

and finally in later childhood and adolescence. In all over 30 separate syndromes are included – reflecting a tendency into “splitting” rather than “lumping”, even though the sheer number of syndromes defined is somewhat intimidating. Some of the chapters are particularly helpful; I especially found those on benign and severe myoclonic epilepsy in infants by Dravet and her colleagues to shed light on a murky area of epilepsy, and as always Aicardi is clear and thoughtful in writing on neonatal myoclonic encephalopathy. Gastaut has a chapter that reviews childhood epilepsy with occipital paroxysms which is updated by Roger. There are good contributions on epilepsy with continuous spike waves during sleep and on reading epilepsy. It is gratifying to note the revisions in the book that have taken place and contribute to the justification for this new edition.

The contributors are almost exclusively from Western Europe. Their different emphasis towards epilepsy makes the book particularly refreshing to a North American audience.

In conclusion, this book is a valuable resource for all those who deal with epilepsy in the pediatric age group, and is strongly recommended.

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SURGERY OF THE EAR AND TEMPORAL BONE. 1992. Edited by Joseph B. Nadal and Narold F. Schuknecht. Published by Raven Press. 480 pages. \$198.00 Cdn.

This is, without doubt, one of the best books of its type that I have read.

The indications for surgery, common and not so common, are clearly outlined and the authors have made more attempts to

present variations in clinical presentation rather than just “text-book presentations”.

The writing is concise, the photographs clear, and the diagram art work is excellent. Having many of the operative drawings done in colour certainly does increase their overall and immediate understanding than pure black and white diagrams.

There are several comments that I wish to make: The first, concerning the chapter, “Evaluation of the vestibular system” pages 57 to 70. I realize this is a complex field and the more important diagnoses and tests are offered but the following clinical signs examination are now well known and practised routinely:

1. Abnormal vestibulo-ocular reflex suppression.
2. Abnormal vestibulo-ocular reflex gain.
3. Headshake test to assess the fast receptors of vestibular system (as opposed to bithermocolorics which assess the slow receptors of the vestibular system).
4. Possibly the concept of hypoactive and compensatory nystagmus in assessing peripheral lesions.

One of the more difficult clinical assessments is that of perilymph fistula and it possibly would have been appropriate in this chapter, although I notice it is mentioned elsewhere in the book.

In Chapter No. 26 (287 to 296) “neurectomy procedure” for vertigo on page 290 second column, first paragraph, it is stated “the saccule has no known vestibular function in man”. This is untrue and the function of the saccule is clearly outlined in the Chapter on the vestibular system.

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