

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.



Use of Stool Counts

To the Editor:

The small infant with frequent loose stools presents a common clinical dilemma. With limited information available about the normal stool pattern during early infancy, physicians often have difficulty deciding between pathogenic diarrhea and normal stools. For this reason and with the support of the Worcester Hahnemann Hospital Fund for Pediatric Education and Research, 21 infants were studied prospectively by a home questionnaire to determine stool frequency for a total of 377 days during the first two months of life. Although the stools of breast-fed infants tended to be more frequent and more liquid than bottle-fed infants, both groups experienced a steady decline in stool counts over time. In the first three weeks of life, five or more stools were recorded on 50 percent of the study days for breast-fed infants compared with only 10 percent of the days for bottle-fed infants. By eight weeks of age, zero to two stools were counted on 90 percent of the study days for bottle-fed infants and only

50 percent of the days for breast-fed infants. The average number of stools for bottle-fed infants (SMA formula, provided by Wyeth Laboratories) decreased from 2.8 per day to 1.6 by eight weeks of age. Breast-fed infants initially experienced an average of 4.6 stools per day which then declined to 2.5 at the end of the study period. There were no differences between breast- and bottle-fed infants regarding questionnaire data on vomiting, colic, or the administration of other liquid or solid foods.

Lemoh and Brooke¹ studied 11 British neonates between eight days and one month of age receiving proprietary milk formulas. They found stool frequency ranged from zero to six per day with a mean of 2.2.

This result is consistent with the present study for bottle-fed infants. The discussion in *Pediatrics*² states that breast-fed infants pass two to four stools per day in the first month of life and two to three stools thereafter. The present study suggests an even greater decline in stool frequency during the first two months of life. The rapid decline in

stool counts may have been underestimated in a previous retrospective recall study, which concluded that newborns have two to five mushy stools while infants have two to three soft stools a day.³ While breast- and bottle-fed infants differ in frequency of stools, both appear to decline sharply over time.

The clinical correlation of this information is supported by the following case report. Without clinical signs of fever or hematochezia, an eight-week-old white female infant was diagnosed and treated for an infection of *Salmonella enteritidis*, serotype C-2, with positive cultures from stool and blood. The most important evidence distinguishing this child from normal was the stool frequency. By the mother's description, the child had liquid stools, five to eight times a day since birth. According to the present study, this bottle-fed infant would have been expected to reduce her stool count to two or less stools by eight weeks of age. The decline in stool counts over time may provide important historical data for physicians caring for small infants. Stool counts can be a useful addition to the history in many cases.

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Tricyclic Antidepressant Toxicity

To the Editor:

I wish to bring to your attention an apparent typographical error in your August issue. The article, "Tricyclic Antidepressant Overdose," by Dr. R. Kevin Smith and Karen O'Mara (*J Fam Pract* 15:247, 1982), mentions that a QRS interval of 10 msec or more implies severe toxicity. It should have read 100 msec. They also state that prolongation of QRS 10 msec or more usually correlated with a plasma level of 1,000 ng/mL or more. Here again it should have been 100 msec, not 10 msec.^{1,2}

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1. Tricyclic antidepressant overdose. *JACEP* 8:10, 1979
2. Biological therapies in psychiatry. *Massachusetts General Hospital Newsletter*, April, 1982, vol 5, No. 4

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

I would like to thank Dr. Reddy for correctly noting this error. A QRS duration of 100 msec or more implies severe toxicity and usually correlates with a plasma level of 1,000 ng/mL or more.

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Behavioral Science in Family Medicine

To the Editor:

I would like to comment on several recent interrelated articles concerning the role of the family physician in dealing with patients' psychosocial problems.

The Schwenk et al¹ and Kiraly et al² studies both report patient expectations from urban areas, which have a wide array of mental health resources other than family physicians, as did the only other studies cited.^{3,4} Compared with nonurban patients, urban patients tend to have more limited expectations of family physicians for numerous clinical problem areas, including many non-behavioral areas such as obstetrics, orthopedics, and cardiology.

Since a large proportion of residency-trained family physicians have been choosing to practice in nonurban areas, the editorial recommendation to deliberately limit training for definitive psychosocial problem management⁵ appears to be based on insufficient data which omit an important portion of the population, ie, nonurban patients. The application of such logic to other clinical areas would suggest also limiting resident education in the definitive care of pregnancy and childbirth, simple fractures, and heart attacks, since most urban patients probably neither expect nor desire family physician expertise for these problems.

The Schwenk et al study is commendable in its conceptual foundation and design clarity. However, the data would be more appropriately discussed from its presentation as response frequencies (Table 1), rather than by the use of weighted means, as was done. The data is really ordinal level (rank-ordered categories) not interval level (numerical scale with

equidistant intervals separating scale points). Calculating means makes the unwarranted assumption that each level (no help, referral, some help, and expert help) differs from its adjacent level by an equal amount. Arbitrarily assigning numbers 1 through 4 to the categories does not create true interval data. A reasonable alternative scale might assign 0 to no help, 6 to referral, 8 to limited help, and 10 to expert help.

Looking at the response frequency data for problems having means of level 3 (some help), a majority of patients expected level 4 (expert) help for abortion, birth control counseling, drug problems, and menopause (52 to 54 percent). A plurality of patients (most frequent response category) expected expert help for family hereditary counseling, long-term emotional illness, nervousness or tension, hospitalized family member, child developmental problems, bed wetting, child abuse or neglect, suicide attempt, alcoholism, and depression (32 to 48 percent). Contrary to the perspective created by the discussion of mean values, one concludes from analysis of the response frequencies that a substantial proportion of patients expect or desire expert help for numerous psychosocial problems.

Should the educational goals for behavioral science skills training be redefined to a more limited level, as Schwenk and Geyman suggest, simply because patient expectations are not uniformly high in this area and we have not yet managed to meet our goals? To do so would be to retreat from one of family practice's strongest claims to distinctiveness from other specialties—the comprehensive holistic management of most of our patients' health problems. The family

physician who is unwilling or unable to provide expert psychosocial help forfeits many opportunities to help his patients, especially in situations where limited help is insufficient and referral may be impractical or unacceptable to the patient or family.

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References

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3. Hyatt JD: Perceptions of the family physician by patients and family physicians. *J Fam Pract* 10:295, 1980
4. Chatterton HT, Clapp NE, Gehlbach SH: Patterns of health care utilization in an academic family practice. *J Fam Pract* 14:893, 1982
5. Geyman JP: Public perceptions of psychosocial problems and roles of the family physician. *J Fam Pract* 15:225, 1982

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

My colleagues and I feel that one of the most desirable outcomes from our research on behavioral science skills in family physicians would be to stimulate scholarly debate and disagreement. It would appear from the letter by Dr. Crouch that we have been successful. I will address his comments in order of their presentation.

First, we are certainly in agreement with the statement that the data, obtained from an urban patient population, must be cautiously interpreted for other patient populations. As we noted in the ar-

ticle, there are many areas of fruitful further research, some of which is taking place at this very time with other demographic and socioeconomic populations. I would suggest that patients may differ less than we anticipate in their psychosocial expectations of their family physicians, no matter their demographic characteristics.

Second, I am most appreciative of the attention which Dr. Crouch has given to our data, particularly his discussion of response frequencies in Table 1 of our paper. That the items fall into different lists, depending on how the data are analyzed is not particularly troublesome to me. Our point was that the education of a family physician should be somewhat more selective, and should recognize that different problems are best taught at different levels of comprehension and intervention by the physician. Until this study is replicated and extended to other patient populations, I do not think that we can suggest one specific curriculum for all family practice training. I do think, however, that family medicine educators must accept that family physicians cannot be all things to all patients, but should provide care of a degree that matches the patients' expectations.

I would note, with regard to the calculation of weighted means, that the point made by Dr. Crouch regarding the assignment of one point to level 1, two points to level 2, and so on, does indeed make an arbitrary assumption about how one level differs from another. I would also note that his suggestion about assigning the values 0, 6, 8, and 10 makes equally arbitrary assumptions about the relative value of each level of intervention, and therefore has no greater value than does our system.

Finally, the statements made by Dr. Crouch regarding the "claims to distinctiveness" by family practice, that the family physician offers "comprehensive holistic management," denies the foundation upon which the family practice specialty was organized: the desires of our patient population. To offer services not wanted by our patients and to become experts in solving problems patients take elsewhere ignore a valuable source of strength to our developing specialty. That is the point which we wished to make in our paper.

Thomas L. Schwenk, MD
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A New Iatrogenic Cause of Anisocoria

To the Editor:

The presence of a fixed and dilated pupil in a patient who has not sustained ocular trauma and who has no other complaints except for the sudden onset of blurred vision and difficulty with reading is very often due to accidental instillation of atropine or some other belladonna-like agent. This is very common in the hospital population among nurses who are required to instill eye drops and who inadvertently rub their eyes with their contaminated fingers, or in mothers who have been instilling drops in their children's eyes prior to an ophthalmic examination.

A new variation on this theme is the fixed and dilated pupil due to the recently introduced motion sickness medication, Transderm-V, which is applied topically behind the ear once every three days. We have had one in which the patient had initially overlooked the

use of this medication in her medical history. Possibly because she applied it infrequently she did not consider this a form of medicine owing to the means of application. This led to needless hospitalization, computerized tomographic scans of the head, and neurological consultation.

Transderm-V is a small membrane-like disc impregnated with scopolamine, a belladonna alkaloid related to atropine. It is not clear whether the pupillary dilatation in this case resulted from direct contamination via the fingers or, less likely, simply occurred as a direct side effect of its application.

In the eye, topical application of scopolamine causes mydriasis and cycloplegia satisfactory for refraction within one hour, and its effect lasts four to seven days. This anticholinergic blockage, or "atropinic" mydriasis, may be easily demonstrated by failure of the pupil to constrict in response to 0.1 percent topical pilocarpine. Iris damage with sphincter involvement may also fail to constrict. However, neurological deficit resulting from III nerve palsy will show pupillary constriction in response to this test. It must also be mentioned that in the fixed and dilated pupil, cholinergic supersensitivity, as seen in Adie's tonic pupil, may first be ruled out by failure to constrict in response to 2.5 percent topical methacholine or 0.1 percent pilocarpine.

As can be seen from the above, the successful workup of the patient with a fixed and dilated pupil requires a careful history. Also, those prescribing Transderm-V should be aware of the 0.1 percent pilocarpine test as a simple means of differentiating the pharmacological dilated pupil from the III nerve paresis, thereby preventing needless

neurological studies and expense.

Matthew P. Koehler, MD

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Riboflavin and Phototherapy

To the Editor:

The article on phototherapy by Dr. Avrum L. Katcher (*J Fam Pract* 14:1123, 1982) was well done, and I congratulate his efforts on behalf of our mutual patients. There is some confusion regarding the dosage of riboflavin. At one point 3 mg/kg/day is recommended as an adjunct. Later in the article daily supplementation with 0.3 mg is recommended. As the average infant weighs roughly 3.5 kg, there would seem to be a discrepancy between 10.5 mg and the recommended 0.3 mg. Perhaps this is a typographical error that could be clarified for your readers and myself.

Wm. MacMillan Rodney

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

Dr. Rodney is quite accurate in his comment about the dosage of riboflavin. It should be the lower dosage, 0.3 mg.

Avrum L. Katcher, MD

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Actions—Average magnitude of increased weight loss of drug-over placebo-treated patients in studies of anorectics in general is ordinarily only a fraction of a pound a week. Rate of weight loss is greatest in first weeks for both drug and placebo and tends to decrease in succeeding weeks. Total impact of drug-induced weight loss over that of diet alone must be considered clinically limited.

Indication—Management of exogenous obesity as short-term (few weeks) adjunct in regimen of weight reduction based on caloric restriction. Limited usefulness of agents of this class (see "Actions") should be measured against possible inherent risk factors, as described below.

Contraindications—Glaucoma; hypersensitivity or idiosyncrasy; mazindol; agitated states; history of drug abuse; during or within 14 days following the administration of MAO inhibitors (hypertensive crises may result).

Warnings—Tolerance to many anorectics may develop within few weeks; if it occurs, recommended dose should not be exceeded in attempt to increase effect; rather, drug should be discontinued. Mazindol may impair ability of patient to engage in potentially hazardous activities, as operating machinery or driving motor vehicles; patient should be cautioned accordingly.

Drug Interactions—Mazindol may decrease hypotensive effect of guanethidine; patients should be monitored accordingly. Mazindol may markedly potentiate pressor effect of exogenous catecholamines. If it is necessary to give pressor amine (e.g. levarterenol or isoprotenerol) to a patient in shock (e.g. from a myocardial infarction) who has recently been taking mazindol, extreme care should be taken in monitoring blood pressure at frequent intervals and initiating pressor therapy with low initial dose and careful titration.

Drug Dependence—Mazindol shares important pharmacologic properties with amphetamines. Amphetamines and related stimulants have been extensively abused and can produce tolerance and severe psychologic dependence. In this regard, manifestations of chronic overdose or withdrawal of mazindol have not been determined in humans. Abstinence effects have been observed in dogs after abrupt cessation for prolonged periods. There was some self-administration of the drug in monkeys. EEG studies and "liking" scores in human subjects yielded equivocal results. While abuse potential of mazindol has not been further defined, possibility of dependence should be kept in mind when evaluating desirability of including mazindol as part of weight-reduction program.

Usage in Pregnancy—An increase in neonatal mortality and possible increased incidence of rib anomalies in rats were observed at relatively high doses. Although these studies have not indicated important adverse effects, use of mazindol by women who are or may become pregnant requires that potential benefit be weighed against possible hazard to mother and infant.

Usage in Children—Mazindol is not recommended for use in children under 12 years.

Precautions—Insulin requirements in diabetes mellitus may be altered in association with mazindol and concomitant dietary regimen. Least amount of mazindol feasible should be prescribed to minimize overdose. Use only with caution in hypertension with monitoring of blood pressure. Mazindol is not recommended in severely hypertensive patients nor in patients with symptomatic cardiovascular disease including arrhythmias.

Adverse Reactions—Most common are: dry mouth, tachycardia, constipation, nervousness, and insomnia. Cardiovascular: Palpitation, tachycardia. CNS: Overstimulation, restlessness, dizziness, insomnia, dysphoria, tremor, headache, depression, drowsiness, weakness. GI: Dry mouth, unpleasant taste, diarrhea, constipation, nausea, other GI disturbances. Skin: Rash, excessive sweating, clamminess. Endocrine: Impotence, rare changes in libido. Eye: Treatment of dogs with high doses of mazindol for long periods resulted in some corneal opacities, reversible on cessation of drug; no such effect observed in humans.

Dosage and Administration—Lowest effective dose should be used. To determine this, therapy may be initiated at 1 mg once a day, and adjusted to the response. If GI discomfort occurs, give mazindol with meals.

Overdosage—There are no human data as yet on acute overdosage. Manifestations of acute overdosage with amphetamines and related substances include restlessness, tremor, rapid respiration, dizziness. Fatigue and depression may follow stimulatory phase. Cardiovascular effects include tachycardia, hypertension, and circulatory collapse. GI symptoms include nausea, vomiting, and abdominal cramps. While similar manifestations of overdosage may be seen with mazindol, their exact nature is not yet determined. Management of acute intoxication is largely symptomatic. Data are not available on treatment of acute intoxication with mazindol by hemodialysis or peritoneal dialysis, but the drug is poorly soluble except at very acid pH. **How Supplied**—in bottles of 30 tablets: 1 mg, NDC 0008-0071, white, round, scored tablet marked "WYETH" and "71".

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Prescribing of Antibiotics

To the Editor:

The study reported by Robinson et al¹ provoked an editorial² in your journal calling for heightened awareness of the problem of inappropriate prescribing of antibiotics. While respecting this viewpoint, and recognizing the interesting results provided by Robinson and his colleagues, a number of points are worth raising.

1. Although the authors agree that no written criteria to judge appropriateness of prescribing were used in the study, this fact must lead to a cautious interpretation of results when one considers the well-known variation in physicians' clinical judgment.

2. While it was interesting that "appropriate prescribing" dropped from 80 percent in first-year residents to 50 percent in third-year residents, there was no evidence produced to show that first- and third-year residents were dealing with comparable groups of patients in terms of presenting conditions, age, sex, and socioeconomic class. The latter and the physician's use of time are both factors which have a notable effect on physicians' consulting and prescribing habits.³ It would be a mistake to accept the comment that increased "inappropriate prescribing" in the third-year residents was a disturbing finding when information about important variables is not available.

3. One confusing feature of the published study¹ was that the reference list did not always match the equivalent reference in the text. The reference list included Howie's study on clinical judgment,⁴ but it was rather surprising that the discussion contained no account of his important findings. By the imagi-

native use of illustrated booklets containing standard physical signs, but variable social and psychological information relating to patients with presumed upper respiratory tract infections, he was able to demonstrate that variations in social and psychological history had a significant effect on family physicians' use or nonuse of antibiotics.

Audit of antibiotic prescribing is both necessary and desirable, but the results of the study described cannot be accepted unchallenged when flaws may have existed in the methods used to determine "appropriate/inappropriate prescribing." In addition, any analysis of "appropriate/inappropriate prescribing" is likely to be unproductive in the absence of methods of measurement that take into account patients' physical, psychological, and social features, which together will frequently influence physicians' prescribing.

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3. Bain DJG: The relationship between time and clinical management in family practice. *J Fam Pract* 8:551, 1979
4. Howie JGR: Clinical judgment and antibiotic use in general practice. *Br Med J* 2:1061, 1976

Physician Responses to Difficult Patients

To the Editor:

The report "Patient Characteristics that Elicit Negative Responses from Family Physicians"

(*J Fam Pract* 14:881, 1982) by Dr. David Klein and associates was of great interest to us. For the past two years we have been studying why physicians make errors in their practice and have developed a "hassle index" to measure vexation among practitioners.

This index covers 28 variables and has been given to 200 internists, family physicians, and psychiatrists practicing in Alabama, Florida, Mississippi, and Texas. Data derived from this survey were tabulated and analyzed by the statistical analysis system (SAS). A common factor analysis was done to determine the underlying dimensions that were assessed by these 28 items. Three dimensions of the general concept of hassle were identified. Factor I concerns aspects of running a practice (paperwork, inadequate time, night and weekend calls, etc). Factors II and III concern patient characteristics and behaviors. These two factors correspond roughly to the intuitive groupings Klein and associates call medical conditions and social characteristics.

Factor II included patients presenting with trivial and undiagnosable complaints, patients who are not sick, and hypochondriacal patients. Patient Factor III included patients who do not follow directions, patients who request procedures, drunk or "high" patients, threatening or hostile patients, "dumped" patients, and patients who waste physicians' time. It appears that patients hassle physicians when they present problems with which the physician cannot deal effectively. Personally offensive or threatening patients also annoy physicians.

A multivariate analysis of variance (MANOVA) was performed to determine if physicians in differ-

ent settings differed in the degree to which they found these three factors hassling. A significant ($P < .0001$) difference was found in Factor I, which deals with the running of the practice. This indicates that physicians in different practice settings experience different degrees of hasslement. On the other hand, physicians in all types of practice appeared to find patient characteristics and behaviors equally hassling, summarized under Factors II and III.

We regard patients who elicit negative responses from physicians as a source of stress in medical practice. The report by Klein and his associates should help create a sense of awareness of the negative feelings that physicians may feel toward patients. A better understanding on the part of all physicians of their negative feelings should decrease stress in practice and thereby improve the overall quality of medical care.

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Debts of Medical Graduates and Career Choice

To the Editor:

As the time for the interviews for next year's incoming class of residents draws near, I have been reflecting on what I perceive as an increasing problem in continuing to attract the best students to family practice, considering the cost of medical education. It is not unusual, in the applicants whom I interview, for debts to exceed \$30,000 or \$40,000 when they complete their medical school education. Many of these applicants

have young families and are living on a shoestring. In my opinion, it will be more difficult as the cost of medical education escalates to attract these applicants from some of the higher paying surgical specialties. One might argue that the selection process makes our job easier by favoring those students who are motivated to go into family practice for reasons other than financial gain. But I am enough of a realist to recognize that altruism can only go so far.

My hope would be that, at a national level, the American Academy of Family Physicians might think about establishing a low-interest loan or fellowship program for needy family practice residents. This could be made available to them upon completion of medical school and pay back would not begin until they had been in practice for a year.

There are enough pressures on young physicians to enter practice without having the additional burden of many thousands of dollars of high-interest loans to pay back for their medical education. A national program for low-interest loans in family practice could ease this important problem for medical graduates opting for this specialty.

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Breastfeeding

To the Editor:

The Family Practice Grand Rounds, "Infant Nutrition" by Bourdeax et al (*J Fam Pract* 14: 145, 1982), has been read with great interest at La Leche League International. On the whole, the arti-

cle showed great understanding of the process of lactation and infant feeding.

Dr. Schlagheck seems especially knowledgeable about the emotional impact of breastfeeding on both mother and infant. He has expressed these feelings well when he says "The mother comes in and says, 'I am a failure. I cannot breastfeed my baby because he is not gaining any weight.'" It is hoped that more physicians will now recognize the emotional needs of the mother in this situation and will be able to offer more support than Dr. Schlagheck's fictitious physician who said, "Yes, that's true. Here's a bottle."

I would like to clarify two statements made in the article. First, it has been our experience that while mothers with active herpes simplex do need to take special precautions in the handling and care of their newborns, it does not necessarily preclude a satisfying and successful nursing relationship.

Second, it is always wise to try to avoid medications in the pregnant and lactating woman. However, when medications are necessary, there is conflicting information regarding which medications are contraindicated and which, with proper monitoring of the mother and baby, could be used. A publication that may be of interest to family physicians is "Breastfeeding and Drugs in Human Milk," edited by Gregory White and Mary Kerwin White, in the *Journal of Veterinary and Human Toxicology*, Volume 22, Supplement 1, 1980.

Family physicians can provide family-focused medical care for the nursing dyad. Your article has pointed out that this care is both physical and emotional in nature and that the Peoria School of Medicine Residency in Family Practice

has taken great care in teaching their residents the importance of both factors. Our compliments to them and to your fine journal for this article.

Sally Tobin
La Leche League International
Grand Forks, ND

Internal Medicine and Geriatrics

To the Editor:

In a policy paper, "Geriatric Medicine: A Statement from the Federated Council for Internal Medicine,"¹ internists stake their claim on the turf of the care of the aged. The paper is a fascinating political statement about geriatric medicine, how it is taught, and how care for the aged will be delivered

(more by implication than by statement).

The discipline of geriatric medicine is addressed in a series of 12 recommendations. These are prefaced by an opening declaration: "Geriatric medicine can be defined as that branch of internal medicine. . . ." This is a bit presumptuous in my view and is compounded in recommendation 11, which reads "FCIM recommends that the American Board of Internal Medicine emphasize that certification in internal medicine implies basic competence in geriatric medicine." Given the present state of geriatric education within training programs in the United States, this is no more true for internists than it would be for family physicians.

All primary care physicians

(with the exception of pediatricians) care for the aged. Training in these disciplines is commonly deficient in the area of geriatric medicine, with the absence of interested and trained teachers being the major shortcoming of almost all training programs. The situation will remain unchanged until the number of geriatricians increases substantially.

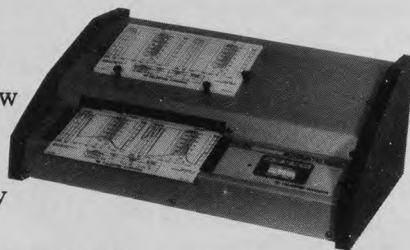
Teachers of family medicine who have an interest in geriatrics (with or without advanced geriatric training) should seek roles of greater collaboration in this area within medical education. If there is a geriatrically trained internist on faculty, seek to utilize his or her expertise for consultation and teaching. Offer your skills and per-

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spective as a family physician in exchange. Seek to foster the development of a multidisciplinary committee of professionals interested in the care of the aged.

Family physicians need to consider whether the training of geriatricians should remain the exclusive area of internal medicine. The English model is one in which a physician can enter training in geriatrics from either internal medicine or general practice. Upon completion of geriatrics training our English counterparts may then take competency certification examinations. Canada recently created a similar examination. However, there the examination is available only to members of the Royal College of Physicians (internal medicine). Though there is a strong feeling in this country against creation of geriatrics as a subspecialty by both internists and family physicians, it may well be that this country will follow the approaches taken in England and Canada. When and if that occurs, mechanisms for the inclusion of family physicians in that process should be in effect.

J. N. Kvale, MD

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Reference

1. Geriatric Medicine: A statement from the Federated Council for Internal Medicine. *Ann Intern Med* 95:372, 1981

Risk of Thyroid Withdrawal in Insulin-Dependent Diabetes

To the Editor:

Recently, Rizzolo and Fisher described a 21-day thyroid hormone withdrawal test for the re-evaluation of thyroid status in pa-

tients on long-term therapy whose initial diagnosis of hypothyroidism was not felt to be well documented.¹ This included patients who had not had a TSH assay performed. The authors recognized that their study was small (10 patients), but they concluded that "this procedure can safely identify truly hypothyroid patients without producing unwanted symptoms."

Recently, in this practice, an elderly diabetic woman sustained multiple hypoglycemic episodes that we believe can be related to the thyroid hormone withdrawal test. She required hospitalization for management. She had been maintained on 40 units of normal protein Hagedorn insulin a day for several years. She was diagnosed as hypothyroid nine years earlier with the only laboratory documentation being a T_7 of 1.3 (T_4 of 3.3 $\mu\text{g}/100\text{ mL}$, T_3 resin uptake of 39 percent), historical data not available in the chart or by patient recall. The patient ran out of levothyroxine (maintained on 0.2 mg daily) four weeks prior to admission. She presented two weeks prior to admission with complaints consistent with hypoglycemic symptoms at night for which she had initiated a decrease in her insulin to 30 units a day. A colleague familiar with the above article saw her in the office and decided not to renew her levothyroxine because the diagnosis had not been documented with an elevated thyroid stimulating hormone (TSH) level. He scheduled a test of TSH level one week later for which the patient failed to return. The patient presented in follow-up two weeks after the office visit, now four weeks off levothyroxine, with a one-week history consistent with daily nighttime hypoglycemic episodes. She had decreased herself to 20 units of NPH insulin

without amelioration of symptoms.

On admission to the hospital she had hypothyroid facies but otherwise no significant hypothyroid symptoms or signs. Admission random serum glucose was 163 mg/100 mL. Later the next day, she had a documented serum glucose level of 66 mg/100 mL followed by hypoglycemic symptoms. There was no evidence of the Somogyi effect. Her T_4 was less than 1 $\mu\text{g}/100\text{ mL}$ (normal, 4.5-11.5) and her TSH was 37.5 $\mu\text{g}/100\text{ mL}$ (normal, 0-10). She restarted back on levothyroxine 0.1 mg per day. Hypoglycemic symptoms resolved quickly with the patient being maintained on 20 units of NPH insulin a day.

This case describes an apparent increased sensitivity to insulin² in a diabetic patient who became hypothyroid while removed from levothyroxine replacement. Symptoms of hypoglycemia started two weeks after serendipitous withdrawal of levothyroxine and peaked at three weeks. This case demonstrates that the 21-day thyroid hormone withdrawal test can be dangerous in an insulin-dependent diabetic who is also hypothyroid. Such a test should be performed with caution if it is to be done at all with this subset of patients.

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