

Diet & Diabinese®

(chlorpropamide)

100-mg and 250-mg Tablets

A proven regimen for effective control of blood sugar.

BRIEF SUMMARY

DIABINESE® (chlorpropamide) Tablets

Contraindications: Diabinese is not indicated in patients having juvenile or growth-onset diabetes mellitus, severe or unstable "brittle" diabetes, and diabetes complicated by ketosis and acidosis, diabetic coma, major surgery, severe infection, or severe trauma.

Diabinese is contraindicated during pregnancy. Serious consideration should be given to the potential hazard of its use in women of childbearing age who may become pregnant.

Diabinese is contraindicated in patients with serious impairment of hepatic, renal, or thyroid function.

Precautions: Use chlorpropamide with caution with barbiturates, in patients with Addison's disease or in those ingesting alcohol, antibacterial sulfonamides, phenylbutazone, salicylates, probenecid, dicoumarol or MAO inhibitors.

Warnings: DIABINESE (CHLORPROPAMIDE) SHOULD NOT BE USED IN JUVENILE DIABETES OR IN DIABETES COMPLICATED BY ACIDOSIS, COMA, SEVERE INFECTION, MAJOR SURGICAL PROCEDURES, SEVERE TRAUMA, SEVERE DIARRHEA, NAUSEA AND VOMITING, ETC.

HYPOGLYCEMIA, IF IT OCCURS, MAY BE PROLONGED.

Adverse Reactions: Usually dose-related and generally respond to reduction or withdrawal of therapy. Generally transient and not of a serious nature and include anorexia, nausea, vomiting and gastrointestinal intolerance; weakness and paresthesias.

Certain untoward reactions associated with idiosyncrasy or hypersensitivity have occasionally occurred, including jaundice (rarely associated with severe diarrhea and bleeding), skin eruptions rarely progressing to erythema multiforme and exfoliative dermatitis, and probably depression of formed elements of the blood. With a few exceptions, these manifestations have been mild and readily reversible on the withdrawal of the drug. Diabinese should be discontinued promptly when the development of sensitivity is suspected. Jaundice has been reported, and is usually promptly reversible on discontinuance of therapy. THE OCCURRENCE OF PROGRESSIVE ALKALINE PHOSPHATASE ELEVATION SHOULD SUGGEST THE POSSIBILITY OF INCIPIENT JAUNDICE AND CONSTITUTES AN INDICATION FOR WITHDRAWAL OF THE DRUG.

Leukopenia, thrombocytopenia and mild anemia, which occur occasionally, are generally benign and revert to normal, following cessation of the drug.

Cases of aplastic anemia and agranulocytosis, generally similar to blood dyscrasias associated with other sulfonylureas, have been reported.

BECAUSE OF THE PROLONGED HYPOGLYCEMIC ACTION OF DIABINESE, PATIENTS WHO BECOME HYPOGLYCEMIC DURING THERAPY WITH THIS DRUG REQUIRE CLOSE SUPERVISION FOR A MINIMUM PERIOD OF 3 TO 5 DAYS, during which time frequent feedings or glucose administration are essential. The anorectic patient or the profoundly hypoglycemic patient should be hospitalized.

Rare cases of phototoxic reactions have been reported. Edema associated with hyponatremia has been infrequently reported. It is usually readily reversible when medication is discontinued.

Dosage: The mild to moderately severe, middle-aged, stable diabetic should be started on 250 mg daily. Because the geriatric diabetic patient appears to be more sensitive to the hypoglycemic effect of sulfonylurea drugs, older patients should be started on smaller amounts of Diabinese, in the range of 100 to 125 mg daily.

After five to seven days following initiation of therapy, dosage may be adjusted upward or downward in increments of 50 to 125 mg at intervals of three to five days. Patients who do not respond completely to 500 mg daily will usually not respond to higher doses. Maintenance doses above 750 mg daily should be avoided.

Supply: 100 mg and 250 mg, blue, 'D'-shaped, scored tablets.

More detailed professional information available on request.

Pfizer LABORATORIES DIVISION
PFIZER INC.

Leaders in Oral Diabetic Therapy

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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.

Telephone Management Training

To the Editor:

A pilot study evaluating the effectiveness of a training exercise for medical students in telephone management of medical problems has previously been published in this journal.¹ That study indicated that formal training improved the students' proficiency. However, the small number of cases studied required cautious interpretation. An interesting finding in that study showed that while proficiency increased, efficiency decreased, though not to a statistically significant degree. This letter summarizes a two-year follow-up of the initial pilot study studying the effectiveness of a telephone management training exercise for medical students, with emphasis both on process and outcome criteria.

Scripts are written for one adult and one pediatric case (abdominal pain in a 52-year-old woman and fever in a 3-year-old child). Actors pose as the simulated callers. The medical students are informed of the exercise and know the encounter is being tape recorded.

The first call is placed to each student during the first three weeks of a required community health/family medicine clerkship. The tapes are reviewed by a faculty member and scored according to standard criteria derived through a Delphi consensus technique.

A one-hour teaching session is conducted during the fourth week

of the clerkship for all students. Feedback is given to the students on their performance, and concepts of decision making for telephone medical problems are discussed. Each student then receives a second telephone call during the last two weeks of the clerkship which is scored in the same manner.

A total of 72 students was eligible to participate in this exercise between August 1979 and July 1981. At least one telephone call was placed to 71 of these students. Thirty-five students received both telephone calls, had the calls recorded, and participated in the teaching session. These 35 students served as the basis for the analysis below. Inability to record both telephone calls for each student resulted from technical malfunctions, unavailability of the student, or unavailability of the simulated caller. The scores of those students who did not receive a second call did not differ significantly from the scores on the first call of those students who did receive the second call.

The overall total number of questions asked, total time of the interview, and proficiency all increased after the teaching session. These results agree with the findings of the initial pilot study. The overall increase in the number of questions was due to the large increase in the pediatric case, since this parameter did not significantly change in the adult case. In contrast to the pilot study, this larger

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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 non-susceptible 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.

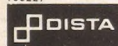
Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

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 Distal Products Company, Division of Eli Lilly and Company, Indianapolis, Indiana 46285.

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Carolina, Puerto Rico 00630

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study shows a small increase in efficiency, though again, it is not statistically significant.

Correct disposition was used as the outcome criterion. This did not change significantly after the teaching session (8/35 incorrect pretest, 10/35 incorrect posttest). The absence of statistically significant improvements in outcome may be due to the nature of the cases utilized and the level of training of the subjects. Many students were reluctant to rely simply on the telephone generated medical history and forego the option of seeing the patient.

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Reference

1. Smith SR, Fischer PM: Patient management by telephone: A training exercise for medical students. *J Fam Pract* 10:463, 1980

Career Satisfaction

To the Editor:

I was quite interested in the observations on the career satisfaction of family physicians in several of the articles of the October issue of *The Journal (J Fam Pract Vol. 11, No. 5)*. The high level of career satisfaction and appropriateness of training are in contrast to what I have seen in many practicing internists. These physicians were trained in tertiary care hospitals largely on inpatient services. In practice, they find their skills as consultants are rarely utilized and they are poorly equipped to handle many of the problems which patients present with. Many of them are quite discouraged by the content of their practice.

My sample is small and based

largely on personal observation since I was trained in a traditional internal medicine residency but have subsequently become board certified in family practice and have practiced as a family physician. It would be interesting to see if my observations hold up in a study using a better sample of the two specialties.

Karl Singer, MD
Exeter, New Hampshire

Home Visits as Curriculum

To the Editor:

Rediscovering the home visit has been a continuing challenge for faculty and residents for seven years in this residency program. At the end of this summer (1981), if all goes well, we will have supervised over 100 entering first year residents in conducting over 1,000 planned home visits as part of their initial orientation period.¹ Although research and service uses of the home visit are assumed, the educational value is at times questioned.

Acknowledging the widely emulated Case-Western Reserve Model of the early 1950s (four-year assignment of one family to each freshman medical student),² the Charleston home visit program has developed a number of its own special features for family medicine.

1. *The get-acquainted, contractual nature* of a new resident's first home visit is emphasized. This resembles the impact of the first office visit and initial history and physical examination, but there are features of intimacy and caring that go beyond the question of the physician's "turf" (the office) and that of the patient (the home). Also, the beginning of a three-year, tenured physician-family relationship is sealed by such a visit.

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BRIEF SUMMARY: Please see package enclosure for complete prescribing information.

DESCRIPTION

Antihistamine/Decongestant
for oral use
for adults and children
(12 years and over)

RONDEC-TR™ Tablet

each timed-release Filmtab® tablet
contains: carbinoxamine maleate,
8 mg; pseudoephedrine
hydrochloride, 120 mg.

INDICATIONS AND USAGE

Rondec-TR is indicated for the relief of seasonal and perennial allergic rhinitis and vasomotor rhinitis symptoms.

Rondec-TR utilizes a gradual release mechanism, thereby providing a prolonged therapeutic effect of about 12 hours duration. This timed-release dosage form allows the convenience of twice daily dosage for patients requiring continuous symptomatic relief.

Rondec-TR may be given concomitantly with analgesics and antibiotics, when indicated.

CONTRAINDICATIONS

Nursing Mothers: Sympathomimetic amines and antihistamines are contraindicated in nursing mothers.

Patients with hypersensitivity or idiosyncrasy to any of its ingredients and in patients taking monoamine oxidase (MAO) inhibitors.

Children under 12: The timed-release form of this drug should not be given to children under 12 years of age.

Antihistamines are contraindicated in patients with narrow-angle glaucoma, urinary retention, peptic ulcer, or in patients undergoing an asthmatic attack.

Sympathomimetic amines are contraindicated in patients with severe hypertension or severe coronary artery disease.

WARNINGS

Use in Pregnancy: Safety for use during pregnancy has not been established.

Sympathomimetic amines should be used with caution in patients with hypertension or ischemic heart disease.

Elderly persons (approximately 60 years and older) are more likely to have adverse reactions to sympathomimetic amines and antihistamines.

PRECAUTIONS

Antihistamines should be used with caution in patients with hypertension, heart disease, asthma, hyperthyroidism, and increased intraocular pressure. Patients particularly sensitive to antihistamines may experience moderate to severe drowsiness. Patients should be cautioned while taking the drug to exercise care in driving or operating appliances, machinery, etc.

Sympathomimetic amines should be used with caution in patients with a history of asthma, diabetes mellitus, hyperthyroidism, increased intraocular pressure, and prostatic hypertrophy. In the presence of enlarged prostate, administration of sympathomimetic amines may cause urinary retention. Those patients particularly sensitive to sympathomimetic amines may note mild central nervous system stimulation.

Patients should be advised to avoid alcohol and other CNS depressants while taking the drug.

Drug Interactions: Antihistamines have been shown to enhance the effects of tricyclic antidepressants, barbiturates, alcohol, and other CNS depressants. MAO inhibitors prolong and intensify the anticholinergic effects of antihistamines. Sympathomimetic amines may reduce the antihypertensive effects of reserpine, veratrum alkaloids, methyldopa and mecamylamine. The effects of sympathomimetics are increased with MAO inhibitors and beta-adrenergic blockers.

Pregnancy Category C: Animal reproduction studies have not been conducted with **Rondec-TR**. It is also not known whether **Rondec-TR** can cause fetal harm when administered to a pregnant woman or affect reproduction capacity. **Rondec-TR** should be given to pregnant women only if clearly needed.

ADVERSE REACTIONS


Adverse reactions to antihistamines in decreasing order of severity are sedation, dizziness, diplopia, vomiting, dryness of mouth, headache, nervousness, nausea, anorexia, heartburn, weakness, polyuria and dysuria. Antihistamines may cause excitability in children.

Adverse reactions to sympathomimetic amines in decreasing order of severity are convulsions, CNS depression, cardiac arrhythmias, respiratory difficulty, increased heart rate, pressor effects, hallucinations, tremors, nervousness, insomnia, weakness, pallor and dysuria.

DOSAGE AND ADMINISTRATION

For adults and children, 12 years and over, one tablet every 12 hours.

HOW SUPPLIED

Rondec-TR Filmtab® tablets are available in bottles of 100, NDC 0074-6240-13. Each blue tablet marked with Ross  and the number 6240 for professional identification. Dispense in USP tight container.

LETTERS TO THE EDITOR

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2. *The timing of the visit* must be separate from acute episodes of illness in order to fulfill basic learning objectives. The interim between-illness house call allows family and physician to concentrate on non-urgent aspects of the encounter. Admittedly, the home may be an inferior place for many needed diagnostic and treatment services, but it is a superior place for teaching the expanded "bedside manner."³

3. *The cross-cultural aspects* of systematically visiting 10 to 12 households in one's first family practice provide an introduction to the cultural variations in the community and a background for the coming three years of health events that resident and family will experience together.

4. *The sharpening of observational skills* is enhanced. The creative use of eye and mind in the home setting is as important as it is in the office or hospital. No matter how knowledgeable the first year resident may be, he or she can still learn and practice the art of systematic data gathering. As teachers experienced in field social work and "shoe leather epidemiology," we try to focus on the essential strengths of the tool. A checklist form helps the resident note interior, exterior, and neighborhood characteristics as well as personal and social ones.

With regard to home visits in the curriculum, we have found that one or two home visits will not suffice. Only a series of supervised and planned experiences with appropriate faculty participation will do the job. Such teaching cannot be delegated or routinized; it must be an active preceptor experience. The home visit offers a unique opportunity for ecologic observation. Whatever

the particular family crisis, diagnostic dilemma, or breakdown in physician-patient communication, there is hardly a household visit that will not yield improved understanding.


Building on such experiences over the years, we have seen home visits grow as a healthy part of our curriculum. Not without cost in terms of faculty, resident, and patient time, the end product of home visits—a family physician who is fairly adept at making an efficient and humane home visit—is worth it. A survey of our alumni practicing in their communities revealed that over 80 percent regularly and voluntarily make home visits, but only for selected conditions.

English and American journals are currently discussing the merits of house calls. The debate centers on who should make them, who will pay for them, and who will decide on their necessity.^{4,5} The debate will go on. In the meantime, in much of the United States, individual family physicians will continue to choose to make home visits at their own discretion and volition.

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