multiplication and sequencing are shown in the figure. A first strand cDNA synthesis kit (Pharmacia) with poly-T primer and specific COX8 primer (P 1–22) was used for cDNA amplification between nucleotides 22 and 472 (figure 1) of the cDNA and the nucleotide sequences reported by Rizzuto et al. The 5’ end of COX8 cDNA, before nucleotide 22, was amplified with the 5’-RACE kit (Life Technology/ Gibco-BRL) and specific COX8 primer (R 231–250, figure 1). Overlapping PCR fragments were sequenced using the dye-terminucleotide chain termination method with fluorescent dideoxynucleotides on an Applied Biosystem 373A DNA sequencer (Perkin Elmer/ABI). We found a hitherto unidentified sequence of 42 nucleotides at the 5’ end of the cDNA, and the rest of the COX8 cDNA sequence was identical to that previously described by Rizzuto et al. (figure 4). From nucleotides –42 to +472, there were no mutations in either the affected or healthy people in the COX8 cDNA.

The promoter region of the COX8 gene, that has not yet been identified, was not analysed. However, all the mutations so far identified in FHC have been described in this region of the COX8 gene (mutations in MYH7 encoding the β myosin heavy chain10, or in an intronic splicing site (mutation in the splice donor sequence of intron 15 of the cardiac troponin T gene11). By analogy with all the data available for FHC, we therefore conclude that the COX8 gene is very unlikely to be the disease gene of the CMH4 locus responsible for FHC.

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BOOK REVIEWS

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This fascinating report provides a comprehensive account of the "promises and problems in genetic testing and counseling.\" The deliberations of the 20 committee members were informed by a series of papers and discussions at workshops, meetings, and a public forum.

The first 28 pages comprises the Executive Summary and provides the reader with a useful synopsis of the 70 plus recommendations. Many of their recommendations mirror those found in the Nuffield report on ethical issues in genetic screening (London: Nuffield Foundation, 1993). One example is the creation of a National Advisory Committee Working Group on Genetic testing to oversee professional practice and determine when new genetic tests are ready for wide-scale use in medical practices. The Nuffield report proposes the setting up of a central coordinating body to review genetic screening programmes and monitor their implementation and outcome.

The report covers the following issues: Genetic testing and assessment; Laboratory issues in human genetics; Issues in genetic counselling; Public education in genetics; Personnel issues in human genetics; Financing of genetic testing; Genetic testing (social, legal, and ethical implications of genetic testing; and Research and policy agenda.

The numerous references for each of these topics are situated at the end of each chapter. The report continuously emphasizes the need to respect the autonomy of people in the way they use genetic information.

In addition to these 70 pages devoted to "Recognizing Social and Cultural Differences". The report identified the need for a variety of information and education on genetics, with balanced descriptions, in a culturally acceptable manner and at an appropriate time. I found the term "teachable moment" a very useful concept (that is, when the person is most able to comprehend the full significance of the information). Recommendations about developing innovative information materials such as interactive computer systems were noted on several occasions. As in the Nuffield report, reference is made to the training needs of primary care practitioners.

It is of interest that the Chairman of the Committee (A G Motulsky) felt the need to add a separate note to the Preface. In it he pointed out that while the majority of the committee favoured voluntary participation in neonatal screening, a minority felt that mandatory screening for phenylketonuria (PKU) and hypothyroidism would be a simpler solution.

On a more personal note, he stated that information about sickle cell trait that is incidentally detected in neonatal screening is difficult to withhold and should be given to the mother with appropriate genetic counselling. This seems to be in contrast to the more confusing recommendation of the report: "When carrier status may be incidentally determined in newborn screening (eg, in sickle cell screening), parents should be informed in advance about the benefits and limitations of genetic information, and that this information is not relevant to the health of their child. If they ask for the results of the incidentally determined carrier status for their own reproductive planning, it should be communicated to them in the context of genetic counselling, and they should be informed that misattributed paternity could be revealed."

This has been a most enjoyable book to read and I would strongly recommend it to anybody interested in the broader issues raised by genetic screening and testing.

ELIZABETH N ANJOWU


How much of this rapidly expanding field can you cover in 452 pages (including references)? The authors of this text have included all the inherited neurological diseases which are likely to be of major interest to clinical neurologists and clinical geneticists. In addition, judging by the number of times this reviewer’s copy was borrowed, molecular geneticists working with these diseases will also find the chapters enlightening.

The 15 chapters are all well written, comprehensible, and, in addition to providing excellent reviews of their subjects, provide an insight into the issues of genetic and pheno- typic diagnosis and classification of specific disease groups. The chapters on hereditary ataxias (Banfi and Zoghbi) and