

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.

Skin Manifestations of Diabetes

To the Editor:

I enjoyed reading Dr. Osment's excellent article recently published in The Journal, "Dermatoses of the Scalp" (J Fam Pract 8:1217, 1979). I was reminded of a patient whose presentation and clinical course is very pertinent to the substance of this article.

In June 1978, a 64-year-old house wife came to my office with a large, multiloculated pustular eruption covering nearly the entire left temporal region of her scalp. Two months earlier a similar but smaller lesion had appeared in the same area but had resolved spontaneously. Cultures of the exudate revealed *Staphylococcus aureus*, coagulase positive. Treatment consisted of frequent incision and drainage procedures and an oral cephalosporin. The patient then left to accompany her husband on an out-of-state business trip, but I instructed her to obtain local medical consultation every three to four days. She complied and returned home in six weeks well-healed and full of praise for her treatment while en route.

Our next encounter was January 8, 1979, when she presented with another skin abscess covering the right maxilla and preauricular areas of the face. She gradually improved

with identical treatment, but this time I felt obligated to check for underlying systemic disease. A fasting blood glucose level was 303 mg/100 ml, and a two-hour postprandial glucose level was 364 mg/100 ml. She was placed on strict dietary control and extensive diabetic counseling. To date she has not returned for the problems of pyoderma or folliculitis.

In light of this experience, I would like to echo Dr. Osment's remarks that the scalp participates in many systemic disorders, frequently as the initial site of involvement. Furthermore, I, along with several other physicians, was perhaps too complacent in not suspecting a more generalized process at the onset of her seemingly well-localized problem.

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Middle-Age Occupational Spectrum

To the Editor:

Taking issue with a single point in Dr. Medalie's otherwise excellent and thorough article, "The Family Life Cycle and Its Implications for Family Practice," in the

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LOMOTIL®

brand of diphenoxylate hydrochloride
with atropine sulfate

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdose or individual hypersensitivity, reactions similar to those after meperidine or morphine overdose may occur; treatment is similar to that of meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN. Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine, and in diarrhea associated with pseudomembranous enterocolitis occurring during, or up to several weeks following, treatment with antibiotics such as clindamycin (Cleocin®) or lincomycin (Lincocin®). **Warnings:** Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In therapy, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop. **Adverse reactions:** Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of 1/2 ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE Searle & Co.
San Juan, Puerto Rico 00936

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

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July issue of *The Journal of Family Practice* (9: 47, 1979) seemed at first petty carping, yet reflecting on it, I feel the omission of one point in the Middle-Age Occupational Spectrum (Table 2) is sufficiently important to warrant comment.

Dr. Medalie lists four positions in the Spectrum: No work, no hope, welfare; Adjusting to a new occupation (until recently, a relatively uncommon situation for the middle-aged); Working, but will never reach top or expectations; and Reached(ing) the top. This list omits one position at least equally important for the person's overall health: Content in stable, mid-level occupational status. In contrast to the four positions listed which all have varying degrees of stress associated with them, either intrinsically or for unfulfilled aspirations, this position would have a salutary effect on health. Some people, an increasing number recently I suspect, are quite content in mid-level positions doing what they can do well, and never aspire to anything higher.

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Sudden Death of Married Couple

To the Editor:

I was fascinated by the article "Sudden Cardiac Death in a Husband and Wife" by Drs. Michael and Arthur Miller (*J Fam Pract* 9:503, 1979), relating psychologic factors and sudden death. May I add two personal clinical examples, relating psychologic factors to sudden death in one case, and myocardial infarction in a husband and wife in the other.

Example 1: Nurse D., working with me in my practice, received a telephone call saying that her only brother, a soldier, had been accidentally killed. In addition to her own shock, she kept saying, "What is going to happen to my father?" Her father, aged 60 and an active dermatologist with moderate hypertension for which he was receiving treatment, had a very close relationship with his only son. Nurse D. notified her mother and together they broke the news to the father. The latter took the news very badly and within a few hours, went into coma and died. He and his son were buried in graves alongside each other at a joint service the next day. No autopsy was performed so I cannot state the cause of death with certainty.

Example 2: Family L. were an elderly couple both in their early 70s who had been patients of mine for a number of years. They were delightful people with a very warm relationship. Both had osteoarthritis; she was slightly obese and had systolic hypertension, while he had prostatic hypertrophy, a total serum cholesterol of nearly 300 mg/100 ml, and developing cataracts.

One night I was called to their home because Mrs. L. was having severe chest pain. I diagnosed myocardial infarction and sent her to the hospital. Mr. L. accompanied her in the ambulance. In the Emergency Room, Mrs. L. had a cardiac arrest and the resident who saw her shouted for the emergency apparatus saying something about her "heart had stopped." Mr. L., who was standing at a little distance from her, thought that she had died, and fainted. Upon reviving him, the nurse noticed that his

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SYNEMOL® (FLUOCINOLONE ACETONIDE) CREAM 0.025%

Description SYNEMOL (fluocinolone acetonide) has the chemical name 6 α , 9 α -difluoro-16 α -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.



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Valium® (diazepam/Roche)

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

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

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: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium (diazepam) Tablets, 2 mg, 5 mg and 10 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.

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pulse was very irregular and he began to complain of chest discomfort. He was admitted, together with his wife (who had been resuscitated) to the acute ward where he, like her, developed definite ECG signs of acute myocardial infarction. Unlike the Miller case, this couple recovered and returned home.

It is difficult for me to believe that experienced clinicians still question the association of emotional factors and acute illness, but if so, let them add these two clinical examples to their collections.

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Preventive Medicine in Family Practice

To the Editor:

I read with great anticipation *The Journal of Family Practice* Preventive Medicine issue (Vol 9, No. 1, 1979). I particularly looked forward to in-depth articles that would integrate concepts of health and disease. However, I was disappointed to find the articles included in the issue concentrating on *pathology* and the traditional approach to *disease* prevention.

Dr. Berg focused upon traditional measures of *disease* and prevention thereof. While this perspective is accurate, it is by no means a complete picture. By limiting the perspective to traditionally quantifiable, measurable factors, many potentially important factors affecting health are not considered. Particularly important factors to

consider include measures of the influence of the family on the health of its members. The family is a primary environmental factor in the lives of its members and the lack of adequate means to measure its influence does not reduce its importance.

Dr. Medalie provided a refined life-cycle model which is useful in anticipating problems which might occur among family members. While this model gives a significantly more comprehensive view of family medicine, many assumptions are made, and no simple, concrete method is included for its application in clinical practice or for the solution of the problems identified.

Dr. Thompson provided the HMO approach. I appreciate his recognition of at least one important family member, the parent of the well child. Dr. Grove identified the work place as important environmentally and shows us some of his methods of altering measurable risk factors of *disease*. Dr. Sloane showed us his way of remembering what *disease* screening to undertake and when to do it. Dr. Schuman alluded to the unique role of the family physician as a practitioner and member of the community in disease prevention. Again, while these are all important aspects of family medicine, they are predominately *disease* oriented.

From my perspective as a clinician and teacher of family medicine, I believe that the prevention, detection, and treatment of pathology or disease are only a part of the practice of family medicine (this orientation is our legacy from the longer established specialties). Many patient problems that have no well-defined relationship to pathology or its prevention face the family phy-

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Keflex® (cephalexin)

Indications: Keflex is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Respiratory tract infections caused by *Streptococcus (Diplococcus) pneumoniae* and group A beta-hemolytic streptococci (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. Keflex is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of Keflex in the subsequent prevention of rheumatic fever are not available at present.)

Otitis media due to *S. pneumoniae*, *Haemophilus influenzae*, staphylococci, streptococci, and *Neisseria catarrhalis*

Skin and skin-structure infections caused by staphylococci and/or streptococci

Bone infections caused by staphylococci and/or *Proteus mirabilis*

Genitourinary tract infections, including acute prostatitis, caused by *Escherichia coli*, *P. mirabilis*, and *Klebsiella* sp.

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

Contraindication: Keflex is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflex.

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

Precautions: Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflex occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflex may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Keflex should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflex, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Adverse Reactions: Gastrointestinal—The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Nausea, vomiting, dyspepsia, and abdominal pain have also occurred.

Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Eosinophilia, neutropenia, and slight elevations in SGOT and SGPT have been reported. [1:21279]

Additional information available to the profession on request.



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sician daily. These were, for the most part, overlooked in the preventive medicine issue. The prevention of nonpathological problems was not addressed adequately even though this is a major consideration in practice. The role of nonpathological problems in the natural history of disease was not discussed. No simple framework was provided with which to integrate the management of health and disease in a busy practice. The role of the family in disease prevention and health maintenance was not discussed.

It is important that we acknowledge our traditional enchantment with the measurement of pathology. We have become preoccupied with the easily obtained numbers derived therefrom. It is time for us in family medicine to develop and employ measures of health and nonpathological problems in order to further define our specialty and improve our practices.

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To the Editor:

In the July 1979 issue of *The Journal of Family Practice*, Grove et al (Grove DA, Reed RW, Miller LC: A health promotion program in a corporate setting. *J Fam Pract* 9:83, 1979) have reported impressive results from their experience with a health promotion program in a corporate setting. The results include significant weight loss and reduction in blood pressure and cholesterol levels. There are, however, three points which deserve mentioning as cautions for the reader against making hasty conclusions concerning the efficacy of such a program.

This is a one group pretest-post-test study. Therefore, concluding that the changes in the parameters measured are attributable to the program is subject to many biases. These include both internal biases (eg, changes in instrumentation accuracy, systematic variation in the parameters due to the passage of time) and external biases (eg, sociocultural changes with time).

A second point lies in the authors' lack of attention to non-participants of the program. What were the characteristics of those persons who (1) returned the questionnaire (54 percent) vs those who did not return the questionnaire, and (2) what were the characteristics of those participating in the intervention vs the nonparticipants? These comparisons are important to determine if the program is reaching those who need it most (those at high risk). Other studies indicate that primary prevention programs are used most frequently by those who need them least.¹

Finally, the authors note that caution must be observed to avoid expectations for rapid change. Similarly, it should be noted that their observations are short-term in nature and that only long-term positive results will bear the "proof of the pudding" . . . a decline in the incidence of disease greater in magnitude than a comparison group.

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Reference

1. Wilhelmsen L: A comparison between participants and non-participants in a primary preventive trial. *J Chron Dis* 29:331, 1976