BOOK REVIEWS

Practical vulvovaginal perspectives


Despite an ongoing clinical interest, I usually find books on vulvovaginal disorders instantly soporific. These authors, who have been working together at a dermogynaecology clinic, have done a fine job making this manual readable. The book reflects a collaborative approach from their different specialties: gynaecology, pathology, dermatology, gynaecological oncology, and psychology. A combination of clinicians ideal in management but, unfortunately, not often available.

I liked most that the manual is applicable to clinical practice and practical — most of us have evolved our own system of examination and investigation through imperfect instruction and trial and error. The vulva and vagina manual covers the basics with great practical detail, such as which position and speculum to use during examination, and how to do a vulval biopsy.

Clinical experience is only acquired over a great period of time and most of us in practice will be confronted by a lesion (or lesions) we’ve never seen before. The most stunning contribution in the manual is the collection of clinical photographs of both common and rare conditions. There is also an extraordinary list of vulvovaginal disorders and their mode of presentation (pruritus, discharge, etc). These should be helpful in sorting out possible diagnoses of conditions when you don’t know what it is you are seeing but you know what it’s not — a common scenario in this field. I would have liked more clinical photographs in the cancer section, which was complete but similar to those in other textbooks.

Whether you are a general practitioner with little experience, or a specialist with experience in the area, you will find this book good value and useful.

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SNAPSHOT

Paraspinal tuberculosis

A 36-year-old man presented to our emergency department with a 6-month history of thoracic back pain. He was born in Ghana and moved to live in the United Kingdom 8 years ago.

Over the preceding 3 months, he had gradually developed symmetrical masses on either side of the thoracic spine (A and B). He denied any respiratory symptoms, fever, sweats or weight loss. On examination, he was afebrile and both masses were fluctuant but not tender or inflamed. Spinal movement was unrestricted and no features of spinal cord compression were present.

Blood tests showed a normal white cell count and differential, a C-reactive protein level of 180 mg/L (reference range, 0–4 mg/L), and an erythrocyte sedimentation rate of 64 mm/h (reference range, 0–15 mm/h). HIV serology was negative. Magnetic resonance imaging of the thoracic cord showed large, bilateral collections within the rectus spinae muscles extending between T3 and T10, and destruction of the spinous process of T5. There was also high signal in the facet joints at this level, suggesting an infection arising from them (C).

About 400 mL of pus was drained percutaneously, auramine staining showed this contained acid-fast bacilli. Fully sensitive Mycobacterium tuberculosis was subsequently cultured. Standard quadruple anti-tuberculous therapy was commenced, and percutaneous aspiration was repeated for re-accumulation of the collections.

The masses had resolved on clinical review after 3 months.

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