Errors and omissions are minimal. To name a few, O'nyongnyong, a tropical disease, is out. *Teat* is defined as *papilla mammaria*, *nipple*. No mention is made of its much more frequent usage in Britain to describe the rubber simulacrum, perforated for bottle feeding and unperforated to operate a pipette. *Opioid* deserves an entry and is needed to avoid confusion with *opiate*. Spelling errors and literals are too few to merit detailed mention in a work of this size. *Victor Schilling* (1883-1960) is given as the originator of (a) a method of classifying and counting neutrophils and (b) a test for pernicious anaemia. The latter test was devised by Robert Frederick Schilling, whose name is not entered. *Butter* is stated to contain 1 mg vitamin D per 100 g; this should be 1 µg. *Sir David Bruce* is described as *English* in his main entry but as *Scottish* subcently in *brucella*. *Physician* (second meaning): *a licensed practitioner of medicine or osteopathy*. In Britain an osteopath is a physician only if medically qualified. *Pill* is *a tablet or a spherical or ovoid solid form of medication*. Pills and tablets of whatever shape are entirely different in mode of preparation and structure.¹ The adoption of pill for tablet has entered medical terminology through its use by the laity, who applied "pill" to the oral contraceptive. There are those who hold that definitions should be allowed to shift to accommodate popular usage. This is in order so long as confusion does not arise with a pre-existing meaning. On the other hand, the stability of the language is not maintained by blowing it about like a weather vane.

Restricted definitions

Some of the definitions, especially those in chemistry and botany, tend to be circumscribed by their respective disciplines, without reference to clinical context—some examples follow. *Phytic acid*. . . . *Its anions bind calcium and magnesium strongly*; no mention of its presence in vegetable foods and in wholegrain bread in particular with consequential impairment of absorption of dietary calcium. *Vitamin D has antirachitic properties*. A positive statement is needed of what vitamin D does in normal metabolism as well as mentioning the disease that is prevented by giving adequate amounts. *Crotalaria*. . . . *is poisonous, especially to grazing animals*; no mention of its presence in West Indian bush tea, ingestion of which may induce Budd-Chiari syndrome in humans. *Bromide*. . . . *is any compound of bromine, especially with another element*; no mention of the fact that potassium and sodium bromides were the most widely used sedatives during the first third of the twentieth century, until displaced by barbiturates. *Bromocriptine* is rightly stated to be used

in the treatment of three uncommon conditions; but no mention is made of its main clinical use in the prevention and suppression of normal lactation. *Buggery* is a popular term for sodomy. Buggery has a specific meaning in British legal terminology.

Commissions

If an omission is something wanted but absent perhaps I may be permitted to coin a phrase for something unwanted but present. *Lithosphere*. . . . *the solid portion of the surface of the earth*; surely the wrong -ology for this dictionary! *Forest*. . . . *an area of vegetation dominated by trees*; no comment. I took pleasure in the retention of some archaisms: *apostema*, *orrhorrhea*, *scelalgia*, *seriflux*, *uberty*—all useful terms to enliven a flagging conversation.

The task of recording the countless drugs currently and recently in use must be daunting. A statement about the policy, if there was one, regarding the choice of exclusions would have been welcome in the editor's introductory note. To take some examples, of 12 β adrenoceptor blockers listed in the *British National Formulary*, only two are entered. Of seven β₂ bronchodilators, two are entered. Of 20 non-steroidal anti-inflammatory drugs, other than salicylates, in the formulary, nine are listed. Was there not space in a work of this size for a comprehensive entry? As well as generic names, many proprietary names are entered, predominantly American. Human insulin, available since July 1982, is out.

Having picked enough nits, I turn to lighter vein. Among the many eponyms is that of Dr P S Physick (1768-1837), an American surgeon. We do not know if his name helped to drum up consultations, but would changing one's name by deed poll to something promotionally eye catching enter the forbidden arena of advertising? The novel *Madame Bovary*, by Flaubert, has given rise to *bovarism*, *a failure to differentiate between fantasy and reality*. This condition is widespread and endemic.

All concerned in the production of this mammoth work deserve praise for their scholarship and attention to detail. At a cost of £285 I imagine that transatlantic usage will predominate. It would, however, be a useful addition to any British library.

¹ Freedman BJ. Pills and tablets. *Br Med J* 1981;282:720.

International Dictionary of Medicine and Biology. In 3 volumes. Editor-in-Chief S I Landau. (Pp 3300; £285 the set.) New York: Wiley, 1986. ISBN 0-471-01849-X.

Liars and hypocrites

TONY SMITH

One evening in the autumn of 1966 Timothy (Timbo) Ward was sorting himself to start at Harrow the next day. He stood on the bathroom scales and found that he had gained a stone in weight in the summer holidays. The cause was fluid retention from glomerulonephritis, and it was a year before he entered his new school, thin and wasted, bald from treatment at Guy's Hospital with cyclophosphamide, with his hopes of athletic distinction gone forever.

By 1970 Timbo was in end stage renal failure and was admitted to hospital in Portsmouth, where a medical decision was made not to attempt dialysis since his doctors believed that it would be fatal in someone with uraemic pericarditis.

His mother took a different view: "since he was without question going to die without the treatment that was a poor reason for denying it." She talked to John Trounce, who had treated her son at Guy's, and he came down to Portsmouth by train that day and persuaded the doctors there to change their minds and begin dialysis.

Elizabeth Ward's fight for her son's life was successful—and she

has continued to fight to keep him alive and as well as can be. She has also used her experience to fight for all patients with renal failure, trying (and succeeding) to improve the services offered by the National Health Service and to improve public awareness of the need for organ donation. At times she has battled with doctors, charmed them, bullied them, cajoled them, and changed their minds. She has been outspoken in condemning what she has described as "the egotistical, self satisfied traits that are the cause of much patient unhappiness in the renal world," and she has antagonised renal physicians, hospital administrators, and civil servants; but she has always had a single aim—to get better treatment and care for patients like her son with a disease that is treatable but is still not always treated.

By 1971 Timbo was on home dialysis and the diet recommended for him was "plenty of steak, chicken, eggs, and fish." How on earth, wondered Mrs Ward, could these instructions be followed by mothers of families with a low income? She began fund raising that year for the National Kidney Research Fund. Both she and Timbo

knew that his life could be transformed by kidney transplantation (but she and her husband had been told that they could not donate one of their own kidneys because of a genetic element in her son's nephritis). Waiting patiently for a kidney was not, however, her style; so in the summer of 1971 she advertised for a cadaver kidney in *The Times's* personal column. The result was a surge of publicity, but it was another year before a kidney did become available.

Sadly, Timbo's first transplant lasted only two years. He had a second, which also failed, and by 1980 was so ill that despite some reservations a third transplant was done using a kidney from his father. That, too, is now failing and he is waiting for another cadaver kidney.

Elizabeth Ward tells this sad story in simple words and while doing so she explains what has, I believe, been her greatest contribution: her attack on medical hypocrisy and dishonesty. In the early 1970s most renal physicians took the view that if no place was available on a dialysis programme the patient and his family should be told that there were medical reasons why dialysis would not be attempted. In the words of a paediatric nephrologist "the parents already had enough to cope with in the knowledge of the impending death of their beloved child without the added burden of knowing that their child's death was unnecessary." Elizabeth Ward flatly rejected that argument (as she had the one that nearly cost her own son his life) and she has changed attitudes in many—but not all—renal units. She has also repeatedly challenged the arrogant

assumption by renal physicians of a right to withhold treatment from patients who are socially disruptive, or have an alcoholic parent, or who are in some other way "difficult."

Fortunately her fund raising has been enormously successful (the British Kidney Patient Association (BKPA) that she set up has been able to finance and staff holiday homes for dialysis patients in France and Spain as well as on the south coast of England)—so she has been able to let it be known that the BKPA would meet the costs of private dialysis for any patient rejected in this way by the NHS—and in 1985 she did so in a blaze of publicity.

The campaigning will continue, for a great deal has still to be done. The continuing disgrace is that 2000 patients still die each year in Britain because the NHS is underfunded. Why, asks Mrs Ward in her final chapter, should renal physicians feel it necessary "to cover up for an inadequate Health Service and pull to wool over the eyes of relatives and patients telling them that dialysis would not save the patient's life when they know the truth is that it would?"

Quite rightly, Mrs Ward points to the honest communication which has now become accepted as essential in the care of patients with cancer. Why should patients with renal failure be treated any worse? Why indeed.

Timbo. A Struggle for Survival. E Ward. (Pp 160; figs; £9.95.) London: Sidgwick and Jackson, 1986. ISBN 0-283-99339-1.

Do it yourself radiology

GODFREY HARVERSON

Third World doctors usually have to read their own x ray films and so will welcome this bold attempt, by a panel of experts, to assist non-radiologist clinicians to recognise common diseases. After all, their problems are not esoteric tropical worms so much as trauma, infection, and malignancy.

Manual of Radiographic Interpretation for General Practitioners concisely expresses a good deal of practical wisdom and is well illustrated with radiographs and line drawings. Each section begins with guidelines—for example, on how to examine a chest radiograph, how to avoid missing a fracture, when to order a skull x ray film, and what to expect from abdominal radiographs: seldom of help in the diagnosis of chronic abdominal pain... of no assistance in excluding acute appendicitis. For obstetrics it is assumed that ultrasound facilities will not be available, which may well be so where this book is most of use.

The aim is to highlight diagnostic problems that are common world wide rather than exclusively tropical ones. The initial section on chest radiography, after dealing with technical faults mimicking disease—for example, poor inspiration—covers causes of chest pain, pleural effusions, collapse of the lung, lung densities (opacities), rounded densities (coin lesions), enlarged lymph nodes, and diffusely increased (reticular) lung markings. Heart disease, pulmonary oedema, and "chests of infants" are mentioned briefly. The section on skeletal radiographs rightly gives wide coverage to traumatic injury, a common "tropical" problem. There is warning of danger areas, such as dislocations of the wrist or ankle, where surgical reduction will be needed. A short account is given of osteomyelitis, arthritis, and common bone tumours.

The chapter on skull disorders begins with a fold out page to illustrate normal sutural and vascular markings. Fractures, facial trauma, the pituitary fossa, lytic defects, increased density, and sinus disease all receive mention. Under spinal disorders age related changes are helpfully included. Trauma is again covered, and also non-traumatic change in vertebral density and shape. The abdominal section describes features of paralytic ileus, obstruction, and perforated viscus. Features of abdominal calcification and some foreign bodies are listed. Coverage of obstetric problems is limited.

Examination of the urinary tract includes plain film radiographs and excretion urography. It is rightly stated that the normal adult dose is between 40 ml and 100 ml, whatever the brand of urographic contrast. "Inject the full dose rapidly; it *must* be given intravenously." (Poor intravenous pyelograms in developing countries are almost always due to too little contrast given too slowly.)

A preliminary chapter, on yellow pages for ready reference, deals