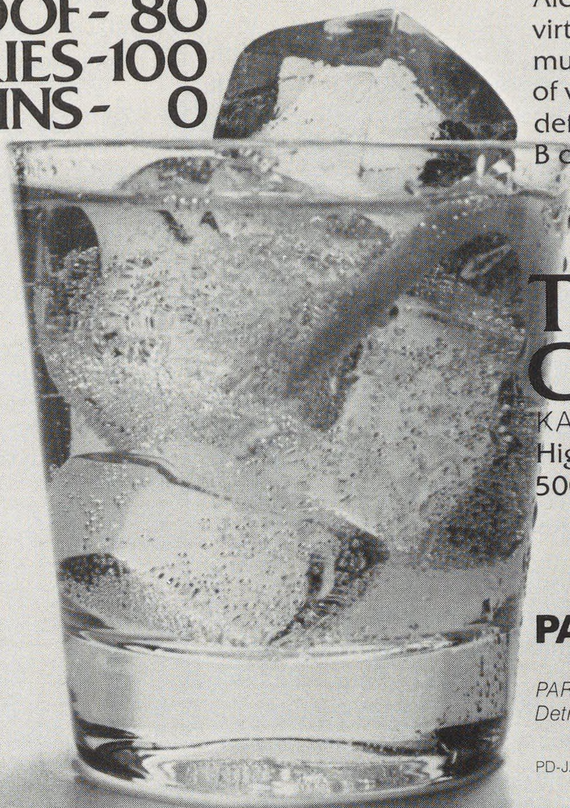

PROOF- 80
CALORIES-100
VITAMINS- 0

Alcohol by itself supplies calories with virtually no vitamins. Eventually, too much liquor with little or no intake of vitamins in the diet results in vitamin deficiencies, particularly those of the B complex.

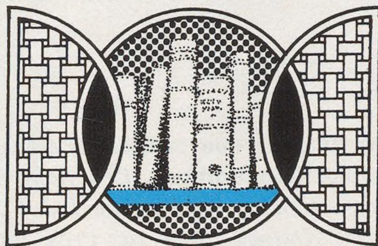
THERA-COMBEX H-P®
KAPSEALS®
High-potency vitamin B complex with 500 mg vitamin C

PARKE-DAVIS

PARKE, DAVIS & COMPANY
Detroit, MI 48232

PD-JA-2355-1A-P (1-78)

Book Reviews



Brief Textbook of Surgery. *Curtis P. Artz, Isidore Cohn, John H. Davis, W.B. Saunders, Philadelphia, 1976, 694 pp., $17.50.*

If the family physician is not interested in performing major surgery this is an excellent book for him/her to have in the library as a quick reference text. It very carefully omits both major and minor surgical techniques and deals primarily with surgical diagnosis, and pre-operative and post-operative care. Chapters are devoted to wound healing, fluid and electrolyte balance, and surgical infection.

Especially useful to the family physician are those chapters which relate to the emergency care of trauma—the acutely injured patient; shock and hemorrhage; fractures, dislocations, and sprains; and thermal, chemical, and electrical injuries.

The remaining chapters address themselves to the individual organ systems and, as stated earlier, deal with surgical diagnosis plus pre and post-operative care.

The prime virtue of this textbook is that it fulfills its intention by providing basic information for the undergraduate medical student and for the nonsurgical clinician. In many instances, the discussion seems rather shallow; still, it adequately treats indications for surgery while avoiding detail unimportant to one not performing the actual surgery.

In summary this publication concerns itself with surgical diagnosis, pre and post-operative care,

Continued on next page

Continued from preceding page

and the emergency care of the injured patient. It does so, in most instances, in a more practical fashion than most surgery texts that deal primarily with techniques.

George E. Burket, Jr, MD
University of Kansas
Medical Center
Kansas City, Kansas

Costs, Risks, and Benefits of Surgery. *Edited by John P. Bunker, Benjamin A. Barnes and Frederick Mosteller. Oxford University Press, New York, 1977, 401 pp., $22.50.*

Costs, Risks, and Benefits of Surgery is the result of two years' work by various members of an Interdisciplinary Seminar in Health and Medicine at Harvard University in 1972. It represents the first comprehensive treatment of surgery from the perspectives in the title.

The basic goal of this book, as stated in the preface, is to attempt to answer the question, "How can we get the most from resources we allocate to medical care?" As such it is directed to the physician and the patient who are contemplating surgery, as well as to the decision-makers in society who are considering questions regarding resource allocation and the setting of priorities. The book also attempts to facilitate surgical decision-making on the basis of logic instead of dogma. On the whole, the 34 contributors have produced an excellent reference work which achieves its goals well. Its strength lies in the deliberate selection for study of examples of surgical procedures about which there is uncertainty and disagreement within the medical profession. These are examined using the methods of cost-benefit analysis, decision analysis, statistical analysis, and economic theory.

Some of the areas examined in detail include: elective inguinal herniorrhaphy vs truss in the elderly, cholecystectomy for silent gallstones, elective hysterectomy, breast cancer, and coronary artery surgery.

Sections of the book are quite technical and somewhat difficult to digest. However, as a reference work it would be appropriate for surgeons, health resource planners, and medical educators in family practice and surgical specialties.

P. G. Hodgetts, MD
Toronto General Hospital
Toronto, Ontario

An Introduction to Electrocardiography (5th Edition). *Leo Schamroth. Blackwell Scientific Publications, Oxford University Press and available from JB Lippincott Company, Philadelphia, 1976, 240 pp., $10.00.*

This is the fifth edition of an introductory treatise on electrocardiography which enjoys worldwide popularity. It is directed primarily to the beginner and thus, simplicity and conciseness were major objectives in its preparation. I found its 240 pages to contain highly understandable and quite complete pre-

Continued on page 244

HYCOMINE® SYRUP

DESCRIPTION Each teaspoonful (5 ml) contains:

Hydrocodone bitartrate 5 mg
WARNING: May be habit forming.
Phenylpropanolamine hydrochloride............ 25 mg

USUAL ADULT DOSE 1 teaspoonful every four hours after meals and at bedtime (not to exceed 6 teaspoonfuls in a 24 hour period).

ACTIONS Hydrocodone bitartrate is an effective semisynthetic narcotic antitussive. Phenylpropanolamine is a sympathomimetic amine which provides nasal decongestion.

INDICATIONS To control cough and to provide symptomatic relief of congestion in the upper respiratory tract due to the common cold, pharyngitis, tracheitis, and bronchitis.

CONTRAINDICATIONS Hypersensitivity to any component of the drug. Should not be used in patients receiving monoamine oxidase inhibitors.

PRECAUTIONS Use with caution in diabetes, hyperthyroidism, hypertension, cardiovascular disease and in the aged. Since drowsiness and dizziness may occur, patients should be cautioned about driving or operating machinery.

Before prescribing antitussive medication to suppress or modify cough, it is important to ascertain that the underlying cause of the cough is identified, that modification of the cough does not increase the risk of clinical or physiologic complications, and that appropriate therapy for the primary disease is provided.

ADVERSE REACTIONS HYCOMINE® SYRUP is generally well tolerated. Occasional drowsiness, cardiac palpitation, dizziness, nervousness or gastrointestinal upset may occur.

HOW SUPPLIED As an orange-colored, fruit-flavored syrup.

CAUTION Federal law prohibits dispensing without prescription. *Oral prescription where permitted by State Law.*

Endo Laboratories, Inc.
Subsidiary of the DuPont Company
Garden City, New York 11530

Continued from page 242

sentation of the most important aspects of the basic principles of electrocardiography as well as the various electrocardiographic abnormalities. The information is current, as new sections on the hyperacute phase of myocardial infarction, variant forms of angina pectoris, and the hem block concept have been added. Illustrations are extensive and clear and are a major asset. The book is the most readable of any of the introductory approaches to this field that I have read, and yet contains sufficient information on the entire subject to make it useful for frequent reference. The section on disorders of cardiac rhythm is especially good. Medical students, family practice residents, and practicing family physicians should all be well served by this beautifully written little book. Its ten-dollar cost is to me the best possible investment for useful information in this field.

Herbert R. Brettell, MD
Denver, Colorado

Early Care of the Injured Patient (2nd Edition). *The Committee on Trauma, American College of Surgeons. W. B. Saunders Company, Philadelphia, 1976, 443 pp., $12.50.*

When the first edition of *Early Care of the Injured Patient* was initially published, there had been a need for a text that gave specific but not exhaustive information on the assessment and management of the traumatized patient. The second edition of this text retains the timeliness and usefulness of the first edition with the valuable addition of considerable updating in respiratory care, resuscitation, renal failure, and venous repair, to mention a few, as well as completely new sections on legal advice, informed consent, and mass casualty treatment. The book's orientation is primarily toward physicians working in Emergency Departments, but contains valuable information on the primary assessment and management of an injured patient, including treatment for shock, and the initial stabilization and treatment of simple fractures.

The organization of this book makes it eminently satisfactory as a rapid reference text. It begins with the most seriously injured patient and gives valuable information in chapters on cardiopulmonary resuscitation, shock and fluid replacement, infection, and anesthesia. There are also chapters on initial care of burns and chemical, electrical, and cold injuries, as well as bites and stings. Subsequent chapters deal in a systematic way with the general areas of the body that might be involved in a traumatic injury. Three chapters are devoted to the management of fractures. There is a general chapter on fracture treatment, followed by one on fractures in adults and one on children's fractures. All of these are accompanied by line drawings which illustrate the principles delineated. Chapters on head trauma and spinal cord injuries are particularly designed to answer specific questions regarding management of the patient and are accompanied by sufficient illustration. In the case of

Continued on page 248

LOMOTIL®

brand of diphenoxylate hydrochloride with atropine sulfate

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. *LOMOTIL* IS NOT *AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years due to the decreased safety margin in younger age groups, in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine, and in diarrhea associated with pseudomembranous enterocolitis occurring during, or up to several weeks following, treatment with antibiotics such as clindamycin (Cleocin®) or lincomycin (Lincocin®).

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co.
Medical Communications Department
Box 5110
Chicago, Illinois 60680

653

Only 1 tablet B.I.D.
Gantanol® DS
sulfamethoxazole/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter,* staphylococcus, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*), in the absence of obstructive uropathy or foreign bodies. Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis). *Usual adult dosage:* 2 Gm (2 DS tabs or 4 tabs or 4 teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection. *Usual child's dosage:* 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: DS (double strength) tablets, 1 Gm sulfamethoxazole; Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Continued from page 244

head injuries, a flow sheet is included which would be useful for the recording of continuous monitoring of the patient who has such an injury.

Early Care of the Injured Patient will serve admirably for a mature family physician who, when confronted with specific problems, desires to have a text to consult for rapid review and an update on current management. The book does suffer from a lack of a bibliography and extensive discussion, particularly in the treatment area; answers to questions in those areas must be sought elsewhere. For the student physician and nurse practitioner, the text likewise can be useful as a rapid reminder or reference source to check the method of treatment to be used, particularly on the subject of fractures, since it gives valuable data on diagnosis and treatment of all the major dislocations and fractures. The chapter on the neck, the description of the emergency cricothyroidotomy and elective tracheostomy are presented in such a way as to be of value to any individual finding him/herself in an emergency situation and wanting a quick review of the procedure.

This 443-page book is a valuable addition to the reference library in any Emergency Department and should be owned by any physician who initially cares for patients following injury. It can well serve as an additional review book for the library of the medical student or family nurse practitioner who is to be involved with the early care of patients who have been traumatized.

Richard C. Barnett, MD
Community Hospital of Sonoma County
Santa Rosa, California

Medical Malpractice—The Duke Law Journal Symposium. *Duke Law Journal. Ballinger Publishing Company, Cambridge, Massachusetts, 1977, 304 pp., $15.00.*

Even those family physicians having more than average interest in the malpractice litigation problem may find this book so exhaustive as to be exhausting. It consists of comprehensive essays written from the legal standpoint and apparently without regard for their ultimate inclusion in a single publication. As a result, there is a great deal of duplication of background material, definitions, and history; as much as a fourth of some of the essays consist of such reiteration.

Another problem is the format, in which footnotes frequently occupy more of the page than the text, making reading slow and laborious.

Family physicians will find little of practical value here, except for those who are intimately involved in organizational activity pertaining to malpractice insurance and legislation. The problems faced by the practitioner—increased premiums, the need to practice defensive medicine, inequitable premiums for part-time practice, etc—are clearly defined and discussed, but no hints are given as to what action the individual can take in seeking relief. All of the solutions suggested involve massive legislative and legal change, and this serves to point up the need for active participation by medical organizations in shaping the course of change. This book, therefore, will be of greatest value to those in legal, political, and administrative positions.

Continued on next page

Continued from preceding page

It is perhaps notable that the point of view of the medical profession is nowhere directly expressed. There are some quotations and citations, but none of the contributors represent organized medicine nor are any contributors practicing physicians. In view of the stated aim of the editor to bring together in one volume "the medical, legal, insurance, and sociological aspects" of the problem, it is unclear whether this omission is intentional or inadvertent.

Collin Baker, MD
Duke University Medical Center
Durham, North Carolina

The Common Symptom Guide. *John Wasson, B. Timothy Walsh, Richard Tompkins and Harold Sox, Jr. McGraw-Hill, New York, 1975, 353 pp., $4.25 (paper).*

While patients come to the physician with symptoms, most textbooks of medicine provide detail about disease. Recognizing that the student of medicine needs assistance to bridge the gap between symptom and disease, the authors prepared *The Common Symptom Guide*. This book provides in outline format pertinent historical and physical findings and also a list of diagnostic considerations which should be considered for each of 100 symptoms commonly presented by adults and children.

The book begins with an index of approximately 400 symptom complexes, identifying for each which of the 100 symptoms covered in the book will be of assistance. Thus, the reader seeking to evaluate a patient complaining of "stiff neck" will be directed to outlines in the book dealing with "fever," "headache," and "neck pain." Under each of these headings the reader finds relevant historical and physical findings which will assist him/her in identifying which diagnostic possibilities need to be seriously considered. Each symptom complex is addressed first to adults and then to children. Information in the *Guide* is drawn from two textbooks of internal medicine, two of pediatrics, and one each of family medicine and surgery. Insofar as possible, references are provided to specific pages in Harrison's *Principles of Internal Medicine*. As might be expected from the reference sources, the symptom of chest pain is more comprehensively addressed than that of vaginal bleeding.

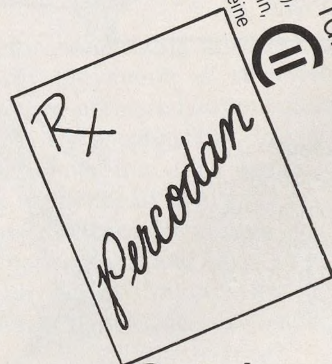
The authors recognize the risks inherent in trying to rigorously fit symptom complexes into disease categories and caution the reader that symptoms presented by the patient may not always be the underlying problem for which the patient seeks assistance.

It is this reviewer's opinion that *The Common Symptom Guide* may be of real assistance to the student of medicine for whom it was primarily developed. It will be of relatively less value to the experienced clinician. The medical student or beginning house officer frequently has real difficulty in knowing what additional information to elicit and which diseases need to be considered. It would be of interest to assess the impact of this book upon the speed whereby clinical students develop valuative and diagnostic skills.

Jack M. Colwill, MD
University of Missouri-Columbia

Continued on page 391

Rx WITH CONFIDENCE
PERCODAN® Tablets Ⓒ II
each yellow, scored tablet contains 4.50 mg oxycodone HCl (WARNING: may be habit forming), 0.38 mg oxycodone terephthalate (WARNING: may be habit forming), 224 mg aspirin, 160 mg phenacetin, 32 mg caffeine



Endo Inc.
Manati, Puerto Rico 00701
Subsidiary of E.I. du Pont de Nemours & Co. (Inc.)
PERCODAN® is a registered trademark of Endo Inc.
EDO-0120 2/77

Continued from page 249

Radiology and Injury in Sport. *Jack W. Bowerman. Appleton-Century-Crofts, New York, 1977, 334 pp., $26.50.*

The relationship of a particular sport activity and injuries peculiar to that sport is an important concept and relates to problems frequently encountered in any busy family practice. This small book puts together this relationship in an interesting fashion and goes a long way toward correlating diagnostic thinking and radiologic techniques to the site of injury and the sport involved.

Bowerman's book is divided into three parts. The first part is a brief compilation of descriptions of radiologic techniques by site of injury. There are some standard views and some unusual views well reproduced and normal and abnormal radiographs presented.

Part 2 is perhaps the most interesting section, in that a discussion of injury and diagnostic radiographs are compiled for some of our most popular sports. The "Little League elbow" and professional "pitcher's elbow" are discussed and interesting radiographs are included. Football injuries, including frequency of injury and examples of same, are included along with a good list of references for further study. Soccer, skiing, motorcycle riding, lacrosse, and karate are all mentioned, though sometimes briefly, but references are given for further study for each sport.

Part 3 is a somewhat brief compilation of teaching radiographs which are well reproduced and which are presented as examples of how the diagnosis of an injury may be demonstrated by radiographic means. Some radiographs are presented twice for self-instruction so that areas of injury can be studied in an unmarked radiograph while the learner covers the explanatory radiograph.

Radiology and Injury in Sport is a useful book for family practice residents as well as family physicians who are seeing patients injured from sporting accidents. This is not a comprehensive reference text but serves more as a stimulus to understanding the mechanism of injury and as a resource for further study. It, indeed, goes far toward helping the physician order, use, and interpret appropriate radiographs for suspected injury from a given sport.

Douglas O. Corpron, MD
Family Medicine-Yakima Valley
Washington

Team Care in General Practice. *Geoffrey Marsh and Peter Kain-Caudle. Croom Helm, London, 1976, 185 pp., (available only in U.K., £7).*

Team Care in General Practice is a major work in the study of health services delivery in primary care. As such, the book is of wide general interest to family physicians, both in teaching and in practice, and to others interested in the study of health services. The book reports a small, concise, and extremely well-designed and well-managed study. Even though the study is small and limited to one unusual practice in England, the issues researched are large and complex and contain broad implications. The book represents a landmark in showing the way a small practice can be used to research some of the critical questions in primary care. As an example of individual as opposed to in-

Continued on next page

new
Magan®
[magnesium salicylate]

650 mg tablets
WARREN-TEED
LABORATORIES, INC.
DIVISION OF ADRIA LABORATORIES INC.
COLUMBUS, OHIO 43215

Continued from preceding page

stitutional research in health-care delivery, this book contains many lessons for primary care physicians.

The first three chapters in the book form an excellent review of general practice health services delivery in England, of the workload of physicians throughout the United Kingdom, and of the primary care team. There are extensive bibliographies at the end of each of these three chapters.

The third chapter reviews the British concept of the primary health-care team which is similar to the American concept with three exceptions: (1) the role of health visitors, (2) the role of midwives, and (3) the role of social workers. The health visitor (usually an RN) is basically a health educator/patient advocate who is involved particularly in perinatal care. The midwife role is well established in Britain but not well established in mainstream health care in America. An unusual aspect is the reluctance of social workers to join into the primary health-care team in England. They work out of agencies and are not generally members of the primary care team.

The fourth chapter reviews the particular practice itself as well as the design of the study. The practice is clinically organized around the physician, who is a member of a five-physician center. This physician (G. Marsh) studied his practice for one year (1972) after organizing it in a nontraditional way, ie, as a team. The book then reviews the methods used by the team and, in general, they are similar to methods used in the United States. There is a daily 15-minute morning meeting to coordinate patient care. The nurse spends a great deal of time making home visits and also deals through the physician in clinical decision-making. The personal physician is an important concept throughout this book as evidenced by the high (85 percent) degree of continuity of that practice population with this one physician (as opposed to others in his medical center).

Chapters 5 and 6 explain and clarify the data in some detail. The overall conclusion is that a low workload is demonstrated for the physician, and hospital referral is also reduced. One of the lowest reported patient visit rates in the United Kingdom was noted for this practice, 2.3 visits per patient per year. The hospital referral rate was 38 percent of the national average.

Part two reviews patient satisfaction; this study was done by an independent sociology team using a personal interview system. There were six hypotheses tested and all were proven to be true. The six hypotheses were: (1) that the patients were satisfied with the overall health-care service they received, (2) that patients were satisfied with the care given by the individual members of the primary care team, (3) that patients preferred a personal doctor service within the setting of the team, (4) that patients clearly distinguished between the competence of the qualified nurses and the receptionist, (5) that patients who had experienced a service would view it more favorably than those who were unfamiliar with it, and (6) that patient satisfaction with the overall service and its components was unrelated to patient age or social class.

In the final chapter, well-qualified conclusions were presented as "findings, not facts." Dr.

Continued on page 396

Tussionex®
(resin complexes of hydrocodone and phenyltoloxamine)

The antitussive that goes further.

Composition: Each capsule, teaspoonful (5 ml.) or tablet contains 5 mg. hydrocodone (Warning: may be habit-forming), and 10 mg. phenyltoloxamine as cationic resin complexes.

Effects: An effective antitussive which acts for approximately 12 hours.

Dosage: Adults: 1 teaspoonful (5 ml.), capsule or tablet every 8-12 hours. May be adjusted to individual requirements. Children: From 1-5 years: ½ teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

Side Effects: May include mild constipation, nausea, facial pruritus, or drowsiness, which disappear with adjustment of dose or discontinuance of treatment.

Overdosage: Immediately evacuate the stomach. Respiratory depression, if any, can be counteracted by respiratory stimulants. Convulsions, sometimes seen in children, can be controlled by intravenous administration of short-acting barbiturates.

How Supplied: Tussionex Capsules, green and white. Bottles of 50. Tussionex Suspension, neutral in taste, golden color; 16 oz. and 900 ml. bottles. Tussionex Tablets, light brown, scored; bottles of 100. A prescription for 2 oz. of the Suspension, or 12 Tablets or Capsules, constitutes a 6-day supply in the average case.

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

HALOG® (Halcinonide)
Cream/Ointment/Solution
Halog Cream 0.025% (Halcinonide Cream 0.025%) and Halog Cream 0.1% (Halcinonide Cream 0.1%) contain 0.25 mg. and 1 mg. halcinonide per gram, respectively, in a specially formulated cream base. Halog Ointment (Halcinonide Ointment 0.1%) contains 1 mg. halcinonide (0.1%) per gram in Plastibase® (Plasticized Hydrocarbon Gel), a polyethylene and mineral oil gel base. Halog Solution (Halcinonide Solution 0.1%) contains 1 mg. halcinonide (0.1%) per ml.
CONTRAINDICATIONS: Topical steroids are contraindicated in vaccinia, varicella, and in those patients with a history of hypersensitivity to any of the components of the preparations. These preparations are not for ophthalmic use.
PRECAUTIONS: *General*—If local infection exists, suitable concomitant antimicrobial or antifungal therapy should be administered. If a favorable response does not occur promptly, application of the corticosteroid should be discontinued until the infection is adequately controlled. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid and suitable precautions should be taken. If irritation or sensitization develops, the preparation should be discontinued and appropriate therapy instituted. Although topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use during pregnancy has not been absolutely established; therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.
Occlusive Dressing Technique—The use of occlusive dressing increases the percutaneous absorption of corticosteroids; their extensive use increases the possibility of systemic effects. For patients with extensive lesions it may be preferable to use a sequential approach, occluding one portion of the body at a time. The patient should be kept under close observation if treated with the occlusive technique over large areas and over a considerable period of time. Occasionally, a patient who has been on prolonged therapy, especially occlusive therapy, may develop symptoms of steroid withdrawal when the medication is stopped. Thermal homeostasis may be impaired if large areas of the body are covered. Use of the occlusive dressing should be discontinued if elevation of the body temperature occurs. Occasionally, a patient may develop a sensitivity reaction to a particular occlusive dressing material or adhesive and a substitute material may be necessary. If infection develops, discontinue the use of the occlusive dressing and institute appropriate antimicrobial therapy.
ADVERSE REACTIONS: The following local adverse reactions have been reported with topical corticosteroids: burning, itching, irritation, striae, skin atrophy, secondary infection, dryness, folliculitis, hypertrichosis, acneform eruptions, and hypopigmentation. The following may occur more frequently with occlusive dressings: maceration of the skin, secondary infection, skin atrophy, striae, and miliaria. Contact sensitivity to a particular dressing material or adhesive may occur occasionally (see PRECAUTIONS).
For full prescribing information, consult package insert.
HOW SUPPLIED: The 0.025% and 0.1% Cream and the 0.1% Ointment are supplied in tubes of 15 g. and 60 g., and in jars of 240 g. (8 oz.). The 0.1% Solution is supplied in plastic squeeze bottles of 20 ml. and 60 ml.

SQUIBB®

Continued from page 392

Marsh is very cautious in generalizing to other practices in the United Kingdom, and we should be even more cautious in generalizing to practices in the United States.

Marshall Eaton, MD
University of Washington
Seattle

Ultrasonography in Obstetrics and Gynecology. *Roger C. Sanders and A. Everette James, Jr., Appleton-Century-Crofts, New York, 1977, 425 pp., $26.50*

Concise, clear, and practical is a good description for *Ultrasonography in Obstetrics and Gynecology.* Edited by Dr. Roger Sanders, Associate Professor of Radiology at Johns Hopkins Medical Institutions, and Dr. Everette James, Jr., Professor of Radiology at Vanderbilt University School of Medicine, this classic publication contains information by a number of contributors from throughout the United States and other countries. These learned people represent a variety of specialties including obstetrics-gynecology, radiology, pediatrics, and the basic science areas of anatomy and reproductive biology.

The justification for such a comprehensive analysis of this subject area is clearly delineated, in that, ultrasound is noninvasive, causes no harm to the fetus, and is used with increasing frequency and accuracy in the field of obstetrics-gynecology. In reviewing the chapters, the outlined objectives of this text are more than fulfilled in all areas. These objectives include:

1. The relationship of physical principles to biologic hazards.
2. The correlation between diagnostic images and embryonic development.
3. The comparison of this modality with other diagnostic stud
4. The presentation of a differ tial diagnosis through its applica and use in the various areas of t specialty.
5. The presentation of new inf mation on the technical advance ultrasonography.

The writing is clear and conc with good and appropriate illus tions, tables, and pictures, and ever-helpful section and paragr headings afford easy referen The book is practical, frank, a realistic and uses case illustrat when appropriate.

The book's content not o covers historical and fundamen principles of ultrasonography also reviews every possible clin application (normal vs abnormal pregnancy grouped according trimester. A recipe approac presented to obstetrical proced such as amniocentesis. In addi alternative clinical approaches offered to problems in gynecol such as fibromyoma, ovarian m ses, and pelvic inflammatory ease. There is a fascinating cha on the management of intraute devices and the value of trasonography in this area.

This book is directed at physician involved in obstet gynecology, whether a fa physician, obstetrician, or radiologist. It will also make a g reference for residents in th specialties and provide some ited use for medical students. highly recommended for its spe subject area to community ho tals, medical libraries, pri clinics, and undergraduate graduate medical education grams.

William Jacott,
Duluth Fa
Practice C
Duluth, Minn