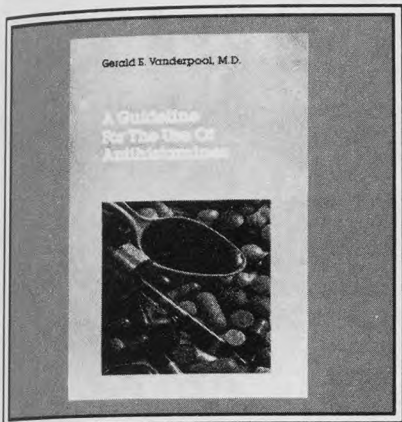


## A Special Service From Ross Laboratories

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



## RONDEC Tablet

(carbinoxamine maleate, 4 mg; pseudoephedrine HCl, 60 mg per tablet) R

### BRIEF SUMMARY:

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

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

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

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

### USUAL DOSAGE OF RONDEC Tablet

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

For full prescribing information, see package insert.

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

B159-9750

## Letters to the Editor

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.

### Treatment of Acute Renal Failure with Hyperkalemia

To the Editor:

I have found the section "Self-Assessment in Family Practice" to be a welcome addition to your excellent journal. In the October 1979 issue, a child with acute renal failure and hyperkalemia was presented (*J Fam Pract* 9:753, 1979). Although one could legitimately debate the priorities for corrective measures mentioned in the answer and discussion, the statement, "Although insulin and glucose, bicarbonate, and calcium gluconate all shift potassium within tissues, they do not remove it," may be somewhat ambiguous. Acute treatment of severe hyperkalemia is with glucose, insulin, and bicarbonate to shift potassium intracellularly, and with sodium and calcium salts to act as physiologic antagonists. Calcium, unlike glucose, insulin, and bicarbonate, does not lower serum potassium levels. Rather, calcium opposes the neuromuscular effects of hyperkalemia by decreasing membrane threshold potential and thereby exerts a cardio-protective effect. After infusion, electrocardiographic and clinical evidence of cardiac toxicity usually rapidly reverses. However, as suggested in the discussion, this effect is relatively transient if the hyperkalemia is not also decreased by other means, including the use



of exchange resins and, if necessary, dialysis.

Robert E. Pieroni, MD  
Associate Professor of  
Internal Medicine  
Associate Professor of  
Family Medicine  
University of Alabama  
University

### Recognition of Child Abuse

To the Editor:

The recent article in the November issue of *The Journal of Family Practice* entitled "Child Abuse: An Approach for Early Diagnosis" (Wilcox K: *J Fam Pract* 9:801, 1979) was extremely well written and, of course, important in both resident training and practitioner relevance.

The topic of child abuse and a preventive approach by the family physician brings to mind the need to emphasize in the office encounter with pediatric patients that the resident (and practitioner) spend some part of that office visit "checking out" parental attitudes and behaviors regarding the children. (This may be as important as the physical examination.)

For example, "Many parents have concerns about their parenting skills and yet seem never able to talk about them. I am interested

Continued on page 790

## Azo Gantrisin®/Roche

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

**Indications:** In adults, urinary tract infections complicated by pain (primarily cystitis, pyelitis and pyelonephritis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

**Important Note:** Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents including the sulfonamides. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

**Contraindications:** Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period. Contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with gastrointestinal disturbances, because of phenazopyridine HCl component.

**Warnings:** Safe use in pregnancy has not been established. Teratogenicity potential has not been thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

**Precautions:** Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, polyarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

**Dosage:** Usual adult dosage for acute, painful phase of urinary tract infections is 4 to 6 tablets initially, then 2 tablets four times daily for up to 3 days. If pain persists causes other than infection should be sought. After relief of pain has been obtained, continued treatment of the infection with Gantrisin (sulfisoxazole/Roche) may be considered.

**NOTE:** Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine soon after ingestion.

**How Supplied:** Tablets, each containing 0.5 Gm sulfisoxazole and 50 mg phenazopyridine HCl—bottles of 100 and 500.

## LETTERS TO THE EDITOR

Continued from page 787

in your thoughts or worries about:

1. How do you feel you are doing as a parent?
2. What kinds of things would you like to change about your parenting skills?
3. What kinds of problems do you seem to be having with your child?
4. What kinds of feelings might you have toward your child that surprise you or worry you?
5. Have you every physically punished your child harder or longer than you wanted to?
6. In what ways may I be able to help you through this period with your child?\*

In addition, the following kind of comment tends to stimulate good physician-patient interaction: "We know that many parents have strong or angry feelings at times towards their children and tend to feel guilty (or remorseful) because of it. It is important to your family that we talk about them. I think we can generally help."

This component of the pediatric evaluation structures a data base of behavior, skills, and attitudes of our patients toward their children. It not only assists in making a diagnosis of real or potential family dysfunction, it tends to develop a "negotiated treatment plan" regarding medical/psychosocial assistance. It elucidates the kind of information that assists the resident and practitioner in developing a protocol for "high-risk families," which includes the abused, neglected, and failure to thrive patient.

I would suggest that this type of questioning occur at least every year regarding the patient population because these patients and their parents may be moving from one life cycle to another and the

stages themselves may bring on difficulties that had not been present at earlier times.

This preventive aspect of family practice tends to have many families see their resident and practitioner as a helping, interested, and exceedingly skillful physician. Important to this issue, the resident and practitioner become cognizant of families, particularly mothers,\* who might now be able to speak of anxieties and fears of losing control of these angry feelings and who might be burdened with guilt over their fears of potentially hurting their children. Alternative resources, including professional counseling, are available to such families with the practitioner remaining as the primary health care provider.

We have structured this early intervention-prevention program into our residency training program. It appears that almost all residents can learn to deal with this highly charged emotional issue if faculty and preceptors believe that it fits into the "art" as well as the "science" of family medicine and practice.

I refer the reader to "The Fear of Committing Child Abuse: A Discussion of Eight Families" in the April issue of *Child Welfare* 56(4):249-257, 1977, for further information on this subject.

Alan S. Wolkenstein, ACSW  
Director of Behavioral Science  
Education  
St. Lukes' Family Practice Center  
Milwaukee, Wisconsin

\*My own work on the subject tends to show that a neurotic fear of committing child abuse tends to occur in mothers more than fathers. Further research is indeed indicated.

ROCHE

ROCHE LABORATORIES  
Division of Hoffmann-La Roche Inc.  
© Nutley, New Jersey 07110