

make it *easy* for me to sort out the syndromes of UIP (usual interstitial pneumonia), NSIP (nonspecific interstitial pneumonitis), LIP (lymphocytic interstitial pneumonitis), DAD (diffuse alveolar damage), DIP (desquamative interstitial pneumonitis), and organizing pneumonia, they do help.

I found the discussion of sarcoidosis particularly easy to follow. Its recommendations for treatment regimens of various sarcoid syndromes are detailed and useful. Connective-tissue-associated lung disease is also well presented. Reading that chapter gave me a better sense of these processes overall and a better sense for how they compare with idiopathic diffuse disease. It also gives me a place to go for a quick review when my next patient confounds me.

Here and there the international perspective gives some surprises. The French authors of the chapter on bacterial pneumonia recommend amoxicillin for outpatients whose presentation doesn't specifically suggest chlamydia, mycoplasma, or Legionella. This fits the British Thoracic Society guidelines but differs from those of the American and Canadian Societies, which recommend macrolides for most outpatients. Experts on this side of the Atlantic think it's pretty hard to predict which patients have these atypical organisms, and there are some data that outpatients treated with macrolides fare better than those treated with aminopenicillins or cephalosporins.

The highly regarded Italian authors of the chapter on acute respiratory distress syndrome present a ventilator-support strategy that differs from the usual American approach. They routinely employ chest computed tomography to evaluate the effects of varying PEEP, and they perform helium lung-volume measurement to guide their understanding of the patient's physiology. Their gas-exchange target is a  $P_{aO_2}$  of 80 mm Hg (rather than the more common 55–70 mm Hg), and they are concerned that tidal volume of 6 mL/kg (per the low-tidal-volume strategy of the Acute Respiratory Distress Syndrome Network study) may be too low. They advocate "high PEEP," while keeping tidal volume low enough to keep plateau pressure < 35 cm H<sub>2</sub>O. Although it may seem confusing that recommendations in this chapter differ from those in the chapter on mechanical ventilation, I think it serves to illustrate the diversity of approaches among international experts. At the same time, similarities in other aspects of venti-

lator strategy (eg, avoiding high plateau pressure, permissive hypercapnia, trial of prone position) show that there are areas where data are sufficient to inform the choice of techniques.

Textbooks are often better now than they used to be, partly because e-mail now allows faster (and thus more) communication between authors, editors, and contributors. Different views and different subjects can be integrated into a more cohesive whole. The writing and publishing process can be accelerated to bring the student a more timely and authoritative resource. At the same time, computer publishing provides capacity for lots of great graphics—better looking pages that are easier to access. Textbook production has been revolutionized. When the process works well, you get a great resource that is timely, authoritative, clear, and approachable. I think the process did work well with **Clinical Respiratory Medicine**. At \$149, physicians and therapists will find this text a real value.

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**ICU Recall**, 2nd edition. Nelson L Thiemert MD and Curtis G Tribble MD. Philadelphia: Lippincott, Williams & Wilkins. 2005. Soft cover, illustrated, 637 pages, \$32.95.

**ICU Recall**, 2nd edition, as with all the books in the popular Recall Series, is aimed to "provide young trainees with concise information and understanding." In doing so, this book serves as a great introductory resource to the intensive care unit (ICU), not only for medical students and junior residents, but also for other health care professionals, such as nurses and respiratory therapists, who require a solid working knowledge of the pathophysiology, diagnostic modalities, and therapeutic options their patients confront. One of the reasons for the popularity of this series is its no-frills, nuts-and-bolts approach to complex topics. This approach, which presents complex information in palatable, easily digestible portions that build, one upon the next, until the entire topic is explained, helps the reader understand what may be unfamiliar and difficult concepts. **ICU Recall**, 2nd edition, often lives up to the precedent set by its predecessors by providing clear, logical explanations to many issues that are often confus-

ing for those new to the ICU style of care. Unfortunately, this book is also cluttered with some extraneous, outdated, and even incorrect information that often bogs down the flow of the text and distracts from the better organized, more clinically relevant parts of the book.

The book is well organized, with 4 sections, 33 chapters, and a comprehensive index. There are few pictures, diagrams, and charts, but those that are included are well explained, relevant, and contribute to the overall understanding of the topic. Most of the chapters are written by residents, while the remainder by medical students and staff physicians.

The book is written in the familiar Recall Series format, in which a question is posed on the left side of the page and the answer is given on the right side of the page. This format is ideal for medical students studying for examinations, as the right side of the page can be covered while the questions are answered from memory. Questions such as, "What is the normal pulmonary artery pressure?" and "What is the formula for Poiseuille's law?" work well in this format, because they deal with simple, linear topics about which there is little debate, and it is in presenting this kind of information that the book shines.

This format is less successful when complex, lengthy, or detailed answers are required. For instance, questions such as, "How can clotting factor deficiency be diagnosed and treated?" are too broad and not specific enough (entire volumes and careers have been devoted to that question). Likewise, questions such as, "What are the 6 ways that computed tomograms can be used with critically ill patients?" incorrectly suggest that there are only 6 reasons to perform a computed tomogram on an ICU patient. The question-and-answer format tends to dichotomize complex issues into a series of yes/no propositions that leave little gray area; however, as anyone with experience working in an ICU can attest, most clinical questions can be answered only in the context of the patient's actual situation. There are very few absolutes in clinical medicine; the dichotomous "yes/no" nature of this book's format does not effectively speak to that reality.

That being said, this book is very good at explaining the basics of ICU care, such as hemodynamic monitoring, bedside procedures, and basic mechanical-ventilation strategy—the topics most germane to med-

ical students and junior residents. Basic information is presented first, followed by layer upon layer of information, until finally the whole idea comes together. This strategy of building from the ground floor up works very well in these sections, in large part because of the nature of the material being covered. There is little debate regarding how to calculate the mean arterial pressure or the location of the left subclavian vein, and that type of information is efficiently presented and well laid out.

The major issues in this book—those most likely to be of interest to medical students and junior residents—are presented in a clear, lucid manner; unfortunately, much of the rest of the book is littered with sections that seem out of place and off-topic. For instance, the generally well-written section on procedures contains a completely unnecessary section that details the proper way to perform bronchoscopy, the fine procedural details of which are unlikely to be of interest to a medical student or junior resident. Likewise, questions such as, “In 1918, what was the leading cause of death?” do not appreciably contribute to the book, and in fact distract from the flow of the text and thus slow the reader’s effort to grasp the topic in its entirety. Too much clutter surrounds the good, meaty sections of the book that are most clinically relevant and most important to the reader.

Also, probably as a function of the format of the book, some controversial topics are presented as dogma. For instance, the section on ventilator management flatly states that synchronized intermittent mandatory ventilation is the most appropriate mode for post-surgical patients; the section on bronchoscopy suggests that the bronchoscope should be held with the left hand and that the bronchoscopist should stand at “the right side of the patient, facing the head of the bed”; and the hematology section states that “all patients with platelet counts less than 20,000/ $\mu\text{L}$ ” should receive platelet-concentrate transfusions. Those statements are made without regard for the tremendous controversy surrounding ventilator management and weaning strategies, the fact that bronchoscopic technique differs widely from institution to institution, and the idea that, though there are guidelines that recommend transfusion of platelets to patients who have less than 20,000 platelets/ $\mu\text{L}$ , there are certainly instances in which platelets should not be given in that situation. Widely held opinions, regional practice pref-

erences, and guidelines are presented as dogma and result in giving the incorrect impression that there is only one approach to these issues, without giving voice to the controversy that surrounds them.

If I were asked by a medical student, junior resident, ICU nurse, or respiratory therapist if **ICU Recall**, 2nd edition, would be a useful book for familiarizing oneself with relevant ICU issues, I would very quickly say *yes*. The book has great discussions of the ICU basics, and it would certainly help lay a good foundation on which more detailed understanding could be built. Everything the ICU novice needs to get started is contained in this book, and it is laid out in a readable, understandable fashion. Unfortunately, this book also contains some questions, passages, and sections that are not relevant or are answered in a manner that does not acknowledge other reasonable positions or standpoints. Perhaps if future editions contain less “chaff,” the remaining relevant “wheat” will be easier to find, use, and appreciate.

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**Cystic Fibrosis: A Guide for Patient and Family**, 3rd edition. David M Orenstein MD and 9 contributing authors. Philadelphia: Lippincott Williams & Wilkins. 2004. Soft cover, 465 pages, \$29.95.

Your assignment is to interview the family of a 1-month old infant, and the family nervously awaits you in the cystic fibrosis (CF) teaching center. The evidence is conclusive: the diagnosis is CF. The educational journey begins, and the family looks to you with worried, tired eyes: for this journey, you are the guide. You go to your files and begin to collect the dog-eared copies and pamphlets used in patient education, noting that some are copies-of-copies, in poor condition, outdated, and in some cases, illegible. You look to your clinic teammates and ask, “Now what do we do?”

David M Orenstein and 9 contributing authors have responded to this dilemma with the finely crafted text **Cystic Fibrosis: A Guide for Patient and Family**. This guide is a superb work that views patient education through the “tired eyes” of the concerned family member, and the narrative is aimed at creating dialogue between a mul-

tidisciplinary health care team and patients or family members who wish to learn about CF. Dialogue, in this case, suggests that well-informed patients and family members will ask better questions, resulting in the need for better-informed CF team members, medical staff, and educators on the issues that are daily confronted by people living with CF.

The book is affordably priced, and the 3rd edition is the benchmark against which all CF patient-education texts should be measured. It is one of those refreshing and rare assemblages of information that present CF for what it truly is: a chameleon-like disease with a constellation of potential issues that may or may not arise as the patient matures.

The authors do not use specific case-study methodology, but interestingly build vignettes around events most likely to emerge as the patient grows to maturity. The book is marketed and advertised as having been written for patients and families who wish to learn about CF, but it is also a must-read text for other audiences involved in all aspects of CF care.

I carefully read the book to discern the difference between it and other education resources touted as patient-focused. The primary difference is clear: Orenstein *listened*. And he dedicated the book “To all those patients and families who have so enriched my life, and have taught me so well.” In the acknowledgments, Orenstein praised his mentors Leroy Matthews, Carl Doershuk, Bob Stern, Tom Boat, and Bob Wood, who stand among the giants of pulmonary medicine. The lessons Orenstein learned from patients in his practice were also evident in his willingness to listen to clinical colleagues and family members. This book restates those lessons.

The book was printed on fine paperback stock, and I found no mistakes or spelling errors. The radiographic images ranged in quality. The image on page 58 relies heavily on arrows to give the reader an idea of what happened to the deflated lung in the case of a pneumothorax. The infant chest radiograph on page 62 is an excellent picture of atelectasis. Chest radiographs on pages 73 and 74 clearly show the difference between a normal, well-aerated chest, compared to the hyperexpanded lateral chest radiograph. The radiographs were a bit hazy (probably due to reproduction), but they did provide an important visual prompt that will (along with the explanation) create meaning for the lay-