

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.

## HEALTH CARE IN NICARAGUA

To the Editor:

I was surprised and disappointed to see "A Report on Health Care in Nicaragua" in the Family Practice Grand Rounds (*Drickey R, Gin D, Rapp J: A report on health care in Nicaragua, J Fam Pract 1987; 24: 349-356*). I do not believe it meets your own definition of the purpose of Grand Rounds, and I do not believe the report is necessary so that physicians would understand that war causes bad health. Thus, what is the purpose of this article? My interpretation is that the article was presented out of political motivations and obviously deals with a very controversial topic in our society. If its purpose was to garner support for the Sandinista government in Nicaragua, only the readers as a group can tell us what the impact has been. After reading the article, I felt that at best it disinformed us, and at worst it was more propaganda from the Sandinista government. Here's why I believe this.

What is the source of information? Many statements were made that are judgmental, and the way in which these judgments were reached is not stated. On p 349 Daisy Gin makes the statement, "... health facilities that were targeted by Contra activity." How does she know that they were targeted? Could the facilities have been victims of an attack and not specifically designated as targets? Were health facilities marked as such, so that during an attack everyone, Sandinistas and Contras, would know what kind of facilities they were? This statement is highly political in nature, and if it is true, then it would be hard to justify continued support for the Contras regardless of one's political

views on the US involvement. This assertion is again repeated on p 353 and even implies "health workers . . . are targeted." If this statement is not more propaganda, where is the support for these assertions? Finally, I believe the statement that "The health care system serves as a stabilizing force in the country" is either naive or arrogant because I do not believe that health care systems, other than offering improved nutrition, sanitation, and immunization status, have much impact on a culture's well-being.

Next, on p 350, Dr. Jonathan Rapp presents "some statistics reflecting the health of the Nicaraguan people under the two systems." The source of these statistics is not given. Why not? I am sure that the public health measures instituted by the government have had a positive impact on the health of those citizens who the "war during the revolution had a devastating effect on" (p 350). Thus, it appears to be self-serving to compare current statistics on health with data from a time when the country was in the midst of a revolution, as is done in Table 1. A more realistic comparison would be the current data compared with similar data taken from a time before the revolution was in full swing.

Again on p 353, numbers are given on casualties without sources of information, and a very political statement is made: "The Contras operate mainly by terrorizing the rural population with attacks and ambushes on small towns." If the sources of information are the citizenry, then how was the information obtained from them, ie, controlled by the government, through government interpreters, in their homes, etc? Nothing is said about the health of political prisoners or about those injured, killed,

or missing because they opposed the Sandinista government.

In conclusion, I do not believe this article has a place in *The Journal of Family Practice* and appears to have a political agenda. Warfare is harmful to any culture, especially in the country where it takes place, and this article does nothing to further our knowledge of this fact.

Patrick Mongan, MD  
Department of Family Practice  
Medical College of Georgia  
Augusta, Georgia

*The preceding letter was referred to Dr. Drickey and colleagues, who respond as follows:*

We appreciate the opportunity to respond to Dr. Mongan's comments regarding our Family Practice Grand Rounds on health care in Nicaragua.

Dr. Mongan believes that the article does not meet "your own definition of the purpose of Grand Rounds." As stated in the The Journal's Information for Authors, Family Practice Grand Rounds are "normally based on an interactive teaching conference . . . illustrating one or more of the basic concepts of family medicine." In the Family Health Center at San Francisco General Hospital, we serve many refugees and immigrants from Central America. To understand and work within the entire context of their lives is imperative. Central Americans in San Francisco remain very connected to their roots in their countries of origin. As community-oriented health workers and as responsible citizens, we are attempting to learn, therefore, about what is happening in Central America.

Dr. Mongan says he does "not believe the report is necessary so that physicians would understand that war

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# HYDERGINE<sup>®</sup> LC

(ergoloid mesylates) liquid capsules  
1 mg

## LETTERS TO THE EDITOR

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causes bad health." The implication is that since it is known that war causes bad health, we do not need to talk about it further. We disagree. We believe that we must learn the facts about this war because it is a war in which the United States is involved.

Dr. Mongan asks how we know that health facilities were targeted by the Contras. The facts speak for themselves. As we stated in the article, 61 health facilities have been completely or partially destroyed since the war began (that number has risen to 68 since the article was written). We refer Dr. Mongan to a current article that substantiates the numbers that we cited.<sup>1</sup> Dr. Mongan goes on to say that if it is true that health facilities are being targeted, "then it would be hard to justify continued support for the Contras regardless of one's political views on the US involvement." We couldn't agree more fully.

Dr. Mongan believes that health care systems, other than offering improved nutrition, sanitation, and immunization, have little impact on a culture's well-being. We agree that preventive measures have more impact upon the long-term well-being of a society than do acute medical services. It is precisely these types of measures in which the reorganized health system in Nicaragua is most heavily involved. Its programs in nutrition, sanitation, and immunization have been lauded by the World Health Organization as model primary health care programs for the developing world.

The source for statistics on health care in Nicaragua, which Dr. Mongan requested, was the national Ministry of Health of Nicaragua.<sup>2</sup>

Dr. Mongan questions the comparison of statistics on health status and health care delivery from 1978, when the system was damaged by the war of revolution, with data from 1985. Garfield and Taboda<sup>3</sup> have shown that no significant changes occurred in the Nicaraguan health care system from 1974 to 1978. However, if one wishes to consider how special circumstances might impair health care delivery, it is worth noting that the US economic embargo of Nica-

ragua has made it impossible for that nation to obtain pharmaceutical and medical supplies from this hemisphere's major source of those items, the United States. As a result, vaccines, antibiotics, even spare parts for x-ray machines are in short supply.

As the Iran-Contra hearings have illustrated, our government is often the source of disinformation about events in Central America. We traveled to Nicaragua to see for ourselves what is happening there. We talked with people (unaccompanied by government officials or interpreters), we saw the devastation that is being wrought, and we cite our own observations as documentation for our comments in the article. We invite Dr. Mongan and others to go and see for themselves.

Robert Drickey, MD

Daisy Gin, RN

Jonathan Rapp, MD

Department of Family and

Community Medicine

University of California

San Francisco

## References

1. Garfield RM, Frieden T, Vermund SH: Health-related outcomes of war in Nicaragua. *Am J Public Health* 1987; 77:615-618
2. Office of Popular Health Education and Communication: The National Unified Health System, 1985. Managua, Nicaragua, Ministry of Health, 1985
3. Garfield RM, Taboda E: Health services reform in revolutionary Nicaragua. *Am J Public Health*, 1985; 74:1138-1144

## INITIAL PRESCRIPTION FILLING

To the Editor:

I agree with Dr. Krogh and Dr. Wallner<sup>1</sup> that initial prescription filling is difficult to measure, especially when no central clearinghouse exists where all filled prescriptions can be collected and checked. Their survey of initial compliance using orange prescription pads was successful, but undoubtedly some compliant patients were missed because their pharmacists refused to participate.

Perhaps a more reliable method of

Indications: Symptomatic relief of signs and symptoms of idiopathic decline in mental capacity (i.e., cognitive and interpersonal skills, mood, self-care, apparent motivation) in patients over sixty. It appears that individuals who respond to HYDERGINE therapy are those who would be considered clinically to suffer from some ill-defined process related to aging or to have some underlying dementing condition, such as primary progressive dementia, Alzheimer's dementia, senile onset, or multi-infarct dementia. Before prescribing HYDERGINE<sup>®</sup> (ergoloid mesylates), the physician should exclude the possibility that signs and symptoms arise from a potentially reversible and treatable condition, particularly delirium and dementiform illness secondary to systemic disease, primary neurological disease, or primary disturbance of mood. Not indicated for acute or chronic psychosis regardless of etiology (see Contraindications).

Use of HYDERGINE therapy should be continually reviewed, since presenting clinical picture may evolve to allow specific diagnosis and specific alternative treatment, and to determine whether any initial benefit persists. Modest but statistically significant changes observed at the end of twelve weeks of therapy include: mental alertness, confusion, recent memory, orientation, emotional lability, self-care, depression, anxiety/fears, cooperation, sociability, appetite, dizziness, fatigue, bothersome(ness), and overall impression of clinical status.

Contraindications: Hypersensitivity to the drug; psychosis, acute or chronic, regardless of etiology.

Precautions: Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing HYDERGINE (ergoloid mesylates) preparations.

Adverse Reactions: Serious side effects have not been found. Some transient nausea and gastric disturbances have been reported, and sublingual irritation with the sublingual tablets.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3-4 weeks.

How Supplied: HYDERGINE LC (liquid capsules); 1 mg, oblong, off-white, branded "HYDERGINE LC 1 mg" on one side, "S" other side. Packages of 100 and 500. (Encapsulated by R. P. Scherer, N.A., Clearwater, Florida 33518).

HYDERGINE (ergoloid mesylates) tablets (for oral use); 1 mg, round, white, embossed "HYDERGINE 1" on one side, "S" other side. Packages of 100 and 500.

Each liquid capsule or tablet contains ergoloid mesylates USP as follows: dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

Also available: HYDERGINE sublingual tablets; 1 mg, oval, white, embossed "HYDERGINE" on one side, "78-77" other side. Packages of 100 and 1000. 0.5 mg, round, white, embossed "HYDERGINE 0.5" on one side, "S" other side. Packages of 100 and 1000.

HYDERGINE liquid; 1 mg/ml. Bottles of 100 mg with an accompanying dropper graduated to deliver 1 mg.

[HYD-Z224-6 15 84]

Before prescribing, see package circular for full product information. HYD-1087-1

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studying initial compliance is to visit patients in their homes a few days after their clinic visits. One can then ask to see the medicine bottles and know which ones were filled. Boyd and coworkers<sup>2,3</sup> studied compliance in this way in Oklahoma in 1974. They found that almost 94 percent of patients filled their prescriptions. This method is costly and time consuming and may overestimate initial compliance because compliant persons may be more likely than noncompliant persons to grant home interviews.

In the winter of 1986, I conducted a pilot study of initial compliance at the Family Practice Center of Charlotte Memorial Hospital and Medical Center (Charlotte, NC). The patients were free to fill their prescriptions at any pharmacy. I mailed each patient a survey concerning his or her initial compliance. If the patient did not respond, he or she was contacted by telephone. Eighteen patients filled 24 of the 27 prescriptions they received, achieving an 89 percent rate of initial compliance. Two patients did not comply because they felt they did not need the medicine. One said that he could not afford his medication.

Initial noncompliance leads to increased morbidity and mortality and is often more destructive than secondary noncompliance.<sup>3</sup> More research is needed to find the causes of not filling prescriptions. Health maintenance organizations and state Medicaid offices may provide the central collection areas needed to better study this issue. We physicians must know which factors we can change to ensure higher rates of initial prescription filling.

*Hunter E. Woodall  
Fairfax, South Carolina*

#### References

1. Krogh C, Wallner L: Prescription-filling patterns of patients in a family practice. *J Fam Prac* 1987; 24:301-302
2. Boyd JR, Covington TR, Stanaszek WF, Coussons RT: Drug defaulting: Part I. Determinants of compliance. *Am J Hosp Pharm* 1974; 31:362-367
3. Boyd JR, Covington TR, Stanaszek WF, Coussons RT: Drug defaulting: Part II. Analysis of noncompliance patterns. *Am J Hosp Pharm* 1974; 31:485-491

## RESULTS OF REMINDING FAMILY PHYSICIANS ABOUT ADMINISTRATION OF FLU VACCINE

To the Editor:

As influenza vaccination time approaches, we would like to share a study the nurses in our office did last fall with the consent of one of our

senior physicians. We decided to see what effect reminding the residents and staff physicians in our family practice office would have upon their requesting that influenza vaccine be administered to their patients.

For two weeks we attached a slip of paper on which was printed, "Do you want this patient to have flu vac-

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## The wart medicine you can recommend with complete confidence.

Because you know the importance of preventing autoinoculation as well as the transmittance of the wart virus, you may wish to recommend Compound W.<sup>®</sup> Compound W contains Salicylic Acid 17% (the maximum strength your patients can buy) in a flexible collodion vehicle which has been classified safe and effective to remove warts.\* Compound W, in liquid and gel, is an economical way for your patients to eliminate infectious and embarrassing warts. For the past 25 years, Compound W has been an effective and safe wart remedy. You can recommend it with complete confidence.

\*FDA Tentative Final Monograph On Wart Remover Drug Products For Over-The-Counter Human Use, The Federal Register, (Vol. 47, No. 172), pgs. 39102-39105, Sept. 3, 1982.



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# Maximum Strength Compound W

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**MONISTAT\* Dual-Pak\***

Suppositories/Cream

**MONISTAT\* 3 Vaginal Suppositories**

(miconazole nitrate 200 mg)

**MONISTAT-DERM\* Cream**

(miconazole nitrate 2%)

**INDICATIONS AND USAGE:** MONISTAT 3 Vaginal Suppositories are indicated for the local treatment of vulvovaginal candidiasis (moniliasis). Effectiveness in pregnancy or in diabetic patients has not been established.

**MONISTAT-DERM Cream**—For topical application in the treatment of cutaneous candidiasis (moniliasis).

**CONTRAINDICATIONS:** MONISTAT 3 Vaginal Suppositories—Patients known to be hypersensitive to the drug.

**MONISTAT-DERM Cream** has no known contraindications.

**PRECAUTIONS:** MONISTAT 3 Vaginal Suppositories—General. Discontinue drug if sensitization or irritation is reported during use. The base contained in the suppository formulation may interact with certain latex products, such as that used in vaginal contraceptive diaphragms. Concurrent use is not recommended.

**Laboratory Tests:** If there is a lack of response to MONISTAT 3 Vaginal Suppositories, appropriate microbiological studies (standard KOH smear and/or cultures) should be repeated to confirm the diagnosis and rule out other pathogens.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Long-term animal studies to determine carcinogenic potential have not been performed.

**Fertility (Reproduction):** Oral administration of miconazole nitrate in rats has been reported to produce prolonged gestation. However, this effect was not observed in oral rabbit studies. In addition, signs of fetal and embryo toxicity were reported in rat and rabbit studies, and dystocia was reported in rat studies after oral doses at and above 80 mg/kg. Intravaginal administration did not produce these effects in rats.

**Pregnancy:** Since imidazoles are absorbed in small amounts from the human vagina, they should not be used in the first trimester of pregnancy unless the physician considers it essential to the welfare of the patient.

**Clinical studies,** during which miconazole nitrate vaginal cream and suppositories were used for up to 14 days, were reported to include 514 pregnant patients. Follow-up reports available in 471 of these patients reveal no adverse effects or complications attributable to miconazole nitrate therapy in infants born to these women.

**Nursing Mothers:** It is not known whether miconazole nitrate is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when miconazole nitrate is administered to a nursing woman.

**MONISTAT-DERM Cream**—If a reaction suggesting sensitivity or chemical irritation should occur, use of the medication should be discontinued. For external use only. Avoid introduction of MONISTAT-DERM Cream into the eyes.

**ADVERSE REACTIONS:** MONISTAT 3 Vaginal Suppositories—During clinical studies with the MONISTAT 3 Vaginal Suppository (miconazole nitrate, 200 mg) 301 patients were treated. The incidence of vulvovaginal burning, itching or irritation was 2%. Complaints of cramping (2%) and headaches (1.3%) were also reported. Other complaints (hives, skin rash) occurred with less than a 0.5% incidence. The therapy-related dropout rate was 0.3%.

**MONISTAT-DERM Cream**—There have been isolated reports of irritation, burning, maceration, and allergic contact dermatitis associated with application of MONISTAT-DERM.

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cine?" on the charts of all patients aged over 65 years. During that time 57 reminder slips resulted in 53 requests that we administer influenza vaccine. During the next two weeks, when we did not ask the physicians whether influenza vaccine should be given, only 14 influenza shots were requested.

As we did not make sure that there were as many elderly patients seen during the second period as during the first, we cannot attest that our experiment is statistically significant. However, we all feel certain that physicians will immunize more people against influenza when they are directly reminded to do so.

*Lynda Dannehower, RN  
Ellen Devenney, RN  
Jean Henry, RN  
Gladys Winchester, LPN  
Wilmington Hospital  
Wilmington, Delaware*

pletion of the examination. The sigmoidoscope is then advanced in the usual manner. We have used this technique in 150 examinations with no difficulties. In fact, when used in conjunction with good technique for the remainder of the procedure, many patients will have a painless examination.

We have been pleased with the effectiveness, ease, low cost, and safety of this "Warshaw maneuver" and believe other physicians will find it very useful.

*Timothy M. Empkie, MD  
Ira Warshaw, MD  
Department of Family Medicine  
Brown University  
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*Thomas T. Gilbert, MD  
Providence, Rhode Island*

**PAINLESS SIGMOIDOSCOPY**

To the Editor:

Flexible sigmoidoscopy permits the examination of more colon than the rigid instrument with less discomfort to the patient. Early in our experience with the new device, it was clear that one obstacle still needed to be overcome. Precisely because the tip of the sigmoidoscope is flexible and flat, it can be difficult and painful to insert into the anal canal of many patients, especially those with hemorrhoids, proctitis of any cause, obesity, or patients who are extremely anxious and have increased sphincter tone.

We have solved this problem by using a simple, disposable plastic anoscope. The anoscope is gently inserted to its full depth (about 10 cm) and the trochar withdrawn. The sigmoidoscope is then inserted through the anoscope to a depth of 10 to 12 cm. The anoscope is withdrawn over the sigmoidoscope back to the control head, where it is left until the com-

**SCREENING FOR URINARY TRACT INFECTIONS IN ELDERLY WOMEN**

To the Editor:

The article by Bertakis and Ross (*Bertakis KD, Ross JL: Office evaluation of urinary tract infections in elderly women. J Fam Pract 1987; 24: 72-75*) is interesting but beside the point. To screen for an asymptomatic disease that has been present more than three months (by their definition) is probably important, but certainly does not require speed. A less complex schema is to await the results of culture, and if there is any question about the result, reculture the urine. There is no particular rush to diagnose a process that causes no short-term problem and certainly no advantage to using (and paying for) less than the gold standard when the gold standard is also to be done.

*Berthold E. Umland, MD  
Department of Family, Community  
and Emergency Medicine  
University of New Mexico  
Albuquerque*

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*Monistat  
Dual-Pak*

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## WOMEN'S ADJUSTMENT TO MARITAL SEPARATION

To the Editor:

In the article "The Impact of Daily Stressors on Women's Adjustment to Marital Separation" (*J Fam Pract* 1987; 24:507-511), Oppenheimer concludes that "daily stressors are better predictors of psychological distress than the major life event of marital separation." However, the study findings do not support this conclusion, and in fact, the design of the study does not allow for an assessment of the effect of marital separation or divorce on psychological distress. The study group consisted only of women who had experienced a separation or divorce sometime during the preceding three years. No women who had not experienced separation or divorce were studied. To determine the impact of this major life event, women who were exposed to it would need to be compared with women who were not exposed. Considering the individual variability in the length of time necessary to cope with and adjust to such a major life event, recency of the separation or divorce is probably not an adequate proxy measure of the impact of the event.

Even if one accepts the assumption that recency of separation or divorce does reflect the impact of the event, there is a problem with the conceptual base of the analysis in this study. On the basis of the results of a multiple-regression analysis, Oppenheimer concludes that daily stressor frequency is associated with psychological distress on follow-up, while recency of separation is not. However, including stressor frequency and stressor intensity as independent variables in the multivariate model may obscure the association of recency of separation or divorce with distress. This confounding would occur if daily stressors constitute an intervening or intermediary variable in a causal pathway between recency of separation or divorce and distress.<sup>1</sup> In the introduction the author speculates that daily hassles or stressors might mediate the relationship between the

event and distress; if this were true, including stressors as an independent variable in the regression analysis would partially or completely cancel out the variance in distress that is explained by recency of separation or divorce.

To explore the possible mediating role of daily stressors, additional analysis is necessary. The correlation of stressors with recency of separation or divorce should be determined. Then the association of recency with distress should be examined with and without the daily stressor variables included in the regression model. The hypothesis of a mediating effect of daily stressors would be supported by the finding of a correlation of stressors with recency and by the finding of an association of recency with distress that decreased or disappeared when stressor variables were added to the regression equation. Unfortunately, in this study daily stressors are conceptualized as mediators of the relationship between marital separation or divorce and distress, but are analyzed as confounders of this relationship.

Robert L. Blake, Jr., MD  
Department of Family and  
Community Medicine  
University of Missouri-Columbia

### Reference

1. Rothman KJ: *Modern Epidemiology*. Boston, Little, Brown, 1986, p 91

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

It appears that Dr. Blake misinterpreted the purpose and therefore the design of my study. First, he faults the design by saying that "... the design of the study does not allow for an assessment of the effect of marital separation or divorce on psychological distress." He continues by asserting that a control group is necessary to answer this question. Blake is correct on this point, if I had wished to examine the effect of marital separation on psychological distress. However, this relationship is no longer an interesting research question, as it has

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## TUSS-ORNADE®

Each capsule contains 40 mg. caramiphen edisylate and 75 mg. phenylpropanolamine hydrochloride.

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FOR COLDS WITH COUGHS\*

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

### Indications

For the symptomatic relief of coughs and nasal congestion associated with common colds.

N.B.: A final determination has not been made on the effectiveness of this drug combination in accordance with efficacy requirements of the 1962 Amendments to the Food, Drug and Cosmetic Act.

**Contraindications:** Hypersensitivity to either component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease. Do not use Tuss-Ornade Spansule capsules in children under 12 years of age.

**Warnings:** Warn vehicle or machine operators of possible drowsiness. Warn patients of possible additive effects of alcohol and other CNS depressants.

**Precautions:** Use with caution in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, thyroid disease or diabetes, and in patients in whom productive cough is desirable to clear excessive secretions from bronchial tree. Patients taking this medication should be cautioned not to take simultaneously other products containing phenylpropanolamine HCl or amphetamines.

**Usage in Pregnancy:** Do not use in pregnancy, nursing mothers, or women of childbearing potential unless the anticipated benefits outweigh the potential risks.

**Adverse Reactions:** Drowsiness; nervousness; insomnia; nausea, constipation, diarrhea; dizziness; weakness; tightness of chest; angina pain; irritability; palpitations; headache; incoordination; tremor; difficulty in urination; hypertension, hypotension; anorexia; visual disturbances; dysuria; gastrointestinal upset.

**Supplied:** Tuss-Ornade Spansule capsules, in bottles of 50 and 500.

BRS-TO-L32

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LOZOL® indapamide 2.5 mg tablets

## BRIEF SUMMARY

**DESCRIPTION:** LOZOL (indapamide) is an oral antihypertensive/diuretic.

**INDICATIONS AND USAGE:** LOZOL is indicated for the treatment of hypertension, alone or in combination with other antihypertensive drugs.

LOZOL is also indicated for the treatment of salt and fluid retention associated with congestive heart failure.

*Usage in Pregnancy:* (see PRECAUTIONS).

**Contraindications:** Anuria, hypersensitivity to indapamide or other sulfonamide-derived drugs.

**WARNINGS:** Hypokalemia occurs commonly with diuretics, and electrolyte monitoring is essential. In general, diuretics should not be given concomitantly with lithium.

**PRECAUTIONS: GENERAL:** 1. *Hypokalemia and Other Fluid and Electrolyte Imbalances:* Periodic determinations of serum electrolytes should be performed at appropriate intervals. In addition, patients should be observed for clinical signs of fluid or electrolyte imbalance, such as hyponatremia, hypochloremic alkalosis, or hypokalemia. Electrolyte determinations are particularly important in patients who are vomiting excessively or receiving parenteral fluids, in patients subject to electrolyte imbalance (including those with heart failure, kidney disease, and cirrhosis), and in patients on a salt-restricted diet. The risk of hypokalemia secondary to diuresis and natriuresis is increased when larger doses are used, when the diuresis is brisk, when severe cirrhosis is present and during concomitant use of corticosteroids or ACTH. Interference with adequate oral intake of electrolytes will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis, such as increased ventricular irritability. Dilutional hyponatremia may occur in edematous patients; the appropriate treatment is restriction of water rather than administration of salt, except in rare instances when the hyponatremia is life threatening. However, in actual salt depletion, appropriate replacement is the treatment of choice. Any chloride deficit that may occur during treatment is generally mild and usually does not require specific treatment except in extraordinary circumstances as in liver or renal disease. 2. *Hyperuricemia and Gout:* Serum concentrations of uric acid increased by an average of 1.0 mg/100 ml in patients treated with indapamide, and frank gout may be precipitated in certain patients receiving indapamide (see ADVERSE REACTIONS). Serum concentrations of uric acid should therefore be monitored periodically during treatment. 3. *Renal Impairment:* Renal function tests should be performed periodically during treatment with indapamide. 4. *Impaired Hepatic Function:* Indapamide, like the thiazides, should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. 5. *Glucose Tolerance:* Latent diabetes may become manifest and insulin requirements in diabetic patients may be altered during thiazide administration. Serum concentrations of glucose should be monitored routinely during treatment with indapamide. 6. *Calcium Excretion:* Calcium excretion is decreased by diuretics pharmacologically related to indapamide. Indapamide may decrease serum PBI levels without signs of thyroid disturbance. 7. *Interaction With Systemic Lupus Erythematosus:* Thiazides have exacerbated or activated systemic lupus erythematosus.

**DRUG INTERACTIONS:** 1. *Other Antihypertensives:* LOZOL (indapamide) may add to or potentiate the action of other antihypertensive drugs. 2. *Lithium:* See WARNINGS. 3. *Post-Sympathectomy Patient:* The antihypertensive effect of the drug may be enhanced in the post-sympathectomized patient. 4. *Norepinephrine:* Indapamide may decrease arterial responsiveness to norepinephrine, but this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. **CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY:** Both mouse and rat life-time carcinogenicity studies were conducted. There was no significant difference in the incidence of tumors between the indapamide-treated animals and the control groups.

**PREGNANCY/Teratogenic Effects:** PREGNANCY CATEGORY B. Diuretics are known to cross the placental barrier and appear in cord blood. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**NURSING MOTHERS:** It is not known whether this drug is excreted in human milk. If use of this drug is deemed essential, the patient should stop nursing.

**ADVERSE REACTIONS:** Most adverse effects have been mild and transient. In long-term controlled clinical studies, equal to or greater than 5% cumulative adverse reactions are headache, dizziness, fatigue, weakness, loss of energy, lethargy, tiredness, or malaise, muscle cramps or spasms, or numbness of the extremities, nervousness, tension, anxiety, irritability, or agitation; and less than 5% cumulative adverse reactions are lightheadedness, drowsiness, vertigo, insomnia, depression, blurred vision, constipation, nausea, vomiting, diarrhea, gastric irritation, abdominal pain or cramps, anorexia, orthostatic hypotension, premature ventricular contractions, irregular heart beat, palpitations, frequency of urination, nocturia, polyuria, rash, hives, pruritus, vasculitis, impotence or reduced libido, rhinorrhea, flushing, hyperuricemia, hyperglycemia, hyponatremia, hypochloremia, increase in serum urea nitrogen (BUN) or creatinine, glycosuria, weight loss, dry mouth, tingling of extremities. Clinical hypokalemia occurred in 3% and 7% of patients given indapamide 2.5 mg and 5.0 mg, respectively.

**OVERDOSAGE:** Symptoms include nausea, vomiting, weakness, gastrointestinal disorders and disturbances of electrolyte balance. In severe instances, hypotension and depressed respiration may be observed. If this occurs, support of respiration and cardiac circulation should be instituted. There is no specific antidote. An evacuation of the stomach is recommended by emesis and gastric lavage after which the electrolyte and fluid balance should be evaluated carefully.

**HOW SUPPLIED:** White, round film-coated tablets of 2.5 mg in bottles of 100, 1,000, 2,500, and in unit-dose blister packs, boxes of 100 (10 x 10 strips).

**CAUTION:** Federal (U.S.A.) law prohibits dispensing without prescription.

See product circular for full prescribing information.

## ROPER PHARMACEUTICALS

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been well-documented that persons who have experienced marital separation appear more pathological on virtually every outcome measure than persons who have not experienced marital separation.<sup>1</sup> In addition, implicit in the group comparison method is the assumption that persons who have experienced marital separation comprise a homogeneous group. Research has demonstrated that there is variability in the amount of distress reported following marital separation.<sup>2</sup> Thus, the interesting research question becomes: Given that marital separation has occurred, what are the variables that predict distress following marital separation? This question is exactly that which my study was designed to answer. Since I investigated predictors of distress within a group, no separate control group is needed.

Blake's second point, that "recency of separation or divorce is probably not an adequate proxy measure of the impact of the event," is not supported by the divorce literature or crisis theory, which served as the theoretical basis for my investigation. Within a crisis theory model, separation or divorce is a stressful life event that results in a temporary state of psychological disorganization and disequilibrium.<sup>3</sup> Generally, the acute distress lasts for a period of several weeks to a few months,<sup>3,4</sup> although research has shown that the disorganizing experience of divorce can extend over several years.<sup>5,6</sup> However, studies have suggested that the psychological sequelae of marital separation is greatest in the first six months following the event,<sup>7</sup> and that women who have been separated three or more years do not significantly differ from their married counterparts on indices of psychological distress.<sup>8</sup> Thus, the decision to operationalize the impact of marital separation by the recency of the event was both theoretically and empirically derived.

Third, Blake contends that there is a conceptual problem with my study. He stated, "Oppenheimer concludes that daily stressor frequency is associated with psychological distress on follow-up, while recency of separation

is not." The key word here is association. A correlation between two variables does not suggest that they are causally related. The conceptual problem seems to be in Blake's apparent assumption that my study was designed to demonstrate that daily hassles cause psychological distress. My findings indicated that daily hassles are better predictors of psychological distress than the mere fact that separation has occurred, thus making this clinically useful information for physicians. Furthermore, I acknowledge in the discussion the potential confounding of these variables by stating that a limitation of this study was that both measures were self-reported, thus allowing the possibility that high levels of psychological distress may have resulted in increased perceptions of events as stressful (p 510). Thus, Blake's statistical argument seems superfluous given that invalid assumptions were made with respect to the rationale for the study, the hypotheses tested, and the research design.

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