apheresis and continuous haemofiltration were started and the eosinophilia and acute kidney injury gradually improved. However, the patient unfortunately died 10 days after intensive treatment.

Post-mortem examination revealed fulminant renal infarction at the lower part of the left kidney (Fig 1b). Microscopic histology revealed typical cholesterol crystals in the aorta (Fig 1c) and the renal arcuate artery (Fig 1d).

Cholesterol embolisation syndrome (CES) is a systemic disease which occurs when cholesterol crystals and other contents of an atherosclerotic plaque embolise from a large proximal artery to smaller distal arteries, causing ischaemic end-organ damage.[1] Diabetes and increasing age are thought to be predisposing factors.[2] In this case, the trigger of cholesterol embolism was thought to be warfarin administration. To date, no specific diagnostic test, other than clinical signs and biopsy for CES has been developed.[3] Peripheral cutaneous involvements, such as blue toe is one of specific findings and a clue for prompt and accurate diagnosis. ■

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Book reviews

Advancing the human right to health

Zuniga JM, Marks SP and Gostin LO, eds. Oxford: Oxford University Press, 2013. 480 pp.

This substantial volume commemorates the 65th anniversary of the Universal Declaration on Human Rights. As Paul Hunt (former special rapporteur to the United Nations on the right to health) writes in his foreword, since that Declaration 'the right to the highest attainable standard of health has come a long way [but] the challenges remain enormous and diverse'.

Though the three editors are all US-based, they have recruited authors from several European countries as well as from Africa, South America, Japan and Haiti. Most are academics in law or in public health. The book has two very substantial sections – one on 'the right to health in action' (which provides a series of country-based overviews of recent experience) and one on 'challenges and opportunities', which is disease- rather than country-based. These are framed by an opening section on 'the right to health in perspective' and a concluding chapter on 'the consequences of failure'.

The opening chapter (by Stephen Marks, one of the book's editors) provides a lucid but somewhat acronym-laden summary of the international legal framework and concludes that whereas 'every country has accepted that human rights are universal' and that all are 'bound by at least one treaty containing a provision on the fright to health', these rights are 'of little value without effective means of promotion and protection at the national and international levels'.

In Section 2, Cabrera and Ayala then examine the potential of litigation to advance health rights and the potential for courts to undermine as well as to promote these rights. Nygren-Krug emphasises the need to enhance accountability at international, national and local levels. A provocative chapter by Pablos-Mendéz and Stone highlights the 'moral imperatives' towards health and equity and the potential synergy between promoting health and strengthening nations. Examples cited include responses to conflict (as in Timor-Leste) and to specific health challenges (such as HIV in Botswana). Friedman and Gostin then make the case for adopting a 'Framework Convention on Global Health' with the aim of setting a global health agenda and reducing health inequalities.

The third section provides summaries of current health and human rights legislation in Haiti, Ghana, India, South Africa, the Philippines, China, Brazil, Peru, Mexico, the UK, Japan and the US. These are useful sources of reference but make somewhat turgid reading. It would have been helpful to have more information on the extent to which newer legislation is (or is not) being translated into better and more equitable standards of healthcare.

To my mind, Section 2 is the most useful section of the book. Baer *et al* examine human health rights through the lenses of HIV, tuberculosis and malaria and emphasise the potential health benefits to HIV care of tackling discrimination, to malaria prevention of promoting the right to food, water, sanitation and housing and that attempts to control TB through involuntary hospitalisation and isolation breach individual

human rights, whereas these rights can be respected through an emphasis on early diagnosis and better access to treatment. Cabrera and Gostin argue that 'human rights and tobacco control are mutually reinforcing pillars' whose connection needs to be strengthened 'both in litigation and in policy development'. Yamin argues on similar lines for the linkage between women's rights and health. Other chapters examine the health rights of prisoners, the right to nutrition, issues of access to expensive medical products and technologies, health and human rights during conflicts and emergencies, and the potential role of genomics in enhancing health rights. Bochenek provides a lengthy and thoughtful analysis highlighting the ubiquity of state-sponsored torture and ill-treatment, the wide range of ill-treatment practiced in addition to torture, and the unacceptability of legislation that compels complicity in ill-treatment such as requiring involuntary sterilization or placing unacceptable restrictions on abortion. I would have welcomed some discussion on the continuing difficulties in accessing healthcare that asylum seekers often experience after fleeing from torture and other ill-treatment.

In the concluding chapter (which could and should have been much longer) Grover, Citro and Mankad focus on the needs of vulnerable and marginalised groups, on the protection of health-related freedoms (such as privacy, confidentiality and informed consent) and on the need for, and potential of, public participation in enhancing the right to health.

Lawyers and public health doctors are not always the easiest of bedfellows. This book represents a useful collaboration between their disciplines. It is at its best when examining specific and practical examples of challenges to health rights and successful initiatives to enhance those rights. ■

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The stomach: a biography

By Jeremy Hugh Baron. North Charleston, SC: CreateSpace, 2013. 358 pp.

Hugh Baron has written what must be the definitive medical and social history of the stomach, and it moves steadily from Mesopotamia to present times.

It seems that acidity has been a symptom for the past 4,000 years, but the problem is that, for much of that time, there was no precision about anatomy, physiology or pathology. The reader is taken though the abdominal symptoms recorded in ancient Greece and Rome, the Middle Ages, the Renaissance and each century from the 1600s onwards.

Baron makes liberal reference to literally hundreds of references in each chapter. In most instances, the literature describes symptoms that relate to somewhere in the abdomen. Symptoms alone can be interesting: did you know that, although Shakespeare used 29,066 words and the word 'stomach' 50 times, none of his characters had stomach ache or pain, just indigestion. However, symptoms did not define pathology for most of those 3,800 years.

Some of the first hints of pathology being related to symptoms were when dyspeptic monarchs were subject to postmortem examination or embalming, a diagnostic benefit denied those who were executed, because their cause of death was known. It seems that post-mortems only became common during the 18th century and, for the first time, there was clear definition of gastric and duodenal ulceration. Indeed, gastric ulceration always arrived ahead of duodenal ulceration (a special research interest of Baron) and, in retrospect, this might have been because of the transient epidemic of *Helicobacter pylori*.

During the late 19th century, a few lucky, or perhaps unlucky, dyspeptic patients fell into the hands of surgeons, who performed a laparotomy to get a more precise diagnosis before they died, and to perhaps treat them. During the early 20th century (I am uncertain because this seems the only omission in this encyclopaedic volume), the introduction of barium meals began to add some diagnostic precision, but the invention of flexible fiberoptic endoscopy was the big advance. I was a house officer at the Hammersmith Hospital in 1970 when a visiting endoscopist (and I am pretty certain it was Baron himself) performed a few endoscopies each Saturday morning on selected patients, who were not only sedated but also blindfolded!

Endoscopy demonstrated that symptoms were an extremely poor guide to a precise diagnosis. Gradually, epidemiological studies of dyspeptic symptoms evolved into studies of defined diseases, and these are all documented in *The Stomach*. There then followed clinical trials and the proven benefits of surgery, followed by H_2 receptor antagonists, proton pump inhibitors, *H pylori* eradication, and the avoidance of non-steroid anti-inflammatory drugs. All are documented in this volume.

Baron must be congratulated: he has written what must be the definitive work encompassing the stomach. I know that it will be appreciated by not only gastric scholars, but also those after-dinner speakers needing an unlimited supply of quotations about dyspepsia. ■

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