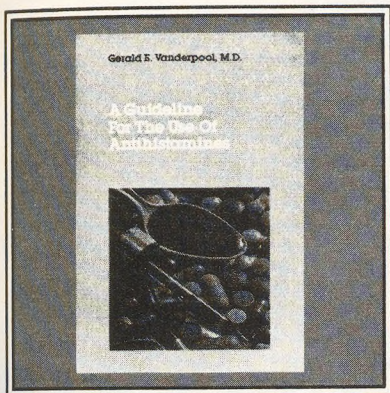


A Special Service From Ross Laboratories

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) 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.

USUAL DOSAGE OF RONDEC Tablet

age	dose	frequency
adults and children 6 years and older	1 tablet	4 times a day

For full prescribing information, see package insert.

ROSS LABORATORIES
COLUMBUS, OHIO 43216
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B159-9750

Letters to the Editor

The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.



Evaluation of Family Care

To the Editor:

Dr. Stamps proposes a Family Utilization Index as a tool for evaluating the provision of family oriented health care in a family practice (*Toward the evaluation of family practice: Development of a family utilization index. J Fam Pract 7:767, 1978*). I question the validity of testing the Index on a population of patients that is predominantly composed of lower class urban blacks. A recent anthropological study indicates that black families undergo profound structural and functional changes as a means of adapting to and coping with exigencies of poverty.¹ A major component of the adaptation entails a diffusion of responsibility and tasks among an extensive kinship network with a concomitant reduction in the importance and efficacy of the nuclear family. The various categories listed in Table 1 of the article that contribute to the second component of the Index seem to be strongly oriented toward a model of a nuclear family composed of parents and children. How appropriate is such a conceptual model for the assessment of family units characterized by a high

incidence of female heads and extensive kinship systems? Dr. Stamps does not address the crucial question of what constitutes a family among this population. If, in this study, the family is synonymous with the household then the Index contains no provision for the health seeking behavior of grandparents, aunts, uncles, cousins, and other potential household members.

Dr. Stamps reports the results of two cross-sectional studies of users of a family practice unit which are separated by a five-year interval. Comparison of the Family Utilization Indices computed for the two distinct samples suggests that the utilization behavior of families in the second sample is more concordant with the principles of family practice than that of the first sample. Dr. Stamps correctly points out that no antecedent-consequent association can be inferred from these findings since this was not a cohort study. However, this qualification is somewhat obscured by the statement in another part of the article that the study was "in-

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Fastin® 30 mg. (phentermine HCl)

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.

DOSE 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 phenolamine (REGITINE) has been suggested for possible acute, severe hypertension, if this complicates phentermine overdosage.

CAUTION: Federal law prohibits dispensing without prescription.

LETTERS TO THE EDITOR

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tended to identify whether patients were utilizing a family practice in a manner consistent with the theoretical framework noted by the model and then to note changes over time as the patients were exposed to the model." This statement implies a longitudinal design which, in fact, does not exist in this study. I disagree with the author's conclusion that differences in the demographic profiles of the two samples could not account for differences in the observed family utilization of health care services. As noted by the author, the 1975 sample contains a significantly higher proportion of families headed by a single adult female. The corollary to this is that the 1975 sample contained fewer families with both male and female heads. There is considerable evidence that adult males (particularly blacks) have lower rates of medical care utilization than adult females and children: thus the decreased number of adult males in the families sampled in 1975 has direct implications for the patterns of family utilization reflected by the Index. A family composed of both female and male heads and children in which the female head and all the children had been to the clinic would qualify for Category G and be assigned a weight of 60 percent. Deletion of the male head from the family with the same pattern of utilization by other family members would transfer the family to Category B with a weight of 100 percent. The demographic differences between the two samples as noted by the author indicate that a significant number of male heads were lost from family units during the five-year period. In summary, given the known utilization behav-

ior of adult males as compared to females and children, the selective loss of adult males from the families would, in and of itself, result in higher family utilization indices.

The apparent differences in the utilization of family practice services between the two samples may also be explained by variables completely independent of the family practice clinic itself. For example, changes in the availability of alternative sources of health care could account for differences in patterns of utilization. According to the article there was no change in the proportion of users who reported concurrent utilization of other health care resources. However, in 1970 a primary care physician was the most common alternative source of health care, while in 1975 an immunization clinic was the most common alternative resource. Does this change reflect a decrease in the availability of other primary care physicians in the area? A reduction in financial barriers to health services could also account for the change in utilization behavior between the two samples. Did a higher proportion of the 1975 families have Medicaid as compared to the 1970 families?

This study raises some interesting research issues: however, the major question of whether or not contact with a family practice over a period of time occasions changes in patient attitudes and behavior in the direction of the conceptual framework of family medicine remains to be answered. In addition, as an instrument of evaluation, the Family Utilization Index remains to be tested on a population of families that is structurally concord-

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ant with the nuclear family model presumed by the Index.

Robert L. Blake, Jr, MD
Assistant Professor
Department of Family and
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University of Missouri-Columbia
Columbia

Reference

1. Stack CB: All Our Kin: Strategies for Survival in a Black Community. New York, Harper and Row, 1974

The preceding letter was forwarded to Dr. Stamps who responds as follows:

Dr. Blake raises several interesting issues in his letter in response to my article on developing evaluation strategies for family practice (*Stamps PL: Toward the evaluation of family practice: Development of a family utilization index. J Fam Pract 7:767, 1978*). His major argument concerns the relevance of the proposed Family Utilization Index to a non-nuclear family structure. Table 1 and the discussion of the four components of the Index (pp 769-770) were intended to demonstrate that every effort was made to determine the composition and relevance of the extended family of every respondent. Perhaps it is the use of the term "head of household" that is inappropriate, as this usually connotes a father or a mother. Indeed, as discussed within the description of the first component, a great deal of time and effort was spent de-

termining the relevant denominator. This denominator, of course, is the extended family. "Head of household" is intended to refer to whatever responsible adult lives in the household, regardless of identity, sex, or kinship. Category K (Table 1), which may contribute to a misunderstanding of terminology, was meant to imply those visits for only obstetrical reasons. The term "mother" is probably too narrow for this usage.

The arguments relevant to the impact of the change in marital status on the utilization patterns are well taken. Those persons who were left as single member households were excluded precisely to prevent this type of bias. It may be that those female-headed households may have been unfairly placed into category B (100 percent weighting) rather than into category G (60 percent weighting). This may be magnified by the relatively low utilization patterns of males, as noted by Dr. Blake. However, it is also true that there were more total visits to the clinic due to an overall increase in the number of family members per family unit using the clinic.

It is true that there are several limitations to this study. One is certainly the overall inability to control important environmental and external factors, including Medicaid support. These limitations are due to the inability to conduct a prospective study. However, these limitations of methodology as well as the limitations of the Index itself, are clearly pointed out in several places in the article.

In summary, I do not believe that the conclusions of this study are overstated: at no time is a

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For UTI in their sexually active years... Macrochantin® (nitrofurantoin macrocrystals)

Capsules: 25 mg, 50 mg, 100 mg

INDICATIONS: Macrochantin is indicated for the treatment of urinary tract infections when due to susceptible strains of *Escherichia coli*, enterococci, *Staphylococcus aureus* (it is not indicated for the treatment of associated renal cortical or perinephric abscesses), and certain susceptible strains of *Klebsiella* species, *Enterobacter* species, and *Proteus* species.

NOTE: Specimens for culture and susceptibility testing should be obtained prior to and during drug administration.

CONTRAINDICATIONS: Anuria, oliguria, or significant impairment of renal function (creatinine clearance under 40 ml per minute) are contraindications to therapy with this drug. Treatment of this type of patient carries an increased risk of toxicity because of impaired excretion of the drug. For the same reason, this drug is much less effective under these circumstances.

The drug is contraindicated in pregnant patients at term as well as in infants under one month of age because of the possibility of hemolytic anemia due to immature enzyme systems (glutathione instability).

The drug is also contraindicated in those patients with known hypersensitivity to Macrochantin, Furadantin® (nitrofurantoin), and other nitrofurantoin preparations.

WARNINGS: Acute, subacute and chronic pulmonary reactions have been observed in patients treated with nitrofurantoin products. If these reactions occur, the drug should be withdrawn and appropriate measures should be taken.

An insidious onset of pulmonary reactions (diffuse interstitial pneumonitis or pulmonary fibrosis, or both) in patients on long-term therapy warrants close monitoring of these patients.

There have been isolated reports giving pulmonary reactions as a contributing cause of death. (See Hypersensitivity reactions.)

Cases of hemolytic anemia of the primaquine sensitivity type have been induced by Macrochantin. The hemolysis appears to be linked to a glucose-6-phosphate dehydrogenase deficiency in the red blood cells of the affected patients. This deficiency is found in 10 percent of Negroes and a small percentage of ethnic groups of Mediterranean and Near-Eastern origin. Any sign of hemolysis is an indication to discontinue the drug. Hemolysis ceases when the drug is withdrawn.

Pseudomonas is the organism most commonly implicated in superinfections in patients treated with Macrochantin.

PRECAUTIONS: Peripheral neuropathy may occur with Macrochantin therapy; this may become severe or irreversible. Fatalities have been reported. Predisposing conditions such as renal impairment (creatinine clearance under 40 ml per minute), anemia, diabetes, electrolyte imbalance, vitamin B deficiency, and debilitating disease may enhance such occurrence.

Usage in Pregnancy: The safety of Macrochantin during pregnancy and lactation has not been established. Use of this drug in women of childbearing potential requires that the anticipated benefit be weighed against the possible risks.

ADVERSE REACTIONS: Gastrointestinal reactions: Anorexia, nausea, and emesis are the most frequent reactions; abdominal pain and diarrhea occur less frequently. These dose-related toxicity reactions can be minimized by reduction of dosage, especially in the female patient. Hepatitis occurs rarely.

Hypersensitivity reactions: Pulmonary sensitivity reactions may occur, which can be acute, subacute, or chronic.

Acute reactions are commonly manifested by fever, chills, cough, chest pain, dyspnea, pulmonary infiltration with consolidation or pleural effusion on x-ray, and eosinophilia. The acute reactions usually occur within the first week of treatment and are reversible with cessation of therapy. Resolution may be dramatic.

In subacute reactions, fever and eosinophilia are observed less often. Recovery is somewhat slower, perhaps as long as several months. If the symptoms are not recognized as being drug related and nitrofurantoin is not withdrawn, symptoms may become more severe.

Chronic pulmonary reactions are more likely to occur in patients who have been on continuous nitrofurantoin therapy for six months or longer. The insidious onset of malaise, dyspnea on exertion, cough, and altered pulmonary function are common manifestations. Roentgenographic and histologic findings of diffuse interstitial pneumonitis or fibrosis, or both, are also common manifestations. Fever is rarely prominent.

The severity of these chronic pulmonary reactions and the degree of their resolution appear to be related to the duration of therapy after the first clinical signs appear. Pulmonary function may be permanently impaired even after cessation of nitrofurantoin therapy. This risk is greater when pulmonary reactions are not recognized early.

Dermatologic reactions: Maculopapular, erythematous, or eczematous eruptions; pruritus; urticaria, and angioedema.

Other sensitivity reactions: Anaphylaxis, asthmatic attack in patients with history of asthma, cholestatic jaundice, drug fever, and arthralgia.

Hematologic reactions: Hemolytic anemia, granulocytopenia, leukopenia, eosinophilia, and megaloblastic anemia. Return of the blood picture to normal has followed cessation of therapy.

Neurological reactions: Peripheral neuropathy, headache, dizziness, nystagmus, and drowsiness.

Miscellaneous reactions: Transient alopecia. As with other antimicrobial agents, superinfections by resistant organisms may occur. With Macrochantin, however, these are limited to the genitourinary tract because suppression of normal bacterial flora elsewhere in the body does not occur.

References: 1. Center for Disease Control: *National Nosocomial Infections Study Report*. Annual Summary 1976, issued February 1978. Washington, DC, U.S. Department of Health, Education, and Welfare, p 8. 2. Cooper J, et al: Diagnostic and chemoprophylactic importance of perineal microbial carriage, in Siegenthaler W, Luthy R (eds): *Current Chemotherapy*. Washington, DC, American Society for Microbiology, 1978, vol 1, pp 189-200. 3. Buckley RM, McGuckin M, MacGregor RR: Urine bacterial counts after sexual intercourse. *N Engl J Med* 298:321-324, 1978. 4. PMR Bacteriologic Report, Summer Series, 1978; a national bacteriologic monitoring service for 200 acute-care hospitals of 100 beds or more.

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Address medical inquiries to:
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Norwich, New York 13815

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causal relationship implied, nor is the utilization of the Index in its present form suggested. Rather, it is the purpose of this article to suggest that we begin the long and tedious process toward developing adequate measurement instruments that can be utilized to evaluate the impact of the model of family practice.

Paula L. Stamps, PhD
Associate Professor
Health Services Administration
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Amherst

Follow-up Studies in Thyroiditis

To the Editor:

The *Journal of Family Practice* Grand Rounds discussion of thyroiditis, in December 1978 (Wherry RA, Purdy DD, Eilers GA: *Thyroiditis: A case presentation and discussion. J Fam Pract* 7:1221, 1978), suggests that the I^{131} uptake is the test by which to follow the course of thyroiditis. It suggests that treatment continue until the I^{131} uptake returns to normal. Given the increasing concern of the long-term effects of thyroid irradiation, a more appropriate test may be the I^{123} uptake since I^{123} follows the normal iodine metabolic pathway and offers less radiation exposure. Comparison of the estimated dose of irradiation to the adult thyroid for I^{123} scans versus I^{131} scans is 2.8 rads vs 100 to 200 rads, respectively.¹ The I^{131} radiation dose exceeds the I^{123} dose by 33 to 66 times. If the radiation exposure difference of uptakes is similar to

that of scans, then the I^{123} uptake is the preferred test as it does less harm.¹

Timothy G. Reekie, MD
The Family Practice Program of
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Philadelphia, Pennsylvania

Reference

1. Irradiation-Related Thyroid Cancer. In Division of Cancer Control and Rehabilitation, National Cancer Institute (Bethesda, Md): DHEW publication No. (NIH) 77-1120. Government Printing Office, 1977, p 20

The Family in Family Medicine

To the Editor:

In response to a recent Journal article by Authier and Land (*Family: The unique component of family medicine. J Fam Pract* 7:1066, 1978) criticizing the paucity of emphasis on the "family" in family practice residency training, we would like to make a few observations. Looking at the lack of appropriate family orientation by residency staff or the impracticality of a family therapist viewpoint is placing the blame one step beyond the real problem which is the definition of family medicine. Until we know what family medicine is, what it means to treat a family as well as an individual, neither physicians with episodic training backgrounds nor family therapists will be able to teach it.

Efforts to define family medicine to this point have mainly emphasized what family physicians already do.^{1,2} (Certainly what is de-

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Sanorex® (mazindol) ©

Indication: In exogenous obesity, as a short-term (a few weeks) adjunct in a weight-reduction regimen based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors.

Contraindications: Glaucoma; hypersensitivity or idiosyncrasy to the drug; agitated states; history of drug abuse; during, or within 14 days following, administration of monoamine oxidase inhibitors (hypertensive crisis may result).

Warnings: Tolerance to many anorectic drugs may develop within a few weeks; if this occurs, do not exceed recommended dose, but discontinue drug. May impair ability to engage in potentially hazardous activities, such as operating machinery or driving a motor vehicle, and patient should be cautioned accordingly.

Drug Interactions: May decrease the hypotensive effect of guanethidine; patients should be monitored accordingly. May markedly potentiate pressor effect of exogenous catecholamines; if a patient recently taking mazindol must be given a pressor amine agent (e.g., levarterenol or isoproterenol) for shock (e.g., from a myocardial infarction), extreme care should be taken in monitoring blood pressure at frequent intervals and initiating pressor therapy with a low initial dose and careful titration.

Drug Dependence: Mazindol shares important pharmacologic properties with amphetamines and related stimulant drugs that have been extensively abused and can produce tolerance and severe psychologic dependence. Manifestations of chronic overdosage or withdrawal with mazindol have not been determined in humans. Abstinence effects have been observed in dogs after abrupt cessation for prolonged periods. There was some self-administration of the drug in monkeys. EEG studies and "liking" scores in human subjects yielded equivocal results. While the abuse potential of mazindol has not been further defined, possibility of dependence should be kept in mind when evaluating the desirability of including the drug in a weight-reduction program.

Usage in Pregnancy: An increase in neonatal mortality and a possible increased incidence of rib anomalies in rats were observed at relatively high doses.

Although these studies have not indicated important adverse effects, the use of mazindol in pregnancy or in women who may become pregnant requires that potential benefit be weighed against possible hazard to mother and infant.

Usage in Children: Not recommended for use in children under 12 years of age.

Precautions: Insulin requirements in diabetes mellitus may be altered. Smallest amount of mazindol feasible should be prescribed or dispensed at one time to minimize possibility of overdosage. Use cautiously in hypertension, with monitoring of blood pressure; not recommended in severe hypertension or in symptomatic cardiovascular disease including arrhythmias.

Adverse Reactions: Most commonly, dry mouth, tachycardia, constipation, nervousness, and insomnia. **Cardiovascular:** Palpitation, tachycardia. **Central Nervous System:** Overstimulation, restlessness, dizziness, insomnia, dysphoria, tremor, headache, depression, drowsiness, weakness. **Gastrointestinal:** Dryness of mouth, unpleasant taste, diarrhea, constipation, nausea, other gastrointestinal disturbances. **Skin:** Rash, excessive sweating, clamminess. **Endocrine:** Impotence, changes in libido have rarely been observed. **Eye:** Long-term treatment with high doses in dogs resulted in some corneal opacities, reversible on cessation of medication; no such effect has been observed in humans.

Dosage and Administration: Usual dosage is 1 mg, three times daily, one hour before meals, or 2 mg, once daily, one hour before lunch. Use lowest effective dose, which can be determined by starting therapy at 1 mg, once a day and adjusting to the need and response of the patient. Should GI discomfort occur, mazindol may be taken with meals.

Overdosage: There are no data as yet on acute overdosage with mazindol in humans. Manifestations of acute overdosage with amphetamines and related substances include restlessness, tremor, rapid respiration, dizziness. Fatigue and depression may follow the stimulatory phase of overdosage. Cardiovascular effects include tachycardia, hypertension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting and abdominal cramps. While similar manifestations of overdosage may be seen with mazindol, their exact nature have yet to be determined. The management of acute intoxication is largely symptomatic. Data are not available on the treatment of acute intoxication with mazindol by hemodialysis or peritoneal dialysis, but the substance is poorly soluble except at very acid pH.

How Supplied: Tablets, 1 mg, and 2 mg., in packages of 100. Before prescribing or administering, see package circular for Prescribing Information

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financed here is primary care, and not family medicine.) Theoretical definitions, such as the officially sanctioned AAFP definition, use vague, global terminology: "continuing, comprehensive...care."³ Neither of these definitions confronts the basic dilemma as mentioned above. That is, family physicians treat individual patients and *not* the family. It is true that they keep family records and often think about the influence of the family (as well as school, work, etc) on the problem at hand. But while family therapists literally treat the entire family, family physicians have yet to find family diseases. This whole area of research has yet to be adequately explored.⁴

Thus, until research finds family pathology which requires family physicians' intervention, we will continue to treat individuals, albeit as "whole persons." And, of course, we will, therefore, not be able to teach residents anything but this "whole person" medicine.

David Swee, MD

Karen Swee, MEd

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References

1. Marsland DW, Wood M, Mayo F: A data bank for patient care, curriculum, and research in family practice: 526, 196 patient problems. *J Fam Pract* 3:25, 1976
2. Anderson JE, Lees REM: Patient morbidity and some patterns of family practice in southeastern Ontario. *Can Med Assoc J* 113:123, 1975
3. The official AAFP definition of family practice, Family Physician. *AAFP Reporter* 2(6):10, 1975
4. Weakland JM: Family somatics: A neglected edge. *Fam Process* 16:263, 1977

The preceding letter was referred to Dr. Authier and Ms. Land who respond as follows:

With reference to our paper, "Family: The Unique Component of Family Medicine" (*Authier J, Land T: J Fam Pract* 7:1066, 1978), Swee and Swee contend that the real problem is "the definition (or lack thereof) of family medicine." It appears to us that searching for a definition of family medicine is analogous to asking Webster for a definition of the term dictionary. Family medicine has been defined since its inception. As Carmichael has stated: "There is no better resort to those who ask the question, 'What is family medicine?' than to respond, 'Read Medialie'."¹ We would also respond, read Geyman, Curry, Bauman and Grace, Carmichael, Stephens, Rakel, and Burket.

Granted, as Swee and Swee indicate, some previous efforts to define family medicine have entailed looking at what family physicians already do. However, the aforementioned authorities agree this is inappropriate since to date too few "ideal" family physicians exist. That is, currently, few practicing family physicians clinically apply the theoretical and philosophical definition of family medicine which makes them different from other medical specialists, most notably the general practitioner, as few have received training in those parameters. The specialty of family medicine is a relatively new academic discipline. As such, it is in the process of developing its own clinical model, which realistically cannot be drawn totally from existing models.

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FOR DEEP INTRAMUSCULAR INJECTION ONLY.
Indications: In treatment of infections due to penicillin G-sensitive microorganisms susceptible to the low and very prolonged serum levels common to this dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and clinical response.

The following infections usually respond to adequate dosage of IM penicillin G benzathine.
Streptococcal infections (Group A—without bacteremia). Mild to moderate upper respiratory infections (e.g., pharyngitis).

Veneral infections—Syphilis, yaws, bejel, and pinta.

Medical conditions in which penicillin G benzathine therapy is indicated as prophylaxis:
Rheumatic fever and/or chorea—Prophylaxis with penicillin G benzathine has proven effective in preventing recurrence of these conditions. It has also been used as followup prophylactic therapy for rheumatic heart disease and acute glomerulonephritis.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. Anaphylaxis is more frequent following parenteral therapy but has occurred with oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. Severe hypersensitivity reactions with cephalosporins have been well documented in patients with history of penicillin hypersensitivity. Before penicillin therapy, carefully inquire into previous hypersensitivity to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and treat with usual agents, e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma. Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injection may produce neurovascular damage.

In streptococcal infections, therapy must be sufficient to eliminate the organism, otherwise the sequelae of streptococcal disease may occur. Take cultures following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote overgrowth of non-susceptible organisms including fungi. Take appropriate measures if superinfection occurs.

Adverse Reactions: Hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness-like reactions, laryngeal edema and anaphylaxis. Fever and eosinophilia may frequently be only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy and nephropathy are infrequent and usually associated with high parenteral doses.

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Composition: (units penicillin G benzathine as active ingredient in aqueous suspension): 300,000 units per ml—10-ml multi-dose vial. Each ml also contains sodium citrate buffer approximately 6 mg lecithin, 3 mg povidone, 1 mg carboxymethylcellulose, 0.5 mg sorbitan monopalmitate, 0.5 mg polyoxyethylene sorbitan monopalmitate, 1.2 mg methylparaben and 0.14 mg propylparaben. 600,000 units in 1-ml TUBEX® (sterile cartridge-needle unit) Wyeth, packages of 10.

900,000 units, 1.5-ml fill in 2-ml TUBEX, packages of 10.

1,200,000 units in 2-ml TUBEX, packages of 10, and in 2-ml single-dose disposable syringe, packages of 10.

2,400,000 units in 4-ml single-dose disposable syringe, packages of 10.

Each TUBEX or disposable syringe also contains sodium citrate buffer and, as w/v, approximately 0.5% lecithin, 0.6% carboxymethylcellulose, 0.6% povidone, 0.1% methylparaben and 0.01% propylparaben.

INJECTION

BICILLIN® LA

(STERILE PENICILLIN G
BENZATHINE SUSPENSION)

Wyeth Laboratories Philadelphia, Pa. 19101

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It appears that Swee and Swee are suggesting training without objectives and goals. We submit that the current definition of family medicine (which incidentally is rather generally agreed upon by the authors cited above) provides for such objectives and goals and that it is our educational charge to realize their attainment within family practice residency programs. Once objectives and goals have been achieved, research logically follows to determine if such training results in greater preventive medicine and better patient care. Indeed, as Geyman stated: "The development and continued evolution of the academic discipline of family medicine, including an active emphasis on research, is the major task of Phase Two. . ."² in the development of family medicine. Implied in such a statement is that Phase One is comprised of developing family medicine in terms of objectives and goals, which are necessary before progressing to family medicine as a more clearly defined academic discipline, part of which requires the establishment of a more solid research base.

Research demonstrating family pathology already exists (eg, the relationship of genetic predisposition to such medical problems as diabetes, hypertension, and heart disease). Other family problems have also been described and defined. As Schmidt reports: "There is a considerable volume of evidence that documents how important to the individual's health is his family. This material has been organized into four categories: (1) the family's contribution to the 'cause' of disease, (2) the family's contribution to the 'cure' of disease, (3) the family's response to serious or

chronic disease, and (4) the family's desire and/or need for family oriented care."³

To reiterate such elementary points concerns us as it demonstrates that, for some, family medicine is still in the "premarital phase." Therefore, while some are still planning the wedding, current thinking suggests the wedding between family medicine and whole person medicine has already been consummated and a family begun, and we are ready to "foster" research to further stabilize the family system. Family medicine has made and continues to make tremendous progress. It is in a dynamic state of growth, developing its body of knowledge, practice skills, and research base, and placing a more systematic emphasis on the family. The time has come for those involved in the field to actively participate in the further development of family medicine and to generate research to ensure the discipline's continued survival.

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1. Carmichael LP: Introduction. In Medalie JH (ed): Family Medicine: Principles and Applications. Baltimore, Williams and Wilkins, 1978, p xvii
2. Geyman JP: On entry into phase two in family practice development. *J Fam Pract* 4:15, 1977
3. Schmidt DD: The family as the unit of medical care. *J Fam Pract* 7:303, 1978

PERCOCET-5 ^{Tablets} (II)

Brief Summary of Prescribing Information

DESCRIPTION Each tablet of PERCOCET[®]-5 contains 5 mg oxycodone hydrochloride (WARNING: May be habit forming), 325 mg acetaminophen (APAP).

INDICATIONS For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS Hypersensitivity to oxycodone or acetaminophen.

WARNINGS Drug Dependence Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCOCET[®]-5, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCOCET[®]-5 is subject to the Federal Controlled Substances Act.

Usage in ambulatory patients Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCOCET[®]-5 should be cautioned accordingly.

Interaction with other central nervous system depressants Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCOCET[®]-5 may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Usage in pregnancy Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCOCET[®]-5 should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in children PERCOCET[®]-5 should not be administered to children.

PRECAUTIONS Head injury and increased intracranial pressure The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions The administration of PERCOCET[®]-5 or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients PERCOCET[®]-5 should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, skin rash and pruritus.

DOSAGE AND ADMINISTRATION Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. PERCOCET[®]-5 is given orally. The usual adult dose is one tablet every 6 hours as needed for pain.

DRUG INTERACTIONS The CNS depressant effects of PERCOCET[®]-5 may be additive with that of other CNS depressants. See WARNINGS. 6085 BS

DEA Order Form Required.

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