Christine Falls. Benjamin Black (*nom de plume* of John Banville). London, UK: Picador, 2007. ISBN 13: 978-0-33044532-0. Price: £7.99. Pages: 400 (paperback)

Aptly named, the book represents many fallen Christians. The main character is a pathologist named Quirke who was brought up with Malachy Griffin (Mal), now an obstetrician at the same hospital. Griffin's father, a prominent judge, rescued Quirke from an orphanage and favoured him over Mal, giving rise to feelings of indebtedness towards the judge, and guilt and conflict with Mal. A large and shambling man, Quirke has lived alone since his wife died during childbirth years before (his wife, Delia, was the sister of Mal's wife, Sarah) and, while he has apparently moderated his drinking quite a bit, he still drinks so much, you wonder how he ever does any work.

The book is set in the 1950s, mostly in Dublin but partly in Massachusetts, USA. We meet Quirke as he unsteadily visits his department at Holy Family Hospital late one night after a going-away party for a nurse taking a baby to the USA. Mal the obstetrician is, strangely, in the pathology office writing a report. Nearby is the body of a young woman named Christine Falls. Quirke later discovers that this body has been sent from the hospital to the morgue. He has it brought back and finds that the cause of death on the release form, pulmonary embolism, is incorrect. Christine Falls bled to death after giving birth.

Quirke also learns that Christine Falls worked for a while in Mal Griffin's house, as did Dolly Moran, the old woman in whose house she was living when she died. He gets Christine Falls' record of admission changed, thinking to protect Mal, who he suspects of complicity in the pregnancy and cover-up of the death. He visits Dolly, who is later found tortured and murdered. Quirke himself is first warned off investigating, then savagely mugged by a pair of heavies, nicely described as "they would beat or maim or blind or kill without rancour, going about their workaday task methodically, thinking of something else".

The nurse delivers the baby to the orphanage and unmarried mother's 'refuge', the Mother of Mercy Laundry. Nuns, priests and a lay group called the Knights of St Patrick (an authoritarian and secretive network) figure prominently, doing what they regard as good. Quirke, while trying to trace what happened to Christine Falls and her baby, comes up against the well-guarded secrets of Dublin's high Catholic society, among them members of his own family.

Little Christine, Christine Falls' baby, goes from the orphanage to a young couple, Claire and Andy Stafford. Nervous and fragile, Claire is besotted. Andy, a nasty piece of work, dislikes the baby and the idea of a baby, and ends up making it with the older woman downstairs, Cora, the "homely but hungry for it" menopausal stereotype. These lesser characters are rather predictable. Andy regards women as prey that would always want to have sex with him. Mal's wife, Sarah, has funny turns, finds it difficult to deal with her alien status as an American, and in general withdraws when the going gets rough. Sarah and Mal have a daughter: naïve, pretty Phoebe. Phoebe wants to marry a Protestant – but we have to assume knowledge of how terrible this would have been in Ireland in the 1950s, as no sense of the outrage comes across in the narrative.

This book is not a thriller in the ordinary sense, but is more of a novel, carrying the reader on with meticulous, but depressing descriptions (it always seemed to be rainy, foggy or dirty), and well-delineated characters. It's far from a rattling yarn; more of a meander through some intrigues of the authoritarian Catholic church in 1950s Ireland, including trying to deter Quirk from his laboured investigations, not only into the mystery, but into his own emotional state.

Despite the elegant language and the writing that holds your attention, the book is disappointing in what it doesn't achieve. Where is the fury or desolation felt by the young women punished for becoming pregnant and then deprived of their babies? The physical description of the reddened hands and swollen ankles of pregnant Maisie at the Mother of Mercy Laundry is painstaking, but what of her feelings? Where is the anger towards the Catholic hierarchy, who so clearly believe they have the right to manage other people's lives? The inner journey of Quirke to the realisation of his own involvement and responsibilities lags behind the reader's understanding, including those of the twists and turns of the plot.

What will a health professional gain from this book? Perhaps a sense of the clinical detachment, amounting to emotional attenuation, that Quirke seems to have. Is this the result of his early upbringing in the orphanage compounded by his choice of occupation as a forensic pathologist? Or is it one of the risks of working as a doctor? We read of the dangers of "knowing what is best" not just for those women unfortunate enough to have transgressed the "moral Christian code", but for their offspring, condemning them forever to be obedient to their masters in the Catholic hierarchy. As doctors and nurses, it is all too easy to slip into believing that we, too, "know what is best", to demand that patients follow our own moral code, however derived. We can see manoeuvres, today, for example, of refusing treatment, making treatment difficult or unpleasant, or turning care into punishment. Enjoyment of what others may perceive as 'sinful' – too much booze, smoking, eating, drugs, and particularly sex – often result now in condemnation and restriction of access to repair the harm caused. Read the book and reflect on those caught up in this Catholic spider's web of intrigue. How much can you judge them as different from yourself and others around you? And would you have the courage to go on investigating like Quirk?

Reviewed by **Gill Wakley**, MD, FFSRH
Advisory Editor, Journal of Family Planning and Reproductive Health Care

We hope that journal readers enjoyed reading *Christine Falls*, and also discovering whether their opinion of the book matched that of our guest reviewer. In the January 2009 issue, the fiction book under scrutiny will be *The Outcast* by Sadie Jones (448 pages, Vintage Books, 2008, ISBN-13: 978-0-099-51342-1). We want to remind journal readers that if they would like to offer to review an appropriate fiction title of their own choosing then they should contact the Journal Editorial Office by e-mail (journal@fsrh.org) in the first instance with details of their nominated title.

Quality of life and acceptability of medical versus surgical management of early pregnancy failure. Harwood B, Nansel T; National Institute of Child Health and Human Development Management of Early Pregnancy Failure Trial. *Br J Obstet Gynaecol* 2008; **115**: 501–508

Background
Traditionally, evacuation of retained products of conception (ERPC) was the only management available for early pregnancy failure. Today, women can be offered a choice of expectant, medical or surgical treatment. As the efficacy and safety of medical management improves, it is likely to become more widely offered by clinicians and chosen by women. This study looked at the Quality of Life (QOL) and treatment acceptability of women randomised to misoprostol versus vacuum aspiration for primary treatment of early pregnancy failure (EPF). It was a planned secondary analysis from a multicentre randomised clinical trial of misoprostol versus surgical treatment of early pregnancy failure conducted at four urban university hospitals in the USA (ie, Columbia, Miami, Pennsylvania and Pittsburgh).

Methods
A total of 652 patients were randomised in a ratio of 3:1 between misoprostol and surgical treatment. For this secondary analysis the sample size provided 80% power to detect a 2.9–3.5 point difference in each of the Short Form 36 Health Survey Revised (SF-36R) QOL scales. Randomisation occurred on the day of medical treatment or within 24 hours of surgical treatment. Participants completed a diary prospectively of symptoms experienced for the 2 weeks after treatment. A questionnaire was administered on visit study day 15 (2 weeks after treatment) including QOL, depression, stress and treatment acceptability. The QOL questionnaire was the SF-36R (good validity and US norms established). A separate scale was used for depression-happiness instead of the mental health scale in the SF-36 (also stated to have good internal consistency and test-retest reliability).

Results
There was a good response rate for this analysis: 93% completed each of the study instruments for this analysis, 96% completed symptom diaries, 94% completed QOL and well-being questionnaires and 93% completed questionnaires on acceptability and recovery.

Women receiving medical treatment for EPF reported greater bodily pain and lower symptom-related acceptability than those undergoing surgical treatment. All other dimensions of QOL and overall acceptability for both procedures were similar. Women with medical treatment reported a greater number of symptoms, and medical treatment was also associated with a greater number of treatment failures. Symptoms did not affect overall acceptability of procedure but treatment failure did. Overall QOL was not affected in either case.

Limitations
Expectant management was not a treatment arm: this is something that is offered more often in the UK. There was a single measurement period 2 weeks after treatment; no long-term data are available. This may not be particularly relevant, as most women would have been expected to complete treatment by the end of the 2 weeks. It would have been interesting to note the occurrence of complications thereafter and their impact on QOL. The sample may not be representative of non-urban population (the

women tended to be more educated and 70% had a high school diploma). The women were recruited from four different geographical regions and included large Hispanic and black populations. Some selection bias is also likely because of the 3:1 ratio of medical to surgical treatment (women with a strong preference for surgical treatment would not have agreed to be randomised). Urban populations in the UK are far more diverse and the educational level varies significantly depending upon the area a particular hospital serves. This could have a greater impact on the women's understanding of treatment choices and subsequent side effects likely to occur, thus affecting QOL.

Conclusions
This study aims to inform us about the focus of counselling prior to patients undergoing the procedure and helps women to better understand the differences in experiences, expected adverse effects, and efficacy between the two methods as well as the similarities in recovery and QOL measures. It is unlikely to change the actual points we use when counselling women about different treatment options for EPF, but gives the clinician more confidence in assuring women about changes in QOL following their treatment choice.

Reviewed by **Neelima Deshpande**, MRCOG, DFSRH
Staff Grade Doctor in Sexual and Reproductive Healthcare, Heart of Birmingham Teaching PCT, Birmingham, UK

Crocus sativus L. (saffron) in the treatment of pre-menstrual syndrome: a double blind, randomised and placebo controlled trial. Agha-Hosseini M, Kashani L, Aleyaseen A, Ghoreishi A, Rahmanpour H, Zarrinara AR, *et al*. *Br J Obstet Gynaecol* 2008; **115**: 515–519

Saffron is the world's most expensive spice, which has been traditionally advocated for stomach, digestive problems and mood disorders. Iran produces 81% of the world's supply so it is not surprising that the first trial of saffron in premenstrual syndrome should come from the University of Tehran, Iran. This group have previously published on the use of saffron in depression.

The paper reports a double-blind placebo controlled study to investigate whether saffron could relieve symptoms of premenstrual syndrome. I would suggest that it is probably a pilot study since only 50 women were recruited of whom 47 completed. This should not detract from the study, which appears to have been very well designed and performed.

The authors are to be congratulated in that they recruited 78 women of whom 50 enrolled for a 4-month trial that had only three dropouts in a 12-month period. UK researchers may be envious of the speed of recruitment; but most participants were recruited after advertisement.

This was a 4-month study: the first 2 months acted as the control period in which women kept a daily symptom report of 17 premenstrual symptoms, attended for screening by a psychiatrist, and completed the Hamilton Depression Rating scale at the end of the second month. After being randomly allocated to saffron or placebo, the participant returned in cycles 3 and 4 to complete the Hamilton Depression Rating scale with a psychiatrist. The analysis appears appropriate and the study showed that there was a significant difference between saffron and placebo.

As the authors admit, participant numbers were not large and this study needs to be repeated. I would suggest that both larger numbers and different populations are used in future studies. This study has attracted a lot of interest on the Internet and some women's groups are already citing it to encourage women to increase saffron in the diet; which as well as not being evidence-based is costly to the woman concerned (saffron currently retails at £25–£35 per ounce).

Reviewed by **Gillian Robinson**, FRCOG, FFSRH
Associate Specialist, Southwark Primary Care Trust, Department of Sexual and Reproductive Health, Artesian Centre, London, UK

Safety and efficacy of a testosterone metered-dose transdermal spray for treating decreased sexual satisfaction in premenopausal women: a randomized trial. Davis S, Papali M, Norman RJ, O'Neill S, Redelman M, Williamson M, *et al*. *Ann Intern Med* 2008; **148**: 569–577

Background
Considerable interest has been created by the publication of a few articles (and many commentaries) suggesting that correcting low testosterone levels in women may increase their sexual satisfaction.

Methods
This was a double-blind trial with 261 premenopausal women randomised into four almost equal groups. Women were recruited by means of press and radio advertisements. From the initial 480 women, 219 were excluded mainly because they did not meet the inclusion criteria (e.g. anyone with medical or psychiatric illnesses was excluded.) Those selected completed a 4-week pre-treatment diary. At completion of the 16 weeks of the trial, dropout rates (between 11 and 16) were similar for each group. Each group received one of three strengths of testosterone, or placebo, and completed a record of sexually satisfying sexual encounters (SSE) as the primary outcome measurement. One of the secondary outcomes measured was the Sabbatsberg Sexual Self-rating Scale score (included in article as an Appendix).

Results
All groups reported an increase in SSE. Compared with placebo, the increase only reached significance for the middle strength of testosterone. The increase was 0.8 SSE per month. No correlation between measured free testosterone and outcome was found. The total scores for the Sexual Satisfaction Scale, although slightly higher in the active treatment groups, did not differ statistically from the placebo group. The safety data showed few side effects at this low dose, mainly excess hair at the spray site and a slight increase in acne in the treated groups.

Relevance to current practice
Measurement of testosterone and free testosterone was developed mainly to investigate levels in men and identify high levels in women with conditions such as hirsutism. It is still unclear how identifying low levels in women can be used in sexual medicine, especially, as shown again in this article, correlation between testosterone levels and sexual satisfaction is poor or non-existent. A large number of articles have appeared discussing the reliability of measuring free testosterone levels, and although this trial used a sensitive method, doubts remain about the usefulness of such tests in clinical practice.[1,2] The Endocrine Society guidelines stated: "We recommend against making a diagnosis of androgen deficiency in women at present because of the lack of a well-defined clinical syndrome and normative data on total or free testosterone levels across the lifespan that can be used to define the disorder".[3]

The lack of correlation between hormone levels and sexual satisfaction confirms other work suggesting that the situation is more complex than just a low testosterone level. The (cited) large Australian community-based, cross-sectional study of 1423 women aged 18–75 years, who were randomly recruited via the electoral roll in Victoria, Australia, from April 2002 to August 2003, showed no correlation.[4]

It seems unlikely that most women would want to use a testosterone spray to their abdomen once a day to correct their (possibly) low testosterone levels in order to perhaps achieve less than one extra SSE a month.

Reviewed by **Gill Wakley**, MD, FFSRH
Advisory Editor, Journal of Family Planning and Reproductive Health Care

References

1 Sacks SS. Are routine testosterone assays good enough? *Clin Biochem* 2005; **26**: 43–45.
2 Rosner W, Auchus RJ, Azziz R, Sluss PM, Raff H. Utility, limitations, and pitfalls in measuring testosterone: an Endocrine Society Position Statement. *J Clin Endocrinol Metab* 2007; **92**: 405–413.
3 Wierman ME, Basson R, Davis SR, Khosla S, Miller KK, Rosner W, *et al.* Androgen therapy in women: an Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab* 2006; **91**: 3697–3710.
4 Davis SR, Davison SL, Donath S, Bell RJ. Circulating androgen levels and self-reported sexual function in women. *JAMA* 2005; **294**: 91–96.