing normal variations in hymenal configuration.

This is not a book from which the inexperienced doctor should seek reassurance about his or her 'diagnosis' when presented with a child with an anal or genital complaint, as it cannot replace discussion and advice from a more experienced clinician. Those who are regularly asked to examine children who may have been abused will find it a useful reference text.

**HILARY SMITH**
Consultant paediatrician in community child health


Clinical practice is a delicate balance between dynamic pragmatism and scientific certainty. As far as glucose homeostasis is concerned, there has been a slow but sure shift towards the latter, attributable in considerable measure to the efforts of the editors of this book. The new, extensively revised edition is one of those rare books that is a must for every paediatrician because it contains a wealth of practical advice based on sound pathophysiology. It is written in concise, clinically oriented sections which deal with the whole spectrum of metabolic disorders that are relevant to glucose homeostasis.

It lays out clearly that which is certain and illustrates our complete ignorance of areas pertinent to everyday practice (dynamic pragmatism to the fore). The most telling of these is that there is still no agreement on the exact definition of hypoglycaemia after 30 years of research! The authors comment that a properly controlled prospective trial of plasma glucose concentration v neurological outcome in newborn infants has never been done to define a 'safe' value. At a practical level, there is an excellent discussion on the problems of the poor precision of reagent strips for the diagnosis of hypoglycaemia. New sections have been included on the common problem of hypoglycaemia in the extremely low birthweight infant (or in their terminology 'the micropreemie') and transient neonatal diabetes mellitus is given a chapter of its own.

The book is divided into two broad areas, the first half is an update on hypoglycaemia (very useful for the research fellow starting on a project) with a particularly helpful section on the management of the infant with persistent severe hypoglycaemia. The second half contains separate chapters devoted to the special problems relating to glycogen storage diseases (we will have to revise what we teach the medical students: glucose-6-phosphatase is not that simple anymore), galactosaemia/fructosaemia (ranging from the molecular genetics to the clinical prognosis), and metabolic diseases which masquerade as hypoglycaemia (rare, but always a severe clinical problem). At the end of the book there is an excellent section on the substances which are known to interfere with the reliability of glucose estimations in the laboratory (frighteningly large). The references alone are worth the price!  

**ANIL MEHTA**
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MMR x 2?
In Britain it is currently recommended that the measles, mumps, and rubella (MMR) vaccine be given only once, between the first and second birthday or at the time of the preschool booster for those not immunised in their second year. In most children, immunisation gives protection lasting for 20 years or more so such a policy successfully pursued with a high take up rate should see the elimination of the disease from a community. Why, then, has measles not disappeared from the United States where in 1989 there were more than four times as many cases as in the previous year and 40% of the affected children had been immunised? Two national advisory bodies, the American Academy of Pediatrics (AAP) and the Centers for Disease Control (CDC), have recommended routine reimmunisation for all children in order to combat the problem. The AAP recommends reimmunisation at 11 or 12 years and the CDC at 4 to 6 years of age.

A study done in Texas and reported in Pediatrics (Robert Wittler and colleagues, 1991;88:1024–30) throws further light on the subject. They obtained paired sera before and after repeat immunisation from 183 subjects aged between 4 and 20 years. Immunobiological measles susceptibility was defined as a fourfold or greater rise in measles specific IgG titre in the post reimmunisation sample and on that basis 10% of subjects were susceptible and therefore vaccine failures. Vaccine failure may be primary (no immune response) or secondary (initial immune response which wanes). After primary failure successful repeat immunisation should produce an IgM antibody response but there should be no such response after secondary failure. Using this criterion 28% of vaccine failures in this study were primary. As the immune response demonstrated by a fourfold rise in measles titre is evidence of susceptibility to infection but not necessarily to disease, the vaccine failure rate derived in this way is probably an over estimate. Previous estimates have varied between 2 and 10%.

In the present study, the main correlation with vaccine failure was age at first immunisation, the failure rate being some four or five times greater in those first immunised at under 12 months of age than in those first immunised at over 15 months. The British Department of Health recommends reimmunisation for children immunised under 1 year of age. Nevertheless, of the 18 measles susceptible subjects in the Texas study, only two had been immunised before their first birthday. Simply eliminating too early immunisation, therefore, is unlikely to solve the problem. Neither is reimmunising only those with a low measles IgG titre as, although such people are more likely to be susceptible, susceptibility was demonstrated in some with fairly high titres.

The question of optimal timing of the second dose is not settled. There is some suggestion from the Texas data that reimmunisation at the later age (11 or 12 years) might be more successful but the evidence is inconclusive.

The stated aim when MMR was introduced in Britain was to eliminate these diseases. American experience suggests that, at least in the case of measles, a single dose may not do so.