

LETTERS TO THE EDITOR

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.

Monistat
Dual-Pak

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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.

ELDER ABUSE

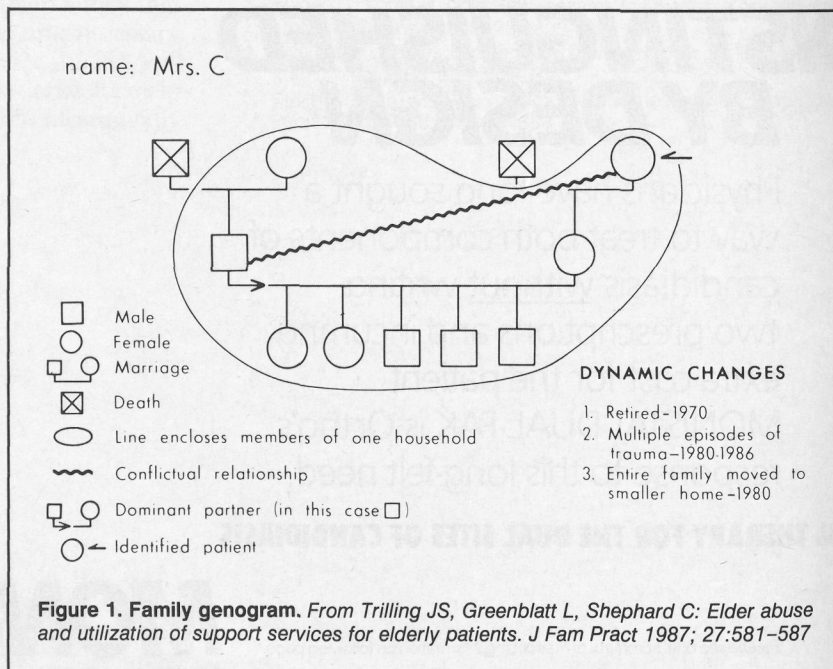
To the Editor:

The Family Practice Grand Rounds in the June issue of The Journal on elder abuse (Trilling JS, Greenblatt L, Shephard C: *Elder abuse and utilization of support services for elderly patients. J Fam Pract* 1987; 24:581-587) was stimulating. Unfortunately elder abuse is a common problem, estimated to occur with 10 percent of the elderly population.¹ I was pleased to see the family genogram (Figure 1) used to help explain two overwhelming aspects of elder abuse. First is delay in diagnosis and treatment, and second is patient and family denial.

Perhaps further family genogram analysis in light of family systems theory would help illuminate this

tragedy.^{2,3} For brevity, let's concentrate upon the key players; the abused and the abuser (a conflictual relationship represented by the wavy diagonal line). Mr. B. (the presumed abuser) has lost his father. These circumstances often shed light. Does he blame his mother? If so, does he direct this blame toward his mother-in-law (herself widowed)? Also, Mr. B.'s family experience concerning abuse would be significant information. Was he abused? Was there abuse in his family?

Turning to the abused, Mrs. C., does she have a family experience of abuse prior to Mr. B.? Lastly, Mrs. C. is a widow. Has she successfully completed her grieving process?⁴ If not, does she experience residual guilt and blame herself for her husband's death,



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NIX FOR LICE®

CREME RINSE

permethrin 1%

PEDICULICIDAL/OVICIDAL ACTIVITIES: *In vitro* data indicate that permethrin has pediculicidal and ovicidal activity against *Pediculus humanus var. capitis*. The high cure rate (97-99%) of Nix in patients with head lice demonstrated at 14 days following a single application is attributable to a combination of its pediculicidal and ovicidal activities and its residual persistence on the hair which may also prevent reinfestation.

INDICATIONS AND USAGE: Nix is indicated for the single-application treatment of infestation with *Pediculus humanus var. capitis* (the head louse) and its nits (eggs). Retreatment for recurrences is required in less than 1% of patients since the ovicidal activity may be supplemented by residual persistence in the hair. If live lice are observed after at least seven days following the initial application, a second application can be given.

CONTRAINDICATIONS: Nix is contraindicated in patients with known hypersensitivity to any of its components, to any synthetic pyrethroid or pyrethrin, or to chrysanthemums.

WARNING: If hypersensitivity to Nix occurs, discontinue use.

PRECAUTIONS:

General: Head lice infestation is often accompanied by pruritus, erythema, and edema. Treatment with Nix may temporarily exacerbate these conditions.

Information for Patients: Patients with head lice should be advised that itching, redness, or swelling of the scalp may occur after application of Nix. If irritation persists, they should consult their physician. Nix is not irritating to the eyes; however, patients should be advised to avoid contact with eyes during application and to flush with water immediately if Nix gets in the eyes. In order to prevent accidental ingestion by children, the remaining contents of Nix should be discarded after use.

Combing of nits following treatment with Nix is not necessary for effective treatment. However, patients may do so for cosmetic or other reasons. The nits are easily combed from the hair treated with Nix after drying.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Six carcinogenicity bioassays were evaluated with permethrin, three each in rats and mice. No tumorigenicity was seen in the rat studies. However, species-specific increases in pulmonary adenomas, a common benign tumor of mice of high spontaneous background incidence, were seen in the three mouse studies. In one of these studies there was an increased incidence of pulmonary alveolar-cell carcinomas and benign liver adenomas only in female mice when permethrin was given in their food at a concentration of 5000 ppm. Mutagenicity assays, which give useful correlative data for interpreting results from carcinogenicity bioassays in rodents, were negative. Permethrin showed no evidence of mutagenic potential in a battery of *in vitro* and *in vivo* genetic toxicity studies.

Permethrin did not have any adverse effect on reproductive function at a dose of 180 mg/kg/day orally in a three-generation rat study.

Pregnancy: Teratogenic Effects: Pregnancy Category B: Reproduction studies have been performed in mice, rats, and rabbits (200-400 mg/kg/day orally) and have revealed no evidence of impaired fertility or harm to the fetus due to permethrin. There are, however, no adequate and well-controlled studies in pregnant women. 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. Because many drugs are excreted in human milk and because of the evidence for tumorigenic potential of permethrin in animal studies, consideration should be given to discontinuing nursing temporarily or withholding the drug while the mother is nursing.

Pediatric Use: Nix is safe and effective in children two years of age and older. Safety and effectiveness in children less than two years of age have not been established.

ADVERSE REACTIONS: The most frequent adverse reaction to Nix is pruritus. This is usually a consequence of head lice infestation itself, but may be temporarily aggravated following treatment with Nix. 5.9% of patients in clinical studies experienced mild temporary itching; 3.4% experienced mild transient burning/stinging, tingling, numbness, or scalp discomfort; and 2.1% experienced mild transient erythema, edema, or rash of the scalp.

DOSAGE AND ADMINISTRATION:

Adults and Children: Nix is intended for use after the hair has been washed with shampoo, rinsed with water and towel dried. Apply a sufficient volume of Nix to saturate the hair and scalp. Nix should remain on the hair for 10 minutes before being rinsed off with water. A single treatment is sufficient to eliminate head lice infestation. Combing of nits is not required for therapeutic efficacy, but may be done for cosmetic or other reasons.

SHAKE WELL BEFORE USING.

HOW SUPPLIED: Nix (Permethrin) 1% (wt./wt.) Creme Rinse is supplied in plastic squeeze bottles that contain 2 fl. oz. weighing 56 g. (NDC-0081-0780-81)

Store at 15°-25°C (59°-77°F).

1 DiNapoli J, Austin R, Englander S, et al: Eradication of lice with a single treatment (unpublished data, 1987). 2 Taplin D, Meinking T, Castillero P, et al: Permethrin 1% creme rinse for the treatment of pediculus humanus var capitis infestation. *Pediatr Dermatol* 1986; 3:4:344-348. 3 Davies J, Dedhia H, Morgade C, et al: Lindane poisonings. *Arch Dermatol* 1983; 119:142-144.

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thus feeling deserving of the son-in-law's abuse?

Analysis by means of family systems theory can expand upon the family genogram approach and help to further explain the basis of this serious problem. As Trilling points out, the denial is often the result of fear, ignorance, and apathy or helplessness. Understanding the family dynamics can often, as Trilling so aptly states, lead to "a determination of its etiology" and "help the abuser as well as the abused in establishing the best possible course of posthospital therapy."

Barry M. Kerzin, MD
Department of Family Medicine
University of Washington
Seattle

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2. Minuchin S: Families and Family Therapy. Cambridge, Harvard University Press, 1974, p 46-66
3. McGoldrick M, Gerson R: Genograms in Family Assessment. New York, WW Norton, 1985, p 103-104
4. Parkes CM: Bereavement. *Br J Psychiatry* 1985; 146:11-17

TREATMENT OF PRURITUS

To the Editor:

With regard to the article by Richard Rubenstein (*Pruritus: A new look at an old problem. J Fam Pract* 1987; 24:625-629), he mentions in passing the use of "scalding hot water."

This means of treatment is more effective than Dr. Rubenstein acknowledges and will give relief from the itching for 4 to 24 hours. Because it is somewhat painful, it is limited to use with older children and adults and when the itching is confined to reasonably limited areas of the body.

To do the treatment properly, the patient is told to take a small towel and hold it under the hot water tap.

The water must be hot enough that when the patient wrings out the towel, it is found to be distinctly uncomfortable. The patient is told to then rapidly fold the towel three or four thicknesses and apply it to the itching area. Again, the sensation should be one of distinct discomfort for approximately 10 seconds. If the discomfort persists longer than that, the towel should be removed immediately to prevent scalding. The towel should then be left on for a total of approximately one minute.

Immediately thereafter the area will be both pain free and itch free for a period of some number of hours. I have not found that treatment has any particular effect on whatever pathological process caused the irritation.

It would be nice to do a well-controlled double-blind study on this treatment, but I suspect that such a study would pose methodologic difficulties. Physicians and patients may wish to give this an empiric trout period.

John W. Beasley, MD
Department of Family Practice
University of Wisconsin
Medical School
Madison

CASE MANAGEMENT AND GATEKEEPING

To the Editor:

I take issue with several points raised by Dr. Essman in his letter concerning gatekeepers in primary care (*Essman TM: Gatekeepers in primary care, letter. J Fam Pract* 1987; 24:574). *Case manager* is not just a sanitized synonym for *gatekeeper*: the terms describe related but different and equally important roles.

Ideally a case manager is a generalist who can provide primary care and who can coordinate, interpret, and advise on necessary secondary and tertiary care as an advocate for a patient and his family. To do this

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Entex[®] LA

PHENYLEPHRINE HYDROCHLORIDE 75 mg
GUAIFENESIN 400 mg

IN A SPECIAL BASE TO PROVIDE A PROLONGED THERAPEUTIC EFFECT.

OR

Entex[®] LIQUID

Each 5 ml (one teaspoonful) contains:
PHENYLEPHRINE HYDROCHLORIDE 5 mg
PHENYLEPHRINE HYDROCHLORIDE 20 mg
GUAIFENESIN 100 mg
ALCOHOL 5%

Before prescribing or administering, see package circular for full product information. The following is a brief summary.

INDICATIONS AND USAGE: Entex is indicated for the symptomatic relief of sinusitis, bronchitis, pharyngitis, and coryza when these conditions are associated with nasal congestion and viscous mucus in the lower respiratory tract.

CONTRAINDICATIONS: Entex is contraindicated in individuals with known hypersensitivity to sympathomimetics, severe hypertension, or in patients receiving monoamine oxidase inhibitors.

WARNINGS: Sympathomimetic amines should be used with caution in patients with hypertension, diabetes mellitus, heart disease, peripheral vascular disease, increased intraocular pressure, hyperthyroidism, or prostatic hypertrophy.

PRECAUTIONS: Information for Patients: Do not crush or chew Entex LA tablets prior to swallowing.

Drug Interactions: Entex should not be used in patients taking monoamine oxidase inhibitors or other sympathomimetics.

Drug/Laboratory Test Interactions: Guaifenesin has been reported to interfere with clinical laboratory determinations of urinary 5-hydroxyindoleacetic acid (5-HIAA) and urinary vanilmandelic acid (VMA).

Pregnancy: Pregnancy Category C. Animal reproduction studies have not been conducted with Entex. It is also not known whether Entex can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Entex should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It is not known whether the drugs in Entex are excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants, a decision should be made whether to discontinue nursing or to discontinue the product, taking into account the importance of the drug to the mother.

Pediatric Use: Entex LA: Safety and effectiveness of Entex LA tablets in children below the age of 6 have not been established.

Entex Liquid: Safety and effectiveness of Entex Liquid in children below the age of 2 have not been established.

ADVERSE REACTIONS: Possible adverse reactions include nervousness, insomnia, restlessness, headache, nausea, or gastric irritation. These reactions seldom, if ever, require discontinuation of therapy. Urinary retention may occur in patients with prostatic hypertrophy.

OVERDOSAGE: The treatment of overdosage should provide symptomatic and supportive care. If the amount ingested is considered dangerous or excessive, induce vomiting with ipecac syrup unless the patient is convulsing, comatose, or has lost the gag reflex, in which case perform gastric lavage using a large-bore tube. If indicated, follow with activated charcoal and a saline cathartic. Since the effects of Entex may last up to 12 hours, treatment should be continued for at least that length of time.

DOSE AND ADMINISTRATION: Entex LA: Adults and children 12 years of age and older — one tablet twice daily (every 12 hours); children 6 to under 12 years — one-half (1/2) tablet twice daily (every 12 hours). Entex LA is not recommended for children under 6 years of age. Tablets may be broken in half for ease of administration without affecting release of medication but should not be crushed or chewed prior to swallowing.

Entex Liquid: All dosage should be administered four times daily (every 6 hours).

Children:
2 to under 4 years 1/2 teaspoonful (2.5 ml)
4 to under 6 years 1 teaspoonful (5.0 ml)
6 to under 12 years 1 1/2 teaspoonfuls (7.5 ml)

Adults and children 12 years of age and older:
2 teaspoonfuls (10.0 ml)

HOW SUPPLIED: Entex LA is available as a blue, scored tablet imprinted with "ENTEX LA" on the smooth side. **Entex Liquid** is available as an orange-colored, pleasant-tasting liquid.

Entex LA
NDC 0149-0436-01 bottle of 100
NDC 0149-0436-05 bottle of 500

Entex Liquid
NDC 0149-0414-16 16 FL. OZ. (1 Pint) bottle
CAUTION: Federal law prohibits dispensing without prescription.
LQ-BSS/LA-BSS
REVISED JULY 1985 (Entex LA)
REVISED SEPTEMBER 1985 (Entex Liquid)

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"without regard to any costs to society" or for costs to the patient would be neither responsible nor in the best interests of the patient or the society.

To be a gatekeeper, whether in a strictly defined sense or in a broad conceptual framework, means to provide cost-effective fiscally responsible care, without sacrificing quality. This is compatible with the physician's obligation "to do all [he] can for [his] patient" (within an individualized context) but not "without regard to any costs to society."

That more tests, more medications, more referrals, more hospitalizations often do not translate into better care and may, in fact, have exactly the opposite outcome has been well demonstrated.¹⁻⁵ I agree with Dr. Essman that "it is important to teach residents cost-effective medical treatment." We will only confuse them more, and fail, if we teach them one standard and expect them to perform at another.

Michael A. Krall, MD

Department of Primary Care
Kaiser-Permanente Salem Medical
Office
Salem, Oregon

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DIAGNOSIS OF ECTOPIC PREGNANCY

To the Editor:

I enjoyed reading Dr. Andolsek's article on ectopic pregnancy from the family physician's point of view: diagnosing ectopic pregnancy before it ruptures (*Andolsek KM: Ectopic pregnancy: 'Classic' vs common presentation. J Fam Pract* 1987; 24:481-485). Understandably, it is a critical diagnosis to make as early as possible. Her case reports were most instructive.

In at least two places in the article, however, she refers to urine pregnancy tests as unsuitable for diagnostic use in ectopic pregnancy, since they are "less sensitive" than serum pregnancy tests. I would point out that there are now available in the office laboratory some very sensitive urine tests for pregnancy, including the ecotopic variety.¹

Although qualitative by design, many enzyme-linked immunosorbent assays (ELISA) employ monoclonal antibody specific for the beta-subunit of the human chorionic gonadotropin (hCG) molecule. In ectopic pregnancy, as in normal gestation, hCG is present in both urine and serum, albeit in lower concentrations and at times demonstrating a high beta-hCG subunit-whole hCG unit ratio. Sensitivity of the test is the crucial element in testing, not urine vs serum substrate. Newer ELISA tests are routinely sensitive to 50 mIU/mL or less of hCG. (One test claims a sensitivity down to 20 mIU/mL.²) This concentration is consistent with common estimates of the level of hCG at one week following implantation.

Such technology has been taken beyond theoretical considerations. In a simple but convincing study, Buck and colleagues³ correctly diagnosed 30 of 30 cases of ectopic pregnancy with four commercially available ELISA urine tests in an ambulatory setting. Concomitantly, they avoided falsely diagnosing any of 16 nonpreg-

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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 spasm, 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.

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nant women presenting with similar complaints serving as controls.

Thus, we have come (rapidly) a long way from the earlier days of "slide" urine pregnancy tests, the sensitivities of which only began in the range of 1,000 to 2,000 mIU/mL. Office physicians are no longer bound so tightly to hospital or reference laboratories with their technical equipment. Furthermore, although an ultimately sensitive radioimmunoassay test may be needful in some cases (eg, to quantitate falling hCG titers in a treated molar pregnancy or when clinical judgment supervenes in a doubtful case), we have arrived at a point at which we may usually diagnose ectopic pregnancy at the bedside with readily available office laboratory technology.

*James L. Fletcher, Jr., MD
Department of Family Medicine
Medical College of Georgia
Augusta*

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2. Package insert for Ventrescreen hCG-Urine. Portland, Me, Ventrex Laboratories, 1987
3. Buck RH, Norman RJ, Reddi K, et al: Various methods for determining urinary choriongonadotropin evaluated for the early diagnosis of ectopic pregnancy. Clin Chem 1986; 32:879-882

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

To the Editor:

Dr. Fletcher reminds us that optimal laboratory use requires knowledge of available options. The physician needs to take into account the abilities of the individual performing the test, the sensitivity and specificity of the test, the cost, patient acceptability, and the likelihood the result will be believed by the physician.

Dr. Fletcher points out that family physicians no longer need to be tied to hospitals or reference laboratories—a point with which I wholeheartedly agree. Either the more sensitive urine tests he describes, or a sensitive serum pregnancy test, such as the ICON which we use, are available for the office. Urine substrate vs serum are theoretically comparable. However, by using the serum pregnancy test we avoid the practical distinction of needing a relatively concentrated sample (or needing to confirm with a concurrent specific gravity determination) or the obfuscation of a poorly obtained clean catch specimen, urinary cloudiness, or proteinuria. The cost to us for either test is virtually identical—approximately \$2.50 per test. However, start-up costs to convert to using the newer urine tests would be \$200 to \$300.

Finally, most of our physicians retain an emotional distrust of the urine pregnancy test. If the test were negative, most would order the serum pregnancy test "just to make sure." As sensitive urinary tests become more widespread, remain stable on the market, and less costly, I suspect they will gain wider physician acceptance.

*Kathryn M. Andolsek, MD
Duke-Watts Family Medicine
Program
Durham, North Carolina*

PATIENTS' EXPECTATIONS AND FAMILY CONFERENCES

To the Editor:

First, we would like to thank Dr. Thomas Schwenk for drawing attention to our work in his guest editorial in the May issue of *The Journal of Family Practice* (Caring about and caring for the psychosocial needs of patients. *J Fam Pract* 1987; 24:461-463). While we agree with many of his comments regarding emphasis on the therapeutic aspects of the physi-

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HYDERGINE[®] LC

(ergoloid mesylates) liquid capsules
1 mg

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[®] (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.

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cian-patient relationship, we feel that he fails to acknowledge several important conclusions supported in the Hansen et al study.¹ For example, one of the psychosocial skills that patients definitely do want is a physician who allows them time to discuss psychosocial problems, especially when the patient perceives that talking about such things is helpful. In Dr. Schwenk's zeal to restrict the scope of behavioral sciences skills training in the family practice, he appears to ignore what our data say regarding what patients want from family physicians, namely, listening skills, the ability to provide some advice and treatment for psychosocial problems and to refer, if necessary, for these problems.

We also feel that Dr. Schwenk places the wrong emphasis on the findings from the Kushner et al study² regarding patients' interest in family conferences. Dr. Schwenk writes that this study "described patients' desire for family physicians to convene family conferences related to specific psychosocial problems." While it is true that we looked at patients' desire for family conferences for "psychosocial problems," we also examined their desire for family conferences for "medical problems." While our patients did indicate a high degree of interest in family conferences for serious behavioral problems, they expressed even more desire for family conferences in cases of serious medical illness. In this research we have taken pains to draw the distinction between family therapy and a family conference with the physician. In no way do we mean to imply, nor do we feel our data imply, that patients want "treatment" for their psychosocial problems in the family conferences with their physician. Rather, we view the family conference more as a logical outgrowth of Schwenk's "therapeutic aspects of the physician-patient relationship." Specific mental health skills," we agree, fall more legitimately within the purview of mental health professionals. We feel that the

family conference is an ideal way for the physician to provide "concern, support, explanations, advice, suggestions, and 'professional hand-holding,'" as suggested by Schwenk.

Careful reading of these two studies and the others referenced in Dr. Schwenk's editorial indeed tell us as much about what patients want (and thus what family physicians should be prepared to provide) as what patients do not want.

Daniel L. Meyer, PhD

James A. Bobula, PhD

Kenneth Kushner, PhD

John P. Hansen, MD, MSPH

Department of Family Medicine

and Practice

University of Wisconsin

Medical School

Madison

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1. Hansen JP, Bobula J, Meyer D, et al: Treat or refer: Patients' interest in family physician involvement in their psychosocial problems. *J Fam Pract* 1987; 24:499-503
2. Kushner K, Meyer D, Hansen M, et al: The family conference: What do patients want? *J Fam Pract* 1986; 23:463-467

SPORTS MEDICINE CURRICULUM AND REHABILITATION EXERCISES

To the Editor:

The American Academy of Family Physicians has endorsed core curriculum guidelines on sports and recreational medicine for family practice residents. As facilitator of the sports medicine component at our Family Practice Residency Program, I have become aware that residents appear to receive minimal exposure to rehabilitation and exercise as a part of a treatment program. Rarely do residents suggest rehabilitating an injured area following an acute injury.

To confirm this perception, I worked with our chief resident, who

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

Indications and Usage: For the treatment of the symptoms of seasonal and perennial allergic rhinitis and vasomotor rhinitis, including nasal obstruction (congestion); also for the treatment of runny nose, sneezing and nasal congestion associated with the common cold.

Contraindications: Hypersensitivity to either ingredient and chemically related antihistamines; severe hypertension; coronary artery disease; concurrent MAOI therapy. Newborns, premature infants, nursing mothers.

Warnings: May potentiate the effects of alcohol and other CNS depressants. Should not be taken simultaneously with other products containing phenylpropanolamine HCl or amphetamines.

Use with considerable caution in patients with narrow-angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction, symptomatic prostatic hypertrophy, or bladder neck obstruction.

In infants and children, antihistamines in *overdosage* may cause hallucinations, convulsions, or death. They may also diminish mental alertness, and produce excitation, particularly in the young child.

In patients approx. 60 or older, risk of dizziness, sedation, and hypotension is greater.

Precautions: Use cautiously in patients with lower respiratory disease including asthma, hypertension, cardiovascular disease, hyperthyroidism, increased intraocular pressure, or diabetes.

Caution patients about activities requiring alertness (e.g., operating vehicles or machinery).

Drug interactions: MAOIs prolong and intensify the anticholinergic effects of antihistamines and potentiate the pressor effects of sympathomimetics.

Phenylpropanolamine HCl should not be used with ganglionic blocking drugs (e.g., mecamylamine) or with adrenergic blocking drugs (e.g., guanethidine sulfate or bethanidine).

Concomitant use of antihistamines may inhibit the action of oral anticoagulants; antagonize the action of β -adrenergic blockers; decrease the effects of corticosteroids; potentiate the cardiovascular effects of norepinephrine and the CNS depressant and atropine-like effects of anticholinergics. Concomitant use with phenothiazines may produce an additive CNS depressant effect; it may also cause urinary retention or glaucoma.

See also WARNINGS.

Carcinogenesis, mutagenesis, impairment of fertility: Chlorpheniramine Maleate—A long-term oncogenic study in rats produced no increase in the incidence of tumors in the drug-treated groups, as compared with controls, nor was evidence of mutagenicity found in a battery of mutagenic studies, including the Ames test. A reduction in fertility was observed in female rats at 67 times the human dose. Rabbits and rats, at doses up to 50 and 85 times the human dose, showed no reduction in fertility.

It is unknown whether phenylpropanolamine HCl has carcinogenic or mutagenic effects or impairs fertility.

Pregnancy, teratogenic effects, pregnancy category B: Reproduction studies with chlorpheniramine maleate in rabbits and rats at doses up to 50 and 85 times the human dose and with phenylpropanolamine HCl in rats at doses up to 7 times the human dose revealed no harm to the fetus. There are no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, 'Ornade' should be used during pregnancy only if clearly needed.

Nonteratogenic Effects: Studies of chlorpheniramine maleate in rats showed a decrease in the postnatal survival rate of offspring of animals dosed with 33 and 67 times the human dose.

Nursing Mothers: See CONTRAINDICATIONS.

Pediatric use: Safety and effectiveness in children under 12 years have not been established.

Adverse Reactions: The following have been reported with antihistamines and/or sympathomimetic amines: anaphylactic shock; chills; drug rash; excessive dryness of mouth, nose and throat; increased intraocular pressure; excessive perspiration; photosensitivity; urticaria; weakness; angina pain; extrasystoles; headache; hypertension; hypotension; palpitations; tachycardia; agranulocytosis; hemolytic anemia; leukopenia; thrombocytopenia; blurred vision; confusion; convulsions; diplopia; disturbed coordination; dizziness; drowsiness; euphoria; excitation; fatigue; hysteria; insomnia; irritability; acute labyrinthitis; nervousness; neuritis; paresthesia; restlessness; sedation; tinnitus; tremor; vertigo; abdominal pain; anorexia; constipation; diarrhea; epigastric distress; nausea; vomiting; dysuria; early menses; urinary frequency; urinary retention; thickening of bronchial secretions; tightness of chest and wheezing; nasal stuffiness.

How Supplied: Bottles of 50 and 500 capsules; in Single Unit Packages of 100 capsules (intended for institutional use only).

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TABLE 1. ANKLE REHABILITATION EXERCISES

After an ankle sprain the joint remains weak and prone to repeat injury for the following six months. Simple exercises that take no more than 30 minutes a day can significantly lessen this risk.

1. Alphabet exercises: Hold your foot in the air and write the alphabet twice. This duplicates every motion the ankle makes.
2. Paint can exercises: Move a paint can or similar object weighing 10 lb across a tile floor to the left and then back to the right. By pivoting at the ankle you strengthen it for both inversion and eversion (turning under and turning out).
3. Isometrics: Step down on a tennis ball with the ball of the foot and hold for 10 seconds. Repeat 10 times. Lift up your toes against a table or unmovable object and hold for 10 seconds. Repeat 10 times.
4. Cord exercises: Use surgical tubing, an inner tube, or bungi cords to loop around your anterior foot. While holding resistance with the cord, stretch your foot inward, outward, and in all possible motions.
5. Balance: Your sense of balance is often altered by a previous ankle injury. Many athletes recover more quickly by practicing standing on a balance board, skate board, or simply the side of their feet until this exercise is not difficult.

surveyed her peers asking the question, "Do you prescribe specific rehabilitative exercise for patients after an acute injury of the ankle, knee, or shoulder?" Of our 18 residents, only six (two in each residency year) responded that they prescribe such exercises; this number was not increased by completion of an orthopedics elective. This is disappointing, as rehabilitation is one of the seven expected skills in the sports medicine core curriculum.

Based on these results, a simple set of rehabilitation exercises was developed for the ankle, shoulder, knee, and neck. These were then placed in a centrally located area. Through conferences and direct feedback from the above survey, residents were made aware that specific patient instruction material for these injuries was available. Currently, these specific exercises are in their third reprinting. Sample exercises for rehabilitation of the ankle are detailed in Table 1; ex-

ercises developed for rehabilitation of the shoulder, knee, and neck are available on request from the authors.*

We are encouraged that, by providing information to the residents about these rehabilitation exercises, the residents will be more aware of the exercises and will feel at ease giving at least printed information to their patients. Perhaps in the future an assessment of their comfort with giving more specific instructions to patients recovering from acute injuries will be possible.

Karl B. Fields, MD
Donna R. Gates, MD
Family Practice Center
Moses H. Cone Memorial Hospital
Greensboro, North Carolina

* Family Practice Center, Moses H. Cone Memorial Hospital, 1125 N. Church Street, Greensboro, NC 27401-1007.