

3. Suter PM, Fairley HB, Isenberg MD: Optimum end-expiratory airway pressure in patients with acute pulmonary failure. *N Engl J Med* 292:284-289, 1975
4. Trichet B, Falke K, Togut A, et al: The effect of pre-existing pulmonary vascular disease on the response to mechanical ventilation with PEEP following open-heart surgery. *ANESTHESIOLOGY* 42:56-67, 1975
5. Eckenhoff JE: The vertebral venous plexus. *Can Anaesth Soc J* 18:487-495, 1971
6. Lofgren J: Mechanical Basis of the CSF Pressure-Volume Curve in Intracranial Pressure. II. Edited by N Lundberg, U Ponten, M Brock. Berlin, Springer-Verlag, 1975, pp 79-81
7. Dardenne G, Dereymaeker A, Lacheron JM: Cerebrospinal fluid pressure and pulsatility. *Eur Neurol* 2:193-216, 1969
8. Alexander SC, Lassen NA: Cerebral circulatory response to acute brain disease. *ANESTHESIOLOGY* 32:60-68, 1970
9. Geraud C, Bes A, Viguie E, et al: Effects of posture and increased thoracic pressure on cerebral hemodynamics in monkey and man. Blood Flow and Metabolism in the Brain. Proceedings of the Seventh International Symposium on Cerebral Blood Flow and Metabolism, Aviemore, Scotland, June 1975. Edited by Harper AM, Jennet WB, Miller JD, et al. Edinburgh, Churchill, Livingstone (Longman), 1976, p 19
10. Lundberg N: Continuous recording and control of ventricular fluid pressure in neurosurgical practice. *Acta Psychiatr Neurol Scand* 36 (suppl 149, 1-193, 1960
11. Risberg J, Lundberg N, Ingvar DH: Regional cerebral blood volume during acute transient rises in the intracranial pressure. *J Neurosurg* 31:303, 1969
12. Langfitt TW: Increased intracranial pressure. *Clin Neurosurg* 16:436-471, 1968
13. Thompson RK, Malina S: Dynamic axial brain stem distortion as a mechanism explaining the cardiorespiratory changes in increased intracranial pressure. *Neurosurg* 16:664-674, 1959
14. Schutta HE, Kassell NF, Langfitt TW: Brain swelling produced by injury and aggravated by arterial hypertension. *Brain* 91:281-294, 1968
15. Cheney FW, Martin WE: Effects of continuous positive pressure ventilation on gas exchange in acute pulmonary edema. *J Appl Physiol* 30:378-381, 1971

Critical Care

COST-BENEFIT IN THE CRITICALLY ILL Increasing amounts of medical resources are being devoted to the care of the critically ill. What can be learned from an objective evaluation of the costs and benefits involved in this area? The authors report data derived from the consecutive treatment of 226 patients during a year. The average duration of hospitalization was 35 days. At the end of a month, 123 patients (54 per cent) had died. Of patients surviving a month, almost a third had returned home. The remainder progressed in two different ways: some showed gradual improvement to full recovery, while others declined and died within the year. At the end of a year, 164 patients (73 per cent) had died. Evalua-

tion of all patients surviving during the first year showed that 26 (12 per cent of the entire study group) were functioning normally. This had been accomplished at a total hospital cost (excluding physician fees) of \$3,232,647. The cost of blood and blood products represented 21 per cent of the total cost. The authors conclude that the data "document the use of increasingly limited resources in the management of critically ill patients. The medical profession must make difficult decisions to allocate these resources effectively." (Cullen DJ, and others: *Survival, hospitalization charges and follow-up in critically ill patients. N Engl J Med* 294: 982-987, 1976.)