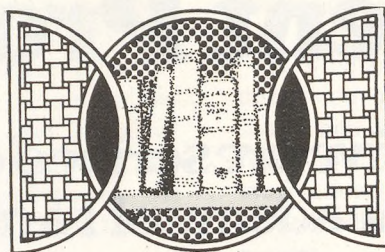


Book Reviews



Scientific Quotations: The Harvest of a Quiet Eye. *Selected by Alan Mackay; Maurice Ebison (ed). Crane, Russak, and Company, New York, 1977, 167 pp., \$14.00.*

Alan Mackay is a crystallographer at the University of London. Trained in the physical sciences, he also received a classical education in his native England. It was a classics master who, in 1940, required him and his fellow students to keep a notebook record of quotations from their daily reading. This established a habit which persists and has provided us with this delightful selection. The title is somewhat misleading. Rather than "Scientific Quotations," the volume contains a very broad selection of phrases and ideas articulated by poets, philosophers, theologians, and politicians, as well as those penned by the supporters and detractors of science. Pertinent graffiti noted in public places receive equal billing with Galileo and Darwin.

This book will certainly appeal to those who are fond of spicing their own lectures and writings with quotes from the past. The index is well done, enabling the reader to track down from key words, phrases incompletely remembered. I enjoyed roaming through the pages discovering intriguing ideas recorded by thinkers and doers previously unknown to me. I could only wish for more biographical data with the names I do not recognize. But, that concession

to my laziness would certainly increase the reasonable cost and weight of the book.

Finally, a sobering thought for those of us who enjoy such books, Ralph Waldo Emerson is quoted as follows: "I hate quotations. Tell me what you know."

*Theodore J. Phillips, MD
University of Washington
Seattle*

Modern Practical Neurology. *Peritz Scheinberg. Raven Press, New York, 1977, 247 pp., \$9.95 (paper).*

The author of this small volume states that it is intended to provide "a brief, practical . . . review of the principles of diagnosis and management of some important neurologic disorders . . . [which] is not intended to be encyclopedic . . . and deals with common problems rather than esoterica." In this it succeeds admirably. Of especial value are the sections dealing with common presenting complaints such as headache, dizziness, and low back syndromes. The differential diagnosis and work-up of patients with these complaints is presented in a thorough, yet very practical way. The neurological examination is approached in a common-sense way that will be especially useful to those who have been led to believe that any neuro-

Continued on page 1046

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. Regrotron or Demi-Regrotron 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

Continued on facing page.

Fastin® 30 mg. (phentermine HCl)

BOOK REVIEWS

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 a 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 hypertension, if this complicates phentermine overdosage.

CAUTION: Federal law prohibits dispensing without prescription.

Continued from page 1042

logical evaluation requires at least two hours of intensive examination.

Perhaps a bit more attention is devoted to description of involuntary movement disorders and neuromuscular disorders than is justified by their frequency, but this is more than compensated for by excellent passages such as the chapter on management of the unconscious patient and evaluation of head injury. On the whole, the book well merits the attention of all family physicians.

Collin Baker, MD
University of South Carolina
Columbia

Current Therapy 1978. Howard F. Conn (ed). W.B. Saunders Company, Philadelphia, 1978, 947 pp., \$25.50, \$28.50 (Canada).

This book belongs in the library, and preferably on the desk, of all primary care physicians. It should be particularly useful to family physicians and family practice residents. The information from the 339 contributors is clearly, concisely, and carefully expressed and amazingly uniform from chapter to chapter. There are few illustrations, but the multiple tables are quite useful. As an immediate source, quickly read, this book is excellent for the subjects presented.

Most commonly confronted problems are discussed, but the reader must recognize that some chapters are more applicable to colleagues practicing elsewhere in the world. On the other hand, these chapters are appropriate for North American physicians when one

considers the extensive world travel by our patients and, also, remembers that this book is distributed worldwide.

One defect in this book is there by design; with no references, the reader is actually consulting one physician. This is advantageous to most of us when faced with a need for quick information. However, this demands knowledge and experience from the reader. Thus, the neophyte physician will appreciate this book but should seek additional opinions in the establishment of his therapeutic information base. Physicians not practicing a primary care specialty will also find this text useful when dealing with a patient problem outside of their area of expertise.

T. Eugene Temple, Jr, MD
Riverside Hospital
Newport News, Virginia

Fracture Management: A Practical Approach. J. Ted Hartman. Lea & Febiger, Philadelphia, 1978, 338 pp., \$21.50.

This book was designed and executed as a handbook to aid in the diagnosis and management of fractures and dislocations. It includes some general principles, such as the management of patients with injuries and a specific section on fractures in children. The book then goes through body systems in an anatomic approach to fractures and dislocations. The book is profusely illustrated and the illustrations are pertinent to the text. The organization of the text allows for easy reference.

Considerable emphasis is given to the closed management of frac-

Continued on page 1056

Beecham
laboratories
Bristol, Tennessee 37620

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tures. Since this will be the most common area of inquiry that might concern physicians in family practice, the book is a valuable addition to the working library of a practicing family physician. It also should be of interest and value to medical students. Suitable reference material is appended to each chapter to allow for further reading should this be required. Much of the reference material includes standard texts which should be available in any medical library.

To anyone who treats acute fractures and dislocations, or who sees trauma, this book will provide a valuable working library text for ready reference. It may well be the initial review required of students beginning work in the trauma area, where many times the desire is to learn the ideal way of treating specific fractures including recommended periods of immobilization and approaches to follow-up care. For this use, the book is a valuable addition to the readable library of a practicing physician.

*Richard C. Barnett, MD
Community Hospital
of Sonoma County
Santa Rosa, California*

Death and Dying. *Richard G. Benton. Van Nostrand Reinhold, New York, 1978, 345 pp., \$12.95.*

Dr. Richard G. Benton, a Texas psychologist, has presented us with an addition to what has been a growing literature on death and dying. His book, *Death and Dying*, is presented as he states in the preface "as a core text for the undergraduate nursing curriculum course called 'Death and Dying' or as a supplementary text to other nurs-

ing courses and community and public health education." The book contains eight chapters dealing with a range of subjects from philosophical considerations of termination of life to more mundane material such as facsimiles of death certificates, "Living Bank" forms, and a check list of religious rites. Other chapters deal with a range of issues, such as euthanasia, grieving, funerals and death rituals, and nursing intervention for the dying and bereaved. One chapter presents a number of transcripts of interviews attempting to make more personal some issues on the subject. It is unfortunate that transcripts of interviews generally fail to convey the immediacy and emotional impact of a live interview. The bibliography at the end of each chapter represents a scholarly attempt to cover a range of subjects too large for one book.

The book may well prove worthwhile as a springboard for discussion in the setting in which the author proposed it. However, in the attempt to be comprehensive, some sections become too superficial. The subject itself has, of course, vaulted into prominence primarily due to the work of Dr. Kübler-Ross. One might suspect, however, that we may have reached the zenith in enthusiasm on the subject since the essential aspect of the process of death does not lend itself to definitive modification. One might expect, therefore, that eventually those who have become involved in this area will move on to other avenues of interest.

This book, like others in the behavioral sciences which deal with soft data, may well serve to

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PERCOCET-5 ^{tablets}

Brief Summary of Prescribing Information

DESCRIPTION Each tablet of PERCOCET®-5 contains 5 mg oxycodone hydrochloride (WARNING: May be habit forming), 325 mg acetaminophen (APAP).

INDICATIONS For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS Hypersensitivity to oxycodone or acetaminophen.

WARNINGS Drug Dependence Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCOCET®-5, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCOCET®-5 is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCOCET®-5 should be cautioned accordingly.

Interaction with other central nervous system depressants Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCOCET®-5 may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Usage in pregnancy Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCOCET®-5 should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children PERCOCET®-5 should not be administered to children.

PRECAUTIONS Head injury and increased intracranial pressure The 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. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCOCET®-5 or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCOCET®-5 should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, skin rash and pruritus.

DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. PERCOCET®-5 is given orally. The usual adult dose is one tablet every 6 hours as needed for pain.

DRUG INTERACTIONS The CNS depressant effects of PERCOCET®-5 may be additive with that of other CNS depressants. See WARNINGS. 6085 BS

DEA Order Form Required.

PERCOCET® is a U.S. registered trademark of Endo Inc.

Endo Inc.

Manati, Puerto Rico 00701
Subsidiary of Endo Laboratories, Inc.
Subsidiary of the DuPont Company



ENDO-357E/78

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facilitate the communication process between "helping persons." It is the hope, of course, that such a process will result in alteration in the manner in which such persons conduct themselves with patients and families. Whether increasing intellectual grasp does, in fact, increase the capacity for genuine relatedness in the human struggle of life and death remains open to question.

*Albert Liebman, MD
Thiensville, Wisconsin*

Neurology for the House Officer, (2nd Edition). Howard L. Weiner and Lawrence P. Levitt. Williams & Wilkins Company, Baltimore, 1978, 180 pp., \$9.95 (paper).

Thirty years ago, when I finished neuroanatomy at the University of Wisconsin, my professor, Frederick Geist, MD, stated that I knew more neurology than I would at anytime in my life, unless I became a neurologist or a neurosurgeon. He was right, but I have reached the second plateau after reading *Neurology for the House Officer*. This is the type of small book that will be invaluable in the office for the physician doing family practice, in the Emergency Room for the ER physician, and for any physician who must inevitably make judgments on neurological problems. The book is small, easily read, well organized, and adequately illustrated.

The organization of the book consists of sections devoted to common neurological findings, such as right hemiplegia, left hemiplegia, coma, TIA, selected stroke syndromes, aphasia, head-

ache, vertigo, seizures, hyper and hyporeflexia, myopathies, tremor, ataxia, and peripheral nerve and root dysfunction. There are sections specifically on the neurology of diabetes, alcohol, and uremia. The book contains specific discussions of raised intracranial pressure, head trauma, and a section that is very understandable on neuroanatomy with an excellent section on eye deviation and eye signs.

Certain key points in the book are emphasized typographically. The specific treatment of emergencies and problems are given in specific dose tables, including the treatment of Parkinsonism and the use of steroids and mannitol for increased intracranial pressure. The do's and don'ts of spinal taps are well outlined. The importance of CAT scanning is emphasized.

My only criticism is that some of the neurological reflexes are described and defined and others only mentioned by name; but unfamiliar ones can easily be reviewed.

In summary, this is one of the best 180-page books that I have ever read and it will make an excellent addition to almost any physician's library. I will refer to it frequently.

*Paul L. Bower, MD
Rolling Hills, California*

Practical Endocrine Diagnosis (2nd Edition). Nelson B. Watts, Joseph H. Keffer. Lea & Febiger, Philadelphia, 1978, 123 pp., \$9.75 (paper).

The editors state the purpose of this book is to present up-to-date methods for diagnosis of endocrine diseases with emphasis on hormone measurement. The reader

Continued on page 1062

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 overdose or individual hypersensitivity, reactions similar to those after meperidine or morphine overdose 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 overdose; 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 overdose may cause severe, even fatal, respiratory depression. Signs of overdose include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiri after overdose. 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. A plastic dropper calibrated in increments of 1/2 ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE Searle & Co.
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co.
Medical Communications Department
Box 5110
Chicago, Illinois 60680

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.

BOOK REVIEWS

Continued from page 1058

should be able to extract the material pertinent to his patient or the problem at hand with a minimum of distraction. This manual was developed as a result of interaction between the physician in charge of the laboratory and the physician involved in patient care. It emphasizes the dynamics of a given hormone system.

The editors made no attempt to be complete in the subjects treated and the non-hormonal aspects of the diseases are not stressed.

There are 11 chapters, including Basic Concepts, The Hypothalamus and the Anterior Pituitary, The Adrenal Cortex and Glucocorticoids, Renin-Angiotensin System, Aldosterone, Pheochromocytoma, The Thyroid Gland, The Parathyroid Glands, Reproductive Endocrinology, Insulin and Glucose Homeostasis, and an Appendix.

There are numerous line drawing schema of hormone interrelationships and actions which I found somewhat lacking in clarity. More explanation under some of the illustrations would correct this minor deficiency.

This book is not a source for clinical descriptions of disease entities, their diagnosis or management, nor was it intended to be. What it is is a very handy reference to turn to when the physician asks himself, "How do I go about establishing the diagnosis of the endocrine problem in question?" There is an index page before each chapter on which the subjects to be discussed are summarized. The text is concise and precise, with few wasted words. A limited bibliography is presented after each chapter, usually references to the latest in the literature for the subjects discussed.

The authors have met their stated intentions very well. The book would be most useful to the practicing physician, including the family physician and the internist who is himself managing endocrine problems.

Eldon Berglund, MD
Hennepin County Medical Center
Minneapolis

Surgical Skills in Patient Care. Charles W. Van Way, III, Charles A. Buerk. C. V. Mosby, St. Louis, 1978, 200 pp., \$10.95 (paper).

In *Surgical Skills in Patient Care* the authors tackle 14 areas of concern, and these are all high-frequency procedural tasks common at the house officer level. Such tasks as aseptic technique, knot tying, local anesthesia, intravenous techniques, and intubations (eg, bladder, gastrointestinal sonogram, and endotracheal) are discussed in some detail. Illustrations are good and techniques are limited to those preferred by the authors, thereby avoiding the possible confusions of multiple approaches.

This paperback book is readable, well organized, and well illustrated. It would be most useful for the senior medical student or new house officer, and would seem to fill an obvious need in that area. To the experienced practicing physician and more advanced family practice resident, it would have less to offer.

This reviewer was most impressed with the section on sutures, needles, knot tying, and care of the wound, and the section on intravenous and arterial techniques. This book will be useful as an initial learning tool, but not particularly useful as a reference text.

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Family Medicine Yakima Valley
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