what overemphasized. Noninvasive positive-pressure ventilation and pulmonary rehabilitation programs are adequately covered. The 6-full-pages discussion on lung-volume-reduction surgery is thorough but somewhat out of proportion in length, especially when compared to the 4 lines dedicated to lung transplantation.

The review of COPD exacerbation in Chapter 6 covers the standard etiologies and treatments, including an excellent discussion on and practical approach to noninvasive positive-pressure ventilation. Limitations of this chapter include the lack of references to studies that support the use of systemic corticosteroids. The author's conclusion that "use of intravenous glucocorticoids is also controversial" is not supported by more recent studies. Theophylline is also not discussed, despite its use in one of the case studies in the last chapter.

The short chapter on outcome measures provides a good discussion of the limitations of traditional physiologic measurements in COPD and gives a good review and comparison of various health-related questionnaires. Chapter 8 explores the economic burden of COPD in the United Kingdom and some of the barriers to timely diagnosis and treatment of the disease. It discusses the importance of good spirometry technique, but, rather than reviewing appropriate technique, the author refers clinicians to spirometry courses. Self-management action plans similar to those used by asthma patients are briefly mentioned, but details are only referenced and not discussed.

The final chapter consists of 3 case studies, covered in 3 pages, with each case followed by a very short discussion. These are representative COPD cases, with typical problems and standard treatments. The author steered clear of any controversial issues and missed the opportunity to discuss such topics as inhaled and systemic corticosteroids, which frequently arise in the routine care of these patients.

Taken in total, **Clinicians' Guide to Chronic Obstructive Pulmonary Disease** is well written and relatively free of typographical errors. It does provide a good, broad overview of COPD that many respiratory professionals would find useful, especially if only a short, relatively inexpensive reference is needed. However, it probably does not provide enough detail or adequate references about some of the more controversial issues to allow a practitioner to make an informed decision on the best treatment options for his or her particular patient.

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REFERENCE

1. Fabbri LM, Hurd SS; GOLD Scientific Committee. Global strategy for the diagnosis, management and prevention of COPD: 2003 update. Eur Respir J 2003;22(1):1–2.

100 Questions & Answers About Chronic Obstructive Pulmonary Disease. Campion E Quinn MD. Sudbury, Massachusetts: Jones and Bartlett Publishers. 2006. Soft cover, illustrated, 175 pages, $16.95.

In the introduction to this book, Dr Quinn purposefully defines the work as a reference text for patients with chronic obstructive pulmonary disease (COPD) and their families. What it is not, he declares, is a comprehensive narrative, but a bare-bones listing dealing only with useful, factual information and commonly asked questions about COPD. The words this prominent East Coast physician employs to sum up his objectives clearly limit the work's intended usefulness to that of an organized resource for patients in search of unvarnished counsel on facing their hard-to-define disease.

Who am I, then, to suggest that the book offers more than its author meant it to? More to the point is who I was—a professional writer/editor/critic, an inveterate traveler, a theater-lover, and a weekend haunter of antique shops and flea markets. Oh, and long-time smoker. Of cigarettes. Who I am now is a COPD patient, diagnosed some 5 years ago, but probably harboring the developing dysfunction at least a decade longer. As a native Texan living in Dallas, I am doubly fortunate in having continuing access to the myriad supportive resources required to help growing numbers of us survive by learning to live with a too-mildly-named disease—one that cannot be cured but only somewhat delayed in its progress.

What Dr Quinn's book includes is several influences that bring softening warmth to the more chilling facts necessarily contained in his honest answers to COPD questions. Immediately following his steely introduction, for instance, is a prologue of deep personal intensity. Titled "COPD Is Not a Death Sentence," its writer, retired East Coast journalist Susie Bowers, touchingly recounts her own surprise midlife diagnosis as a patient with severe COPD, whose reduced life expectancy is being enriched by her deeper pleasure in making time to savor it. Ms Bowers is co-founder and editor of http://www.copd-international.com, and she writes a weekly online newsletter.

When the answer to the book's very first question involves a bald admission that there is no cure for COPD, a couple of italicized paragraphs appear, pointing out some of the ways the illness's progress may be slowed. Modestly referred to as "Cecil's Comments," subsequent similar interpretations appear frequently throughout the book when hopes seem thinnest. It goes unexplained who Cecil is; I assume he is an interested patient participant in Dr Quinn's practice. For the book's reading patients, in any case, Cecil's comments are a godsend.

The page layout format followed throughout is often useful. Straight copy blocks are set nearer the bound side of the pages, allowing unusually wide margins on the outside for brief drop-in definitions and clarifications of terms contained in the narrative. These terms are printed in smaller, boldface type that separates them cleanly from the text they explain. This placement offers time-saving relief from having to refer, say, to a footnote. Less effective, though, are the italicized marginal repetitions of statements lifted verbatim from the text alongside them, prompting pauses in continuity of subject matter. These might have been more effective left in their narrative position, possibly in bold type for emphasis.

Apart from such allowable idiosyncrasies, Dr Quinn's book seems to me to be exactly what he promised: a scrupulously chronicled catalog of 100 questions and answers about COPD. That he chose to divide the book into 10 parts seems instantly logical. So, however, is the discovery that parts do not break cleanly into 10-question segments; COPD, like the lungs it affects, is far too multi-branched to fit tidily into numbered cells of knowledge.

The first question grows from a simple one-sentence answer to varied listings of multiple causes, symptoms, and affected body parts and processes involved in the developing disease. Those that naturally fol-

low pick a revealing view through the mystery affliction's contradictions.

Is COPD the same as emphysema and chronic bronchitis? As asthma? Yes and no, with how and why. Is COPD serious? It is the fourth leading cause of death in this country and expected to move up to third in the next 15 years. Can COPD be cured? No. But, in the first genuinely heartening statement contained in this section, the doctor points out that in most cases its progress can be vastly slowed. This thin ray of sunshine, though, is clouded by the fact that the symptoms of COPD are obvious to those who have them—smokers, usually—who tend to feel that phlegm and shortness of breath are just part of smoking or aging, and who always detect their presence but without recognizing them as part of a disease. Almost bitterly, Dr Quinn points out the alarming fact that while 70% of smokers see a primary physician at least once a year for some reason, few of these clinicians bother to review the history of smoking and symptoms that would identify those who could be saved by early diagnosis.

If I may interject a personal bit of my own history here, I am prompted to mentally replay the mild passing counsel I heard from various clinicians in my own past, including those who kindly suggested I might try to give up smoking. Some even urged, gently, and almost all were willing to prescribe a patch or tranquilizer that might help me quit. None, however, had ever suggested testing for anything as specific as COPD. I heard the term only after an alert leader of the aquatic exercise program I finally tried to join referred me to a pulmonary program. I share Dr Quinn's bitterness more deeply than I can say.

Without laboring the point-by-point thoroughness with which they are developed, the 9 parts succeeding the first apply the same disciplined relevance to their subjects. Part 2's discussion on complications and associated diseases segues seamlessly into Part 3's discussion on lung-function monitoring and Part 4's discussion on living with COPD. In Part 5, Questions 54 and 56 correct myths about smoking and COPD and provide realistic advice for quitting. Part 6 explores medical treatment of COPD. Questions 57 through 73 define β agonists, steroids, and expectorants, and discuss specific treatment suggestions for the different levels of COPD. Part 7, on oxygen therapy for COPD, suggests general guidelines for proper care and safety of oxygen and oxygen medical equipment, and defines oxygen-related therapy.

Part 8 discusses the steps in a pulmonary rehabilitation program and answers common questions on this important subject. Part 9 describes and explains surgical treatment of COPD, discussing candidacy for lung-volume-reduction surgery, lung transplantation, and bullectomy. Part 10 sets out nutritional guidelines for people with COPD, including the effects of deficient diets, anabolic steroids, alternative medicines, malnourishment, and the impact of nutrition on immunity.

Ultimately, Dr Quinn's altogether helpful book applies more specifically to its avowed subject matter than any other I've encountered that covers the same ground, with authority and conviction. His 100 questions and answers provide a multitude of correlating facts that call for further reading and research. To that end, the book includes an unusually extensive appendix, glossary, and index, which fill some 25 pages. In my opinion, the near-total lack of illustrations does not detract from the book's strong impact as a basic reference.

In conclusion, I'd like to thank Cheri Duncan RRT, Pulmonary Rehabilitation Coordinator for Baylor University Medical Center at Dallas, Texas, for recommending me as this book's reviewer; and the rest of the pulmonary staff for keeping me alive.

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Current Essentials of Critical Care. Darryl Y Sue MD and Janine RE Vintch MD. New York: Lange Medical Books/McGraw-Hill. 2005. Soft cover, 293 pages plus index, $29.95.

Pocket reference books, designed to be a "peripheral brain" for health-care providers, are available for almost every specialty in medicine. A new critical care pocket reference guide, **Current Essentials of Critical Care**, is available from Lange Medical Books. Although the editors do not explicitly state their target audience, this hip-pocket-sized manual advertises itself as a "must for medical students, residents, internists, surgeons, anesthetists, nurse practitioners, and physician assistants." This paperback contains single-page reviews of 234 clinical syndromes that commonly occur in the critical-care setting. Each review addresses the diagnosis, differential diagnosis, and treatment, using bulleted points, and concludes with a clinical pearl and a single citation of interest. The topics are grouped by organ system (eg, pulmonary, renal, cardiology) or conceptual grouping (eg, supportive care, pregnancy).

With its advertised audience including physicians, medical students, and clinical providers, this book may be courting too large a readership. The brevity and breadth of the topics make it useful to anyone working in a general intensive care unit (ICU) with both surgical and medical patients, but it lacks the depth that most physicians, physician's assistants, and nurse practitioners need. Its concise and digestible structure is ideal for students rotating through an ICU clerkship. Respiratory therapists might find this book helpful for understanding the clinical syndromes that necessitate mechanical ventilation, but they may be disappointed to see their role in the ICU summed up in a few bulleted pages.

The breadth of topics covered is the book's strongest point. They include standard critical-care pocket-book topics such as shock and acute respiratory distress syndrome, as well as some less-commonly covered topics such as critical care in pregnancy and end-of-life care. The dermatology chapter offers excellent coverage of germane and often overlooked dermatologic critical-care topics, such as miliaria, toxic epidermal necrosis, and drug reactions.

The book has a well-defined structure; each page covers a single topic with bulleted points, a clinical pearl, and a citation. This structure would make it perfect for a medical student trying to cram studying into a busy call night, or an ICU nurse who wants a quick review of botulism before a patient arrives from the emergency department. Unfortunately, the single-page format gives disproportionate weight to certain subjects while minimizing others. Ventilator-associated pneumonia (VAP) receives only a single bulleted page, as does iron-overdose and *Mycobacterium tuberculosis*. Both of the latter diseases appear infrequently in the critical-care arena, whereas VAP occurs in 10–25% of ventilated patients. Yet each topic receives a page in the book, which might cause inexperienced readers to overestimate the importance and frequency of certain diseases.

The quality of recommended management is excellent, although occasionally it is compromised by the constraints of the single-page format. In the page on acute

Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by airway obstruction due to inflammation of the small airways. It is caused predominantly by inhaled toxins, especially via smoking, but air pollution and recurrent respiratory infections can also cause COPD. Some individuals are genetically predisposed to COPD, particularly those with Î±1-antitrypsin deficiency (AATD). Chronic obstructive pulmonary disease is a lung disease that is characterized by a persistent reduction of airflow. The symptoms of COPD are progressively worsening and persistent breathlessness on exertion, eventually leading to breathlessness at rest. It tends to be underdiagnosed and can be lifethreatening. The more familiar terms â€œchronic bronchitisâ€ and â€œemphysemaâ€ have often been used as labels for the condition. Risk factors. The primary cause of COPD is tobacco smoke (including secondhand or passive exposure). Other risk factors may include Chronic Obstructive Pulmonary Disease Dorsal Respiratory Group Internal Intercostal Muscles Blood Pressure Regulation Total Lung Capacity. Terms in this set (127). What three regions is the Pharynx divded into?Â â€¢ ANSWER 1. Cardiac disease. â€¢ Rationale: â€¢ Many elderly women complain of vague symptoms when having a myocardial infarction including fatigue, epigastric pain, and sleep disturbances. Pancreatic disease would present pain in the abdominal region. Chronic Obstructive Pulmonary Disease, or COPD, is a disabling and potentially fatal illness affecting more than 13 million people and is the fifth leading cause of death in the United States.Â Written by a prominent physician and leader in patient support for this devastating lung disease, with commentary from an actual COPD patient, 100 Questions & Answers About Chronic Obstructive Pulmonary Disease gives you authoritative, practical answers to your questions, including diagnosis, medical, surgical, and rehabilitative treatment options, how to work with your physician to improve your health and avoid hospitalizations, cautions and pre-cautions Chronic obstructive pulmonary disease (COPD) is comprised primarily of three related conditions: 1) chronic bronchitis, 2) chronic asthma, and 3) emphysema. With each of these three conditions there is a chronic obstruction of air flow through the airways and out of the lungs. The obstruction generally is permanent and may progress over time. Patients with COPD are often classified by the symptoms they are experiencing at the time of an increase of the symptoms of the disease.Â In rare cases, COPD may be caused by alpha-1 antitrypsin deficiency. Alpha-1 antitrypsin deficiency is an inherited disorder that can cause lung disease in adults and liver disease in adults and children. back to top â†‘. Q:Out of 100 smokers, how many will likely develop COPD? A:15.