VALIUM® IV
diazepam/
Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; 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 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 been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. 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:* Anxiety disorders, symptoms of anxiety, 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/Roche) 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 in trays of 10.

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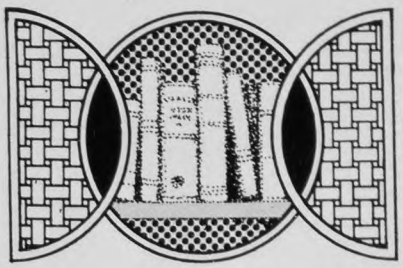
Book Reviews



General Dermatology. *Franklin S. Glickman. PSG Publishing Company, Littleton, Massachusetts, 1979, 366 pp., $32.50.*

General Dermatology was intended by its author to be a comprehensive guide to dermatologic conditions encountered by nondermatologists in daily practice, and the text turns out to be exactly that. Busy family physicians, as well as other primary care providers, will find this text relevant and useful.

Diagnosis of common cutaneous conditions encountered on a daily basis in family practice are thoroughly covered in an interesting and well-organized manner. Descriptions are made utilizing appropriate, easily readable, and understandable terminology. Diagnostic descriptions, although concise, are in enough detail to assist the reviewer in making a diagnosis, or suggesting the differential diagnosis, in most daily practice situations. Emphasis is on the common, although less common cutaneous conditions are also given appropriate coverage.

Therapy for easily treatable common skin problems is described in sufficient detail. More complex therapeutic regimens for some relatively common skin conditions are not as comprehensively described. These are the types of conditions in which some family physicians will appropriately obtain consultation, while others will seek more detailed references, and making use of previous experience, manage the therapy themselves.

The major weakness of this text is the quality of illustrations; all are in textbook black and white which adds little to the good descriptive text. For those who desire or require good illustrations for diagnostic assistance, a color atlas is advised to supplement this text.

In the opinion of this reviewer, *General Dermatology* is a good basic text for familiarizing senior medical students and family practice residents with common cutaneous conditions. Color slides or an atlas would probably be a necessary supplement at this level. For the practicing family physician, this text provides well-organized, rapidly utilizable diagnostic information and enough therapy to enable appropriate management of

Continued on page 688

. . . *too valuable to keep in reserve*

Macrodantin®
(nitrofurantoin macrocrystals)
Capsules: 25,50,100mg

INDICATIONS: Macrodantin is indicated for the treatment of urinary tract infections when due to susceptible strains of *Escherichia coli*, enterococci, *Staphylococcus aureus* (it is not indicated for the treatment of associated renal cortical or perinephric abscesses), and certain susceptible strains of *Klebsiella* species, *Enterobacter* species, and *Proteus* species.

NOTE: Specimens for culture and susceptibility testing should be obtained prior to and during drug administration.

CONTRAINDICATIONS: Anuria, oliguria, or significant impairment of renal function (creatinine clearance under 40 ml per minute) are contraindications to therapy with this drug. Treatment of this type of patient carries an increased risk of toxicity because of impaired excretion of the drug. For the same reason, this drug is much less effective under these circumstances.

The drug is contraindicated in pregnant patients at term as well as in infants under one month of age because of the possibility of hemolytic anemia due to immature enzyme systems (glutathione instability).

The drug is also contraindicated in those patients with known hypersensitivity to Macrodantin, Furadantin® (nitrofurantoin), and other nitrofurantoin preparations.

WARNINGS: Acute, subacute and chronic pulmonary reactions have been observed in patients treated with nitrofurantoin products. If these reactions occur, the drug should be withdrawn and appropriate measures should be taken.

An insidious onset of pulmonary reactions (diffuse interstitial pneumonitis or pulmonary fibrosis, or both) in patients on long-term therapy warrants close monitoring of these patients.

There have been isolated reports giving pulmonary reactions as a contributing cause of death. (See Hypersensitivity reactions.)

Cases of hemolytic anemia of the primaquine sensitivity type have been induced by Macrodantin. The hemolysis appears to be linked to a glucose-6-phosphate dehydrogenase deficiency in the red blood cells of the affected patients. This deficiency is found in 10 percent of Negroes and a small percentage of ethnic groups of Mediterranean and Near-Eastern origin. Any sign of hemolysis is an indication to discontinue the drug. Hemolysis ceases when the drug is withdrawn.

Pseudomonas is the organism most commonly implicated in superinfections in patients treated with Macrodantin.

Hepatitis, including chronic active hepatitis, has been observed rarely. Fatalities have been reported. The mechanism appears to be of an idiosyncratic hypersensitive type.

PRECAUTIONS: Peripheral neuropathy may occur with Macrodantin therapy; this may become severe or irreversible. Fatalities have been reported. Predisposing conditions such as renal impairment (creatinine clearance under 40 ml per minute), anemia, diabetes, electrolyte imbalance, vitamin B deficiency, and debilitating disease may enhance such occurrence.

Usage in Pregnancy: The safety of Macrodantin during pregnancy and lactation has not been established. Use of this drug in women of childbearing potential requires that the anticipated benefit be weighed against the possible risks.

ADVERSE REACTIONS: Gastrointestinal reactions: Anorexia, nausea and emesis are the most frequent reactions; abdominal pain and diarrhea occur less frequently. These dose-related toxicity reactions can be minimized by reduction of dosage, especially in the female patient. Hepatitis occurs rarely.

Hypersensitivity reactions: Pulmonary sensitivity reactions may occur, which can be acute, subacute, or chronic.

Acute reactions are commonly manifested by fever, chills, cough, chest pain, dyspnea, pulmonary infiltration with consolidation or pleural effusion on x-ray, and eosinophilia. The acute reactions usually occur within the first week of treatment and are reversible with cessation of therapy. Resolution may be dramatic.

In subacute reactions, fever and eosinophilia are observed less often. Recovery is somewhat slower, perhaps as long as several months. If the symptoms are not recognized as being drug related and nitrofurantoin is not withdrawn, symptoms may become more severe.

Chronic pulmonary reactions are more likely to occur in patients who have been on continuous nitrofurantoin therapy for six months or longer. The insidious onset of malaise, dyspnea on exertion, cough, and altered pulmonary function are common manifestations. Roentgenographic and histologic findings of diffuse interstitial pneumonitis or fibrosis, or both, are also common manifestations. Fever is rarely prominent.

The severity of these chronic pulmonary reactions and the degree of their resolution appear to be related to the duration of therapy after the first clinical signs appear. Pulmonary function may be permanently impaired even after cessation of nitrofurantoin therapy. This risk is greater when pulmonary reactions are not recognized early.

Dermatologic reactions: Maculopapular, erythematous, or eczematous eruption, pruritus, urticaria, and angioedema.

Other hypersensitivity reactions: Anaphylaxis, asthmatic attack in patients with history of asthma, cholestatic jaundice, hepatitis, including chronic active hepatitis, drug fever, and arthralgia.

Hematologic reactions: Hemolytic anemia, granulocytopenia, leukopenia, eosinophilia, and megaloblastic anemia. Return of the blood picture to normal has followed cessation of therapy.

Neurological reactions: Peripheral neuropathy, headache, dizziness, nystagmus, and drowsiness.

Miscellaneous reactions: Transient alopecia. As with other antimicrobial agents, superinfections by resistant organisms may occur. With Macrodantin, however, these are limited to the genitourinary tract because suppression of normal bacterial flora elsewhere in the body does not occur.

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most common conditions. All of the above could find this text most useful as a review for both daily practice and board examinations.

Stanley Erney, MD
University Center at Binghamton
New York

Family Practice: Foundation of Changing Health Care. *John P. Geyman. Appleton-Century-Crofts, New York, 1980, 543 pp., $28.50.*

The author of this book is extremely modest when he states that it is written primarily for medical students, family practice residents, and medical educators. It may have been written for that purpose but indeed it should be read by everyone interested in health or medical care. Awaiting it should be a place not only in medical libraries, but public libraries as well, where its availability will provide ready access for information and reference.

The book begins by tracing the history of General Practice and its transition to Family Practice. It carefully describes the social forces and the deficiencies in health and medical care which have brought Family Practice into being as a strong and growing specialty. Dr. Geyman, with great insight, discusses the areas of primary care, the changing health care system, and changing trends in medical education.

All segments of education in and for family practice are described and discussed with great accuracy, as one would expect from an individual whose life interest has been in this field. Patterns of practice of family physicians are described and one of the most interesting chapters deals with family practice as a career option. This part of the book discusses such things as misconceptions about family practice, personal satisfactions in family practice, and requisites for the family physician. And finally, research opportunities and options are presented, indicating that family medicine does have a place in clinical investigation, meeting needs not being met by other specialties.

All information in this book is carefully supported by well-collected data and references. Accompanying charts and graphs are appropriate to the written material and easily understood.

It should be emphasized that this is not a clinical textbook on family practice. Rather it is, as the title implies, a book on Family Practice, the foundation stone of a changing system of health care. It should be read by everyone interested in health, but particularly those close to health care delivery, medical care, and education.

George E. Burket, Jr., MD
Leawood, Kansas

Dying: Facing the Facts. *Hannelore Wass (ed). Hemisphere Publishing Company, Washington, DC, 1979, 426 pp., $19.95 (cloth), $10.95 (paper).*

The prospect of reviewing yet another book on death and dying was not, at first, an appealing one. How could this volume contribute

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to the already burgeoning literature in the field? Further examination, however, revealed that it may, indeed, be a significant advance of great practical usefulness to residents in training and physicians in practice.

Edited by Dr. Hannelore Wass, who has also written some of the chapters, the book contains an impressive list of other contributors. Through Dr. Wass's efforts to keep the style and terminology uniform, the language non-technical, and the layout systematic, the reader is spared the confusion often encountered where many authors contribute to a single text.

The book begins with several chapters which examine historical aspects of death and dying and their effects in our society and on ourselves. It later deals with the institutional aspects of dying and describes current developments in hospice care. Individual sections are devoted to "Death and the Elderly," "Children and Death," and "Bereavement and Grief."

The last several chapters consider some of the more difficult issues facing society and medicine today, such as the definition of death and the question of euthanasia. The concluding chapter presents a view of the death education movement, as well as some strategies to help us come to terms with our own mortality. Each chapter is well organized and contains an extensive bibliography.

The family physician frequently deals with the family of the dying patient as a unit—and a chapter devoted to this issue would have strengthened the content and added a new dimension of practical usefulness for most physicians.

In her preface, Dr. Wass expresses the hope that the book will become a standard basic text. It is very readable despite the difficult subject matter. Each topic is addressed in a scholarly and detailed manner, yet the language remains comprehensible to both the lay public and the professional. It is informative and stimulating without being superficial and, as any good textbook in a new field should, it leaves many questions unresolved,

Continued on page 690

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yet succeeds in defining those questions clearly. Time and student acceptance will dictate whether the book is to become a standard text in death and dying, but it should stand an excellent chance.

Peter Coggan, MD
University of Washington
Seattle

ECG Arrhythmia Interpretation: A Programmed Text for Health Care Personnel. *Harold A. Braun, Gerald A. Diettert. Reston Publishing Company, Reston, Virginia, 1979, 400 pp., $13.95.*

This book provides a painless way to learn the basics of the diagnosis of arrhythmias. It is carefully planned and clearly presented with appropriate diagrams and ECG tracings.

Interpretation of the electrocardiogram lends itself to "programmed learning." The student is systematically presented with information, and questions are asked at intervals to test his/her grasp of the concepts and facts. A correct answer allows the student to continue; an incorrect answer is followed by immediate feedback. It is a logical and effective way to learn, ideally suited to noncontroversial knowledge and skills such as interpretation of the ECG.

Although the book only covers this one aspect of electrocardiography, it will be particularly useful for those, including family practice residents, medical students, and other health care professionals, who work in Intensive Coronary Care Units and Emergency Rooms and need to recognize normal and abnormal cardiac rhythms. It does not take long to work through the program and upon completion, the reader should have a grasp of the important practical aspects of the subject.

James Cox, MD
Morpeth, Northumberland
England

Legal Medicine Annual: 1978. *Cyril H. Wecht (series ed). Appleton-Century-Crofts, New York, 1979, 461 pp., $32.50.*

Legal Medicine Annual: 1978 contains 21 chapters by 25 authors. The first 12 chapters are of interest mainly to attorneys, forensic pathologists, and physicians involved in medicolegal investigations. Later chapters provide an extensive review of professional liability and its many complexities. Sections on informed consent, malpractice prevention, arbitration, and methods of coping with professional liability issues are presented in excellent detail.

The changes evolving in hospital law are of genuine interest to hospital administrators, medical staff leaders, and program directors of residency training programs. Sections on regulations affecting health care are informative and provocative.

This volume provides a valuable reference regarding medicolegal issues, presented in a well-organized and readily understood manner.

Legal Medicine Annual: 1978 is recommended as a reference text for physicians with special interest in medicolegal issues, especially those related to professional liability or forensic medicine.

William A. Fisher, MD
University of Oregon
Portland

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Composition: Each capsule, teaspoonful (5 ml.) or tablet contains 5 mg. hydrocodone (Warning: may be habit-forming), and 10 mg. phenyltoloxamine as cationic resin complexes.

Effects: An effective antitussive which acts for approximately 12 hours.

Dosage: Adults: 1 teaspoonful (5 ml.), capsule or tablet every 8-12 hours. May be adjusted to individual requirements. Children: From 1-5 years: ½ teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

Side Effects: May include mild constipation, nausea, facial pruritus, or drowsiness, which disappear with adjustment of dose or discontinuance of treatment.

Precaution: In young children the respiratory center is especially susceptible to the depressant action of narcotic cough suppressants. Benefit to risk ratio should be carefully considered especially in children with respiratory embarrassment. Estimation of dosage relative to the age and weight of the child is of great importance.

Overdosage: Immediately evacuate the stomach. Respiratory depression, if any, can be counteracted by respiratory stimulants. Convulsions, sometimes seen in children, can be controlled by intravenous administration of short-acting barbiturates.

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References:

1. Cass LJ, Frederik WS: The prolonged use of a sustained release antitussive. Cambridge, Mass, University Health Services, Harvard University, 1959.
2. Cass LJ: The clinical evaluation of a new sustained-release antitussive of low narcotic content. *Curr Ther Res* 3:355-359, 1961.
3. Chan YT, Hays EE: A resin complex for prolonged antitussive effects. *Am J Med Sci* 234:207-212, 1957.

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