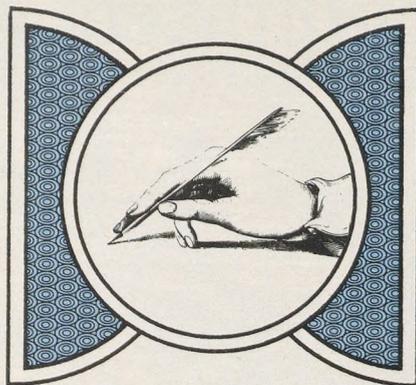


# Letters to the Editor



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 Hypertension To the Editor:

I would like to commend Dr. Forsyth on his survey of hypertension in office practice (*Hypertension in a primary care practice. J Fam Pract 10:803, 1980*). It is encouraging that studies of office based populations are now being done. Of particular interest to me was his suggestion that the later onset of cardiovascular disease in women as compared to men may be related to the later onset of hypertension in women shown in his population.

However, I have some serious reservations about two of Dr. Forsyth's four conclusions, namely, that "the level of diastolic blood pressure receive primary consideration when a determination is made as to whether or not an individual should be treated . . . (and) . . . the diastolic blood pressure be used to monitor the response to medication." I contend that these conclusions on the one hand are not warranted by his data and, on the other, are misleading and not supported by the preponderance of current epidemiologic information. As regards the first point, it is interesting that Dr. Forsyth finds a marked difference in the patterns of systolic and diastolic blood pressures in differ-

ent age groups; he also notes that the age distribution of diastolic hypertension in his study population correlates better with the age distribution for coronary risk found in the Framingham Study. But this correlation is hardly justification for his conclusions, particularly when one considers that Dr. Forsyth himself admits that his data bear no conclusive relationship to the prevalence of hypertension in the community at large. Secondly, data from The Framingham Study<sup>1</sup> showed clearly that elevated systolic pressure is a risk factor for cardiovascular disease. Other studies have shown that diastolic pressure is no better a predictor of coronary risk than is systolic pressure.<sup>2,3</sup> Lastly, he does not consider the risk of stroke which is clearly related to levels of systolic pressure.<sup>4,5</sup> Any physician following Dr. Forsyth's guidelines literally (eg, ignoring the systolic component of hypertension when judging response to medication) would probably be doing his patients a disservice.

I reiterate that I find Dr. Forsyth's data interesting and stimulat-

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\* Based on a review of this drug by the National Academy of Sciences - National Research Council and/or other information, FDA has classified the following indications as "probably effective" for Dimetapp Elixir: The symptomatic treatment of seasonal and perennial allergic rhinitis and vasomotor rhinitis; and "lacking substantial evidence of effectiveness as a fixed combination" for the following indications: Symptomatic relief of allergic manifestations of upper respiratory illnesses, acute sinusitis, nasal congestion, and otitis.

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**CONTRAINDICATIONS:** Hypersensitivity to antihistamines of the same chemical class. Dimetapp is contraindicated during pregnancy and in concurrent MAO inhibitor therapy. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma.

**WARNINGS:** *USE IN CHILDREN.* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

**PRECAUTIONS:** Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness, such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

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**DOSAGE AND ADMINISTRATION:** *ADULTS* - 1 to 2 teaspoonfuls 3 or 4 times daily. *CHILDREN (4 TO 12 YEARS)* - 1 teaspoon 3 or 4 times daily; (2 TO 4 YEARS) - 3/4 teaspoonful 3 or 4 times daily; (7 MONTHS TO 2 YEARS) - 1/2 teaspoonful 3 or 4 times daily; (1 TO 6 MONTHS) - 1/4 teaspoonful 3 or 4 times daily.

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Rev. Sept. 1978

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**Precautions:** In the first trimester of pregnancy, Mycelex should be used only when considered essential to the welfare of the patient.

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**Dosage and Administration:** Gently massage sufficient Mycelex Cream or Solution into the affected and surrounding skin areas twice a day, in the morning and evening.

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**References:** 1. Spiekermann PH, Young MD: Clinical evaluation of clotrimazole: A broad-spectrum antifungal agent. *Arch Dermatol* 112:350-352, 1976. 2. Duhm B, et al: The pharmacokinetics of clotrimazole <sup>14</sup>C. *Postgrad Med J*, July suppl, 1974, pp 13-16.

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ing as far as they go. The kind of inquiry he conducted needs to be done. But I object to the unwarranted conclusions of his paper and fear they may encourage mismanagement of hypertension.

David L. Hahn, MD  
W. J. Blevins Medical Group  
Woodland, California

## References

1. Kannel WB: Some lessons in cardiovascular epidemiology from Framingham. *Am J Cardiol* 37:269, 1976
2. Salel AF, Fong A, Zelis R, et al: Accuracy of numerical coronary profile correlation of risk factors with arteriographically documented severity of atherosclerosis. *N Engl J Med* 296:1447, 1977
3. Reid DD, Hamilton PJS, McCartney P, et al: Smoking and other risk factors for coronary heart-disease in British civil servants. *Lancet* 2:979, 1976
4. Rabkin SW, Mathewson AL, Tate RB: Predicting risk of ischemic heart disease and cerebrovascular disease from systolic and diastolic blood pressures. *Ann Intern Med* 88:342, 1978
5. Kannel WB, Dawber TR, Sorlie P, et al: Components of blood pressure and risk of atherothrombotic brain infarction: The Framingham study. *Stroke* 7:327, 1976

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

In criticizing my May 1980 article on hypertension, Dr. Hahn inaccurately states that the article advocates "ignoring the systolic component of hypertension" thereby risking strokes. He also states that "correlation is hardly justification for . . . conclusions." The relevant

quotes from my article are that the "findings suggest that for the prevention of coronary heart disease, emphasis should be placed on the . . . treatment of diastolic hypertension" and "the diastolic blood pressure (should) be used to monitor the response to medication."

To emphasize the control of the diastolic blood pressure in the prevention of coronary heart disease is in no way equivalent to ignoring the role of systolic blood pressure in strokes. Dr. Hahn was not justified in ignoring prior qualifying statements.

His comments on correlations and conclusions have some merit. It is a fact that a correlation does not confirm the presence of a cause and effect relationship. However, this does not mean that it is improper to state one's findings and then note the implications regarding treatment. That is precisely what was done in the studies which Dr. Hahn cites. The Framingham study<sup>1</sup> found that there was a strong correlation between systolic blood pressure and strokes. The therapeutic implication of that finding is that systolic blood pressure should be lowered regardless of the level of the diastolic blood pressure (eg, treat a patient with a blood pressure of 170/80 mmHg). That recommendation has been made and is being followed despite the fact that the controlled studies which have demonstrated a reduction in strokes have been based on diastolic hypertension. I found that diastolic blood pressure correlated with coronary heart disease pattern more than did systolic. The therapeutic implication is that diastolic blood pressure

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be treated despite the systolic blood pressure (eg, 140/100 mmHg). To point this out does not constitute "an unwarranted conclusion."

What needs to be discussed are the contradictory findings and not the legitimate therapeutic implications of those findings. Dr. Hahn seems to imply that my findings are invalid because previous studies have found that systolic and diastolic blood pressures are equivalent risk factors for coronary heart disease. Were he to have critically analyzed the Framingham study, he would have found that it did not differentiate between data from hyper-

tensives rendered normotensive by treatment and data from normotensives. It did not differentiate between data from reactive hypertensives and sustained hypertensives. It employed controversial statistical techniques<sup>2</sup> such as including data from the same individual up to five times in a ten-year cohort, and the application of multivariate analysis. It was not, as was my study, designed specifically to analyze hypertension. Hence, I cannot downgrade my findings and their implications simply because they are at variance with dogma.

Roger A. Forsyth, MD  
Department of Family Practice  
Southern California Permanente  
Medical Group  
Los Angeles

#### References

1. The Framingham Study: An epidemiological investigation of cardiovascular disease. Bethesda, Md, National Heart Institute, 1968
2. Werko L: Risk factors and coronary heart disease: Fact or fancy? *Am Heart J* 91: 87, 1976

#### Compliance-Oriented Prescribing

To the Editor:

It is a pity that Dr. Fischer's article "Compliance-Oriented Prescribing: Simplifying Drug Regimens" (*Fischer RG: J Fam Pract*

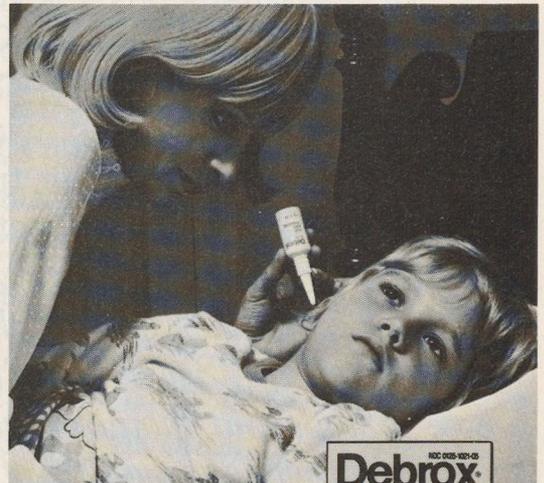
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# Valium® diazepam/Roche

LETTERS TO THE EDITOR

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10:427, 1980) is incomplete, in that he leaves out thyroxine and digoxin as two other drugs which, in this country at least, are still often given twice a day, and which could easily be given once a day.

It would also be a shame if many people got the impression that dose regimens were a very important factor in compliance. Many of us feel that this is much more dependent upon the physician-patient relationship.

Donald W. Gau  
Senior Lecturer in  
General Practice  
Middlesex Hospital  
Medical School  
London

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

In response to Dr. Gau's letter, I am sorry he perceives my article to be incomplete. The main objective of this article (*Fischer RG: Compliance-Oriented Prescribing: Simplifying Drug Regimens. J Fam Pract 10:427, 1980*) was to make physicians aware that many drugs originally approved by the FDA for multiple daily use are now approved for single-daily administration. Other drugs, without FDA approval for single daily administration but with reports in the literature, are also described. Both thyroxine and digoxin have always been approved for once a day administration and it is my experience most physicians in

the United States are aware of this fact. Medical teaching and practice may be different in London and, if so, I apologize for omitting these drugs. In regard to thyroxine, this is also routinely prescribed for once a day administration in this country. Since the plasma half-life approaches seven days, this drug may be administered less often. Several studies have reported success with once a week administration.<sup>1-3</sup>

I agree with Dr. Gau that it would be a shame if readers gained the impression that simplification of dosage regimens was the single most important answer to improving patient non-compliance. Obviously, there are many factors involved in patient non-compliance, some more important than others in specific patients. This article focuses on one area, simplifying drug regimens, which may be the prime reason for non-compliance in many patients, especially the elderly, the illiterate, and those on multiple medications.

Richard G. Fischer, PharmD  
Assistant Professor of Clinical  
Pharmacy  
University of Mississippi  
Medical Center  
Jackson

## References

1. Sekadde B, Slaunwhite WR, Aceto JR, et al: Administration of thyroxine once a week. *J Clin Endocrinol Metab* 39:759, 1974
2. Bernstein RS, Robbins J: Intermittent therapy with L-thyroxine. *N Engl J Med* 281:1444, 1969
3. Thein-Wai W, Larson PR: Effects of weekly thyroxine administration on serum thyroxine, 3,4,3-Triiodothyroxine, thyrotropin, and the thyrotropin response to thyrotropin-releasing hormone. *J Clin Endocrinol Metab* 50:560, 1980

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; adjunctive 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/Roche) 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 anti-depressants 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).

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