

Mandelamine* (methenamine mandelate)
CAUTION: Federal law prohibits dispensing without prescription.

Description. Mandelamine, a urinary antibacterial agent, is the chemical combination of mandelic acid with methenamine.

Indications. Mandelamine (methenamine mandelate) is indicated for the suppression or elimination of bacteriuria associated with pyelonephritis, cystitis, and other chronic urinary tract infections; also for infected residual urine sometimes accompanying neurologic diseases. When used as recommended, Mandelamine is particularly suitable for long-term therapy because of its safety and because resistance to the nonspecific bactericidal action of formaldehyde does not develop. Pathogens resistant to other antibacterial agents may respond to Mandelamine because of the nonspecific effect of formaldehyde formed in an acid urine.

Contraindications. Contraindicated in renal insufficiency.
Precautions. Dysuria may occur (usually at higher than recommended dosage). This can be controlled by reducing the dosage and the acidification. When urine acidification is contraindicated or unattainable (as with some urea-splitting bacteria), the drug is not recommended.

To avoid inducing lipid pneumonia, administer Mandelamine Suspension Forte and Mandelamine Suspension with care to elderly, debilitated or otherwise susceptible patients.

Adverse Reactions. An occasional patient may experience gastrointestinal disturbance or a generalized skin rash.

Dosage and Management. The average adult dosage is 4 grams daily given as 1.0 gram after each meal and at bedtime. Children 6 to 12 should receive half the adult dose and children under 6 years of age should receive 250 mg per 30 lb body weight, four times daily. (See chart.) Since an acid urine is essential for antibacterial activity with maximum efficacy occurring at pH 5.5 or below, restriction of alkalinizing foods and medication is thus desirable. If testing of urine pH reveals the need, supplemental acidification should be given.

Mandelamine Dosages	ADULTS	CHILDREN
	Tablets and Granules	
1.0 gram	1 tablet q.i.d.	—
	1 packet* q.i.d.	—
0.5 gram	2 tablets q.i.d.	(Ages 6-12) 1 tablet q.i.d.
	—	1 packet* q.i.d.
0.25 gram	—	(Age under 6) 1 tablet per 30 lb body weight q.i.d.
Suspension Forte		
500 mg/5 ml teaspoonful	2 teaspoonfuls (10 ml) q.i.d.	(Ages 6-12) 1 teaspoonful (5 ml) q.i.d.
Suspension		
250 mg/5 ml teaspoonful	—	(Age under 6) 1 teaspoonful (5 ml) per 30 lb body weight q.i.d.

*Contents of packet to be dissolved in 2-4 oz water immediately before using.
 Shake Suspensions well before using.

STORE BETWEEN 59° and 86°F (15° and 30°C).

Supplied: 1.0 gm Tablets W/C 172: purple, enteric coated in bottles of 100 (N 0047-0172-51) and 1000 (N 0047-0172-60); also unit dose in 10 x 10 strips (N 0047-0172-11).

Granules (1.0 gm): orange-flavored individual packets; cartons of 56 (N 0047-0176-11).

0.5 gm Tablets W/C 171: brown, enteric coated in bottles of 100 (N 0047-0171-51) and 1000 (N 0047-0171-60); unit dose in 10 x 10 strips (N 0047-0171-11).

Granules (0.5 gm): orange-flavored individual packets; cartons of 56 (N 0047-0177-11).

0.25 gm Tablets W/C 170: brown, enteric coated in bottles of 100 (N 0047-0170-51) and 1000 (N 0047-0170-60).

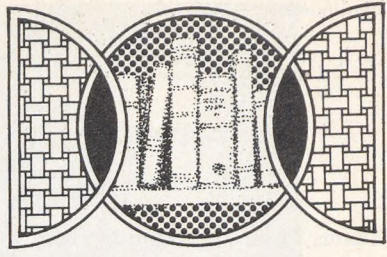
Suspension Forte, † 500 mg/5 ml teaspoonful: pink, cherry-flavored in bottles of 8 fl oz (N 0047-0174-08) and 16 fl oz (N 0047-0174-16). Unit Dose—10 ml (N 0047-0174-10). U.S. Patent No. 3,077,438.

Suspension, † 250 mg/5 ml teaspoonful: cream-colored, coconut-flavored in bottles of 4 fl oz (N 0047-0173-04) and 16 fl oz (N 0047-0173-16).

† Full information is available on request. **M-GP-61-4/c**

† Suspensions are in vegetable oil. Shake well before using.

Book Reviews



Manual of Pediatric Therapeutics. *Children's Hospital Medical Center, Boston.* Edited by John W. Graef and Thomas E. Cone, Jr. Little, Brown and Company, Boston, 1974, 525 pp., \$8.95 spiralbound.

This is a welcome addition to the Little, Brown Manual Series. The familiar soft cover and spiralbound loose-leaf format of the series makes the manual attractive and inexpensive.

The book was written by the house staff at the Children's Hospital Medical Center in Boston for other house staff as well as Emergency Room physicians, general pediatricians, and family doctors. One wonders how well a book can address itself to such a diverse audience, but the *Manual* has excellent information on inpatient critical procedures and ambulatory pediatrics.

The book is divided into two broad categories. The first eight chapters include general approaches to common problems of pediatrics in the hospital as well as the office. The chapter on "Emergencies and Child Abuse" is clear and concise with expert guidance through thorny areas. Chapter eight is especially helpful to the busy generalist, listing ten common office problems, including fever and hepatosplenomegaly, and providing a rational approach to them.

The subsequent 15 chapters outline pediatric specialty problems. Many disorders mentioned are quite common and may be handled routinely by the family physician. Excellent and informative reviews from a diagnosis as simple as pediculosis to a life-threatening Addisonian crisis are included.

The text is in a general outline form and gives only the most salient points in etiology and diagnosis of the problem. However, the therapy may be quite detailed, even down to the intravenous infusion rate in ml/kg. The index is excellent and provides detailed listings not only by diagnosis but in a problem-oriented format. Charts, graphs, and tables abound in most chapters and give valuable details in direct patient management.

The text suffers from a disappointing lack of drawings and illustrations. Anchoring an IV to an infant scalp or positioning a child for an emergency spinal tap are procedures better illustrated than written about. Also, at times the authors use highly specialized terms that are not previously defined, and one may have to resort to other sources to understand the text.

In spite of these minor drawbacks, the book is very successful and is indeed useful to house staff and family doctors. The concise language and modest cost should put the *Manual of Pediatric Therapeutics* on the most-wanted list.

James E. Crutcher, MD
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Adams Physical Diagnosis (15th Edition). John W. Burnside. Williams & Wilkins Company, Baltimore, 1975, 234 pp., \$9.95.

In the preface to this recent edition of a classic textbook, Dr. Burnside confesses that the exponential growth of knowledge prohibits the production of a comprehensive textbook on physical diagnosis without becoming encyclopedic. Instead, he hopes to provide a framework of technique and a pathophysiological thought process which might allow the student of physical diagnosis to define a disease even if he has never encountered it or read of it before. He claims to have de-emphasized rote memory and to have concentrated on the development of dynamic skills. This reviewer believes that he has accomplished these admirable goals.

In the lengthy introductory chapter, it is stressed that the book is written for students in medical school and house officers who have recently graduated. It outlines a holistic approach to the medical care of patients that has long been espoused by family practitioners. From the outset, Dr. Burnside discusses such issues as privileged communication, moral judgments, and honesty in medicine. In the taking of the medical history, he places as much importance on obtaining psychosocial information as on obtaining a detailed description of symptoms.

Each subsequent chapter begins with a discussion of the review of symptoms appropriate to each organ system. The author has made a commendable effort to explain the pathophysiology responsible for the production of each symptom. The descriptions of physical findings are equally impressive because of his ability to describe the underlying physiology.

The chapter on the heart is outstanding. Before discussing a single heart sound, he asks that the reader carefully study a drawing that simultaneously depicts the electrocardiogram, the aortic pressure, left atrial

and left ventricular pressure, pulmonary artery pressure, right atrial and right ventricular pressure, and the phonocardiogram. The classic heart murmurs are depicted in similar drawings that correlate sound with function. I have compared this chapter with similar sections from other standard textbooks of physical diagnosis and find that none can match this effort to provide an understanding of the events that produce physical findings.

I disagree with Dr. Burnside. This textbook is not only for medical students and house officers. It is for all physicians who strive for a better understanding of clinical medicine.

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Practical Paediatric Problems (4th Edition). James H. Hutchison, Year Book Medical Publishers, Chicago (distributor for Lloyd-Luke Medical Books, Ltd, London), 1975, 666 pp., \$22.00

In his preface to this fourth edition of *Practical Paediatric Problems*, Dr. Hutchison states, "I have resisted suggestions that completely new sections on . . . prenatal and perinatal physiology, growth and development, community pediatrics, and the influence of social class on mortality and morbidity should be included." This is unfortunate since these sections would have represented the areas of most pediatric interest in this country. These subjects probably account for the bulk of new information in current pediatrics. These omissions, coupled with the book's predominantly British orientation and style, diminish its usefulness in the United States.

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Brief Summary

K-LORTM (POTASSIUM CHLORIDE SUPPLEMENT)
TM-Trademark

Indications:

K-LOR is indicated in the treatment and prevention of hypokalemia and hypochloremic alkalosis where the severity of the condition does not warrant parental therapy. Conditions or factors which may give rise to potassium deficiency include diarrhea and vomiting, decreased potassium intake, increased renal excretion of potassium which may occur in acidosis, diuresis, adrenocortical hyperactivity, or the administration of exogenous adrenocortical steroids, injection of potassium-free fluids, and increased glucose uptake such as occurs in insulin-treated diabetic acidosis.

Potassium chloride may be particularly useful to help prevent the hypokalemia which may be induced by the administration of most diuretic agents.

Contraindications

Potassium chloride is contraindicated in the presence of severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps, and hyperkalemia from any cause.

Potassium chloride should not be employed in patients receiving potassium-sparing agents such as aldosterone antagonists and triamterene.

Precautions

With normal kidney function, potassium intoxication from oral administration is not likely to occur, since renal excretion of the ion increases in response to a rise in the concentration of body potassium. Nevertheless, potassium supplements must be administered with caution, since the dietary or daily amount is not accurately known. Frequent checks of the patient's clinical status and periodic ECG and/or serum potassium levels should be done. High serum concentrations of potassium ion may result in death through cardiac depression, arrhythmia, or arrest. The drug should be used with caution in the presence of cardiac disease and systemic acidosis.

Adverse Reactions

Side effects include abdominal discomfort, nausea, vomiting and diarrhea.

In the presence of renal dysfunction it may be possible to induce hyperkalemia by oral administration of potassium salts. The symptoms and signs of potassium intoxication include paresthesias of the extremities, weakness and heaviness of the legs, flaccid paralysis, listlessness, mental confusion, fall in blood pressure, cardiac arrhythmias and heart block. Electrocardiographic abnormalities such as disappearance of the P wave, widening and slurring of the QRS complex, changes of the S-T segment and tall peaked T waves may be noted with hyperkalemia.