

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.

Acknowledgement of Society of Teachers of Family Medicine

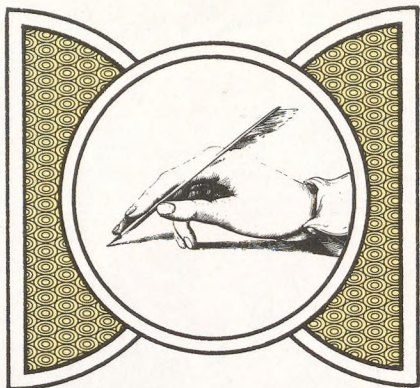
Through an unintentional oversight, acknowledgement of the role of the Society of Teachers of Family Medicine was not included in the July 1979, Special Issue of *The Journal of Family Practice* on "Preventive Medicine in Family Practice." Five of the nine papers in that issue (Medalie; Frame; Froom et al; Thompson; Grove et al) were adapted from presentations made at the October 1978, STFM meeting in New Orleans, Louisiana, on the theme of "Family Medicine and the Boundaries of Health." The efforts of Frank Snope, MD, Program Chairman of the STFM, in planning the meeting and in making available drafts of the presentations for editorial review by *The Journal*, are gratefully acknowledged.

--the Editor

Continuing Medical Education Requirements

To The Editor:

The commentary by Lawrence on the continuing education policies of The American Board of Family Practice (*Lawrence DA: J Fam Pract 8:407, 1979*) may be read at two different levels. At the factual level some of his specific points have merit, although the problem may be more complex than a reading of the paper would suggest. Considering the issue of



style, the essay in question appears to be an attempt to solve a problem by polarization and confrontation rather than by persuasion and conciliation. Readers will note phrases like "woeful shortsightedness," "grave oversight," and the concluding prediction that by 1983 the ABFP "will no longer be represented by the mythological phoenix rising from the ashes, but rather the proverbial ostrich with its head buried in the sand."

There are also some places in the article where complex issues have been oversimplified. One example is the paragraph in which the ABFP is accused of judging journal reading, teaching of medical students and residents, hospital staff meetings, and university hospital teaching rounds to be "of no value to the practicing physician" (emphasis in original).

Hopefully Lawrence's essay will stimulate further thinking at both levels: defining and measuring appropriate continuing medical education experiences for family physicians; and communicating in a way which creates a maximum amount of progress.

Robert D. Gillette, MD
Director

Riverside Family Practice Center
Toledo, Ohio

Continued on page 387

SYNEMOL® (FLUOCINOLONE ACETONIDE) CREAM 0.025%

Description SYNEMOL (fluocinolone acetonide) has the chemical name $\delta\alpha$, 9α -difluoro- 16α -hydroxyprednisolone- 16 , 17 -acetonide.

The cream contains fluocinolone acetonide 0.25 mg./g. in a water-washable aqueous emollient base of stearyl alcohol, cetyl alcohol, mineral oil, propylene glycol, sorbitan monostearate, polysorbate 60, purified water and citric acid.

Indications Inflammatory manifestations of corticosteroid-responsive dermatoses.

Contraindications Topical steroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Precautions If irritation develops, discontinue the product and institute appropriate therapy.

In the presence of an infection institute the use of an appropriate antifungal or antibacterial agent. If a favorable response does not occur promptly, discontinue the corticosteroid until the infection has been adequately controlled.

If extensive areas are treated or if occlusive technique is used, there will be increased systemic absorption of the corticosteroid and suitable precautions should be taken, particularly in children and infants.

The safety of topical steroids in pregnant women has not absolutely been established. In laboratory animals, increases in incidences of fetal abnormalities have been associated with exposure of gestating females to topical corticosteroids, in some cases at rather low dosage levels. Therefore, drugs of this class should not be used extensively on pregnant patients, in large amounts or for prolonged periods of time.

SYNEMOL® (fluocinolone acetonide) cream is not for ophthalmic use.

Adverse Reactions Local adverse reactions reported with topical corticosteroids: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliaria.

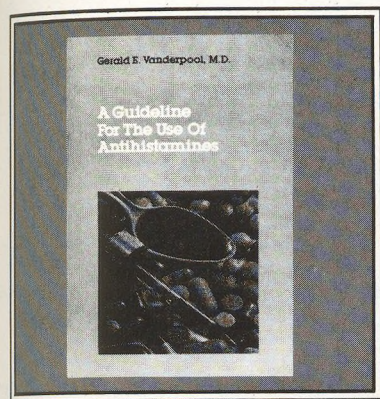
How Supplied
SYNEMOL® (fluocinolone acetonide)
Cream 0.025% — 15, 30 and 60 g. tubes.



Syntex Laboratories, Inc.
Palo Alto, California 94304

A Special Service From Ross Laboratories

Ross Laboratories is pleased to make available the booklet, *A Guideline for the Use of Antihistamines*, by Gerald E. Vanderpool, MD. This is an excellent guide to antihistamines and their clinical application. Requests for free copies should be sent to Ross Laboratories, PO Box 1317, Columbus, OH 43216.



RONDEC Tablet

(carbinoxamine maleate, 4 mg; pseudoephedrine HCl, 60 mg per tablet) \mathcal{R}

BRIEF SUMMARY:

ADVERSE REACTIONS: Those patients sensitive to pseudoephedrine may notice mild central nervous system stimulation. Sedation has been observed with the use of carbinoxamine maleate. Patients particularly sensitive to antihistamines may experience moderate to severe drowsiness.

PRECAUTIONS: Use pseudoephedrine with caution in patients with hypertension. Because of carbinoxamine maleate, patients should be cautioned to exercise care in driving or operating machinery until the possibility of drowsiness is determined. If sensitivity reaction or idiosyncrasy should occur, withdraw the drug. Safety in pregnancy has not been determined. **RONDEC Tablet** should be used in pregnant women only when the benefits outweigh the risks.

CONTRAINDICATIONS: There are no known contraindications for the use of **RONDEC Tablet**.

INDICATIONS: **RONDEC Tablet** is indicated for seasonal and perennial allergic rhinitis and vasomotor rhinitis.

USUAL DOSAGE OF RONDEC Tablet

age	dose	frequency
adults and children 6 years and older	1 tablet	4 times a day

For full prescribing information, see package insert.

ROSS LABORATORIES
COLUMBUS, OHIO 43216
Division of Abbott Laboratories, USA

B159-9750

LETTERS TO THE EDITOR

Continued from page 384

To The Editor:

I cannot strongly enough support the thoughts of Duane A. Lawrence, MD, in his article entitled, "The American Board of Family Practice: Phoenix or Ostrich in 1983?" in the Family Practice Forum of the February issue of *The Journal of Family Practice* (8:407, 1979). We are, of course, all proud that the new specialty of family medicine was the first to require the documentation of continuing medical education efforts, chart audit of our own actual practice, and periodic re-examination to prove continued competency. Any method of logging or documenting our efforts at continuing medical education has to be somewhat tedious and in part arbitrary. However, to have the American Board of Family Practice and the American Academy of Family Physicians use different systems is destructive to the positive attitudes with which most of us approach the process of keeping ourselves current. A refresher course in family medicine may be of value to Dr. Pisacano but for the majority of us who are recently residency trained in family medicine, the refresher course generally is far too superficial or too poorly focused to meet our own perceived specific areas of weakness. It is well documented in the educational literature that different individuals learn better with different types of educational format. To exclude various types of continuing medical education such as Audiotape Digests is to create an impediment to learning for many individuals. I further support Dr. Lawrence's notion that the medical center or the resort hotel is nowhere near as effective a location for training family physicians as are educational approaches that

keep the physicians in their practice sites where new information learned can be immediately reinforced by direct patient contact. We need to reinforce the community hospital as a source of continuing medical education rather than to de-emphasize it. Our discipline will be hurt badly if we do not encourage clinicians from the community to remain involved in teaching and if we do not continue to encourage residency trained graduates to think of their own practices as research laboratories for advancing the knowledge and data base of our discipline through publication. These latter two methods of continuing medical education are perhaps the most valuable in that they require active participation, review of the literature, and an attitude of intellectual curiosity. If the Board is concerned that it is impossible to document these experiences adequately, then I would point out that the fact that a physician has paid a tuition fee for a refresher course in family medicine should be of more interest to the Internal Revenue Service than to the American Board of Family Practice. I hope that others feel this way and will join me in encouraging the Board to reconsider its policy before the recertifying process of which we were once so proud becomes an "Ostrich in 1983."

Haigh P. Fox, MD
Assistant Director
Providence Family Medical
Center
Seattle, Washington

Emotions and Seizures

To The Editor:

In your January 1979 issue Professor Richard E. Minter asks

Continued on page 390

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

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. *Geriatric patients:* 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium[®] (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose[®] packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs[®] (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

Continued from page 387

“Can Emotions Precipitate Seizures.” Before my year at the US Prison for Women in Alderson, West Virginia, I had heard of people who could bring on grand mal seizures at will. At the prison I met two inmates who confided their ability to have a grand mal seizure at will. One of these proceeded to do so directly before my unbelieving eyes by hyperventilating. Alas, she was not attached to an EEG machine, but her seizure was complete and perfect in all observable respects.

Does this answer Dr. Minter's question?

Richard R. Parlour, MD
Associate Professor
Department of Psychiatry
University of Alabama
University

Geographic Maldistribution of Physicians

To the Editor:

In his Guest Editorial, “Impact of Family Practice Residency Programs on Geographic Maldistribution of Physicians” (*J Fam Pract* 8:461, 1979), William L. Stewart quoted from the American Academy of Family Physicians 1978 survey, that 52.1 percent of last year's family practice residency graduates settled in communities of less than 25,000 population.¹ This is encouraging data, but not sufficient evidence to suggest, as Stewart has, that the problem “appears to be solving itself” independent of federal intervention.

Slightly older data compiled by the Rural Practice Project show that where the location decisions of young physicians are concerned, small towns and underserved towns are not the same thing. This study—of young (under age 45) physicians who began practice in the nation's 1,730 most rural counties between 1973 and 1976—showed that only 14 percent went to towns where less than two others were already practicing. However, 41 percent of those who were in the US Public Health Service went to these kinds of communities. This is, of course, in keeping with the statutory mandate that National Health Service Corps physicians be assigned only to designated medically underserved areas in order to serve the people most affected by the geographic maldistribution.

Communities of less than 25,000 contain more than 55 percent of the nation's population.² The rural medically underserved areas to which most NHSC physicians are assigned contain about six percent of the population.³ I think it is very unlikely that anywhere close to six percent of the family practice residency graduates have gone, are now going, or will go to these areas independent of assignment and support through the NHSC.

When additional data from the survey show that I am wrong, we can believe that the problem may “solve itself” and that the NHSC is no longer needed. (Lists of NHSC assignees and of medically underserved areas are readily available to the AAFP so that identification of these locations and exclusion of NHSC assignees from the survey

Continued on page 392



Continued from page 390

results can easily be made.) But the 1978 survey results as reported permit no such conclusion.

Donald L. Madison, MD
The Rural Practice Project—
A Robert Wood Johnson
Foundation
National Program
University of North Carolina
Chapel Hill

References

1. Report on Survey of 1978 Graduating Family Practice Residents, reprint No. 155 D. Kansas City, American Academy of Family Physicians, 1978
2. Statistical Abstract of the United States 1978. In Department of Commerce, Bureau of the Census, (Suitland, Md). Government Printing Office, 1978
3. Manpower—A Change in Course. In Bureau of Health Manpower (Bethesda, Md): Annual Report Fiscal 1978. DHEW publication No. (HRA) 79-41. Government Printing Office, 1979

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

Dr. Madison has raised several interesting issues with respect to geographic maldistribution of physicians.

First of all, it is interesting to note that the figure that he chose to quote from my article (*Stewart WL: Impact of family practice residency programs on geographic maldistribution of physicians. J Fam Pract 8:461, 1979*), was the one with respect to the number of family practice residency graduates locating their practices in communities of 25,000 or less. He chose to ignore the fact that 11.5 percent of 1978 graduates are in practice in communities of less than 2,500 and that an additional 2.6 percent are serving in inner-city low income areas. One wonders why these figures were ignored.

Secondly, Dr. Madison quotes figures in his letter that were obtained for the years between 1973 and 1976, when family practice residencies were graduating relatively few physicians.

Thirdly, it is interesting that Dr. Madison quotes a figure of 41 percent of US Public Health Service physicians serving in the nations most rural counties. I am surprised that it is not an even higher percentage if the US Public Health Service is really assigning physicians where they are needed.

Fourthly, Dr. Madison uses as an argument that graduates of family practice programs are not meeting the needs of rural America the fact that "most National Health Service Corps physicians are assigned to areas containing six percent of the population." Further he "thinks that it is very unlikely that anywhere close to six percent of the family practice residents have gone into these areas." It is interesting that he fails to define "most" and he provides no real facts or figures relative to the graduates of family practice residencies practicing in these areas—only opinion. But most importantly of all, he begs the question—How many National Health Service Corps physicians stay in these areas when their two years of obligated service are over? Put another way—Does it make any sense at all to put physicians in an economically nonviable practice setting on a temporary basis?

Finally, nowhere in my article did I state that the NHSC "is no longer needed." I merely disparaged this as the *only or best* solution to the maldistribution problem.

William L. Stewart, MD
Professor and Chairman
Department of Family Practice
Southern Illinois University
Springfield

For UTI in their
sexually active years...

Macrochantin® (nitrofurantoin macrocrystals)

Capsules: 25 mg, 50 mg, 100 mg

INDICATIONS: Macrochantin is indicated for the treatment of urinary tract infections when due to susceptible strains of *Escherichia coli*, enterococci, *Staphylococcus aureus* (it is not indicated for the treatment of associated renal cortical or perinephric abscesses), and certain susceptible strains of *Klebsiella* species, *Enterobacter* species, and *Proteus* species.

NOTE: Specimens for culture and susceptibility testing should be obtained prior to and during drug administration.

CONTRAINDICATIONS: Anuria, oliguria, or significant impairment of renal function (creatinine clearance under 40 ml per minute) are contraindications to therapy with this drug. Treatment of this type of patient carries an increased risk of toxicity because of impaired excretion of the drug. For the same reason, this drug is much less effective under these circumstances.

The drug is contraindicated in pregnant patients at term as well as in infants under one month of age because of the possibility of hemolytic anemia due to immature enzyme systems (glutathione instability).

The drug is also contraindicated in those patients with known hypersensitivity to Macrochantin, Furadantin® (nitrofurantoin), and other nitrofurantoin preparations.

WARNINGS: Acute, subacute and chronic pulmonary reactions have been observed in patients treated with nitrofurantoin products. If these reactions occur, the drug should be withdrawn and appropriate measures should be taken.

An insidious onset of pulmonary reactions (diffuse interstitial pneumonitis or pulmonary fibrosis, or both) in patients on long-term therapy warrants close monitoring of these patients.

There have been isolated reports giving pulmonary reactions as a contributing cause of death. (See Hypersensitivity reactions.)

Cases of hemolytic anemia of the primaquine sensitivity type have been induced by Macrochantin. The hemolysis appears to be linked to a glucose-6-phosphate dehydrogenase deficiency in the red blood cells of the affected patients. This deficiency is found in 10 percent of Negroes and a small percentage of ethnic groups of Mediterranean and Near-Eastern origin. Any sign of hemolysis is an indication to discontinue the drug. Hemolysis ceases when the drug is withdrawn.

Pseudomonas is the organism most commonly implicated in superinfections in patients treated with Macrochantin.

PRECAUTIONS: Peripheral neuropathy may occur with Macrochantin therapy; this may become severe or irreversible. Fatalities have been reported. Predisposing conditions such as renal impairment (creatinine clearance under 40 ml per minute), anemia, diabetes, electrolyte imbalance, vitamin B deficiency, and debilitating disease may enhance such occurrence.

Usage in Pregnancy: The safety of Macrochantin during pregnancy and lactation has not been established. Use of this drug in women of childbearing potential requires that the anticipated benefit be weighed against the possible risks.

ADVERSE REACTIONS: Gastrointestinal reactions: Anorexia, nausea and emesis are the most frequent reactions; abdominal pain and diarrhea occur less frequently. These dose-related toxicity reactions can be minimized by reduction of dosage, especially in the female patient. Hepatitis occurs rarely.

Hypersensitivity reactions: Pulmonary sensitivity reactions may occur, which can be acute, subacute, or chronic.

Acute reactions are commonly manifested by fever, chills, cough, chest pain, dyspnea, pulmonary infiltration with consolidation or pleural effusion on x-ray, and eosinophilia. The acute reactions usually occur within the first week of treatment and are reversible with cessation of therapy. Resolution may be dramatic.

In subacute reactions, fever and eosinophilia are observed less often. Recovery is somewhat slower, perhaps as long as several months. If the symptoms are not recognized as being drug related and nitrofurantoin is not withdrawn, symptoms may become more severe.

Chronic pulmonary reactions are more likely to occur in patients who have been on continuous nitrofurantoin therapy for six months or longer. The insidious onset of malaise, dyspnea on exertion, cough, and altered pulmonary function are common manifestations. Roentgenographic and histologic findings of diffuse interstitial pneumonitis or fibrosis, or both, are also common manifestations. Fever is rarely prominent.

The severity of these chronic pulmonary reactions and the degree of their resolution appear to be related to the duration of therapy after the first clinical signs appear. Pulmonary function may be permanently impaired even after cessation of nitrofurantoin therapy. This risk is greater when pulmonary reactions are not recognized early.

Dermatologic reactions: Maculopapular, erythematous, or eczematous eruption, pruritus, urticaria, and angioedema.

Other sensitivity reactions: Anaphylaxis, asthmatic attack in patients with history of asthma, cholestatic jaundice, drug fever, and arthralgia.

Hematologic reactions: Hemolytic anemia, granulocytopenia, leukopenia, eosinophilia, and megaloblastic anemia. Return of the blood picture to normal has followed cessation of therapy.

Neurological reactions: Peripheral neuropathy, headache, dizziness, myasthenia, and drowsiness.

Miscellaneous reactions: Transient alopecia. As with other antimicrobial agents, superinfections by resistant organisms may occur. With Macrochantin, however, these are limited to the genitourinary tract because suppression of normal bacterial flora elsewhere in the body does not occur.

References: 1. Center for Disease Control: *National Nosocomial Infection Study Report*, Annual Summary 1976, issued February 1978. Washington, DC, U.S. Department of Health, Education, and Welfare, p. 8. 2. Cooper J. et al.: Diagnostic and chemoprophylactic importance of perineal microbial carriage, in Siegenthaler W, Luthy R (eds): *Current Chemotherapy*, Washington, DC, American Society for Microbiology, 1978, vol 1, pp 198-200. 3. Buckley RM, McGuckin M, MacGregor RR: Urine bacterial counts after sexual intercourse. *N Engl J Med* 298:321-324, 1978. 4. PMR Bacteriology Report, Summer Series, 1978; a national bacteriologic monitoring service for 200 acute-care hospitals of 100 beds or more.

Eaton Laboratories Inc.

A subsidiary of Morton-Norwich Products, Inc.
Manati, Puerto Rico 00701

Address medical inquiries to:
Norwich-Eaton Pharmaceuticals
Medical Department
Norwich, New York 13815