therapeutic hope and euphuisms. In spite of 58 listed papers by Rutter *et al* this is hardly simple to find, if indeed present. Most estimates are based on clinical diagnosis quoting the American reference www.ninds.nih.gov/disorders/ – '3.4 for every 1,000' but this seems high.[1] Both the 2005 single-author papers and Rutter relate to reviews – the scanning techniques now available that should define the presence of irreversible developmental in clinical autism are yet to come.

The remaining chapters cover the deep waters of numerical approaches to decipher the influence of various features, but are confounded by a novel use of established terms and a casual disregard for history. Falconer's great book of 1960 was almost 60 years after Pearson's group had developed and tabulated the tetrachromic functions, illustrated their model, and applied it to Galton's data on measurements, especially the height, of various pairs of relatives. This, and Morton's much misquoted comments on a 'lod of three' bounded the era of those pioneers who were fluent in both biological reality and could apply appropriate methods of analysis.

Chapter 7, 'What genes do', is particularly difficult but at least it refers to a recent textbook.[2] This discusses and illustrates the multifactorial problem with particular clarity.

Chapter 8 enters the deep waters of numerical estimates, but not without error. It is difficult to combine sets of data using MLODS, as demonstrated by the failure to find a clear-cut locus at or near a segment on the eighth chromosome related to schizophrenia clearly present in both Iceland and Scotland. The 'haplotype relative risk' (HRR) of method of Falk and Rubinstein, rightly honoured with a reference, uses the classical definition of haplotypes and is exact. The transmission disequilibrium test test involves alleles and is only exact if Mendelian transmission is consistent with obedience to what Stern called Mendel's first law. The chapter ends with the conclusion that genes 'do not have direct effects on any trait or disorder'.

Chapter 9 is on 'finding and understanding specific susceptibility genes'. It is simpler to use the term allele, and these can be 'influential' in which case one is a susceptibility allele and the other a resistance allele. Multifactorial starts with 'Alzheimer's' disease, as in modern usage. Although Alzheimer was stated to have claimed it as a dominant disorder of early middle age, it has since been modernised and is now polygenic and senile. The original paper seems to have escaped bibliographers and should be found and translated if it still exists.

The major value of Rutter's book is in its last three chapters that, even if not devoid of mathematical problems and misprints, and overlooking the well established habit of familial disorders to include rare Mendelian dominants, as well as conditions due to the cumulative effects of alleles with minor influence, as so clearly defined in cancer of the breast – the traditional nurse of the pathology of cancer. These are very important papers, providing a well argued case for a much neglected but very important field of enquiry, and it is good to end on a triad of chapters of such power.

Readers might start with these last three chapters with well argued problems, the argument not being substantially weakened by the minor obstacles imposed by some claims of reality, or confounded by some errors in the figures. They convey a clear and much neglected problem. The other chapters hardly compete with recent textbooks on genetics. The multifactorial problem is particularly well handled in Strachan and Read.

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Reference

1 Rutter M. Incidence of autism spectrum disorders: changes over time and their meaning. *Acta Paediatr* 2005;94:2–15.
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Dizziness: a practical approach to diagnosis and management

By Adolfo Bronstein and Thomas Lempert. Cambridge University Press, New York 2007. 238 pp. £35.00.

Dizziness is a headache. This seems to have been true, as far we can tell, in all times and places: the Greeks (taking a broad systemic perspective) linked it to the wanderings of the womb, while Avicenna attributed it to melancholia, and everybody agreed that the prognosis was guarded. Shakespeare is far from silent on the topic: in *King Lear*, he has Edgar threaten Gloucester with the miseries of visual vertigo (factitious, to boot), while Benvolio's advice to Romeo in *Romeo and Juliet*, '…turn giddy, and be holp by backward turning…', would do equally well as a remedy for lovesickness or positional vertigo. Patients, by and large, do not know what they mean by dizziness, which would not be so bad if doctorswere good at finding out. In truth, however, the complaint of dizziness is still apt to make medical hearts sink much as they must have done in Hippocrates' time.

The reasons for this are all too obvious. As a presenting symptom, dizziness is not only among the most notoriously difficult to describe, it comes trailing in its wake a fearsome retinue of anatomy and physiology – abstruse, intricate and precise. The vestibular apparatus is yoked to the brainstem, cerebellum and eye muscles, territory where even neurologists tread with trepidation. And it does not stop with the central nervous system. A host of diseases affecting quite different and remote organ systems can just as well produce it. Added to this is the well-known propensity of dizziness to send patients mad, encouraging spirited and probably futile debate as to which came first: the psyche or the balance organs. What is needed is a road map to see our hapless patients and their medical attendants safely between the Hill of Difficulty and the Slough of Despond. Fortunately, such a map is at hand, in the form of Adolfo Bronstein's and Thomas Lempert's book.

The book is one of a burgeoning family of Cambridge Clinical Guides, and bodes well for the series as a whole. It begins with a clear and concise review of the essential anatomy and physiology, and core examination techniques. This gives the authors the opportunity to anticipate and debunk some of the standard excuses offered by busy clinicians for not properly assessing dizzy patients in clinic: no longer will a badly positioned couch get you off the hook! After this initial scene setting, Bronstein and Lempert wisely elect to pursue a symptom-led approach (after all, patients do not come along to clinic neatly labelled with a diagnosis, as many a weightier

tome might suggest). The key symptom headings – the single episode of prolonged vertigo, recurrent vertigo and dizziness, positional vertigo, chronic dizziness, and dizziness and imbalance in the elderly – encompass a surprisingly broad sweep of neurological and general medical practice in succinct and practical form. A brief general section on treatment concludes the book. The authors manage to keep the harassed clinician firmly in view throughout, and successfully resist the temptation to stray into esoterica (no mean feat considering their formidable accumulated erudition and experience). The text is supplemented by useful tables and the illustrations are on the whole clear and occasionally surprising (who could have expected to encounter a medieval exorcism in the middle of a down-to-earth discussion of psychogenic dizziness?). Each chapter concludes with a section, 'What to do if you don't have a clue' which seems set to salvage many an ill-fated outpatient appointment. The enclosed CD is a particular strength of the book; it really does amplify the text and stands alone as a teaching aid in what remains a richly clinical enclave of internal medicine.

Perhaps the single most refreshing thing about this book is the unpretentious and accessible style with which it is written. Bronstein and Lempert make their subject engaging and humane. If not exactly Shakespearean, their book is nonetheless a worthy addition to the canon on this often baffling and too often mysterious symptom. Hippocrates would be proud to own it.

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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 sent by e-mail to: Clinicalmedicine@rcplondon.ac.uk

Response to personal viewpoint on revalidation

Editor – Goddard and Cunliffe liken their experience of assessment for certification in colonoscopy to procedures which may be used in revalidation (*Clin Med* June 2007 pp 304–5). They end their letter with the comment that, 'Revalidation will not be good news for everyone, but everyone should be better for it'. Really?

Firstly, nobody yet knows for certain what revalidation will involve – indeed, doubts have already been cast on its legality in respect of doctors now on the specialist register. Secondly, if revalidation is to mean anything, it presumably could mean, potentially, the loss of a doctor's livelihood. I suggest that this risk would be considerably more stressful than failing colonoscopy certification, notwithstanding the blow to the authors' pride, and the delay in establishing their trust's screening programme that would result. Thirdly, how many of us, or our patients, would genuinely benefit from our (effectively) re-sitting our Royal College diploma on a five yearly basis for the rest of our working lives, particularly as we grow older, and more experienced/specialised?

There are many unanswered questions in relation to revalidation, but above all, I should like to see some hard evidence as to its real value. Or is it just another management concept that does not need testing before its wholesale imposition?

I accept that some form of periodical reassessment of medical staff *may* be desirable, but I consider Goddard and Cunliffe's largely uncritical welcome of revalidation both premature and naive.

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The future of coronary heart disease prevention

Editor – Though the recent article by David Wald (*Clin Med* August 2007 pp 392–6) starts well it seems to drift into an advert for the Polypill. The claim that a Polypill will reduce cardiovascular disease by over 80% in both primary and secondary cardiovascular prevention is impressive. This is made in the absence of clinical trial data, or even a product. From a public health perspective, prevention of heart disease is simple. The up-most risk factor is smoking, with a dose linear relationship. The chances of myocardial infarction are about 12-fold greater with 40 cigarettes/day when compared to non-smokers.[1]

Hypertension sets the threshold at which cholesterol becomes important. Hypertension and age-related increases in blood pressure are unknown in societies with a salt intake <3 g/day; the UK average is 10 g/day.[2]

Lipid-lowering agents should only be used as part of the overall management of risk factors for cardiovascular disease and it is important not to over interpret the data.[3,4] Stopping smoking, increasing exercise, and increasing fruit and vegetable intake should be recommended, as these factors are responsible for 80% of heart disease.[1] The restriction of dietary salt to <3 g/day should also be added to this list as a public health measure.

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