

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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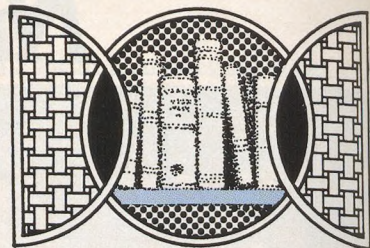
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PARKE-DAVIS

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Morris Plains, NJ 07950

**WARNER
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Book Reviews



Disease of the Ears, Nose, and Throat: A Guide to Diagnosis and Management. *Thane R. Cody, Eugene B. Kern, Bruce W. Pearson.* Year Book Medical Publishers, Chicago, 1981, 512 pp., \$36.95.

This excellent, concise textbook on diseases of the ears, nose, and throat (ENT) was a delight to review. In the preface, the authors, all of whom are from the Mayo Medical School and consultants in the Mayo Clinic, set out as their goal to write a book of ENT diseases, specifically directed toward the primary care physician in active practice. They also state that their emphasis is on the differential diagnosis of ENT symptoms. This is, as they state, a radical departure from a usual textbook format, giving the book a more clinical orientation. The organization of the book does, in fact, meet these goals superbly. I cannot remember another textbook, at least in this area, more valuable as a source of information to the busy practicing family physician.

The book is divided into three segments, each author taking one section. The first part is on diseases and disorders of the ears, the second part on diseases and disorders of the nose, and the third part on disorders of the throat. Each author has a relaxed style, which makes the book very readable. My only complaint about the organization is that the type used to indicate

subheadings was at times a bit confusing and it was necessary to refer to the table of contents occasionally to help sort out the organization.

Several sections bear specific comment. The complex problem of dizziness was well handled, including some excellent brief summaries at the ends of chapters. This section also had a useful set of tables which summarized important points in the history, physical examination, and laboratory findings. All three authors included sound therapeutic suggestions, including useful information for your patients regarding what they might expect from different treatment modalities.

A very good section on epistaxis was replete with practical pointers. Under the heading of "Throat Disorder" the author has set down a very practical approach to the management of sore throats in the office setting. There was also a responsible set of guidelines for tonsillectomy and adenoidectomy.

There are several minor complaints to be made about the book, the prime one being a lack of illustrations. Only rudimentary sketches were presented. However, for the type of book that this purports to be, ie, a predominately clinically oriented approach to ENT disorders, this is not a major flaw.

This book is highly recom-

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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 tablet.

More detailed professional information available on request.

Pfizer LABORATORIES DIVISION
PFIZER INC.

Leaders in Oral Diabetic Therapy

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SELF-ASSESSMENT

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1. Propranolol
 2. Hydralazine
 3. Prazosin
 4. Clonidine
4. As a family physician, you are aware of the importance of modifying the risk factors of cigarette smoking and obesity in this patient. Which of the following constitutes an acceptable initial educational technique?

1. Printed handouts about risk factors
2. Follow-up appointments with the physician
3. Physician appointments plus group patient education
4. Physician appointments plus individual psychosocial counseling

Over the next three months, the patient returned each month but needed two phone reminders for the second return visit. His blood pressure recordings were 154/96, 150/90, and 148/86 mmHg. His weight was 230, 225, and 225 lb. He was unable to reduce his smoking. On a third visit he complained of lassitude and fatigue by noon on hot days, and he expressed dissatisfaction with his treatment and the cost of visits. A serum potassium was 3.2 mEq/L. You offer him a taste test of a soluble potassium preparation, and he indicates he would not take it.

5. Which of the following might you then select?

1. Prescribing a more expensive combination drug that conserves potassium
2. Consider changing to a β -blocking agent as an alternate step I drug
3. Prescribe a potassium tablet that is taken three times daily
4. Stop his medication, since blood pressure is normal

Answers and Discussion on page 578

BOOK REVIEWS

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mended, not only for practicing family physicians but also for family practice residents. Medical students in their clerkship years would also benefit from having this book available to them, since it could be used well in conjunction with other, more classical, ENT textbooks.

P. G. Hodgetts, MD
Newmarket, Ontario, Canada

The Ocular Fundus: Methods of Examination and Typical Findings (4th Edition). Arno Nover. Lea & Febiger, Philadelphia, 1981, 196 pp., \$35.00.

This recent translation of a classic German text is clear, well-organized, and filled with superb photographs of retinal abnormalities seen in ophthalmologic and systemic diseases. The first section gives a concise and readable explanation of methods of examination of the eye. Clear review of the anatomy and appearance of the normal fundus follows. The bulk of the book gives descriptions of the fundus findings in a wide variety of diseases of interest to the family physician. The photographs of the fundus, supplemented by occasional drawings, photomicrographs, and fluorescein angiograms, make these findings clear and understandable.

While the author discusses techniques of examination and diseases of the fundus beyond the scope of the nonophthalmologist, the book is not an ophthalmology text. No information is given on the natural history or treatment of the conditions for which the diagnosis is so beautifully depicted. Only conditions of the ocular fundus are covered: refraction, vitreous, optic nerve, retina, and choroid.

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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 indications 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 of 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 renal 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, hypoproliferative anemia 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 pain, 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).

ROSS LABORATORIES
COLUMBUS, OHIO 43216
Division of Abbott Laboratories, USA

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This book can serve as a text on ophthalmoscopy for the student or family practice resident and as an atlas for hospital or clinic libraries. The average practicing family physician is unlikely to find this book useful.

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Seattle

Physicians Business Manual (Volume 1). *Richard M. Klass. Appleton-Century-Crofts, New York, 1981, 294 pp., \$23.50.*

This book, written by Richard M. Klass, MBA, a professional practice consultant from Miami, Florida, would be properly used as a textbook in a class that should be taught in all medical schools. Its usefulness to a physician in family practice could be quite high, however, under a number of circumstances. Among these would be the opening of a new practice, changing the type of practice, such as from solo practice to partnership or to corporation, or as a reference text in checking on various aspects of the physician's practice. The numerous charts, formulas, and flow sheets could easily be used or adapted to most practices to provide a systematic study of the practice (eg, the number, source, and nature of new patients).

The book is divided into (1) type of practice, (2) financial planning for the practice, including choosing and designing an office, and (3) organization, staffing, and training of office employees. A discussion of employee compensation, employee relations, use of advisors (eg, attorneys, accountants, tax advisors) is included. Also, there is a section on keeping of business and medical rec-

ords, including billing and accounting procedures, and a discussion of some electronic data processing systems. There is a good discussion of internal office security.

Perhaps one of the most impressive parts of the book is an office efficiency evaluation form, which is actually a checklist of the many facets of opening and running a medical practice, so that the physician can do this in the most cost-effective and businesslike fashion.

Paul L. Bower, MD
Rolling Hills, California

An Introduction to Family Medicine (2nd Edition). *Ian R. McWhinney, Oxford University Press, New York, 1981, 214 pp., \$16.95, \$9.95 (paper).*

The author of this small volume has succeeded admirably in accomplishing the objectives established in the preface. The book attempts to distill the essence or core of knowledge required by the experienced and skillful family physician. It emphasizes concepts unique to family medicine and provides a conceptual framework for the neophyte physician.

There is no attempt to deal with every subject germane to family medicine and, in particular, there is no reference to the clinical practice of medicine. The book is well organized and eminently readable. There are very few tables or illustrations, but this in no way detracts from the text.

This book should be extremely valuable for medical students, family practice residents, and family medicine faculty. It would probably be of relatively little interest to the busy practitioner. However, it should certainly have a place in the library of every medical school and family practice residency program.

William L. Stewart, MD
University of Florida—Gainesville