

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.

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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.

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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