ONE A DAY

LOZOL®

INDAPAMIDE 2.5mg

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. Known hypersensitivity to indapamide or to other sulfonamide-derived drugs.

WARNINGS: Hypokalemia occurs commonly with diuretics, and electrolyte monitoring is essential, particularly in patients who would be at increased risk from hypokalemia, such as those with cardiac arrhythmias or who are receiving concomitant cardiac glycosides.

In general, diuretics should not be given concomitantly with lithium because they reduce its renal clearance and add a high risk of lithium toxicity. Read prescribing information for lithium preparations before use of such concomitant therapy.

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. Warning signs include dry mouth, thirst, weakness, fatigue, lethargy, drowsiness, restlessness, muscle pains or cramps, hypotension, oliguria, tachycardia, and gastrointestinal disturbance. 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 below). Serum concentrations of uric acid should therefore be monitored periodically during treatment.

3. *Renal Impairment:* Indapamide, like the thiazides, should be used with caution in patients with severe renal disease, as reduced plasma volume may exacerbate or precipitate azotemia. If progressive renal impairment is observed in a patient receiving indapamide, withholding or discontinuing diuretic therapy should be considered. 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 Lozol.

6. *Calcium Excretion:* Calcium excretion is decreased by diuretics pharmacologically related to indapamide. In long-term studies of hypertensive patients; however, serum concentrations of calcium increased only slightly with indapamide. Prolonged treatment with drugs pharmacologically related to indapamide may in rare instances be associated with hypercalcemia and hypophosphatemia secondary to physiologic changes in the parathyroid gland; however, the common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulcer, have not been seen. Treatment should be discontinued before tests for parathyroid function are performed. Like the thiazides, 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 and this possibility should be considered with indapamide as well.

DRUG INTERACTIONS: 1. *Other Antihypertensives:* Lozol (indapamide) may add to or potentiate the action of other antihypertensive drugs. In limited controlled trials that compared the effect of indapamide combined with other antihypertensive drugs with the effect of the other drugs administered alone, there was no notable change in the nature or frequency of adverse reactions associated with the combined therapy.

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, like the thiazides, 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. Reproduction studies have been performed in rats, mice and rabbits at doses up to 6,250 times the therapeutic human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Lozol. Postnatal development in rats and mice was unaffected by pretreatment of parent animals during gestation. There are however, no adequate and well-controlled studies in pregnant women. Moreover, 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. There may be hazards associated with this use such as fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in the adult.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because most drugs are 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, cumulative adverse reactions ≥ 5% 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. Cumulative adverse reactions < 5% 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 (i.e., lowered serum potassium concentration with concomitant clinical signs or symptoms) occurred in 3% and 7% of the patients given indapamide 2.5 mg and 5.0 mg, respectively. In a long-term study of both doses (157 patients given indapamide), potassium supplementation was given to 12% of patients on indapamide 2.5 mg and 27% of patients on indapamide 5.0 mg.

Other adverse reactions reported with antihypertensive/diuretics are jaundice (intrahepatic cholestatic jaundice), sialadenitis, xanthopsia, photosensitivity, purpura, necrotizing angiitis, fever, respiratory distress (including pneumonitis), and anaphylactic reactions; also, agranulocytosis, leukopenia, thrombocytopenia, and aplastic anemia. These reactions should be considered as possible occurrences with clinical usage of LOZOL.

HOW SUPPLIED: Lozol (indapamide). White, round film-coated tablets of 2.5 mg in bottles of 100 (NDC 0075-0082-00), 1,000 (NDC 0075-0082-99), and in unit-dose blister packs, boxes of 100 (10 x 10 strips) (NDC 0075-0082-62).

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

Keep tightly closed. Store at room temperature; avoid excessive heat. Dispense in tight containers as defined in USP.

See product circular for full prescribing information. Revised: November 1988 (AS)

References: 1. Weidmann P, Gerber A: Effects of treatment with diuretics on serum lipoproteins. *J Cardiovasc Pharmacol* 1984;6(suppl):260-268. **2.** Meyer-Sabellek W, Gotzen R, Heitz J, et al: Serum lipoprotein levels during long-term treatment of hypertension with indapamide. *Hypertension* 1985;7(suppl 2):170-174. **3.** Beling S, Vukovich RA, Neiss ES, et al: Long-term experience with indapamide. *Am Heart J* 1983;106:258-262. **4.** Scalabrino A, Galeone F, Giuntoli F, et al: Clinical investigation on long-term effects of indapamide in patients with essential hypertension. *Curr Ther Res* 1984;35:17-22.

See product circular for full prescribing information.

Product of Servier Research Institute

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Electrocardiography: Self-Assessment. *Edward K. Chung. Appleton & Lange, Norwalk, Connecticut, 1988, 438 pp., $49.95 (paper). ISBN 0-8385-2168-1.*

In *Electrocardiography: Self-assessment* Dr. Chung uses 200 electrocardiograms (ECGs) as learning tools for all the major areas of ECG interpretation. He has sections on ischemia, hypertrophy, fascicular blocks, and so on, with a rich array of ECGs to demonstrate each diagnostic point. Each ECG is presented as an unknown, with an interpretation on the following page.

The strength of the book is the wide variety of ECGs, which could be particularly useful for an educator or lecturer. The book is best read with a companion ECG text, though, because some of the explanations are somewhat difficult to comprehend, such as stating that a "tall (or relatively tall) R wave in lead V1" is one of the diagnostic criteria for right ventricular hypertrophy. How tall is tall? With that caveat, the book might prove interesting reading for a physician anxious to challenge his or her skills of ECG interpretation.

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Medical Complications During Pregnancy (3rd Edition). *Gerald N. Burrow, Thomas F. Ferris (eds). W. B. Saunders, Philadelphia, 1988, 616 pp., $70.00.*

This book is intended as a reference for consultants and primary physicians providing care for pregnant women. Because each chapter contains a wealth of information about pathophysiology and an extensive bibliography, it will also be useful for advanced students and their teachers. The book has a decided internal medicine slant, since the editors and 29 of 37 contributors are specialists in internal medicine. The material on obstetrics is not treated with equal richness; normal pregnancy and psychosomatic topics are beyond the scope of this work. Pregnancy and disease are reified and discussed as if separable from the host.

The range of medical complications included is comprehensive; I could think of only two, in my own experience with over 1500 pregnant patients, with which I would have received little help from this book. The most common complications—toxemia, diabetes, and nutritional disorders—each fill a chapter. There are also chapters on each organ system, on infectious, genetic, and neoplastic diseases, drug abuse, and obstetric care of high-risk patients. The material in different chapters is remarkably well integrated by the editors, who have eliminated, for the most part, repetitive and conflicting information.

The illustrations vary in quality and salience by chapter. The tables and diagrams, with few exceptions, are good. The photographs of skin disorders unique to pregnancy will be particularly useful. Several illustrations of abnormal ultrasounds do not reproduce well. Photographs in the thyroid chapter seem more appropriate (for their shock value) in a lecture, but add little to the book chapter.

This third edition contains many timely revisions. It includes information on chorionic villi sampling and other new methods of prenatal diagnosis, calcium channel blockers, angiotensin converting enzyme inhibitors, newer antibiotics, AIDS, current high-risk obstetric management, nutrition, and exercise. Most outdated material has been eliminated, though the book still mentions intravenous alcohol as a tocolytic. Some readers, I suspect, will disagree with the section on treatment of hypertension and preeclampsia, which advocates routine use of diuretics and β-blockers, and virtually omits magnesium sulfate as a treatment for central nervous system irritability during labor.

This excellent reference book deserves a place in the libraries of hospitals and training sites, where family physicians doing prenatal care are likely to find it a useful "consultant." A complementary reference on obstetric management will also be necessary.

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Neurology for Non-Neurologists (2nd Edition). *Wigbert C. Wiederholt. W. B. Saunders, Philadelphia, 1988, 356 pp., $39.50. ISBN 0-9089-1911-3.*

The editor correctly acknowledges that primary care physicians care for a large number of patients with neurological signs and symptoms. Many, if not most, of these physicians have been poorly prepared to care for these patients because of inadequate neurology training in either medical school or residency.

The purpose of this book is to present the primary care physician with concise and up-to-date information about common neurological entities that will be of immediate practical value. According to the editor, the first edition of the book was well received and the second edition has been appropriately revised in accordance with the criticisms about the original edition.

The book is easy to read and is well organized into four major parts: Introduction, Neurological Examination, Ancillary Methods of Study, and Specific Neurologic Disorders. The Introduction is a review of neuroanatomy. This is a nice feature of the book since an understanding of this subject forms the basis for an understanding of most neurological disorders. Unfortunately, the illustrations accompanying the text are small and crowded with labeling and are of little help in fixing the facts of neuroanatomy in one's mind. Neurological Examination reviews the neurological history and physical examination in both adults and children and is adequate. Ancillary Methods of Study covers lumbar puncture, cerebrospinal examination, electromyography, nerve conduction, electroencephalography, evoked potentials, neuroradiology, and neuropsychological testing. These brief discussions point out indications and limitations for each method of examination. Brief discussions of the common problems in Specific Neurological Disorders cover headache, cerebrovascular disease, dementias, multiple sclerosis, amyotrophic lateral sclerosis and other motor system diseases, toxic and metabolic encephalopathies, muscle diseases and disorders of neuromuscular transmission, diseases of peripheral and cranial nerves, seizure disorders, Parkinson's disease and movement disorders, infections of the nervous systems, dizziness and vertigo, congenital anomalies and inherited disorders, learning disabilities, tumors, craniospinal trauma, and radiculopathies. Liberal use of tables to summarize information is a nice feature of these chapters. Illustrations are few and of poor quality in all but the first of the book's four parts.

While this book fulfills its purpose in a marginal manner, the poor illustrations and the price are factors that should make primary care providers examine other texts that fulfill the same purpose.

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Manual of Antibiotics and Infectious Diseases (6th Edition). *John E. Conte, Jr., Steven L. Barriere. Lea & Febiger, Philadelphia, 1988, 392 pp., $19.50 (paper). ISBN 0-8121-1107-9.*

The authors designed this 18-ounce paperback manual for "health professionals involved in the day-to-day care of patients with infectious diseases." The book contains seven sections: antibiotics, with about a one-page synopsis of each of 80 drugs (87 pages); empiric antibiotic therapies, categorized by infected organ system (13 pages); therapy of established infection, listed by organism for each site of infection (26 pages); prophylactic antibiotic regimens (34 pages); immunizing and antiparasitic agents (140 pages); and sexually transmitted disease guidelines (32 pages). It is well indexed (30 pages).

The strongest point of this work is the compilation of much information required for the day-to-day management of infectious diseases into one reference. Other strengths are easy-to-find data about drug metabolism and dosage corrections for renal impairment. Material about drug use in pregnancy is sparse. The authors use readable, self-explanatory tables throughout the text.

Potential purchasers should be aware that this edition primarily relies on pre-1986 information. Since the book was written, there have been changes in guidelines, antibiotic recommendations, and immunizations (eg, new vaccines for Hemophilus influenza, hepatitis B, rabies, and inactivated poliomyelitis). Perhaps recognizing the rapidity of change, the authors devoted only two pages to human immunodeficiency virus (HIV) infections.

I was disappointed to find only one page of information on each of the newer antibiotics. In fact, for imipenem-cilastatin, the function of cilastatin is not mentioned. Also, the alphabetic organization of the drug review section was not conducive to comparisons within a class and led to occasional omissions, such as imipenem's potential cross-reactivity in penicillin-allergic patients. The manual does not include any comparative costs for medications. As a personal bias, I was also surprised to find ampicillin (rather than amoxicillin) frequently recommended for oral therapy of nonenteric infections.

Additionally, this manual has occasional inconsistencies in philosophy and in recommendations. For example, the authors are conservative in recommending that metronidazole never be used in pregnancy, yet liberal in listing ceftriaxone, 125 mg intra-

muscularly, as a therapy for gonorrhea. In different sections, therapeutic recommendations occasionally vary, such as penicillin plus streptomycin for empiric therapy of subacute bacterial endocarditis, but penicillin plus gentamicin for definitive therapy.

In summary, this manual contains much clinically useful information in one source. By the time such an endeavor appears in print, however, parts of it are outdated.

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The Illness Narratives: Suffering, Healing and the Human Condition. *Arthur Kleinman. Basic Books, New York, 1988, 304 pp., $19.95. ISBN 0-465-03202-8.*

To review a book that has on its jacket a recommending quotation from John Geyman, MD, the editor of this journal, is a challenge. Geyman is quoted: "An elegant and insightful presentation of the advantages of, and the need for, the biopsychosocial model of health care, the book identifies new challenges . . . ." The book is dedicated to those who suffer chronic illness, to those who share the experience of disability as members of the family or social circle, and to the professionals who care for them. Arthur Kleinman has certainly added a valuable contribution to the growing literature that stresses the need for physicians to listen to their patients.

The basic premise is that there is a difference between illness and disease. Illness is really the patient's perspective: it includes not only present symptomatology, but a great deal of other background to this perception, including culture, education, social background, and the current circumstances and stresses. Disease, on the other hand, is the problem from the practitioner's perspective. From the biomedical perspective, disease is a very complex process. This very fact deters many physicians from exploring psychosocial areas, and relating these to their biomedical constructs. Kleinman's work has caused him to concentrate on chronic illness.

Among the most valuable features of the book are the numerous accounts that Kleinman has collected from the time of medical student days to his experience now as a psychiatrist in the Department of Social Medicine at Harvard Medical School and as Professor of Anthropology at Harvard University.

Of particular value are his verbatim accounts of physician-patient interactions. Some of these involve his own patients, and some those of other physicians. All names, characteristics, and identifying details in the case histories have been changed, but there is obvious validity to the narrative accounts. He points out that clinical and behavioral science research possesses no category to describe suffering, yet for each of the narratives he offers interpretations. It is inevitably possible to offer alternative explanations and interpretations, yet the narratives frequently speak for themselves and are very powerful. Kleinman's interpretations are clearly those of a psychiatrist, and many family physicians might have alternatives. My main criticism is that in developing these interpretations, Kleinman seems to have relied extensively on his own experience and training, and in only very few of the narratives exampled in the book does he develop alternative stories with the patient fully involved in that development.

Howard Brody, who has also written recently about the importance of the patient's story, in a personal communication has suggested an alternative working hypothesis for patient presentation. He suggests that the patient come to the physician saying, "Something is happening to me, and either I cannot make sense of it, or else the only story I can think of to explain it scares the daylights out of me. Can you help me to tell a better story that will cause me less distress?" To this reviewer, such an approach, in which the physician develops together with the patient the alternative stories and interpretations, is more valuable and develops more successfully the concept of patient-centered rather than physician-centered interactions.

In spite of this criticism, the physician reading Kleinman's book is likely to be challenged and to find a need to change established patterns of "taking a history." As such, it is a book that is well worth reading, and I warmly recommend it.

For those involved in medical education, his final chapter on the challenge of a meaning-centered model has implications for introduction to clinical medicine courses, and his concern about the dehumanization that occurs as the result of professionalization is shared by many. It is high time the medical curriculum was revised to emphasise other aspects of the physician-patient relationship. While there are social science and humanities components in medical education, I agree with Kleinman that at present most medical students regard them as poor relations and few feel comfortable associating with them. I can wholeheartedly agree with Kleinman's assertion that "when we place care at the center of medicine, we are forced to rethink medical training." The revolution, however, would be even more profound if instead of care we substituted centralizing the patient.

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Year Book of Family Practice 1988. *Robert E. Rakel (ed), Robert F. Avant et al (assoc eds). Year Book Medical Publishers, Chicago, 1988, 578 pp., $42.95. ISBN 0-8151-7038-6.*

Although the purpose of the *Year Book of Family Practice* is not specifically outlined in the 1988 edition, it is evidently aimed at informing family physicians of important articles in a wide range of specialties, in-

NEW
Rogaine®
TOPICAL SOLUTION
minoxidil 2%

INDICATIONS AND USAGE
Male pattern baldness (alopecia androgenetica) of the vertex of the scalp. No effect has been seen on frontal baldness. At least four months of treatment are generally required before evidence of hair growth can be expected; further growth continues through one year. The new growth is not permanent; cessation of treatment will lead to its loss in a few months.
CONTRAINDICATIONS
Hypersensitivity to minoxidil, propylene glycol or ethanol.
WARNINGS
1. Need for normal scalp: Before starting treatment, make sure that the patient has a normal, healthy scalp. Local abrasion or dermatitis may increase absorption and hence the risk of side effects.
2. Potential adverse effects: Although extensive use of topical minoxidil has not revealed evidence that enough minoxidil is absorbed to have systemic effects, greater absorption due to misuse, individual variability or unusual sensitivity could, at least theoretically, produce a systemic effect.
Experience with oral minoxidil has shown the following major cardiovascular effects (Review the package insert for LONITEN® Tablets for details):
—salt and water retention, generalized and local edema
—pericardial effusion, pericarditis, tamponade
—tachycardia
—increased incidence of angina or new onset of angina
Patients with underlying heart disease, including coronary artery disease and congestive heart failure, would be at particular risk of these potential effects. Additive effects could also emerge in patients being treated for hypertension.
Potential patients should have a history and physical, should be advised of potential risks and a risk/benefit decision should be made. Heart patients should realize that adverse effects may be especially serious. Alert patients to the possibility of tachycardia and fluid retention, and monitor for increased heart rate, weight gain or other systemic effects.
PRECAUTIONS
General Precautions: Monitor patients one month after starting ROGAINE and at least every six months afterward. Discontinue ROGAINE if systemic effects occur.
The alcohol base will burn and irritate the eye. If ROGAINE reaches sensitive surfaces (eg, eye, abraded skin and mucous membranes) bathe with copious cool water.
Avoid inhaling the spray.
Do not use in conjunction with other topical agents such as corticosteroids, retinoids and petrolatum or agents that enhance percutaneous absorption. ROGAINE is for topical use only. Each mL contains 20 mg minoxidil and accidental ingestion could cause adverse systemic effects.
Decreased integrity of the epidermal barrier caused by inflammation or disease of the skin, eg, excoriations, psoriasis or severe sunburn, may increase minoxidil absorption.
Patient Information: A patient information leaflet is included with each package and in the full product information.
Drug Interactions: No drug interactions are known. Theoretically, absorbed minoxidil may potentiate orthostatic hypotension in patients taking guanethidine.
Carcinogenesis, Mutagenesis and Impairment of Fertility: No carcinogenicity was found with topical application. Oral administration may be associated with an increased incidence of malignant lymphomas in female mice and hepatic nodules in male mice. In rats, there was a dose-dependent reduction in conception rate.
Pregnancy Category C: ROGAINE should not be used by pregnant women.
Labor and Delivery: The effects are not known.
Nursing Mothers: ROGAINE should not be administered.
Pediatric Use: Safety and effectiveness have not been established under age 18.
ADVERSE REACTIONS
ROGAINE was used by 3510 patients in placebo-controlled trials. Except for dermatologic events, no individual reaction or reactions grouped by body systems appeared to be increased in the minoxidil-treated patients.
Respiratory (bronchitis, upper respiratory infection, sinusitis) 5.95%; **Dermatologic** (irritant or allergic contact dermatitis) 5.27%; **Gastrointestinal** (diarrhea, nausea, vomiting) 3.42%; **Neurology** (headache, dizziness, faintness, lightheadedness) 2.56%; **Musculoskeletal** (fractures, back pain, tendinitis) 2.17%; **Cardiovascular** (edema, chest pain, blood pressure increases/decreases, palpitation, pulse rate increases/decreases) 1.28%; **Allergy** (non-specific allergic reactions, hives, allergic rhinitis, facial swelling and sensitivity) 1.03%; **Special Senses** (conjunctivitis, ear infections, vertigo) 0.94%; **Metabolic-Nutritional** (edema, weight gain) 0.60%; **Urinary Tract** (urinary tract infections, renal calculi, urethritis) 0.46%; **Genital Tract** (prostatitis, epididymitis) 0.46%; **Psychiatric** (anxiety, depression, fatigue) 0.28%; **Hematology** (lymphadenopathy, thrombocytopenia) 0.23%; **Endocrine** 0.09%.
Patients have been followed for up to 5 years and there has been no change in incidence or severity of reported reactions. Additional events reported since marketing include: eczema, hypertrichosis, local erythema, pruritus, dry skin/scalp flaking, sexual dysfunction, visual disturbances including decreased visual acuity, exacerbation of hair loss, alopecia.
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cluding primary care, that may affect their clinical practice. The editor notes with satisfaction (and I agree) the increasing number of papers published by family physicians.

The book contains subsections of the different specialty areas, each with subjects of specific medical content. Each paper is clearly referenced and summarized by the reviewer with subsequent interpretation, comments and recommendations. It is not clear whether the methodology of the reported studies has been evaluated in terms of design or statistics; I have the impression that the papers are often accepted at face value. There is a good subject and author index.

This book provides an excellent resource for practicing physicians to review current management of many common or important clinical problems. It is also a useful text for residency programs, since many of the articles provide faculty with rapid access to useful material for conferences and teaching.

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Obstetrics for the House Officer (2nd Edition). *William F. Rayburn, Justin P. Lavin, Jr. Williams & Wilkins, Baltimore, 1988, 245 pp., $14.95 (paper), $15.95 (Canada). ISBN 0-683-07159-9.*

This manual, now in a second edition, was designed to provide guidelines for the house officer to handle routine and uncommon obstetrical problems. The authors acknowledge that each hospital has its own protocols for managing specific complications of pregnancy, labor, and delivery.

The text is divided into ten general topics, including prenatal care, medical disorders of pregnancy, antepartum obstetrical complications, perinatal infections, fetal surveillance techniques, fetal disorders, special procedures, intrapartum monitoring, intrapartum complications, and postpartum care. For each chapter, pertinent peer-review journal articles are included in a suggested reading section. There are also appendices detailing effects of specific drugs on the human fetus and in breast milk.

Although the manual contains no photographs, there are many tables, figures, and flow charts. They generally complement a very readable but appropriately detailed text. The reader will find the index most helpful in locating specific information.

Family medicine residents and practicing family physicians will be able to use this manual as a quick reference for both hospital-based and ambulatory obstetrical problems. It should be stressed that this manual is definitely problem oriented and does not include such topics as the management of uncomplicated labor and delivery. The only other limitation of this work will be time, as the technological advances in the field are so rapidly changing.

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Textbook of Pediatric Emergency Medicine (2nd Edition). *Gary R. Fleisher, Stephen Ludwig (eds), Fred M. Henretig et al (assoc eds). Williams & Wilkins, Baltimore, 1988, 1,382 pp., $112.50.*

This large textbook covers essentially all the pediatric emergencies that would be seen by a primary care physician. It is extremely relevant in that it not only discusses at length many of the common pediatric emergencies but also serves as a resource for some of the unusual pediatric problems. Its presentation is well organized, usually including the clinical manifestations and management of each emergency.

The illustrations are excellent. They range from numerous tables to figures, some of which are in color. A unique feature is the inclusion of nu-

merous computed tomography scans in the discussion of various clinical problems. These scans are particularly helpful to the family physician who has a busy practice in the emergency room.

My only criticisms of this textbook are editorial in nature. Specifically, there are several typographical errors, an upside-down radiograph, and wrong page numbers in the index.

This textbook would be best utilized by the family physician who is exposed to a number of pediatric emergencies. It is strictly a reference book and probably would be most usefully located in the emergency room to be available not only for the family physician, but for other primary care physicians working in that environment. Certainly, it is an excellent reference for the medical student and other allied health professionals looking for an authoritative source to the many pediatric emergencies seen in primary care.

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Conn's Current Therapy 1988. *Robert E. Rakel (ed). W. B. Saunders, Philadelphia, 1988, 1,092 pp., $49.95. ISBN 0-7216-2429-4.*

Since 1949, *Conn's Current Therapy* has provided the practicing physician with important annual updates on the diagnosis and treatment of a wide variety of medical conditions. The 1988 edition, continuing in this very successful tradition, is a well-written, encyclopedic text that includes contributions from 346 leading medical authorities on 282 major clinical subjects.

In my clinical practice, I have found the text to be a handy quick reference for the great majority of problems seen in the office, emergency room, or hospital. New topics covered this year include irritable bowel syndrome, temporomandibular disorders, and bulimia nervosa. The clinical summaries are clear, concise, and practically targeted to the needs of the busy practitioner. Treatment options and controversies in patient management are frequently highlighted, and tables are liberally used to illustrate the key therapeutic points. Although a biomedical focus (with an emphasis on pharmacotherapeutics) tends to pervade the writing, one sees the beginnings of an integrated biopsychosocial approach to current therapy with periodic mention made of various cognitive treatment approaches (eg, individual psychotherapy, behavioral therapy, family therapy).

Conn's Current Therapy 1988 is designed to reach a large clinical audience and should continue to successfully do so. In terms of suggestions for further improvements, the following might be considered: (1) employing a "life cycle approach to clinical therapeutics" as an organizing paradigm (this was effectively utilized in two chapters, "Epilepsy in Adolescence and Adults" and "Epilepsy in Infants and Children"); (2) adding a chapter on health maintenance and the care of the "worried well" (it should be noted that only five of the 346 contributing authors were family physicians); (3) adding new chapters on ophthalmologic and otolaryngologic problems as well as on developmental disabilities and mental retardation; (4) greatly expanding the section on psychiatric disorders (only 28 pages) to include such topics as somatopsychic illness, stress management, sexual dysfunction, nicotine dependency, grief and anniversary reactions, and childhood behavior disorders; and (5) including an introductory (or concluding) chapter on the broader socioeconomic and political context in which current therapy occurs—this might include some discussion of managed care systems, utilization and quality review organizations, malpractice issues, and medical ethics.

Aside from these few selected thoughts, I am pleased to be able to strongly recommend this valuable text to practicing family physicians and residents in training. Let us hope that future editions of this major medical work continue to measure up to the high standards set by Dr. Rakel in this year's volume.

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Consultation in Neurology. *Louis R. Caplan, John J. Kelly, Jr. B. C. Decker, Toronto and Philadelphia, 1988, 388 pp., price not available (paper). ISBN 1-55009-009-7.*

This small pocket handbook seems to have royal aspirations. It refers to neurology as the queen of clinical disciplines. The preface opens with a statement by the Queen of Hearts quoted from *Through the Looking-Glass* by Lewis Carroll. "Now here, you see, it takes all the running you can do, to keep in the same place." The book is aimed at nonneurologists who seek the help of their neurologic colleagues. It is meant as a road map to orient the consulting physician about the usual problems that neurologists are often asked to help solve.

The limitations of a pocket handbook are obvious, and it seems that this little work has been outpaced by its eminent authors in an endeavor to keep up to date. Some of the omissions seem to be rather striking. For example, the neurologic sequelae of head injury receive very little mention. The nomenclature for seizures is not that which has recently been advised for international use.

Having opened the book with excitement, on putting it down I wonder whether it really does deserve a place on my book shelf or that of any other busy family physician.

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