

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.

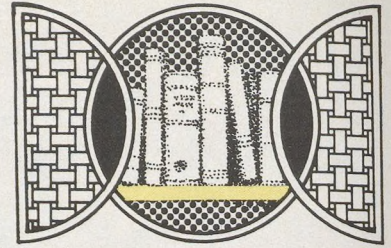
More detailed professional information available on request.

Pfizer LABORATORIES DIVISION
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Leaders in Oral Diabetic Therapy

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Book Reviews



Primary Care. John Fry (ed). William Heinemann Medical Books, London, 530 pp, \$30.00.

Dr. Fry, a well-known figure in medical education in this country and abroad, has gathered a group of articles from 29 contributors in this ambitious work. This book will be of great value to those seeking an understanding of the development of family medicine and primary care concepts in recent years. There are excellent expositions of problems of distribution of health care, the right to health care (although confused with "the right to health"), philosophical problems of demand vs limited resources, and problems of quality of care assessment.

Recognition should also be given to the authors of the chapters on methods of undergraduate, graduate, and continuing education in primary care, and on patient's rights issues, all of which are discussed thoroughly, yet concisely.

There are, however, some areas that might be improved. Many of the chapters seem to be taken directly from previous publications, and as a result, there is considerable duplication of information. This is especially true of sections dealing with the history and present structure of systems of health care in the United States and the United Kingdom, and of the development of organizations of primary care physicians.

There is also, perhaps inevitably, some evidence of regional bias. Discussions of the history, mechanisms, and problems of the Na-

tional Health Service are described in much more detail than are the health care delivery systems of this and other countries, and some of the contributors give evidence of an incomplete understanding of the past and present politics of the family medicine movement in the United States. For example, one describes adoption of the term *family practice* as "fashionable," with no apparent appreciation of the political factors which led to the substitution of this term for *general practice* in the United States.

There are also some sections which, though well done, seem somewhat removed from the historical/philosophical approach of the rest of the book. There is an excellent chapter, for example, on prescribing patterns and abuses, with suggestions for improving the use of prescriptions in primary care. One wishes that this chapter, together with those covering clinical decision making and clinical practice in the management of common disorders, might have been published in a book more precisely directed toward the family physician, who may consider only a small part of this book to be of practical clinical applicability.

This book should be required reading for any teacher of family medicine who lacks a broad background of information in the field of primary health care delivery. This would apply especially to those entering the academic world from private practice and to recent graduates of family practice residency

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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 inhaled 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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Morris Plains, NJ 07950

**WARNER
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BOOK REVIEWS

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programs who are moving directly into fellowships or teaching positions. For this reason, it may well be a valuable addition to departmental libraries. Most other family physicians will find little to justify its purchase.

Collin Baker, MD

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Instructional Decision-Making: Self-Study Modules for Teachers in the Health Professions (Preview Package, Parts 1-6). Hilliard Jason, Jane Westberg. National Center for Faculty Development in the Health Professions, Miami, Florida, 1980, 262 pp., \$24.00 (preview package), \$5.00 (individual modules).

These modules form a series intended to prepare health professionals for their responsibilities as teachers. Modules for specific instructional areas, such as test construction, lecturing, clinical supervision, and research supervision, are available. Each module begins with an introduction to the area and an orientation to the task required. Recommendations for individual and group use precede a written, sequential, decision making stimulation of an instructional problem. These simulations use latent image technology to guide the learner through the various sections of the problem. Each requires 10 to 15 minutes and is followed by "a recommended approach" in which the authors comment on the possible choices and reveal a consistent rationale and educational philosophy. Key issues which should guide instructional decision making are summarized in succinct statements. The "recommended approach" section is followed by a section entitled "your colleagues' approaches,"

which provides an opportunity to compare one's own approach to those taken by other full-time medical school faculty. Finally, each module concludes with a well-organized and well-selected annotated bibliography.

The materials should be exceptionally helpful in group use. Their organization makes them ideal as a well-tested workshop package, complete with an organizational structure, a participatory task, and materials for guided discussion through both ideal and real educational practices.

The solo learner familiar with the patient management problem (PMP) format may be disappointed at the lack of challenge in the simulations. Unlike PMPs, these simulations do not reward or punish by the ensuing consequences of the learner's choices. Instead, the intent is to permit nonjudgmental expression of one's educational approach and afterwards to stimulate reflection by comparison between the choices made, the authors' explicit views, and the responses of colleagues. Thus, the solo learner is not really "hooked" until completing the simulation and entering the "recommended approach" section.

This series is an ambitious undertaking which should succeed in making educational planning and management decisions understandable to those health professionals who have not had preparation for teaching responsibilities. These modules, developed with extensive investigation and field testing, should be especially welcomed by family medicine faculty charged with faculty development responsibilities.

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