

25th Edition!

New from Lange

Current Medical Diagnosis and Treatment 1986

EDITORS

Marcus A. Krupp, MD
Milton J. Chatton, MD
Lawrence M. Tierney, Jr., MD

The most recent accepted methods of diagnosis and treatment of medical diseases and disorders. **New in this edition:** new and approved drugs for 1984-85, update on toxicology, latest information on AIDS, and much more.

- ✓ Complete and up-to-date
- ✓ Reliable
- ✓ Clear and readable

1986 1170 pages \$29.50

Order Form

Please send me **Current Medical Diagnosis & Treatment, 1986**

(A1413-2, \$29.50) on 30-day approval.

Payment enclosed (save on postage and handling). Please include appropriate state sales tax.

Bill me later

Name _____

Address _____

City/State/Zip _____

I wish to charge my purchase to:

MasterCard Visa

Acct. No. _____

Exp. Date _____

Signature _____

Prices subject to change without notice. Prices advertised apply in the United States, its territories, and possessions only.

Mail to: Appleton-Century-Crofts/
Lange Medical Publications
25 Van Zant St.
E. Norwalk, CT 06855

Dept. B JFP8/86 AMA733-6

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.

PRENATAL FLUORIDE SUPPLEMENTATION

To the Editor:

Rigilano, Friedler, and Ehemann (*Rigilano JC, Friedler EM, Ehemann LJ: Fluoride prescribing patterns among primary care physicians. J Fam Pract 1985; 21:381-385*) study an important preventable health problem. The authors establish that current practices of postnatal fluoride supplementation are erratic. They propose routine recommendation of prenatal fluoride supplementation.

Although the value of fluoride supplementation for infants and children is proven and well-accepted, prenatal fluoride supplementation remains controversial. Rigilano et al base their recommendation for prenatal fluoride supplementation on a study by Glenn et al, which has serious flaws.¹ It is retrospective, and treatment and control groups were poorly matched. The children whose mothers had taken prenatal fluoride were younger (mean age 5.2 years) than their untreated controls (mean age 9.0 years), and therefore had less time to develop caries. Because the mean age of treated children was 5.2 years, little can be said about their future permanent teeth. Children exposed to prenatal fluoride were more often third and fourth children, while the untreated children were more often second- and firstborns. The mothers were older when carrying

the treated children than when pregnant with the control children. Importantly, Glenn et al discuss neither how women were selected for prenatal fluoride supplementation nor how women were selected for no treatment. The women who accepted prenatal fluoride supplementation may have been more likely to ensure good brushing and dietary habits as well as compliance with postnatal fluoride supplementation than the untreated controls. Numerous other factors were not controlled for or examined: the amount of prenatal consumption of fluoridated water and calcium by mothers, mothers' compliance with prenatal fluoride supplements, the children's dietary and brushing habits, and the children's compliance with fluoride supplements. Finally, safety of prenatal fluoride supplementation is hardly proven with only 117 treated women. Before prenatal fluoride supplementation is recommended for routine care, prospective studies should prove its safety and efficacy.

Joan Hamblin, MD
Winston-Salem, North Carolina

Reference

1. Glenn FB, Glenn WD, Duncan RC: Fluoride tablet supplementation during pregnancy for caries immunity. A study of the offspring produced. *Am J Obstet Gynecol* 1982; 143:560-564

Continued on page 108

Norgesic[®] Forte TABLETS

(orphenadrine citrate, 50 mg; aspirin,
770 mg; caffeine, 60 mg)

Stops the pain, not the patient.

Brief Summary

Indications:

1. Symptomatic relief of mild to moderate pain of acute musculo-skeletal disorders.
2. The orphenadrine component is indicated as an adjunct to rest, physical therapy, and other measures for the relief of discomfort associated with acute painful musculo-skeletal conditions.

The mode of action of orphenadrine has not been clearly identified, but may be related to its analgesic properties. Norgesic and Norgesic Forte do not directly relax tense skeletal muscles in man.

Contraindications:

Because of the mild anticholinergic effect of orphenadrine, Norgesic or Norgesic Forte should not be used in patients with glaucoma, pyloric or duodenal obstruction, achalasia, prostatic hypertrophy or obstructions at the bladder neck. Norgesic or Norgesic Forte is also contraindicated in patients with myasthenia gravis and in patients known to be sensitive to aspirin or caffeine.

The drug is contraindicated in patients who have demonstrated a previous hypersensitivity to the drug.

Warnings:

Norgesic Forte may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; ambulatory patients should therefore be cautioned accordingly.

Aspirin should be used with extreme caution in the presence of peptic ulcers and coagulation abnormalities.

Usage in Pregnancy:

Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

Usage in Children:

The safe and effective use of this drug in children has not been established. Usage of this drug in children under 12 years of age is not recommended.

Precautions:

Confusion, anxiety and tremors have been reported in few patients receiving propoxyphene and orphenadrine concomitantly. As these symptoms may be simply due to an additive effect, reduction of dosage and/or discontinuation of one or both agents is recommended in such cases.

Safety of continuous long term therapy with Norgesic Forte has not been established; therefore, if Norgesic Forte is prescribed for prolonged use, periodic monitoring of blood, urine and liver function values is recommended.

Adverse Reactions:

Side effects of Norgesic or Norgesic Forte are those seen with aspirin and caffeine or those usually associated with mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness and rarely, urticaria and other dermatoses. Infrequently an elderly patient may experience some degree of confusion. Mild central excitation and occasional hallucinations may be observed. These mild side effects can usually be eliminated by reduction in dosage. One case of aplastic anemia associated with the use of Norgesic has been reported. No causal relationship has been established. Rare G.I. hemorrhage due to aspirin content may be associated with the administration of Norgesic or Norgesic Forte. Some patients may experience transient episodes of light-headedness, dizziness or syncope.

Caution:

Federal law prohibits dispensing without prescription. NG-7

References: 1. Colket T, Mann LB: Electromyographic data presented at the following scientific meetings: American Academy of General Practice, Atlantic City, NJ, Apr 1964; American Academy for Cerebral Palsy, Dallas, Tex, Nov 1963; Loma Linda University School of Medicine, Scientific Assembly, Los Angeles, Calif, Alumni Postgraduate Convention, Mar 1964. 2. Masterson JH, White AE: Electromyographic validation of pain relief: Pilot study in orthopedic patients. *Am J Orthop* 1966;8:36-40. 3. Perkins JC: Orphenadrine citrate: Clinical and electromyographic controlled study in patients with low back pain. Data on file, Medical Department, Riker Laboratories, Inc. 4. Gold RH: Treatment of low back syndrome with oral orphenadrine citrate. *Curr Ther Res* 1978;23:271-276.

RK NF-1157

Riker Laboratories, Inc.
St. Paul, Minnesota 55144-1000



LETTERS TO THE EDITOR

Continued from page 106

The preceding letter was referred to Drs. Rigilano, Friedler, and Ehemann, who respond as follows:

We appreciate Dr. Hamilton's comments on the issue of prenatal fluoride, and we agree that the study by Glenn et al has certain flaws. We stated in our article: "There is no question that further prospective studies on the use of prenatal fluoride are needed." We maintain, however, that while efficacy remains controversial, the safety of prenatal fluoride is not an issue, as it has been widely used for many years in Europe, Canada, and Australia, and no ill effects have been observed. Additionally, there are many regions in the United States where the natural fluoride content of the water delivers a considerably higher dose of fluoride per day without ill effects on the fetus having been noted. The Food and Drug Administration recognizes fluoride as being safe for use in pregnancy.

John C. Rigilano,
CAPT, USAF MC
Edward M. Friedler,
MAJ, MC, USA
Larry J. Ehemann,
COL, USAF MC
Department of Family Practice
Uniformed Services University of
the Health Sciences
Bethesda, Maryland

GRADED EXERCISE TESTING

To the Editor:

I am pleased to see articles on experiences of family physicians performing procedures as found in the Zoller and Boyd article on graded exercise testing in a family practice office (Zoller DP, Boyd GE: Six-year experience with graded exercise testing in a model

family practice office. *J Fam Pract* 1985; 21:451-454). However, this article should have contained more comparison to the known literature on the rate of complications of the procedure. The article notes that there were two patients of the 275 receiving the test with complications; one required emergency bypass surgery and another had a myocardial infarction. This rate is equivalent to 72.7 complications per 10,000 tests. One large study of 518,448 exercise stress tests had a complication rate of 8.86 per 10,000 tests and 3.58 myocardial infarctions per 10,000 tests.¹

The higher rate of complication in the family practice office is discomforting. In doing an exercise stress test, one of the important aspects is knowing when to stop the test. If the patient is pushed too hard, there is likely to be a higher rate of complications. This theory as to why there may have been an unusually high rate of complications could also explain the low rate of false-negative studies. If the tests were not stopped soon enough, there would be a lower rate of false-negative studies.

With only two complications, it is difficult to tell whether the difference between this study and national figures is real and meaningful. However, there are clearly negative consequences, and further follow-up after more tests have been done is necessary.

Marjorie A. Bowman, MA, MPA
Director
Division of Family Medicine
and Family Practice Residency
Georgetown University
School of Medicine
Washington, D.C.

Reference

1. Stuart RJ, Ellestad MH: National survey of exercise stress testing facilities. *Chest* 1980; 77:94-97