1. Pabinger-Fasching I, Bertina RM, Lechner K, Niessner H, Korninger C. Protein C deficiency in two Austrian families. Thromb Haemost 1983; 50:810-3.
2. Horellou MH, Conard J, Bertina RM, Samama M. Congenital protein C deficiency and thrombotic disease in nine French families. Br Med J 1984; 289:1285-7.
3. Seligsohn U, Berger A, Abend M, et al. Homozygous protein C deficiency manifested by massive venous thrombosis in the newborn. N Engl J Med 1984; 310:559-62.
4. Marciniak E, Wilson HD, Marlar RA. Neonatal purpura fulminans: a genetic disorder related to the absence of protein C in blood. Blood 1985; 65:15-20.

VIDEO-CAMERA VISION: TRANSIENT MONOCULAR DIPLOPIA

To the Editor: A myopic but otherwise healthy 42-year-old man had unilateral monocular diplopia after prolonged use of a portable video camera outdoors in bright sunlight. The symptoms were limited to the left eye, with two well-focused and equally prominent images displaced vertically to a small extent in the center of the visual field. These two images were seen even when the right eye was covered. Placing a card across the lower half of the left pupil obliterated one of the images; similarly, covering the upper half of the pupil obliterated the other. Vision returned to normal within 18 hours of the onset of symptoms. To test the hypothesis that use of the video camera caused the diplopia, the patient again used the camera in bright sunlight, with prompt recurrence of the monocular diplopia.

Although monocular diplopia may occur as a consequence of retinal or neurologic dysfunction,[1-3] its pathogenesis is most commonly optical, and it is attributable to irregularities or defects in either the lens or the cornea.[4-7] Of particular relevance is the report of Knoll,[5] whose own bilateral monocular diplopia and corneal distortion occurred after several minutes of reading. He found he could prevent the diplopia by holding his eyelids open with his thumbs, and suggested that his eyelids were deforming his cornea.

The video image in portable video cameras is typically viewed by holding the right eye to a protected eyepiece, while the left eye remains uncovered and is generally held closed. In the present case, the left eye was shut particularly firmly to exclude sunlight during the prolonged videotaping. This squinting apparently deformed the corneal surface, causing the unilateral double images. This distressing symptom may become increasingly frequent as the use of video cameras becomes more common.

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1. Meadows JC. Observations on a case of monocular diplopia of cerebral origin. J Neurol Sci 1973; 18:249-53.
2. Landesman KP, Bornstein L. Monocular diplopia associated with retinal detachment surgery. J Am Optom Assoc 1985; 56:926-7.
3. Lepore FE, Yarian DL. Monocular diplopia of retinal origin. J Clin Neuro Ophthalmol 1986; 6:181-3.
4. Mandell RB. Bilateral monocular diplopia following near work. Am J Optom Arch Am Acad Optom 1966; 43:500-4.
5. Knoll HA. Bilateral monocular diplopia after near work. Am J Optom Physiol Opt 1975; 52:139-40.
6. Records RE. Monocular diplopia. Surv Ophthalmol 1980; 24:303-6.
7. Amos JF. Diagnosis and management of monocular diplopia. J Am Optom Assoc 1982; 53:101-15.

BOOK REVIEWS

Human Organ Transplantation: Societal, Medical-Legal, Regulatory, and Reimbursement Issues

Edited by Dale H. Cowan, Jo Ann Kantorowitz, Jay Moskowitz, and Peter H. Rheinstein. 304 pp. Ann Arbor, Mich., Health Administration Press, 1986. $34.

The subjects discussed by the distinguished contributors to this book are of great importance in medicine today, addressing some of the most vexing issues facing not only the transplantation field but all of medicine. This book developed from a conference on the subjects set out in the title; those in attendance were assembled by the American Society of Law and Medicine. The first half of the resultant book consists of 17 short chapters. The second half, entitled "Background on Issues," includes 18 additional chapters on cognate subjects.

Several questions recur throughout. One concerns the allocation of transplants, since it is projected that there will not be enough to go around. Other questions address how transplant treatment is to be diffused throughout our medical care system, when a new treatment should be fully "accepted" (and accordingly paid for), and of course, how and how much of the cost of such new procedures can be borne, and by whom.

Caplan, of the Hastings Institute, calls attention to the inadequacy of current information about potential organ donors and recipients. He recognizes that the number of patients considered to be appropriate potential recipients depends, to some extent, on the availability of donor organs. He casts doubt, as does Annas, on the ability of physicians to select patients fairly, and suggests that selection on the basis of "medical suitability" can easily degenerate into "obfuscation." A common suggestion is that once a pool of acceptable recipients is identified medically, the final selection should be by lottery. The system currently under trial in the United States, under the aegis of the newly established United Network for Organ Sharing, is a point system that assigns a priority score to each patient on the basis of multiple weighted considerations. The chapter by Evans and Yagi in this area is the kind of objective, information-filled contribution that we have learned to expect from the Batelle Institute.

Cooper emphasizes the rapid development of organ transplantation and some of the resultant organizational challenges. Young, commissioner of the Food and Drug Administration, reminds us that his agency does not regulate surgical operations and donor organs, only the various drugs and solutions employed. In a good analysis of the alternatives to regulation in the introduction of new treatments, Cowan evaluates approaches based on the tort system, peer review, the institutional-review-board model, the Food and Drug Administration model, and other special review boards. He concludes that a special review process should be developed.

Other respected contributors include Davis, former administrator of the Health Care Financing Administration, and Senator Gore. They add to the value of the book. They also emphasize how many voices have now joined the chorus of experts on current issues in health care. By my reckoning, only 3 of 28 contributors to this compendium are actually engaged in caring for transplant patients. This underlines the importance of continuing active communication, not only among administrators, legal specialists, and philosophers (and others who may have valuable contributions to make), but also among those engaged in patient care, who may need reminding to participate. I hope that these clinical colleagues are not so myopic as to be devoid of useful perspectives in this area.

This book should help to provide further lively discussion in a field that is one more proving ground for many developments of the future.

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When Doctors Get Sick

Edited by Harvey Mandell and Howard Spiro. 460 pp. New York, Plenum Press, 1987. $25.

Here is a collection of 50 autobiographical accounts of illness, written by physicians. When doctors become patients, the roles and assumptions of both groups are laid bare to scrutiny. Thanks to the extraordinary courage of these physician-writers, readers of this collection come close to both the terror and the commonplace of illness.

Many themes course through these essays. The writers describe denial, shame, guilt, uncertainty, anger, and fear. They discuss the anguish of ceding control and of not knowing whom to trust. Both the difficulty of becoming dependent on care givers and the unconditional support of loved ones and colleagues are nicely documented. Many tell of personal growth, of victory over illness, and of unexpected bonuses derived from illness, such as renewed time to devote to family.