

(Continued from preceding page)

**Nursing Mothers:** Captopril is secreted in human milk. Exercise caution when administering captopril to a nursing woman, and, in general, nursing should be interrupted.

**Pediatric Use:** Safety and effectiveness in children have not been established although there is limited experience with use of captopril in children from 2 months to 15 years of age. Dosage, on a weight basis, was comparable to that used in adults. Captopril should be used in children only if other measures for controlling blood pressure have not been effective.

**ADVERSE REACTIONS:** Reported incidences are based on clinical trials involving about 4000 patients.

**Renal**—One to 2 of 100 patients developed proteinuria (see WARNINGS). Renal insufficiency, renal failure, polyuria, oliguria, and urinary frequency in 1 to 2 of 1000 patients.

**Hematologic**—Neutropenia/agranulocytosis occurred in about 0.3% of captopril treated patients (see WARNINGS). Two of these patients developed sepsis and died.

**Dermatologic**—Rash (usually mild, maculopapular, rarely urticarial), often with pruritus and sometimes with fever and eosinophilia, in about 10 of 100 patients, usually during the 1st 4 weeks of therapy. Pruritus, without rash, in about 2 of 100 patients. A reversible associated pemphigoid-like lesion, and photosensitivity have also been reported. Angioedema of the face, mucous membranes of the mouth, or of the extremities in about 1 of 100 patients—reversible on discontinuance of captopril therapy. One case of laryngeal edema reported. Flushing or pallor in 2 to 5 of 1000 patients.

**Cardiovascular**—Hypotension in about 2 of 100 patients. See WARNINGS (Hypotension) and PRECAUTIONS (Drug Interactions) for discussion of hypotension on initiation of captopril therapy. Tachycardia, chest pain, and palpitations each in about 1 of 100 patients. Angina pectoris, myocardial infarction, Raynaud's syndrome, and congestive heart failure each in 2 to 3 of 1000 patients.

**Dysgeusia**—About 7 of 100 patients developed a diminution or loss of taste perception; taste impairment is reversible and usually self-limited even with continued drug use (2 to 3 months). Gastric irritation, abdominal pain, nausea, vomiting, diarrhea, anorexia, constipation, aphthous ulcers, peptic ulcer, dizziness, headache, malaise, fatigue, insomnia, dry mouth, dyspnea, and paresthesias reported in about 0.5 to 2% of patients but did not appear at increased frequency compared to placebo or other treatments used in controlled trials.

**Altered Laboratory Findings:** Elevations of liver enzymes in a few patients although no causal relationship has been established. Rarely cholestatic jaundice and hepatocellular injury with secondary cholestasis have been reported. A transient elevation of BUN and serum creatinine may occur, especially in volume-depleted or renovascular hypertensive patients. In instances of rapid reduction of longstanding or severely elevated blood pressure, the glomerular filtration rate may decrease transiently, also resulting in transient rises in serum creatinine and BUN. Small increases in serum potassium concentration frequently occur, especially in patients with renal impairment (see PRECAUTIONS).

**OVERDOSAGE:** Primary concern in correction of hypotension. Volume expansion with an I.V. infusion of normal saline is the treatment of choice for restoration of blood pressure. Captopril may be removed from the general circulation by hemodialysis.

**DOSAGE AND ADMINISTRATION:** CAPOTEN should be taken one hour before meals. Dosage must be individualized; see DOSAGE AND ADMINISTRATION section of package insert for detailed information regarding dosage in hypertension and in heart failure. Because CAPOTEN (captopril) is excreted primarily by the kidneys, dosage adjustments are recommended for patients with impaired renal function. **Consult package insert before prescribing CAPOTEN (captopril).**

**HOW SUPPLIED:** Available in tablets of 25, 50, and 100 mg in bottles of 100, and in UNIMATIC® unit-dose packs of 100 tablets.



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Princeton, NJ 08540 524-501  
Issued: January 1984

## Book Reviews

### **Manual of Dermatology: An Introduction to Diagnosis and Treatment.**

*Jeffrey P. Callen, Marek A. Stawiski, John J. Voorhees. Year Book Medical Publishers, Chicago, 1980, 294 pp., \$22.50 (paper).*

The *Manual of Dermatology* is intended to be a bridge between a textbook and an atlas on dermatology, and it serves that purpose fairly well. It is not a heavily in-depth review of dermatology; rather, it is a good review of basic dermatologic terminology and conditions. Each condition is described in several paragraphs so that the reader can quickly understand the most common manifestations of the appearance of the skin in each specific condition. There is also a description of etiology and pathogenesis, differential diagnosis, and specific therapy.

The conditions described in the book cover the usual range of papulosquamous, vesicular, and infectious etiologies. Although there are more chapters on various types of infectious diseases, probably in a disproportionate emphasis to those lesions that are most commonly seen, the infectious causes are dealt with in more depth so that they can be more appropriately described. There are also interesting chapters on the effects of sunlight on the skin, regional cutaneous disorders, and general principles of cutaneous therapy. A chapter on the latter reviews numerous therapeutic agents, both in their generic and trade names.

The major drawback to the book is that the pictures are all black and white, and many descriptive photographs have been eliminated because they cannot be distinguished from each other when photographed in black and white. The

preface indicates that the reader needs to supplement this book in a clinical setting with color pictographic atlases as well as careful examination of the skin. That statement in itself points out that this book can be useful but does not give as much information in attempting to differentiate various lesions as do some other books. Some of the pictures, despite being black and white, are of extremely good quality.

The book would be of use to students, residents, practicing physicians, and ancillary medical personnel. Its use, however, is limited to a background review of dermatologic conditions, their differential diagnosis and treatment.

*Ross R. Black II, MD  
Akron, Ohio*

**Teachers and Teaching in U.S. Medical Schools.** *Hilliard Jason, Jane Westberg. Appleton-Century-Crofts, E. Norwalk, Connecticut, 1982, 320 pp., \$38.95.*

This book presents the results and interpretation of a multifaceted survey of medical school teachers and teaching practices. Given the topic and the rather prosaic title, the reader might expect a dry almanac of facts and figures. But Jason and Westberg draw the reader's attention to the importance of the data and unabashedly reveal their own interpretations, concerns, and intimations of the future. Their organization and a gift for uncluttered prose make the study readable; likewise, the tables are comprehensible and easy on the eyes.

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# ACTIFED-C<sup>®</sup>

## EXPECTORANT C<sup>✓</sup>

**INDICATIONS:** Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications as follows: "Lacking substantial evidence of effectiveness as a fixed combination." For the symptomatic relief of cough in conditions such as: the common cold, acute bronchitis, allergic asthma, bronchiolitis, croup, emphysema, tracheobronchitis. Final classification of the less-than-effective indications requires further investigation.

### 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, codeine and sympathomimetic amines for infants generally and for newborn and premature in particular, Actifed-C Expectorant therapy is contraindicated in nursing mothers.

**Use in Lower Respiratory Disease:** Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Actifed-C Expectorant is also contraindicated in the following conditions:

Hypersensitivity to: 1) triprolidine hydrochloride and other antihistamines of similar chemical structure; 2) sympathomimetic amines including pseudoephedrine; and/or 3) any of the other ingredients.

Monoamine oxidase inhibitor therapy (see Drug Interactions Section).

**WARNINGS:** Actifed-C Expectorant should be used with considerable caution in patients with:

Increased intraocular pressure (Narrow angle glaucoma)	Hypertension
Stenosing peptic ulcer	Diabetes mellitus
Pyloroduodenal obstruction	Ischemic heart disease
Symptomatic prostatic hypertrophy	Hyperthyroidism
Bladder neck obstruction	

Sympathomimetics may produce central nervous system stimulation with convulsions or cardiovascular collapse with accompanying hypotension.

Codeine can produce drug dependence of the morphine type, and therefore has the potential of being abused.

**Use in Children:** As in adults, the combination of an antihistamine and sympathomimetic amine can elicit either mild stimulation or mild sedation in children.

While it is difficult to predict the result of an overdose of a combination of triprolidine, pseudoephedrine, and codeine the following is known about the individual components:

In infants and children especially, antihistamine in overdose may cause hallucination, convulsion or death. Large doses of pseudoephedrine are known to cause weakness, lightheadedness, nausea and/or vomiting. An overdose of codeine may cause CNS depression with muscular twitching and convulsion, weakness, disturbed vision, dyspnea, respiratory depression, collapse and coma.

**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:** Triprolidine and codeine phosphate have 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. Overdosages of sympathomimetics in this age group may cause hallucinations, convulsions, CNS depression, and death.

**PRECAUTIONS:** Actifed-C Expectorant should be used with caution in patients with: history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension.

**DRUG INTERACTIONS:** MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines and overall effects of sympathomimetics. Sympathomimetics may reduce the antihypertensive effects of methyldopa, decamylamine, reserpine, and veratrum alkaloids.

The CNS depressant effect of triprolidine hydrochloride and codeine phosphate may be additive with that of other CNS depressants.

### ADVERSE REACTIONS:

- General:** Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose and throat.
- Cardiovascular System:** Hypotension, headache, palpitations, tachycardia, extrasystoles.
- Hematologic System:** Hemolytic anemia, thrombocytopenia, agranulocytosis.
- Nervous System:** Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions, CNS depression, hallucination.
- G.I. System:** Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.
- G.U. System:** Urinary frequency, difficult urination, urinary retention, early menses.
- Respiratory System:** Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

**NOTE:** Guafenesin has been shown to produce a color interference with certain clinical laboratory determinations of 5-hydroxyindoleacetic acid (5-HIAA) and vanillylmandelic acid (VMA).

**HOW SUPPLIED:** Bottles of 1 pint, 1 gallon and 4 oz Unit of Use Bottle with Child Resistant Cap.

**Burroughs Wellcome Co.**  
Research Triangle Park  
North Carolina 27709

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Following an introductory section on background and methodology, the substantive content is divided between two major investigations. In the first investigation the authors describe the characteristics of teaching faculty (grouped into basic science, primary care, and other clinical departments), along with each group's views on such educational issues as appropriate preparation for teaching, useful instructional and evaluational practices, and the goals these teachers ascribe to themselves and their medical schools. This section concludes with rankings of areas in which faculty want help in improving their teaching competence.

In a second investigation, faculty were presented with simulated problematic situations involving course design, test construction, lecturing, small-group discussion, clinical supervision, and research supervision. Their chosen decisions and actions in these situations constitute the data for this section. Not surprisingly, the simulated choices reveal a less flattering picture of faculty than the self-reports of the first investigation.

Throughout the monograph, Jason and Westberg express two strongly held points of view. First, they note that medical school faculty are, by definition, professional teachers. This implies an expectation of theoretical grounding and technical mastery of instruction practice. With equal conviction the authors hold that an autocratic, impersonal fact-oriented education that ignores the motivation, daily stresses, social needs, and professional goals of students will inevitably perpetuate the image of the autocratic, impersonal, fact-oriented physician whom the public

has rejected. From these perspectives they find areas of encouragement as well as areas of substantial concern.

The authors find consistent and sizeable differences between the perspectives of basic science and clinician faculty, with clinicians reporting more interest in improving their teaching skills and expanding their teaching repertoires. Clinician faculty also report a greater interest than basic science faculty in such affective issues as stimulating self-directed learning habits among students, linking the relevance of course work to students' eventual career goals, and fostering a scientific attitude toward inquiry. Differences on these issues between faculty of primary care departments (internal medicine, pediatrics, and family medicine) and other clinician faculty are unsatisfying, since 60 percent of the designated "primary care" faculty did not regard themselves as such.

This book is certain to stimulate discussion, since it raises fundamental issues about the commitment of medical schools to teaching excellence, the fundamental aims of medical education, and the relative influence and roles of basic science and clinical departments in the medical school curriculum. Departments of family medicine will find themselves generally among the "good guys" and may turn to this book for authoritative opinions and hard data that support positions generally favored in family medicine. Aside from the provocative thoughts and the wealth of information it provides, this book may be important for department chairmen and educational coordinators to have digested in preparation for curriculum battles ahead.

Michael J. Gordon, PhD  
Seattle, Washington