in a population of 93 patients, which included premature, low-birth-weight (>1200 g) newborn infants. Two additional studies are concerned with small data sets and selected patients: 103 patients, Clinical Classification System class IV only (4); 128 patients in the three tertiary centers (5). No study reported on the effect of age and PRISM scoring.

I agree with Dr. Ruttimann and colleagues that it is important to emphasize that PRISM is well associated with severity of illness, both in our patients and in other reported studies. However, my data continue to demonstrate overestimation of mortality risk in infancy, particularly early infancy. I have no good explanation for the discrepancy between my results and those results reported in their letter, although it would be interesting to know how completely their variables have been recorded. I do not believe that infants and neonates receive exceptional quality of care in our institution. Rather, I stick to my conclusion that a reappraisal of the parameter ranges for infants is required. Also, for the time being, comparisons between units should be viewed with caution. At the very least, it appears that Dr. Ruttimann and colleagues concur that premature neonates treated on a pediatric ICU should be excluded from analysis of PRISM data.

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Hypothermia, a Pertinent Clinical Prognostic Factor in Severe Systemic Inflammatory Response Syndrome

To the Editor:

The ability to predict sepsis outcome remains elusive, despite consensual definition (1). Accurate prediction is a crucial priority, especially when the purpose is to evaluate a new therapy. Thus, intensivists need to increase their ability to define specific subgroups of patients with a low survival rate. Hypothermia seems to be a pertinent prognostic factor in severe systemic inflammatory response syndrome (SIRS).

We performed a prospective, quadricenter study to assess the epidemiology and hospital outcome of severe SIRS. Inclusion criteria were those criteria proposed by Ziegler et al. (2) for the HA-1A study. Underlying disease, preadmission status, and organ failure were classified according to the standard definitions. Severity on admission and inclusion into the study was assessed with the Simplified Acute Physiology Score (3). Study analysis focused on hypothermic patients, but all included patients were analyzed.

Among the 1,781 patients admitted during a 9-month period, 183 (10.6%) patients were enrolled, 33 (17.8%) of whom were hypothermic (<35.6°C) on inclusion into the study. Infection was documented in 155 of 183 cases. Mortality rate was higher in hypothermic patients than in febrile patients (81.8% vs. 55.3%; $p < .02$). When we compared the two groups, hypothermic patients differed significantly in terms of mean age (58.6 ± 17.8 [SD] vs. 51.7 ± 18.1 yrs; $p < .05$), mean length of intensive care unit stay (9.2 ± 9.9 vs. 14 ± 15.2 days; $p < .001$), mean Simplified Acute Physiology Score on admission (20.3 ± 5.7 vs. 16.7 ± 5.9; $p < .01$), and mean score at the time of inclusion into the study (22 ± 5 vs. 18.2 ± 5.8; $p < .001$). Univariate analysis showed that mortality rate depended on temperature, immunodepression, delayed appearance of SIRS (Table 1), mean Simplified Acute Physiology Score on admission (nonsurvivors 18.8 ± 6.4 vs. survivors 15.4 ± 5; $p < .001$), mean systolic blood pressure with adequate fluid status (86.2 ± 29.4 vs. 99.5 ± 24.2 mm Hg; $p < .005$), and mean intensive care unit length of stay (9.3 ± 10.2 vs. 18.7 ± 17.8 days; $p < .001$). Using a stepwise, multiple-regression analysis, hospital outcome was linked to immunodepression ($p < .001$), temperature ($p < .01$), delayed SIRS (>2 days) ($p < .001$), Simplified Acute Physiology Score measured at enrollment ($p < .001$), and length of stay ($p < .001$). Among these factors, a temperature of <35.6°C (sensitivity 0.24 ± 0.06; specificity 0.91 ± 0.04; positive predictive value 0.818; predictive value of negative test 0.446) is clinically pertinent and the most simple.

Our data and those data previously reported (4) have identified and evaluated hypothermia as a clinical criterion

Table 1. Univariate prognostic analysis

	Mortality Rate (%)	*p* Value	Odds Ratio	Confidence Interval (95%)
Temperature				
<35.6°C (n = 33)	81.8	—	—	—
>38.3°C (n = 150)	55.3	<.005	3.632	1.5–17
Immunodepression				
Presence (n = 73)	76	—	—	—
Absence (n = 110)	48.6	<.001	3.334	2.5–4.4
Delayed SIRS (>2 days/admission)				
Presence (n = 27)	77.7	—	—	—
Absence (n = 156)	57.4	<.05	2.595	1.8–4.7

SIRS, systemic inflammatory response syndrome.

that can be easily used to define a subgroup of patients with a particular high risk of mortality.

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Note: The author was offered the opportunity to reply, but felt no response was indicated.

To Treat or Not To Treat: An Unanswerable Question?

To the Editor:

I would like to compliment Dr. Modell for his wise discussion of the dilemma regarding the treatment of drowning victims (1). In particular, I wish to support his recommendation to treat all such cases initially, but permit the attending physician to make the decision to cease treatment as in other medical situations. Such a concept has been indirectly suggested previously, based on a continuous "therapeutic" trial over 4, 24, and 48 hrs (2). Although it may reduce the number of severely damaged individuals, the guide is not infallible, because individuals can improve but stop short of full recovery. A shorter "time" trial as recommended by Lavelle and Shaw (3) may well be an improvement, but such a trial must be supported by a multi-institutional, randomized, prospective study as previously recommended (4).

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Note: The author was offered the opportunity to reply, but felt no response was indicated.

Book Reviews

Principles of Critical Care edited by Jesse B. Hall, Gregory A. Schmidt, Laurence D. H. Wood, 2000 pp, $135.00, McGraw-Hill, New York, 1991.

This is an outstanding textbook on critical care medicine. I believe that it is clearly the finest textbook available in the field. The editors have done a superb job in providing a comprehensive approach to the broad issues in critical care medicine. For example, in addition to covering the basic physiology, diagnosis, and management of respiratory, cardiac, gastrointestinal, and central nervous system dysfunction in critically ill patients, they have done a very good job of covering other related areas. For example, there are excellent sections on procedures and technology in the intensive care unit, stabilization and transport of the critically ill patient, transplantation, nutrition, infectious diseases, neuropsychiatric disorders, drug overdoses, and poisoning. Each chapter is well referenced, often with references within the last 5 yrs as well as the inclusion of several classic citations. The figures clearly illustrate the explanations in the text. The number of tables is reasonable; in general, they are used to provide information in an efficient manner.

The editors have included authors from several specialties that relate to critical care medicine, including internal medicine, anesthesiology, surgery, and pediatrics, as well as the nursing profession. There is even a section devoted to international perspectives on critical care.

In summary, this textbook has set very high standards for what a comprehensive, in-depth approach to critical care should be. The editors, associate editors, and contributors to this book should be congratulated on a superior effort.

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A Colour Atlas of Burn Injuries by John A. Clarke, 120 pp, $99.95, Chapman & Hall Medical, London, 1993.

Photographically speaking, this is a superior atlas. Classification of burns, types, management, complications, and sequelae are covered with superb color illustrations supplemented by clear drawings and diagrams from the author's vast clinical experience.

Unfortunately, the effort to be concise and dogmatic, admirable by itself, has led to biased generalizations that could mislead nonspecialists (the principal audience of this work). Recommendations for colloid rather than crystalloid resuscitation, the use of hyperbaric oxygen, the put-down