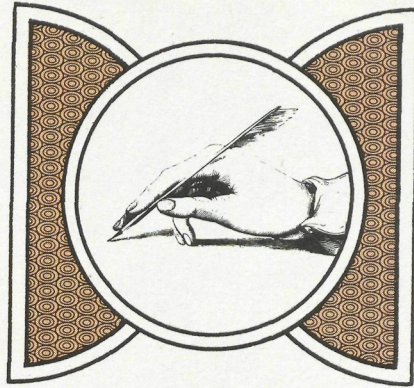


Letters to the Editor



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.

Care of Hypochondriacal and Resistive Patients

To the Editor:

I am writing to express some reactions to the article, "Hypochondriacal and/or Resistive Patients" (*Authier J, Long WB, Clemens D, et al. J Fam Pract 8: 839, 1979*).

Let me begin by wondering why so little attention is paid to the use of psychotropic medications in the situations presented. Though some caveats are proposed, the general tone is one of acceptance of the general use of these drugs. Thus, "... a 31-year-old white female . . . with a history of withdrawal, depression, and suicide attempts, resulting in lengthy hospitalizations . . ." is given chlordiazepoxide and diazepam, presumably over a long period of time. Further, "... a 27-year-old white male [who] has a past history of abuse of Darvon and other analgesics . . ." and who gives the impression of being "... a tranquilizer abuser . . ." is given an antihistamine and Doxepin, on separate occasions. It is difficult indeed to discern any rational principles of drug prescribing in these episodes.

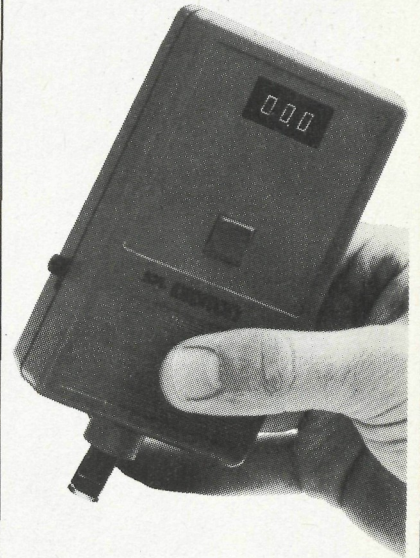
I believe that it is insufficient justification to say that "We are in

the business to 'relieve pain and suffering'," particularly because such a rationalization avoids the question of the origins of emotional pain and the likelihood that significant personal development often requires painful impetu. It is especially important in family practice that we challenge the notion that we can buy continued visits and 'compliance' through our early prescribing of medications. This is a common assumption and a rationalization used to justify the giving of psychotropic medications, yet I know of no evidence that justifies it.

The second matter is that almost overwhelming urge we have as physicians and health care professionals to label our patients or clients. Thus we end up with hypochondriacal, hysterical, passive-aggressive, passive-dependent, resistive, and hostile/angry patients, when what is likely closer to the truth is that we have a terrible time dealing with those patients because of the feelings we experience in response to them and the difficulty we have in separating their functions from our own.

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Oral and Intravenous Brief Summary

Indications: For the treatment of susceptible gram-positive and gram-negative organisms. For full list of approved indications consult labeling.

Contraindications: Hypersensitivity to any tetracycline.

Warnings: Intravenous use, particularly in pregnancy, in daily doses exceeding 2 grams has been associated with deaths through liver failure. When need for intensive treatment outweighs potential dangers, perform renal and liver function tests before and during therapy; also follow serum concentrations. In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, use lower total doses, and, in prolonged therapy, determine serum levels. This hazard is of particular importance in I.V. use in pregnant or postpartum patients with pyelonephritis. In such cases, the blood level should not exceed 15 mcgm/ml, and liver function tests should be made at frequent intervals. Do not prescribe other potentially hepatotoxic drugs concomitantly. The use of tetracyclines during tooth development (last half of pregnancy, infancy and childhood to the age of 8 years) may cause permanent discoloration of the teeth (yellow-gray-brown). This is more common during long-term use but has been observed following repeated short-term courses. Enamel hypoplasia has also been reported. Tetracyclines, therefore, should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. Photosensitivity manifested by an exaggerated sunburn reaction has been observed in some individuals taking tetracyclines. Advise patients apt to be exposed to direct sunlight or ultraviolet light that such reaction can occur, and discontinue treatment at first evidence of skin erythema. Studies to date indicate that photosensitivity is rarely reported with MINOCIN *Minocycline HCl*. In patients with significantly impaired renal function, the antianabolic action of tetracycline may cause an increase in BUN leading to azotemia, hyperphosphatemia, and acidosis. CNS side effects (lightheadedness, dizziness, vertigo) have been reported, may disappear during therapy, and always disappear rapidly when drug is discontinued. Caution patients who experience these symptoms about driving vehicles or using hazardous machinery while taking this drug. **Pregnancy:** In animal studies, tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Embryotoxicity has been noted in animals treated early in pregnancy. **Newborns, infants and children:** All tetracyclines form a stable calcium complex in any bone-forming tissue. Prematures, given oral doses of 25 mg./kg. every 6 hours, demonstrated a decrease in fibula growth rate, reversible when drug was discontinued. Tetracyclines are present in the milk of lactating women who are taking a drug in this class.

Precautions: Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, institute appropriate therapy. In venereal diseases when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (e.g., renal, hepatic and hemopoietic) in long-term use. Treat all group A beta-hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.

Adverse Reactions: GI: (with both oral and parenteral use): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. **Skin:** maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). **Renal toxicity:** rise in BUN, dose-related (see "Warnings"). **Hypersensitivity reactions:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. **Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia. **CNS:** (see "Warnings"). When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

NOTE: Concomitant therapy: Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that absorption of MINOCIN *Minocycline HCl* is not notably influenced by foods and dairy products.

References: 1. Data on file, Lederle Laboratories, Pearl River, New York. 2. MacCulloch D, Richardson RA, Allwood GK: The penetration of doxycycline, oxytetracycline and minocycline into sputum. *N Z Med J* 80: 300-302, 1974. 3. Macdonald H, Kelly RG, Allen E, et al: Pharmacokinetic studies on minocycline in man. *Clin Pharmacol Ther* 14: 852-861, 1973.

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The point is that though labels can be of considerable value in making prognoses and in striking management plans, they can also be pejorative and damaging to the helper/client relationship. It is a matter of particular concern to me that this article leaves the impression that there is a consistent management plan available, once such labels can be applied, when my experience tells me clearly that the development of a caring and therapeutic relationship in such situations requires all of the skill and creativity that I can muster.

Family medicine teaching must give as imperatives the need to understand—with all of the resources of knowledge and personality at our disposal—the origins of patients' pains, and the importance of using the bond of our relationship with those patients to reach mutual conclusions regarding the "label" and appropriate responses to it. The complexities of practice cannot be reduced through the use of medications and standardized protocols.

J. Paul Newell, MD

Associate Professor of
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The preceding letter was referred to Drs. Authier and Long who respond as follows:

We would like to compliment Dr. Newell for various points that

he makes regarding the recent article, "Hypochondriacal and/or Resistant Patients," by Authier J, Long WB, Clemens D, et al (*J Fam Pract* 8:839, 1979), since we do not see ourselves in disagreement with him in a general sense. Indeed, his responses appear valid to us based on the fact that perhaps our article did not sufficiently convey that our Rounds was being presented to a group of family practice residents. If we were speaking to physicians in practice our expectations would be higher, our labeling of patients may have been different, and we certainly would have been discouraging the overuse of psychotropic medications.

Dr. Newell wondered why so little attention was paid to the use of psychotropic medications in the case examples. We do pay a significant amount of attention to the use of psychotropic drugs in our training program, but perhaps our article did not make this sufficiently clear. In essence, we are stating that in our experience residents, especially new residents, have a tendency to underutilize psychotropic medications. As a result, we attempt to give residents considerable latitude in the prescribing of medications, so they can learn within a structured framework the appropriateness of prescribing psychotropic drugs. Specifically, the second patient, the 27-year-old white male who had been a tranquilizer abuser, was given antihistamines as a hypnotic because of his abuse history, and Doxepin was used not only as an antidepressant but as an anti-anxiety agent, again because of his abuse history and the fact that both of these medications are non-

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habituating and nonaddictive.

Dr. Newell's second point of there being insufficient justification to say that we are in the business to "relieve pain and suffering" is taken out of context because it does not completely portray the intention of that particular statement. The intent was one of helping residents overcome their overreaction to prescribing psychotropic drugs since they have been imbued with the knowledge that older physicians overutilize said medications. In the process, of course, a number of patients are denied significant benefits of psychotropic medications on a short-term basis.

We appreciate that labeling patients can often have a "pejorative and damaging" impact on the physician-patient relationship but are hopeful that in our training setting we are successful in teaching the main purpose of labels, ie, a professional shorthand rather than a labeling for labeling's sake. Moreover, we are hopeful that the labels are helpful in setting general management plans but certainly did not intend to convey that a consistent management plan is always possible as a result of the label. We appreciate Dr. Newell's point that often patients which physicians find difficult to manage are more of a result of the physicians' own feelings in response to these kinds of patients, rather than specifically a problem with the patient. The published Rounds did not provide an in-depth emphasis on self-awareness, an area which we feel is a very important aspect of successfully managing the "hypochondriacal" and/or resistive patient. However, self-awareness is emphasized

during other portions of our training program.

*Jerry Authier, PhD
Associate Professor
Clinical Psychologist
William B. Long, MD
Associate Professor
Psychiatrist
Section of Family Behavior
Department of Family Practice
The University of Nebraska
Medical Center
Omaha*

Hospital Practice of the Family Physician

To the Editor:

The recent editorial in the May issue of *The Journal of Family Practice* entitled "Hospital Practice of the Family Physician" (*Geyman JP: J Fam Pract 8:911, 1979*), is an appropriate and timely article reviewing the present status of the family physician in the hospital setting. While retrospective and cross-sectional studies document what family physicians do in urban and rural hospitals, the key element for critical discussion relates to the comparison of family physicians with other specialists in the care of hospitalized patients. It was unfortunate that your editorial referred to an as yet unpublished report from Garg NL et al as a basis for this critical element. Fundamental questions in this area can be elucidated through carefully controlled prospective studies of recent graduates in approved residencies in

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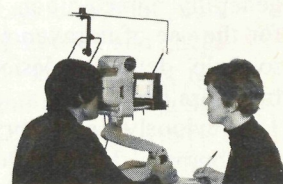
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both family practice and general internal medicine. I look forward to future studies comparing the quality of hospital care provided by family physicians with that provided by other specialists.

*Anthony F. Vuturo, MD
Associate Dean
Office of Continuing Medical
Education and Outreach
University of Arizona
Tucson*

Indications for CT Scanning

To the Editor:

At the Second Annual Meeting of the Society for Computerized Tomography and Neuro-Imaging held at Hilton Head Island, South Carolina, October 29, 1978, the subject of contrast enhancement in CT Scanning was discussed. The generally agreed upon indications for the use of intravenous contrast to help delineate lesions of the brain are as follows:

1. Previously treated brain tumors
2. Abnormal Isotope Scans, cerebral arteriograms, or other positive neurodiagnostic tests
3. Possible posterior fossa lesions, especially cerebellar pontine angle tumor
4. Metastatic disease
5. Arteriovenous malformations or aneurysms
6. Patients with focal central nervous system signs
7. Sellar and parasellar lesions

An excess of enhancements in CT Scans are being done throughout this country routinely. Contrast enhancement can lead to reactions in five percent of patients and mor-

tality in anywhere from 1 in 30,000 to 50,000 cases. Because of this, contrast should only be given when central nervous system disease is strongly suspected and/or when one of the aforementioned criteria is present. The situations in which contrast enhancement is least productive are congenital lesions, degenerative diseases, infarct, and trauma. Caution should be exercised in patients over 70 years of age, in those with cardiac disease (especially failure), and in any seriously ill patient.

Neurologists and neurosurgeons order fewer contrast enhancement CT Scans than other physicians. This may be because the indications have not been spelled out to the large body of physicians who are ordering these tests.

Computerized tomography is an expensive procedure, and there are times when the physician is forced to order one in spite of the fact that it is very unlikely that a lesion is present, eg, persistent headaches. The routine CT Scan without contrast yields much information. The use of contrast should be carefully considered, and then it should be used only when indications are present. In this way, a remarkable diagnostic procedure without any morbidity or mortality will not become a procedure with the possibility of complications.

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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 no pressor 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, arotitis 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 a 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, dysuria, 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.



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