# A Complicated Nail Puncture Wound

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n May 1983, a 10-year-old boy wearing sneakers stepped on a nail while playing in a rural part of Alabama. The following day he was seen in the outpatient clinic, and inspection revealed a small, nonpurulent, nonerythematous puncture wound on the lateral forefoot, with no swelling or foreign or necrotic material. An x-ray film showed no bony or soft tissue abnormality. He received a tetanus shot, instructions for local wound care, and a prescription for penicillin. The wound was not probed. Five days later he returned with redness, swelling, and pain in the forefoot. No purulent material was present at the puncture wound site, the white cell count was  $11.4 \times 10^9$ / L  $(11.4 \times 10^3/\mu L)$ , and his temperature was 37.8 °C (100 °F). He was admitted to the hospital, blood cultures and a subcutaneous culture of the wound were obtained, and intravenous nafcillin was started for a diagnosis of cellulitis.

All cultures from admission showed no growth, and findings on an x-ray film of the foot were normal. Over the next three days the boy showed gradual, though not complete, improvement. The findings on a foot x-ray examination were again normal. Sedimentation rate was 91 mm/h. An orthopedic consultant saw the patient and added tobramycin. On the 15th day after injury, results of an x-ray examination, a bone scan, and a computed tomographic scan of the foot were normal. Persistence of symptoms necessitated surgical exploration of the foot. revealing a loculated abscess with a small area of osteomyelitis of the fourth metatarsal. Cultures of the abscess and bone showed a light growth of Pseudomonas aeruginosa. In the succeeding six months the patient underwent two more hospitalizations and a right cuboidectomy. Five years after the injury he has no residual problems and is able to run, play baseball, and lift weights.

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## DISCUSSION

Osteomyelitis following nail puncture wounds to the foot is difficult to diagnose because the clinical presentation is quite different from that seen with osteomyelitis of hematogenous origin, the usual osteomyelitis of childhood. A patient appears to recover from the injury and is asymptomatic for a variable period, usually 7 to 10 days, although it can be as long as eight years. Subsequently, signs of local inflammation with minimal systemic toxicity develop. The leukocyte count may be normal or mildly elevated, and the sedimentation rate may or may not be abnormal.

In a retrospective study of 887 children presenting with puncture wounds of the foot,  $^2$  14.9 percent eventually developed cellulitis or abscess. Gram-positive organisms, especially penicillin-resistant Staphylococcus aureus, S epidermidis, and  $\alpha$ -hemolytic streptococcus, were predominant. Most of these infections responded to soaking, elevation, rest, and antimicrobial therapy. Osteomyelitis developed in 1.8 percent of the 887 patients, with a mean interval between injury and diagnosis of 1.6 weeks. If the patients with osteomyelitis who were referrals from other hospitals are excluded, the incidence of osteomyelitis developing after a puncture wound of the foot is 0.6 percent.

Pseudomonas is a strictly aerobic, gram-negative bacillus found in moist areas, including soil, swimming pools, whirlpools, hot tubs, contact lens solution, disinfectants (eg. hexachlorophene), sinks, and distilled water. Because of its absolute requirement for oxygen, it is an organism of low virulence, rarely causing problems without a disruption of a person's normal defenses (eg, a break in the skin, burns, catheters) or a dysfunction of the immune system.<sup>3</sup> Various sources for the origin of the infecting organism have been proposed, including the skin, the sneakers, the nail, the soaking solution, and distant sites by means of hematogenous seeding. Out of 370 moist cotton-swab cultures from various sites, including the feet and shoes of children and of metal nails collected from the ground, P aeruginosa was isolated only once, from the interdigital space of a child wearing sneakers.4 Cultures

Continued on page 641

Continued from page 640

from various parts of sneakers of children with documented Pseudomonas osteomyelitis found the organism in the spongy inner sole. No Pseudomonas was recovered from new sneakers.<sup>5</sup> Thus, it is probable that the spongy inner soles of sneakers are the source of Pseudomonas in complicated puncture wound cases rather than the skin or the nail. Theoretically, hematogenous seeding to the injured area from colonized areas is possible. Rates of Pseudomonas colonization range from 2.6 to 24 percent in the stool, 0 to 6.6 percent in the throat, and 0 to 3.3 percent in the nose. These rates may exceed 50 percent in persons treated with antibiotics.<sup>6</sup>

Initial management of a puncture wound involves cleansing with iodophor, debriding dead skin, unroofing the site to prevent premature closure of the wound, and gentle, sterile probing of the wound for foreign bodies.<sup>2</sup> An x-ray film should be obtained to look for radiopaque foreign bodies.<sup>7</sup> Tetanus prophylaxis is needed if more than five years have passed since the previous immunization. Rest, elevation, and daily soaking of the foot are also recommended.<sup>8</sup>

The administration of antibiotics at the initial presentation is controversial. If the wound appears heavily contaminated by dirt, a prophylactic broad-spectrum antibiotic should be considered. No single antibiotic is consistently active against all potential puncture wound contaminants. The combination of amoxicillin and clavulanate potassium has good activity against streptococcus, staphylococcus, and anaerobes, the most common organisms causing cellulitis associated with puncture wounds. Ciprofloxacin may show promise, being bactericidal and active in vitro against all aerobic microorganisms; however, clinical trials for its use in skin and soft tissue infections are needed.

Cellulitis will usually respond to rest, elevation, and antibiotics.<sup>2</sup> Those cases that progress to osteomyelitis need surgical exploration to confirm the diagnosis and to treat infection adequately, even if adequate antibiotic

therapy was instituted earlier. Pseudomonas will survive in indolent form until all necrotic tissue is removed. Also, drug penetration into infected sites is often poor.

In summary, nail puncture wounds to the feet are common, and fewer than 15 percent develop complications, usually cellulitis. Most of these problems will resolve with conservative management. A very small percentage of patients, however, will develop bone or joint infection, usually caused by P aeruginosa, and will need surgical drainage. Prophylactic antibiotics, if used at the time of injury, should be broad-spectrum, especially covering staphylococcal and streptococcal species. If symptoms persist longer than four or five days, the possibility of a bone or joint infection should be considered and more aggressive management instituted.

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## Index to Volume 27

Pages	Number	Date
1-120	a susmaraus ol valuos	<b>July</b> 1988
121-232	2	August 1988
233-344	3	September 1988
345-448	4	October 1988
449-560	5	November 1988
561-656	6	December 1988

## SUBJECT INDEX

## A

ABSENTEEISM CERTIFICATION and the physician's role (Ash) (Letter) 464 (Fried) (Reply) 464

ACANTHAMOEBA KERATITIS in contact lens wearers (White Jr et al) 104

AGING infections and the immune system (Haddy) 409 ALCOHOL and acute renal failure (Elsasser et al) 221

ALCOHOL ABUSE in an adolescent (Forney et al) 65
ALPHA-FETOPROTEINS screening for in maternal serum

(Reed et al) (Letter) 20 (Campbell) (Reply) 26
ALTITUDE and exercise in young adults (Perna et al) 279
ANKYLOSING SPONDYLITIS abnormalities of the hand

and wrist (Hogikyan et al) 533

ASTHMA theophylline dosing and testing in (Moore III & Taylor) 57

## B

BLOOD PRESSURE MONITOR automatic in primary care (Maines) (Letter) 357 (Ornstein) (Reply) 357
BOOK REVIEWS

Alcoholism: A Guide for the Primary Care Physician (Barnes et al) 334

Clinical Method: A General Practice Approach (Fraser) 546

Community-Oriented Primary Care: From Principle to Practice (Nutting) 546

Comprehensive Gynecology (Droegemueller et al) 633 Current Medical Diagnosis & Treatment (Schroeder et al) 633

Cutaneous Side Effects of Drugs (Bork) 545

Emergency Procedures and Techniques (Simon & Brenner) 224

Family-Centered Medical Care: A Clinical Casebook (Doherty & Baird) 432

Handbook for the Academic Physician (McGaghie & Frey) 546

Harrison's Principles of Internal Medicine Companion Handbook (Braunwald et al) 334

Infections of the Hand (Mann) 545

Interpretation of Arrhythmias: A Self-Study Program (Stein) 634

Medicine: Preserving the Passion (Manning & De-Bakey) 432

Neurology (Bernat & Vincent) 545

Nutrition, Weight Control, and Exercise (Katch & McArdle) 634

Office Gynecology (Glass) 634

Oxford Textbook of Medicine (Weatherall) 633

Pediatrics (Rudolph) 332

The Physician as Teacher (Schwenk & Whitman) 435 Primary Care Medicine: Office Evaluation and Man-

agement of the Adult Patient (Goroll et al) 434 Procedures in Ambulatory Care (Gillette) 224

Questions & Answers on AIDS (Frumkin & Leonard)
434

Setting Limits: Medical Goals in an Aging Society (Callahan) 432

Textbook of Diagnostic Medicine (Samiy) 224

Textbook of General Medicine and Primary Care (Noble) 332

Year Book of Family Practice 1987 (Rakel) 332 BULIMIA NERVOSA and diuretic abuse (Pomeroy et al) 493

#### C

CANCER endometrial screening for (Greenburg) (Letter)

CAPITATED REIMBURSEMENT physician satisfaction with (Murray) 108

CARDIOPULMONARY RESUSCITATION the slow code a hidden conflict (Neher) 429

CESAREAN SECTION

fever and abnormal chest x-ray in (Miller et al) 259 strategies to avoid (Glasser) 514

CHOLESTEROL elevated management in primary care (Vivier et al) 167

CHROMIUM and hypocholesterolemic effects (Urberg et al) 603

CLINICAL REVIEWS

Aging infections and the immune system (Haddy) 409 Bacterial vaginosis (Weaver & Mengel) 207

Fever in children younger than three months of age: A pooled analysis (Gehlbach) 305

Medical management of pressure sores (Knight) 95 Preoperative evaluation of the elderly patient (Galazka) 622

Strategies to avoid unnecessary cesarean sections (Glasser) 514

COMPARTMENT SYNDROME chronic in an elderly man (Lutz et al) 417

COMPUTER

assisted exercise prescription (Brown & Cordes) 267 assisted literature searches the comprehensiveness of (DeNeef) 404

drug interactions screening and reduction of adverse reactions (Paulshock) (Letter) 330

genogram development and evaluation of (Ebell & Heaton) 536

CONTACT LENSES acanthamoeba keratitis in wearers (White Jr et al) 104

CONTINUITY OF CARE and population mobility (Mc-Whinney et al) 291 (commentary) (Dietrich) 294

CONTROVERSIES IN FAMILY PRACTICE

Is screening mammography routinely indicated for women between 40 and 50 years of age? An affirmative view (Dodd) 313

Is screening mammography routinely indicated for women between 40 and 50 years of age? An opposing view (Taplin) 316

Is ultrasound of the prostate indicated for screening purposes? An affirmative view (Lee et al) 521

Is ultrasound of the prostate indicated for screening purposes? An opposing view (Ansell) 525

COST EFFECTIVENESS principles for research (Ganiats & Schneiderman) 77

## D

DECISION MAKING evaluation of two tools in acute cardiac ischemia (Corey) (Letter) 576 (Green) (Reply)

DECUBITUS ULCERS medical management (Knight) 95 DEPRESSION

and physical illness (Reifler) 27

in the elderly (Cadoret & Widmer) 71 medical and psychosocial correlates (Duer et al) 609 somatization and social factors (Katon) 579

DIAGNOSTIC TEST for theophylline and training of office personnel (Fischer et al) 497

DIURETIC ABUSE in patients with bulimia nervosa (Pomeroy et al) 493

DRUG INTERACTIONS and reduction of adverse reactions by computerized screening (Paulshock) (Letter) 330 DYSTOCIA diagnostic criteria and management (Byrd et

al) 595

## E

**EDUCATION IN FAMILY PRACTICE** 

The effect of a rural preceptorship during residency on practice site selection and interest in rural practice (Norris & Norris) 541

Variations in content of care in a family medicine residency relating to types of insurance coverage (Johnson & Murata) 87

ENALAPRIL serum potassium and hypertension (Hume) 217

ENDOCARDITIS infective (Peterson) (Letter) 329

ENDOMETRIAL CANCER screening for (Greenberg) (Letter) 258

ENDOSCOPY cleaning endoscopes and prevention of HIV infection (Katner et al) 271

EPIGLOTTITIS acute and gastrointestinal bleeding (Kyrcz & Indyk) 102

ERECTILE IMPOTENCE (Greico) (Letter) 357 (Heller & Gleich) (Reply) 357

EXERCISE at high altitude in young adults (Perna et al)

EXERCISE PRESCRIPTION microcomputer assisted (Brown & Cordes) 267

## F

FAITH HEALING family practice patients' experiences (King et al) 505

FAMILY MEDICINE

and religion (Brody & Foglio) 473 residency training (Kerr) (Letter) 462

FAMILY PHYSICIANS

and hospital privileges (Ferentz et al) 297 use of sigmoidoscopy (Buckley et al) 197

FAMILY PRACTICE

and obstetrics (Krall) (Letter) 329 and obstetrics (Salyards) (Letter) 252

and obstetrics (Toffler & Wall) (Letter) 16 (Eggertsen) (Letter) 16 (Meenan) (Letter) 17 (Weyrauch & Berman) (Letter) 17 (Rosenblatt) (Reply) 17

and obstetrics in Ohio (Salyards) (Letter) 252

FAMILY PRACTICE AND THE HEALTH CARE SYSTEM

Physician satisfaction with capitation patients in an academic family medicine clinic (Murray) 108

Specialty bias in obstetric care for high-risk socioeconomic groups in Maine (Onion & Mockapetris) 423

FAMILY PRACTICE FORUM

The "slow code": A hidden conflict (Neher) 429

FAMILY PRACTICE GRAND ROUNDS

Caring for the paraplegic patient and her family (Bluestein et al) 365

Fever and abnormal chest x-ray findings after cesarean section (Miller et al) 259

Headache and chronic pain in primary care (Greer et al) 477

Male sexual impotence: A case study in evaluation and treatment (Halvorsen et al) 583

A married man seropositive for human immunodeficiency virus (Prichard et al) 33

Nutritional assessment of the hospitalized patient (Lipsky et al) 149

FEBRILE INFANT management of (Shelov) 247

FEVER IN INFANTS

management of (Shelov) 247

younger than three months of age (Gehlbach) 305

## G

GASTROINTESTINAL BLEEDING and acute epiglottitis (Kyrcz & Indyk) 102

GENOGRAM computer development and evaluation of (Ebell & Heaton) 536

GERIATRICS

compartment syndrome in an elderly man (Lutz et al)
417

depression in the elderly (Cadoret & Widmer) 71 infections and immune system (Haddy) 409 preoperative evaluation of the elderly patient (Galazka)

## H

## HEADACHE

and chronic pain in primary care (Greer et al) 477 in primary care (Becker et al) 41 (commentary) (Bass & McWhinney) 46

HEALTH CARE AND POOR PATIENTS perceptions of residents (Price et al) 615 (commentary) (Roter) 620

HIV seropositive in a married man (Prichard et al) 33 HIV INFECTION prevention in cleaning endoscopes (Katner et al) 271

HMO procedure selection in (Norman) 327

HOME VISITS follow-up study in an urban program (Gillette) (Letter) 360 (Balaban) (Reply) 436

HOMOSEXUALITY attitudes toward (Prichard et al) 637

#### HOSPITAL PRIVILEGES

documentation of students' experiences in training (Franks) (Letter) 142 (Schneeweiss et al) (Reply) 142 for family physicians (Ferentz et al) 297

HYPERCHOLESTEROLEMIA

management in primary care (Vivier et al) 167

should cholesterol-lowering drugs be used (Crouch) (Letter) 574 (Zweig) (Reply) 575

treatment with nicotinic acid and chromium (Urberg et al) 603

HYPERTENSION serum potassium and enalapril (Hume) 217

## manuscription will be stated

IBUPROFEN and acute renal failure (Elsasser et al) 221 IMMUNE SYSTEM aging and infections (Haddy) 409 IMPOTENCE male sexual (Halvorsen et al) 583

IMPOTENCE ERECTILE evaluation and management (Greico) (Letter) 357 (Heller & Gleich) (Reply) 357

INFANT LOW BIRTHWEIGHT and comparison of maternal factors of blacks with Mexican-Americans (Dowling & Fisher) (Letter) 551

INFERTILITY a psychosocial description (Sahaj et al) 393 INFLUENZA VACCINE routine indicated for people aged over 65 years an affirmative view—an opposing view (Glezen) (Letter) 253 (Frame) (Reply) 256

INSULIN RESISTANCE (Keenan Jr & Abgott) 635

INSURANCE STATUS relationship to content of care (Johnson & Murata) 87

ISCHEMIC HEART DISEASE ACUTE applying a predictive instrument (Corey) (Letter) 576 (Green) (Reply) 577

#### L

LOW BACK PAIN

clinical predictors of outcome (Lanier & Stockton) 483 (commentary) (Cherkin) 488

LSD intoxication (Schwartz & Hopkovitz) (Letter) 550 LYMPHADENOPATHY unexplained in family practice (Fijten & Blijham) 373

## M

MAILED REMINDERS FOR SIGMOIDOSCOPY patient response (Petravage & Swedberg) 387

**MAMMOGRAPHY** 

screening (Bourguet et al) 49

screening for women aged 40 to 50—an affirmative view (Dodd) 313

screening for women aged 40 to 50—an opposing view (Taplin) 316

MANAGED HEALTH CARE procedure selection in (Norman) 327

METRONIDAZOLE and atypical postpartum psychosis (McCahill & Braff) 323

## N

NICOTINE CHEWING GUM

effectiveness and the influence of patient education (Blaise) (Letter) 146 (Shaughnessy et al) (Reply) 146 used in smoking cessation therapy (Oswald et al) 179

NICOTINIC ACID and hypocholesterolemic effects (Urberg et al) 603

NUTRITIONAL ASSESSMENT of the hospitalized patient (Lipsky et al) 149

## 0

OBESITY ADULT patient perceptions and weight loss (Levy & Williamson) 285

OBSTETRICAL CARE

access to a growing crisis (Robertson) 361 specialty bias in (Onion & Mockapetris) 423

OBSTETRICAL OUTCOMES in a rural practice (Kriebel & Pitts) 377 (commentary) (Smith) 381

OBSTETRICAL PRACTICE attrition from among family practice residency graduates (Krall) (Letter) 329

OBSTETRICAL RISK assessment of risk scoring systems (Wall) 153 (commentary) (Scherger) 162

**OBSTETRICS** 

in family practice (Krall) (Letter) 329

in family practice (Manahan) (Letter) 330

in family practice (Salyards) (Letter) 252

in family practice (Toffler) (Letter) 16 (Eggertsen) (Letter) 16 (Meenan) (Letter) 17 (Weyrauch & Berman) (Letter) 17 (Rosenblatt) (Reply) 17

in Ohio (Krall) (Letter) 329

in Ohio (Salyards) (Letter) 252

strategy to avoid cesarean section (Glasser) 514

OSTEOMYELITIS due to pseudomonas (Gallo) 529

#### P

PAIN chronic and headache in primary care (Greer et al)
477

PAIN LOW BACK clinical predictors of outcome (Lanier & Stockton) 483 (commentary) (Cherkin) 488

PAPANICOLAOU SMEARS

improved endocervical cell yield with Cytobrush (Shadel) (Letter) 551 (Ruffin) (Letter) 577

techniques in a family practice setting (Ruffin) (Letter) 577

PARADIGMS disciplines specialties (Phillips) 139

PARADIGMS lost

a dilemma (Ruane) 133 disciplines and specialities (Phillips) 139 PARAPLEGIA caring for the patient with (Bluestein et al) 365

PATIENT EDUCATION effectiveness with nicotine chewing gum (Blaise) (Letter) 146 (Shaughnessy et al) (Reply)

PHARYNGITIS management of (Walker) (Letter) 436 (Wald) (Reply) 438

PHYSICAL ILLNESS and depression (Reifler) 27

PHYSICIAN-PATIENT RELATIONS how patients and physicians address each other (Bergman et al) 399

POSTPARTUM PSYCHOSIS atypical and metronidazole (McCahill & Braff) 323

POTASSIUM levels in enalapril-treated hypertension (Hume) 217

PRACTICE SELECTION effect of rural preceptorship (Norris & Norris) 541

PREGNANCY ectopic vs classic presentation (Bluestein et al) (Letter) 252

PRENATAL PATIENTS alpha-fetoprotein testing on in family practice (Ganiats) (Letter) 465 (Weiss) (Reply) 469 (Osborne) (Reply) 550

PREOPERATIVE EVALUATION of the elderly patient (Galazka) 622

PREVENTION screening patient perspective (Williamson et al) 187

PRIMARY CARE automatic blood pressure monitor in (Maines) (Letter) 357 (Ornstein) (Reply) 357

PROSTATE CANCER

screening with ultrasound—an affirmative view (Lee et al) 521

screening with ultrasound—an opposing view (Ansell) 525

PSEUDOMONAS OSTEOMYELITIS following puncture wound (Gallo) 529

PSYCHOSOCIAL CORRELATES of depressive symptoms (Duer et al) 609

PSYCHOSOCIAL DESCRIPTION OF INFERTILE COUPLES (Sahai et al) 393

PSYCHOSOCIAL PROBLEMS screening for in primary care (Wagner) (Letter) 462

PUNCTURE WOUND complicated (Chesebro) 640

#### R

RELIGION

faith and family medicine (Brody & Foglio) 473 in family practice patients faith healing (King et al) 505

in The Journal of Family Practice (Craigie et al) 509
RENAL FAILURE acute associated with ibuprofen and alcohol (Elsasser et al) 221

RESEARCH principles of cost-effectiveness (Ganiats & Schneiderman) 77

RESIDENCY TRAINING in family medicine (Kerr) (Letter)
462

RESIDENT EDUCATION documentation of for hospital privileges (Franks) (Letter) 142 (Schneeweiss et al) (Reply) 142

RESIDENTS

attitudes toward homosexuality (Prichard et al) 637 perceptions regarding health care and poor patients (Price et al) 615 (commentary) (Roter) 620

RISK obstetrical assessment of scoring systems (Wall) 153 (commentary) (Scherger) 162

RURAL PRACTICE obstetrical outcomes in (Kriebel & Pitts) 377 (commentary) (Smith) 381

RURAL PRECEPTORSHIPS and practice selection (Norris & Norris) 541

## S

## SCREENING

examinations patient perspective (Williamson et al) 187 for endometrial cancer (Greenberg) (Letter) 258 for prostate cancer with ultrasound—an affirmative view (Lee et al) 521

for prostate cancer with ultrasound—an opposing view (Ansell) 525

for psychosocial problems in primary care (Wagner) (Letter) 462

mammography (Bourguet et al) 49

sigmoidoscopy and patient response to mailed reminders (Petravage & Swedberg) 387

SIGMOIDOSCOPY

flexible is screening worthwhile (Long) (Letter) 144 (Frame) (Reply) 145 (Rodney) (Reply) 145

patient response to mailed reminders (Petravage & Swedberg) 387

use of by family physicians (Buckley et al) 197 (erratum) 574

SMOKING CESSATION using nicotine gum (Oswald et al)

SOMATIZATION depression and social factors (Katon) 579 SPONDYLITIS ankylosing of the hand and wrist (Hogikyan et al) 533

## T

## TELEPHONE CALLS

documentation quality implications (Daugird & Spencer) 420

nature and content of to physicians (Spencer & Daugird) 201

THEOPHYLLINE

diagnostic test training of office personnel (Fischer et al) 497

dosing and testing (Moore III & Taylor) 57

TRAINING of office personnel with a diagnostic test for theophylline (Fischer et al) 497

## V

VAGINITIS bacterial vaginosis (Weaver & Mengel) 207

## **AUTHOR INDEX**

#### Δ

Abgott, Michael A 635 Anderson, Regina 253 Ansell, Julian 525 Ash, Wallace H 464

## B

Balaban, Donald J 436
Bale, Ronald M 637
Barone, Eugene J 221
Bass, Martin J 46, 291
Becker, Lorne 41
Benyi, Judith 603
Bergman, James J 399
Berman, Henry S 17
Blaise, Judith C 146
Blijham, Geert H 373
Bluestein, Daniel 253, 365

Bourguet, Claire C 49
Braff, David L 323
Braunstein, Ethan 533
Brody, Howard 473
Brown, William D 267
Buckley, Robert L 197, 271
Butler, Stephen 477
Byrd, Janis E 595

## C

Cadoret, Remi J 71
Calonge, Ned 41
Campbell, Thomas L 26
Caplan-Tuke, Dee 477
Cherkin, Daniel C 399, 488
Chesebro, Marcia J 640
Chrisman, Noel 477
Colgan, Richard 297
Conway, Kathleen E 279

Cordes, Dorian H 267 Corey, George A 576 Cotton, Ernest K 279 Cox, Jack Landon 179 Coyne, James C 609 Craigie, Frederic C Jr 509 Crouch, Michael A 574

#### D

Danforth, Anne 393
Daugird, Allen J 201, 420
Davis, Denise 365
DeForge, Bruce R 505
DeNeef, Peter 404
Desmond, Sharon M 615
Dial, Lanyard K 637
Dietrich, Allen J 167, 294
Dodd, Gerald D 313
Donner, Allan 291

Dowling, Patrick 551 Driscoll, Charles E 187 Droesch, James 365 Duer, Susan 609 Dvorak, Laine D 187

#### E

Ebell, Mark H 536
Eby, Paul 149
Eggertsen, Sam C 161, 399
Ellsbury, Kathleen 142
Elsasser, Gary N 221
Eugley, Carol 253
Evans, Ellen 221
Everett, W Douglas 259

#### F

Ferentz, Kevin Scott 297 Fijten, Gerda H 373 Fischer, Paul M 497
Fisher, Michael 551
Foglio, John P 473
Forney, Mary Ann 65
Forney, Paul D 65
Frame, Paul S 145, 256
Franks, Peter 142
Freeman, William L 41
Fried. Robert A 464

## G

Galazka, Sim S 622 Gallo, Joseph J 529 Ganiats, Theodore G 77, 465 Garber, Keith A 187 Gehlbach, Stephen H 305 Gilchrist, Valerie J 49 Gillette, Robert D 360 Glasser, Morton 514 Gleich, Paul 357 Glezen, W Paul 253 Goolishian, Harry 33 Gordon, Katherine C 142 Gore, Ed 142 Green, Lee 577 Greenberg, Maury J 258 Greer, Thomas 477 Greico, Alan 357

## H

Haddy, Richard I 409
Halvorsen, John G 583
Hankin, Fred 533
Heaton, Caryl J 536
Heller, John E 357
Henderson, Audrey M 271
Hewes, Robert A 393
Hoddinott, Susan 291
Hogikyan, John 533
Holler, Jacob W 142
Holloway, Richard L 637
Hopkovitz, Aviva M 550
Houseknecht, Robert A 393
Hume, Anne L 217
Hunter, David 583

#### I

Indyk, Diane 102 Iverson, Donald C 41

#### J

John, Reynold 603 Johnson, Richard A 87

#### K

Kandula, Manju 49
Kaplowitz, Haley Jo 637
Katner, Harold P 197, 271
Katon, Wayne 477, 579
Keenan, William F Jr 635
Kelly, Kim L 497
Kerr, Colin P 462
Kimmel, Kathryn L 393
Kimmel, Sanford R 615
King, Dana E. 505
Knight, Aubrey L 95
Krall, Michael A 329
Kriebel, Stephen H 377
Kyrcz, Robert W 102

#### L

Lange, Paul 583
Lanier, David C 483
Larson, David B 509
Leduc, Lawrence B 393
Lee, Fred 521
Levy, Barcey T 285
Lipsky, Martin S 149
Littrup, Peter J 521
Liu Ingrid Y 509
Long, Howard F 144
Lopez, Lenora 221
Lundergan, Maureen K 104
Lutz, Lawrence J 417
Lyons, John S 509
Lytton, Diane E 595

#### M

Maines, John G 357 Manahan, William D 330 Mattingly, Linda 149 McCahill, Margaret E 323 McLeary, Richard D 521 McWhinney, Ian R 46, 291 Meenan, Anna L 17 Mehr, Samuel B 259 Mengel, Mark B 207 Metz, Michael 583 Mever, Barbara E 393 Miller, Rebecca S 41 Miller, Thomas R 259 Mitchell, James E 493 Mockapetris, Anne M 423 Mommsen, Craig 583 Montano, Daniel 142 Moore, L Doyle III 57 Moore, Patricia 365 Moriarty, James A 583

Morris, C Jay 33 Mosley, Mark 637 Murata, Paul J 87 Murdock, Richard T 104 Murray, James P 108

#### N

Naumberg, Betsy 142 Neher, Jon O 429 Norman, Lee A 327 Norris, Sandy B 541 Norris, Thomas E 541

## 0

Onion, Daniel K 423 Ornstein, Steven 357 Osborn, Lucy M 550 Oswald, Jeffrey Sylvan 179

## P

Paulshock, Bernadine Z 330 Perna, John 279 Peterson, Larry J 329 Petravage, Jacqueline 387 Phillips, Theodore J 139 Phillips, William R 399 Pitts, James D 377 Pomeroy, Claire 493 Price, James H 615 Prichard, John G 33, 637

#### R

Raczek, James A 595
Ratcliffe, Stephen 20
Reed, Barbara D 20, 417
Reed, Frank M 41
Reeder, C Eugene 146
Reifler, Burton V 27
Ripley, William K 65
Robertson, William O 361
Rodney, Wm MacMillan 145
Rosenblatt, Roger A 17
Roter, Debra L 620
Ruane, Thomas J 133
Ruffin, Mack T 578

#### S

Sahaj, David A 393 Salyards, Harry E 252 Sayres, William 20 Scherger, Joseph E 162 Schneeweiss, Ronald 142 Schneiderman, Lawrence J 77 Schwartz, Joyce G 550

Schultz, Janet K 399 Schwenk, Thomas L 609 Seim, Harold C 493 Seppala, Marvin 493 Shadel, Robert F 551 Shank, J Christopher 187 Shaughnessy, Allen F 146 Shelov, Steven P 247 Shelp, Earl E 33 Slate-Filice, Becki 497 Smith, C Kent 393 Smith, Mike U 197, 271 Smith, Mindy A 381 Snyder, Frank F 615 Sobal, Jeffery 297, 505 Spencer, Donald C 201, 420 Starling, Elizabeth 365 Steiner, Gerry A 149 Stockton, Patricia 483 Swedberg, Jay 387

## T

Taplin, Stephen 316
Taylor A Thomas 57
Thiese, Steven M 104
Toffler, William L 16
Torp-Pedersen, Soren T 521

#### U

Urberg, Martin 603

#### V

Vivier, Patrick M 167 Vogt, Susan C 595

#### W

Wade, Walter 365
Wagner, Charles M 462
Wald, Ellen R 438
Walker, Phillip M 436
Wall, Eric M 16, 153
Weaver, Charles H 207
Weiss, Barry 469
Weyrauch, Karl F 17
White, George L Jr 104
Widmer, Reuben B 71
Williamson, Paul S 187, 285
Witters, Lee A 167
Wolkenten, Raymond van 253
Worden, William Lamont 179

#### Z

Zeluff, Gary 417 Zweig, Steven 575

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