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Preface
Nonpulmonary critical care

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Guest Editor

My initiation into critical care came on a September morning 16 years ago. I was a fourth-year medical student headed for pediatrics, but somehow I found myself on a medical ICU rotation at St. Luke's Hospital in New York. That day, we admitted a pregnant patient with pyelonephritis and gram-negative bacteremia, soon complicated by acute respiratory distress syndrome, disseminated intravascular coagulation, and renal failure. Within days she developed several tension pneumothoraces and multiple organ failures and died. By the end of the month I had exchanged the pediatrics applications for internal medicine applications and ultimately the drama, challenges, and breadth of critical care.

We often take the marriage between pulmonary and critical care for granted, perhaps because so many medical ICU patients need mechanical ventilation. Most have nonpulmonary disorders as well, leading practicing intensivists to manage a wide range of disorders—in particular, shock, metabolic derangements, renal failure, and sepsis. Beyond respiratory disease, critical care has evolved into a field for generalists specializing in the management of the desperately ill.

To that end, we have devoted this issue of the *Clinics in Chest Medicine* to cutting-edge reviews of nonpulmonary critical care. O'Brien and Abraham open with a discussion of sepsis, critically appraising new therapies that, under some circumstances, appear to decrease mortality. Pinsky follows with an overview of invasive hemodynamic monitoring, emphasizing new concepts and debunking several myths. A discussion of shock by Holmes and Walley provides a fitting complement.

We have included a series of comprehensive reviews by master clinicians and teachers—Peixoto; Goldberg and Inzucchi; Drews; and Proctor—who provide updates in nephrology, endocrinology, hematology, and digestive diseases. In addition, Baudouin and Evans; Avecillas and colleagues; Mokhlesi and Corbridge; and Krishnan and Murray contribute discussions on ICU nutrition, ICU infections, toxicology, and pharmacology. A review by Pisani and colleagues addresses cognitive impairment, an almost universal disorder associated with underrecognized morbidity. In my own review I explore a related problem: agitation.

Recent evidence suggests that outcomes are improving in the ICU. In addition to new therapies, better unit structure and use of evidenced-based guidelines play a crucial role, as explained by Sinuff and Cook. An overview of prognostication by Herridge is joined by fascinating data on long-term outcomes in ICU survivors. Finally, recognizing that ICU admission signals the end for many patients, we have a timely, practical review of end-of-life care by Rubenfeld and Curtis.

I would like to thank the contributing authors, experts all, for the effort and attention paid to their manuscripts. They were a pleasure to read. Thanks also

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