

Pediazole[®]

erythromycin ethylsuccinate
and sulfisoxazole acetyl
for oral suspension

BRIEF SUMMARY:

Please see package enclosure for full prescribing information.

Indication

For treatment of ACUTE OTITIS MEDIA in children caused by susceptible strains of *Hemophilus influenzae*.

Contraindications

Known hypersensitivity to either erythromycin or sulfonamides. Infants less than 2 months of age.

Pregnancy at term and during the nursing period, because sulfonamides pass into the placental circulation and are excreted in human breast milk and may cause kernicterus in the infant.

Warnings

Usage in Pregnancy (SEE ALSO: CONTRAINDICATIONS): The safe use of erythromycin or sulfonamides in pregnancy has not been established. The teratogenic potential of most sulfonamides has not been thoroughly investigated in either animals or humans. However, a significant increase in the incidence of cleft palate and other bony abnormalities of offspring has been observed when certain sulfonamides of the short, intermediate and long-acting types were given to pregnant rats and mice at high oral doses (7 to 25 times the human therapeutic dose).

Reports of deaths have been associated with sulfonamide administration from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indicators of serious blood disorders. Complete blood counts should be done frequently in patients receiving sulfonamides.

The frequency of renal complications is considerably lower in patients receiving the most soluble sulfonamides such as sulfisoxazole. Urinalysis with careful microscopic examination should be obtained frequently in patients receiving sulfonamides.

Precautions

Erythromycin is principally excreted by the liver. Caution should be exercised in administering the antibiotic to patients with impaired hepatic function. There have been reports of hepatic dysfunction, with or without jaundice occurring in patients receiving oral erythromycin products.

Recent data from studies of erythromycin reveal that its use in patients who are receiving high doses of theophylline may be associated with an increase in serum theophylline levels and potential theophylline toxicity. In case of theophylline toxicity and/or elevated serum theophylline levels, the dose of theophylline should be reduced while the patient is receiving concomitant erythromycin therapy.

Surgical procedures should be performed when indicated.

Sulfonamide therapy should be given with caution to patients with impaired renal or hepatic function and in those patients with a history of severe allergy or bronchial asthma. In the presence of a deficiency in the enzyme glucose-6-phosphate dehydrogenase, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and renal stone formation.

Adverse Reactions

The most frequent side effects of oral erythromycin preparations are gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting and diarrhea occur infrequently with usual oral doses. During prolonged or repeated therapy, there is a possibility of overgrowth of nonsusceptible bacteria or fungi. If such infections occur the drug should be discontinued and appropriate therapy instituted. The overall incidence of these latter side effects reported for the combined administration of erythromycin and a sulfonamide is comparable to those observed in patients given erythromycin alone. Mild allergic reactions such as urticaria and other skin rashes have occurred. Serious allergic reactions, including anaphylaxis, have been reported with erythromycin.

The following untoward effects have been associated with the use of sulfonamides:

Blood dyscrasias: Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia.

Miscellaneous reactions: Drug fever, chills and toxic nephrosis with oliguria or anuria. Periarteritis nodosa and L.E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents.

Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration

PEDIAZOLE SHOULD NOT BE ADMINISTERED TO INFANTS UNDER 2 MONTHS OF AGE BECAUSE OF CONTRAINDICATIONS OF SYSTEMIC SULFONAMIDES IN THIS AGE GROUP.

For Acute Otitis Media in Children: The dose of Pediazole can be calculated based on the erythromycin component (50 mg/kg/day) or the sulfisoxazole component (150 mg/kg/day to a maximum of 6 g/day). Pediazole should be administered in equally divided doses four times a day for 10 days. It may be administered without regard to meals.

The following approximate dosage schedule is recommended for using Pediazole:

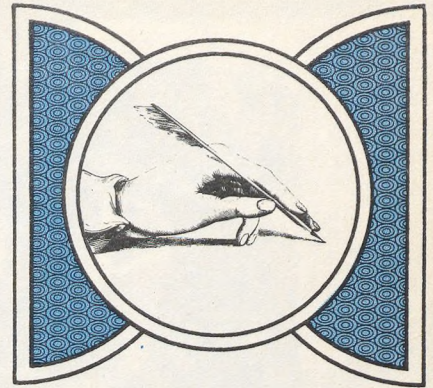
Children: Two months of age or older.

Weight	Dose—every 6 hours
Less than 8 kg (less than 18 lb)	Adjust dosage by body weight
8 kg (18 lb)	1/2 teaspoonful (2.5 ml)
16 kg (35 lb)	1 teaspoonful (5 ml)
24 kg (53 lb)	1 1/2 teaspoonfuls (7.5 ml)
Over 45 kg (over 100 lb)	2 teaspoonfuls (10 ml)

How Supplied

Pediazole Suspension is available for teaspoon dosage in 100 ml (NDC 0074-8030-13) and 200-ml (NDC 0074-8030-53) bottles, in the form of granules to be reconstituted with water. The suspension provides erythromycin ethylsuccinate equivalent to 200 mg erythromycin activity and sulfisoxazole acetyl equivalent to 600 mg sulfisoxazole per teaspoonful (5 ml).

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.

Patient Mobility and Consulting Rates

To the Editor:

Dr. D.J.G. Bain's paper on patient mobility and consulting rates (*J Fam Pract* 12:891, 1981) addresses a pertinent issue in family practice. A mobile population certainly challenges concepts of comprehensive and continuous care.

There appears to be some bias in the study, however. The Livingston, Scotland, sample consisted of "100 consecutive families registered for the first time in a family physician's practice," while the Gainesville, Florida, sample included "50 consecutive families who had recently moved to Gainesville and who had attended the family practice center." These are not, in fact, samples of families who had recently moved; they reflect families who had moved and soon thereafter consulted a family physician. There is a substantial difference.

In Scotland, families are required to register with a general practitioner. This is done immediately if there is an illness (real or perceived) but may not be done by other families until the need arises. In the United States, families are under no obligation to register, and many who have recently moved into a new area will similarly not visit a primary care practitioner until a problem exists.

It is not entirely accurate, then, to generalize from "families who

have recently moved and consulted a family physician" to "patients new in town." Dr. Bain notes that "there are probably personality differences in adults who move house frequently as opposed to those who remain in one area for a prolonged period of time." Likewise, some differences also exist between those who move and consult and those who simply move. The latter group represents a significant demand for health care, but this is unknown, especially in this country, until visits to family physicians are made. While there may be actual differences in consulting rates between mobile and stable families, the differences seem to be overstated in this paper.

*Russell M. Boyle, Instructor
Departments of Biostatistics
and Family Practice
Medical College of Virginia
Richmond, Virginia*

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

Dr. Boyle's comments on my paper are welcomed. While accepting that the two groups of families studied are not strictly comparable, I still consider that there were many similarities which support my conclusions. If I were repeating this study, I would naturally prefer to attempt to control for the variables mentioned.

*D.J.G. Bain, MB, MD
Aberdeen, Scotland*

Continued on page 228

Tenuate® (IV)
(diethylpropion hydrochloride USP)

Tenuate Dospan® (IV)
(diethylpropion hydrochloride USP)

controlled-release
AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma, agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, flatulence, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, erythema, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of June, 1980

Reference: 1. Abramson R, Garg M, Cioffari A, and Rotman PA: An Evaluation of Behavioral Techniques Reinforced with an Anorectic Drug in a Double-Blind Weight Loss Study. *J Clin Psych* 41:234-237, 1980.

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LETTERS TO THE EDITOR

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Ambulatory Blood Pressure Monitoring

To the Editor:

In their paper, "Diagnostic Use of Ambulatory Blood Pressure Monitoring in Medical Practice" (*J Fam Pract* 13:25, 1981), McCall and McCall have demonstrated that a device which monitors blood pressure automatically at 7.5-minute intervals is functional and that blood pressure measurements made in the course of daily life are often lower than those obtained in a physician's office. We have climbed to the top of another mountain, and yet another uncharted valley lies before us.

Armed with this new technology, we can begin to address questions like these: Are the limits of "normal" the same when home readings are counted as when all readings are taken in a health care setting? Or must a new set of "normals" be determined? What are the long-term implications of labile hypertension? Does anxiety affect blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, flatulence, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, erythema, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

For what purposes? Here is another area where family medicine research can play a major role.

Robert D. Gillette, MD

Associate Professor

Department of Family Medicine
University of Cincinnati Medical

Center

Cincinnati, Ohio

Management of Fingertip Injuries

To the Editor:

We read with interest the article

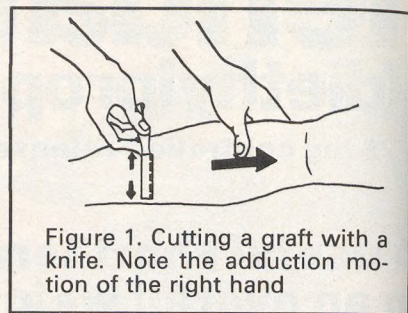


Figure 1. Cutting a graft with a knife. Note the adduction motion of the right hand

"Treatment of Fingertip Trauma" by Thomas W. Fawell (*J Fam Pract* 12:901, 1981). Unfortunately, a point which was not adequately emphasized is the possibility of fingertip replantation. Current reports demonstrate the experience in this field.

Although controversies still exist, there are many surgeons who feel that replantation may be tried when the tip is cleanly cut off, contains no bone, and is no more than 8 to 10 mm wide.¹⁻⁴

Regarding the split thickness skin grafting, the surgeon should operate from the more convenient side of the patient, cut down or up the limb, according to his position, in an adduction motion of his right hand,^{5,6} as shown in Figure 1, contrary to the position illustrated in the paper.

As for the donor site, it is recommended to take the skin graft from the forearm in men and, for aesthetic reasons, from the buttock in women.⁶ Our personal preference is to take the graft from the inner aspect of the arm, since a scar in this area is less noticeable and the skin there is thin and hairless.

A. M. Baruchin

L. Rosenberg

Department of Plastic Surgery
Soroka University Hospital, and
Faculty of Health Sciences

Continued on page 230

BENADRYL® (Diphenhydramine Hydrochloride Capsules, USP)

Before prescribing, please see full prescribing information.

A Brief Summary follows:

INDICATIONS. Benadryl in the oral form is effective for the following indications:

Antihistaminic: For perennial and seasonal (hay fever) allergic rhinitis; vasomotor rhinitis; allergic conjunctivitis due to inhalant allergens and foods; mild, uncomplicated allergic skin manifestations of urticaria and angioedema; amelioration of allergic reactions to blood or plasma; dermatographism; as therapy for anaphylactic reactions *adjunctive* to epinephrine and other standard measures after the acute manifestations have been controlled.

Motion sickness: For active and prophylactic treatment of motion sickness.

Antiparkinsonism: For parkinsonism (including drug-induced extrapyramidal reactions) in the elderly unable to tolerate more potent agents; mild cases of parkinsonism (including drug-induced) in other age groups; in other cases of parkinsonism (including drug-induced) in combination with centrally acting anticholinergic agents.

CONTRAINDICATIONS. Use in Newborn or Premature

Infants: This drug should *not* be used in newborn or premature infants.

Use in Nursing Mothers: Because of the higher risk of antihistamines for infants generally, and for newborns and premature infants in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease: Antihistamines *should NOT* be used to treat lower respiratory tract symptoms, including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to diphenhydramine hydrochloride and other antihistamines of similar chemical structure.

Monooxamine oxidase inhibitor therapy (See Drug Interactions section).

WARNINGS. Antihistamines should be used with considerable caution in patients with narrow-angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction, symptomatic prostatic hypertrophy, or bladder-neck obstruction.

Use in Children: In infants and children, especially, antihistamines in *overdosage* may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants: Diphenhydramine hydrochloride has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc).

Use in Activities Requiring Mental Alertness: Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

PRECAUTIONS. Diphenhydramine hydrochloride has an atropine-like action and, therefore, should be used with caution in patients with a history of bronchial asthma; increased intraocular pressure, hyperthyroidism, cardiovascular disease, or hypertension.

DRUG INTERACTIONS. MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS. The most frequent adverse reactions are underscored.

1. *General:* Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat

2. *Cardiovascular System:* Hypotension, headache, palpitations, tachycardia, extrasystoles

3. *Hematologic System:* Hemolytic anemia, thrombocytopenia, agranulocytosis

4. *Nervous System:* Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesia, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions

5. *GI System:* Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation

6. *GU System:* Urinary frequency, difficult urination, urinary retention, early menses

7. *Respiratory System:* Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness

OVERDOSAGE. Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms, dry mouth; fixed, dilated pupils; flushing, and gastrointestinal symptoms may also occur.

If vomiting has not occurred spontaneously the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful gastric lavage is indicated within 3 hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic or 1/2 isotonic saline is the lavage solution of choice.

Saline cathartics, as milk of magnesia, by osmosis draw water into the bowel and, therefore, are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

HOW SUPPLIED. Supplied in (as) 50- and 25-mg capsules, and Elixir, 12.5 mg/5 ml with 14% alcohol.

PD-64-JA-0796-P-1 (1-82)

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**WARNER
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LETTERS TO THE EDITOR

Continued from page 228

Ben Gurion University of
the Negev
Beer Sheva, Israel

References

1. Esahy NI: When to replant a fingertip after its complete amputation. *Plast Reconstr Surg* 60:14, 1977
2. McDowell F: Editorial note. *Plast Reconstr Surg* 49:609, 1972
3. Elsahy NI: Replantation of completely amputated distal segment of thumb. *Plast Reconstr Surg* 59:579, 1977
4. Mantero R, Bertolotti P: Le cross-finger et reimplanations des extremités digitales. *Ann Chir* 29:1019, 1975
5. McGregor IM: *Fundamental Techniques of Plastic Surgery and Their Surgical Applications*, ed 6. Edinburgh, Churchill Livingstone, 1975, p 75
6. Pulvertaff RG (ed): *Operative Surgery—International Techniques: The Hand*, ed 3. London, Butterworth, 1977, p 53

Stress in Family Practice

To the Editor:

Presentations such as "The Family Physician's Family" by William M. Clements and Randy Paine (*J Fam Pract* 13:105, 1981) deserve to be made in every family practice residency program. The importance of this topic is underlined by the statistics presented by Dr. Clements; however, several points deserve additional comment.

Divorce is an unfortunate sequel to behavioral patterns developed as a result of excessive stress. It was noted that the peak incidence of physician divorce was between the ages 35 and 45 years, with the implication being that this might be the result of stresses accompanying the "establishment of a practice." This could be multifactorial, however, with the period of residency training (and its 88-hour work week) being a significant contributor in establishing the behavior patterns in question.

Secondly, the idea of creating and effectively using free time is certainly critical, though I share the

reservations of Dr. Patten and Dr. Rakel regarding the ethical and legal implications of simply making oneself unavailable. There are probably as many ways of dealing with this aspect of practice as there are practitioners. It is usually possible to arrange for some form of coverage so that "off-call" time can be enjoyed while knowing that emergencies are being competently handled.

Finally, it has not been my experience that message taking by family members or weekends "off call" have been areas of difficulty. If the day following a vacation, long weekened, or holiday is typically busy, creative scheduling (such as that explored by Dr. B. W. Spears in the same issue of this journal) may relieve the problem. Thank you for providing a forum for these ideas to be explored.

Henry R. Ivey, MD
Vinton, Virginia

Alcoholism and Drug Treatment Services

To the Editor:

The recent article by Cassata and Kirkman-Liff entitled "Mental Health Activities of Family Physicians" (*J Fam Pract* 12:683, 1981) struck a particular nerve. As a medical librarian, I appreciate physicians' needs for "access to alcoholism and drug treatment services" because, as cited, there is "limited access to inpatient facilities."

As a librarian, it was my futile search for information on such facilities that led to the establishment of Alcoholism Treatment Directories (ATD). Surveys were sent to hundreds of facilities across the country, and the responses supplied the material contained in our directories; Eastern, Western, and Central/Southern editions are now available.

Sold at cost, they give factual information on the location, admis-

sions director, insurance eligibility, patient census, and duration of program as well as a narrative description of the program offered at each listed facility. We are a shoestring enterprise; we can compile the directories, but we are limited in our efforts to get them into the hands of those who need the information they contain. We believe that the availability of such directories would be of interest to your readers. They can be

obtained on request from ATD Publications, Alcoholism Treatment Directories, West Woods Road, Sharon, CT 06069: *Directory of Residential Alcoholism Treatment Centers, Eastern Edition* (58 centers) \$8.00, *Western Edition* (49 centers) \$8.00, *Central/Southern Edition* (120 centers) \$12.00.

Jean Moore, Editor
ATD Publications
Sharon, Connecticut



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