

Letters to the Editor



TEDRAL®/TEDRAL® SA Sustained Action
CAUTION: Federal law prohibits dispensing Tedral SA without prescription.

Description: Tedral: each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Tedral SA: each tablet of Tedral SA contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); 25 mg phenobarbital in the immediate release layer.

Indications: Tedral and Tedral SA are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal, or perennial asthma.

Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications: Sensitivity to any of the ingredients; porphyria.

Warning: Drowsiness may occur.
PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions: Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions: Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Dosage: Tedral: *Adults*—(average prophylactic or therapeutic dosage)—one or two tablets every 4 hours. With the one-tablet dose, an additional tablet may be taken at onset of symptoms, but dosage should not exceed two tablets in any 4-hour period. *Children* over 60 lb—one-half the adult dose.

Tedral SA: *Adults*—(average prophylactic or therapeutic dosage)—one tablet upon arising and one tablet 12 hours later. Tablets should not be chewed.

Dosage in children under 12 is not recommended because usage has not been established.

Supplied: Tedral: White, uncoated, scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in unit dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in unit dose—package of 10 x 10 strips (N 0047-0231-11). **STORE BETWEEN 59° and 86° F (15° and 30° C).**

T-GP-61-4/c

Full information is available on request.

WC WARNER/CHILCOTT
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Diagnostic Procedures of the Skin

To the Editor:

The article by Krull and Babel (*Krull EA, Babel DE: Diagnostic procedures of the skin. Part one: Wood's light, KOH slide, Gram's stain, and cultures. J Fam Pract 3:309-312, 1976*) was excellent. It pointed out many aspects of these examinations which are often taken for granted.

Nonetheless, I would like to add two points to their otherwise complete discussion.

1. Although a 15 or 20 percent KOH solution has been the standard for examination of skin scrapings, the most recent technique devised by Swartz and Lamkin is probably superior.¹ The Swartz-Lamkin's stain is used in combination with a .5 percent solution of Rose Bengal to produce the Swartz-Medrek contrast stain. This takes no longer to prepare than the standard KOH; however, the resulting slide is prepared at contrasting colors with a background of red, and the fungi in a bright blue. This is not only superior for beginners, but also for those experienced in examining these slides. In my experience, this has greatly shortened the amount of time necessary to determine whether a slide is positive or negative and has enabled me to teach others in the office to prepare these slides as well. The Swartz-Medrek kit is available from Muro-Pharmaceutical Laboratories Incorporated, 121 Liberty Street, Quincy, Mass 02169.

2. The instructions for the Gram's stain are the standard instructions, which probably date back to Professor

Gram himself! Certainly, these were the instructions that were taught to me and many of my colleagues in medical school only a few years ago. However, I think it is common knowledge that most house officers in recent years, and now many practicing physicians, use the so-called "rapid Gram's stain technique." The rapid technique is as follows:

- A. Heat fix the specimen.
- B. Flood the slide with Crystal Violet and *rinse with water immediately*.
- C. Flood the slide with Gram's Iodine, and *rinse the slide with water immediately*.
- D. Decolorize with absolute alcohol until the effluent no longer contains any blue-purple coloring. (This is important since a rather thin slide, as in urine or CSF, will not require a full 15 seconds; however, a rather thick slide, such as sputum or pus, may require more than 15 seconds).
- E. Flood the slide with Safranin and *rinse immediately with water*.
- F. Dry and examine under oil emulsion.

The advantages of the rapid Gram's stain are obvious, particularly for those in a busy office practice or in a busy Emergency Room. Rather than taking nearly three minutes of time, as with the standard technique, the rapid Gram's stain technique often takes no longer than 15 to 25 seconds to perform.

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POLYMOX® (amoxicillin)**Capsules, Oral Suspension and****Pediatric Drops (3) 4/21/76**

For complete information, consult Official Package Circular.

Indications: Polymox® (amoxicillin) is indicated in the treatment of infections due to susceptible strains of the following:

GRAM-NEGATIVE ORGANISMS—*H. influenzae*, *E. coli*, *P. mirabilis*, and *N. gonorrhoeae*.

GRAM-POSITIVE ORGANISMS—Streptococci (including *Streptococcus faecalis*), *D. pneumoniae*, and nonpenicillinase-producing staphylococci.

Therapy may be instituted prior to obtaining results from bacteriological and susceptibility studies to determine the causative organisms and their susceptibility to amoxicillin.

Indicated surgical procedures should be performed.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Anaphylaxis may occur, particularly after parenteral administration and especially in patients with an allergic diathesis. Check for a history of allergy to penicillins, cephalosporins or other allergens. If an allergic reaction occurs, discontinue amoxicillin and institute appropriate treatment. Serious anaphylactic reactions require immediate emergency treatment with epinephrine, oxygen, intravenous steroids and airway management.

Usage in Pregnancy: Safety for use in pregnancy is not established.

Precautions: Mycotic or bacterial superinfections may occur. Cases of gonorrhea with a suspected primary lesion of syphilis should have darkfield examinations before receiving treatment. In all other cases where concomitant syphilis is suspected, monthly serological tests should be performed for a minimum of 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Untoward reactions include: glossitis, black "hairy" tongue, nausea, vomiting and diarrhea, skin rashes, urticaria, exfoliative dermatitis, erythema multiforme and anaphylaxis (usually with parenteral administration). Anemia, thrombocytopenia, thrombocytopenic purpura, eosinophilia, leukopenia, and agranulocytosis have been noted, are usually reversible and are believed to be hypersensitivity phenomena. Moderate elevations in SGOT have been noted.

Usual Dosage: Adults—250 to 500 mg. orally q.8h. (depending on infection site and offending organisms). Children—20 to 40 mg./Kg./day orally q.8h. (depending on infection site and offending organisms). Children over 20 Kg. should be given adult dose.

Gonorrhea, acute uncomplicated—3 Gms. as a single oral dose (see PRECAUTIONS).

Serious infections, such as meningitis or septicemia, should be treated with parenteral antibiotics.

Supplied: Capsules—250 mg. in bottles of 100's and 500's. 500 mg. in bottles of 50's and 100's. Oral Suspension—125 mg./5 ml. and 250 mg./5 ml. in 80 ml. and 150 ml. Pediatric Drops—50 mg./ml. in 15 ml. bottles with marked dropper.

BRISTOL™

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Division of Bristol-Myers Company
Syracuse, New York 13201

I hope that these additional comments will be of use to those actively involved in family practice.

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1. Swartz JH, Medrek TF: Rapid contrast as a diagnostic aid for fungous infections. Arch Dermatol 99:494-497, 1969

On Learning Practice Management

To the Editor:

Shenkel is to be commended for providing feedback to residency directors, family practice educators, and current residents regarding the utilization of residency training in beginning practice (*Shenkel RC: After residency, then what? J Fam Pract 3:171-173, 1976*). In general, the experiences he described reflecting the shortcomings in his training as well as the benefits were similar to my own during the first 1½ years of practice in an urban setting (city of 200,000, drawing area of 950,000).

I wish he had elaborated on some aspects in much more detail. He emphasized that office management and personnel management were skills for which he was poorly prepared. Current residents as well as new practitioners like myself would benefit from a discussion of how many and what specific staff members he eventually employed. Such details as who accomplished the typing of all his dictated notes and whether that was done daily or on the weekly "business" day would be enlightening. The role which the nurse-practitioner filled was not described in his article, nor was it clear whether the nurse-receptionist originally hired was still employed in both capacities. A more detailed second report specifically filling the gaps in residency programs related to personnel management and office management would be appreciated and welcome.

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