

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.

Information on Family Practice Residencies

To the Editor:

In the ten year growth of family medicine, the interest of medical students in the specialty has continued to climb. This is evidenced by not only the number of residency programs and residents, but also the number of applicants to family practice residency positions. Medical students and residents have increasingly requested some format in which basic information about family practice residency programs can be collated. This growing interest also further emphasized the need for program directors to be able to describe their programs in a very succinct manner to potential applicants. These forces were felt by both the American Medical Student Association (AMSA) and the American Academy of Family Physicians (AAFP). As a result of several years' effort on the part of many individuals, this basic information is now available in a publication produced under the co-sponsorship of AMSA and the AAFP.

The Committee on Resident and Student Affairs (CRSA) of the



AAFP worked with representatives from AMSA in compiling a student questionnaire on the areas they considered most important in residency programs and family practice. Then, with the appropriate questions collected, the questionnaire was forwarded to all residency programs for completion. The data from the completed programs were compiled and returned to the program directors for substantiation. The booklet was printed and made available through the AMSA offices in June 1979.

The booklet contains an article by myself and Dan Ostergaard, MD, as the former Assistant Director of the Division of Education of the AAFP, concerning how to choose a residency program. Previous approaches have traditionally dealt with controversial aspects of the university vs community settings, program emphasis, etc. This unique introduction uses the philosophy that a prospective resident can learn much about the appropriateness of a training setting

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SYNEMOL® (FLUOCINOLONE ACETONIDE) CREAM 0.025%

Description SYNEMOL (fluocinolone acetonide) has the chemical name $6\alpha, 9\alpha$ -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, acneiform 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

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when applying his/her own standards and ideas about what really is family medicine. Many potential questions are raised and sample questions are given to the students to ask without any ideal listed for answers. However, the questions are related directly to the definition of family practice as adopted by the American Academy of Family Physicians and the American Board of Family Practice.

The material contained in the booklet is comprehensive, objective, educational, and logistical information about each family practice program which responded to the questionnaire. There are only a few programs which did not respond, but their demographic information is nevertheless listed within the booklet. The project will be continued on a yearly basis and is supported in part by a grant from Ciba-Geigy Pharmaceutical Company. Copies of the booklet may be obtained from the American Medical Student Association, 14650 Lee Road, PO Box 131, Chantilly, VA 22021.

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Throat Cultures for Pharyngitis

To the Editor:

I am writing in regard to the article by Dr. Clive Caplan, "A Case Against the Use of the Throat Culture in the Management of Strep-

tococcal Pharyngitis" (*J Fam Pract* 8:485, 1979). My comment would be that he may be right. However, the possibility of being correct, and the actuality of being correct are two different matters. I would certainly agree with his statements regarding the patient with the clinical diagnosis of streptococcal pharyngitis. My scepticism results from his recommendation that patients with the clinical diagnosis of nonstreptococcal pharyngitis do not need a throat culture and also do not need to be treated.

From his own admission, many of these patients do have positive throat cultures. He did not provide evidence to indicate that the group of patients left untreated will not develop elevations of the ASO titer, or in fact will not develop rheumatic fever. Until that information is forthcoming, I will continue to treat patients showing a positive throat culture, knowing full well that many of them do not require treatment.

James R. Buechler, MD
Director
Family Practice Residency of
Union Hospital
Terre Haute, Indiana

To the Editor:

Since I am not inclined to write Letters to the Editor, I am a bit slow in picking up on Clive Caplan's "A Case Against the Use of the Throat Culture in the Management of Streptococcal Pharyngitis"

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Brief Summary of Prescribing Information

Benylin® Cough Syrup

Each 5 ml contains:

Benadryl® (diphenhydramine hydrochloride) 12.5 mg
Alcohol 5%

Also contains, as inactive ingredients, sugar, water, glucose liquid, glycerin, ammonium chloride, sodium citrate, raspberry imitation flavor, sodium saccharin, citric acid, caramel, menthol, FD&C Red 40, and D&C Red 33.

INDICATIONS. Benylin Cough Syrup is indicated as an antitussive for the control of cough due to colds or allergy.

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified this indication as follows:

There is a lack of substantial evidence that this fixed combination drug has the effect purported. Final classification of the less-than-effective indication requires further investigation.

CONTRAINDICATIONS. Use in Newborn or Premature Infants: This drug should not be used in newborn or premature infants.

Use in Nursing Mothers: Because of the higher risk of antihistamines for infants generally, and for newborns and premature infants in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease: Antihistamines should NOT be used to treat lower respiratory-tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions:

Hypersensitivity to diphenhydramine hydrochloride and other antihistamines of similar chemical structure.

Monooxidase inhibitor therapy (See Drug Interaction section).

WARNINGS. Antihistamines should be used with considerable caution in patients with narrow-angle glaucoma, stenosing peptic ulcer, symptomatic prostatic hypertrophy, bladder-neck obstruction, or pyloroduodenal obstruction.

Use in Children: In infants and children, especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, antihistamines may produce excitation.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants: Diphenhydramine hydrochloride has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness: Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

PRECAUTIONS. Diphenhydramine hydrochloride has an atropine-like action and, therefore, should be used with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, or hypertension.

DRUG INTERACTIONS. MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS. The most frequent adverse reactions are underscored:

1. *General:* Urticaria; drug rash; anaphylactic shock; photosensitivity; excessive perspiration; chills; dryness of mouth, nose, and throat

2. *Cardiovascular System:* Hypotension, headache, palpitations, tachycardia, extrasystoles

3. *Hematologic System:* Hemolytic anemia, thrombocytopenia, agranulocytosis

4. *Nervous System:* Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, parosmias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions

5. *GI System:* Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation

6. *GU System:* Urinary frequency, difficult urination, urinary retention, early menses

7. *Respiratory System:* Thickening of bronchial secretions; tightness of chest and wheezing, nasal stuffiness

OVERDOSAGE. Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms—dry mouth; fixed, dilated pupils; flushing; and gastrointestinal symptoms may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic or one-half isotonic saline is the lavage solution of choice. Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and, therefore, are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

HOW SUPPLIED. Benylin Cough Syrup is supplied in 4-oz., 1-pt., and 1-gal bottles, and unit-dose bottles of 5 ml and 10 ml.

May 1978

PARKE-DAVIS

PARKE-DAVIS
Division of Warner-Lambert Company
Morris Plains, NJ 07950

PD-JA-2628-1-C (3-79)

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in the March 1979 issue (*J Fam Pract* 8:485, 1979).

This should be required reading for all present and future medical practitioners concerned with the management of the patient with a "sore throat."

My practical professors of medicine in medical school (1957) taught that sore throats were streptococcal until proven otherwise, or the patient was well without complications. At that time we were nearing the end of the epidemics of rheumatic fever and glomerulonephritis and the routine throat culture had not become the diagnostic "bible" that dictated whether or not to treat.

Unfortunately, the past 10 to 15 years have caused patients much distress and money in terms of time lost from occupation, visits and revisits to the doctor's office, and costs of the cultures because someone, somewhere preached the gospel that if it were not B hemolytic strep, proved by culture, you should not treat it. It is no wonder that the image of the physician is deteriorated; even the patient can see that his judgment is dictated by peering into a Petri dish.

It is time that we, as physicians, recapture that image that was willed to us by our predecessors, and demonstrate that we have been educated in medicine, that we are capable of exercising practical judgment in both complex and simple matters.

I suggest that there is no better test of diagnostic acumen and practical management of patient problems than that presented by the patient with the "sore throat."

Michael H. Emmick, MD
Port Lions, Alaska

To the Editor:

I enjoyed Dr. Caplan's article on the management of streptococcal pharyngitis (*J Fam Pract* 8:485, 1979). In the extremes, streptococcal pharyngitis and viral upper respiratory illnesses are not difficult to distinguish clinically. Unfortunately, he did not discuss specifically the management of those patients whose pharyngitis is not typical of either extreme. This is clearly an area where the throat culture can be of some help.

More importantly, he overlooked a very useful aspect of frequent throat cultures. By reviewing cultures on a daily basis, a clinician has a continuously updated impression of the incidence of streptococcal disease in his/her own practice. During some weeks our cultures will be positive for strep as often as 75 to 80 percent, while in other weeks it will be the opposite. This does not necessarily correlate in our experience with the seasons, nor would the etiology of these local epidemics be obvious clinically. Clearly we are better able to make judgments in borderline cases with knowledge of our recent culture results.

I believe another reason to get throat cultures is to keep yourself "honest." Upon entering private practice, without the pervasive atmosphere of critical evaluation, many physicians find it is easier to treat all upper respiratory tract illnesses with antibiotics. Routine use of the cultures provides an ongoing check on one aspect of our diagnostic acumen. It is probably worth it for that alone.

Curtis J. Eshelman, MD
Lakewood Family Practice
Center
Durham, North Carolina

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FOR DEEP INTRAMUSCULAR INJECTION ONLY.
Indications: In treatment of infections due to penicillin G-sensitive microorganisms susceptible to the low and very prolonged serum levels common to this dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and clinical response.

The following infections usually respond to adequate dosage of IM penicillin G benzathine.
Streptococcal infections (Group A—without bacteremia). Mild to moderate upper respiratory infections (e.g., pharyngitis).
Veneral infections—Syphilis, yaws, bejel, and pinta.

Medical conditions in which penicillin G benzathine therapy is indicated as prophylaxis:
Rheumatic fever and/or chorea—Prophylaxis with penicillin G benzathine has proven effective in preventing recurrence of these conditions. It has also been used as followup prophylactic therapy for rheumatic heart disease and acute glomerulonephritis.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. Anaphylaxis is more frequent following parenteral therapy but has occurred with oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. Severe hypersensitivity reactions with cephalosporins have been well documented in patients with history of penicillin hypersensitivity. Before penicillin therapy, carefully inquire into previous hypersensitivity to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and treat with usual agents, e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injection may produce neurovascular damage.

In streptococcal infections, therapy must be sufficient to eliminate the organism, otherwise the sequelae of streptococcal disease may occur. Take cultures following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote overgrowth of non-susceptible organisms including fungi. Take appropriate measures if superinfection occurs.

Adverse Reactions: Hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness-like reactions, laryngeal edema and anaphylaxis. Fever and eosinophilia may frequently be only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy and nephropathy are infrequent and usually associated with high parenteral doses.

As with other antisiphilitics, Jarisch-Herxheimer reaction has been reported.

Composition: (units penicillin G benzathine as active ingredient in aqueous suspension): 300,000 units per ml—10-ml multi-dose vial. Each ml also contains sodium citrate buffer approximately 6 mg lecithin, 3 mg povidone, 1 mg carboxymethylcellulose, 0.5 mg sorbitan monopalmitate, 0.5 mg polyoxyethylene sorbitan monopalmitate, 1.2 mg methylparaben and 0.14 mg propylparaben.

600,000 units in 1-ml TUBEX® (sterile cartridge-needle unit) Wyeth, packages of 10.

900,000 units, 1.5-ml fill in 2-ml TUBEX, packages of 10.

1,200,000 units in 2-ml TUBEX, packages of 10, and in 2-ml single-dose disposable syringe, packages of 10.

2,400,000 units in 4-ml single-dose disposable syringe, packages of 10.

Each TUBEX or disposable syringe also contains sodium citrate buffer and, as w/v, approximately 0.5% lecithin, 0.6% carboxymethylcellulose, 0.6% povidone, 0.1% methylparaben and 0.01% propylparaben.

INJECTION

BICILLIN® LA**(STERILE PENICILLIN G BENZATHINE SUSPENSION)**

Wyeth Laboratories Philadelphia, Pa. 19101

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To the Editor:

The article by Caplan, "A Case Against the Use of the Throat Culture in the Management of Streptococcal Pharyngitis" (*J Fam Pract* 8:485, 1979) is somewhat misleading on several issues. Although we agree with the philosophy to improve medical practice by reducing or ending the use of unnecessary procedures, we agree with Bisno¹ that "After all these years the simple sore throat remains a surprisingly complex problem."

Caplan quotes Mondzac's² data to attack the validity of office throat cultures and also refers to Rosenstein³ and Battle⁴ to further support this conclusion. The latter two authors, in fact, took issue with Mondzac and their data actually support the validity of the office culture. Rosenstein reported that when moderate growth was present, office culture's agreement with the health department laboratory was 90.3 percent. Battle found that only four percent of all positive cultures in the reference laboratory were found to be negative in the office and most of these were in the 1+ and 2+ category. Caplan states that even under the best of conditions perhaps 20 percent of throat cultures from patients with genuine streptococcal pharyngitis may be negative. This is not supported, however, by the above authors or by others. Kaplan⁵ showed that a patient harboring Group A streptococcus will have a negative culture ten percent of the time.

He further elaborates that "the degree of unnecessary treatment will be less than if the culture is relied upon, for more than half of positive cultures in acute pharyngitis have already been shown not

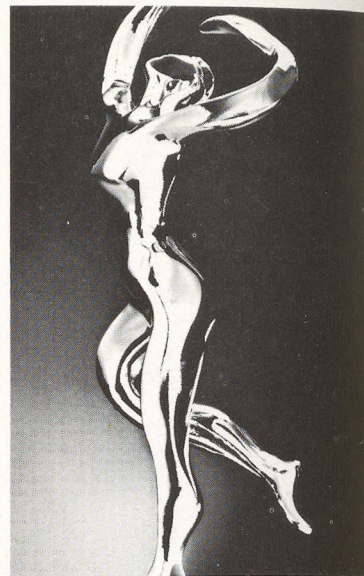
to signify a streptococcal infection." But what of the missed cases? In a careful and detailed study, Honikman⁶ evaluated a total of 6,093 respiratory and febrile illnesses in children using multiple cultures and also titer determinations. In order to have treated 88.1 percent of those clinical infections which resulted in an ASO titer rise, one would have had to treat all children with pure or predominant sore throat and fever of any degree (≥ 37.3) and all children with any illness and fever ≥ 38.3 . Without throat cultures this would be 29.5 percent of 6,093, or 1,798 of these illnesses. If one treated only culture positive children, one would treat 27.3 percent of these 1,798, or only eight percent of the total, compared with 29.5 percent by relying on symptoms alone. To treat indiscriminately with antibiotics carries a real risk of an increased number of allergic reactions and to treat fewer children without a culture would appear to leave an unacceptably high percentage at risk for acute rheumatic fever. We grant that streptococcal pharyngitis can be detected clinically, more reliably in adults than in children, but if the goal is to prevent rheumatic fever one would do well to heed the fact that acute rheumatic fever appears most commonly between 5 and 15 years of age.

Tompkins⁷ cost effectiveness analysis which suggested treating all patients with suspected streptococcal disease refers only to the epidemic situation or to those cases in which the positive throat culture yield is at least 20 percent. When the culture positive yield is 5 to 20 percent, he recommends treatment of only culture positive individuals. Moreover, Honikman⁶ and others point out that a rise in the ASO titer

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MYCELEX®

1% Cream
1% Solution (CLOTRIMAZOLE)



Indications: Mycelex Cream and Solution are indicated for the topical treatment of the following dermal infections: tinea pedis, tinea cruris, and tinea corporis due to *Trichophyton rubrum*, *Trichophyton mentagrophytes*, *Epidermophyton floccosum*, and *Microsporum canis*; candidiasis due to *Candida albicans*; and tinea versicolor due to *Malassezia furfur*.

Contraindications: Mycelex Cream and Solution are contraindicated in individuals who have shown hypersensitivity to any of their components.

Warnings: Mycelex Cream and Solution are not for ophthalmic use.

Precautions: In the first trimester of pregnancy, Mycelex should be used only when considered essential to the welfare of the patient.

If irritation or sensitivity develops with the use of Mycelex, treatment should be discontinued and appropriate therapy instituted.

Adverse Reactions: The following adverse reactions have been reported in connection with the use of this product: erythema, stinging, blistering, peeling, edema, pruritus, urticaria, and general irritation of the skin.

Dosage and Administration: Gently massage sufficient Mycelex Cream or Solution into the affected and surrounding skin areas twice a day, in the morning and evening.

Clinical improvement, with relief of pruritus, usually occurs within the first week of treatment. If a patient shows no clinical improvement after four weeks of treatment with Mycelex, the diagnosis should be reviewed.

How Supplied: Mycelex Cream 1% is supplied in 15 g and 30 g tubes.

Mycelex Solution 1% is supplied in 10 ml and 30 ml plastic bottles.

Store between 35° and 86°F.

Manufactured for Dome Division, Miles Laboratories, Inc., by Schering Corp., Kenilworth, NJ 07033.

Dome Division
MILES

Dome Division Miles Laboratories Inc West Haven Connecticut 06516 USA

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DOM-1789

Fastin® 30 mg. (N) (phentermine HCl)

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.

Beecham
laboratories
Bristol, Tennessee 37620

LETTERS TO THE EDITOR

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can occur in a high percentage of infections that are not classic for streptococcal pharyngitis; and that a high percentage of clinically "classic" streptococcal pharyngitis cases will be culture negative and not followed by a rise in ASO titers.

Although the management of pharyngitis might be simpler if one could treat without a culture, it is our conclusion that the throat culture (or a Gram stain in experienced hands⁸) remains necessary. The throat culture with all its shortcomings and surrounding controversy should definitely not be abandoned.

Sam Eggertsen, MD

Third year resident

Ronald Schneeweiss, MD

Assistant Professor

James Bergman, MD

Assistant Professor

Department of Family Medicine

University of Washington

Seattle

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Training in Office Orthopedics

To the Editor:

I read with interest the comments by Dr. John P. Geyman, in his editorial, "Toward the Definition of Orthopedic Care in Family Practice" (*J Fam Pract* 8:699, 1979).

For some years, I have been connected with the work of Dr. James Cyriax, of London, England, who has developed a method of examination and treatment of nonsurgical problems of the musculoskeletal system, which he calls Orthopedic Medicine. He estimates in his lectures that 20 percent of all patients who come to a family physician's office have problems of the musculoskeletal system, and indeed, this is borne out in my own practice.

I would commend his lectures, which are given twice a year in Rochester, New York, at the School of Medicine, Department of Orthopedics. The last lecture series was held September 20-24, 1979. Additional information may be obtained by writing to the Postgraduate Division of Continuing Education, University of Rochester.

One area of great neglect, in all medical schools with the exception of the University of Rochester, is the teaching of a method of examination of the musculoskeletal system using the concepts of applied anatomy and dermatomes. Dr. Cyriax's system is clear, precise, logical, and reproducible. I would strongly recommend to any of your readers who are interested in expanding their knowledge of the management of nonsurgical problems of the musculoskeletal system that they consider attending these lectures.

D.M. Fraser, MD

St. Catharines, Ontario