

# Book Reviews

**Termination: The Closing at Baker Plant.** Alfred Slote. *The Bobbs-Merrill Company, Indianapolis/New York, 1969, 340 pp., \$11.50.*

Although this is not a new book, it is a classic in its field. With some of the inevitability of a Greek tragedy, it traces the human story of 32 men whose reactions to the closing of their long-time place of work was followed as part of a research study. With a novelist's skill, Slote provides an ancillary psychosomatic textbook in describing the impact of the fundamental change of job termination on the lifestyles and especially the health of salaried and hourly workers alike.

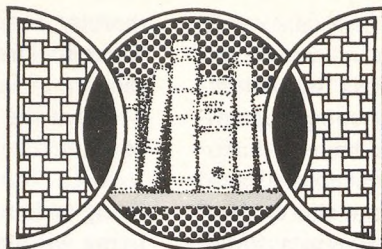
*Termination* is based on a study in community medicine under the auspices of the Institute for Social Research of the University of Michigan. Cobb's research revealed that out of 54 men studied, the Baker closing and its immediate aftermath precipitated "three cases of ulcers, eight cases of arthritis, five cases of hypertension requiring hospitalization, two cases of labile hypertension, six cases of depression severe enough to require medical help, one case of alcoholism, and three industrial accidents suffered by men in new jobs they disliked." In addition there were two cases of alopecia. The difference between success and failure in coping with this difficult change seems to lie in a mixture of luck, job skills,

the kind of wife a man has, his age, his intelligence, and his emotional make-up. In some cases, wives were hit harder than their husbands by the Baker closing. Several of the children were seriously affected, while the "control groups showed no such parallel upsurge in family illnesses and social problems."

Because of the book's readability, it would seem to be useful in helping students and others understand the practical application of the psychosomatic concepts of Holmes and Rahe. Traditionally, lip service is given to the importance of the family and social history in undergraduate courses and in residency programs. Often the reason for this is not well understood by the student or young physician. Through this book the young physician gets a chance to have some intimate, though vicarious, experience with the impact of the exigencies of life on the health of his/her patients. The concept of the usefulness of the "sick role" to replace the discomfort of the "unemployed role" is well brought out in the book. Three case descriptions provide a relatively dispassionate understanding of the psychology of the patient with multiple complaints who seems totally defeated by the disasters of his life.

"Termination" and the study from which it derives could well

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## Regroton®/Demi-Regroton™

### Brief Summary

**Indication:** Hypertension. (See box warning.)

**Contraindications:** Mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.

### Warnings:

These fixed combination drugs are not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

Use with caution in patients with severe renal disease, impaired hepatic function or progressive liver disease. Regroton or Demi-Regroton may potentiate action of other antihypertensive, ganglionic and peripheral adrenergic-blocking drugs. Sensitivity reactions may occur in allergic and asthmatic patients. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Thiazides cross the placental barrier and appear in cord blood. The use of chlorthalidone and related drugs in pregnant women requires that the anticipated benefits of the drug be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Use with care in nursing mothers since thiazides and reserpine cross the placental barrier and appear in cord blood and breast milk. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. If use of the drug is essential, the patient should stop nursing. **Precautions:** Antihypertensive therapy with these drugs should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with these agents two weeks prior to elective surgical procedures. In emergency surgery, use anticholinergic or adrenergic drugs or other supportive measures if needed. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated (hepatic coma may be precipitated). Patients receiving chlorthalidone should have periodic determination of serum electrolytes and should be observed for clinical signs of fluid or electrolyte imbalance (hyponatremia, hypochloremic alkalosis and hypokalemia), particularly if they are receiving digitalis, parenteral fluids, or are vomiting excessively. Hypokalemia may develop with chlorthalidone as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather. Hyperuricemia may occur or gout be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged and latent diabetes mellitus may become manifest. Chlorthalidone and related drugs may decrease arterial responsiveness to norepinephrine. Chlorthalidone and related drugs may decrease serum PBI levels without signs of thyroid disturbance. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** These drugs are generally well tolerated. The most frequent adverse reactions are anorexia, nausea, vomiting, gastric irritation, diarrhea, constipation, headache, dizziness, weakness, muscle cramps, nasal congestion, drowsiness and mental depression. Other potential side effects include skin rash, urticaria, ecchymosis; hyperglycemia and glycosuria (diabetics should be checked regularly), hyperuricemia and acute gout, and impotence. With chlorthalidone: restlessness, transient myopia; dysuria, orthostatic hypotension (may be potentiated by alcohol, barbiturates or narcotics), rare idiosyncratic reactions such as aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, purpura, necrotizing angitis and Lyell's syndrome (toxic epidermal necrolysis); pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged

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serve as an example of much needed research in industrial medicine or community medicine. At the end of the book, there are several recommendations concerning community preventive action which might have decreased the incidence of illness and minimized the economic trauma to the men involved in the closing of Baker plant. *Termination* deserves a place in the annals of medical evolution along with the three classics: *Devils, Drugs, and Doctors; Rats, Lice, and History; and Nine Blue Men.*

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**Toxicologic Emergencies: A Handbook in Problem Solving.** Lewis R. Goldfrank, Robert Kirstein. Appleton-Century-Crofts, New York, 1977, 180 pp., \$9.75 (paper).

*Toxicologic Emergencies* is of interest to physicians in primary and emergency care, medical students, and residents. Practicing physicians will find it an easily read, interesting review of the subject, but its case-history format will make its use as a quick reference difficult. However, it would appear to be an ideal text for medical students and residents during their training in emergency care. There are no illustrations in the text, but several excellent tables complement the text nicely.

The author's discussion, limited to the initial evaluation and treatment of the patient, enhances its usefulness to the Emergency Room physician; however, this limits its usefulness to practicing physicians providing care for the patient after the emergency phase. An addi-

tional limitation is that only two of the 19 cases discussed are pediatric, yet the family physician finds toxicological emergencies a major problem in the pediatric age group.

George Hess, MD  
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**ECG Diagnosis: Self Assessment, Volume II.** Edward K. Chung. Harper and Row, Hagerstown, Maryland, 1972, 444 pp., \$17.95 (paper).

The purpose of this book is to teach electrocardiogram interpretation to physicians, including house staff, family physicians, Emergency Room physicians, internists, cardiology fellows, and cardiologists. Coronary care unit nurses and other emergency personnel would also benefit.

This paperback volume presents 200 electrocardiographic tracings, each with a short case history. On the page following each ECG is a concise, clearly written interpretation of the tracing.

The tracings include the most common electrocardiographic abnormalities that are likely to be encountered in practice, including normal variants, hypertrophy, ischemia, abnormal impulse formation, conduction defects, and arrhythmias.

My sample copy is already becoming dog-eared from use. This promises to become one of the most used books in my library. The conditions are grouped in such a way that the easier interpretations for a given condition, such as hypertrophy, are printed first and the more difficult ones later on in the chapter. A well-arranged cross-index at the end of the book pro-

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## 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 over dosage or individual hypersensitivity, reaction similar to those after meperidine or morphine over dosage 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 overdose; 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 teaspoonsfuls (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 overdose may cause severe, even fatal, respiratory depression. Signs of overdose 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

**AMOXIL®** (amoxicillin)

For complete prescribing information, consult Official Package Insert.

**Indications:** Amoxil® (amoxicillin) is similar to ampicillin in its bactericidal action against susceptible strains of Gram-negative organisms—*H. influenzae*, *E. coli*, *P. mirabilis* and *N. gonorrhoeae*; and Gram-positive organisms—Streptococci (including *Streptococcus faecalis*), *D. pneumoniae* and non-penicillinase-producing staphylococci. Culture and sensitivity studies should be obtained. 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 dark-field examinations before receiving treatment. In all other cases where concomitant syphilis is suspected, monthly serological tests should be performed for a minimum of four months. Assess renal, hepatic and hematopoietic functions intermittently during long-term therapy.

**Adverse reactions:** Untoward reactions include: glossitis, nausea, vomiting and diarrhea, skin rashes, urticaria, exfoliative dermatitis, erythema multiforme and anaphylaxis (usually with parenteral administration). Although anemia, thrombocytopenia, thrombocytopenic purpura, eosinophilia, leukopenia, and agranulocytosis have been noted, they 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—20-40 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, unit-dose cartons of 100.

500 mg in bottles of 50's and 500's, unit-dose cartons of 100.

**for Oral Suspension—**

125 mg/5 ml and 250 mg/5 ml in 80 ml, 100 ml and 150 ml bottles.

**Pediatric Drops for Oral Suspension—**

50 mg/ml in 15 ml bottles with calibrated dropper.

**Beecham**  
laboratories  
Bristol, Tennessee 37620

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vides easy access to all the conditions.

This is a beautiful book for teaching advanced ECG interpretation to people who have a solid grasp of the fundamentals of electrocardiographic interpretation. The book assumes that the reader understands the basic principles and goes on from there. The tracings are clear and can be duplicated easily for the purpose of presenting "unknowns" to learners. Then after the learners commit themselves, the explanations can be provided. In this manner the book can also be used for self-assessment of interpretive skills, and can become a significant factor in continuing medical education.

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**Color Atlas of Physical Signs in General Medicine.** M. Zatouff. Yearbook Medical Publishers, Chicago, 1977, 464 pp., \$47.95.

This hardbound volume consists of 812 color photographs in 464 pages. Each photograph is accompanied by a brief description of the condition presented. The book is intended to be used by undergraduate medical students to learn the appearance of various clinical entities and to increase the skill of careful observation. It is also anticipated that it will be of help to practicing physicians by describing manifestations of unusual diseases.

The author is a physician in Kuwait and an honorary clinical assistant at the Royal Northern Hospital in London. Consequently, there are a number of photographs

of conditions which are rarely, if ever, seen in the United States such as leprosy, kwashiorkor, and active lupus vulgaris (tuberculosis of the skin). Indeed the average American family physician will find a great deal in this book which will never be encountered in clinical practice. Nevertheless, the photographs are of excellent quality and the clinical descriptions are brief and concise.

A book of this size which attempts to provide broad clinical coverage is bound to leave large gaps. Consequently, one will search in vain for a photograph of an inflamed tympanic membrane, or of cervicitis, or of cervical polyps. In addition, the book devotes ten pages to photographs of patients with acromegaly but only two pages to patients with Parkinson disease. Several pages in the section on abdominal problems are devoted to descriptions of how to examine the abdomen. Although that section is well done, it might more properly belong in a textbook on physical examination. For the teachers of family medicine or for the family physician in the United States, this book is likely to have limited usefulness.

It does provide beautifully clear photographs which a physician preparing for board examinations might use to increase powers of observation and it certainly provides photographs of a wide variety of conditions. As such it might be useful for a physician planning to practice in Africa. The practicing physician or the resident or teacher here is not likely to be able to use it either as a reference or in a systematic way for teaching.

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