

charity in the world, largely as a result of major share sales and the final sale to Glaxo. As well as offering some fascinating insights into the evolution of the Trust's policies on medical research he describes, with great gusto and humour, his many visits to the Tropics to establish the Wellcome overseas programmes. He rounds up his story with a delightful account of his post-retirement collaboration in the history of medicine with his wife Billie. His work is also illustrated by the reproduction of several of his papers and lectures on various aspects of tropical medicine and medicinal history.

The story of Peter's experiences as Director of the Wellcome Trust will be of considerable value to medical historians of the future. He was one of the few people who really understood the importance of developing close working relationships in medical research between the rich countries and the developing world. Indeed, it was largely through his vision that the Wellcome Trust, and to a lesser extent the Medical Research Council, were able to develop the sustainable North/South programmes which have been so successful in recent years and which have spawned many leaders in the international health scene. Similarly, in establishing the Trust's broad-based research programme, ranging through clinical to basic research, while at the same time encouraging neglected fields like the history of medicine, veterinary science and infectious disease, he was able to set the scene for his successors to utilise the massive increase in the resources of the Trust for the benefit of medical science in the UK and elsewhere.

Those who know Peter Williams will not be surprised to hear that he gives away little of himself in his autobiography. A mildly alcoholic night spent with him in New York in 1978 planning the future of the Oxford/Thailand overseas programme, and later experiences as a Wellcome trustee during his last years as Director, left me in no doubt that he had a clear vision of exactly where he thought British medical science should be going. And because of his laid-back and outgoing personality he was always able to take his trustees with him, even when they were not quite clear in which direction they were being taken!

A short postscript suggests that Peter is not entirely happy with the current medical or political scene. For example, discussing the disadvantages of the rapid growth in size of modern institutions, he suggests that both the Wellcome Trust and the MRC have lost their personal touch with the scientists that they support, much to the detriment of their activities. He also wonders whether the poorer countries of the world, particularly those of Africa, will ever regain the quality of agriculture and health which they enjoyed in the more ordered days of colonialism, a nostalgic view that some may feel ignores the many downsides of the colonial system. Over-modestly, however, he does not develop this theme further; there is no doubt that the kind of sustainable programmes of collaboration between the rich and poor countries that will be required to improve the current situation are just those that he encouraged through his remarkably far-sighted contribution at the Wellcome Trust. Thankfully, so far his successors seem to have inherited this vital message.

This thoughtful autobiography deserves a wide audience; as well as the wisdom of many of its messages it should at least go some way towards better defining Peter Williams' critical role in the

development of medical science in this country; his influence was considerable and we have much to thank him for.

DAVID WEATHERALL

Regius Professor of Medicine Emeritus,

Weatherall Institute of Molecular Medicine, University of Oxford

Editor's note: To obtain a copy of 'The exotic fruits of my life' readers should send their name, address and a cheque for £23.50 (inc p&p) to RANA, Courtyard House, Church End, Bletchington, Oxon OX5 3DL. The cheque should be payable to Dr Peter O Williams.

Coronary artery disease: genes, drugs and the agricultural connection.

By Ole Færgeman. Elsevier, Amsterdam 2003. 152pp. 35.

This is a remarkable and stimulating monograph, written by a Dane who is a thinker, a scientist and a cardiologist. Seldom has better perspective been presented concerning what can be done to control heart disease and what should and should not be attempted.

Professor Færgeman addresses each of his themes as major societal problems and the focus is catholic. He holds out little hope for any further reduction in the incidence of coronary disease in the West and predicts a huge increase by 2020 in underdeveloped populations. He leads us through the largely unresolved cholesterol controversy to a thoughtful appraisal of food sources and preferences.

All the while, he relates much of this to modern agricultural practices, to corporate farming, the new dependency in developed countries on meat and the 'gross inefficiency of producing food by raising livestock, fed the grain that we could eat'. The fact that 'food avoided by the wise will get into the stomachs of the unwise', or the un-informed and misled, is not likely to promote human health worldwide. The lack of consideration of societal differences and needs by international planners often pre-empts sensible and balanced food distribution.

Outlining genetic diversity, complexity and susceptibility, the author makes it very clear that we should reconsider the commonly held view that there is one specific function for each gene and protein. Their interactions are multiple. Today's scourges of coronary artery disease, type II diabetes and hypertension are, of course, polygenic, and the idea that we will ever find a responsible gene is scientifically naïve.

The diversities of biological and societal influence on the development of diseases receive careful consideration. He exposes some of the appalling ways in which the practice of medicine is now managed by governments. His analyses are depressing and worryingly realistic.

Færgeman is particularly sceptical about the future of basic research in universities, predicting that the worship of biotechnology may lead to the sacrifice of traditional independence. Worse, that the altruism of medical research is being irreversibly eroded by mega-pharma. The limitations of randomised clinical trials are emphasised and the increasing dependence on industry criticised.

Written in scholarly English, Ole Færgeman has provided us with a lively, erudite and often humorous text. It is an informed reflective study written without bias and from a variety of unusual angles. There are also two short appendices providing information on coronary disease and fats.

MICHAEL OLIVER
Professor Emeritus, University of Edinburgh

The turnstone: a doctor's story.

By Geoffrey Dean. Liverpool University Press, Liverpool
2002. 273pp. £15.

Many doctors, I suspect, aspire to writing their autobiography; a few succeed but even fewer have them published. This account of Geoffrey Dean's life, professional and private, makes compulsive reading. The son of a bank manager in Liverpool, Dean was sent to a horrid prep school and then to Ampleforth. He qualified at Liverpool Medicine School under such mentors as Henry Cohen and Robert Coope. He joined the RAF as a medical officer and came under the influence of Sir John Conybeare, the well-known consultant physician at Guy's Hospital and chief medical officer to the RAF. After the war he obtained his MRCP and took a course in tropical medicine in Liverpool. As a ship's surgeon he took passage to

South Africa. Here, initially, he was quite rightly not accepted as a consultant physician but after further training as a medical registrar started a consulting practice in Port Elizabeth.

Dean has an astute and enquiring mind. When as a young man he develops staphylococcal septicaemia, he is treated with extremely painful injections of penicillin and suggests that novocaine is given simultaneously. This was effective and widely used until the penicillin was made in a more purified form. As a registrar Dean does his first epidemiological study of dock-workers who developed unexplained paralysis. This proved to be due to contamination of the oil in which their fish and chips were cooked by orthotricresyl phosphate. His great contribution to medicine is his study of patients in South Africa with porphyria variegata, all of them descended from a common ancestor – an immigrant from Holland. His epidemiological, clinical and chemical studies of these patients in many parts of the world have made him an authoritative expert in this condition. Using similar epidemiological techniques he has studied disseminated sclerosis in many parts of the world before being appointed director of the Medico-Social Research Board in Dublin. Still alive but suffering from carcinoma of the prostate and fibrosing alveolitis, he has given a most readable and enjoyable account of his interesting life.

SIR RICHARD BAYLISS
Former Consultant in Endocrinology, Lister Hospital, London

Letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by e-mail to: Clinicalmedicine@rcplondon.ac.uk.

Is prolonged use of computer games a risk factor for deep venous thrombosis in children?

Editor – Ng *et al* reported a fascinating case of a 12-year-old boy who developed a deep vein thrombosis affecting the left popliteal and left superficial femoral veins following a prolonged period of relative immobility

whilst playing a video game (*Clin Med* November/December 2003, pp 593–4). There was no family history of venous thromboembolism and several thrombophilic tests that they performed gave normal results.

I share the authors' view that this child's thrombosis is highly likely to have arisen from venous stasis caused by a continuous kneeling-like posture lasting four hours. Nevertheless, I would like to make two additional observations about this unusual presentation.

Firstly, current methods of thrombophilia screening suffer from a high false-negative rate. This is borne out by the fact that many families, each with a high prevalence of thromboses amongst its members, are found to be negative for various factors that can be identified by employing routinely available techniques. It is hoped that continued research in this area will reveal new entities and reliable means for their detection. For example, two novel mutations have been discovered in the factor V gene that can demonstrate activated protein C resistance (APCR),^{1,2} one of which has been described in two siblings who

both suffered venous thrombosis in the second decade of life.¹ However, as these loci are different to that associated with Factor V Leiden, they would not be identified by polymerase chain reaction (PCR) assays for its R506Q locus. This might provide an avenue of further investigation for Ng *et al* if their patient can be shown to exhibit APCR.

Secondly, with technical advances in cross-sectional imaging, there is growing recognition of anomalies affecting the inferior vena cava (IVC). One such aberration, atresia of the IVC (AIVC), is thought to predispose to thrombosis. In such individuals the supradiaphragmatic venous return is via azygos and hemiazygos collaterals into the superior vena cava (SVC). This anatomical pattern is thought to be present in 0.6% of the population³ and in those who have developed a thrombotic complication, a calculated incidence of 5.3–9.5%.⁴ This latter group of patients are generally under 40 years of age, have a negative thrombophilia screen and no recognised predisposing factors. They manifest themselves as either bilateral femoral DVT or extensive unilateral DVT.⁴ I feel computed