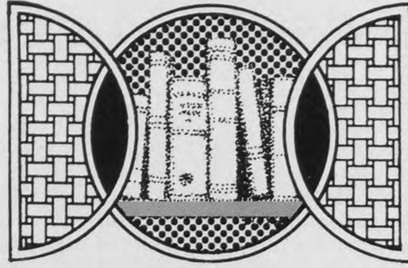
Book Reviews



The Physician and the Mental Health of the Child: Volume 1: Assessing Development and Treating Disorders Within a Family Context. *Herbert J. Grossman, James E. Simmons, Allen R. Dyer, Henry H. Work (eds). George Tarjan (series ed). American Medical Association, Monroe, Wisconsin, 1979, 111 pp., $4.00 (paper).*

This volume represents the first in a series of three monographs for primary care physicians on the mental health of children. It is subtitled "Assessing Development and Treating Disorders Within A Family Context," and is based on the proceedings of an AMA workshop on the mental health of children, held in 1976 and 1977.

The overall goal of this volume is to enable the primary care physician to better identify, manage, and refer children with abnormal development and emotional disturbance. Three interacting components are identified: the child, the family, and the physician. The first three chapters deal with diagnosis. Emphasis is on the "Family Inventory," an outline questionnaire which elicits not only the child's symptoms but also his interpersonal and family relationships. Included also are descriptions of various stages of normal development and brief explanation of many of the standard tests of mental and emotional development currently employed. The next three chapters deal with assessment on a clinical level; first, of the child, with lists of key symptoms, vulnerabilities, and strengths; then, of parents, supplemented by a table of family developmental stages, and lists of desirable parental skills and periods of increased risk. Finally, the emotional concomitants of physical illness are described from the viewpoint of the patient, the parent, and the professional. The last chapter in this section deals with treatment options. There is a shorter second section which discusses the effect that different cultural backgrounds have on patient care and the common problems affecting the mental health of nonmainstream families.

The editors have attempted to cover a large body of information in relatively few pages. The result has been a compilation of many useful diagnostic tables, outlines, and summaries tied together by a readable philosophy rich in empathy.

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A New Approach to Medicine: Priorities and Principles of Health Care. *John Fry. University Park Press, Baltimore, 1978, 149 pp., $12.50.*

In this neat little book, John Fry describes what might be, could be, should be, and can be accomplished

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Brief Summary of Prescribing Information
Indications: Relief and/or prevention of symptoms of asthma and reversible bronchospasm associated with chronic bronchitis and emphysema.
Contraindications: Hypersensitivity to anhydrous theophylline or ethylenediamine.
Warnings: Phyllocontin Tablets–225 mg Are Not Recommended for Children Under the Age of 12.
Phyllocontin Tablets–225 mg are not recommended for use in acute attacks because of the controlled-release action, but are recommended for long-term or prophylactic management. Apparently, tolerance does not develop.
Since excessive aminophylline doses may be associated with toxicity, determination of serum theophylline levels is recommended to assure maximum benefit without undue risk. The incidence of toxicity increases at serum levels greater than 20 mcg/ml. Even with conventional doses, high blood levels of theophylline may occur with associated clinical manifestations of toxicity, especially in: (1) patients with lowered body plasma clearances (due to transient cardiac decompensation); (2) patients with liver dysfunction or chronic obstructive lung disease; (3) patients who are older than 55 years of age, particularly males. Early signs of toxicity, such as nausea and restlessness, may appear in up to 50 percent of patients prior to onset of convulsions. However, ventricular arrhythmias or seizures may occur without any preliminary signs of toxicity. Aminophylline products also may worsen pre-existing arrhythmias. Morphine, curare, and stilbamidine should be used with caution in patients with airflow obstruction since they stimulate histamine release and can induce asthmatic attacks. They may also suppress respiration leading to respiratory failure. Alternative drugs should be used whenever possible.
Usage in Pregnancy: Safe use in pregnancy has not been established.
Precautions: Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, and in the elderly (especially males). Great caution should especially be used in patients with congestive heart failure, since they may show markedly prolonged theophylline blood levels for long periods following discontinuation of the drug.
Use cautiously in patients with a history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract, although gastrointestinal symptoms are more commonly central and associated with serum concentrations over 20 mcg/ml.
Smokers may require larger doses of theophylline or aminophylline since in them the mean half-life is shorter.
Adverse Reactions: Adverse reactions reported in the literature are usually due to overdose and are: *Gastrointestinal:* nausea, vomiting, epigastric pain, hematemesis, diarrhea. *CNS:* headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions. *Cardiovascular:* palpitation, tachycardia, extra systoles, flushing, hypotension, circulatory failure, life threatening ventricular arrhythmias. *Respiratory:* tachypnea. *Renal:* albuminuria, increased excretion of renal tubular cells and red blood cells; potentiation of diuresis. *Others:* hyperglycemia and inappropriate ADH syndrome; rash (associated with ethylenediamine).
Drug Interactions: Toxic synergism with ephedrine has been documented and may occur with other sympathomimetic bronchodilators. Aminophylline with lithium carbonate may cause increased excretion of lithium carbonate. Aminophylline antagonizes the effect of propranolol. Theophylline given with furosemide increases diuresis. Given with hexamethonium, it decreases the chronotropic effect of the latter. Theophylline with reserpine causes reserpine-induced tachycardia. With chlordiazepoxide, it leads to chlordiazepoxide-induced fatty acid mobilization. If given with cyclamycin, TAO (troleandomycin), erythromycin, lincomycin, theophylline plasma levels increase.
Caution: Federal law prohibits dispensing without a prescription.
Supplied: Bottles of 100 controlled-release tablets: 225 mg.

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in health care. Although such global issues are no longer decided by physicians alone, it would be a good idea for any practitioner to scan the text. Medical educators, health economists, family physicians, and politicians involved in health should study it.

Dr. Fry is perhaps the best known of the traditional British general practitioners, and rightly so. He has taught the world about primary care, and records its essential elements in this volume. Such aphorisms as the following, paraphrased for brevity, reflect his philosophies:

•Common diseases occur frequently; rare diseases hardly ever happen.

•A community's medical wants exceed its needs, and its resources.

•Many improvements in health care are more the result of social than medical advances.

•Many disorders and discomforts cannot be cured.

•The objectives of primary care range beyond the individual and family into the local community.

•Through health education bad personal, family, and community habits should be corrected, environmental hazards put right, and vulnerable at-risk groups defined and helped.

•Self-care, self-help, and self-responsibility for health must be encouraged.

•All who seek to cure must also care.

•The hospital should become much more of a *health* center.

In stressing the value of primary care, Dr. Fry notes that more than half of all the physicians in England are general practitioners, but they account for less than ten percent of the health care budget. In treating patients in the community, they serve as the protector of the hospital.

To no one's surprise, Dr. Fry's English heritage comes through in his language, and in his preaching for planning, priorities, rationing, controls, and directives. This orientation does not obscure the value of the many solid observations he makes about family practice and primary care.

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Treating Sexual Problems in Medical Practice. *David K. Kentsmith, Merrill T. Eaton, Jr. Arco Publishing, New York, 1979, 174 pp., $12.00 (paper).*

In the preface the authors state: This work is an attempt by the authors to synthesize into a textbook the current medical art and science of treating patients with sexual problems. The book is organized in such a way that a person intending to provide primary medical care can learn the basic techniques of treating sexual problems in medical practice as well as develop a background of general and practical information in the field of human sexuality. . . . The book specifically addresses the most frequent sexual concerns of patients most clinicians encounter in practice.

Beginning with a chapter on obtaining sexual histories, the text then discusses the physiology of sex and common patterns of sexual behavior. Additional chapters deal with homosexuality and deviant sexual behavior. The final chapters address counseling of patients with sexual problems, referrals for sexual therapy, and issues in sex education. Organizationally, the authors define sexual problems either as symptoms of broader psychosocial or organic problems, or as problems of primary sexual dysfunction.

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Fastin® 30 mg. Ⓒ IV
(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

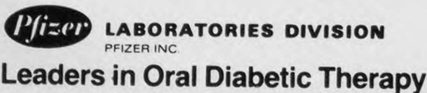
DIABINESE®
(chlorpropamide) 100-mg and 250-mg Tablets

BRIEF SUMMARY
DIABINESE® (chlorpropamide) Tablets

Contraindications: Diabinese is not indicated in patients having juvenile or growth-onset diabetes mellitus, severe or unstable "brittle" diabetes, and diabetes complicated by ketosis and acidosis, diabetic coma, major surgery, severe infection, or severe trauma.
Diabinese is contraindicated during pregnancy. Serious consideration should be given to the potential hazard of its use in women of childbearing age who may become pregnant.
Diabinese is contraindicated in patients with serious impairment of hepatic, renal, or thyroid function.
Precautions: Use chlorpropamide with caution with barbiturates, in patients with Addison's disease or in those ingesting: alcohol, antibacterial sulfonamides, phenylbutazone, salicylates, probenecid, dicoumarol or MAO inhibitors.
Warnings: DIABINESE (CHLORPROPAMIDE) SHOULD NOT BE USED IN JUVENILE DIABETES OR IN DIABETES COMPLICATED BY ACIDOSIS, COMA, SEVERE INFECTION, MAJOR SURGICAL PROCEDURES, SEVERE TRAUMA, SEVERE DIARRHEA, NAUSEA AND VOMITING, ETC.
HYPOGLYCEMIA, IF IT OCCURS, MAY BE PROLONGED.
Adverse Reactions: Usually dose-related and generally respond to reduction or withdrawal of therapy. Generally transient and not of a serious nature and include anorexia, nausea, vomiting and gastrointestinal intolerance; weakness and paresthesias.
Certain untoward reactions associated with idiosyncrasy or hypersensitivity have occasionally occurred, including jaundice (rarely associated with severe diarrhea and bleeding), skin eruptions rarely progressing to erythema multiforme and exfoliative dermatitis, and probably depression of formed elements of the blood. With a few exceptions, these manifestations have been mild and readily reversible on the withdrawal of the drug.
Diabinese should be discontinued promptly when the development of sensitivity is suspected.
Jaundice has been reported, and is usually promptly reversible on discontinuance of therapy. THE OCCURRENCE OF PROGRESSIVE ALKALINE PHOSPHATASE ELEVATION SHOULD SUGGEST THE POSSIBILITY OF INCIPIENT JAUNDICE AND CONSTITUTES AN INDICATION FOR WITHDRAWAL OF THE DRUG.
Leukopenia, thrombocytopenia and mild anemia, which occur occasionally, are generally benign and revert to normal, following cessation of the drug.
Cases of aplastic anemia and agranulocytosis, generally similar to blood dyscrasias associated with other sulfonylureas, have been reported.
BECAUSE OF THE PROLONGED HYPOGLYCEMIC ACTION OF DIABINESE, PATIENTS WHO BECOME HYPOGLYCEMIC DURING THERAPY WITH THIS DRUG REQUIRE CLOSE SUPERVISION FOR A MINIMUM PERIOD OF 3 TO 5 DAYS, during which time frequent feedings or glucose administration are essential. The anorectic patient or the profoundly hypoglycemic patient should be hospitalized.
Rare cases of phototoxic reactions have been reported.
Edema associated with hyponatremia has been infrequently reported. It is usually readily reversible when medication is discontinued.
Dosage: The mild to moderately severe, middle-aged, stable diabetic should be started on 250 mg daily. Because the geriatric diabetic patient appears to be more sensitive to the hypoglycemic effect of sulfonylurea drugs, older patients should be started on smaller amounts of Diabinese, in the range of 100 to 125 mg daily.
After five to seven days following initiation of therapy, dosage may be adjusted upward or downward in increments of 50 to 125 mg at intervals of three to five days.
Patients who do not respond completely to 500 mg daily will usually not respond to higher doses. Maintenance doses above 750 mg daily should be avoided.
Supply: 100 mg and 250 mg, blue, 'D'-shaped, scored tablets.

More detailed professional information available on request.

References: 1. Bunn HF: Glycosylated hemoglobins and diabetes mellitus. *Resident and Staff Physician* 24:53-57, December 1978. 2. Koenig RJ, Peterson CM, Kilo C, et al: Hemoglobin A_{1c} as an indicator of the degree of glucose intolerance in diabetes. *Diabetes* 25:230-232, March 1976. 3. Koenig RJ, Cerami A: Synthesis of hemoglobin A_{1c} in normal and diabetic mice: Potential model of basement membrane thickening. *Proc Natl Acad Sci USA* 72:3687-3691, September 1975. 4. Koenig RJ, Peterson CM, Jones RL, et al: Correlation of glucose regulation and hemoglobin A_{1c} in diabetes mellitus. *N Engl J Med* 295:417-420, August 19, 1976. 5. Peterson CM, Jones RL: The utility of hemoglobin A_{1c} in diabetes mellitus and preliminary studies with chlorpropamide. *Diabetes in Theory and in Practice*. New York, Biomedical Information Corporation, 1978, pp 28-33.



Leaders in Oral Diabetic Therapy

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This is a short textbook which can be read from cover to cover in three to four hours. The authors, relying heavily on the basic work of Masters and Johnson, reflect that they are providing a statement on the current state of the art, and clearly indicate that there has been limited research in the area.

From this reviewer's perspective, the authors have provided a good survey of a very broad area. It is an introductory text which can be of real assistance to students in medicine and nursing. Its very strength is also its weakness. To attempt to cover the field of sexuality from normal functioning through deviant sexual behavior to diagnosis and counseling is a large order for a small text. Several chapters could easily be expanded into books. Don't expect upon completing this book to have an indepth knowledge of human sexuality, deviant sexual behavior, and techniques of sexual counseling. On the other hand, do expect to obtain a good introduction to an area which long has been inappropriately viewed as outside the territory of primary care.

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Psychiatry in General Medical Practice. *Gene Usdin, Jerry M. Lewis. McGraw-Hill, New York, 1979, 736 pp., $19.95.*

The title of this book is misleading. As the authors state in their preface, it is a basic textbook of psychiatry. There is no special applicability to family medicine, primary care, or general practice. However, it is a better elucidation of basic psychiatry by university based psychiatrists than most similar texts, and it does assume that readers are preparing for clinical practice.

A distinctive attempt is made to combine the science and humanism that apply to persons with psychiatric disorders. Brief case summaries illustrate many concepts. An "editors' introduction" precedes each chapter, attempting to link the knowledge in those pages to an actual competency sought or needed by practicing physicians. Definitions are clear and concepts tend to be lucid and succinct. Also, there is an emphasis on the more mild psychiatric entities and the overlapping areas of organic medicine.

Strengths of this text for the practice or teaching of family medicine are mostly in the areas of family dynamics, illness behavior, psychosomatic medicine, and counseling for marital and sexual dysfunction. Even in these areas the objective for the reader should be the improved understanding of basic knowledge. The dominant framework is insight oriented therapy, emphasizing psychoanalytic theory. Learning theory and other frameworks are de-emphasized.

Specific chapters from this text are potentially useful for those persons teaching medical students, student nurse practitioners, or other trainees at a comparable level in areas we might now call "primary care behavioral science." Medical school faculty, preceptors, and persons involved in in-service didactic programs may wish to recommend this text.

Family physicians will not find the content or perspective applicable to most patient care or teaching as it is superficial, basic, and psychoanalytic in its approach.

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