

Letters to the Editor

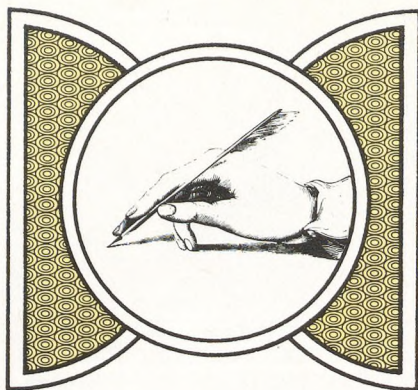
The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Residency Graduates and Full-Time Teaching

To the Editor:

In their excellent article, Family Practice Residency Graduates as Faculty Members (*J Fam Pract* 4:823, 1978), Drs. Hopkins and Green succinctly and comprehensively put into words many of the feelings I have had since joining, upon matriculation, the family practice faculty of the program from which I graduated. I accepted and have enjoyed the job for all the reasons they gave but will be going into private practice soon.

I accomplished much of what I set out to do and feel that my "idealism" (for want of a better word) offset the "inertia of pragmatism" of my more arthritic cohorts. My departure is prompted by what the authors call "a strong concern with getting practice experience" but is fueled by what I call the "PYD Syndrome" (Pay Your Dues). Lack of credibility with the residents is a minor annoyance compared to the older members of the hospital staff who keep asking when I plan to "go to



work for a living." In family practice as in perhaps no other specialty, there is an obsession with "paying your dues." Apparently no matter how capable one may be, the medical community in general and the general/family practice staff specifically have trouble taking you seriously until you have run your own office and assumed your burden of patient care.

This may be unfair but is probably best in the long run. The content of family practice should be defined by those who practice it, and family practice residencies should be run by those who know it best. Recent graduates have much to contribute but need to do it and move on. I'll be back someday after I "pay my dues" when my contribution can be more lasting.

Bert D. Garrett, MD
Instructor in Family Practice
University of Texas
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Houston, Texas

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Regroton®/Demi-Regroton™

Brief Summary

Indication: Hypertension. (See box warning.)
Contraindications: Mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.

Warnings:

These fixed combination drugs are not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

Use with caution in patients with severe renal disease, impaired hepatic function or progressive liver disease. Regroton or Demi-Regroton may potentiate action of other antihypertensive, ganglionic and peripheral adrenergic-blocking drugs. Sensitivity reactions may occur in allergic and asthmatic patients. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. **Use in pregnancy:** Thiazides cross the placental barrier and appear in cord blood. The use of chlorthalidone and related drugs in pregnant women requires that the anticipated benefits of the drug be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Use with care in nursing mothers since thiazides and reserpine cross the placental barrier and appear in cord blood and breast milk. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. If use of the drug is essential, the patient should stop nursing. **Precautions:** Antihypertensive therapy with these drugs should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with these agents two weeks prior to elective surgical procedures. In emergency surgery, use anticholinergic or adrenergic drugs or other supportive measures if needed. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated (hepatic coma may be precipitated). Patients receiving chlorthalidone should have periodic determination of serum electrolytes and should be observed for clinical signs of fluid or electrolyte imbalance (hyponatremia, hypochloremic alkalosis and hypokalemia), particularly if they are receiving digitalis, parenteral fluids, or are vomiting excessively. Hypokalemia may develop with chlorthalidone as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather. Hyperuricemia may occur or gout be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged and latent diabetes mellitus may become manifest. Chlorthalidone and related drugs may decrease arterial responsiveness to norepinephrine. Chlorthalidone and related drugs may decrease serum PBI levels without signs of thyroid disturbance. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** These drugs are generally well tolerated. The most frequent adverse reactions are anorexia, nausea, vomiting, gastric irritation, diarrhea, constipation, headache, dizziness, weakness, muscle cramps, nasal congestion, drowsiness and mental depression. Other potential side effects include skin rash, urticaria, ecchymosis; hyperglycemia and glycosuria (diabetics should be checked regularly), hyperuricemia and acute gout, and impotence. With chlorthalidone: restlessness, transient myopia; dysuria, orthostatic hypotension (may be potentiated by alcohol, barbiturates or narcotics), rare idiosyncratic reactions such as aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, purpura, necrotizing angitis and Lyell's syndrome (toxic epidermal necrolysis); pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged

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Only 1 tablet *b.i.d.* Gantanol[®] DS sulfamethoxazole/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, staphylococcus, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*), in the absence of obstructive uropathy or foreign bodies. Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis). Usual adult dosage: 2 Gm (2 DS tabs or 4 tabs or 4 teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection. Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: DS (double strength) Tablets, 1 Gm sulfamethoxazole; Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

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Rubella Antibody Screening

To the Editor:

I was disappointed to note the omission of mention by Dr. Rosser of rubella antibody screening (Screening in Family Medicine: The Current Situation. *J Fam Pract* 6:503, 1978). The potential benefits of rubella screening and vaccine administration are enormous. The cost of screening and vaccine administration is low and the screening methodology widely available through most state health departments. There is a need for all physicians to be aware of the availability and potential benefits of screening as well as the appropriate timing of vaccine administration.

Vaccine administration has been recommended for the very young with the expectation that having been immunized as children, women of childbearing age (and, thus, their offspring) will be protected against primary gestational rubella infections. It is hoped that the effect of preschool immunization will be the reduction or elimination of unpredictable outbreaks of rubella. Nevertheless, sporadic cases will continue to occur and in many instances uncertainty will remain concerning the rubella antibody status of young girls or women in their childbearing years. Rubella serologic screening may be performed in young prepubertal and adolescent girls, or at the time of premarital testing, and even during the first prenatal visit. In the latter case, and in all instances among girls and women who are

postpubertal, it is essential to remember that the rubella vaccine must not be administered during pregnancy. Vaccine should only be administered to women of childbearing age if pregnancy can definitely be prevented during the three months following administration of the vaccine. In the case of a pregnant woman, screening is still essential and serves several important purposes: (1) Reassurance for the woman who is uncertain of her rubella susceptibility status, (2) Recognition of rubella susceptibility which then permits (a) instructions to reduce the potential for exposure during gestation (b) retesting in the case of suspected exposure, and (c) plans for immunization during the immediate postpartum period.

David J. Lang, MD
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Durham, North Carolina

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

I can assure Dr. Lang that the omission of rubella screening was not a slip of the pen. In fact, we have had a very prolonged and detailed debate in our own Family Medicine Centre about how we should be screening for rubella.

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In our Province, rubella vaccine is given to 15-month-old children. Thus, rubella is not in the realm of screening but of immunization. Taking this into account, problems that we have encountered concerning screening include increasing evidence that the serum that has been currently used to immunize against rubella may, in fact, not give lifetime immunity to rubella.

However, physicians in our Medical Centre have been researching this topic and there is some evidence that measurement of antibodies is not necessarily an accurate test of measurement of immunity to rubella and, therefore, the fact that several papers have reported, after eight to ten years, a drop in rubella antibodies titres may not mean that, in fact, people are not immune to rubella.

I might also mention that our review of the medical literature indicates that although rubella is not recommended to be given to someone during pregnancy, there has never been a reported case of teratogenesis after rubella vaccine has been given during pregnancy.

In summary, the only statement that I can make is that rubella is currently more in the realm of immunization than screening. However, the role of rubella antibodies screening in practice at the present time is confused. Dr. Lang's comments in this context further enhance the understanding of the situation.

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Ottawa, Ontario

P-H Doctor's Tax Report

THE P-H DOCTOR'S TAX REPORT brings you ideas for reducing taxes and increasing wealth. It is recommended that you consult your own professional adviser before acting on these ideas.

The Motel or Hotel Investment Scene

When was the last time you were invited to consider "a perfectly marvelous motel/hotel investment opportunity for the wise physician?" According to INSTITUTE FOR BUSINESS PLANNING, Englewood Cliffs, NJ, publisher of investment guidelines, the hospitality industry is openly inviting prospective investors to consider the potentials of converting low-use space into compatible income-producing facilities.

During the past decade the nation's economy has experienced unprecedented inflation. The effects has been felt in almost every industry, and the hospitality industry is no exception. Cost increases for materials, energy, food, maintenance, payrolls, and employee benefits, etc, have been passed on to hotel and motel guests through rising room rates and meal prices, which of late have attained annual increase rates of 10 percent to over 20 percent. The problem, as pointed out by Stephen Brener, senior vice-president of Helmsley-Spear's Hospitality Division, is

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Endep
amitriptyline HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity. Do not use with monoamine oxidase (MAO) inhibitors or within at least 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Use not recommended during acute recovery phase after myocardial infarction.

Warnings: May block action of guanethidine or similar antihypertensives. Use with caution in patients with history of seizures, urinary retention, angle-closure glaucoma, increased intraocular pressure. Closely supervise cardiovascular patients, hyperthyroid patients and those receiving thyroid medications. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, including amitriptyline HCl, especially in high doses. Myocardial infarction and stroke reported with use of this class of drugs.) May impair alertness; warn against hazardous occupations or driving a motor vehicle during therapy. Weigh possible benefits against hazards during pregnancy, the nursing period and in women of child-bearing potential. Not recommended in children under 12.

Precautions: May exaggerate symptoms in schizophrenic and paranoid patients, or shift manic-depressives to manic stage; reduce dose or administer major tranquilizer concomitantly. Close supervision and careful dose adjustments required when given with anticholinergic or sympathomimetic agents. Exercise care in patients receiving large doses of ethchlorvynol; transient delirium reported with concomitant administration. May enhance effects of alcohol, barbiturates and other CNS depressants. Because of the possibility of suicide in depressed patients, do not permit easy access to large drug quantities in these patients. Because it may increase hazards of electroshock therapy, limit concomitant use to essential treatment. If possible, discontinue drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: Note: This list includes a few adverse reactions not reported with this specific drug but requiring consideration because of similarities of tricyclic antidepressants. **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. **Anticholinergic:** Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. **Endocrine:** Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. **Other:** Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. **Withdrawal Symptoms:** Abrupt cessation of treatment after prolonged administration may produce nausea, headache and malaise. These are not indicative of addiction.

Supplied: Scored Tablets: 10, 25, 50, 75, 100, 150 mg.



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