


TUSSI-ORGANIDIN™
TUSSI-ORGANIDIN™ DM

Before prescribing, please consult complete product information, a summary of which follows: **INDICATIONS AND USAGE:** For the symptomatic relief of irritating, nonproductive cough associated with respiratory tract conditions such as chronic bronchitis, bronchial asthma, tracheobronchitis, and the common cold; also for the symptomatic relief of cough accompanying other respiratory tract conditions such as laryngitis, pharyngitis, croup, pertussis and emphysema. Appropriate therapy should be provided for the primary disease. **CONTRAINDICATIONS:** History of marked sensitivity to inorganic iodides; hypersensitivity to any of the ingredients or related compounds; pregnancy; newborns; and nursing mothers. The human fetal thyroid begins to concentrate iodine in the 12th to 14th week of gestation and the use of inorganic iodides in pregnant women during this period and thereafter has rarely been reported to induce fetal goiter (with or without hypothyroidism) with the potential for airway obstruction. If the patient becomes pregnant while taking any of these products, the drug should be discontinued and the patient should be apprised of the potential risk to the fetus. **WARNINGS:** These products contain an antihistamine which may cause drowsiness and may have additive central nervous system (CNS) effects with alcohol or other CNS depressants (e.g., hypnotics, sedatives, tranquilizers). Discontinue use if rash or other evidence of hypersensitivity appears. Use with caution or avoid use in patients with history or evidence of thyroid disease. **PRECAUTIONS: General**—Antihistamines may produce excitation, particularly in children. Iodides have been reported to cause a flare-up of adolescent acne. Children with cystic fibrosis appear to have an exaggerated susceptibility to the goitrogenic effects of iodides. Dermatitis and other reversible manifestations of iodism have been reported with chronic use of inorganic iodides. Although these have not been a problem clinically with Organidin formulations, they should be kept in mind in patients receiving these preparations for prolonged periods. **Information for Patients**—Caution patients against drinking alcoholic beverages or engaging in potentially hazardous activities requiring alertness, such as driving a car or operating machinery, while using these products. **Drug Interactions**—Iodides may potentiate the hypothyroid effect of lithium and other antithyroid drugs. MAO inhibitors may prolong the anticholinergic effects of antihistamines. **Carcinogenesis, Mutagenesis, Impairment of Fertility**—No long-term animal studies have been performed with Tussi-Organidin or Tussi-Organidin DM. **Pregnancy**—Teratogenic effects: Pregnancy Category X (see CONTRAINDICATIONS). **Nursing Mothers**—Tussi-Organidin or Tussi-Organidin DM should not be administered to a nursing woman. **ADVERSE REACTIONS:** Side effects with Tussi-Organidin and Tussi-Organidin DM have been rare, including those which may occur with the individual ingredients and which may be modified as a result of their combination. **Organidin**—Rare side effects include gastrointestinal irritation, rash, hypersensitivity, thyroid gland enlargement, and acute parotitis. **Codeine**—(Tussi-Organidin only): Nausea, vomiting, constipation, drowsiness, dizziness, and miosis have been reported. **Dextromethorphan**—(Tussi-Organidin DM only): Rarely produces drowsiness or gastrointestinal disturbances. **Chlorpheniramine**—The most common side effects of antihistamines have been drowsiness, sedation, dryness of the mucous membranes, and gastrointestinal effects. Less commonly reported have been dizziness, headache, heartburn, dysuria, polyuria, visual disturbances, and excitation (particularly in children). Serious adverse effects are rare. **DRUG ABUSE AND DEPENDENCE** (Tussi-Organidin only): **Controlled Substance**—Schedule V. **Dependence**—Codeine may be habit-forming. **The following sections are optional: OVERDOSAGE:** There have been no reports of any serious problems from overdosage with Tussi-Organidin nor Tussi-Organidin DM. **DOSAGE AND ADMINISTRATION Adults:** 1 to 2 teaspoonfuls every 4 hours. **Children:** 1/2 to 1 teaspoonful every 4 hours. **HOW SUPPLIED: Tussi-Organidin Elixir**—clear red liquid, in bottles of one pint (NDC 0037-4811-10) and one gallon (NDC 0037-4811-20). **Tussi-Organidin DM Elixir**—clear yellow liquid, in bottles of one pint (NDC 0037-4711-10). Storage: Store at room temperature; avoid excessive heat. Keep bottle tightly closed.

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 **WALLACE LABORATORIES**
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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.

Management of Diabetes in Adolescence

To the Editor:

Although the importance of psychological and iatrogenic factors in so-called "brittle" diabetes is well-illustrated by Greydanus and Hofmann ("A Perspective on the Brittle Teenage Diabetic," *J Fam Pract* 9:1007, 1979), it is unfortunate that they overlooked the seminal work of Minuchin et al¹ on the family dynamics of such superlabile diabetics. In their sample of 13 similar diabetics, 3 to 15 months of family treatment led to good control for all 13, including one patient who had been hospitalized 35 times in the 20 months prior to family treatment. This would suggest a possible route for more optimism in the management of Drs. Greydanus and Hofmann's first three cases. Minuchin et al found these families to be characterized by emotional enmeshment, overprotectiveness, lack of conflict resolution, and rigidity. The child's acute illness provides a temporary resolution to intolerable family conflict and tension. Similar dynamics were found in the families of children with intractable asthma and anorexia nervosa.

Not all family conflict or behav-

ior problems among adolescent diabetics follow this pattern. Minuchin et al² compared the family interactions of adolescent diabetics with good medical control (ie, "normal"), those with good medical control but other behavior problems (ie, "behavioral"), and those with superlabile diabetes (ie, "psychosomatic"), and found these interaction patterns (eg, enmeshment) only among the superlabile diabetics. This perspective, of course, calls for a shift in the focus of treatment from the diabetic patient to the family. The brittleness belongs to the family, not the diabetes.

A.H. Hal Strelnick, MD

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References

1. Minuchin S, Baker L, Rosman BL, et al: A conceptual model of psychosomatic illness in children: Family organization and family therapy. *Arch Gen Psychiatry* 32:1031, 1975
2. Minuchin S, Rosman BL, Baker L: Psychosomatic Families: Anorexia Nervosa in Context. Cambridge, Mass, Harvard University Press, 1978

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The preceding letter was referred to Dr. Greydanus who responds as follows:

I thank Dr. Strelnick for his interest and comments. It was the purpose of the article¹ to present one perspective, and not a complete survey on emotional or psychological brittleness in teenage diabetics. I would refer Dr. Strelnick to a recent review² which includes reference to the well-known work of Dr. Minuchin.

There are many approaches that have been advocated to prevent or deal with the brittle adolescent diabetic. The University of Rochester Adolescent Medical Clinic places care of *this* patient with a pediatrician or adolescent

medicine specialist, who works in close collaboration with a child/adolescent psychiatrist or psychologist. A team approach utilizing a physician, a psychologist, and a social worker has recently been advocated.³ Some brittle patients seem to benefit from family therapy per se, but others do not accept it or seem to be helped by it. Many variables are noted here, including the age of the patient, his/her maturity and cognitive development, type of family instability and interrelationships, capacity for insight, ability to relate to a health care professional, availability of competent therapists, financial status, and many others.

Unfortunately, there are few studies available to help the clinician match a particular patient and family with the best therapeutic modality. Sometimes a different

plan must be developed as the teenager goes through different adolescent phases. It is a complicated subject, and clearly further research is needed in this difficult diagnostic arena.

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References

1. Greydanus DE, Hofmann AD: A perspective on the brittle teenage diabetic. *J Fam Pract* 9:1007, 1979
2. Greydanus DE, Hofmann AD: Psychological factors in diabetes mellitus: A review of the literature with emphasis on adolescence. *Am J Dis Child* 133:1061, 1979
3. Laron Z, Galatzer A, Amir S, et al: A multidisciplinary, comprehensive, ambulatory treatment scheme for diabetes mellitus in children. *Diabetes Care* 2:342, 1979

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