

Keflex®
cephalexin

Brief Summary. Consult the package literature for prescribing information.

Indications: Keflex is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Respiratory tract infections caused by *Streptococcus (Diplococcus) pneumoniae* and group A beta-hemolytic streptococci (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. Keflex is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of Keflex in the subsequent prevention of rheumatic fever are not available at present.)

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

Contraindication: Keflex is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflex.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Precautions: Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflex occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflex may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Keflex should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflex, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Adverse Reactions: Gastrointestinal—The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Nausea, vomiting, dyspepsia, and abdominal pain have also occurred.

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Keflex.

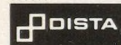
Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Eosinophilia, neutropenia, and slight elevations in SGOT and SGPT have been reported.

[070880R]

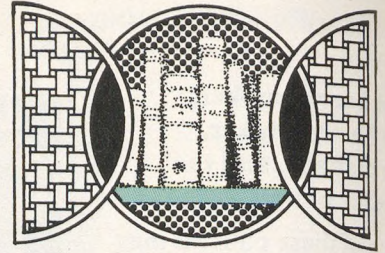
Additional information available to the profession on request from Dista Products Company, Division of Eli Lilly and Company, Indianapolis, Indiana 46285.

000906



Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Book Reviews



Behavioral Science in Family Practice. *Gerald M. Rosen, John P. Geyman, Richard H. Layton (eds).* *Appleton-Century-Crofts, New York, 1980, 304 pp., \$19.50.*

Recent years have seen the growth of the teaching of behavioral medicine in all medical disciplines with family medicine leading many other fields in recognizing its worth. However, a persistent difficulty has been the tendency to have behavioral medicine taught primarily by behavioral scientists rather than to see it as fundamental to what family physicians do and a subject which must be taught by them also. This book begins to address the need for integrating behavioral science, as taught by a partnership of family physicians and the social workers, psychologists, psychiatrists, and other therapists who constitute the behavioral scientists in most family medicine programs, into the larger context of family medicine.

The book is divided into three major sections: normative individual and family development, diagnostic approaches, and treatment. Each section contains chapters by family physicians, non-family physicians, and combinations of the two. The format is sensible and easy to work through, the language on the whole is free of psychological jargon, and there are a few chapters with interesting examples of new approaches such as patient self-monitoring and family health

groups. Case examples are used in many chapters which illustrate the particular point that the author is discussing, and useful tables in many places which clarify general concepts. Chapters by Leaman and Stephens are especially good examples of the integrative style of family physician educators.

One cannot expect a small textbook to be comprehensive, but for a text that will introduce students and residents to principles of behavioral medicine, this is a very good one. As a text it would be particularly helpful in many of the undergraduate interviewing courses taught by family physicians in medical schools.

John J. Frey, MD
University of North Carolina
Chapel Hill, North Carolina

Contemporary Issues in Biomedical Ethics. *John W. Davis, Barry Hoffmaster, Sarah Shorten (eds).* *Humana Press, Clifton, New Jersey, 1978, 320 pp., \$19.50.*

In this anthology philosophers talk with philosophers. The problems they address are those perceived as important by professional philosophers; practicing physicians are likely to identify others as more urgently in need of attention. The

Continued on page 560

Continued from page 550

(token?) physician or two that they engage in their discussions seems to have had little influence in the selection of topics as they are called upon to react to the philosophers' reflections; had the situation been reversed, I suspect that the issues would have been selected and defined differently. This is not to say that this is not a good book, for it is. However, it is not likely to be of value to family physicians who wish to advance their understanding of how they might think about problems encountered in their practices.

This book presents a series of previously unpublished essays that were read in 1977 at a Colloquium on Biomedical Ethics at the University of Western Ontario. Most of the essays are followed by commentaries in which the critic analyzes and, in most cases, disagrees with the arguments presented by the essayist. Since many of the essays deal primarily with metaethical issues, much of the book is concerned with debates between philosophers over how issues in medical ethics ought to be discussed and what language will engender the most felicitous analysis.

While I found several of the essays interesting and provocative, I am constrained by my space allocation to comment on only four. John Ladd observes that much modern discussion of medical ethics inappropriately uses the language of rights and obligations, an approach that he calls "legalism." He argues that this is an appropriate language for use in a court of law or for discussing the ethics of such impersonal relationships as exist between strangers or between

individuals and institutions (eg, hospitals). However, this language is not suitable for analysis of such personal relationships as exist (or should exist) between physician and patient. Ladd contends that personal relationships are more properly discussed in terms of responsibility, the ethics of giving and taking according to abilities and needs, respectively.

Lisa Newton observes, without remorse, that the "Hippocratic tradition" is dead. "An ethic contained in the morally virtuous person of the physician, qualified as a healer by the possession of *secret* wisdom. . . applied to ignorant and trusting patients is gone. It is supplanted by an ethic now in formation, contained in the medical dialog of the profession as a whole, qualified for healing by their *open* wisdom, acquired from continual inquiry and never complete, openly shared by responsible patients. . . . Participation in, and enhancement of, that dialog is the clearest obligation of the physician. . ." (emphases supplied).

David Roy argues that philosophers have a public professional responsibility to develop a system of norms to direct and to regulate the power of the scientific-technological community. In a most interesting fashion, he explores how philosophers may begin to approach this responsibility.

Arthur Dyck opines that, in a physician, compassion is a moral virtue and that we each have an ethical obligation to make ourselves more virtuous. In his view, compassion can and ought to be taught to medical students.

Other essays are concerned with, for example, whether there is

Continued on page 574

Dimetapp[®] Elixir ANTIHISTAMINE/ NASAL DECONGESTANT*

Each 5 ml (1 teaspoonful) contains:

Brompheniramine Maleate, NF	4 mg
Phenylephrine Hydrochloride, USP	5 mg
Phenylpropanolamine Hydrochloride, NF	5 mg
Alcohol, 2.3%	

INDICATIONS

*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.

Final classification of the less-than-effective indications requires further investigation.

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 overdose 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.

ADVERSE REACTIONS: Adverse reactions to Dimetapp may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS depressant and (less often) stimulant effect, increased irritability or excitement, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

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.

HOW SUPPLIED: Grape-flavored Elixir in 4 fl. oz., pints and gallons, and 5 ml Dis-Co[®] Unit Dose Packs (4 × 25s) (NDC 0031-2224).

Rev. Sept. 1978

A-H-ROBINS

A.H. Robins Company
Richmond, VA 23220
Member of Certified
Medical Representatives Institute

Valium® diazepam/Roche

BOOK REVIEWS

Continued from page 560

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 (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:** 2 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.

a morally relevant distinction between killing and allowing to die, whether the capacity to procreate is an important one and whether involuntary sterilization violates a right of privacy, whether it is appropriate—for purposes of ethical analysis—to analogize physicians to automobile mechanics, and whether we should be concerned with harming or benefiting persons who are not yet conceived.

The essays are generally of high quality, lively and interesting in style, and relatively free from the technical jargon that would exclude readers who are not philosophers.

Robert J. Levine, MD
Yale University School of Medicine
New Haven, Connecticut

Guide to Clinical Laboratory Diagnosis (2nd Edition). John A. Koepke. Appleton-Century-Crofts, New York, 1979, 310 pp., \$10.95 (paper).


With the phenomenal growth in the use of the clinical laboratory which greatly increases the data base of the clinician, and contributes materially to the escalating costs of health care, this book should be required reading for all medical students and practicing physicians. It addresses the problem of choosing those laboratory tests which will give the greatest information in the most efficient manner and for the least possible cost. Its aim is to provide guidelines for better use of the clinical laboratory so that when clini-

cians "hear hoof beats, they will think first of horses rather than zebras."

The key to the usefulness of this excellent text is its organization. The topics discussed in the various chapters deal with clinical problems as they present in daily practice, such as chest pain, cough and dyspnea, jaundice, indigestion and diarrhea, headache, and unexplained fever. Almost all of the common problems with which patients present are covered in a brief and concise manner. For each of these topics, basic information is provided prior to discussion of clinical investigation. Under the latter heading, clinical features of a disease entity are presented along with the laboratory studies which include both screening and definitive tests. The interpretation of each of the tests discussed is presented with a refreshing degree of clarity. For instance, in the chapter entitled "Anaemia," a logical rather than haphazard laboratory investigation of anemia is outlined.

In the introductory chapter, the importance of sensitivity and specificity of tests is emphasized, and is related to their predictive value and efficiency. The reader is admonished to be selective in laboratory use. In the following chapters, excellent use is made of both tables and diagrams to illustrate the points made. All of these contribute to the usefulness and readability of the book. In the brief chapter dealing with chronic diseases, there are precise comments on the value of multi-phasic health screening and suggested criteria for screening tests. These are of particular importance to the family physician who, by the nature of the practice,

Continued on page 591

 Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Continued from page 574

is involved in this process. Another brief chapter on the iatrogenic diseases and drug reactions is worthy of special note.

The author notes that almost 80 percent of the problems responsible for hospital admissions are covered in the chapters of the book. All of the subjects discussed are entities seen in a family physician's office. This is a very useful book for sharpening diagnostic expertise.

Irwin W. Bean, MD

*The Wellesley Hospital and the
University of Toronto
Toronto, Ontario*

Atlas of Bedside Procedures.

*Thomas J. Vander Salm, Bruce S. Cutler, H. Brownell Wheeler (eds).
Little, Brown and Company, Boston,
1979, 408 pp., \$18.95.*

This book is designed as a handy reference for persons performing bedside procedures in the hospital or the emergency room. It will be helpful for any physician in a hospital setting who wishes a concise illustrated review of the technique involved. Ancillary personnel will appreciate the inclusion of a list of the equipment needed as well as the position and preparation of the patient. It is well indexed.

The annotated bibliography for each procedure will be helpful for anyone wishing to read further about the procedure. The illustrations are plentiful, simple, clearly presented, and generally adequate, though in some cases they lack anatomic detail.

There are bound to be differences of opinion regarding proce-

dures. In the section on control of epistaxis, for example, the use of a gauze roll posterior pack is illustrated. In my experience, posterior epistaxis is much more likely to be treated with a balloon pack, which is easier to insert and more comfortable for the patient.

Overall, however, the *Atlas of Bedside Procedures* is well done and will be a valuable addition to a hospital ward, emergency room, or resident library.

*John H. Leversee, MD
University of Washington
Seattle, Washington*

**When excess earwax
causes problems
for your geriatric
patients, recommend ...**

DEBROX® Drops

**DEBROX® Drops gently softens
excess earwax for easy removal.**

When Debrox comes in contact with impacted earwax, it forms a dense foam, which softens the accumulation with a chemomechanical cleansing, debriding action. Any remaining earwax may be removed by flushing with warm water, using a soft rubber bulb ear syringe. Avoid excessive pressure.

**Debrox is convenient for both
office and home use.**

Whether used as a pretreatment procedure in your office or as a means for your patients to help lessen the buildup of earwax for themselves at home, Debrox has always been well accepted and is the leading recommended eardrop. Find out for yourself by writing for samples and literature.



Debrox Drops
... the one
recommended
most often.

Another patient benefit product from

**IVL PHARMACEUTICAL DIVISION
MARION
LABORATORIES, INC.**
KANSAS CITY, MO. 64137

