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.

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 may also be 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.

Contraindications:
Confusion, anxiety and tremors have been reported in a 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 and nasal stuffiness. 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.

TABLE 1. IMPROVEMENT SCORE (Percentage Decrease in Number of Symptoms)

<table>
<thead>
<tr>
<th>Percent Antihistamine-Decongestant</th>
<th>Percent Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 5</td>
<td>68</td>
</tr>
<tr>
<td>6</td>
<td>78</td>
</tr>
<tr>
<td>10</td>
<td>83</td>
</tr>
</tbody>
</table>

Primary Care in Academic Health Centers

To the Editor:
Your recent article, "Whither Primary Care in the Academic Health Science Center?" (Schwenk TL, Dettmer DT: J Fam Pract 1986; 23:479-493), was a stimulating review of the reasoning behind our institutional efforts in the development of primary care clinics both on our Academic Health Center campuses and in 25 remote locations. All of our clinics are corporately owned, and all of the physicians have faculty status. Over the last few years, this has led to increasing academic responsibility for the primary care physicians and has stimulated significant faculty development.

The family physician is the admitting and attending physician for all patients referred from the Ambulatory Care Network and the primary care clinics in the academic health centers. The family physician is responsible for health maintenance organization management and controls the nature and degree of specialty input. This clinic system will see approximately 250,000 patient visits this year, and will provide a learning laboratory for supervised student education for 100 junior and 100 senior medical students. Each student will spend 20 weeks, 8 in the junior year
In patients approx. 60 or older, risk of dizziness, sedation, and.

Indications and Usage:
In infants and children.

Contraindications:

Use with considerable caution in patients with narrow-angle

Drug interactions: MAOIs prolong and intensify the anticholinergic

Precautions:

Hypersensitivity to either ingredient and

Use cautiously in patients with lower respiratory

5. 

Adverse Reactions:

Pediatric use: Safety and effectiveness in children under 12 years

CHOICE OF INSTRUMENT FOR FLEXIBLE
SIGMOIDOSCOPY

To the Editor:
In his article Dr. Dervin concludes that the 105-cm flexible sigmoidoscopy may be an appropriate screening instrument for family physicians and should be evaluated as such. This proposal stands in contrast to a rather large body of research that suggests that the shorter, 35-cm flexible sigmoidoscope is the most reasonable instrument for use by generalists in screening asymptomatic, average-risk patients.

Although longer instruments can obviously increase sensitivity, or diagnostic yield, if they are inserted farther, it is not clear that the increase is proportional to the added length of insertion. In several studies reporting the anatomic distribution of lesions detected with the 60- or 65-cm sigmoidoscope, 3-5 much higher proportion of all lesions were found in the area from 20 to 35 cm than in the area from 36 to 60 cm. The 105-cm instrument will routinely accomplish examination of the descending colon when fully inserted, while 65-cm sigmoidoscopes, on average, reach the junction of the sigmoid and descending colon. The descending colon yields a very small proportion of all colorectal cancers according to SEER data. Thus the added depth of insertion may not be beneficial. Moreover, even in Dervin's experienced hands, insertion beyond 65 cm was accomplished in only 57 percent of cases. In the less-experi-
The preceding letter was referred to Dr. Dervin, who responds as follows:

I would like to respond to the letter submitted by Dr. Selby, who raises several important issues. The ability of 105-cm flexible sigmoidoscopy to screen the descending colon is not an issue. The writer states, however, that the descending colon yields a small percentage of cancers. Shinya's data indicate that 23 percent of polyps are located in this region.

Another question is whether insertion beyond 65 cm 57 percent of the time is an important advantage. It may be well if a significant yield of additional polyps can be demonstrated in future studies. Along with this issue is raised the point that not all family physicians will achieve these results. Skilled technique is a traditional challenge to most technical advancements in family practice.

Finally, the writer argues that the 35-cm sigmoidoscope is superior to the 60-cm sigmoidoscope for screening in terms of ease of learning, patient discomfort, and time of examination. The 60-cm instrument is clearly accepted as the standard for family practice. Arguments for the 35-cm examination have not convinced family physicians.

John V. Dervin, MD
Santa Rosa, California

References

Needle Aspiration and Cellulitis

To the Editor:

I would like to commend The Journal for publishing Dr. Ted Epperly's research on the value of needle aspiration (Epperly TD: The value of needle aspiration in the management of cellulitis. J Fam Pract 1986; 23:337-340). Dr. Epperly's work is an example of the kind of research that family physicians can and should do—research that helps to answer common, practical, but important questions. I feel more secure in my practice of treating cellulitis empirically without performing needle aspiration, even though I was taught to do needle aspiration as a medical student.

Dr. Epperly concludes correctly that different sites of aspiration have similar yields, and that no significant differences in ancillary tests and signs (white cell count and differential, erythrocyte sedimentation rate, and temperature) exist between aspirate-positive and aspirate-negative patients. These findings, along with the low yield of the aspirations and the finding of common pathogens in positive aspirates, buttress Dr. Epperly's research on the value of needle aspiration. Dr. Epperly's conclusion that needle aspiration is of no significant benefit in his population. To truly determine the value of needle aspiration in cellulitis, however, information on patient outcome is necessary. For example, if a patient's aspirate grew Staphylococcus aureus resistant to erythromycin and the patient had been empirically started on erythromycin, it is possible that the positive aspirate would shorten the patient's course by alerting his physician to change the patient's treatment before the need for such a change became obvious clinically.

To answer the question definitively, a study that randomized patients to aspiration and no-aspiration
group and then compared outcomes would be necessary. Although I feel it is unlikely that significant differences in outcome would be found, such a study would provide even better evidence of the value of needle aspiration in cellulitis.

James P. Richardson, MD
Department of Family Medicine
University of Maryland School of Medicine
Baltimore

To the Editor:

As family physicians in rural northern New York, we read with interest the study by Dr. Epperly documenting the relatively low yield of positive cultures from needle aspiration in cellulitis (Epperly TD: The value of needle aspiration in the management of cellulitis. J Fam Pract 1986; 23:337-340).

A potentially useful observation we made from the study was not commented on in the report. The edge and midpoint were each positive about one twelfth of the time and were positive independently of each other. Consequently, in this study doing two aspirations on a lesion doubled the yield, and it is likely that doing further aspirations would further increase the yield. It would, therefore, seem to be logical to do multiple aspirations in a case where it is important to recover the causative bacteria. Perhaps the aspirates could be pooled into a single culture specimen so that the cost increase for this increased yield could be kept minimal.

Cost vs benefit certainly is a central issue in deciding how far to pursue a bacterial identification in a case of cellulitis. It would be interesting to know how many of the positive cultures turned out to be useful in the management of the cellulitis and also how many of the 103 total cases failed to resolve on empirical antibiotic therapy. The findings would identify the group who did or would have benefited sufficiently from the isolation of the etiologic agent to justify the expense and discomfort to the patient of obtaining the aspiration.

Jay W. Chapman, MD
Patricia Ledden Chapman, MD
North Oswego County Health Services
Pulaski, New York

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

The observations noted by Drs. Chapman and Chapman are good ones. Indeed, pooled aspirations from multiple sites would increase yield. However, from the data obtained from the population in this study, the organisms recovered proved to be what one would empirically predict (ie, staphylococcus and streptococcus species). Therefore, multiple painful aspirations would only increase the chance of recovering organisms that would be suspected clinically and would not be warranted in this young healthy population. If the patient were immunocompromised, elderly, or not responding to therapy, however, it may be worthwhile to do multiple aspirations to increase the yield of possible unsuspected organisms.

Of all the patients in this study responded to either oral or intravenous antibiotics aimed empirically at staphylococcus and streptococcus organisms, and the positive wound or aspirate cultures did not alter management.

Ted D. Epperly, MD
Medical Corps
Fort Benning, Georgia

To the Editor:


Generally, many would consider this to be one of the significant features of appendicitis. Perhaps there has been a misprint, as this symptom should occur in a significant percentage of appendicitis patients.

William V. Dolan, OFM, MD
Surgery Service
Alaska Native Medical Center
Ankorage, Alaska

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

Dr. Dolan has correctly identified a typographical error. The actual figure in Table 1 under “Appendicitis” should read anorexia in 50 percent, not 5 percent. This figure represents an average for ten reported series, where the prevalence of anorexia in appendicitis patients ranges from 25 percent in Mohammed’s series to 100 percent in Zaitoon’s series.

Kathleen E. Ellsbury, MD
Department of Family Medicine
University of Washington
Seattle, Washington

References