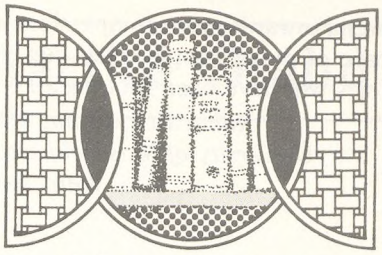
Book Reviews



Exercise in Cardiovascular Health and Disease. *Ezra A. Amsterdam, Jack H. Wilmore, Anthony N. De Maria, (editors). Yorke Medical Books, New York, 1977, 384 pp., $33.00.*

The editors have assembled a truly outstanding group of contributing authors in the preparation of this fine new book. Exercise is currently one of the most pertinent aspects of prevention and rehabilitation in cardiovascular disease. The material covered in the book is divided into five major parts. Part I is a concise, very readable treatise on the epidemiology and pathophysiology of coronary heart disease. Part II deals with physiological aspects of exercise and the biochemistry and physiology of skeletal and cardiac muscle. Much of this section is, through necessity, quite technical and may be of less interest to the nonexpert in this field. Parts III, IV, and V are of particular interest and pertinence to all clinicians who care for patients with cardiovascular disease and have interest in the preventive aspects of this epidemic disease. Chapters on methods of exercise testing, and exercise electrocardiography and its use in diagnosing latent coronary heart disease are concise, very readable, and well illustrated. An exciting, new, noninvasive technique for diagnosing myocardial ischemia using Thallium-210 scintigraphy is also presented. Preventive aspects of coronary heart disease including individualized exercise prescription and the modification of coronary risk factors by exercise have important implications for our patients. These topics along with current recommendations for physical activity following myocardial infarction or coronary bypass surgery are clearly and concisely presented in a manner useful to the physician.

The prevention of disease or improvement in the quality of life of patients with coronary heart disease involves patients of all age groups. The family physician is therefore in the forefront and must be knowledgeable and committed in this field. This book is very well written, extensively and clearly illustrated, complete yet concise, current, and the references are invaluable. It should serve practicing family physicians, clinical teachers of family medicine and family practice residents well in accomplishing the above responsibilities.

Herbert R. Brettell, MD
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Psychosocial Care of the Dying Patient. *Charles A. Garfield (ed). McGraw-Hill, New York, 1978, 430 pp., $13.95.*

This unique and very valuable book comprised of knowledge, expertise, and attitudes of 38 major contributors, provides an important resource for all those physicians and other health care professionals who are engaged in providing some aspects of psychosocial

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care of the dying. The editor's stated purpose in the first sentence of the preface is that the anthology is as much to inspire as to provide information. In fact, the book does both admirably. The book is divided into 8 parts and 39 chapters, which deal with such subjects as Guidelines for Terminal Patient Care, Doctor-Patient Relationship, Emotional Impact, Psychological Needs, and Counseling the Patient's Family. As the book is an anthology, each chapter obviously has a different style, but a remarkably uniform high quality has been achieved throughout. Each chapter is well illustrated by quotations from actual encounters with patients and their families, and is also very well referenced.

This is a book that should find a valued place not only on the book shelf of every family physician, but also often in his hands, as he refers to it in relation to dealings with particular situations. It also should be required reading for every family practice resident. Few books come into this category, but without doubt this is a valuable contribution to a topic which is becoming of increasing concern as physicians strive hard to maintain their humanity in an increasingly technological age. The last chapter outlines a course for medical students on Death and Dying, a subject which is increasingly being brought back into the medical school curriculum. A quote from the epilogue is perhaps a fitting conclusion for this brief review. "This book was compiled specifically for the purpose of affecting peoples' lives—the lives of physicians, and dying patients and their families. To the extent that the ideas and approaches are utilized in the clinical arena towards more compassionate care of dying people, then our efforts will have been successful."

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Clinical Application of Blood Gases (2nd Edition). *Barry A. Shapiro, Ronald A. Harrison, and John R. Walton. Year Book Medical Publishers, Chicago, 1977, 310 pp., $13.95.*

The second edition of this reliable Year Book manual follows four consecutive annual printings of the initial publication. The authors' intent to provide a basic text that will serve physicians, nurses, and respiratory technicians alike has resulted in sacrifice of some readability, since many concepts must be presented without extensive development. The text is, thus, more useful as a handy reference for specific data, and as a resource to standard protocols for the interpretation and clinical application of arterial blood gases.

Three major sections: basic respiratory physiology, clinical interpretation of arterial blood gases, and clinical application of blood gases, provide a logical organization of the content.

A novel section of rather brief (perhaps too oversimplified) clinical problems can be useful for self-testing. A good index and a 226-item bibliography make this small (284 page) handbook a quick refresher for codifying complex clinical data quickly for decision making.

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Regroton®/Demi-Regroton™

Brief Summary

Indication: Hypertension. (See box warning.)
Contraindications: Mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.

Warnings:

These fixed combination drugs are not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

Use with caution in patients with severe renal disease, impaired hepatic function or progressive liver disease. Regroton or Demi-Regroton may potentiate action of other antihypertensive, ganglionic and peripheral adrenergic-blocking drugs. Sensitivity reactions may occur in allergic and asthmatic patients. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Thiazides cross the placental barrier and appear in cord blood. The use of chlorthalidone and related drugs in pregnant women requires that the anticipated benefits of the drug be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Use with care in nursing mothers since thiazides and reserpine cross the placental barrier and appear in cord blood and breast milk. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. If use of the drug is essential, the patient should stop nursing. **Precautions:** Antihypertensive therapy with these drugs should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with these agents two weeks prior to elective surgical procedures. In emergency surgery, use anticholinergic or adrenergic drugs or other supportive measures if needed. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated (hepatic coma may be precipitated). Patients receiving chlorthalidone should have periodic determination of serum electrolytes and should be observed for clinical signs of fluid or electrolyte imbalance (hyponatremia, hypochloremic alkalosis and hypokalemia), particularly if they are receiving digitalis, parenteral fluids, or are vomiting excessively. Hypokalemia may develop with chlorthalidone as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather. Hyperuricemia may occur or gout be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged and latent diabetes mellitus may become manifest. Chlorthalidone and related drugs may decrease arterial responsiveness to norepinephrine. Chlorthalidone and related drugs may decrease serum PBI levels without signs of thyroid disturbance. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** These drugs are generally well tolerated. The most frequent adverse reactions are anorexia, nausea, vomiting, gastric irritation, diarrhea, constipation, headache, dizziness, weakness, muscle cramps, nasal congestion, drowsiness and mental depression. Other potential side effects include skin rash, urticaria, ecchymosis; hyperglycemia and glycosuria (diabetics should be checked regularly), hyperuricemia and acute gout, and impotence. With chlorthalidone: restlessness, transient myopia; dysuria, orthostatic hypotension (may be potentiated by alcohol, barbiturates or narcotics), rare idiosyncratic reactions such as aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, purpura, necrotizing angiitis and Lyell's syndrome (toxic epidermal necrolysis); pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged

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