

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.

Monoamine 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.

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**WARNER
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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.

Membership in Hospital Departments of Family Practice To the Editor:

The Department of Family Practice at the Swedish Hospital Medical Center in Seattle should be commended for taking steps to assure that their Department shall not become a wastebasket for physicians with less than adequate training who do not qualify for membership in any other department (Scardapane JN, McCougall WT: *Membership in family practice departments: An urban hospital model. J Fam Pract 13:455, 1981*). We recently faced the same problem here at Richland Memorial Hospital and promulgated similar guidelines. In addition to eligibility for our board qualified and certified physicians, established physicians in the community were "grandfathered" as to whether or not they had at least one year of approved internship and three years of active practice in general or family medicine.

Since this is a tax supported hospital, other physicians applying for membership in the department who do not meet these qualifications are provided access on a two-year probationary basis, admitting patients under the supervision of

the chief of service. We feel that there will not be enough applications from the physicians in this category to constitute a burden, and thus far this has been proven true.

The status of departments of family medicine in other hospitals may be enhanced by the adoption of similar measures.

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Bacterial Endocarditis To the Editor:

The recent article on bacterial endocarditis by Haddy et al ("Bacterial endocarditis in the community hospital." *J Fam Pract 13:807, 1981*) mentioned that 36 percent of their sample in the retrospective study had underlying valvular heart disease; however, no breakdowns made of the specific valvular involvement. Historically, the mitral valve is most commonly involved in bacterial endocarditis, followed

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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 INCIPENT 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

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by the aortic valve, tricuspid valve, and pulmonic valves, respectively.¹

Echocardiography has also proven to be a most useful tool in evaluating patients with bacterial endocarditis. Wann et al have shown that echocardiography is extremely useful in differentiating the patient with severe bacterial endocarditis who may profit from early valvular replacement.² Horowitz and Smith have also demonstrated vegetations echocardiographically on the prolapsing mitral valve,³ a syndrome now known to be quite common and certainly to become increasingly responsible for bacterial endocarditis in the future. It would be of interest to know what percentage of patients in this study may have had echocardiograms as part of their diagnostic evaluation.

Finally, the authors encourage "appropriate prophylaxis for those at risk." Although the American Heart Association Committee Report published in *Circulation* in 1977 outlined the specific guidelines for bacterial endocarditis prophylaxis,⁴ one must remember that the guidelines are empiric extrapolations from animal data, since no human clinical studies have been available to date.

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References

1. Hurst JW (ed): The Heart. New York, McGraw-Hill, 1978
2. Wann LS, Dillon JC, Weyman AE, Feigenbaum H: Echocardiography in bacterial endocarditis. *N Engl J Med* 295: 135, 1976

3. Horowitz MD, Smith LG: Vegetative bacterial endocarditis on the prolapsing mitral valve. *Arch Intern Med* 137:788, 1977

4. Kaplan EL, Anthony BF, Bisno A, et al: Prevention of bacterial endocarditis. AHA Committee Report. *Circulation* 56(1): 139A, 1977

The preceding letter was referred to Drs. Haddy and Gordon, who respond as follows:

We would like to respond to the comments of Dr. Belardi regarding our recent paper on bacterial endocarditis. We do not have good data on the valves involved, since this was a retrospective study based on clinical diagnoses. Because the study covered 15 years, and the technique has only been available for a few years in our community, echocardiography was carried out in only a few patients. We agree that it is an excellent tool and should be routinely used in suspected endocarditis. With regard to antimicrobial prophylaxis, it would seem prudent for the practitioner to follow the recommendations of the American Heart Association until this nationally respected organization tells us it is of no value. Although we have only animal studies on which to base our approach, there is general agreement that it is logical to use antimicrobials at times of particular risk to kill bacteria which enter the blood stream before they can cause endocarditis.¹

Richard I. Haddy, MD
Ralph C. Gordon, MD
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Reference

1. Scott O: Prevention of infective endocarditis. *Arch Dis Child* 56:581, 1981

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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.

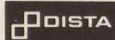
Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

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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Career Orientations in Primary Care

To the Editor:

In a previous study, Plovnick¹ found that senior medical students choosing family medicine careers had different value orientations toward their careers than those choosing internal medicine. The family medicine types expressed more concern for patient care (eg, helping people) and less concern for professional status (eg, intellectual work) than the straight medicine choosers. A follow-up study was conducted on these same students to measure the impact of residency training on their value orientations.

The follow-up data indicated that the value differences between students choosing internal medicine and family medicine as medical school seniors did not change during residency training. The 13 students choosing family medicine as medical school seniors remained more oriented to patient care, although the gap narrowed somewhat, while the 20 internal medicine choosers were more oriented toward professional status.

However, more than one half of the students included in this study indicated a change in specialty choice during their three years of residency training. Some of those who chose family medicine as medical school seniors switched into internal medicine, and some students choosing internal medicine switched into family medicine as residents.

To assess differences in values between practicing physicians, the value orientations of the third year residents were compared based on their current career choices. The results indicated that while third year residents choosing family medicine

were again more concerned about patient care and less concerned about professional status than those choosing internal medicine, the differences between the two groups had decreased below the levels of statistical significance. Those students switching out of family medicine were more oriented to patient care and less oriented to professional status than those switching in.

Contrary to previous studies reporting accentuation of differences between the specialties during the residency years,² the specialty groups in this study became more similar during their residency. Although drawn from a small sample, these results may call into question some previous assumptions made about the characteristics of physicians entering the primary care fields. The results may also raise some questions about family medicine residency training regarding the defection of students with appropriate primary care values and the attraction of students with less appropriate orientations.

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References

1. Plovnick MS: Medical student values, socialization, and primary care career choices. *J Fam Pract* 11:323, 1980
2. Reinhardt A, Gray R: A social psychological study of attitude change in physicians. *J Med Educ* 47:112, 1972