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BOOK REVIEW

1. Slobodan Jugo. **Surgical Atlas of External Rhinoplasty: Decortication Approach**
   New York: Churchill-Livingston; 1995. 172 pages; price: US$125.0
2. Forest M, Tomento B, Vanel D, editors. **Orthopedic Surgical Pathology.**
3. Den Exter A, Hermans H. **The Right to Health Care in Several European Countries'. Includes contributions of the WHO, the Czech Republic, Israel, Italy, The Netherlands, Poland, Russian Federation, Slovenia, Switzerland, and UK.**
   The Hague: Kluwer Law International; 1999. ISBN 9041110879

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1. Slobodan Jugo. **Surgical Atlas of External Rhinoplasty: Decortication Approach**
New York: Churchill-Livingston; 1995. 172 pages; price: US$125.0

The book involves 172 pages, and is printed on a high-quality paper. The format of the book is 30.4 x 21.5 cm. The text is well illustrated by as many as 211 figures, 78% of them color photos. The book is composed of 10 sections, and their titles are as follows: 1) Introduction; 2) History of Decortication Rhinoplasty; 3) Preoperative Considerations; 4) Anesthesia for Decortication Rhinoplasty; 5) Fundamental Surgical Technique; 6) The Nasal Septum; 7) Surgery of the Nasal Airway; 8) Special Situations in Rhinoplasty; 9) Complications of Decortication Rhinoplasty; and 10) Conclusion.
The author of the book is Dr Slobodan Jugo, Croatian by birth, who has been living in the United States for many years. This brilliant atlas makes a significant contribution to the plastic and reconstructive surgery of the nose.
In section 2, the author surveys the history of decortication method of rhinoplasty. The performance of rhinoseptoplasties under direct visual control after elevation of the skin is called ”decortication” or ”external rhinoplasty”. It was introduced in 1955 by Šercer from Zagreb and fully developed by his successors Padovan and Jugo. Special respect is paid to Professor Ante Šercer, who was the first to develop a new technique of rhinoplasty which he named ”decortication”, and to Professor Ivo Padovan, Šercer's student and successor, who continued to develop decortication method of rhinoplasty. Owing to Dr Jugo, the method was further refined and widely adopted not only in the United States but also in the entire medical world.
Several new maneuvers have been developed: 1) improved incision; 2) periosteoperichondrial flap; 3) new method of septal reconstruction, 4) preservation of the perichondrium of the lateral crura of the lower lateral cartilages; 5) resection of the ligament of the nasal tip; 6) new method of sculpturing; and 7) improved technique for augmentation of the nasal dorsum and tip. All of these new maneuvers have been tested on a large number of patients and have been proven to be efficient, safe, and with excellent functional and esthetic outcomes. External rhinoplasty allows modern rhinosurgeons to transform the vision of pioneers in rhinology into a reality and every day routine.
Decortication rhinoplasty is a reliable surgical technique, practiced by a great number of rhinosurgeons, and is especially helpful in patients with a severely crooked nose, significant anterior septal defects, or areas where struts are necessary to be supported from the nasal septum. However, since there is an ever increasing number of surgeons, especially in residency training programs, performing external rhinoplasty, the number of complications and their severity have been on the rise.
In the past decade, numerous literature reports about improvements in the technique of the external rhinoplasty have been published, but the data about risks and complications especially on large series of patients have been missing.
What makes the book especially valuable is an objective assessment of both functional an esthetic outcomes of external rhinoplasty. One should emphasize a great concern Dr Jugo has shown for his patients with respect to preoperative preparation, choice of anesthesia, and postoperative follow-up. Such an approach points to an extensive medical education, and a high ethical awareness of the author.
The book also confirms that Dr Jugo does deserve a special merit in rhinosurgery today, as well as how appreciated the decortication approach is in up-to-date plastic and reconstructive surgery of the

nose. Likewise, Dr Jugo has proven that external rhinoplasty – decortication approach is a routine surgical tool widely adopted by rhinosurgeons of all continents, and is highly appreciated as a recognized surgical technique of septorhinoplasty.
I warmly recommend this book to all the surgeons whose primary concern is rhinoplasty, as well as to ENT departments and other ENT institutions closely associated with this branch of surgery.
No doubt that this book will be welcomed by all readers in the States, adopted homeland of the author, and to the readers from Croatia, the old homeland of the author.

Ivo Padovan

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2. Forest M, Tomento B, Vanel D, editors. **Orthopedic Surgical Pathology.**
Edinburgh: Churchill Livingstone; 1998. 795 pages; ISBN 0-443-05540-8

When I told the editor-in-chief that I was willing to write a book review I meant small-sized book and two hundred pages at most. I was a bit surprised to find on my desk a mega-book of large format and almost eight hundred pages. Although I am in the ”bone business” myself, I was all but happy to read it. Fortunately, I was wrong.
The book is edited by Michel Forest, MD, Professor of Pathology, Head of Department of Pathology, Hospital Cochin, Paris, France. Associate editors are Bernard Tomeno, MD, Professor of Orthopedic Surgery, Head of the Department of Orthopedhic Surgery, Hospital Cochin, Paris, France; and Daniel Valen, MD, Head of the Department of Radiology, Institute Gustave Roussy, Villejuif, France. There are 16 more contributors.
Written in an easy-to-read English, the book has 60 chapters organized in 5 logical sections. There are more then 1,750 pictures, virtually all of them in color (you can't expect an x-ray image to be in color).
The book has an interesting introductory chapter: ”Psychopathology and bone tumor pathology”, written by a psychiatrist. The chapter deals with the patient, his feelings, fears, and anxiety. Although the pathologist and the patient seldom meet, the results of the biopsy can change entire patient's life. The pathologist should have in mind that he does not deal merely with a small piece of tissue, but with a human being.
”Methods of Diagnosis” is the title of the first section of the book. It deals with the imaging methods (plain films, ultrasonography, computed tomography, magnetic resonance imaging, bone scans, and arteriography), biopsy, flow cytometry, cytogenetics, and electron microscopy. Indications, principles, advantages, and limitations of each method are discussed in details. The rationale for the choice of each method is given as well as a diagnostic algorithm for bone lesions.
Following three sections deal with different fields of bone pathology. Section 2 is the ”Pathology of tumors” (osteoma and bone island; osteoid osteoma and osteoblastoma; osteosarcoma; variants of osteosarcoma; osteochondroma; chondroma; chondroblastoma; chondromyxoid fibroma; chondrosarcoma; variants of chondrosarcoma; fibrous cortical defect and non-ossyfing fibroma; desmoplastic fibroma; fibrosarcoma; benign fibrous histiocytoma; malignant fibrous histiocytoma; lipoma and liposarcoma; vascular tumors; muscular tumors; Schwannoma; myxoma, fibromyxoma and xanthoma; hamartoma and mesenchynoma; adamantinoma; chordoma; giant cell tumor; Ewing's sarcoma; primitive neuroectodermal tumor; primary lymphoma of the bone; bone involvement in Hodgkin's lymphoma, leukemias, myeloprolipherative disorders and mastocytosis; myeloma; and bone metastases). Section 3 describes the ”Pathology of pseudotumoral lesions” (solitare bone cyst, aneurysmal bone cyst, ganglion and epidermoid cyst, eosinophilic granuloma, hyperparathyreoidism, osteomyelitis, hydatid disease and tuberculosis, Paget's disease, fibrous dysplasia, osteofibrous dysplasia, giant cell reaction, osteopoikilosis and melorheostosis, membranous lypodystrophy, callus and periosteal reactions, bone infarct, and myositis ossificans). Section 4 deals with the ”Pathology of tumors and pseudo- tumoral lesions of joints” (benign tumors and cysts of synovium, pigmented villonodular synovitis, synovial chondromatosis, and synovial sarcoma).
Each chapter in those sections is organized in very similar manner. It includes: introduction and clinical data, skeletal distribution, imaging, gross pathology, histopathology, cytopathology, immunohistochemistry and histochemistry, flow cytometry, cytogenetics, electron microscopy, course, treatment and prognosis, differential diagnosis, and comments for the surgical pathologists. As you can see, it deals not only with pathology but also with different diagnostic techniques and recent trends in the treatment.

Every chapter is full of pictures, and the book looks more like a pathological atlas than a textbook. Simultaneous photographs of the gross and imaging findings are given whenever possible. X-ray pictures are complemented with CT and MRI scans. The characteristic microscopical features are given on several pictures (most stained with hematoxylin- eosin). Where appropriate, photographs taken using polarized light are given. The illustrations even cover some misdiagnoses made by the authors themselves. I was a bit disappointed to find out that the number of immunohistochemistry photographs is very limited due to lack of space, although immunohistochemical findings are discussed when necessary. But I am very glad that the gross pathology descriptions are included. It seems to me that the modern pathology textbooks deal more with genes and molecular biology than with pathologic anatomy itself.
The book deals with the field of orthopedic surgical pathology only and does not include cranial and facial lesions. Description of pathology of those regions would probably occupy another book. The authors stress that the choice of pseudotumoral lesions is selective and guided by the avaibile material and not by the frequency of the lesions. The reader should know something about the actual look of the lesion, and not only hipothetical mechanisms of mollecular interactions.
The last section of the book deals with the treatment. It includes orthopedic surgery of bone tumors, surgical treatment of malignant bone tumors in children, pathology of bone and joints after orthopedic reconstructive surgery, and chemotherapy and radiotherapy of bone tumors. Different avaibile treatment possibilities are described. The main principles and general rules of treatment are discussed by defining methods and their limitations, advantages and disadvantages, as well as indications for every therapeutic possibility.
Suggestions for the further reading are also given. Although a list of references is given in every chapter, the authors have also included ”a library for the pathologist”. About 70 books are listed, divided in ”classic and invaluable books” and books for those who would like to know more about the bones and bone pathology.
To summarize the review of this great book I will translate 5 aphorisms from the preface. Although the author of the preface, Peter G Bullough, states that they ”should be written large in every department where tumors are diagnosed and treated”, the text is in French ”unfortunately limiting the potential audience” (I wonder why they haven't translated them themselves.)
DON'T
treat without the diagnosis (in 9 out of 10 times, at least, this means treating without the biopsy).
DON'T
take the samples operatively and send one half to Paul and one half to Peter (thou they might be pathologists of great reputation).
DON'T
begin the treatment if you are not sure that you will be able to proceed (technically, intellectually, and psychologically) no matter what the progress was.
DON'T
think of pathology as an art of guessing: give clinical data, include radiological findings.
DON'T
think of a pathologist's report as of supreme law: compare it with the context, discuss it with the pathologist, and repeat the biopsy, if necessary.

Ivan Krešimir Lukiæ

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3. Den Exter A, Hermans H. **The Right to Health Care in Several European Countries'. Includes contributions of the WHO, the Czech Republic, Israel, Italy, The Netherlands, Poland, Russian Federation, Slovenia, Switzerland, and UK.**
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The right to health care is changing over time and its content differs from country to country. The core of the right to health care, access on essential health care services and facilities, is a fundamental human right embedded in international human rights law. Originally solely intended as a political statement stipulated in various international treaties, Member States did not intend to interpret this social right as covering erga omnes obligations and certainly not implying legally enforceable entitlements to certain types of care, which actually may not be available.
Both in international human rights law and health care legal doctrine, however, this situation in

changing. Increasingly, the legal nature of social rights, in particular a right to health care tends to include classical rights' characteristics. According to several national and international gremia, social rights include a tri-partite typology of obligations: obligations to protect, to respect, and to fulfil. These obligations correspond with positive and negative rights contents. Specifying and effectuating these obligations to the health care sector can be considered as a promising instrument to strengthen the generally weak legal status of a right to health care. In this respect the so-called Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (Maastricht Guidelines 1997) should also be mentioned, which elaborate on the previous Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights (Limburg Principles 1987).

In view of today's changing situation, an expert meeting was held in Rotterdam in April 1998, hosted by the Department of Health Policy and Management, Erasmus University Rotterdam (The Netherlands). The papers published in this volume address the many differing meaning and the consequences of a right to health care in reforming health care systems since this right functions as a leading principle in reform programs. In addition, its normative underpinning has been undeservingly given a minor role in this process. Developments surrounding the meaning of the right to access seem to be relevant to both national and international health care policy given legal restrictions of that right. Confronted with rapidly decreasing resources, a general deteriorating health status, increased demand to health care and urge for improving the quality of care, particularly Central and Eastern European (CEE) health policy makers have to cope with the legal dilemma of both guaranteeing as well as limiting access to health care. Rethinking the meaning of a constitutional right to health care in order to guarantee sustainable access to health care will be inevitable. Both from a legal and economic perspective this scientific discourse attempts to develop and discuss pivotal instruments in the health care reform debate. Reviewing knowledge and exchanging experiences from other countries is of importance to participants in health care reform processes to provide a normative and instrumental framework supporting effective reforms in the CEE countries. Here, the experiences with cost-sharing measures are illustrative to the underpinning concept of this meeting – the principle of ”helping others to help themselves”. Both Western and Central and Eastern European Countries are experiencing different (financial) incentives to cost containment (e.g., co-payments). It is in the interest of all the countries to provide and receive both knowledge and advice when experiencing a more or less comparable health care structure.

Hence, a panel of European scientists and policy-makers presented national experiences on the meaning of the right to health care in various countries. Topics open for discussion were:

– the pros and cons of a constitutional right to health care;
– the nature and scope of a right to health care;
– the enforceability of a right to health care;
– (statutory) constraints and infringements;
– the meaning of case law concerning the interpretation of a right to health care;
– the constraints of health care claims/benefit packages and cost containment measures; and
– choices in health care.

Although various health care systems differ substantially, arguments on the pro and cons of the right to health care are comparable. Generally speaking, it is recognised that an absolute right to (access to) health care is untenable. Legal restrictions and other instruments have been developed to limit this right. During the meeting, these developments were explained. Thereafter, an extensive discussion was held in what respect these measures are effective and what the social consequences are (or will be).

In the synthesis, an attempt to converge the results of this meeting has been made. According to Leenen, the best way to strengthen social rights is, of course, to incorporate them into national legis-la-tion. In Italy and the Netherlands the right to health care is protected constitutionally (but on differing legal bases) while the United Kingdom does not have a written constitution. In contrast, Poland, as most Central and Eastern European (CEE) countries, has for many years seen the state take responsibility for the provision, funding, administration, and allocation of health care services and the right to health care was guaranteed theoretically but not in practice because of the lack of (financial) means. However, newly developed Constitutions explicitly anticipate potential limitations to the right to health care. What all these countries have in common is a cost containment perspective, where the future will bring even tighter limits on what resources patients may consume. Despite differences in legal structures between these countries, where they seem to converge is on the consequences of putting limitations on the right to health care. The courts in Italy, the Netherlands and UK have formulated conditions drawn from the acceptance that this right has to be judged within the context of limited resources. It may be concluded that finding a compromise between the right to health care and cost containment policies is also an issue CEE countries will have to face in the

nearest future.
Furthermore, reforming the (public) health expenditure policy has been one of the leading issues in the 1980s and 1990s health care debate. In Western countries the current debate is mainly dominated by cost efficiency and cost effectiveness motives, while in CEE countries generating additional funding seems to prevail the economic debate. Although from different point of view all the countries experienced or will experience a wide and varied range of mechanisms. In Italy, particularly in the 1990s, patient co-payments were applied to a widening range of services and co-payment rates were raised and exemptions reduced. This essentially meant shifting an increased part of health costs to households (G. France). Other measures were indirect, aimed at improving resource utilisation: standards for acquisition and use of plant and equipment; introduction of external and internal audit systems; and what is of especial interest to use here, attempts to limit access by patients to care (in particular, positive and later negative pharmaceutical lists, curtailment of use of private uncontracted providers and of contracted providers, restrictions on the use of foreign health care facilities and less than full reimbursement for authorised care obtained from private providers. Of course, the effect of direct measures to contain expenditure was also to curtail the services available to SSN – Servizio Santitario Nazionale – patients (G. France).
In the current CEE health policy reforms, the introduction of formal direct and indirect restrictions on access to health care have been a matter of highly disputed controversies. In the Czech Republic, for instance, the co-payment discussion was stigmatised by political controversy between right and left-wing interpretation of the same legislative documents, which was arbitrated by the Constitutional Court in 1996 (Krizova). Nonetheless, it is seriously doubted that comprehensive free care can be attained at all. ”It would probably be more reasonable to focus on satisfying defined priority needs of the most vulnerable patient categories by shifting part of the burden to the wealthier family categories” (Sheiman). The ”social solidarity principle” must also apply to the redistribution of private health-related payments. This principle can be implemented through setting a system of limited co-payments for generally used services. That will allow strengthening the financial base of the health care system and relieving the financial burden that the poorest and ill people have to bear today. This is exactly how the system of social security operates in the Western countries with lavish (by Russian standards) public health care financing.
Although the concept of cost sharing (e.g., co-payments, co-insurance, and a deductible component) has an embryonic character, it may, conditionally, provide a useful instrument to contain costs or provide additional/supplementary funding in health care. Nonetheless, WHO demonstrates its negative attitude towards cost sharing. It is said that user charges may decrease utilisation without actually decreasing total health-related costs, and can not be regarded as a strong tool to foster cost effective resource utilisation (European Health Care Reform, Saltman & Figueras, 1997).
One of the questions that needed (and still needs) to be answered concerned the transferability of national experiences. Such a question may however include the danger of transplanting alien concepts for health care reforms. A certain relativation of national experiences to the unique social, cultural setting is therefore essential. This should, however, not result in a ”trial and error”-approach, or as described by one of the participants: ”Health care reforms can often be compared with teenage sex. Everybody is talking about it without knowing it from each other. When doing it happens under lousy circumstances”.
Conclusively, the work includes international and national views, the role of various legal principles and the function of courts, as well as the organisational dimension. It is important to be aware of these multiple perspectives and their ramifications. An exchange of knowledge and experiences from other countries can enhance understanding of the meaning behind health care principles and provides an avenue for shared advice among those countries with commonalities in their systems. The Right to Health Care in Several European Countries offers this diverse range of viewpoints and coverage providing a unique resource for anyone interested in health care rights.
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