PostScript

LETTER

Sneddon's syndrome: additional neurological feature in antiphospholipid (Hughes') syndrome

I was interested to read the article by Hughes on the antiphospholipid syndrome.¹ I agree that primary antiphospholipid syndrome (APS) is a major neurological disease. Disease conditions other than deep vein thrombosis, recurrent fetal loss, or stroke may occur, not only in association with defined systemic lupus erythematosus or "lupus-like" disease, but also with "primary" APS.

Asherson and Cervera included Sneddon's syndrome (cerebrovascular disease with livedo reticularis) in the category of "primary" APS in their review of the disease.² Sneddon's syndrome comprises about 0.26% of total cerebrovascular cases. The pathogenesis of the syndrome has remained largely unclear since its description in 1965.³ Clearly, no immunological testing to detect antiphospholipid antibodies in Sneddon's original patients was undertaken. Sneddon speculated that skin biopsies in future cases would show endarteritis obliterans in dermal arterioles. It was thought that intravascular pathology of a similar nature was responsible for cerebrovascular accidents. There was no serological evidence of systemic lupus erythematosus or other systemic disorders in most reported cases of classical Sneddon's syndrome. None of these studies, however, included specific tests for antiphospholipid antibodies or lupus anticoagulant.³

In a recently reported case of Sneddon's syndrome, repeated attempts to detect anti-cardiolipin antibodies failed to give a positive result.⁴ But in another study of 10 cases of Sneddon's syndrome, seven had systemic lupus erythematosus, five were positive for the Venereal Disease Research Laboratory (VDRL) test, and were also positive for lupus anticoagulant.⁵ Six of these cases had livedo reticularis, all had digital gangrene, cutaneous ulcers, and superficial thrombophlebitis; two had pulmonary embolism. There is little doubt that these cases belonged to the category of "primary" APS, with or without systemic lupus erythematosus.

As the full impact of the APS on neurology is now becoming more widely recognised, I congratulate the author's attempt to highlight the broad spectrum of the neurological conditions in APS, but also suggest that Sneddon's syndrome is included.

R Sinharay

Royal Gwent Hospital, Cardiff Road, Newport, Gwent NP20 2UB, UK; ranjitsinharay@hotmail.com

References

- 1 **Hughes GRV.** Migraine, memory loss, and "multiple sclerosis". Neurological features of the antiphospholipid (Hughes') syndrome. *Postgrad Med J* 2003;79:81-3.

- 2 **Asherson RA,** Cervera R. The antiphospholipid syndrome: a syndrome in evolution. *Ann Rheum Dis* 1992;51:147-50.
- 3 **Sneddon IB.** Cerebrovascular lesions and livedo reticularis. *Br J Dermatol* 1965;77:180-5.
- 4 **Sinharay R.** The antiphospholipid syndrome: a syndrome in evolution. *Ann Rheum Dis* 1992;51:1180.
- 5 **Alegre VA,** Winkelmann RK, Gastineau DA. Cutaneous thrombosis, cerebrovascular thrombosis and lupus anticoagulant—the Sneddon syndrome. Report of 10 cases. *Int J Dermatol* 1990;29:45-9.

BOOK REVIEWS

The reviewers have been asked to rate these books in terms of four items: readability, how up to date they are, accuracy and reliability, and value for money, using simple four point scales. From their opinions we have derived an overall "star" rating: * = poor, ** = reasonable, *** = good, **** = excellent.

The Menopause in Practice.

Catrina Bain, Mary Ann Lumsden, Naveed Sattar, and Ian A Greer. (Pp 71; £14.95.) Royal Society of Medicine Press, 2002. ISBN 1-85315-516-0.***

The field of the management of the menopause is expanding. There is a plethora of data from randomised and observational studies that confirm the effectiveness of HRT in the treatment of menopausal symptoms and for the prevention of postmenopausal bone loss and osteoporotic fractures in addition to a reduction in colon cancer. In the light of the recently published large randomised studies (HERS and WHI), this book will be a useful evidence based guide to general practitioners, postgraduate medical students, and general gynaecologists.

In a modern, well written, easy to comprehend nine chapters, this book tries to give recommendations for the use of HRT. It addresses the definition of the menopause and its symptoms in three chapters as an introduction to the management and use of HRT. There is a general review of the different preparations and route of administration in chapter 4. The risks of osteoporosis, cardiovascular disease, and thromboembolism are addressed in three elegantly written chapters.

Compliance with HRT remains low and abnormal bleeding pattern in addition to fear of cancer, especially breast cancer, has been the main causes of non-compliance. These issues are addressed in chapters 4 and 9. Two four lines summery in a box for a quick and easy take-home message follow each paragraph. The further reading list at the end of each chapter is up to date and provide an excellent opportunity to expend upon the topics covered.

It is arguable whether continuous combined HRT (ccHRT) represent the favourable long term HRT and whether women who are happy on the cyclical sequential HRT should

be transferred to ccHRT. Continuous combined HRT is associated with more incidents of unscheduled bleeding in addition to the antagonistic effect of the progestogen on the lipoprotein profile. More detail, however, is not possible given the size of the book and its design as a brief guide.

Table 5.1 listed the absolute contraindications, but in later chapters, the authors' view was that HRT use in these women is appropriate with an individualised approach preferably in a specialist clinic. In my copy table 9.1 is missing, although mentioned in the text.

Overall I recommend this book as an up to date quick reference addressing the issues of the menopause.

M Wahab

Consultant in Obstetrics and Gynaecology, George Eliot Hospital, Nuneaton, Warwickshire, UK

Conservative Surgery for Menorrhagia.

Edited by Peter O'Donovan, Paul McGurgan, and Walter Prendiville. (Pp 251; £65.) Greenwich Medical Media, 2003. ISBN 1-84110-097-8.***

During the last decade many techniques for endometrial ablation to treat menorrhagia have been developed. Some are difficult to learn, requiring considerable skill and often expensive equipment. Data are available regarding the success rates and complications with the original, often technically demanding techniques. Newer techniques and devices are intended to simplify the surgery and to decrease the severity and frequency of complications, although often they have significant cost implications. For the working clinician the proliferation of techniques and devices is confusing and it is difficult to evaluate them when often the source of advice and assistance is a representative of the equipment manufacturer.

This book brings together a group of authors who are pre-eminent in their field. The initial chapters address the epidemiology and diagnosis of menorrhagia, the use of ultrasound and hysteroscopy, and the classification of ablation techniques. Fifteen methods of endometrial ablation are discussed, each in its own chapter written by the original developer of the technique or by an author with acknowledged experience and reputation. Each technique is described, potential advantages and disadvantages discussed, and reference made to relevant published literature. Chapters on the use of Mirena, uterine artery embolisation, and avoiding surgical complications are all useful contributions.

The book is easy to read and well organised and is a good resource for those wishing to review an approach to the assessment and management of menorrhagia. It also provides the more experienced gynaecologist with a useful appraisal of the several techniques of endometrial ablation and their value.

I W Scudamore

Consultant Obstetrician and Gynaecologist, Leicester General Hospital, Leicester, UK