Is it appropriate to consider this a British textbook, as implied by the adoption of the publishing house's name in the title? One of the four editors is from the USA and it is apparent that a number of the chapters have a distinctly transatlantic tone. Clearly the book is designed to appeal to a broader spectrum than the British rheumatology establishment. This may alienate some readers who might have preferred a more parochial approach to contrast with the established American texts. Others will find the attempt to internationalise the text appropriate.

The overall structure of the book is well thought out. It was the right decision to split the text into two volumes to avoid being too unwieldy. From the outset, age as a determinant of disease expression develops as a theme. This works well, as a discussion of the presentation and management of rheumatic disease in childhood and the elderly population serves as a counterpoint to the bulk of the book which deals with adult rheumatology. The first volume also develops a problem oriented approach, stressing common clinical presentations of rheumatic disease, for example of the spine or in association with other conditions, such as pregnancy. This approach will be particularly appreciated by junior trainees and non-specialists.

Sections on the pathophysiology of musculoskeletal disease and the inflammatory response are of necessity general overviews. They act as useful introductions to complex topics. Readers interested in more detailed and recent information will clearly need to undertake their own literature search using facilities such as 'Medline'. Where the latter fails and where this textbook scores is in providing a historical context and a balanced summary of current ideas.

Most of the second volume is devoted to a discussion of the rheumatic diseases, using an orthodox classification. The chapters are all of a similar layout, but do not follow a structured format. It was obviously the editors' intention not to constrain the authors by insisting on this point. However, it means that the book as a whole misses the opportunity of developing a distinctive style. The difficulties of integrating

contributions from both sides of the Atlantic are most apparent in this volume. An example is the discussion of the treatment of 'Pyogenic Arthritis' which suggests the use of a number of antibiotics which are not in common use, or in some instances not even available, in the UK.

A chapter on rehabilitation is an excellent idea. The only problem is that it is at the end of the book: the effect is to reinforce the tendency to consider rehabilitation as an afterthought. This is, of course, fundamentally wrong and is most certainly not the author's intention. Rehabilitation is an integral part of the management of patients with rheumatic disease. The task of incorporating the topic of rehabilitation, a dimension of medicine rather than a separate discipline, into a formal textbook of rheumatology is probably even more difficult than fitting it into clinical practice, but perhaps should be one of the aims of the next edition.

We enjoyed reading this book and learnt a great deal. It stands comparison with Klippel and Dieppe's textbook which will be the main competitor in this country and which has its own individual style. A decision as to which to purchase will depend largely on the reader's own taste. We look forward to using both.

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Bone histomorphometry. E F Eriksen, D W Axelrod, F Melson. (Pp 74; \$19.00.) New York: Raven Press, 1993. ISBN 0 7817 0122 8.

There is increasing specialisation in histopathology and few of us would be happy to report the full range of biopsies received by a large laboratory. Only experts should diagnose bony tumours and, even then, only after consultation with clinical and radiological colleagues. The same is true of non-neoplastic bone biopsies, for which technical expertise in processing the tissue samples is essential and familiarity with modern histomorphometric techniques highly desirable. This short and beautifully illustrated book is an excellent account of what can be learnt from a bone biopsy. It also summarises current information on bony structure and, in particular, the pattern of bone remodelling in health and disease. The line diagrams, which illustrate the bone remodelling unit, are really excellent. A single glance at figure 3 on page 7 gives an indelible impression of what is happening in this complex process.

This book has only slightly more than 60 pages of text and physicians and rheumatologists who read, or even skim through it, will have a very reasonable impression of what can be learnt from a bone biopsy. The scientific emphasis is very much on the concept of bone remodelling; there are detailed diagrams and tables showing how remodelling occurs in normal bone and in different metabolic diseases. This is not a comprehensive guide on how a bone biopsy should be processed and examined. There are excellent colour photomicrographs illustrating the important features, however, many supplemented by diagrammatic maps illustrating the key features. The authors only touch on details of modern stereological methods and the use of confocal scanning laser microscopy. Pathologists who wish to learn more about these techniques will have to consult specialist texts and articles. If you lack even the time to read through the 60 pages of this small book, then there is an excellent six page summary article published 10 years ago in the *American Journal of Surgical Pathology* (Vigorita V J. The bone biopsy protocol for evaluating osteoporosis and osteomalacia. *Am J Pathol* 1984;8:925-30).

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Fig. 2 Clinical features of pauciarticular-onset juvenile chronic arthritis. (a) Archetypal patient with pauciarticular-onset juvenile chronic arthritis. Note generally healthy young girl with involvement of a single knee. (b) Unilateral flexion contracture as seen frequently in pauciarticular-onset juvenile chronic arthritis. To evaluate for subtle flexion contracture, especially in children with hypermobility, lift both heels equally high and observe for unequal knee height. (c) Thigh atrophy in unilateral disease. This may be a permanent sequela.

LABORATORY FEATURES

No particular laboratory abnormalities are diagnostic of pauciarticular-onset juvenile chronic arthritis. Acute-phase reactants are usually normal to slightly elevated. Occasionally one will see a child with synovitis of a few joints and a markedly elevated erythrocyte sedimentation rate. This should prompt an extensive search for infection or occult inflammation, such as inflammatory bowel disease or leukaemia. Reactive or viral arthritis may also

produce high erythrocyte sedimentation rates. A rare condition, congenital hyperthermogenesis, will cause a persistently elevated erythrocyte sedimentation rate without other laboratory features of inflammation.

Antinuclear antibodies are present in 40 to 75 per cent of children with pauciarticular-onset chronic arthritis, depending on the analytical technique used. These antibodies are directed to a heterogeneous mixture of nuclear antigens and usually give a homogeneous pattern, although a speckled pattern can also be seen. The titres of antinuclear antibody are usually low, less than or equal to three dilutions beyond the threshold of normal. Higher titres, especially in the older patient, should be investigated for specific autoantigens. For example, antibodies to DNA and extractable nuclear antigens would lead to the suspicion of systemic lupus erythematosus or mixed connective tissue disease. Antinuclear antibodies may develop over time; therefore, an initially negative test for them should be repeated within 1 year, owing to its critical importance in determining the risk for uveitis (see below). Most studies find no connection between the titre of antinuclear antibodies and disease activity. There is no evidence that these antibodies precede the development of pauciarticular-onset juvenile chronic arthritis; in fact, most healthy children with an isolated, positive antinuclear antibody will not develop any rheumatic disease when followed over several years.

Rheumatoid factor is distinctly rare, occurring in less than 5 per cent of children with the pauciarticular-onset disease. When

Table 1 Pattern of joint involvement at presentation in 137 consecutive cases of pauciarticular-onset juvenile chronic arthritis

	%
Single joint	62
Two joints	31
Three joints	4
Four joints	3
Knee	47
Ankle	21
Small hand joint	12
Wrist	5
Elbow	3
Hip	3