

PNEUMOVAX®

(Pneumococcal Vaccine, Polyvalent | MSD)

INDICATIONS: PNEUMOVAX is indicated for immunization against lobar pneumonia and bacteremia, caused by those types of pneumococci included in the vaccine, in all persons two years of age or older in whom there is an increased risk of morbidity and mortality from pneumococcal pneumonia. These include: (1) persons having chronic physical conditions such as chronic heart disease of any etiology, chronic bronchopulmonary diseases, chronic renal failure, and diabetes mellitus or other chronic metabolic disorders; (2) persons in chronic care facilities or exposed to conditions of crowding; (3) persons convalescing from severe disease; (4) persons 50 years of age or older.

CONTRAINDICATIONS: Hypersensitivity to any component of the vaccine. Epinephrine injection (1:1000) must be immediately available should an acute anaphylactoid reaction occur due to any component of the vaccine.

Do not give PNEUMOVAX to pregnant females; the possible effects of the vaccine on fetal development are unknown.

Children less than two years of age do not respond satisfactorily to the capsular types of PNEUMOVAX that are most often the cause of pneumococcal disease in this age group. Accordingly, PNEUMOVAX is not recommended in this age group.

WARNINGS: PNEUMOVAX will not immunize against capsular types of pneumococcus other than those contained in the vaccine (see table below).

14 Pneumococcal Capsular Types Included in PNEUMOVAX

Nomenclature	Pneumococcal Types													
U.S.	1	2	3	4	6A	8	9	12	14	19F	23F	25	51	56
Danish	1	2	3	4	6A	8	9N	12F	14	19F	23F	25	7F	18C

If the vaccine is used in persons receiving immunosuppressive therapy, the expected serum antibody response may not be obtained.

PRECAUTIONS: Administer subcutaneously or intramuscularly. **DO NOT GIVE INTRAVENOUSLY.** Any febrile respiratory illness or other active infection is reason for delaying use of PNEUMOVAX, except when, in the opinion of the physician, withholding the agent entails even greater risk.

Children under two years of age may not obtain a satisfactory antibody response to some pneumococcal capsular types. Therefore, the vaccine should not be used in this age group.

ADVERSE REACTIONS: Local erythema and soreness at the injection site, usually of less than 48 hours duration, occurs commonly; local induration occurs less commonly. In a recent study of PNEUMOVAX (containing 14 capsular types) in 26 adults, 24 (92%) showed local reaction characterized principally by local soreness and/or induration at the injection site within 2 days after vaccination. There were no clinically relevant systemic reactions and oral temperatures did not exceed 99.9°F. Low-grade fever (<100.9°F) occurs occasionally and is usually confined to the 24-hour period following vaccination.

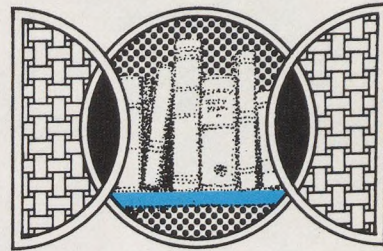
Available data suggest that revaccination before 3 years may result in more frequent and severe local reactions at the site of injection, especially in persons who have retained high antibody levels. (See Full Prescribing Information.)

STORAGE AND USE: Store unopened and opened vials at 2-8°C (35.6-46.4°F). The vaccine is used directly as supplied. No dilution or reconstitution is necessary. Phenol in 0.25% concentration is present in the vaccine as a preservative.

For Syringe Use: Withdraw 0.5 ml from vial using a sterile needle and syringe free of preservatives, antiseptics, and detergents. Use a separate heat-sterilized syringe and needle for each individual patient to prevent transmission of hepatitis B and other infectious agents from one person to another. All vaccine must be discarded by the expiration date.

HOW SUPPLIED: PNEUMOVAX is supplied in 5-dose vials of liquid vaccine, for use with syringe only.

Book Reviews



Dermatology. Hans Rorsman. *A Studentliterature Publication distributed by Year Book Medical Publishers, Inc, Chicago, 1976, 252 pp., price not available.*

This book is "intended for the undergraduate." Introductory chapters cover certain basic principles in dermatology, followed by chapters discussing some dermatological entities seen in practice—generally broken down by etiology, clinical features, differential diagnosis, treatment, and course. Some interesting practical points appear, even in the introductory chapters, such as an interesting paragraph on permanent waving and hair dying. The chapter on the principles of local therapy is useful and to the point. The book is well organized and readable.

The most striking feature is the absence of pictures, which is a serious drawback to the practicing family physician; but then the book is written for the undergraduate. The author states that the Swedish edition is used with the *Atlas of Dermatology*. Because of the absence of pictures and because it is aimed at the undergraduate, it would not be useful for physicians in active practice or in family practice residencies. It probably would be useful in teaching a dermatologic course to undergraduates.

C. Kent Smith, MD
University of Washington
Seattle

Roentgenologic Diagnosis—Volumes I & II (3rd Edition). J. George Teplick and Marvin E. Haskin. W.B. Saunders Company, Philadelphia, 1976, 1477 pp., \$60.00.

This extensively illustrated, two-volume set is designed to complement the textbook of medicine by Beeson and McDermott and is keyed in both organization and material to the contents of that book. The organization, therefore, is by major disease category along the lines of a textbook of medicine. The sections are an easy reference guide. A listing is included on roentgen signs and associated diseases to allow one to move from the abnormal x-ray to the proper illustrative page and book section. The material accompanying the text is brief and explanatory concerning disease entities and the particular x-ray manifestations of those diseases.

Efforts have been made to include illustrative nuclear medicine scans and arteriograms when this would add to the understanding of a problem presented. The illustrations, the definition of the illustrations, and the accompanying indexing material are excellent and extensive. A family practice resident or a family physician who is seeking a reference source which will allow him to interpret x-rays to the advantage of his patient will find

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this illustrative text of considerable value. Medical students probably will want to leave these volumes in the library because they are somewhat exhaustive for a student's review, but are sufficiently detailed to cover almost any situation which might arise in clinical practice. The file of x-rays from which the illustrations were drawn must be extensive since there are cases illustrated which are certainly medical curiosities. Family nurse practitioners might also use this as a reference source in reviewing x-ray findings.

This two-volume set, then, belongs on the shelf of a physician who practices in a relatively isolated area or who has a special interest in diagnostic radiology, and should serve as a ready reference guide to other students. To the physician who is responsible for the initial x-ray reading and early care of patients it may also serve as a reference guide, but it is quite extensive and may be somewhat difficult to use on a regular basis when seeing patients in a clinical practice because of the amount of exotic material that is included.

*Richard C. Barnett, MD
Santa Rosa, California*

Psychosocial Counseling in General Medical Practice. *Allen Hodges. D.C. Heath, Lexington, Massachusetts, 116 pp., 1977, \$12.50.*

Clinical psychologist Allen Hodges presents a model for integrating the physical and emotional aspects of treatment in primary

medical practice patients. Specifically, he describes how a clinical psychologist can collaborate with a primary care physician in the physician's practice setting. The material is presented in a well-organized, systematic manner. Most chapters contain an overview of the topic being considered, one or more case examples, a summary, and references. The case histories make extensive use of MMPI profiles. They are among the best that I have read, being clearly written and integrating physical and psychosocial data. There are excellent discussions of counseling for depression, grief, and marital problems. The author's statement—that the goal of conjoint therapy during a crisis of separation is to support the patient through the crisis with minimal personality damage rather than to attempt reconciliation—has important ramifications for those providing this form of treatment.

Despite its strengths, the book has two significant drawbacks which call into question its value to primary health-care professionals. First, theoretical material tends to be superficially covered. The author does not elaborate on the concepts and the forms of therapy he presents. Other than in the chapters on depression, grief, and marital problems, readers are likely to find little to enhance their understanding of the theoretical framework of psychosocial counseling. Secondly, the book focuses only on services which can be provided by a clinical psychologist in a primary care setting. The author says practically nothing about how physicians can intervene directly as psychosocial counselors. Thus he

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neglects what in most primary care clinics would be the predominant mode of providing psychosocial services.

This book offers, in well-organized fashion, an outline of psychosocial counseling in a primary care setting, particularly when a clinical psychologist collaborates with a physician. For psychologists in such a setting, the book will be useful to orient them to the types of patient needs they will encounter. However, the book is only tangentially applicable to other health-care professionals who themselves might want to counsel primary medical patients.

Ray M. Conroe, PhD
University of Minnesota
Medical School
Minneapolis

Psychosomatic Medicine: Current Trends and Clinical Applications. Z. J. Lipowski, Don R. Lipsitt, Peter C. Whybrow (eds). Oxford University Press, New York, 1975, 1976, 625 pp., \$19.50.

Psychosomatic Medicine may be to the well and to the worried well what Harrison's *Principles of Internal Medicine* is to the ill. The volume is the result of a collaboration by people with diverse professional backgrounds who seek to elaborate upon the role that thoughts and emotions have in modifying bodily functions and in contributing to the development and outcome of disease.

Although the editors divide the book into five parts, three divisions are especially pertinent to the

practicing physician. The first section is primarily involved with the basic science of psychosomatic medicine. These first chapters correlate the complex and highly interactive processes that occur between mind and body. Included here is a summary of currently known interactions and the scientific basis for the second major part: the clinical application. The final section deals with the teaching of psychosomatic medicine. Each chapter tends to be a summary of many of the different areas of research that deal with psychosomatic medicine. An extensive list of references is given at the end of each chapter.

"Clinical Approaches" and "Psychosomatic Approach in the Practice of Medicine" are two sections most likely to be of interest to the practicing primary care physician. These chapters go into considerable detail about areas of medicine that are poorly covered in traditional texts. The chapters on somatic conditions, sleep disorders, therapy-resistant depression, hypnosis, and psychophysiologic disorders in children contain a great deal of relevant information to the everyday practice of medicine. "Management of the Persisting Somatizer" is an exceptionally clear chapter and provides useful insight into patients so often labeled "crocks."

Although the clinician may be naturally attracted to these more clinically relevant chapters, the section on the basic science of psychosomatic medicine contains a wealth of useful information. The

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chapters "Psychological Stress and Adaptation of Illness" and "Biosocial Resonance" are particularly good examples.

The book suffers from a few of the drawbacks one comes to expect from the collected works of many authors. The readability varies remarkably from author to author. Some chapters read fluently and clearly while others are halting and lack a sense of orientation. Also, because the book is a summary of research done and of clinical methods practiced, the interpretation of the data or the methods used is often subject to the bias of the author. Although bias itself is not necessarily a criticism, it can present conflicting views to the reader and is sometimes confusing.

Finally, the book is addressed to: "students, practitioners, research workers, and clinicians in all areas of medicine and the medical behavioral sciences. . . ." Certain terms and trends mentioned in the book may not be clearly defined or understandable to such a diverse audience. Some of the technical terminology of psychology and sociology may be particularly difficult for the clinician to grasp.

In summary, sections of the book are relevant to just about any practitioner who works with patients on a day-to-day basis. I recommend the book as a needed text to the practitioner in the art of healing the well and the worried well but the practical clinical advice needs to be extracted from among a wealth of other data.

*James E. Crutcher, MD
Milton S. Hershey Medical Center
Hershey, Pennsylvania*

Clinical Endocrinology: A Survey of Current Practice. Calvin Ezrin, John O. Godden, Paul G. Walfish. Appleton-Century-Crofts, New York, 1977, 334 pp., \$18.50.

This book is small (6" x 9" x 5/8"), concise, and up to date. There are 26 chapters by 24 contributors, mostly Toronto Canadians, with the exception of one contributor from Winnipeg and one from Boston. The preface states, "This book briefly surveys the practice of endocrinology and metabolism. Beginning with obesity, a disorder of energy balance, the authors provide enough applied physiology to keep clinicians abreast of the relevant developments in various related fields." The statement is accurate. The authors write like clinicians, that is, they supply the latest information on research that applies to the clinical situation in their respective fields. The lists of references for each subject are current and extensive. The writing is of the kind I have usually associated with English or Canadian schooling—clear, expressive, simple, free of clichés (there is not a "parameter" in the whole book).

Special attention is paid to such common important subjects as diabetes and thyroid disorders. Under the broad subject of diabetes there are chapters on the metabolic effects of insulin, juvenile diabetes, insulin therapeutics, the hyperglycemic comas, management of diabetic nephropathy, diabetic retinopathy, oral hypoglycemic agents and hypoglycemia. There are chapters on tests of thyroid function, diagnosis and management of thyroid nodules, and the management of hyperthyroidism.

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Each tablet contains acetaminophen, 300 mg, plus codeine phosphate in one of the following strengths: #3—30 mg (gr $\frac{1}{2}$) and #4—60 mg (gr 1), (Warning—may be habit-forming).

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WARNINGS: Drug dependence: Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with the same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Caution patients that these products may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

Use in pregnancy: Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

PRECAUTIONS: Head injury and increased intracranial pressure: Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: These products or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients: Administer with caution to certain patients such as elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS: Most frequently include lightheadedness, dizziness, sedation, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; others include: euphoria, dysphoria, constipation and pruritus.

DRUG INTERACTIONS: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.



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Among other topics covered are the parathyroid, growth hormones, calcitonin, obesity, hypothalamic hormones, male and female infertility, hypogonadism, hirsutism, and endocrine hypertension and the adrenal glands. Everyone may not agree with the recommendations of the authors on all subjects, eg, "the strict control management of diabetes mellitus," but one would have to agree that the recommendations are based on evidence presented, not just on revealed wisdom.

The book is not heavily illustrated (about 85 figures), but the illustrations used are appropriate as supplements to the text. The book is written for clinicians, but should be equally valuable for residents and medical students.

Eldon B. Berglund, MD
Hennepin County
Medical Center
Minneapolis, Minnesota

Behavioral Approaches to Medical Treatment. Redford B. Williams, Jr., W. Doyle Gentry. Ballinger Publishing Company, Cambridge, Massachusetts, 1977, 304 pp., \$15.00.

Early in this book the statement is made by the authors that behavioral medicine is an idea whose time has come and that this book marks the new field's coming of age.

There is a veritable glut of books facing family physicians which deal with the psychiatric aspects of disease situations, most of which are either too esoteric for use by the family physician or too cumbersome

some for ready reference. Certainly this volume successfully avoids both these charges in a delightful and light manner. The book is actually a collection of essays on commonly seen problems such as asthma, insomnia, headache, and obesity—each discussed in its own chapter with one additional section devoted to 13 lesser problems of sufficient importance to be included.

Most family physicians have a special interest in one aspect or another of medicine, be it allergy, geriatrics, or whatever. Mine happens to be alcoholism so I spent a bit more time on that subject. I found the discussion to be in part interesting and illuminating, and in part confusing. The confusion I believe is my own doing, for at this time I do not feel sufficiently facile with the behavioral science lingo to be entirely comfortable with it. I dare say this statement obtains for many fellow physicians—including other specialists.

In short, I very much liked the book and would recommend it to our discipline. I could not accept it as the *Bible* all the way to Revelations but it certainly could represent the Book of Genesis. Since there is such a large problem related to sexual dysfunction it would have been nice to have attention to that subject. It is refreshing to find discussions aimed at specific problems rather than using the shotgun approach of many psychiatric treatises. I am confident that the psychologists will prove to be worthy members of the health-care team.

Thomas M. Hart, MD
York, Pennsylvania

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LOMOTIL®

brand of diphenoxylate hydrochloride with atropine sulfate

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. **LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.** *Indications:* Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine, and in diarrhea associated with pseudomembranous enterocolitis occurring during, or up to several weeks following, treatment with antibiotics such as clindamycin (Cleocin®) or lincomycin (Lincocin®).

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop. *Adverse reactions:* Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: **Lomotil is contraindicated in children less than 2 years old.** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdosage. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. (plastic dropper calibrated in increments of 1/2 ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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CONTRAINDICATIONS: Topical steroids are contraindicated in vaccinia, varicella, and in those patients with a history of hypersensitivity to any of the components of the preparations. These preparations are not for ophthalmic use.

PRECAUTIONS: General—If local infection exists, suitable concomitant antimicrobial or antifungal therapy should be administered. If a favorable response does not occur promptly, application of the corticosteroid should be discontinued until the infection is adequately controlled. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid and suitable precautions should be taken. If irritation or sensitization develops, the preparation should be discontinued and appropriate therapy instituted. Although topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use during pregnancy has not been absolutely established; therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Occlusive Dressing Technique—The use of occlusive dressing increases the percutaneous absorption of corticosteroids; their extensive use increases the possibility of systemic effects. For patients with extensive lesions it may be preferable to use a sequential approach, occluding one portion of the body at a time. The patient should be kept under close observation if treated with the occlusive technique over large areas and over a considerable period of time.

Occasionally, a patient who has been on prolonged therapy, especially occlusive therapy, may develop symptoms of steroid withdrawal when the medication is stopped. Thermal homeostasis may be impaired if large areas of the body are covered. Use of the occlusive dressing should be discontinued if elevation of the body temperature occurs. Occasionally, a patient may develop a sensitivity reaction to a particular occlusive dressing material or adhesive and a substitute material may be necessary. If infection develops, discontinue the use of the occlusive dressing and institute appropriate antimicrobial therapy.

ADVERSE REACTIONS: The following local adverse reactions have been reported with topical corticosteroids: burning, itching, irritation, striae, skin atrophy, secondary infection, dryness, folliculitis, hypertrichosis, acneform eruptions, and hypopigmentation. The following may occur more frequently with occlusive dressings: maceration of the skin, secondary infection, skin atrophy, striae, and miliaria. Contact sensitivity to a particular dressing material or adhesive may occur occasionally (see PRECAUTIONS).

For full prescribing information, consult package insert.

HOW SUPPLIED: The 0.025% and 0.1% Cream and the 0.1% Ointment are supplied in tubes of 15 g. and 60 g., and in jars of 240 g. (8 oz.). The 0.1% Solution is supplied in plastic squeeze bottles of 20 ml. and 60 ml.

BOOK REVIEWS

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Elements of Psychotherapy. Allen J. Enelow. Oxford University Press, New York, 1977, 146 pp., \$8.95.

This short textbook relating psychiatry and psychology to the general practice of medicine is the third such written by this author during the past decade. It, as well as the other two, *Psychiatry in the Practice of Medicine* and *Interviewing and Patient Care*, would be most helpful to any health professional who takes care of people.

This easily read and well-organized introductory text presents basic concepts in psychotherapy. It describes the behavior of the therapist and the similarities and differences between the various approaches to psychotherapy in common use. The author shows that each approach provides methods which can be combined for the most effective therapy.

The book begins with some definitions of psychotherapy and a discussion of the assumptions on which it rests. The second chapter describes the therapist's behavior by defining the basic actions taken to carry out verbal psychotherapy, such as facilitation, confrontation, and interpretation. The establishment of therapeutic goals is next considered.

Since insight-oriented psychotherapy is generally viewed as the basic method, it is discussed first with the illustrative examples provided. The author then describes the process-oriented derivatives of psychoanalytic methods, which foster the emergence of the patient's characteristic neurotic

communication, to create an awareness of its impact on others. In combination, these two approaches are the therapies most widely used.

The author next considers supportive psychotherapy, which he has found to be effective with depressed and chronically ill patients. Chapters on crisis intervention (of wide applicability) and on social rehabilitation (useful with chronically psychotic and with alcoholic patients) are based on the author's extensive experience in community mental health programs.

Lastly, the author describes behavior therapy and group psychotherapy. Case vignettes and sample interchanges are provided throughout the book. I recommend the inclusion of this book in the library of every practicing family physician and every residency program to be read and reread.

Leland Blanchard, MD
San Jose, California

Acute Myocardial Infarction: Reaction and Recovery. Rue L. Cromwell, John J. Curry, Frances M. Brayfield, Earl C. Butterfield. C.V. Mosby Company, St. Louis, Missouri, 1977, 224 pp., \$10.50.

The stated purpose of this book is to build a bridge from facts of individual research to the way those facts are applied. Its audience includes nurses, physicians, research scientists, psychologists, and educated laymen.

This book has a heavy behavioral science orientation, primarily in the area of psychology.

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The book is divided into three main parts, has an introduction and references, and has 24 black-and-white illustrations of good quality. Part I contains seven chapters in 99 pages. This part presents the history, methodology, and results of a collaborative research project in which the authors participated between 1964 and 1967. The objective of the federal research grant was a "major study of stress, personality, and nursing factors involved in recovery from acute myocardial infarction."

Part II consists of two chapters in 37 pages. It was written for the physician audience. Its objective is "to translate research findings into the broad art and science of patient care."

Part III consists of 75 pages of psychological research appendixes.

Part I is difficult to read and is poorly organized. The history, methodology, and results of the research project are mixed in such a way that the reader will find it difficult to determine precisely what occurred. The objectives and methodology of evaluation are even more difficult to discover. Part I was disappointing to this reviewer as it has no relevance to the family physician.

Part II is more readable and will be of some interest to family physicians, particularly those with a psychological research interest. It discusses some of the psychological and nursing aspects of the management of patients in the coronary care unit. In the second chapter of Part II, the authors discuss their ideas on prevention of myocardial infarction with particular reference

to the role of exercise. Unfortunately, it was difficult to tie Parts I and II together.

Part III is a rather extensive group of appendixes which might be of interest to the research psychologist.

In my opinion there is very little to commend this book to family physicians. In my own opinion the book does not meet its stated objectives, which are commendable and of vital importance to family physicians. The book will not provide either motivational or technical assistance to the physician who has no research background but who wishes to get involved in the very important aspects of controlled clinical research. This book has a little bit for everyone, but not very much for anyone.

I cannot recommend it for the family physician's bookshelf whether in the university, the community hospital residency, or a private practice.

*John L. Buckingham, MD, MPH
University of Alabama
Birmingham*

Case Studies in Echocardiography: A Diagnostic Workbook. *Ralph D. Clark, W.B. Saunders Company, Philadelphia, 1977, 334 pp., \$14.95 (US), \$15.40 (Canada).*

In recent years echocardiography has become a common diagnostic tool, providing information not otherwise easily available without risk to the patient. This book is

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