Book reviews

A Short English-Swahili Medical Dictionary. By T. HEDLEY WHITE. Expanded and edited by C. E. Sorsbie, Nathan Mbwele, and Anne Ndubbi. Pp. 128. £3.50. Churchill Livingstone: London. 1979.

Swahili is a beautiful and growing language which is rapidly becoming the national tongue of Kenya. The purpose of this English/Swahili medical dictionary (in 2 volumes) is to translate standard medical vocabularies used all over the world by English-speaking peoples into Swahili and thus provide accurate communication between doctor, patient, and nurse. It is a pioneer piece of work because many of the technical medical terms have no absolute equivalent in the Swahili language, and Lady Sorsbie and her two collaborators Nathan Mbwele and Anne Ndubbi are to be congratulated on the time and care which they have spent with the author on this dictionary with a view to making it easier for the primary-care doctor to make a scientific diagnosis and apply appropriate treatment. Ophthalmology, which is said to have a sublanguage of its own, is well represented, as well it should be considering the amount of ocular disease which still exists in East Africa. Designed to fit into the pocket of a doctor's or nurse's white coat, the dictionary will prove a tireless medical auxiliary. We wish it every success.

S. J. H. MILLER

Ocular Toxoplasmosis and Pars Planitis. By T. F. SCHLAEGEL, JR. Pp. 378. \$34.75. Grune and Stratton: New York. 1978.

This book of 378 pages tells the story of toxoplasmosis and pars planitis in some detail. It traces the advances in our knowledge contributed by many research workers.

Systemic toxoplasmosis is a protozoan infection of man and most of the animal kingdom. It is present worldwide, being more common in warm, moist, sea-board climates. It is usually asymptomatic, but when it is symptomatic it produces lymphadenopathy in man.

In 1923 Janků, of Prague, described a boy who became blind at the age of 3 months and died of hydrocephalus. This infant had a granulomatous inflammation of the eyes due to the protozoan *Toxoplasma gondii*. In 1948 Sabin and Feldman presented their dye test, and in the same year Frenkel introduced the toxoplasmin skin test and showed its value in providing evidence of toxoplasmosis as a presumed cause of posterior uveitis. In 1952 Helenor Wilder demonstrated *T. gondii* in tissue sections in 53 adults who showed retinochoroiditis, and 30 of these cases had previously been diagnosed as probable tuberculosis.

The feline is the definitive host of toxoplasma but the organism is ubiquitous. The discovery of the coccidial stage of toxoplasma in intestines of cats and of oocysts excreted in cat faeces suggests that the oocyst form of the parasite may be the major source of transmission. Since there is an increasing prevalence of positive serological titres with increasing age it would appear that

many people acquire the disease at some time during their lives.

In congenital systemic toxoplasmosis the organism is transmitted to the fetus from the maternal circulation or a focus in the uterus. It has a predilection for nervous tissue. Characteristic features are an encephalomyelitis succeeded by areas of calcification in the brain and bilateral chorioretinal lesions often affecting the maculae. High antibody titres are found in sera from mothers who have just been delivered of diseased children, but the mother does not give birth to more than 1 child with congenital toxoplasmosis. Once a woman has had toxoplasmosis and has become immune she cannot give it to any subsequent children. Most authorities now think that ocular toxoplasmosis is usually congenital in origin, and as 3000 of the 3 million babies born in the United States each year have congenital toxoplasmosis there is still a sizeable medical problem to be solved.

Wilder pointed out that it is not the level of serum titre that is important in the diagnosis of ocular toxoplasmosis but rather the presence of a positive skin test or dye test. A rising titre in ocular toxoplasmosis does not occur except in those rare patients with acquired systemic toxoplasmosis complicated by toxoplasmic retinochoroiditis. The vast majority of cases of toxoplasmic retinochoroiditis are of congenital origin. *Toxoplasma* organisms lie dormant as cysts in the retina, to be awakened later. The incidence of ocular toxoplasmosis in posterior uveitis is variously estimated from 25% (Perkins) up to 70% (Cassady).

Satellite foci are most helpful in pointing to the presumed aetiology of the toxoplasmosis, since most cases of toxoplasmic retinochoroiditis occur at the edge of a previous scar. It affects patients between the ages of 11 and 40 years and is often unilateral and single. Cells appear in the vitreous and disappear with recovery. The diagnosis should be based on a typical clinical picture plus laboratory evidence of toxoplasmosis. The mainstay of the diagnostic armamentarium is still the Sabin-Feldman dye test.

In treatment at least one antimicrobial agent must be used if corticosteroids are employed because of the hazard of generalised toxoplasmosis in the immunologically compromised patient. The common routine is to give triple sulphonamides in a dosage of 3 500-mg tablets every 6 hours with 100 mg of pyrimethamine twice the first day and 25 mg twice a day thereafter. It is important that the patient receives 3 mg of citrovorum factor or folic acid once weekly.

Pars planitis was first described by Schepens in 1950 after the introduction of the binocular ophthalmoscope. The condition involves retinal phlebitis with leakage into the vitreous and the late development of collagen in the vitreous. It accounts for 4 to 8% of patients with uveitis, and it affects mainly children and young adults.

A child with uveitis has about 1 chance in 5 of having pars planitis. There is no sex predilection. Two-thirds of the cases are bilateral. Symptoms and external signs are minimal. The type of complaint consists of seeing black spots, strands, or thin veils or having blurred vision. Most cases in the population at large, perhaps as many as 80%, do not need any treatment. In cases lasting from

15 to 26 years severity is no greater than in the less chronic.

If vision is found to be reduced at first examination it is usually due to posterior subcapsular cataract, organised anterior vitreous opacities, macular cystic changes, or disc oedema or a combination. If keratic precipitates are kept to a minimum and the patient is comfortable, flare and cells in the anterior chamber with a moderate number of cells in the vitreous should be discounted.

One of the most typical features of a pars planitis is leakage of fluorescein into the vitreous apparently from the retinal veins and from neovascularisation in the ciliary body region. The vitreous is quickly filled with fluorescein. It is only later that dye is seen in the anterior and posterior chambers. This rapid leakage of fluorescein dye into the vitreous adjacent to the ciliary body is most characteristic of the disease. It is always difficult to define an end point, because cells in the vitreous may persist for many years and relapses can occur.

Therapy on the whole is disappointing, though corticosteroids have a place in the treatment of most cases. Immunosuppressants should be employed only in severe cases in which corticosteroids have failed to have any effect. Diathermy, cryocoagulation, and photocoagulation have nothing to offer.

S. J. H. MILLER

Directory of Agencies Serving the Visually Handicapped in the US. 30th edn. Pp. 436. \$10.00. American Foundation for the Blind: New York. 1978.

This the 20th edition provides over 400 pages of condensed information. The *Directory* makes no attempt to evaluate or endorse any of the organisations or services that are listed, nor does it claim to be absolutely comprehensive, for it lists only nonprofit organisations. Clear instructions on how to obtain further information are given in the introduction.

There are two sections, the first listing services State by State. These are classified into educational services, library services, and rehabilitation services. Comprehensive information is given on criteria for eligibility, how the agency is funded—that is, State, charity, or client fees—and precisely what services are available. The potential client who needs, for example, braille or mobility training is able to make an independent informed decision and can approach the named director personally. No attempt is made to quantify or evaluate specific services.

Section 2, entitled 'Supplementary Lists of Specialized Agencies and Organizations', seems to be aimed at professionals of various disciplines working with the visually handicapped. State by State it lists research organisations, guide dog schools, and professional preparation centres. The largest subsection is devoted to low-vision services, with hospital clinics and university departments (both ophthalmology and optometry) and fee-based private facilities being included. Again the discriminating reader should be able to use the information provided to decide which of the accessible facilities is the most appropriate.

Few criticisms of this useful volume can be made. It should perhaps be available in large print or braille, and

obviously any such directory is inevitably out of date before the print is set. But so much information so readily accessible would be extremely useful in any eye clinic and social worker's office. It is to be hoped that a similar directory will be made available for the United Kingdom.

JANET SILVER

Ocular Pharmacology. 4th edn. WILLIAM H. HAVENER. Pp. 762. £37.80. Henry Kimpton: London. 1978.

The 4th edition of this popular textbook follows the pattern of previous editions. The first part covers drugs in ophthalmic practice and the second part deals with current ophthalmic therapy. There is a useful chapter on evaluation of the therapeutic response, including placebo and reassurance therapy. This is followed by a chapter on routes of administration which includes soft lens and membrane delivery.

The drugs are described in alphabetical order of therapeutic groups. In general the pharmacological action is described from a clinical approach, experimental evidence being kept to the minimum essential for this purpose. There is a good description of the clinical use of each drug, so that the title could have been 'Ocular Pharmacology and Therapeutics'.

Generous references are supplied throughout (2573 references) and the illustrations are well chosen, often from the original reference. Toxic reactions are well described. As with any such book taking time to revise and print, there are bound to be omissions, the obvious example being that there is no mention of the beta blocker timolol.

The author admits to a number of healthy prejudices, such as preferring local to general anaesthesia for many forms of surgery, being unconvinced of the beneficial value of photocoagulation in diabetic retinopathy, and preferring fascia to silicone implants in retinal detachments. The chapter on general anaesthesia includes a section on cardiac arrest. In addition to the larger groups of drugs there are useful chapters on the smaller groups such as adhesives, biological drugs and alpha-chymotrypsin.

The second part, on current therapy, includes chapters on cataract, external diseases, glaucoma, and infection. There is a fascinating description of all the different drugs, some with opposite action, used to treat traumatic hyphaema. The conclusion would appear to be that the spontaneous course of hyphaema is unchanged by any form of medical management, including bed rest.

This whole book makes most enjoyable reading, which is not usual in pharmacology textbooks, and can be thoroughly recommended.

S. J. CREWS

Contact Lenses. A Clinical Approach to Fitting. By ROBERT H. HALES. Pp. 248. \$26.50. Williams and Wilkins: Baltimore, Maryland. 1978.

Up to date and practical, this book deals with the fitting of all available contact lenses in a clear step-by-step manner. There are useful chapters on contact lens solutions and the choice of contact lenses. The chapter