

E.E.S.[®]

(erythromycin ethylsuccinate)

INDICATIONS: *Streptococcus pyogenes* (Group A beta hemolytic streptococcus): Upper and lower respiratory tract, skin, and soft tissue infections of mild to moderate severity.

Injectable benzathine penicillin G is considered by the American Heart Association to be the drug of choice in the treatment and prevention of streptococcal pharyngitis and in long-term prophylaxis of rheumatic fever.

When oral medication is preferred for treatment of the above conditions, penicillin G, V, or erythromycin are alternate drugs of choice.

When oral medication is given, the importance of strict adherence by the patient to the prescribed dosage regimen must be stressed. A therapeutic dose should be administered for at least 10 days.

Alpha-hemolytic streptococci (viridans group): Although no controlled clinical efficacy trials have been conducted, oral erythromycin has been suggested by the American Heart Association and American Dental Association for use in a regimen for prophylaxis against bacterial endocarditis in patients hypersensitive to penicillin who have congenital heart disease, or rheumatic or other acquired valvular heart disease when they undergo dental procedures and surgical procedures of the upper respiratory tract. Erythromycin is not suitable prior to genitourinary or gastrointestinal tract surgery. NOTE: When selecting antibiotics for the prevention of bacterial endocarditis the physician or dentist should read the full joint statement of the American Heart Association and the American Dental Association.

Staphylococcus aureus: Acute infections of skin and soft tissue of mild to moderate severity. Resistant organisms may emerge during treatment.

Streptococcus pneumoniae (Diplococcus pneumoniae): Upper respiratory tract infections (e.g., otitis media, pharyngitis) and lower respiratory tract infections (e.g., pneumonia) of mild to moderate degree.

Mycoplasma pneumoniae (Eaton agent, PPLO): For respiratory infections due to this organism.

Hemophilus influenzae: For upper respiratory tract infections of mild to moderate severity when used concomitantly with adequate doses of sulfonamides. (See sulfonamide labeling for appropriate prescribing information). The concomitant use of the sulfonamides is necessary since not all strains of *Hemophilus influenzae* are susceptible to erythromycin at the concentrations of the antibiotic achieved with usual therapeutic doses.

Tréponema pallidum: Erythromycin is an alternate choice of treatment for primary syphilis in patients allergic to the penicillins. In treatment of primary syphilis, spinal fluid examinations should be done before treatment and as part of follow-up after therapy.

Corynebacterium diphtheriae: As an adjunct to antitoxin, to prevent establishment of carriers, and to eradicate the organism in carriers.

Corynebacterium minutissimum: For the treatment of erythrasma.

Entamoeba histolytica: In the treatment of intestinal amebiasis only. Extraenteric amebiasis requires treatment with other agents.

Listeria monocytogenes: Infections due to this organism.

Bordetella pertussis: Erythromycin is effective in eliminating the organism from the nasopharynx of infected individuals, rendering them non-infectious. Some clinical studies suggest that erythromycin may be helpful in the prophylaxis of pertussis in exposed susceptible individuals.

Legionnaires' Disease: Although no controlled clinical efficacy studies have been conducted, *in vitro* and limited preliminary clinical data suggest that erythromycin may be effective in treating Legionnaires' Disease.

CONTRAINDICATIONS: Erythromycin is contraindicated in patients with known hypersensitivity to this antibiotic.

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.

Areas of localized infection may require surgical drainage in addition to antibiotic therapy.

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.

Usage during pregnancy and lactation: The safety of erythromycin for use during pregnancy has not been established.

Erythromycin crosses the placental barrier. Erythromycin also appears in breast milk.

ADVERSE REACTIONS: The most frequent side effects of 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.

Allergic reactions ranging from urticaria and mild skin eruptions to anaphylaxis have occurred.

There have been isolated reports of reversible hearing loss occurring chiefly in patients with renal insufficiency and in patients receiving high doses of erythromycin.



3053545

Book Reviews

Approaches to Teaching Primary Health Care. Harry J. Knopke, Nancy L. Diekelmann (eds). C.V. Mosby Company, St. Louis, 1981, 322 pp., price unavailable.

Finally, here is a compendium of the educational technology that is most useful to family medicine educators in academic settings. In spite of its clear efforts to aim at the wider audience of educators in "primary care," including predoctoral and graduate "educational programs in medicine, nursing, and many other health care professions," this book retains its cogency for family medicine. In fact, one third of its 27 authors are currently affiliated with departments of family medicine. Only one chapter has little relevance to family medicine, though several focus upon relationships with community and rural teaching sites. Family physicians based in community hospitals will find less relevance in this book, unless they have a strong university affiliation and responsibility for teaching medical students.

Sections of the book cover planning, development, management, and evaluation of educational programs. The authors are clearly both well trained and experienced in the field of medical education for primary care. Good examples are used, and "pearls" based upon successes and failures abound. Humanistic teaching and the biopsychosocial approach are basic philosophies. Chapters on modular instruction, evaluation by simulation, and systematic planning are especially useful.

The approach is assertive in that the institution's necessary major commitment to primary care education is repeatedly stressed. Good arguments are made that a half-

hearted attempt to assuage legislators, alumni, or the public dooms the process from the start. Faculty, good teaching sites, appropriate patient care models, community interrelationships, and political clout require core commitment by the institution.

Though this information provides slow reading and is occasionally too detailed or too superficial, it is an excellent book for its organization, comprehensiveness, and cogency. Full-time junior faculty members, fellows, and those involved in faculty development will appreciate having this up-to-date material and references in one place on their library shelf.

Richard M. Baker, MD
Chapel Hill, North Carolina

Drug Therapy in Obstetrics and Gynecology. William F. Rayburn, Frederick P. Zuspan (eds). Appleton-Century-Crofts, E. Norwalk, Connecticut, 1982, 384 pp., \$38.50.

This first edition is divided into three sections: obstetrics, gynecology, and drugs for general use. The authors' goal is to provide information about specific drugs in daily clinical practice. Each chapter begins by introducing a specific patient disorder or patient concern, then reviews the appropriate physiology, followed by a discussion of the indications and uses of various pharmaceutical agents. The manner in which these issues are integrated provides the reader with extensive factual data plus guidance in clinical decision making. The combined sections on obstetrics and gynecology make up 80 percent of the text. Oncologic chemotherapy is the only chapter that does

Continued on page 484

New Pump!

Nasalide[®]

(flunisolide) nasal solution 0.025%

Brief Summary

Description: Each bottle contains flunisolide in a solution of propylene glycol, polyethylene glycol 3350, citric acid, sodium citrate, butylated hydroxyanisole, edetate disodium, benzalkonium chloride, and purified water, with NaOH and/or HCl added to adjust the pH. It contains no fluorocarbons.

Indications: For relief of the symptoms or seasonal or perennial rhinitis when effectiveness of or tolerance to conventional treatment is unsatisfactory.

Improvement is usually apparent within a few days after starting Nasalide but may take as long as 2 weeks in some patients. Although systemic effects are minimal at recommended doses, Nasalide should not be continued beyond 3 weeks in the absence of significant symptomatic improvement. Nasalide should not be used in the presence of untreated localized infection involving nasal mucosa.

Contraindications: Hypersensitivity to any ingredients.

Warnings: Patients transferred from systemic steroid therapy to Nasalide should be monitored to avoid acute adrenal insufficiency in response to stress. Since some patients may experience symptoms of withdrawal, attention must be given to patients previously treated for prolonged periods with systemic corticosteroids, particularly those with associated asthma or other clinical conditions where too rapid a decrease in systemic corticosteroids may cause a severe exacerbation of symptoms. Nasalide should be used with caution in patients on alternate-day prednisone for any disease.

Precautions: General: Localized *Candida albicans* infections of the nose and pharynx occurred only rarely in clinical studies, but if such an infection presents, treatment with appropriate local therapy or discontinuation of Nasalide treatment may be required.

Flunisolide is absorbed into the circulation. Systemic effects have been minimal with recommended doses but larger doses should be avoided since excessive doses may suppress hypothalamic-pituitary-adrenal function.

Nasalide should be used with caution in patients with active or quiescent tuberculosis infections of the respiratory tract; untreated fungal, bacterial, or systemic viral infections; or ocular herpes simplex.

In patients who have experienced recent nasal septal ulcers, recurrent epistaxis, nasal surgery, or trauma, a nasal corticosteroid should be used with caution until healing has occurred.

Information for Patients: Nasalide should be used as directed at the prescribed dosage. Nasal vasoconstrictors or oral antihistamines may be needed until the effects of Nasalide are fully manifested. The patient should follow the Patient Instructions carefully and should contact a physician if symptoms do not improve, if the condition worsens, or if sneezing or nasal irritation occurs.

Carcinogenesis: While no evidence of carcinogenicity was found in a 22-month study in Swiss-derived mice, there was a slight increase in the incidence of pulmonary adenomas which was well within the range of spontaneous adenomas previously reported for untreated Swiss-derived mice.

Impairment of Fertility: Female rats receiving high doses of flunisolide (200 mcg/kg/day) showed some evidence of impaired fertility. Reproductive performance in low and mid dose groups was comparable to controls.

Pregnancy: Pregnancy Category C. The drug has been shown to be teratogenic and fetotoxic in rabbits and rats. The drug should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Because other corticosteroids are excreted in human milk, caution should be exercised when the drug is administered to nursing women.

Adverse Reactions: The most frequent complaints were mild transient nasal burning and stinging (reported in approximately 45% of patients). These complaints do not usually interfere with treatment; in only 3% of patients was it necessary to decrease dosage or stop treatment because of those symptoms.

Incidence of 5% or less: nasal congestion, sneezing, epistaxis and/or bloody mucus, nasal irritation, watery eyes, sore throat, nausea and/or vomiting, headaches and loss of sense of smell and taste. In rare instances, nasal septal perforations were observed during the studies but a causal relationship with Nasalide was not established.

Systemic corticosteroid side effects were not reported during the controlled clinical trials. If recommended doses are exceeded, or if individuals are particularly sensitive, symptoms of hypercorticism could occur.

Dosage and Administration: Full therapeutic benefit requires regular use and is usually evident within a few days, but up to 3 weeks may be required for some patients to achieve maximum benefit. Patients should use a decongestant and clear their nasal passages of secretions prior to use. Recommended starting dose in adults: 2 sprays in each nostril b.i.d. If needed, increase to 2 sprays t.i.d.

Recommended starting dose in children (6-14 years): 1 spray in each nostril t.i.d. or 2 sprays in each nostril b.i.d. Not recommended for use in children less than 6 years old.

Total daily doses: not to exceed 8 sprays in each nostril for adults and 4 sprays in each nostril for children.

Maintenance dose: smallest amount necessary to control symptoms.

How Supplied: Each 25 ml Nasalide[®] (flunisolide) nasal solution spray bottle (NDC 0033-2906-40) contains 6.25 mg (0.25 mg/ml) of flunisolide and is supplied with a nasal pump unit with dust cover, and patient instructions.



Syntex Laboratories, Inc.
Palo Alto, CA 94304

BOOK REVIEWS

Continued from page 480

not address a common problem in family practice. Even the chapters on inhibition of premature labor and care of toxemia focus on the needs of the generalist. Medical students, family practice residents, and practicing family physicians all will find these sections to be of great value.

The last section of the book, "Drugs for General Use," is inferior compared with the first two sections. The chapter on antibiotic therapy is poorly organized and provides inadequate attention to specific patient problems, such as pelvic inflammatory disease, amnionitis, and puerperal fever. The other chapters in the section deal with anticoagulant agents and psychoactive drugs. Neither of these areas provides adequate information on clinical problems relevant to obstetrics and gynecology.

With the exception of the third section, this is an easy-to-read book, having such clarity of organization that it is a handy reference source as well as a basic text. Tables, graphs, and charts have been effectively used to summarize the text and provide rapid integration of multiple subject areas in each chapter. The manner in which each drug is used, its dosage, frequency, and mode of administration are well presented both in the text and in companion tables.

In spite of the glaring weaknesses of one section, *Drug Therapy in Obstetrics and Gynecology* is an excellent text that provides the family physician with a synthesis of material not readily available in standard obstetrics and gynecology texts or periodical journals.

Charles E. Payton, MD
University of Utah School of
Medicine
Salt Lake City, Utah

Current Literature Review in Internal Medicine. Paul Friedman (ed). Appleton-Century-Crofts, New York, 1982, 157 pp., \$12.95 (paper).

The major objective of this book is to challenge the reader's command of the internal medicine literature of 1980. To that end, the editor presents questions based on articles in the *Annals of Internal Medicine*, *The American Journal of Medicine*, and *The New England Journal of Medicine*. The editor clearly states that the intent is not to critique the original articles or to review the entire literature relevant to specific topics; rather, the intent is to focus on the major points made in the articles.


The book contains 300 true-or-false and multiple-choice questions, the bulk of which deal with problems in infectious disease, endocrinology, immunology, cardiology, oncology, and pharmacology. Questions about problems in hematology, gastroenterology, medical obstetrics, neurology, metabolic disease, and dermatology are included in limited numbers. Although the multiple-choice questions often have more than one correct answer, the editor has fortunately avoided complex responses.

The answers are in a separate section at the back of the book. Most of the five- to ten-line answers specifically address each of the responses presented in the question, which enhances the educational value of the book. The full reference is printed after each answer to facilitate review of the original article if desired.

I found the book stimulating, for it clearly challenged my command of the recent internal medicine literature. Even though the book was published in 1982, it is unfortunate that 1981 literature was not in-

Continued on page 492

- References:** 1. Kales J et al: *Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. 2. Kales A et al: *Clin Pharmacol Ther* 18:356-363, Sep 1975. 3. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 4. Kales A et al: *Clin Pharmacol Ther* 32:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 6. Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. 7. Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. 8. Greenblatt DJ et al: *Sleep* 5 (Suppl 1):S18-S27, 1982. 9. Kales A et al: *Pharmacology* 26:121-137, 1983. 10. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 11. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 12. Amrein R et al: *Drugs Exp Clin Res* 9(1):85-99, 1983.

Dalmane®  flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation. GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

BOOK REVIEWS

Continued from page 484

cluded as well. By reviewing only 1980 articles, the editor has unavoidably limited the useful lifetime of the book. Although articles in the three journals reviewed for this book often cover esoteric topics with little relevance for family practice, the editor carefully selected articles with direct clinical applications. Nevertheless, there are some questions that are interesting and stimulating but not particularly useful in day-to-day family practice.

The medical student, resident, or practicing physician who is preparing for board examinations should find this book useful. Others who are interested in testing their command of the internal medicine literature will find the book challenging. On the other hand, the book is not useful as a reference, since there is no index to facilitate review of a particular topic or access to a relevant article.

John Rogers, MD, MPH
Piscataway, New Jersey

Synopsis of Gynecology (10th edition). Daniel Winston Beacham, Woodard Davis Beacham. C.V. Mosby Company, St. Louis, 1982, 331 pp., \$21.95 (paper).

This tenth edition of *Synopsis of Gynecology*, which was begun in a publication in 1932, is an update of information in concepts of disorders of the female reproductive system. The aim of the first edition was to provide a concise and up-to-date general knowledge of principles and features necessary to the intelligent practice of gynecology by the nonspecialist and as a source of review and concise summary for gynecologists wishing to supplement larger textbooks. Its organization, starting with anatomy and

physiology and ending with medical-legal aspects of gynecology, considers and makes current principles and practices in management in which there has been considerable change through the years. Infectious agents, their methods of diagnosis, and tests are all included in the present edition. Selected references following each chapter have been updated to include more recent information in detail and allow for the review of any subject in depth, if that is required. This synopsis, as the title suggests, is readable, is readily understandable, and provides for a rapid review of any specific area of gynecology. For family physicians, it provides a concise review, but further details of management will be needed from other sources. The review allows for a useful updating for diagnosis and management. The sections on anatomy, physiology, and basic information are excellent and should provide a medical student with an overview of the field.

The illustrations throughout the text are well done; most are line drawings and some are photographs (there are no color photographs), which serve to supplement the material in the text.

For the family physician or family practice resident who desires a quick reference or review for evaluation of a current case or problem, the latest edition of *Synopsis of Gynecology* should serve extremely well. Its place on the bookshelf of the outpatient clinic or emergency room to provide a ready reference and to answer clinical questions, as well as to serve as a rapid review of concepts, is amply justified.

Richard C. Barnett, MD
Community Hospital of
Sonoma County
Santa Rosa, California