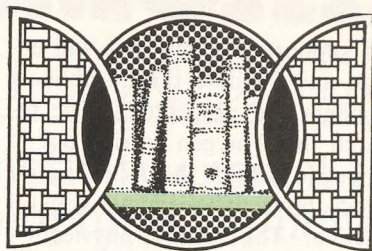


# Book Reviews



The authors have done an admirable job of making the introductory learning of this subject as interesting and clear as any text I know. Illustrations and reproductions of electrocardiograms are generally of high quality and supplement the written material well. The various chapters in the book are arranged in a very logical progression, and in keeping with the self-instructional approach, important concepts are easily identified and repeated often enough to facilitate learning. Although the book is written primarily for medical students, family practice residents, and family physicians who either never had a formal course in electrocardiography or learned it in the traditional manner could easily

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**Interpretation of Electrocardiograms: A Self-Instructional Approach.**  
 Nora Laiken, Stuart L. Laiken, Joel S. Karliner. Appleton-Century-Crofts, New York, 1978, 207 pp., \$12.95 (paper).

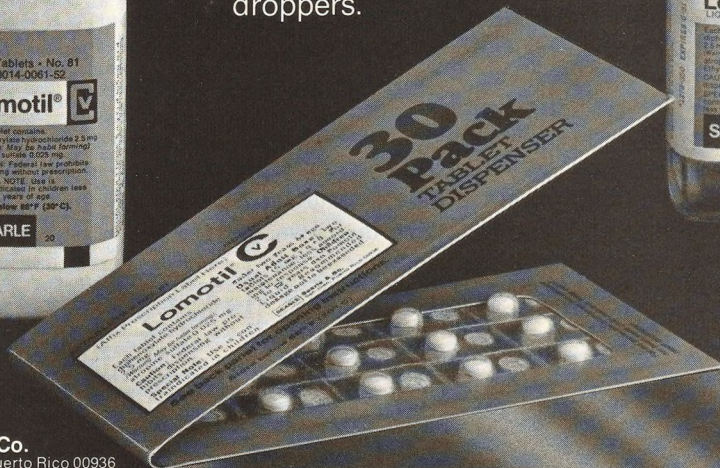
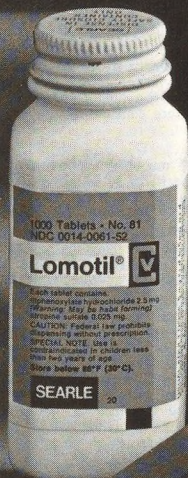
This book outlines the authors' method of teaching electrocardiography to medical students at the University of California, San Diego, School of Medicine. It is intended to provide a practical working knowledge of this subject. Basic principles of the vectorcardiogram are explained and clearly

demonstrated throughout the earlier chapters in order to enable the student to conceptualize the electrical forces involved rather than to memorize patterns. Standard electrocardiograms are used throughout the book and the vector loops merely add to the reader's understanding of the abnormalities of the standard electrocardiogram. As the title of the book indicates, self-instructional methods are utilized and the entire format is organized to permit each reader to progress at his/her own pace.

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expand their understanding by reading this nice little book. For a general reference in electrocardiography, one of the more comprehensive standard texts would be more appropriate.

Herbert R. Brettell, MD  
University of Colorado  
Denver

**Family Medicine—The Medical Life History of Families.** F. J. H. Huygen. Dekker and Van de Vegt, Nijmegen, The Netherlands, 1978, 163 pp., (price not available).

Some academicians in family medicine are concerned that the teacher and the community practitioner are becoming increasingly estranged. The publication of Huygen's *Family Medicine: The Medical Life History of Families* should allay these fears, since the author, a practicing physician in the Netherlands, demonstrates that education and research in family medicine can be successfully achieved in the community. Huygen's epidemiological research, based on a 30-year study of patients in his general practice, documents not only family structure, but family function as well. His book is a report of a carefully conceived study of family and community, but more than that it is a verification of the goals of the modern movement in family medicine.

In defining the scope of family medicine, Huygen utilizes the framework for academic general practice recommended by Richardson.<sup>1</sup> This thesis holds that the discipline should: (1) study a population group with a definable morbidity, (2) utilize specific problem solving skills, (3) teach an identifiable philosophy, and (4) create

and support research that will enlarge and validate the discipline's concepts and procedures. The research that Huygen carried out in Nijmegen fulfills the four criteria noted above for academic general practice. The family physician's touch is evident in the structure of Huygen's book. Huygen humanizes the text by introducing the reader to the families under his care. Part One of the book contains a series of case histories that give the reader an intimate view of family problems that the author managed (eg, "a young family, a father dies, a mother with a chronic illness"). The reader enters the home and the lives of the patients and is made to feel part of the community.

Part Two of the book brings the reader to Huygen's major studies—the data from an analysis of 100 younger families, 100 older families, and a three-generation family. The blending of the case histories with the epidemiological studies gives the reader both a subjective and an objective view of Huygen's patients.

The results obtained from Huygen's research highlight and reinforce some of the basic problems of family function.

1. Research findings on stress and family function suggest that "in illness the family has to be regarded as a unit, and that families tend to be consistent in illness patterns over the years."

2. The physician can gain insight into the problems of the child as the projected patient, as Huygen's findings show that "disagreement between the parents has more repercussions on the medical data of their children . . . than on their own medical data."

3. Although the reasons for vul-

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## Novafed<sup>®</sup> A Capsules

Decongestant Plus Antihistamine  
Controlled-Release

**ACTIONS:** NOVAFED A combines the action of a nasal decongestant, pseudoephedrine hydrochloride, and an antihistamine, chlorpheniramine maleate. These ingredients are combined to provide prompt and sustained nasal and upper respiratory decongestant and antihistaminic action.

Pseudoephedrine hydrochloride is an orally effective nasal decongestant. Pseudoephedrine is a sympathomimetic amine with peripheral effects similar to epinephrine and central effects similar to, but less intense than, amphetamines. It has, therefore, the potential for excitatory side effects. At the recommended oral dosage, pseudoephedrine has little or nopressor effect in normotensive adults. Patients taking pseudoephedrine orally have not been reported to experience the rebound congestion sometimes experienced with frequent repeated use of topical decongestants.

Chlorpheniramine maleate is an antihistaminic drug which possesses anticholinergic and sedative effects. It is considered one of the most effective and least toxic of the histamine antagonists. Chlorpheniramine antagonizes many of the pharmacologic actions of histamine. It prevents released histamine from dilating capillaries and causing edema of the respiratory mucosa.

**INDICATIONS:** NOVAFED A is indicated for the relief of nasal congestion and eustachian tube congestion associated with the common cold, sinusitis and acute upper respiratory infections. It is also indicated for perennial and seasonal allergic rhinitis, vasomotor rhinitis, allergic conjunctivitis due to inhalant allergens and foods and for mild, uncomplicated allergic skin manifestations of urticaria and angioedema. Decongestants in combination with antihistamines have been used for many years to relieve eustachian tube congestion associated with acute eustachian salpingitis, aerotitis media, acute otitis media and serous otitis media. NOVAFED A may be given concurrently, when indicated, with analgesics and antibiotics.

**CONTRAINDICATIONS:** Sympathomimetic amines are contraindicated in patients with severe hypertension, severe coronary artery disease, hyperthyroidism, and in patients on MAO inhibitor therapy. Antihistamines are contraindicated in patients with narrow-angle glaucoma, urinary retention, peptic ulcer, during an asthmatic attack, and in patients receiving MAO inhibitors.

Children under 12: NOVAFED A controlled-release capsules should not be used in children less than 12 years of age.

**Nursing Mothers:** Pseudoephedrine is contraindicated in nursing mothers because of the higher than usual risk for infants from sympathomimetic amines.

**Hypersensitivity:** This drug is contraindicated in patients with hypersensitivity or idiosyncrasy to sympathomimetic amines or antihistamines. Patient idiosyncrasy to adrenergic agents may be manifested by insomnia, dizziness, weakness, tremor or arrhythmias.

**WARNINGS:** Sympathomimetic amines should be used judiciously and sparingly in patients with hypertension, diabetes mellitus, ischemic heart disease, increased intraocular pressure, or prostatic hypertrophy. See, however, Contraindications. Sympathomimetics may produce central nervous system stimulation and convulsions or cardiovascular collapse with accompanying hypotension.

Antihistamines may impair mental and physical abilities required for the performance of potentially hazardous tasks, such as driving a vehicle or operating machinery, and mental alertness in children. Chlorpheniramine maleate has an atropine-like action and should be used with caution in patients with increased intraocular pressure, cardiovascular disease, hypertension or in patients with a history of bronchial asthma. See, however, Contraindications.

Do not exceed recommended dosage.

**Use in Pregnancy:** The safety of pseudoephedrine for use during pregnancy has not been established.

**Use in Elderly:** The elderly (60 years and older) are more likely to have adverse reactions to sympathomimetics. Overdosage of sympathomimetics in this age group may cause hallucinations, convulsions, CNS depression, and death. Therefore, safe use of a short-acting sympathomimetic should be demonstrated in the individual elderly patient before considering the use of a sustained-action formulation.

**PRECAUTIONS:** This drug should be used with caution in patients with diabetes, hypertension, cardiovascular disease and hyperreactivity to ephedrine. The antihistaminic may cause drowsiness and ambulatory patients who operate machinery or motor vehicles should be cautioned accordingly.

**ADVERSE REACTIONS:** Hyperreactive individuals may display ephedrine-like reactions such as tachycardia, palpitations, headache, dizziness, or nausea. Patients sensitive to antihistamines may experience mild sedation.

Sympathomimetic drugs have been associated with certain untoward reactions including fear, anxiety, tenseness, restlessness, tremor, weakness, pallor, respiratory difficulty, dyspnea, insomnia, hallucinations, convulsions, CNS depression, arrhythmias, and cardiovascular collapse with hypotension.

Possible side effects of antihistamines are drowsiness, restlessness, dizziness, weakness, dry mouth, anorexia, nausea, headache and nervousness, blurring of vision, heartburn, dysuria and very rarely, dermatitis.

**DRUG INTERACTIONS:** MAO inhibitors and beta adrenergic blockers increase the effect of sympathomimetics. Sympathomimetics may reduce the antihypertensive effects of methyldopa, mecamylamine, reserpine and veratrum alkaloids. Concomitant use of antihistamines with alcohol, tricyclic antidepressants, barbiturates and other central nervous system depressants may have an additive effect.

**DOSAGE AND ADMINISTRATION:** One capsule every 12 hours. Do not give to children under 12 years of age.

**CAUTION:** Federal law prohibits dispensing without prescription.



**DOW PHARMACEUTICALS**  
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**AMOXIL®** (amoxicillin)

For complete prescribing information consult Official Package Insert.

**Indications:** Amoxil® (amoxicillin) is similar to ampicillin in its bactericidal action against susceptible strains of Gram-negative organisms—*H. influenzae*, *E. coli*, *P. mirabilis* and *N. gonorrhoeae*, and Gram-positive organisms—Streptococci (including *Streptococcus faecalis*), *D. pneumoniae* and non-penicillinase-producing staphylococci. Culture and sensitivity studies should be obtained. Indicated surgical procedures should be performed.

**Contraindications:** A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

**Warning:** Anaphylaxis may occur, particularly after parenteral administration and especially in patients with an allergic diathesis. Check for a history of allergy to penicillins, cephalosporins or other allergens. If an allergic reaction occurs, discontinue amoxicillin and institute appropriate treatment. Serious anaphylactic reactions require immediate emergency treatment with epinephrine, oxygen, intravenous steroids and airway management.

**Usage in Pregnancy:** Safety for use in pregnancy is not established.

**Precautions:** Mycotic or bacterial superinfections may occur. Cases of gonorrhea with a suspected primary lesion of syphilis should have dark-field examinations before receiving treatment. In all other cases where concomitant syphilis is suspected, monthly serological tests should be performed for a minimum of four months. Assess renal, hepatic and hematopoietic functions intermittently during long-term therapy.

**Adverse reactions:** Unwanted reactions include glossitis, nausea, vomiting and diarrhea, skin rashes, urticaria, exfoliative dermatitis, erythema multiforme and anaphylaxis (usually with parenteral administration). Although anemia, thrombocytopenia, thrombocytopenic purpura, eosinophilia, leukopenia, and agranulocytosis have been noted, they are usually reversible and are believed to be hypersensitivity phenomena. Moderate elevations in SGOT have been noted.

**Usual Dosage:** Adults—250 to 500 mg orally q, 8h (depending on infection site and offending organisms) Children—20-40 mg/kg/day orally q, 8h (depending on infection site and offending organisms). Children over 20 kg should be given adult dose.

Gonorrhea, acute uncomplicated—3 Gms as a single oral dose (see PRECAUTIONS). Serious infections, such as meningitis or septicemia, should be treated with parenteral antibiotics.

**Supplied:****Capsules—**

250 mg in bottles of 100's and 500's, unit-dose cartons of 100.

500 mg in bottles of 50's and 500's, unit-dose cartons of 100.

**for Oral Suspension—**

125 mg/5 ml and 250 mg/5 ml in 80 ml, 100 ml and 150 ml bottles.

**Pediatric Drops for Oral Suspension—**

50 mg/ml in 45 ml bottles with calibrated dropper.

nerability of families to illness were not ascertained, it was evident from Huygen's studies that certain families demonstrated vulnerability both over a period of many years and spread over different disease categories.

The chapter on family therapy should prove of value to practitioners who wish to help their patients resolve family conflict. Huygen recommends principles of family therapy that make eminently good sense: (1) therapy should be directed at improving inter-member relationships; (2) the therapist should encourage discussion of symptoms and problems, and not spend much time in dealing with causes; (3) the therapist should deal with the here and now problems and not ruminate over the past; (4) therapy should be short term—approximately four sessions held over a period of a few months seems to be the most appropriate for the management of family problems; (5) families seem most responsive to therapy initiated at the time of crisis; and (6) components of family function and structure should be examined during therapy. These include such items as communication styles, life cycle, and role assignments.

For the family physician who wishes to do epidemiological studies in the community, Huygen includes two valuable appendices in his book. The first is a documentation of his research procedures and the second consists of examples of the family charts that served as the central data base for his research.

Dr. Huygen's contribution should be considered a textbook. As such, the absence of a subject index must be considered a slight

weakness in a book that is otherwise well organized.

Much of being a good family physician has been considered to be common sense. But an academic discipline cannot survive on anecdotal and empirical knowledge. The new academic discipline of family medicine requires validation of its philosophies. The knowledge base of common sense, therefore, must be identified, collated, and evaluated. This can take place best in the laboratory of the family physician—the community. Huygen has demonstrated that knowledge can accrue from careful investigation of families in their community environment. His book is recommended to all students, practitioners, and teachers who believe that the patient should be cared for within the context of family and community.

Gabriel Smilkstein, MD  
University of Washington  
Seattle

**Reference**

1. Richardson IM: The value of a university department of general practice. *Br Med J* 4:740, 1975

**Psychosomatic Families: Anorexia Nervosa in Context.** Salvador Minuchin, Bernice L. Rosman, Lester Baker. Harvard University Press, Cambridge, Massachusetts, 1978, 351 pp., \$15.00.

This book focuses on the increasingly prevalent and ever-perplexing problem of anorexia nervosa; however, the psychosomatic family model presented is much more central to family prac-

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tice. The importance of this study lies in what the authors demonstrate empirically (and family physicians already know subjectively)—that adequate and successful interventions for many “medical” problems can *only* be made at the family level.

The volume continues to develop the “structural” approach to understanding and intervening in families begun by Salvador Minuchin in his previous works, *Families of the Slums: An Exploration of their Structure and Treatment* and *Families and Family Therapy*. As in these books, a summary of the “structural” concepts is followed by extended family interviews with commentary highlighting the concepts and interventions.

Although this book concentrates upon anorexia nervosa, it represents only part of a larger study of psychosomatic problems, including children with intractable asthma (in excess of organic findings) and those with labile, juvenile onset diabetes. If the family physician keeps in mind that Minuchin and his co-workers found the same interactional patterns in all three groups of families, then this book will be invaluable for understanding the family patterns which lead to a child becoming a patient with severe psychosomatic illness.

Besides providing a review of the literature and a history of the treatment of anorexia nervosa, Minuchin et al contrast several models for understanding illness in general: the medical, psychodynamic, behavioral, and systems models, choosing the latter as a paradigm for their own work. Most impressive is their comparison of the outcome of their 53 anorectic

patients and families with one to seven years of follow-up to the outcomes in the literature: their 86 percent recovery rate (both medically and psychologically) has no peer. Criticism of these remarkable results, published previously as separate papers, is more than adequately answered here. Their work with diabetics and asthmatics, published elsewhere, is equally impressive.

Minuchin et al emphasize the importance of autonomy and belonging in the development of identity in the family. In order to accomplish this development, the family differentiates into subsystems by generation, sex, and interest or function; the most important and stable of these are the spouse, parental, and sibling subsystems. Boundaries between subsystems are maintained through rules which define and guide participation in transactions: “who does what with whom and when.” Equally important is the family’s capacity to change with changing conditions. Diffuse boundaries between subsystems lead to “enmeshed” families, while rigid boundaries yield “disengagement.” At times during the family life cycle one style or the other might be more functional and appropriate, such as the “enmeshment” of the mother-infant relationship during the first year of life.

The four transactional patterns which characterized the psychosomatic families were enmeshment, overprotectiveness, lack of conflict resolution, and rigidity and adherence to the status quo in the face of changing conditions. The children have some physiological vulnerability but become caught between the two parents; the

Continued on page 706

## Sanorex® (mazindol) C

**Indication:** In exogenous obesity, as a short-term (a few weeks) adjunct in a weight-reduction regimen based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors.

**Contraindications:** Glaucoma; hypersensitivity or idiosyncrasy to the drug; agitated states; history of drug abuse; during or within 14 days following administration of monoamine oxidase inhibitors (hypertensive crisis may result).

**Warnings:** Tolerance to many anorectic drugs may develop within a few weeks; if this occurs, do not exceed recommended dose, but discontinue drug. May impair ability to engage in potentially hazardous activities, such as operating machinery or driving a motor vehicle, and patient should be cautioned accordingly.

**Drug Interactions:** May decrease the hypotensive effect of guanethidine; patients should be monitored accordingly. May markedly potentiate pressor effect of exogenous catecholamines; if a patient recently taking mazindol must be given a pressor amine agent (e.g., levarterenol or isoproterenol) for shock (e.g., from a myocardial infarction), extreme care should be taken in monitoring blood pressure at frequent intervals and initiating pressor therapy with a low initial dose and careful titration.

**Drug Dependence:** Mazindol shares important pharmacologic properties with amphetamines and related stimulant drugs that have been extensively abused and can produce tolerance and severe psychological dependence. Manifestations of chronic overdose or withdrawal with mazindol have not been determined in humans. Abstinence effects have been observed in dogs after abrupt cessation for prolonged periods. There was some self-administration of the drug in monkeys. EEG studies and “liking” scores in human subjects yielded equivocal results. While the abuse potential of mazindol has not been further defined, possibility of dependence should be kept in mind when evaluating the desirability of including the drug in a weight-reduction program.

**Usage in Pregnancy:** An increase in neonatal mortality and a possible increased incidence of rib anomalies in rats were observed at relatively high doses.

Although these studies have not indicated important adverse effects, the use of mazindol in pregnancy or in women who may become pregnant requires that potential benefit be weighed against possible hazard to mother and infant.

**Usage in Children:** Not recommended for use in children under 12 years of age.

**Precautions:** Insulin requirements in diabetes mellitus may be altered. Smallest amount of mazindol feasible should be prescribed or dispensed at one time to minimize possibility of overdose. Use cautiously in hypertension, with monitoring of blood pressure; not recommended in severe hypertension or in symptomatic cardiovascular disease including arrhythmias.

**Adverse Reactions:** Most commonly, dry mouth, tachycardia, constipation, nervousness, and insomnia. **Cardiovascular:** Palpitation, tachycardia. **Central Nervous System:** Overstimulation, restlessness, dizziness, insomnia, dysphoria, tremor, headache, depression, drowsiness, weakness. **Gastrointestinal:** Dryness of mouth, unpleasant taste, diarrhea, constipation, nausea, other gastrointestinal disturbances. **Skin:** Rash, excessive sweating, clamminess. **Endocrine:** Impotence, changes in libido have rarely been observed. **Eye:** Long-term treatment with high doses in dogs resulted in some corneal opacities, reversible on cessation of medication; no such effect has been observed in humans.

**Dosage and Administration:** Usual dosage is 1 mg, three times daily, one hour before meals, or 2 mg, once daily, one hour before lunch. Use lowest effective dose, which can be determined by starting therapy at 1 mg, once a day and adjusting to the need and response of the patient. Should GI discomfort occur, mazindol may be taken with meals.

**Overdosage:** There are no data as yet on acute overdose with mazindol in humans. Manifestations of acute overdose with amphetamines and related substances include restlessness, tremor, rapid respiration, dizziness. Fatigue and depression may follow the stimulatory phase of overdose. Cardiovascular effects include tachycardia, hypertension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting and abdominal cramps. While similar manifestations of overdose may be seen with mazindol, their exact nature have yet to be determined. The management of acute intoxication is largely symptomatic. Data are not available on the treatment of acute intoxication with mazindol by hemodialysis or peritoneal dialysis, but the substance is poorly soluble except at very acid pH.

**How Supplied:** Tablets, 1 mg, and 2 mg., in packages of 100. Before prescribing or administering, see package circular for Prescribing Information

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® (chloridiazepoxide 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® (chloridiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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child's symptoms are used to avoid underlying, more painful conflicts, and thus function to reduce the family's anxiety as a whole. The tactics the authors outline for intervention make the several family interviews dramatic reading.

Most important (and gratifying) for the family physician is the evidence presented throughout the book that a family intervention is the treatment of choice for this group of medical problems, a judgment that is based on hard, clinical data and not romanticism. That alone makes it worth reading for all those engaged in family medicine.

A. H. Strelnick, MD  
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Bronx, New York

**The Practicing Physician's Approach to Headache (2nd Edition).** Seymour Diamond, Donald J. Dalessio. *The Williams and Wilkins Company, Baltimore, 1978, 154 pp., \$20.00.*

This monograph is designed, as the title suggests, to provide the practicing physician with a practical approach to the management of patients with headache. The authors, both well known in the area of headache management, draw from their extensive clinical experience.

The monograph consists of 13 chapters beginning with four chapters dealing with classification, obtaining history, performing the examination, and indications for additional studies to evaluate patients with headaches. The following five chapters are devoted to specific types of headaches, includ-

ing migraine, cluster, other vascular headaches, traction and inflammatory headaches, and muscle contraction headaches. The monograph then concludes with chapters touching upon headaches in children, drug abuse and headaches, pain mechanisms, pain clinics, and conditioning through biofeedback and operant technics.

This monograph is well organized, and clearly and simply written. It can be completed in two to three hours. Chapters conclude with brief summaries and easily self-administered true/false and multiple choice tests. The chapters on history taking and indications for additional studies in headache evaluation are especially useful. Helpful physiological hypotheses are utilized to assist in explaining the mechanism of several syndromes.

By way of critique, the monograph clumps all headaches into the classical spectrum of vascular, muscle contraction, and traction, or inflammatory origins. One has to suspect that this categorization, though long held, reflects more the incompleteness than completeness of our current knowledge. The final chapter, introducing concepts of biofeedback and operant conditioning, views headaches generically as problems of pain which may have organic, behavioral, and environmental determinants. Such an organizing theme for the entire monograph would have enhanced not only the approach to patients with classical syndromes but also the approach to the many patients who do not seem to fit into a classical mold.

The authors suggest a variety of approaches to headache manage-

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# Ilosone® (erythromycin estolate)

## WARNING

Hepatic dysfunction with or without jaundice has occurred, chiefly in adults, in association with erythromycin estolate administration. It may be accompanied by malaise, nausea, vomiting, abdominal colic, and fever. In some instances, severe abdominal pain may simulate an abdominal surgical emergency.

If the above findings occur, discontinue Ilosone promptly.

Ilosone is contraindicated for patients with a known history of sensitivity to this drug and for those with pre-existing liver disease.

**Indications:** *Streptococcus pyogenes* (Group A Beta-Hemolytic) — Upper and lower respiratory tract, skin, and soft-tissue infections of mild to moderate severity.

Injectable penicillin G benzathine is considered by the American Heart Association to be the drug of choice in the treatment and prevention of streptococcal pharyngitis and in long-term prophylaxis of rheumatic fever.

When oral medication is preferred for treating the above-mentioned conditions, penicillin G or V or erythromycin is the alternate drug of choice.

The importance of the patient's strict adherence to the prescribed dosage regimen must be stressed when oral medication is given. A therapeutic dose should be administered for at least ten days.

**Alpha-Hemolytic Streptococci (Viridans Group)** — Short-term prophylaxis against bacterial endocarditis prior to dental or other operative procedures in patients with a history of rheumatic fever or congenital heart disease who are hypersensitive to penicillin. (Erythromycin is not suitable prior to genitourinary surgery when the organisms likely to lead to bacteremia are gram-negative bacilli or belong to the enterococcus group of streptococci.)

***Staphylococcus aureus*** — Acute infections of skin and soft tissue which are mild to moderately severe. Resistance may develop during treatment.

***S. (Diplococcus) pneumoniae*** — Infections of the upper respiratory tract (e.g., otitis media, pharyngitis) and lower respiratory tract (e.g., pneumonia) of mild to moderate severity.

***Mycoplasma pneumoniae* (Eaton Agent, PPL0)** — Respiratory tract infections due to this organism.

***Haemophilus influenzae*** — May be used concomitantly with adequate doses of sulfonamides for upper respiratory tract infections of mild to moderate severity. Not all strains of this organism are susceptible at the erythromycin concentrations ordinarily achieved.

***Treponema pallidum*** — As an alternate treatment in penicillin-allergic patients. In primary syphilis, spinal-fluid examinations should be done before treatment and as part of follow-up after therapy.

***Corynebacterium diphtheriae*** — As an adjunct to antitoxin, to prevent establishment of carriers, and to eradicate the organism in carriers.

***C. minutissimum*** — In the treatment of erythrasma.

***Entamoeba histolytica*** — For intestinal amebiasis only. Extra-intestinal amebiasis requires treatment with other agents.

***Listeria monocytogenes*** — Infections due to this organism.

**Legionnaires' Disease** — Although no controlled clinical efficacy studies have been conducted, in vitro and limited preliminary clinical data suggest that erythromycin may be effective in treating Legionnaires' disease.

**Contraindication:** Known hypersensitivity to this antibiotic.

**Warnings:** (See Warning box above.) The administration of erythromycin estolate has been associated with the infrequent occurrence of cholestatic hepatitis. Laboratory findings have been characterized by abnormal hepatic function test values, peripheral eosinophilia, and leukocytosis. Symptoms may include malaise, nausea, vomiting, abdominal cramps, and fever. Jaundice may or may not be present. In some instances, severe abdominal pain may simulate the pain of biliary colic, pancreatitis, perforated ulcer, or an acute abdominal surgical problem. In other instances, clinical symptoms and results of liver function tests have resembled findings in extrahepatic obstructive jaundice.

Initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy. Symptoms reappear promptly, usually within 48 hours after the drug is readministered to sensitive patients. The syndrome seems to result from a form of sensitization, occurs chiefly in adults, and has been reversible when medication is discontinued.

**Usage in Pregnancy** — Safety of this drug for use during pregnancy has not been established.

**Precautions:** Caution should be exercised in administering the antibiotic to patients with impaired hepatic function.

Recent studies of erythromycin reveal that its use in patients receiving high doses of theophylline may be associated with an increase in serum theophylline levels and potential theophylline toxicity. In such a case, the dose of theophylline should be reduced while the patient is receiving concomitant erythromycin therapy.

Surgical procedures should be performed when indicated.

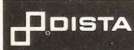
**Adverse Reactions:** The most frequent side effects are gastrointestinal (e.g., abdominal cramping and discomfort) and are dose related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses.

During prolonged or repeated therapy, overgrowth of non-susceptible bacteria or fungi is possible. If such infections arise, the drug should be discontinued and appropriate therapy instituted.

Mild allergic reactions, such as urticaria and other skin rashes, have occurred. Serious allergic reactions, including anaphylaxis, have been reported.

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## BOOK REVIEWS

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ment that have appeared to be of assistance in their own or in other hands. It is difficult to define which therapies have been documented effective in controlled studies. While a list of approximately 115 selected references are included, this reviewer would have preferred bibliographic references.

In summary, the monograph is an easily read book and is helpful in assisting the physician in identifying headache syndromes and approaches to management. This reviewer's frustrations lie in the realization that we have a long way to go before achieving a comprehensive understanding of mechanisms and management of headache—among the most perplexing problems facing the primary care physician.

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**The Golden Cage: The Enigma of Anorexia Nervosa.** Hilda Bruch. Harvard University Press, Cambridge, Massachusetts, 1978, 150 pp., \$8.95.

Dr. Bruch has created a masterful teaching device with this concise, easily readable book whose goal is to clarify anorexia nervosa for primary care physicians. By using case vignettes from her series of 70 patients, she focuses on the pre-illness problems of these young patients and highlights recurring themes which may alert the physician early in the course of the disease.

Points of emphasis are woven into the eight chapters, each of which develops an important facet

of the disease. The crucial fact rests in her description of anorexia nervosa as a disease of "inner doubt, uncertainty, failure of self-expression," and not one of appetite derangement. An equally important characteristic is its association with disordered family dynamics, which may be overlooked because of the usual initial assertion by all family members that harmony and happiness are the rule.

The anoretics' viewpoint includes the pride of accomplishing something difficult (starvation) and an adoption of an artificial facade of perfection and superiority which shields them from blame and criticism. This is the "golden cage" which dazzles observers but entraps the patient. Increasing social isolation, subsequent bizarre thoughts or goals, ritualistic binge eating with vomiting, and a paradoxical interest in food preparation and cooking may be features of the disease.

Treatment of the starvation must be done immediately, often by intravenous hyperalimentation. The psychic components of starvation itself may include ego splitting, de-personalization, and severe ego defects. Immediate individual psychotherapy is necessary for those patients with severe personality deficiencies, but family therapy can be employed in most other instances. In my view, it is here that Dr. Bruch errs. She insists that the medical aspects of nutritional therapy should be managed by "an internist or pediatrician who has a good and open working relationship with a psychiatrist." The value of a family physician is evident, since he/she knows the family members, can

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identify early warning signs, and can anticipate the depression or marital problems which may occur in the parents as the anorectic child is treated. Undeniably the psychiatrist's expertise is also helpful. The consultant's task is succinctly defined in the final chapter, which also includes much pragmatic advice on the content of the initial interview, communication style, dealing with hostility, common patient delaying tactics, and signs of progress.

In summary, this book should be read by all primary care physicians. It may stimulate others, as it did me, to read some of Bruch's earlier works, *Eating Disorders*<sup>1</sup> and *Learning Psychotherapy*.<sup>2</sup>

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## References

1. Bruch H: *Eating Disorders: Obesity, Anorexia Nervosa, and the Person Within*. New York, Basic Books, 1973
2. Bruch H: *Learning Psychotherapy: Rationale and Ground Rules*. Cambridge, Mass, Harvard University Press, 1974

**Psychological Interventions in Medical Practice.** James J. Strain. *Appleton-Century-Crofts, New York, 1978, 222 pp., \$12.50.*

This small volume is apparently directed toward "front line" physicians, and the author expresses the hope that "it will prove useful to physicians at every phase of their professional development." However, this may have been too ambitious a goal. The organization of the material into three sections—conceptual, clinical, and educational—suggests that a better product might have been

three small treatises, for each section has something of value for a different audience.

The section entitled "The Conceptual Framework" is subdivided into headings that this reviewer found confusing and repetitious. It would perhaps be of some value as a text for a course in psychosomatic medicine for students in psychology, but many psychologists will take issue with the terminology used and the organization of the material.

The topics of greatest interest to the primary care physician are contained in the section on "Selected Clinical Issues," especially the part on noncompliance, which is well thought out and clearly written in a way that may give the clinician new insights on the motivations of non-compliant patients.

The section on obesity does less well—the important concept of body image, for example, is barely mentioned, and some of the treatment methods suggested are subject to question.

Finally, "Extensions of the Model of Psychological Medicine" describes some interesting approaches to teaching psychosomatic topics and raising the awareness of clinicians to psychological concerns. It could be of value to behavioral scientists and others involved in training programs or continuing education courses, but is not of much interest to the practitioner.

One notes that Dr. Strain has previously written a text suitable for use in teaching liaison psychiatry. In attempting to write a book directed to the primary care physician, he has arrived at the same goal.

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University of South Carolina  
Columbia

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, nystagmus, 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 Infections 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 Bacteriologic Report, Summer Series, 1978; a national bacteriologic monitoring service for 200 acute-care hospitals of 100 beds or more.

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