issue with him over an aspect of end-of-life problems exemplified by the famous case of Terry Schiavo, that he believes could have been avoided by having a living will. I strongly endorse people having such end-of-life documents, but I also believe that in heated controversy over high-profile cases, legal sophistry can and often does override common sense. I also differ with Petty on his view of health-maintenance organizations (HMOs). Many of these groups have failed for reasons that seem justified, but based upon my own experience working for a successful HMO for almost 30 years, I can say the care given to its members has been the equal of that in the community. In addition many of the complaints made by people in other care programs have long ago been solved by my HMO. Petty’s complaint against the pharmaceutical industry is valid but tiresome. Making a profit is the oxygen that keeps these industries alive, and I too am disgusted with the direct advertising to patients, the exorbitant costs of new drugs, the shady attempts to manipulate clinical results of drug testing, and failure to invest particularly in research for orphan drugs, but I remain skeptical of the suggested alternatives to our present system.

The author has some advice for patients to help get the most out of our system of health care. I was struck by the naiveté in his recommendation that patients “insist that doctors take enough time to get to know us.” Most doctors in full-time practice have limits on the amount of control they have on their time, and we all have seen patients who, given the opportunity, go on and on, oblivious to the fact that the meter is running and others are waiting. He also admonishes patients to “begin to redirect medicine,” which I also take issue with, because patients can’t do it. There was a time when doctors could do it, but no longer. More and more doctors have become employees, referred to as providers, and as such they carry no more influence than others who are viewed as “caregivers.”

The last item Petty discusses I strongly applaud: the return of spirituality to the practice of medicine. I do not mean the direct injection of a doctor’s religious beliefs; rather, to be aware of and to encourage the expression of any, possibly latent, spiritual beliefs the physician may discern. I am sure Petty’s opinion on this matter reflects his experience as a patient as well as a physician, and I hope his view that spirituality is returning to medical practice is true; so many parts of this country are Laodicean, such changes will be difficult.

This is a very useful book that should appeal to most professionals working in pulmonary medicine; for doctors it should be of greater interest to those not specializing in pulmonary disorders, and those who want a brief but clear discussion of oxygen therapy, ARDS, or COPD will find it here. Medical students will find value from those sections dealing with the broader areas of medical practice as presented by an experienced physician. The book is well written with clear illustrations, though some of the photographs are somewhat blurred. There is no index, but a glossary is offered, which may be of more value to the layman, rather than to anyone already working in health care.

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The book is composed of 7 sections: asthma in the 21st century; diagnosis of asthma; assessment; management; treatment; special situations in the management of asthma; and education.

As an Expert Consult title, the book is useful to researchers and physicians, especially the sections on diagnosis, assessment, management, treatment, and special situations in the management of asthma. But respiratory therapists and nurses will find this book interesting in the sections on acute asthma management in hospitalized and intensive-care patients. The sections on environmental modification, allergen avoidance, teaching patients to manage their asthma, and asthma education are really what respiratory therapists, nurses, and asthma educators need.

Based on the 2 most important and updated guidelines, the Global Initiative for Asthma (GINA 2006) and the 2007 National Asthma Education and Prevention Program (NAEPP) Expert Panel Report 3, combined with the contributions of world experts in asthma, the authors have achieved their aims in providing a practical and useful resource for health-care practitioners in asthma management.

The material is well selected and organized. Clinical pearls of wisdom precede each chapter and help the reader to grasp key concepts. The arguments are clear and logical. Based on the 2 prestigious guidelines and references from renowned journals, the statements of fact are generally accurate. The style is clear, concise, and readable.

The chapter on the natural history of asthma into adulthood is very interesting. It raises the very important issue of protecting asthmatic children from fixed airway obstruction, which is very common.

Box 5.5 details the differential diagnosis possibilities of asthma, which is very important, but the term “recurrent cough not due to asthma” is not specific enough to be considered a cause.

The whole chapter “How Do You Diagnose Asthma in the Child?” is very important, as diagnosis is much more difficult in this patient group. The differential diagnosis in the chapter on diagnosing asthma in adults is helpful.

The chapter dealing with pulmonary function tests, which describes the elastic properties of the lungs and chest walls, pressure-volume curves, and the static pressure-volume relationship of the lungs, is not very practical for daily management of asthma. A more detailed text and illustrations of full flow-volume curves from spirometry would be much more useful.

In the chapter on clinical assessment of asthma, the part of self monitoring is very informative. The section “How Do You Classify Asthma by Severity?” compares the classification methods of NAEPP and GINA.

The section on instruments for assessing asthma control is rich and introduces the important concept of the 2 asthma-control domains: current impairment and future risk.

In the section on management of persistent asthma in children, cromolyn and nedocromil are introduced as medications for prevention and treatment of mild persistent asthma, but the authors don’t comment on the weak evidence about and debatable efficacy of these drugs.

The pros-and-cons tables in the section on management of persistent asthma in adults are real pearls. They provide convincing, original, and important arguments.
that will help physicians choose appropriate strategies.

The whole chapter on monitoring for adverse effects of treatment is excellent. The adverse effects, monitoring parameters, and prevention strategies in Table 35-2 give clear guidance on this important issue.

The section on treatment, which provides details on new medications such as soluble tumor-necrosis factor (TNF) receptor, humanized anti-TNF, and anti-interleukin-1β antibodies, is interesting, as these are usually presented sparsely in the guidelines.

I believe the section on special situations in asthma management will satisfy clinicians, as it details all the common and rare situations.

The last section, on asthma education, is very special, as it provides in-depth discussion of many aspects of this important issue: among them the very difficult problem of improving patient adherence to therapy. Evaluation of individual and program outcomes, which are often neglected topics, is discussed in a whole chapter!

I have some suggestions for a future edition:

- Figures 3-1, 3-2, and 3-3 should be more fully explained.
- On page 64, in the passage “β-agonist responsiveness 12% improvement of FEV₁ or an increase of 200 mL,” that “or” should be “and” (as on page 69).
- On page 65, the passage “FEF50/FIF50 > 1” should be “FEF50/FIF50 > 1.”
- On page 128, “FEV₁/PEF ≥ 60%” should be “FEV₁/PEF ≤ 60%.”
- On page 166, the legend of Figure 19.1 should define the abbreviations in the figure.
- On page 170, the dagger symbol (†) should have a corresponding footnote.
- On page 171, Figures 19.4 and 19.5 are purported to give treatment steps, but they only have classification of asthma severity and control.

The general appearance of the book is attractive. I found no typographical errors. Most of the illustrations are clear. The references cited are from peer-reviewed journals and are very good. The index is useful, and readers will find topics easily.

The authors achieved their stated aim of providing an authoritative, up-to-date source about asthma. The book provides a comprehensive yet practical review and a useful overview of recent research. Clinicians, educators, researchers, and students will find this book very helpful.

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In the last few years there has been a marked increase in airway-management devices introduced to the United States market. Even existing products such as the laryngeal mask airway have witnessed a dramatic increase in product design modification, in an effort by companies to achieve a "competitive edge" and sway clinicians toward the use of one product versus another. These "new and improved" airway devices will, hopefully, result in an increased ventilation/intubation success rate in experienced hands, with the ultimate goal of improving patient outcomes and reducing emergency airway management-related morbidity/mortality.

This decade has also seen an increasing trend toward the use of "visual aids" to intubation, evidenced by the different video laryngoscopes introduced in recent years, to the point that "blind approaches" to airway management are increasingly frowned upon as technology advances and the risks of blind approaches on patient safety are coming to the forefront.

One of the strengths of the Manual of Emergency Airway Management is its ability to compile the different airway-management devices and tools and review their indications and their roles in the difficult-airway management algorithms, while providing clear illustrations on the steps involved in their use.

The authors have identified that "emergency" airway management is not a time for trying out new equipment, and therefore walk the readers through a step-by-step approach to familiarize them with the proper techniques of using airway tools.

The Manual of Emergency Airway Management is divided into 7 sections. The first section takes the reader through a series of "logically flowing" chapters. The reader is introduced to the indications of intubations, followed by the "core" chapter on the emergency airway algorithms. This is by far the hardest chapter to digest, and, despite the author’s attempt to provide a basic overview of the universal emergency airway algorithms and how the different algorithms interact, it requires more than one reading in order to be able to reproduce the steps in an emergency situation. In addition, some parts of the difficult-airway algorithm may be confusing, such as the author’s statement that, “if there is a reasonable likelihood of success with oral intubation, despite the difficult airway, then rapid-sequence induction (RSI) may be undertaken.” The authors, however, explain their rationale for this approach in Chapter 7, “Identification of the Difficult and Failed Airway,” and help the reader in understanding the dimensions and predictors of a difficult airway.

Chapter 5 of this section is a must-read for anyone involved in airway management. It uses comprehensive illustrations to teach the most important skill in airway management: the ability to provide effective bag-mask ventilation.

A drawback in this chapter is the use of non-transparent face masks in the illustrations. The disadvantage of these masks, as the authors mention in the text, is the lack of immediate recognition of regurgitation of stomach contents, and the potential for subsequent aspiration, since these non-transparent masks block the operator’s view from recognizing what’s underneath the mask. Unfortunately, the authors also chose to use the same type of non-transparent mask for their front-page illustration, which can give the reader a false impression that the book is outdated.

Each chapter in section 2 is dedicated to the step-by-step, illustration-enhanced description of an intubation technique (lighted stylet intubation, flexible fiberoptic intubation). I found this section a very effective teaching tool for enhancing the clinician’s familiarity with airway equipment and its correct use. Even airway management experts are likely to find an airway gadget in those chapters that they have not utilized before.