ducible angina of effort. Sheehan from the Seattle group has contributed an excellent chapter on occlusion and reperfusion of the coronary artery bed, but makes the point that occluding thrombus and not spasm is the problem in most clinical situations.

Finally, the last seven chapters are devoted to an extensive review of the treatment of coronary artery spasm, with a sensible discussion on the rare need for bypass surgery by the editor. This book is clinically oriented and will serve as a useful source, both for the researcher in this subject and the general cardiologist.

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Reoperative Surgery of the Abdomen, ed by Donald E. Fry (Dekker).

Reoperative surgery is a difficult subject. It is difficult sometimes for the surgeon to admit emotionally and intellectually that a patient must be returned to the operating room, and it is frequently difficult technically to do so. This text is one of the few contributions to this area. Another similar book previously published which should be consulted is *Reoperative Gastrointestinal Surgery* by Drs. Thomas T. White and R. Cameron Harrison.

The topics are principally abdominal-gastrointestinal in nature with chapters on vascular surgery, transplant surgery, endoscopy, and urology. The primary thrust of the book is its gastrointestinal content.

Not all of the text contains advice in reoperative surgery. A considerable portion of the book can be considered to deal with primary surgical topics and not necessarily reoperations. The quality of the chapters was variable; some of the chapters were excellent, others were too basic, or were long and not well organized. The chapters on surgery for recurrent peptic ulcer disease and reoperation for postgastrectomy syndromes were concise and informative. Some duplication of material among chapters was found.

The surgeon with a gastrointestinal interest would most likely benefit from this text. I do not feel that enough material exists to make it a worthwhile purchase for the vascular, transplant, endoscopic, or urologic surgeon. The difficulty in assembling a textbook of this nature is recognized. Reoperative surgery is one of the humbling and frustrating parts of medicine.

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Patient-Controlled Analgesia, by M. Harmer, M. Rosen, and M. D. Vickers (Blackwell)

Relief from postoperative pain can be successful but seldom is, and the drugs are not to blame. Fixed doses of analgesic are ordered, nurses may reduce these, and patients vary. The routine has prevailed for decades since it is simple, economical, undemanding, and safe—because the doses are so often ineffective. Patients undoubtedly would be better off now if the effort to develop new analgesic drugs had included improving the method of administration. This publication, under the auspices of the European Academy of Anaesthesiology, provides some incentive for change.

Among the 25 participants are two from the U.S.A. and eight representing manufacturers of equipment; the foreword is by E. M. Papper, former Dean of the University of Miami and also prominent in the annals of American anesthesiology. The title is self explanatory: the doctor prescribes, the nurse prepares, but the patient controls (with a simple push button) increments of opiate according to need. Although the intravenous route has received most attention, the technique is being applied epidurally and intramuscularly; sublingual buprenorphine and sustained-release oral morphine are also mentioned here.

There are three main sections, the first concerned with terminology, with the pharmacokinetics of opiate administration, with patient characteristics which influence pain relief, and with the design of clinical trials. Jargon definitions are few—"lock-out time," which is the minimum period between patient-controlled doses, and the familiar "bolus," applied here to increment or infusion (solid matter made liquid by common medical usage!). Doubt is expressed about applying pharmacological data to patients who are in pain and in complex states of postoperative recovery; age (rather than body weight or sex) has the greater influence on opiate requirement; and doses with PCA are no lower than by conventional methods (for example, 30 mg morphine per day).

The second section deals with equipment and its design. "Nonlinear" demand interferes with mathematical models for PCA, and so does the wide variation between patients. Another snag to greater machine control is the poor relation between analgesia and plasma concentration of drug. Among design options, compactly summarized in a table, the most variable is the facility for infusion, continuous or intermittent, patient regulated or not, sometimes using microprocessors to calculate future dose from past requirement. The main features of eight machines are listed on a two-page spread (only two U.S. suppliers being named at the time of publication).

Most of the clinical information is in the third section, beginning with an impressive review, from Upsalla, of the performance record of the first 15 years of PCA (yes, it is so long in a few centers). Respiratory depression, the threat lurking in all discussions of PCA, is considered specifically, for it may fluctuate according to pain and conscious level. Precautions are emphasized: to limit bolus size, to protect against air embolus and accidental overdose, to use special intravenous cannulas. For reassurance, one contributor refers to 4,000 administrations of PCA

without a fatality. And, in a comparison of 11 drugs given after cholecystectomy (a popular operation for study), morphine holds its place as miraculously as ever, but with strong competition from fentanyl—shorter acting, more controllable. Also described here are a single trial in obstetrics and one for terminal cancer.

With this technique, pain relief cannot be constant and complete; if it were, the patient would not be motivated to press the button, which again raises the issue of machine, rather than patient, control, with feedback from sources poorly defined but certain to include respiration (the current apnea-monitors being considered inadequate). The impression gained is that a computerized infusion upon which small "on-demand" doses can be superimposed will be more effective than a simpler "press-when-it-hurts" system.

Surgeons and anesthesiologists in a reactionary mood ("there is nothing new," etc.) may feel supported by the general view that most patients do not try for complete analgesia but settle for a tolerable level of pain; and why not make use of all this information from PCA to improve conventional methods? But now we are exposed to media coverage of new methods of pain management after surgery; an individual patient may request epidural morphine; and there are even signs of interest from disciplines remote from the surgical environment. Some of us, reminded of the slow development of intensive care by the dedicated few, may foresee a similar acceptance by attrition: space and staff, step-down units for individualized pain relief after selected procedures. As to expense, the estimates seem trifling when amortized over three to five years. Whereas the price of pain is incalculable.

The book is easy to read, well printed, with few obvious slips (some erratic editing of references and, on page 4, a comic spelling error related to the acronym PCA).

Over the years, some of the bitterest comments about the inadequacy of postoperative pain relief have been penned by doctor-patients. This publication is recommended to all who are in a position to accept a challenge as humanitarian as any existing today. The time for change is now.

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Positive Approaches to Living with End Stage Renal Disease: Psychosocial and Thanatologic Aspects, ed by Mark A. Hardy, Gerald B. Appel, John M. Kiernan, Austin H. Kutscher, Martha L. Orr, Carole Smith Torres, and Lissa Parsonnet (Praeger).

This volume approaches many issues which impact on patient care from a perspective too often forgotten by health care professionals. While we tend to judge success or failure of treatment modalities from an objective standpoint as it involves life or death, working or not working, graft success vs. graft failure, multiple issues keenly linked to the overall effect of the disease process and treatment on the patient tend to be forgotten.

The variety of contributing authors to this volume, which include physicians, social workers, nurse educators, and patients, blends together a common theme emphasizing the patient with chronic renal failure as the focus of total medical care. This book not only raises issues relevant to the quality of life for patients with end stage renal disease, but offers helpful insights into dealing with those life issues that patients and families with renal failure face.

While the term thanatology is little known to physicians and allied health professionals, it is an approach to patients and disease that emphasizes a form of care giving that encompasses a link between the patient's emotional status and the disease process, a heightened awareness and understanding of the dying process, and the impact of treatment, whether it be successful or unsuccessful on the actual individual. Since many peaks and valleys occur in the treatment of chronic renal failure, it is important to understand alternative ways of improving the quality of life for patients beyond the actual treatment success or failure.

The content of this book may be divided into two specific areas: the first dealing with transplantation and the second with chronic dialysis. The approach to the presentation of material offers insights through actual patient cases, as well as the input of certain authors who themselves had experienced transplants and/or dialysis.

Those issues related to organ donation (presumed consent, living nonrelated donors), physiological stresses, national policy, and the impact of the transplant experience on patients and family are reviewed. A number of chapters raise more issues than provide solutions, but the mere presentation of these issues improves our awareness, which in itself will improve the quality of care.

As the population of patients within the United States requiring dialysis increases, both in numbers and age, a critical view to preparing patients for the dialysis experience and transferring information to them regarding this treatment modality is extremely important. Too often patients enter dialysis programs with heightened expectations which can never be achieved by the actual treatment selection. Information should be given to patients by thorough pre-crisis or pre-ESRD education. Patients need to grow with the idea of dialysis and how their life could fit into the regimen of a specific dialytic therapy. Not only is the introduction of information early on important, but numerous questions arise for a number of people who may not totally benefit from initiating dialysis or continuing therapy. This aspect of care is emphasized by R. Freeman, M.D., in the chapter entitled "Living with End Stage Renal Disease: Prolonging Life or Extending the Dying Process."

The physician who does not deal with end stage renal disease may not find this book helpful in the