

**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.

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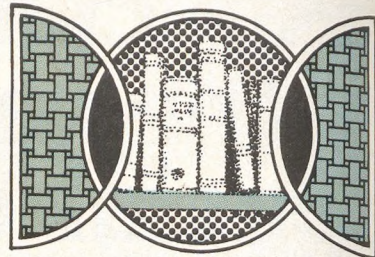
Additional information available to the profession on request from Dista Products Company, Division of Eli Lilly and Company, Indianapolis, Indiana 46285.

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## Book Reviews



**What Are My Chances?** *Ben Eisenman.* WB Saunders Company, Philadelphia, 1980, \$14.95.

**Clinical Decision Analysis.** *Milton C. Weinstein, Harvey V. Fineberg.* WB Saunders Company, Philadelphia, 1980, 400 pp., price not available.

Clinical decision making is a major area of interest to clinically oriented researchers, both in biomedically oriented specialties as well as in primary care. It is the single most active area of research in the North American Primary Care Research Group.

Clinicians spend their lives making decisions, in choosing investigations or selecting treatments for their patients. They must estimate (subjectively for the most part) the likelihood of a patient's response to treatment or the likely contribution of an investigation to clarifying a patient's illness. Clinical decision making theories provide a basic conceptual framework for observing and analyzing the practice of clinical medicine; they also provide a scientific language for describing day-to-day clinical judgments of the physician.

The two books reviewed here represent important contributions to understanding clinical decision making. Both have an essentially biomedical orientation and show relatively little sensitivity to the psychosocial dimensions of clinical practice.

The first book, *What Are My Chances?* written by a distinguished

surgeon with a long career of active surgical practice behind him, provides a lucid account of the prognoses and key outcomes of a wide variety of common, surgically oriented illnesses. Its subtitle is, "What you need to know about the surgical and medical odds of getting well." It covers 110 separate conditions under 12 headings ranging from head and neck to breast, vascular, and abdomen, with some limited attention to gynecology, orthopedics, oncology, and urology.

After a brief and lucid explanation of the concepts of probability and risk, the key technical terms to be used in the text are clearly defined. A standard life expectancy table is provided for a comparison between the risks associated with the specific conditions dealt with in the book and the risks for a normal, "healthy" population. For each condition or topic, a simple decision diagram is complemented by detailed but concise explanatory notes.

*What Are My Chances* is directed at the issue of assessing risks in a "no-risk" society, where failure of a procedure (or treatment) is assumed to be due to incompetence, not to chance. It provides an invaluable method of helping patients understand the choices facing them. It will also help these same patients to make their own choices. The main technical criticism of the text is that the probability estimates and

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**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 teaspoonsful 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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risks are all subjective "guesstimates" based on the author's subjective analysis of the literature. There is little justification in the text for the probabilities used. Nevertheless, this is the method most widely used by practicing physicians, and has much to commend it as long as it is seen as the viewpoint of one particular physician (albeit a very experienced one). It is highly recommended to family physicians.

The second text, *Clinical Decision Analysis*, is an excellent treatise on the various techniques of decision analysis. Topics such as probability theory and decision theory are well presented, although somewhat technically so for a physician with no experience in the decision making field. Many clinical problems are tackled in a highly analytic way. Topics range from child abuse to the management of angina by cardiovascular surgery. The text was conceived and developed in the Center for the Analysis of Health Practices of the Harvard School of Public Health, and is more relevant to formulating health policy than to the management of individual patients. It is not recommended for the working clinician, except as interesting background reading. The perspective in the text is not that of the practicing clinician but is more that of the policy maker. It would serve as an excellent reference text, particularly in health planning exercises, in the analysis of complex clinical problems, or in the assessment of new or well-established medical technologies.

In summary, the first text is strongly recommended for family physicians in daily practice, with only minor reservations. The second has a limited attraction to the working physician, but is a lucid and

well-organized treatise on the technical aspects of both clinical decision making and policy oriented decision analysis.

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**Disorders of the Foot.** Arthur J. Hel-  
 fet, Daniel M. Gruebel Lee (eds). JB  
 Lippincott Company, Philadelphia,  
 1980, 253 pp., \$27.50.

This is an interesting summary of foot disease by eleven authors (four from South Africa, four from the United States, three from Great Britain). It is identified as a text of interest to "all practitioners concerned in the management of patients with discomfort, disability, and deformity of the feet." Dr. Apple's forward quickly reminds one of the frequency with which foot problems are neglected, the seriousness of painful feet, and the widely divergent qualities required of feet.

The twenty chapters are arranged logically from terminology and function to orthotics. A chapter on clinical anatomy of the foot is excellent in content and style. Disease descriptions are succinct, readable, and augmented by well-chosen black-and-white clinical photographs, radiographs, and line drawings. Brief references to anatomy, physiology, and biomechanics aid in understanding pathophysiology.

Sections of special value to family physicians are those on dysfunction (fatigue, strain, metatarsalgia, tarsal tunnel, foot in old age), the foot in athletics, developmental abnormalities (metatarsus adductus, pes cavus, osteochondritis), acquired deformity of the toes, and painful conditions of the foot. The latter includes an excellent sum-

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## Oral and Intravenous Brief Summary

**Indications:** For the treatment of susceptible gram-positive and gram-negative organisms. For full list of approved indications consult labeling.

**Contraindications:** Hypersensitivity to any tetracycline.

**Warnings:** In the presence of renal dysfunction, intravenous use, particularly in pregnancy, in daily doses exceeding 2 grams has been associated with deaths through liver failure. When need for intensive treatment outweighs potential dangers, perform renal and liver function tests before and during therapy; also follow serum concentrations. In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, use lower total doses, and, in prolonged therapy, determine serum levels.

This hazard is of particular importance in parenteral use in pregnant or postpartum patients with ptyalism. In such cases, the blood level should not exceed 15 mcg/ml and liver function tests should be made at frequent intervals. Do not prescribe other potentially hepatotoxic drugs concomitantly. THE USE OF TETRACYCLINES DURING TOOTH DEVELOPMENT (LAST HALF OF PREGNANCY, INFANCY AND CHILDHOOD TO THE AGE OF 8 YEARS) MAY CAUSE PERMANENT DISCOLORATION OF THE TEETH (YELLOW-GRAY-BROWN). This is more common during long-term use but has been observed following repeated short-term courses. Enamel hypoplasia has also been reported. TETRACYCLINES, THEREFORE, SHOULD NOT BE USED IN THIS AGE GROUP UNLESS OTHER DRUGS ARE NOT LIKELY TO BE EFFECTIVE OR ARE CONTRAINDICATED. Photosensitivity, manifested by an exaggerated sunburn reaction, has been observed in some individuals taking tetracyclines. Advise patients apt to be exposed to direct sunlight or ultraviolet light that such reaction can occur, and discontinue treatment at first evidence of skin erythema. Studies to date indicate that photosensitivity is rarely reported with MINOCIN Minocycline HCl. The antianabolic action of tetracycline may cause an increase in BUN. In patients with significantly impaired renal function, higher serum levels of tetracycline may lead to azotemia, hyperphosphatemia and acidosis. CNS side effects (lightheadedness, dizziness, vertigo) have been reported, may disappear during therapy, and always disappear rapidly when drug is discontinued. Caution patients who experience these symptoms about driving vehicles or using hazardous machinery while taking this drug.

**Pregnancy:** In animal studies, tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Embryotoxicity has been noted in animals treated early in pregnancy. **Newborns, infants and children:** All tetracyclines form a stable calcium complex in any bone-forming tissue. Prematures, given oral doses of 25 mg/kg every 6 hours, demonstrated a decrease in fibula growth rate, reversible when drug was discontinued. Tetracyclines are present in the milk of lactating women who are taking a drug of this class.

**Precautions:** Use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, discontinue and institute appropriate therapy. In venereal diseases, when coexistent syphilis is suspected, darkfield examination should be done before treatment is started and blood serology repeated monthly for at least four months. Patients on anticoagulant therapy may require downward adjustment of such dosage. Test for organ system dysfunction (e.g., renal, hepatic and hemopoietic) in long-term use. Treat all Group A beta-hemolytic streptococcal infections for at least 10 days. Avoid giving tetracycline in conjunction with penicillin.

**Adverse Reactions: GI:** (with both oral and parenteral use): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in anogenital region. **Skin:** maculopapular and erythematous rashes. Exfoliative dermatitis (uncommon). Photosensitivity is discussed above ("Warnings"). Pigmentation of the skin and mucous membranes has been reported. **Renal toxicity:** rise in BUN, dose-related (see "Warnings"). **Hypersensitivity reactions:** urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus. In young infants, bulging fontanels have been reported following full therapeutic dosage, disappearing rapidly when drug was discontinued. **Blood:** hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia. **CNS:** (see "Warnings"). When given in high doses, tetracyclines may produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

**NOTE:** Rapid administration is to be avoided. Parenteral therapy is indicated only when oral therapy is not adequate or tolerated. Oral therapy should be instituted as soon as possible. If intravenous therapy is given over prolonged periods of time, thrombophlebitis may result.

**Concomitant therapy:** Antacids containing aluminum, calcium, or magnesium impair absorption; do not give to patients taking oral minocycline. Studies to date indicate that absorption of MINOCIN is not notably influenced by foods and dairy products.

CNS side effects including lightheadedness, dizziness, or vertigo have been reported with MINOCIN. Patients who experience these symptoms should be cautioned about driving vehicles or using hazardous machinery while on minocycline therapy. Enamel hypoplasia/tooth staining may occur in children under eight years of age.

**References:** 1. MacCulloch D, Richardson RA, Allwood GK: The penetration of doxycycline, oxytetracycline and minocycline into sputum. *N Z Med J* 80: 300-302, 1974. 2. Data on file, Lederle Laboratories, Pearl River, New York. 3. Iwasawa T, Kido T: Clinical and experimental studies on minocycline. *Jpn J Antibiot* 22: 511-521, 1969.

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## BOOK REVIEWS

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mary of plantar fasciitis and calcaneal ridge ("winter heel" syndrome). It describes nine reasons for pain in the heel. The "foot regimen" described appears very useful. It includes contrast bathing, nonweightbearing, and weightbearing exercises.

The minimal bibliography for each chapter warrants mild criticism. Only the section on athletic related conditions is documented adequately by recent (1970 to 1980) references.

I disagree with the recommendation to use either curettage or electrocautery as treatment for plantar warts. Either of these therapies may produce symptomatic permanent scarring. Careful surgical paring in conjunction with topical application of 40 percent salicylic acid plasters, although unmentioned in this text, is an effective therapy. The chapters on the diabetic foot and orthotics were disappointing. The former gave little new information, no specific data concerning infection, and was not clear in defining management plans. The latter was divided into comments about specific orthotic devices rather than approaches to specific diseases. Interesting items (depth shoes, Plastizol) were given superficial coverage.

As a starting point for gaining a clinical perspective on a variety of foot disorders, this is an excellent text. Recognition and understanding of many diseases are stressed. Although it needs augmentation from the recent literature in several areas, it would make a useful addition to most clinical libraries.

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**Harrison's Principles of Internal Medicine (9th Edition).** Kurt J. Isselbacher, Raymond D. Adams, Eugene Braunwald, Robert G. Petersdorf, Jean D. Wilson (eds). McGraw-Hill, New York, 1980, 2072 pp., \$45.00 (one-volume edition), \$55.00 (two-volume edition).

The ninth edition represents the latest product of over thirty years of sustained effort by a carefully chosen group from the American academic internal medicine community. They have again produced an authoritative, contemporary, topically succinct, encyclopedia of patient care philosophy and knowledge, relating to diagnosis and treatment of diseases within the province of internal medicine. The initial leader of this monumental ongoing effort was Dr. Tinsley R. Harrison, now deceased, whose founding contribution is memorialized in the title. Names of the principal editors and chapter contributors have changed gradually over the years as time and the dictates of advances in the subspecialties of internal medicine have brought new names and new knowledge to the forefront.

The ninth edition has 220 listed authors from a wide geographic representation of departments of internal medicine and closely allied disciplines, almost exclusively from medical schools in the United States. All are authorities in their respective fields.

This new edition has essentially the same number of pages (2,073) as the eighth edition published in 1977, but there are 16 more chapters. There are nine additional chapters in the section dealing with infections and parasitic diseases. In some of the additional new chapters are discussed abnormalities of leu-

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**Mycelex**<sup>®</sup> (clotrimazole)1% Cream  
1% Solution

**Indications:** Mycelex Cream and Solution are indicated for the topical treatment of the following dermal infections: tinea pedis, tinea cruris, and tinea corporis due to *Trichophyton rubrum*, *Trichophyton mentagrophytes*, *Epidermophyton floccosum*, and *Microsporium canis*; candidiasis due to *Candida albicans*; and tinea versicolor due to *Malassezia furfur*.

**Contraindications:** Mycelex Cream and Solution are contraindicated in individuals who have shown hypersensitivity to any of their components.

**Warnings:** Mycelex Cream and Solution are not for ophthalmic use.

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

If irritation or sensitivity develops with the use of Mycelex, treatment should be discontinued and appropriate therapy instituted.

**Adverse Reactions:** The following adverse reactions have been reported in connection with the use of this product: erythema, stinging, blistering, peeling, edema, pruritus, urticaria, and general irritation of the skin.

**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.

Clinical improvement, with relief of pruritus, usually occurs within the first week of treatment. If a patient shows no clinical improvement after four weeks of treatment with Mycelex, the diagnosis should be reviewed.

**How Supplied:** Mycelex Cream 1% is supplied in 15 g and 30 g tubes, and 90 g package (2 x 45 g tube).

Mycelex Solution 1% is supplied in 10 ml and 30 ml plastic bottles.

Store between 35° and 86°F.

**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.



Miles Pharmaceuticals

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kocytes, biochemical abnormalities as presenting findings, and endorphins. There is evidence of revision and updating in all chapters. The latest bibliographic references throughout are dated 1978. There is a total of ten color plates illustrating dermatologic lesions and hemocytology. The editorial emphasis is on clear, succinct prose, together with summary tables, plus a scattering of black-and-white photographs and diagrammatic illustrations.

The table of contents has been improved in two ways. First, an abbreviated table of contents lists in sequence the five major parts of the book and the 50 subsections with their page numbers. This is in addition to the full table of contents, which lists the above headings plus the 383 chapters under their respective sections with authors and page numbers. The improved second table of contents shows bold columnar listing of page numbers, making them more readily found than in the eighth edition.

In traditional Harrison style, the text begins with discussion of the physician's approach to the patient, the physician-patient relationship, the physician's responsibility to the patient, the process of diagnosis and management, and a number of legal and ethical issues inherent to medical practice. A new topic in this section is "Incurability and Death," in which is discussed how life prolonging technology has tended to blur the distinction between life and death and the ethical implications thereof. A basis for resolution of this contemporary dilemma is proposed: "If the medical profession, in accord with social sanction, can be brought to redefine life as a state in which cerebral action subserves awareness of envi-

ronment and the possibility of expressing intellect, emotion, personality and character, and if it can equate the opposite of this with death, the dilemma can be avoided." Four guidelines for determining brain death are given, all of which are sound, with one exception: "The family and nurses should be informed of the irreversibility of brain function but should not be asked or permitted to make the decision whether medical treatment should be discontinued." The statement could be interpreted as suggesting that the family not even be consulted in the decision making process. Many family physicians would take serious issue with this interpretation as well as with the ambiguity of this guideline.

Chapters on cardinal manifestations of disease (eg, pain, fever, weight changes) occupy 13 percent of the book; an updated section on basic biological processes (genetics, immunology, nutrition, and metabolism), 12 percent; biological and environmental agents of disease, 22 percent; and diseases of organ systems, 52 percent. All are well written and useful for students, residents, and physicians. The text is heavily oriented to physical disease and reflects the disciplinary emphasis of the field of internal medicine.

This is definitely a book of value to family physicians. Either this text or the latest edition of one of the one or two other comprehensive, authoritative internal medicine texts should be readily available in the office as a day-to-day reference for every physician who practices general adult medicine.

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