Comparison of ^{57}Co : ^{58}Co ratios when the Dicopac method is used and when the Dicopac reagents are used to perform conventional Schilling tests. The line of equality is shown.

were higher with the conventional Schilling test than with the Dicopac ($p < 0.001$ by paired t test; $t = 5.0$ with 12 degrees of freedom). This difference in ratio could be ascribed to the ^{58}Co excretion being higher in the Dicopac method than in the conventional Schilling test, the respective means being 4.3 and 1.9% ($p < 0.001$ by paired t test). There was no difference in ^{57}Co excretion in the Dicopac and conventional Schilling method, the respective means being 8.5 and 9.5% ($p > 0.05$ by paired t test).

The most likely explanation for this phenomenon is that the ^{57}Co Cn-Cbl attached to intrinsic factor exchanges in the patient's gut with the free ^{58}Co Cn-Cbl when both capsules are given together in the Dicopac method; Knudsen and Hippe² consider that the dissociation constant for the Cn-Cbl intrinsic factor complex is low enough for such a reaction to occur.

The Radiochemical Centre draw attention to discrepancies between the Dicopac and the Schilling test in their instructions which state "typically, for cases of pernicious anaemia, the cobalt-58 value will be slightly higher than the excretion in the first part of the Schilling test." However, our results show that the ^{58}Co excretions in the Dicopac method are often considerably higher than the ^{58}Co excretions in the first part of the Schilling test. This large discrepancy effectively invalidated the Dicopac technique in our pernicious anaemia patients since it brought their ^{57}Co : ^{58}Co ratios unacceptably close to those which are regarded as normal.

We wish to thank Mrs L Warne for typing this paper.

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Book reviews

Cutaneous Aspects of Internal Disease. JP Callen. (Pp 682; illustrated; £66.00) YB Medical Publishers Ltd. 1981.

The ability to diagnose systemic disease on the basis of cutaneous changes poses a continual challenge to both internal physicians and dermatologists. Since Irwin Braverman wrote his classical monograph on this subject our understanding of disease processes has been magnified by spectacular advances particularly in the field of immunopathology and this has helped to clarify the relationship between internal diseases and their cutaneous manifestations. In this recent addition to the literature Jeffrey Callen has marshalled an impressive array of dermatological experts who deal individually with the pathogenesis, clinical features, and treatment of multi-system diseases. With large numbers of contributors there is always the risk of repetition but the author was clearly aware of this problem and the result is a comprehensive and authoritative text which can be used as a standard reference work by any practicing physician. For the dermatologist the information contained in this volume is obligatory reading but the book is clinically orientated and contains no detailed pathology.

E WILSON JONES

Atlas of Kidney Biopsies. TT Antonovsky and FK Mostofi. (Pp 386; illustrated; \$16.00). Armed Forces Institute of Pathology, Washington. 1980.

This comprehensive atlas of renal biopsy pathology has been published in the same basic format as the AFIP tumour fascicle, but is rather longer—covering some 385 pages. The book is pleasant to handle and it contains a large number of black and white illustrations of light and electron microscopy. In addition there are occasional pages of immunofluorescence pictures in colour. Anyone new to the subject would gain the impression that the light microscopy was unimportant and that electron microscopy was required for an accurate diagnosis in every case. In fact almost all cases can be accurately diagnosed by light microscopy provided one strives to attain high technical standards of slide preparation.

I personally liked the layout of the book, consisting as it does of a series of illustrative case histories. The danger of course that the reader may find