fine levels of antimyeloperoxidase antibodies were detectable by enzyme linked immuno- 
sorbent assay (ELISA). Antinuclear (titre, 
1:640 by indirect immunofluorescence) and 
antihistone autoantibodies (strongly positive 
by ELISA) were also detectable. Antibodies 
to native DNA were moderately positive by 
ELISA but negative by indirect immunofluo-
rescence using cultures of Crithidia luciliae. 
The rash subsided within two weeks when 
levamisole was withdrawn. All autoantibodies 
were still detectable seven months later.

The clinical features in our case strongly 
resemble those described in the literature 
with the exception that in our patient the 
reaction occurred after a treatment period 
with levamisole of five years, by comparison 
with one to three months in the reported 
patients.2,4

This observation indicates that cutaneous 
vasculitis induced by levamisole may be 
associated with circulating autoantibodies.

R LAUX-END
D INABNIT
H A GERBER
M G BIANCHETTI
University of Berne,
Inolpital,
CH-3010 Berne,
Switzerland

1 Kurman MR. Recent clinical trials with leva-
2 Macfarlane DG, Bacon PA. Levamisole-induced 
vastulitis due to circulating immune com-
3 Scheinberg MA, Gomes Bezerra JB, Almeida FA, 
Silveira LA. Cutaneous necrotising vasculitis 
4 Ferlazzo B, Barreto G, Puglisi A. Vasculite necro-
 tissante cutanea da imunocomplexos em corso 
di trattamento con levamisole. Bull Ist Sieroter 

Autumn Books


When the history of the eighties comes to 
be written there may be more than a passing 
reference to the epidemic of child abuse uncov-
ered during this decade. Together with the 
collapse of communism and the march of 
materialism, there was enormous social 
damage. The rapid, untrammelled growth of 
the developed democracies from smoke 
stack to service economies had severe conse-
quences for the large communities of labour-
ing populations no longer required in the 
manufacturing corporations. This social in-
volution destroyed longstanding support net-
works, some of which had concealed or con-
tained abusive behaviour towards children. 
Coupled with changes in family formation, 
this resulted in increasing pressures on 
parents: some of whom found that declaring 
abuse uncovered resources.

Beliefs influence decisions and diagnoses—event if we are unaware of them. 
There is a human tendency to conform with 
firmly expressed opinions rather than as 
religious sects fall into doctrinal rigidity. One 
belief comes to dominate and any opposition is 
damned as heretical. Paediatricians in Britain 
will be aware of the problems that arose after 
overzealous investigations in communities as 
disparate as Rochdale and Orkney; American 
readers would be similarly aware of Merivale 
and Wetschtech.

Two of the pioneering workers in the field 
of child abuse in the 1980s were doctors 
Hobbs and Wynn who worked together in 
London. They envisaged a more authoritative 
but like many pioneers, not without opposition 
or criticism. The time may now be opportune 
to reflect objectively on this body of work. The 
atlas may be of value as suggested by 
Vandeven and Emanus whereby photographs of 
lesions should be reviewed by panels of 
experts to establish an audit of clinical crite-
ria for a diagnosis of child abuse (Arch Dis 
Child 1998; 73: 469-71). Hobbs and Wynn’s 
atlas provides a firm pictorial record of the 
material on which they based their opinions.

This atlas is beautifully presented with 
many colour illustrations, radiographs, and 
growth charts that sum up the satori 
experience of seeing violence against the 
innocent. The introduction suggests that it 
is important as a resource for practically 
everybody involved in child protection (from 
judges to nurses and police). The atlas may be 
helpful.

The book would benefit from strict editing 
with a layout in a more logical form to facili-
tate access and cross referencing. More rigid 
selection of photographs is needed to indicate 
the relative importance of different condi-
tions.

It is always refreshing to review colleagues’ 
views. There is much to learn in this atlas for 
many professionals. Teachers may be inter-
ested to know that ‘spanking may have sexual 
overtones’, dentists that ‘untreated dental 
caries are part of the picture of neglect’, dieti-
cians that ‘failure to thrive and obesity may 
be part of the same attachment difficulty which 
amounts to abuse’, and gynaecologists to 
learn that ‘children who insert foreign bodies 
have almost always been sexually abused’. 
The inclusion of accidental burns and 
visible deprivation as abusive acts serves 
only to confuse, weakens efforts to help the 
underprivileged, and may indicate a lack of 
objectivity, in their arguments.

International referees cited by the editor of 
Child Abuse and Neglect questioned the 
very high level of positive findings among 
Leeds children, together with the low level of 
legislation by the Child Abuse and Neglect 
1989; 13: 165). Such a fraught area requires 
careful reflection, repeated reassessments of 
objectivity together with full assessment of 
all aspects of the child’s history. Overstatement 
may lead to scepticism with consequent 
egregation of those in need of help. The time 
is right for the establishment of clear criteria 
and guidelines for the diagnosis of child 
abuse. Unfortunately this book does not 
serve this purpose.

There are several excellent alternative 
teaching aids I prefer: ABC of Child Abuse 
(edited by S R Meadows, London); BMJ 
Pubs, 1989 (this includes the work of 
the authors of this atlas). Atlas of Child Sexual 
Abuse (edited by D Chadwick et al); Chicago: 
Yearbook, 1989 (a masterly 
photograph, The Cambridge Child Abuse, 
by S M Smith); London: Butterworth, 1975

(Smith in 27 illustrations shows most aspects 
of physical abuse and has a useful historical 
introduction). Child Abuse (edited by 
Blumenthal); London: Edward Arnold, 1994

(uses line drawings rather than photographs in 
a balanced comprehensive text). Clinical Foren-
sic and Psychiatric Medicine, edited by 
Blumenthal, 1996.) A Handbook for Health 
Care Practitioners (by I Blumenthal); 
London: Edward Arnold, 1994, (uses line 
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text). Clinical Forensic Medicine, edited by 
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The Child with a Disability, 2nd Ed. By 
David M B Hall and Peter D Hill. (Pp 386; 

David and Hall offer this book to hospital 
paediatricians and general practitioners 
working in the community to help them and 
to non-medical disciplines but curiously do 
not mention community paediatricians spe-
cifically as the target audience. It assumes 
previous knowledge of paediatrics and is 
clearly not an introductory text. Polnay and 
Hull’s Community Paediatrics is therefore a 
better buy for undergraduates or the senior 
house officer entering the world outside hospital 
for the first time. But this book undoubtedly 
gaps a field in the market for specialist 
registrars embarking on the more specialised 
aspects of developmental assessment in a 
community setting or the child development 
centre. Until now such skills have tended to 
be taught by word of mouth backed up with 
relevant teaching materials. The advent 
of a core text will be a blessing to those of 
us involved in specialist training.

The first seven chapters address in detail 
the assessment of children referred with 
developmental delay and the management 
of disclosure of developmental problems. 
The layout is pleasing to the eye, having two 
columns per page, with lots of headings. 
There are numerous tables giving useful 
hints on how to approach initial interviews and 
how to extract useful information by appro-
priately phrased questions (which are ana-
doned in the tables). The review of normal 
development is useful and hearing and vision 
assessment is described separately. Tests used 
in the assessment of intelligence, speech, 
language and general development are 
reviewed and their limitations and uses dis-
cussed. Headings will allow readers to dip 
into the text but the book is also eminently 
readable.

The rest of the book is devoted to specific 
developmental disorders including their clini-
cal features, investigation, and long term 
management. The choice of conditions is 
decided to detail rather than coverage. 
This is nicely done with a half page on the genetic variants of 

Arch Dis Child: first published as 10.1136/adc.75.4.356-a on 1 October 1996. Downloaded from http://adc.bmj.com/ on September 17, 2023 by guest. Protected by copyright.
fragile X syndrome but only a page and a half on all single gene disorders including the mucopolysaccharidoses, degenerative disorders, phenylketonuria, etc. The detailed illustrations in the chapter on cerebral palsy are worth a thousand words and could have been used to good effect when describing dystrophic syndromes elsewhere in the text. The chapter on educational underachievement describes specific learning disabilities including reading disability (dyslexia), motor disability (chorea), attention deficit disorder (hyperactivity). The most important lesson is that the changes in terminology do not necessarily indicate improvement in understanding and that the management of children with such difficulties is often based on fashion rather than evidence.

As expected when a child psychiatrist is a coauthor, the behavioural and emotional aspects of developmental disorders are given prominence both throughout the text and in the separate chapter on managing behaviour problems. The response of parents and family to disclosure and subsequent management of any such group of disorders. Possible reasons for different parental responses are discussed, for example a parent’s feeling of rejection by a blind baby because of the importance of eye contact in establishing mutual relationships. It will give excellent insight to doctors in training in the strain of looking after a child with a disability. What could be improved? A more balanced approach to the discussion of individual conditions would, I think, improve the book overall. A paperback edition at reduced cost would make it more accessible to impoverished trainees. But the authors are to be congratulated on the production of an excellent source book for the community paediatric syllabus which contains references as recent as 1995 and is therefore both


In 1981, I read in the BMJ Wendy Valerie Harman’s account of the cot death of her 10 week old son Charles.1 This was no calm, dignified, personal reflection on a common family tragedy: it was a shocking, unsenti- mental description of a death and its aftermath, full of anger, pain, and indigna- tion. In two pages Mrs Harman taught me more about the impact of sudden infant death on a family, and how we as carers could help or hinder grieving parents, than three years of paediatric training had achieved. Although I had experienced the feelings of inade- quacy I had experienced as a registrar when talking to bereaved parents, it also made it clear that we as paediatricians could help. It struck a chord and it made me think and behave differently.

I soon learnt that the Foundation for the Study of Infant Deaths was a valuable source of information and advice. Their series of leaflets for parents and health professionals, their local parent support groups, and their telephone helpline, all proved useful in setting up a local support service for bereaved families. Their gentle but persistent cam- paigning ensured that cot death, which is still the commonest cause of death between the ages of 1 month and 1 year, received more attention than it would otherwise have received.

Now the foundation has distilled 25 years of experience into a workbook for profession- als. This is not another textbook reviewing what we know and don’t know about cot death, or an academic dissection of the complexities of grief. It is a flexible, modular educational package written with the goal of helping health professionals listen to and support families better.

The final section discusses working with bereaved families. There are suggestions for various learning activities that may help profes- sionals appreciate the issues that are important to different members of the bereaved family. As ever, the quotations from parents themselves are often the most thought provoking statements. The impor- tance of our listening rather than succ- cumbing to the urge to fill embarrassing silences is rightly emphasised.

The second section gives ‘the necessary facts’. I found the interactive approach less appealing and effective here, but I confess to being of that opinion still. It will stick its necessary facts served up raw in succinct edito- rials or review articles rather than in the fashionable sauce of group activities. The essential information is all here.

The final section consists of a series of action plans for general practitioners, health visitors, midwives, accident and emergency staff, and paediatricians. These are little gems: models of clarity, brevity and wisdom, which it would be difficult to improve upon, and which could be adopted and adapted easily.

Overall, it is difficult to find fault with this book. I hope it will be widely read; I hope it will stimulate more care in the way those of us act who come into contact with one of the 500 families in this country who lose a baby from cot death this year.

CLiona Ni Bhrolchain
Consultant community paediatrician


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JON COURIEL
Consultant in paediatric respiratory medicine


In a world of science and technology, the common condition of epilepsy remains rela- tively unknown in the public consciousness. People often hold very distorted impressions of what the condition means; therefore, to be diagnosed as epileptic—especially as a child—can initially be very frightening with countless questions arising: what did you do during the crucial three minutes which are blocked out of your brain? Is it going to hap- pen again? Why you? And, most importantly, are you normal?

This volume tries to answer these ques- tions and more through generous illustration and a clear and comprehensible text. Prob- ably aimed chiefly at the 8 to 14 age group, this is a clear A-Z of all areas of epilepsy and is easy to use because of its good use of keywords to connect one entry to another.

Dr Appleton covers all aspects of epilepsy, starting at the first diagnosis. He explains the causes of the condition and the range of tests and treatment that the recently diagnosed child can expect to undergo. Perhaps if my friends had read this book, particularly the section on what to do in the event of a seizure, I wouldn’t have found myself stumbling off a crowded coach at accident and emergency, to be greeted by numerous doctors and nurses who were obviously expecting more casual- ties than one confused epileptic.

Perhaps the most important element of the book is the emphasis Dr Appleton places on the indivi- duality of the condition. Julia Cae- sar, Van Gogh, and Dostoevsky are just three of the famous people mentioned to prove that epilepsy need not be an inhibiting condition. While there are paroxysms that are not suitable for epileptics, it is pointed out that those are greatly outnumbered by those that can be practised by anyone, showing that the condi- tion should not greatly affect your life. The author’s demystification of epilepsy under- lines this, making this book a valuable edition to the bookshelves of any young epileptic and an essential for every school library.

CATHERINE WILSON
Student and patient


The overall risk of developing epilepsy during childhood and adolescence is of the order of 1%. Many more children will present at clin- ics in casualty department with disorders such as febrile seizures, breath holding spells, or vasovagal syncope that will need to be distinguished from epilepsy. When epilepsy is diagnosed, a variety of investigative tests may be required to determine, where possible, the epilepsy syndrome and the underlying cause. Judgments will need to be made as to whether to treat with anticonvulsants, and what anticonvulsants to use. Advice will need to be given on drug side effects, risk minimi- sation, and the management of major convul- sive episodes should they occur. There will need to be discussion about prognosis, schooling and, in adolescence, driving, car- reers, and pregnancy. Fifteen to 25% of chil- dren with childhood epilepsy will be resistant to treatment and both newer medications and new pharmacological treatments including epilepsy surgery may need to be considered. In those in whom the epilepsy is well control- led with treatment, a decision as to when to withdraw treatment will need to be made.

Given the prevalence of the disorder, most paediatricians will spend some time in epilepsy diagnosis and management. For those with a specifically neurodevelopmental interest, de- spite difficult epilepsies repre- sent a considerable proportion of the work- load.