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1	incidence of kidney disease in patients with diabetes Details	569	Display
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Irwin & Rippe's Intensive Care Medicine
Editor(s): Irwin, Richard S., Rippe, James M.
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[+] Principles of Operation
[+] Conventional Positive-Pressure Ventilation
[+] Disease-Oriented Mechanical Ventilation Strategies
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[+] 59 - Mechanical Ventilation Part II: Noninvasive
[+] 60 - Mechanical Ventilation Part III: Discontinuation
[+] 61 - Gas Embolism Syndromes: Venous Gas Emboli, Arterial Gas Emboli, and Decompression Sickness
[+] 62 - Respiratory Adjunct Therapy
[+] 63 - Chest Radiographic

37. Hilbert G, Gruson D, Vargas F, et al: Noninvasive ventilation in immunosuppressed patients with pulmonary infiltrates, fever, and acute respiratory failure. N Engl J Med 344:481–487, 2001.
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38. Girou E, Schortgen F, Delclaux C, et al: Association of noninvasive ventilation with nosocomial infections and survival in critically ill patients. JAMA 284:2361–2367, 2000.
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39. Azoulay E, Alberti C, Bornstain C, et al: Improved survival in cancer patients requiring mechanical ventilatory support: impact of noninvasive mechanical ventilatory support. Crit Care Med 29:519–525, 2001.
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40. Brochard L: Non-invasive ventilation for acute exacerbations of COPD: a new standard of care (editorial). Thorax 55:817–818, 2000.
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41. Antonelli M, Conti G, Bufi M, et al: Noninvasive ventilation for treatment of acute respiratory failure in patients undergoing solid organ transplantation: a randomized trial. JAMA 283:235–241, 2000.
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42. Antonelli M, Conti G, Rocco M, et al: A comparison of noninvasive positive-pressure ventilation and conventional mechanical ventilation in patients with acute respiratory failure. N Engl J Med 339:429–435, 1998.
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LIPPINCOTT WILLIAMS & WILKINS

Critical Care Medicine
OFFICIAL JOURNAL OF THE SOCIETY OF CRITICAL CARE MEDICINE

Volume 29(3) March 2001 pp 519-525

Improved survival in cancer patients requiring mechanical ventilatory support: Impact of noninvasive mechanical ventilatory support

[Clinical Investigations]

Azoulay, Elie MD; Alberti, Corinne MD; Bornstain, Caroline MD; Leleu, Ghislaine MD; Moreau, Delphine MD; Recher, Christian MD; Chevret, Sylvie MD PhD; Le Gall, Jean-Roger MD; Brochard, Laurent MD PhD; Schlemmer, Benoît MD

From the Medical Intensive Care Unit (Drs. Azoulay, Bornstain, Leleu, Moreau, Recher, Le Gall, and Schlemmer) and the Department of Biostatistics (Dr. Chevret), Saint Louis University Hospital and University Paris 7; and U444-INSERM, Medical Intensive Care Unit (Dr. Brochard), Henri Mondor University Hospital and University Paris XII. Assistance publique des hôpitaux de Paris, France.

Upstream management of critically ill cancer patients may increase the chances of longer survival with an acceptable quality of life.

Presented, in part, at the Congress of The French Society of Critical Care Medicine in January 2000.

Address requests for reprints to: Elie Azoulay, MD, Medical ICU, Saint Louis University Hospital, 1 avenue Claude Vellefaux, 75010 Paris, France. E-mail: elie.azoulay@sls.ap-hop-paris.fr

Outline

- Abstract
- PATIENTS AND METHODS
  - Cohort Study.
  - Exposed–Unexposed Nested Cohort Study.
  - End Points.
  - Statistical Analysis.
- RESULTS
  - Cohort Study
    - Chronic Health Status and Co-Morbidities.
    - Characteristics of the Malignancy.
    - Patient Characteristics.

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1. **Source:** *Hurst's The Heart*

Editors: Valentin Fuster, R. Wayne Alexander, Robert A. O'Rourke

Publisher: McGraw-Hill, 2001

Chapter: WOMEN AND CORONARY ARTERY DISEASE

Passage: ... on diagnosis begins with discussion of the ways that CAD presents in asymptomatic women and then reviews models to assess CAD risk with attention

1. **Source:** *Hurst's The Heart*
Editors: Valentin Fuster, R. Wayne Alexander, Robert A. O'Rourke
Publisher: McGraw-Hill, 2001
Chapter: WOMEN AND CORONARY ARTERY DISEASE
Passage: ... on diagnosis begins with discussion of the ways that CAD presents in asymptomatic women and then reviews models to assess CAD risk with attention to gender. Finally, symptomatic CAD in women is discussed, including the management of the women with angina and myocardial infarction. The chapter closes with an update on gender differences in sudden death. PREVENTION: GENDER-SPECIFIC ISSUES It is especially important to identify women at high risk for CAD for possible primary prevention. Young women with coronary artery mortality4 are more likely to have a history of tobacco exposure, obesity, hypertension, diabetes, early menopause, or, less often, cocaine abuse.5 These risk factors are also important in predicting nonfatal myocardial infarction.1 Gender differences are reviewed in ...

Complete Reference • Ovid Full Text

Score: ★★★★★

2. **Source:** *Oxford Textbook of Clinical Nephrology*
Editors: Alex M. Davison, J. Stewart Cameron, Jean-Pierre Gruunfeld, David N.S. Kerr, Eberhard Ritz, Christopher G. Winearls
Publisher: Oxford University Press, 1998
Chapter: Clinical approach to hypertension
Passage: ... over what the target blood pressure should be in treating essential hypertension since it has been suggested that there is a J-shaped curve relating mortality to treated blood pressure. In patients with known ischaemic heart disease the least mortality was seen when the diastolic blood pressure was 85 to 90 mmHg and was signficantly greater when the diastolic blood pressure was less than 85 mmHg (Cruickshank et al. 1987). However, a similar pattern was seen in the 'Heart attack primary prevention in hypertension' study, from which patients with ischaemic heart disease were excluded (Wilhelmsen et al. 1987), and others have also been unable to relate increased mortality at lower diastolic pressures to cardiovascular complications at entry (Staessen et al. 1989). It has ...

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Score: ★★★★★

3. **Source:** *Drugs in Pregnancy and Lactation*
Editors: Gerald G. Briggs, Roger K. Freeman, Sumner J. Yaffe
Publisher: Lippincott Williams & Wilkins, 2002
Chapter: TIMOLOL
Passage: ... after myocardial infarction, for the prophylaxis of migraine headache, and topically for the treatment of glaucoma.

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Score: ★★★★★

4. **Source:** *Novak's Gynecology*
Editors: Jonathan S. Berek
Publisher: Lippincott Williams & Wilkins, 2002
Chapter: Primary Care in Gynecology
Passage: ... small molecule in biology (33). The dietary influence of cholesterol on atherosclerosis and its relationship to hypertension and cardiovascular events (myocardial infarction and stroke) has been widely debated in both the scientific and lay communities (34). The controversy centers on the influence of dietary cholesterol in risk assessment and prevention of cardiovascular disease (35). Many assume that all cholesterol and fat in the diet have negative health consequences. Furthermore, cholesterol metabolism is complex and our understanding in some cases is extrapolated from animal models. The role of cholesterol testing (who, when, and at what age) is hotly debated among health care professionals. Cholesterol testing is fraught with multiple variables that affect results. The ...

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Irwin & Rippe's Intensive Care Medicine
Editor(s): Irwin, Richard S., Rippe, James M.

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[+] II - Cardiovascular Problems and Coronary Care
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Anticonvulsants

Cynthia K. Aaron

Anticonvulsants can be divided into four groups based on their primary mechanism of action: those that primarily act on neuronal membranes (membrane-active agents), those that act on neurotransmitters or their receptor sites (synaptic agents), those with multiple sites of action, and those that are not yet understood. Membrane-active agents alter ion fluxes and include carbamazepine (CBZ), oxcarbazepine, ethosuximide, zonisamide, phenytoin, and lamotrigine (LTG). Synaptic agents primarily affect the activity of gamma-aminobutyric acid (GABA) and include barbiturates, benzodiazepines, gabapentin (GBP), tiagabine, and vigabatrin. Agents that have multiple sites of action include valproate, GBP, felbamate, and topiramate, and those for which mechanisms of action still are not understood are levetiracetam, stiripentol, and remacemide [1,2 and 3]. Barbiturates and benzodiazepines are discussed in Chapter 149. The precise mechanisms of action of many of the newer anticonvulsants also remain unknown. Even within groups, the site or mechanism of action may differ. Pharmacologic differences are important from a therapeutic standpoint. In the treatment of seizures, combining agents from different groups may be effective whenever a single agent is ineffective or requires a toxic dose for efficacy. Such therapeutic synergism may also occur when different agents of the same group are combined (e.g., benzodiazepines and barbiturates).

Phenytoin

Phenytoin (diphenylhydantoin) is the most commonly used anticonvulsant medication [4]. It is also used in the treatment of trigeminal neuralgia. Phenytoin was the antidysrhythmic of choice for digitalis toxicity before the advent of digitalis Fab fragments [5]. Iatrogenic intoxications may occur with drug interactions because distribution, protein binding, and clearance of phenytoin are affected by other medications and disease states. Toxicity may occur when the daily administered dose exceeds endogenous metabolism and elimination [6,7

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entity [75] or instances of renal failure enhancing intercurrent disorders that predispose to hypoglycemia [76].

These might include drug ingestion, liver disease, and adrenal or pituitary insufficiency.

Fasting Hypoglycemia Due to the Unavailability of Gluconeogenic Substrate.

The prototypic condition in which substrate deficiency leads to hypoglycemia is ketotic hypoglycemia of childhood [77]. Patients with this condition, a variant of the normal response to starvation, are usually diagnosed between 18 months and 5 years of age. The hallmark of the condition is a low basal blood concentration of the gluconeogenic precursor alanine, and the hypoglycemia can be corrected by glucose or by infusion of alanine.

In adult populations, low levels of alanine are associated with chronic renal disease, and extrapolation from animal data suggests that glucocorticoid deficiency may result in the suboptimal release of alanine and other gluconeogenic precursors from muscle. Severe malnutrition from any cause diminishes the supply of gluconeogenic precursors and can lead to hypoglycemia. In severe malnutrition, glycogen, fat, and lean body mass are reduced, adding to the propensity to develop hypoglycemia.

OTHER CAUSES

Sepsis.

Sepsis has occasionally been implicated as a cause of hypoglycemia [78,79,80 and 81]. Shock and liver failure were concurrent problems in some reported cases [79]. Under conditions of decreased hepatic reserve, the combination of circulatory failure and impairment of gluconeogenesis by endotoxin might be postulated to lead to hypoglycemia.

Septic hypoglycemic patients are often acidotic, and the fatality rate is high [78,79]. In one study, only 1 of 15 such patients survived 1 month after the onset of hypoglycemia and hypotension [79].

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Cancer: Principles & Practice of Oncology

Editor(s): DeVita, Vincent T., Hellman, Samuel, Rosenberg, Steven A.
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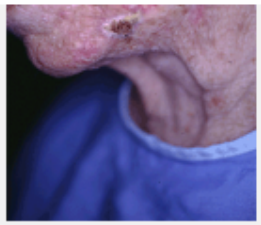

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Web Site

http://www.cdc.gov/ncipc/osp/data.htm (CDC National Center for Injury Prevention & Control)

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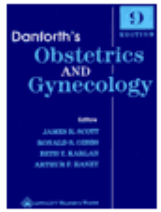
4. 

Danforth's Obstetrics & Gynecology
Editor: Scott, James R.; Gibbs, Ronald S.; Karlan, Beth Y.; Haney, Arthur F.
Publisher: Lippincott Williams & Wilkins
ISBN: 0-7817-3730-3
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5. 

Diseases of the Breast
Editor: Harris, Jay R.; Lippman, Marc E.; Morrow, Monica; Osborne, C. Kent
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