

**Critical Care: The Lung (2nd edition).**  
*John B. Berté. Appleton-Century-Crofts, Norwalk, Connecticut, 1986, 282 pp., \$29.95 (paper).*

This single-authored cloth textbook has the goal of providing "the practicing physician with a workable outline" in the management of pulmonary emergencies. It is directed to an audience that the author states includes medical students, house officers, attending faculty, intensive care nurses, and respiratory therapists. The book's most distinctive features are its conversational writing style, its use of actual clinical management vignettes, and its elaboration of a set of hospital orders suitable for each of the subjects described. The nine chapters cover clinical pulmonary physiology (35 pages), aspiration and asphyxia (33 pages), respiratory failure and shock lung (58 pages), bronchospastic disorders (33 pages), pneumothorax (27 pages), pulmonary edema and pleural effusions (13 pages), hyperbaric and hypobaric states (43 pages), chest trauma and hemoptysis (10 pages), and high-frequency ventilation (4 pages). The contents of several chapters are not obvious from their title. The aspiration-asphyxia chapter includes gastric aspiration, drowning, foreign bodies, upper airway obstruction, acute chemical or smoke inhalations, air pollution and industrial exposures, and carbon monoxide poisoning. Bronchospastic disorders addressed are asthma, including status asthmaticus, pulmonary embolism, and fat embolism.

The text is well written and fun to read. For the intern struggling with a patient admitted with one of these problems, the hospital orders sections would be valuable. These orders are comprehensive in content and written clearly. The illustrations often add little. Photographs of equipment (ventilators, PEEP/retard devices,

Bennett IPPB machine, control panel of the Bennett 7200, hyperbaric chambers, etc) are equivocal in value in such a text. Schematic diagrams and small-format reproductions of chest radiographs are acceptable in quality, but not extremely helpful. It seems difficult to justify the space allocation (some might argue even the inclusion) given to the hypobaric and hyperbaric states. The chapter concerning respiratory failure and shock lung (ARDS) perhaps is the best written in the book.

As family physicians are by nature analytic, I quickly found myself comparing this work with several others: (1) *Manual of Acute Respiratory Care* by Gary Zagelbaum and JA Peter Pare (eds), Little, Brown (spiral manual series), 1982, 300 pages, \$17.50; (2) *Manual of Clinical Problems in Pulmonary Medicine* by Richard Bordow and Kenneth Moser (eds), Little, Brown (another spiral manual), 1985, 492 pages, \$18.95; and (3) *Intensive Care Medicine* by James Rippe, Richard Irwin, Joseph Alpert, and James Dalen (eds), Little, Brown, 1985, 1203 pages, \$85. The first of these comparison books (Zagelbaum, Pare) is more fundamental in approach and content. Its six contributing authors (one, Dr. Janet Christie-Seely's husband, John) have fashioned 23 chapters that provide a clear, concise summary of all the issues in Berté's text except hypobaric and hyperbaric states. Important inclusions (not found in Berté) are a chapter on acute respiratory infections and diagrams nicely illustrating many pulmonary procedures (thoracentesis, transtracheal aspiration, Gram staining a sputum specimen, etc). This manual provides an excellent starting point for medical students beginning clinical rotations. The lack of references handicaps its value to house officers.

The second manual (Bordow, Moser) provides 112 chapters written by 49 authors. Each reference has a one-sentence annotation summarizing its central idea. For size and price, this manual is an excellent work. Its text, however, is characterized by long paragraphs that tend to hypnotize the reader. It fails to provide as many useful tables or graphs as the first manual. The text is peppered with facts, but unlike many manuals of the spiral series, important data often are not emphasized by bold type or outline format. Giving this manual full marks for comprehensive topic selection, I found myself eager to return to Berté's prose and the clarity of his writing, which usually reads like a personal conversation with an attending physician, pausing to emphasize major facts and giving pragmatic advice on avoiding pitfalls of management.

The third book, because of its hardbound format, scope, and cost, may be an "orange" while the other texts are "apples," but it is such a superb textbook that it deserves comment. Gargantuan in size (142 chapters, 119 contributors, 1,203 pages, 6.8 lb), *Intensive Care Medicine* is constructed beautifully, with outstanding diagrams, well-chosen photographs, and a comprehensive text augmented by a layout that boldly announces major sections and critical facts. It devotes 17 chapters (275 pages) to pulmonary problems in the intensive care unit, including several topics not chosen by Berté: pulmonary hypertension, cor pulmonale, problems of temperature regulation, immunological lung diseases, and a detailed review of the chest radiograph. Data on mechanical ventilation and respiratory adjunct therapy are clustered as chapters rather than discussed under management sections for specific diseases.



How best to decide among these resources? *Critical Care: The Lung* would be an excellent text for medical students. It also is a wonderfully written, synoptic work that would be great to read while sitting in the intensive care unit awaiting blood gas results or in reviewing for board examination. I especially like its practical discussion of ventilator therapy, something with which house officers often struggle. I probably would carry the Bordow-Moser manual in the pocket of my white coat. If, however, I were limited to using one text, one that offered comprehensiveness, clarity, and well-referenced citations, I would opt for *Intensive Care Medicine*, certainly one of the best critical care textbooks available.

Benjamin W. Goodman, Jr., MD  
Medical University of  
South Carolina  
Charleston

**Principles of Exercise Testing and Interpretation.** by Karlman Wasserman, James E. Hansen, Darryl Y. Sue, Brian J. Whipp. *Lea & Febiger, Philadelphia, 1987, 274 pp., \$39.50.*

According to the authors, this book is designed to provide a guide for exercise physiologists and for physicians wishing to set up a laboratory for the purpose of (1) diagnosing the cause of exertional dyspnea, (2) evaluating the severity of impairment of exercise performance, and (3) evaluating the effect of medical, surgical, or physical rehabilitative therapy. This book approaches exercise evaluation from the standpoint of physiology and pathophysiology.

Chapter two, "The Physiology of Exercise," which covers the biochemistry and physiology of skeletal muscle and metabolic cardiovascular ventilatory coupling, defines the focus of the book. Measurement of the physiologic response to exercise,

touching on such measurements as maximal oxygen uptake, anaerobic threshold, flow patterns, and so on, is next discussed. The pathophysiology of disorders limiting exercise is dealt with in chapter four, which contains a nice summary table. Protocols for exercise testing at a level that is more detailed than the average family physician will utilize is then reviewed. The authors discuss arterial catheters and generally focus on a method of evaluating exercise that includes a 12-lead electrocardiogram, arterial samples for blood gas, and pH measurements taken at frequent time intervals. They favor the cycle ergometer. They review normal values and principles of interpretation.

These introductory chapters are followed by what makes up the bulk of the book, a series of 52 case presentations. Each case is marked by a series of graphs, tables, and charts as well as a somewhat more straightforward summary of selected exercise data and selected respiratory function data.

This book would not be relevant to the practice of the average family physician. It is technical and physiologically oriented and, I believe, designed to be used primarily by the exercise physiologist. It is well organized and readable, and it might be the sort of book a family physician would pull out of the library if exercise testing were a particular area of expertise. With the increased focus on fitness and in a group doing detailed cardiovascular pulmonary evaluations, this book might be of interest. I believe it would still be the unusual family physician who is doing a combination cardiac-arterial blood gas-respiratory type of evaluation of patients to evaluate dyspnea. This book is directed more to a subspecialty audience and would not be recommended for a general family medicine audience.

Charles Kent Smith, MD  
Norfolk, Virginia

**Useful Procedures in Medical Practice.** Paul W. Roberts. *Lea & Febiger, Philadelphia, 1986, 610 pp., \$34.50 (\$46 Canada) (paper).*

This text makes an attempt to compile the essential information for a wide range of procedures. Although the drawings and text for many procedures are good, there are inadequacies in the text. There is not appropriate emphasis on common procedures, and there is too much detail on procedures likely to be done only by a specialist. For example, there is a section on enucleation of the eye and no section on dilation and curettage for incomplete abortion, no section on treatment of ingrown toe nails, and a too-brief section on newborn circumcision. This text is not as concise and useful as other available texts such as *Basic Procedures in Family Practice*. The discussion relating to advanced cardiac life support is now out of date.

Although there is much useful information in this text, it is too all-inclusive of many procedures not useful for primary care and inadequate for many common procedures done by family physicians.

Sam Eggertsen, MD  
University of Washington  
Seattle

**Sir James Mackenzie MD, 1853-1925, General Practitioner (2nd edition).** Alex Mair. *The Royal College of General Practitioners, London, 1986, 374 pp., price not available.*

"When we search for the recondite and obscure we fail to recognise the simple and obvious"—James Mackenzie.

This fine biography of one of the great generalist physicians of our modern industrial society has been meticulously written by Alec Mair, who superbly collates and integrates personal reminiscences and correspondence with the early researchers in physiology and cardiology, and brings to life the character of James



Mackenzie. The book has a special relevance and appeal to family practice because it creates for us both a hero and a mentor, even though it speaks to us from history. Much that is in the book will encourage both young and mature family physicians to continue to believe in their work and contribution to society. Indeed, there are many of Mackenzie's writings from the 1920s that are worth reading for their views on primary care and medical education. The book should be offered as optional or required reading for students, residents and faculty, particularly as it is very readable in a personal and un-scholastic style.

James Mackenzie was the third son of a Scottish farmer. He left school when he was 15 years old and returned for a while to work on the farm and help in a drugstore before going to Edinburgh University. He chose to go into general practice and entered practice in Burnley, a grim industrial town in the north of England beset with poverty, oppression, human misery, and ill-health. After settling into the routine life of a town doctor, he gradually developed his skills as a human naturalist (even to the extent of writing two unsuccessful novels). He kept detailed records of his patients and began to publish case reports. He was most fascinated by the natural history of heart disease, which he was able to observe in patients over many years. He collected data on changes in size and position of the heart, murmurs, and variations in rhythm and rate. At that time the physiological basis of cardiac disease was relatively unknown. Because he could not find the answers to his questions in the current textbooks, he began to correspond with leading researchers in the field at Oxford and Cambridge. He also sent them the hearts of his deceased patients so that he could correlate the findings with earlier clinical symptoms. He invented the clinical polygraph, made by a local watchmaker, which recorded radial and venous pulse waves

in a variety of cardiac conditions and could be used in the patient's home. This device was eventually sold and copied all over the world. This work led to his first great book on heart disease and pregnancy.

Mackenzie never intended to specialize, seeing himself as a generalist with a special interest. He selected pain and cardiac disease as two areas for special study. After 13 years in practice he had become a leader in the new field of cardiology. He also began, at that time, his international career and was visited by many luminaries including Osler and Wenkebach (also a general practitioner, from Holland). Subsequently, Mackenzie moved to Edinburgh and then to London to become a specialist and internationally renowned physician and researcher.

At the peak of his career but with some warning symptoms of angina, he gave up the glamour and accolades and returned to general practice in the form of an Institute of Medical Research. The aims of this institute were simply to study the signs and symptoms of early disease and train generalists to study their practice populations. For various reasons it never became a success, and his ill-health became an obstacle to its development.

Although generalists, nowadays, are unlikely to discover new medical facts or diseases as did Mackenzie, it should be remembered that his early work was based on years of observation. Often he found out, sometime later, that someone had already studied and reported on the subject, but his data from practice and knowledge of early symptoms allowed him to place a completely different interpretation on the data. This we can still do. There are many dogmas in medicine that deserve a second look from the generalist.

*Peter Curtis, MD*  
University of North Carolina at  
Chapel Hill

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## BRIEF SUMMARY

**DESCRIPTION:** LOZOL (indapamide) is an oral antihypertensive/diuretic.

**INDICATIONS AND USAGE:** LOZOL is indicated for the treatment of hypertension, alone or in combination with other antihypertensive drugs.

LOZOL is also indicated for the treatment of salt and fluid retention associated with congestive heart failure.

Usage in Pregnancy: (see PRECAUTIONS).

**Contraindications:** Anuria, hypersensitivity to indapamide or other sulfonamide-derived drugs.

**WARNINGS:** Hypokalemia occurs commonly with diuretics, and electrolyte monitoring is essential. In general, diuretics should not be given concomitantly with lithium.

**PRECAUTIONS: GENERAL:** 1. *Hypokalemia and Other Fluid and Electrolyte Imbalances:* Periodic determinations of serum electrolytes should be performed at appropriate intervals. In addition, patients should be observed for clinical signs of fluid or electrolyte imbalance, such as hyponatremia, hypochloremic alkalosis, or hypokalemia. Electrolyte determinations are particularly important in patients who are vomiting excessively or receiving parenteral fluids, in patients subject to electrolyte imbalance (including those with heart failure, kidney disease, and cirrhosis), and in patients on a salt-restricted diet. The risk of hypokalemia secondary to diuresis and natriuresis is increased when larger doses are used, when the diuresis is brisk, when severe cirrhosis is present and during concomitant use of corticosteroids or ACTH. Interference with adequate oral intake of electrolytes will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis, such as increased ventricular irritability. Dilutional hyponatremia may occur in edematous patients; the appropriate treatment is restriction of water rather than administration of salt, except in rare instances when the hyponatremia is life threatening. However, in actual salt depletion, appropriate replacement is the treatment of choice. Any chloride deficit that may occur during treatment is generally mild and usually does not require specific treatment except in extraordinary circumstances as in liver or renal disease.

2. *Hyperuricemia and Gout:* Serum concentrations of uric acid increased by an average of 1.0 mg/100 ml in patients treated with indapamide, and frank gout may be precipitated in certain patients receiving indapamide (see ADVERSE REACTIONS). Serum concentrations of uric acid should therefore be monitored periodically during treatment. 3. *Renal Impairment:* Renal function tests should be performed periodically during treatment with indapamide. 4. *Impaired Hepatic Function:* Indapamide, like the thiazides, should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. 5. *Glucose Tolerance:* Latent diabetes may become manifest and insulin requirements in diabetic patients may be altered during thiazide administration. Serum concentrations of glucose should be monitored routinely during treatment with indapamide. 6. *Calcium Excretion:* Calcium excretion is decreased by diuretics pharmacologically related to indapamide. Indapamide may decrease serum PBI levels without signs of thyroid disturbance. 7. *Interaction With Systemic Lupus Erythematosus:* Thiazides have exacerbated or activated systemic lupus erythematosus.

**DRUG INTERACTIONS:** 1. *Other Antihypertensives:* LOZOL (indapamide) may add to or potentiate the action of other antihypertensive drugs. 2. *Lithium:* See WARNINGS. 3. *Post-Sympathectomy Patient:* The antihypertensive effect of the drug may be enhanced in the post-sympathectomized patient. 4. *Norepinephrine:* Indapamide may decrease arterial responsiveness to norepinephrine, but this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. **CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY:** Both mouse and rat life-time carcinogenicity studies were conducted. There was no significant difference in the incidence of tumors between the indapamide-treated animals and the control groups.

**PREGNANCY/TERATOGENIC EFFECTS: PREGNANCY CATEGORY B.** Diuretics are known to cross the placental barrier and appear in cord blood. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**NURSING MOTHERS:** It is not known whether this drug is excreted in human milk. If use of this drug is deemed essential, the patient should stop nursing.

**ADVERSE REACTIONS:** Most adverse effects have been mild and transient. In long-term controlled clinical studies, equal to or greater than 5% cumulative adverse reactions are headache, dizziness, fatigue, weakness, loss of energy, lethargy, tiredness, or malaise, muscle cramps or spasm, or numbness of the extremities, nervousness, tension, anxiety, irritability, or agitation; and less than 5% cumulative adverse reactions are lightheadedness, drowsiness, vertigo, insomnia, depression, blurred vision, constipation, nausea, vomiting, diarrhea, gastric irritation, abdominal pain or cramps, anorexia, orthostatic hypotension, premature ventricular contractions, irregular heart beat, palpitations, frequency of urination, nocturia, polyuria, rash, hives, pruritus, vasculitis, impotence or reduced libido, rhinorrhea, flushing, hyperuricemia, hyperglycemia, hyponatremia, hypochloremia, increase in serum urea nitrogen (BUN) or creatinine, glycosuria, weight loss, dry mouth, tingling of extremities. Clinical hypokalemia occurred in 3% and 7% of patients given indapamide 2.5 mg and 5.0 mg, respectively.

**OVERDOSAGE:** Symptoms include nausea, vomiting, weakness, gastrointestinal disorders and disturbances of electrolyte balance. In severe instances, hypotension and depressed respiration may be observed. If this occurs, support of respiration and cardiac circulation should be instituted. There is no specific antidote. An evacuation of the stomach is recommended by emesis and gastric lavage after which the electrolyte and fluid balance should be evaluated carefully.

**HOW SUPPLIED:** White, round film-coated tablets of 2.5 mg in bottles of 100, 1,000, 2,500, and in unit-dose blister packs, boxes of 100 (10 x 10 strips).

**CAUTION:** Federal (U.S.A.) law prohibits dispensing without prescription.

See product circular for full prescribing information.

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## BOOK REVIEWS

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**Clinician's Pocket Reference (5th edition).** Leonard G. Gomella, Richard Braen, Michael Olding. Appleton-Century-Crofts, Norwalk, Connecticut, 1986, 565 pp., \$16.50 (paper).

The *Clinician's Pocket Reference* is the most recent edition of a reference based on the University of Kentucky house manual entitled *So You Want To Be A Scut Monkey—Medical Students' and House Officers' Clinical Handbook*. The preceding editions were derived from a "scut monkey" program at the University of Kentucky College of Medicine. This reference manual was envisioned to be an aid to third- and fourth-year students and house officers. Though the name has changed in the fifth edition to be called *Clinician's Pocket Reference*, this book remains true to its original intention to be a significant aid to the third- and fourth-year medical student or the beginning house officer.

The book has essential segments for the beginning clinician. The manual discusses the rudimentary aspects of house staff organization, how to do a physical examination, what is essential with chart work, and then details the outlines of the numerous procedures that may need to be performed on patients in the training environment. Included are such procedures as lumbar puncture, the pelvic examination, peritoneal lavage, skin testing, and thoracentesis. There is a section on differential diagnosis both of common symptoms and laboratory values. The text then details on a very simple level what the beginning clinician would need to understand in the utilization of urine studies, clinical microbiology, use of blood gases, use of fluid and analysis of electrolytes, dietary orders, the use of blood bank products, and the use of radiology and nuclear scans. The manual is completed by an introduction to the operating room, suturing techniques, and critical care topics. The last section is a brief introduction to commonly used drugs.

The manual is well written, well organized, and is a good addition to the armamentarium of the beginning clinician. It would be an excellent gift for a medical student. The title is not appropriate, however. Most experienced clinicians would find this reference to be not detailed enough and too simple for their needs. The practicing family physician would not find this reference useful as part of the office library.

Bruce C. Perry, MD, MPH  
Group Health of Puget Sound  
Lynnwood, Washington

**The Medical Annual—1986.** D. J. Pereira Gray (ed), Jill Pereira Gray (asst ed). PSG Publishing, Littleton, Massachusetts, 1986, 293 pp., \$35.

*The Medical Annual—1986* is a clearly written review of important primary care studies found in the British and European literature as well as commentaries on recent rules and regulations passed by the National Health Service and by The Royal College of General Practitioners.

Efficiently organized into five sections, this volume addresses the current clinical practice of medicine as well as societal and practice management issues. Specifically, the defined areas deal with (1) health and disease, (2) human development, (3) human behavior, (4) medicine and society, and (5) practice organization.

The first three sections are of particular interest to the American family physician. The studies reviewed in these sections offer significant contributions to the ambulatory management of hypertension, diabetes, respiratory diseases, and the cost effectiveness of domiciliary care. A controlled study of women who had pregnancies following previous induced abortions suggested that the consequence of abortion upon subsequent pregnancy was negligible.

The section on human behavior



# Portrait of the Great American Investor

cites studies supporting the effectiveness of intervention in tobacco, alcohol, and drug abuse that are encouraging to the weary practitioner.

Of special importance for all primary care physicians were the findings of Freeling et al, who demonstrated the relative insensitivity of general practitioners to the diagnosis of depression in their patients. Almost one half of waiting room patients identified as severely depressed by this study went unrecognized by their physician.

The last two sections are more germane to the problems of bureaucratic control of the physicians of the United Kingdom and the efforts being made by the physicians to ensure their needs for equipment, personnel, and continuing medical education. Although the issues are somewhat different from our own, this section sends a foreboding message to the US physician who is becoming increasingly under government control.

The reviewer found this book to be interesting, clearly written, and thought provoking. The resources that enable the National Health Service to gather detailed information from an extraordinary population base is impressive. In one hypertension study, 17,345 double-blinded patients were screened from one-half million citizens. This resource book is excellent for review of pertinent research literature in primary care conducted in the United Kingdom and Europe.

I recommend it as a reference source in the libraries of medical teaching hospitals and institutions.

*D. Stratton Woodruff, MD  
Bryn Mawr, Pennsylvania*



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