

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.



Technique of Vasectomy

To the Editor:

I would like to make several comments regarding the article in the February 1983 issue on vasectomy (*Brownlee HJ, Tibbels CK: Vasectomy. J Fam Pract 16:379, 1983*). The article in general is excellent. My personal technique is to manipulate and grasp the vas superior-lateral, and while holding it in position infiltrate on either side with xylocaine anesthesia using a 26- or 27-gauge needle, then use a small towel clip for immobilization of the vas. Making an incision over the vas between the jaws of the towel clamp allows ready accessibility. The vas is dissected free with blunt dissection and at least a 2-cm section is dissected free, each end is tied with plain chromic sutures, the towel clamp is then removed, and each vas end will retract. The wound is then closed with one or two plain chromic sutures, which dissolve in three to four days. The plain suture allows for sealing over the vas ends without residual fibroma and scrotal discomfort. The masturbation-produced ejaculate is examined after three weeks of condom use. The vas specimens are always sent to the pathologist for confirmation. This technique has resulted in a total operating time of 15 to 20

minutes with very little morbidity. I allow the patient full activity immediately with use of a scrotal support and 50 mg of meclufenamate (Meclomen) four times a day for four days.

*Richard Hopkins, MD
Columbus, North Carolina*

Serum Digoxin Levels

To the Editor:

In an article that appeared in the December 1982 issue of the journal on digoxin (*Grauer K, Curry RW Jr, Robinson D: Prediction of serum concentrations of digoxin in a family practice center. J Fam Pract 15:1081, 1982*), no mention was made of the dosages of the drugs administered.

What was the dose of Lanoxin used, and how was the dose related to the serum concentration of digoxin?

*D.A. Berberian, MD
Loudonville, New York*

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

I am happy to write in response to Dr. Berberian's questions about the dose of Lanoxin used in our article, and how this dose is related to the serum concentration of digoxin.

The dose of Lanoxin varied for different patients. Specifically, the most commonly used doses were .25 mg or .125 mg. Other patients were on an alternating regimen of .125 mg one day and .25 mg the next, or .25 mg one day and .375 mg the next.

As to how the dose was related to the serum concentration of digoxin, the thrust of the article was that the actual dose of this medication was only one of many factors that determined serum digoxin concentration. The other factors include the time that the last dose of digoxin was administered, the age of the patient, the condition being treated, the presence of other significant medical conditions, renal and electrolyte status, and finally other medications that the patient might be concurrently taking. These conditions were all listed and discussed in the early part of our conclusion.

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Clues for Suspecting Giardiasis in a Day-Care Center

To the Editor:

While there is nothing new about the potential of a preschool child in a day-care setting to harbor and disseminate a wide variety of enterorespiratory pathogens, the United States is experiencing major increases in the number of working mothers with children under age six years.¹ At last count, over 11 million preschool children are in day-care settings ranging from informal neighborhood baby-sitting to large

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Diet & Diabinese

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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, thiazides, phenylbutazone, salicylates, probenecid, dicoumarol or MAO inhibitors. Adequate dietary intake should be assured in all patients using Diabinese.

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. HERE, INSULIN IS INDISPENSABLE.

HYPOGLYCEMIA, IF IT OCCURS, MAY BE PROLONGED. (SEE ADVERSE REACTIONS.) IN INSTANCES OF CONCOMITANT USE WITH INSULIN, PATIENTS SHOULD BE CAREFULLY MONITORED.

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, skin eruptions rarely progressing to erythema multiforme and exfoliative dermatitis, and probably depression of formed elements of the blood. They occur characteristically during the first six weeks of therapy.

With a few exceptions, these manifestations have been mild and readily reversible on the withdrawal of the drug. The more severe manifestations may require other therapeutic measures, including corticosteroid therapy. 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 total daily dosage is generally taken at a single time each morning with breakfast. Occasionally, cases of gastrointestinal intolerance may be relieved by dividing the daily dosage. A LOADING OR PRIMING DOSE IS NOT NECESSARY AND SHOULD NOT BE USED. 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.

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LETTERS TO THE EDITOR

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licensed private pay operations.² Health agencies, including the Centers for Disease Control, have documented serious outbreaks and are investigating preventive measures (including aggressive immunoglobulin administration to all contacts of day-care centers with two or more cases of hepatitis A).³

In the course of a three-year study of children with giardiasis, I visited day-care centers rather regularly to collect stool specimens and epidemiologic data. I wish to share the following "clues" for suspecting hyperendemic person-to-person transmission among the toddlers and teachers.

1. The towel: a common towel or soapdish for 20 persons is not unusual.

2. The table: a fine multipurpose work-surface. It accommodates food preparation, meal taking, snacks, diaper changes, arts and crafts, toys, even homework for older children.

3. The kitchen: lacking the heavy-duty dishwashers required in most food establishments. Sometimes a common utility room is used for food preparation and laundering of diapers and bedding. Adults move freely between kitchen and diaper area with inconsistent handwashing.

4. The favorite toy: one or more large cuddly stuffed animals receive many moist kisses and sticky-fingered embraces during the day.

5. The wading pool: an attractive feature for recreation and teaching water skills. Depends for disinfection on sunshine and chlorination, to which giardia are resistant.

6. The little helper: older children assist the overworked teachers with cleanup, dressing chores, retrieving pacifiers and rubber toys. Mixing age groups is com-

mon. In fact, family-style serving of meals is encouraged to mix age groups.

7. The urgent telephone message: the bulletin board notes that certain parents "cannot drive the car pool today." Another bout of unexplained "gastrointestinal flu."

None of the above clues are diagnostic. The suspicion needs to be confirmed by reliable laboratory examinations of stool or duodenal fluid for cysts or trophozoites. In the meantime, endemic giardiasis in US day-care centers may force us to rediscover the basic principles of hygiene and control of person-to-person transmission of disease.⁴⁻⁷ Teamwork among physicians, parents, day-care providers, the health department, and social services will be required to control opportunistic infections in child-care settings.

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