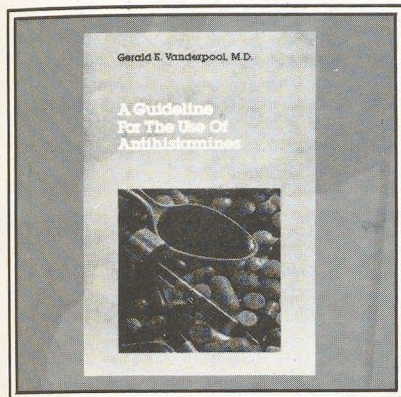


A Special Service From Ross Laboratories

Ross Laboratories is pleased to make available the booklet, *A Guideline for the Use of Antihistamines*, by Gerald E. Vanderpool, MD. This is an excellent guide to antihistamines and their clinical application. Requests for free copies should be sent to Ross Laboratories, PO Box 1317, Columbus, OH 43216.



RONDEC Tablet

(carbinoxamine maleate, 4 mg; pseudoephedrine HCl, 60 mg per tablet) \mathcal{R}

BRIEF SUMMARY:

ADVERSE REACTIONS: Those patients sensitive to pseudoephedrine may note mild central nervous system stimulation. Sedation has been observed with the use of carbinoxamine maleate. Patients particularly sensitive to antihistamines may experience moderate to severe drowsiness.

PRECAUTIONS: Use pseudoephedrine with caution in patients with hypertension. Because of carbinoxamine maleate, patients should be cautioned to exercise care in driving or operating machinery until the possibility of drowsiness is determined. If sensitivity reaction or idiosyncrasy should occur, withdraw the drug. Safety in pregnancy has not been determined. **RONDEC Tablet** should be used in pregnant women only when the benefits outweigh the risks.

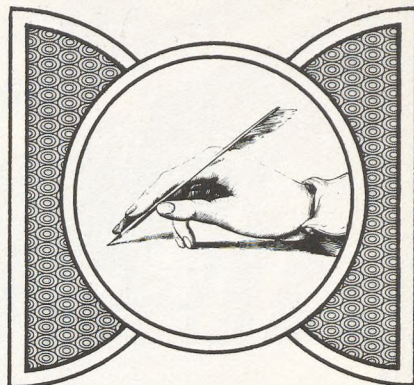
CONTRAINDICATIONS: There are no known contraindications for the use of **RONDEC Tablet**.

INDICATIONS: **RONDEC Tablet** is indicated for seasonal and perennial allergic rhinitis and vasomotor rhinitis.

For full prescribing information, see package insert.

ROSS LABORATORIES
COLUMBUS, OHIO 43216
Division of Abbott Laboratories, USA

Letters to the Editor



Screening for Depression

To the Editor:

As one interested in the theory and justification for screening tests, I read with particular care the article "Recognition of Depression by Family Medicine Residents: The Impact of Screening" (*Moore JT, Silimperi DR, Bobula JA: J Fam Pract 7:509, 1978*). Although the authors show that notifying residents of possible depression increases the "diagnosis" of depression, several important questions remain.

Despite Zung's own data on sensitivity and specificity of the screening instrument, the fact that in *this* study 96 of 212 patients were identified by the depression inventory as mildly to moderately depressed raises serious questions about either the instrument or the representativeness of the population studied. Surely a prevalence of depression of over 45 percent exceeds estimates available for the primary care setting. The most likely explanation for this extraordinary rate of depression is that the instrument identified many as depressed who, on more rigorous examination, may not have been. The fact that residents notified of test results tended to agree perhaps says more about the suggestibility of residents than about the prevalence of depression.

The issue of the Zung instrument as a valid screening device is inadequately addressed in the article. What of the costs incurred by the false positive results—not only in terms of additional diagnostic tests, but the personal costs in patient anxiety about being incorrectly labeled depressed, and perhaps unnecessary drugs, counseling, and office visits? What about the depressed patients that the instrument misses? How does the Zung instrument compare to other diagnostic systems—is it the most cost effective?

I must disagree with the statement that screening for depression differs in some qualitative way from screening for other conditions. Labeling a person depressed or not depressed is difficult using any criteria, and the evaluation of a diagnostic tool as a screening test then becomes all the more critical. The criteria for depression were developed and, indeed, almost all well-designed studies of the effectiveness of treatment for depression have been done on groups of patients with advanced symptoms and fairly clear findings. Identification of earlier forms of depression is of unknown significance, particularly with respect to the effectiveness of treatment—two

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

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation; increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chloridiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chloridiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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areas rather glibly taken for granted by the authors. Unfortunately, the logic followed by the authors in recommending the Zung test as a screening device is precisely that used to justify discredited screening tests such as the routine chest x-ray and multichannel blood tests: "We're just trying to stimulate physician recognition of treatable problems." A great deal more information regarding the specificity, sensitivity, costs, benefits, and outcomes is necessary before the Zung test can be routinely recommended.

Alfred O. Berg, MD

Department of Family Practice
University of Washington
Seattle

The preceding letter was referred to Drs. Moore and Bobula who respond as follows:

Dr. Berg raises several questions in his letter which we will attempt to address. Approximately 45 percent of our study's patients scored in the depressed range on the screening test. This led Dr. Berg to wonder, first, about the representativeness of the patient sample and, secondly, about the validity of the screening instrument. The issue in this study was not to systematically determine the prevalence of depression in the general population, but rather to assess the extent to which depressive symptoms were recognized by physicians in one practice setting. Thus, the representativeness question is academic; however, it is of interest to note that estimates of the prevalence of psychiatric morbidity in general medical practices vary widely, eg, a recent study identified 83 percent of one clinic's patients

as having psychiatric morbidity.¹ Dr. Berg did not cite the studies supporting his feeling that 45 percent is a high prevalence finding.

While the question about the screening test seems more pertinent, Dr. Berg does not suggest any specific reasons to impugn the validity of the SDS other than the number of persons it identified as having depressive symptoms. In addition to the validation studies referenced in the manuscript, a recent study is pertinent. Raft and colleagues² screened 69 patients in a medical outpatient clinic with the SDS. Each patient also received a psychiatric interview. In this setting, 30 percent of patients had SDS index scores greater than 60 while 42 percent were considered depressed by the interviewer. The authors concluded that the weakness of the SDS as a screening test was the high number of false negatives, not of false positives as Dr. Berg suggests. (The number of false negatives may have decreased had the authors used an SDS index of 50 rather than 60 as an indicator of depression.) We continue in our opinion that validation studies of the SDS, coupled with its low cost and simplicity, support its usefulness as a screen for depression.

Dr. Berg states the fact that screening enhanced recognition of depression says perhaps more about the suggestibility of physicians than the prevalence of depression. Once again, prevalence was not the central issue. With regard to "suggestibility," we found that without knowledge of SDS results residents identified 22 percent of their patients with depressive symptoms (SDS ≥ 50). With knowledge, identification rose to 56 percent. We construed this finding as

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Fastin® 30 mg. (IV) (phentermine HCl)

LETTERS TO THE EDITOR

Before prescribing FASTIN® (phentermine HCl), please consult Complete Product Information, a summary of which follows:

INDICATION: FASTIN is indicated in the management of exogenous obesity as a short-term (a few weeks) adjunct in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate-to-severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma, Agitated states.

Patients with a history of drug abuse.
During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued.

FASTIN may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: FASTIN is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of FASTIN should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia.

Usage in Pregnancy: Safe use in pregnancy has not been established. Use of FASTIN by women who are or who may become pregnant, and those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and infant.

Usage in Children: FASTIN is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing FASTIN for patients with even mild hypertension.

Insulin requirements in diabetes mellitus may be altered in association with the use of FASTIN and the concomitant dietary regimen.

FASTIN may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure. *Central Nervous System:* Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria. *Endocrine:* Impotence, changes in libido.

DOSAGE AND ADMINISTRATION: *Exogenous Obesity:* One capsule at approximately 2 hours after breakfast for appetite control. Late evening medication should be avoided because of the possibility of resulting insomnia.

Administration of one capsule (30 mg.) daily has been found to be adequate in depression of the appetite for twelve to fourteen hours. FASTIN is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage with phentermine include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension, and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

Management of acute phentermine intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard. Acidification of the urine increases phentermine excretion. Intravenous phentolamine (REGITINE) has been suggested for possible acute, severe hypertension, if this complicates phentermine overdosage.

CAUTION: Federal law prohibits dispensing without prescription.

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residents' enhanced recognition of depression associated with screening. Had the recognition rate risen to 90+ percent, we too might have suspected "suggestibility"; we do not consider it the best explanation for the actual findings.

Dr. Berg disagrees with our statement that screening for depression should be thought of differently than screening for physical disease. We still contend that screening for depression differs from screening for most physical disease in that a physical screen probes for asymptomatic disease whereas the depression screen aims at identifying patients with manifest symptoms being overlooked by their physicians. We agree that proper diagnosis of depression is difficult and did not mean to imply that the SDS be used alone to make the diagnosis. But we do propose it as a reasonably valid measure of depression.

More widespread use of such measures could help prevent the documented underdiagnosis of psychiatric problems. This logic of stimulating recognition as a basis for intervention, apparently held in some disrepute by Dr. Berg, is central to all screening whether or not a particular screening method stands the test of time and continued scrutiny. We agree that questions remain about screening for psychiatric disorders—often a problem of detecting unrecognized rather than asymptomatic disease—and we hope to see more research efforts directed toward this area.

James T. Moore, MD

James A. Bobula, PhD

Duke-Watts Family Medicine

Program

Duke University Medical Center

Durham, North Carolina

References

1. Glass RM, Allan AT, Uhlenhuth EH, et al: Psychiatric screening in a medical clinic: An evaluation of a self-report interview. *Arch Gen Psychiatry* 35:1189, 1978

2. Raft D, Spencer RD, Tommey T, et al: Depression in medical outpatients. Use of the Zung scale. *Dis Nerv Syst* 38:99, 1977

To the Editor:

The recent article in *The Journal* highlighting the use of the Self-Rating Depression Scale developed by Zung (Moore JT, Silimperi DR, Bobula JA: *Recognition of depression by family medicine residents: The impact of screening. J Fam Pract* 7:509, 1978) was both enjoyable and stimulating. I would like to share with your readers some additional thoughts regarding the SDS as it is used in our family practice.

The SDS was introduced to me during my residency training and I think played a role in developing a sensitivity for affective states. Once the suspicion of possible depression is raised, the SDS is used to document and quantify the presence of depression. This can be used to help demonstrate to the patient that the physician's initial impression regarding the presence of depression was correct and can act as both a guideline for treatments (depending on the severity of depression) and a baseline for comparison in follow-up. In addition, certain target symptoms can be identified which are helpful when choosing medication if that is necessary.

The article also highlighted two reservations I have regarding the use of the SDS. The authors state that "failure to recognize depression among general medical patients may well subject patients

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to unnecessary, costly, and occasionally dangerous diagnostic procedures in an effort to identify a physical explanation for symptoms." Residents should be reminded that making the diagnosis of depression does not necessarily rule out organic disease. Experience may be the best guide in knowing when to proceed with tests. A second problem we have encountered is third-party reimbursement for conducting an SDS. In our area, psychologists charge an average of \$10.00 for administering and scoring this test. Some third-party payers do not recognize a family physician's ability to administer this test and some will not pay for this type of test regardless of how it is administered or used. In spite of these drawbacks, we continue to find the SDS useful in clinical practice and hope that as a result of this recent paper more family physicians might become aware of this simple diagnostic tool.

Henry R. Ivey, MD
Vinton, Virginia

Costs of Information System

To the Editor:

I read with great interest "A Family Medicine Information Service: The Beginning of a Network for Practicing and Resident Family Physicians." (Green LA, Simmons RL, Reed FM, et al: *J Fam Pract* 7:567, 1978). I have questions relating to the cost of their computer system.

What is the cost of the programing and is programing available to other family practice programs?

The authors quote monthly costs, cost per patient encounter, and cost per registered family per month. The costs stated in the text

do not coincide with the costs illustrated in Table 1. In the 35-patient per day practice, the costs illustrated in the table are higher than the intown practice by 51 percent and 53 percent; in the rural practice, the costs are higher by 78 percent and 81 percent. Likewise, the 70-patient per day practice costs again are higher in the table than in the text by 14 percent and 19 percent in the intown practice, and 33 percent and 34 percent in the rural practice.

I feel that to be fair to readers who are not aware of computer costs, the costs of programing should be stated. These costs could be amortized over a three to five-year period. For instance, if the cost of software is \$25,000, you could amortize these costs over three years. In an 18,000 patient visit-per-year practice, which equals to 54,000 over three years, the additional cost per encounter is 46 cents. In your 9,240 patient per year practice, or 27,720 patients per three years, the additional cost per encounter is 90 cents.

Often, we in academic medicine and people selling computer services fail to take into account the total costs in their encounter, and if we are going to have credibility with the practicing physician and the resident in training, he/she must know the full story of costs.

Merrill A. Anderson, MD
Associate Professor of Family Practice
University of South Carolina
School of Medicine
Columbia

The preceding letter was referred to Drs. Green and Simmons who respond as follows:

Thank you for forwarding Dr. Merrill Anderson's letter concern-

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MYCELEX[®]
1% Cream
1% Solution (CLOTRIMAZOLE)



Indications: Mycelex Cream and Solution are indicated for the topical treatment of the following dermal infections: tinea pedis, tinea cruris, and tinea corporis due to *Trichophyton rubrum*, *Trichophyton mentagrophytes*, *Epidermophyton floccosum*, and *Microsporum canis*; candidiasis due to *Candida albicans*; and tinea versicolor due to *Malassezia furfur*.

Contraindications: Mycelex Cream and Solution are contraindicated in individuals who have shown hypersensitivity to any of their components.

Warnings: Mycelex Cream and Solution are not for ophthalmic use.

Precautions: In the first trimester of pregnancy, Mycelex should be used only when considered essential to the welfare of the patient.

If irritation or sensitivity develops with the use of Mycelex, treatment should be discontinued and appropriate therapy instituted.

Adverse Reactions: The following adverse reactions have been reported in connection with the use of this product: erythema, stinging, blistering, peeling, edema, pruritus, urticaria, and general irritation of the skin.

Dosage and Administration: Gently massage sufficient Mycelex Cream or Solution into the affected and surrounding skin areas twice a day, in the morning and evening.

Clinical improvement, with relief of pruritus, usually occurs within the first week of treatment. If a patient shows no clinical improvement after four weeks of treatment with Mycelex, the diagnosis should be reviewed.

How Supplied: Mycelex Cream 1% is supplied in 15 g and 30 g tubes.

Mycelex Solution 1% is supplied in 10 ml and 30 ml plastic bottles.

Store between 35° and 86°F.

Manufactured for Dome Division, Miles Laboratories, Inc., by Schering Corp., Kenilworth, NJ 07033.

Dome Division
MILES

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ing our article "Family Medicine Information System" in the September issue of *The Journal of Family Practice* (Green LA, Simmons RL, Reed RM, et al: *J Fam Pract* 7:567, 1978). The following is our response.

We appreciate Dr. Anderson's comments and share his concern about costs.

The apparent discrepancies between costs mentioned in the text and costs listed in the table rises from the fact that the costs in the text refer to using FMIS in batch-mode, whereas costs in Table 1 refer to cost using FMIS on-line. Although this is stated in the text, it is certainly not emphasized and we are pleased to have the opportunity to clarify the apparent discrepancy.

Dr. Anderson's second question refers to the cost of programing this system and it implies that we have failed to account for the cost in describing the cost per encounter. The development of the FMIS was supported through sources contributed by the M/POP consortium and the federal government, both of which are nonprofit and non-commercial organizations. Unlike the commercial environment, the FMIS development costs are not amortized since they do not represent an investment to be returned to stockholders. Thus, these costs do not have to be recovered in the charges for system operation. This is the reason we believe operational and developmental costs should be kept entirely separate. We do not object to revealing developmental costs of the FMIS, but our intention in the article was to indicate what the users of FMIS are paying to operate the system in the fashion in which it is described.

As we indicated, a basic premise

of FMIS is that it must be affordable to its users. We continue to be committed to the development of a system that will carry its own weight without continued subsidy from any source.

The other issue discussed in Dr. Anderson's letter relates the availability of the FMIS to other family practice programs. So far, FMIS has not been exported outside of Colorado, but we are not averse to sharing the system with other physicians or programs. We would be please to entertain requests or proposals.

Larry A. Green, MD

Assistant Professor

Department of Family Medicine
University of Colorado

Denver

Roger Simmons, Director

Program Development

Community Electrocardiographic

Interpretive Service

Denver, Colorado

Clinical Teaching Conferences To the Editor:

Dr. Massad's refinement of the clinical conference as a residency training tool is to be emulated (*Massad SC: The clinical conference in family practice training. J Fam Pract* 7:589, 1978). Faced with increasing somnolence and apathy to the classical conference format, we, too, have moved to "problem solving" consultation rounds. We have amplified on this somewhat as follows.

A monthly publication containing summaries of the cases discussed is circulated by the resident in charge. Reprints of pertinent references are included as well as

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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 overdose or individual hypersensitivity, reactions similar to those after meperidine or morphine overdose 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.

Use 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 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 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 1/2 ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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BACTRIM™



(trimethoprim and sulfamethoxazole)

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

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morgani*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections. For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age. For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized 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:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
22	10	1 teasp. (5 ml)	½ tablet
44	20	2 teasp. (10 ml)	1 tablet
66	30	3 teasp. (15 ml)	1½ tablets
88	40	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

PNEUMOCYSTIS CARINII PNEUMONITIS: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20, Tablets each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Pediatric Suspension*, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, cherry flavored—bottles of 16 oz (1 pint). *Suspension*, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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the monthly census of our Family Practice Inpatient Service.

As we are a university based "academic" program which employs the two-team paired internship concept, only half of the resident group is present for each conference. The publication of these conferences allows residents away, on vacation, or engaged in emergency care to profit from these discussions.

Sharing with the entire health care team is facilitated as residents gain a sense of problem illnesses in patients seen daily at the front desk, nursing station, or in the laboratory. They, and residents not in the hospital, become aware of which patients of the group required hospitalization and why.

Clinical faculty, who attend one half-day per week, three to six months per year, are given a sense of continuity with the model unit's patient population. Furthermore, the discussion summaries and reprints provide pertinent continuing medical education.

Finally, the universal paucity of qualified full-time faculty serendipitously has allowed UCLA to address the issues raised by Drs. Smith and Wilkins (*Smith CW, Wilkins EB: On training residents for careers in academic family medicine. J Fam Pract 7:605, 1978*). Residents, in coordinating these conferences, gain practical teaching and writing experience, which it is hoped will lead to earlier recognition of those with the enthusiasm and dedication necessary for full-time teaching of family medicine.

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