

Before prescribing FASTIN® (phentermine HCl), please consult Complete Product Information, a summary of which follows:

INDICATION: FASTIN is indicated in the management of exogenous obesity as a short-term (a few weeks) adjunct in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate-to-severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma.

Agitated states.
Patients with a history of drug abuse.
During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued.

FASTIN may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: FASTIN is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of FASTIN should be kept in mind when evaluating the desirability of including a drug as part of weight-reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia.

Usage in Pregnancy: Safe use in pregnancy has not been established. Use of FASTIN by women who are or who may become pregnant, and those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and infant.

Usage in Children: FASTIN is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing FASTIN for patients with even mild hypertension.

Insulin requirements in diabetes mellitus may be altered in association with the use of FASTIN and the concomitant dietary regimen.

FASTIN may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure. *Central Nervous System:* Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria. *Endocrine:* Impotence, changes in libido.

DOSAGE AND ADMINISTRATION: *Exogenous Obesity:* One capsule at approximately 2 hours after breakfast for appetite control. Late evening medication should be avoided because of the possibility of resulting insomnia.

Administration of one capsule (30 mg) daily has been found to be adequate in depression of the appetite for twelve to fourteen hours. FASTIN is not recommended for use in children under 12 years of age.

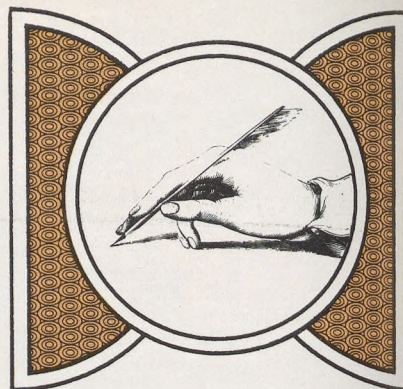
OVERDOSAGE: Manifestations of acute overdosage with phentermine include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension, and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

Management of acute phentermine intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard. Acidification of the urine increases phentermine excretion. Intravenous phentolamine (REGITINE) has been suggested for possible acute, severe hyper-tension, if this complicates phentermine overdose.

CAUTION: Federal law prohibits dispensing without prescription.

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Letters to the Editor



The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Pediatric Lap Examination

To The Editor:

I read with considerable interest Dr. Gabriel Smilkstein's description and pictures of The Pediatric Lap Examination (*J Fam Pract* 4:743, 1977).

Having done countless numbers of these in practice, I agree completely with its importance and with Dr. Smilkstein's general approach. I would like to suggest one modification which has proved quite valuable to me. Instead of placing the child on the table to check the mouth and throat, I merely examine him in the sitting position on the mother's lap. The mother is asked to grasp and restrain the child's two hands within her own left hand and to put her right hand across the child's forehead, clasping his head to her chest. This position allows for leisurely exploration of the oro-

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pharynx and elicitation of gag reflex as a terminal part of the exam. Except for checks of gait and posture the child has never left the mother's lap.

*Richard F. White, MD
Yardley, Pennsylvania*

To The Editor:

I was pleased to see the article, "The Pediatric Lap Examination" by Dr. Gabriel Smilkstein, in the April issue of *The Journal of Family Practice*. This examination technique is widely taught in Europe, and the pediatric examining table is almost unknown in England.

The "lap" technique is most effective on home visits, and a significant aspect of the examination is for the physician to maintain his or her head position at the same level as that of the child, so as not to tower over the patient possibly provoking fear or anxiety. In the home this may however mean that the physician has to kneel to perform the examination. In the office the "lap" technique allows the child to play with some toy (as well as the stethoscope as Dr. Smilkstein suggests) and remain distracted while the examination proceeds, but there may be tears at the end of the consultation when the toy is taken away.

I would like to call Dr. Smilkstein gently to task with regard to his method of examining the abdomen, mouth, and throat. From his description and illustration it is evident this is not an examination in the lap, and the immobilization and constraints are directed not by the mother, but by the physician who in the photograph takes rather a threatening posture.

To examine the throat using the lap technique the mother, facing the physician, can hold the child in her lap holding both arms with one of hers, and the child's forehead against her chest with the other.¹ The physician can examine the child face to face or from the side.²

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Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B₁₂.

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The abdominal examination can be performed with the child in the upright position in or by the mother's lap (helpful for assessing the presence of hernias and descent of the testicles).³ The procedure can also be undertaken with the child supine across the mother's knees, and there is some evidence that abdominal masses are more easily palpable with the patient in the prone position supported by the physician's two hands.

Peter Curtis, MD
University of North Carolina
Chapel Hill

References

1. Bates B: A Guide to Physical Examination: The Pediatric Physical Examination. Philadelphia, J.B. Lippincott, 1974, p 322
2. Apley J: Pediatrics. Baltimore, Williams and Wilkins, 1973, p 82
3. Mackeith, R: Child Care: Pediatric Consultation. British Medical Association, London, 1966, p 7

The preceding letter was referred to Dr. Smilkstein who responds as follows:

Dr. Curtis' comments on the "Pediatric Lap Examination" are appreciated.

In reference to the picture that shows the physician and the mother controlling the child's body and head, the text of the article indicates that this position is used only with an uncooperative child. The supine position also allows optimum visualization of the throat. I have found that when the "lap" position is used for the examination of the throat of an uncooperative child, the child's head and neck position makes the examination difficult.

The other advantages of the supine position are that the physician can complete the examination in the shortest possible time, and control of the twisting, squirming child affords the child protection from injury by the tongue blade or from falling.

Gabriel Smilkstein, MD
University of California, Davis