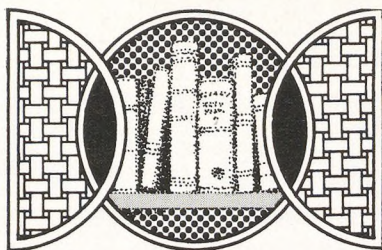


## Book Reviews

**Review of Medical Pharmacology (6th Edition).** *Frederick G. Meyers, Ernest Jawetz, Alan Goldfien.* Lange-Medical Publications, Los Altos, Calif, 1978, 762 pp., \$14.50 (paper).

*Review of Medical Pharmacology* is a text written for the student and clinician. Although therapeutic uses of drugs are discussed, this is not a therapeutics text but a general pharmacology reference, and the authors suggest consulting the package insert before prescribing new or unfamiliar drugs.

This book is well organized and easy to read. The first seven chapters review general information including pharmacokinetics, clinical evaluation, drug administration, drug abuse, and adverse drug reactions. The remainder of the book is comprised of chapters of drug groups according to their pharmacologic class. Each chapter is a review of a pharmacologic class with respect to chemical structure, kinetics, metabolism, pharmacology, side effects, clinical uses, contraindications, dosages, and preparations. The authors admit that the sections discussing available preparations may be inaccurate and recommend that a physician check with his pharmacist regarding available dosage forms and strengths. Although individual statements are not referenced in the text, a list of references, which usually emphasize the clinical aspects of the drugs, are presented at the end of each chapter.



The authors were careful to list only references from major journals or books. In the appendix, a 17-page table of the common effects of drugs on laboratory tests is useful, while a table of drugs hazardous in pregnancy is too brief to be of value. A desirable feature of the index is that drugs are listed both according to their generic and common trade names.

For those practitioners desiring a pharmacology text less comprehensive, easier to read, and more clinically oriented than Goodman and Gillman's *Pharmacological Basis of Therapeutics*, *Review of Medical Pharmacology* would be an appropriate choice. The list price of only \$14.50 also makes this paperback book attractive.

Steve Erickson, RPh  
University of Washington  
Seattle

**Shands' Handbook of Orthopaedic Surgery (9th Edition).** *H. Robert Brashear, Jr, R. Beverly Raney, Sr. C. V. Mosby Company, St. Louis, 1978, 548 pp., \$21.50.*

*Shands' Handbook of Orthopaedic Surgery* was first published 41 years ago and now appears in its ninth edition. It is undoubtedly a tried and true friend for many physicians and allied health care professionals.

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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., levaterenol 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 psychological dependence. Manifestations of chronic overdose 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 overdose. 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 overdose with mazindol in humans. Manifestations of acute overdose with amphetamines and related substances include restlessness, tremor, rapid respiration, dizziness. Fatigue and depression may follow the stimulatory phase of overdose. Cardiovascular effects include tachycardia, hypertension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting and abdominal cramps. While similar manifestations of overdose 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



Continued from page 522

This handbook does not deal with the treatment of fractures or dislocations but addresses itself to most of the other aspects of orthopedics. The text is well written and pertinent. The material is organized well, so that problems and related conditions are easily located. The numerous photographs and illustrations are of exceptional quality. An unusual and most helpful feature is an excellent bibliography indexed to chapter and subject matter.

This is a "handbook" and not a definitive work. Therefore, one must be content without all subjects covered in detail. Current common problems such as those encountered by joggers or runners—for example, plantar fasciitis—are not covered.

This book will serve many of the needs of practicing family physicians, family practice residents, medical students, and allied health care professionals. It will be most appreciated by old friends who have used this text in the past and have become accustomed to its emphasis and style.

*Jack H. Leversee, MD  
University of Washington  
Seattle*

**Clinical Psychiatry in Primary Care.** *Steven L. Dubovsky, Michael P. Weissberg. The Williams and Wilkins Company, Baltimore, 1978, 220 pp., \$10.95 (paper).*

This small and useful book in paperback format of 220 pages is divided into nine chapters. Each chapter is structured in the same fashion. There is a general descrip-

tion of the subject of the chapter, such as Chapter 1, "Hypochondriasis," with a simple list of clues to the diagnosis. Next, a description of an encounter with a typical patient, followed by the physician's reaction to this patient. Then, a discussion follows of common unsuccessful approaches, with the patient's response and the reasons the approaches were unsuccessful. Finally, a discussion is presented of successful approaches with the patient's response and why these are more apt to be successful. Each chapter has a discussion of the limitations for the family physician and the point at which consultation or referral to a psychiatrist is advisable. There is a description of specific differential diagnoses and further description of specific drug therapy for the problem being discussed.

The nine chapters are on (1) Hypochondriasis, (2) Depression, (3) Organic Brain Syndromes, (which I found extremely interesting and which gave me a far better understanding of the diagnosis of this problem), (4) Substance Abuse, (5) Sexual Dysfunction, which I would rate as only fair in its discussion, (6) Reactions to Illness, (7) Family Problems, (8) Schizophrenia, and (9) Psychiatric Emergencies.

This is a well organized and useful small book. It is specific and has practical suggestions for the psychiatric problems that primary physicians see and care for frequently.

*Paul L. Bower, MD  
Rolling Hills,  
California*

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# PERCOCET<sup>®</sup>-5

**Brief Summary of Prescribing Information**  
**DESCRIPTION** Each tablet of PERCOCET<sup>®</sup>-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<sup>®</sup>-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<sup>®</sup>-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<sup>®</sup>-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<sup>®</sup>-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<sup>®</sup>-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<sup>®</sup>-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<sup>®</sup>-5 or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

**Special risk patients** PERCOCET<sup>®</sup>-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<sup>®</sup>-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<sup>®</sup>-5 may be additive with that of other CNS depressants. See WARNINGS. 6085 BS

**DEA Order Form Required.**

PERCOCET<sup>®</sup> is a U.S. registered trademark of Endo Inc.

**Endo Inc.**

Manati, Puerto Rico 00701  
Subsidiary of Endo Laboratories, Inc.  
Subsidiary of the DuPont Company



EDO-629E-379



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**Family Practice (2nd edition).** Robert E. Rakel, Howard F. Conn (eds). W. B. Saunders Company, Philadelphia, 1978, 1,186 pp., \$38.50, \$44.30 (Canada).

This book is the definitive text on family practice. Its uses are multiple. For the practitioner, it can serve as a handy reference for almost any problem arising in office practice. For the student, it can function magnificently as a survey course presenting the essential elements of the basic specialties involved in family practice. For the specialty trained primary physician, it opens up the whole world of behavioral health and of continuing comprehensive patient care in family and community settings.

Let there be no misunderstanding. No single volume textbook can compete with the *Encyclopedia Britannica*, much less compress the world literature in medicine between its covers. Don't sell *Family Practice* short however. Much of its material is presented in outline, or even tabular form. Pearls can be found in almost every chapter. Its relevance to clinical family practice has been assured by the unique marriage of an academic specialist to a veteran family physician-teacher as co-authors of most chapters. The result is trenchant, readable, understandable prose that makes for pleasurable browsing or practical reviewing.

In organization, the text moves from a global picture of health care delivery through the principles of primary care to the specifics of clinical problems. The behavioral sciences are particularly well presented, with graphic descriptions of most components as applied to the care of families. The chapters on

the more traditional specialties are also tightly written. In all cases, the extensive bibliographies provided offer references to the definitive literature for the serious student or the clinician with a complex problem.

By and large, the book uses illustrations well, and employs tables and charts to compress ideas into graphic form. It is surprising that the chapter on cardiology uses no ECGs to illustrate the text, and astounding that the text is silent on the subject of myocardial infarction. Management of the menopause might also deserve attention, as might human growth and development in Pediatrics. Room could be made for these topics because some duplication exists. For example, breast examinations are covered in Surgery and in Gynecology; GI bleeding in Surgery and in Gastroenterology; and asthma in Chest Diseases and in Allergy and Immunology.

That this volume is in its second edition is a tribute to its quality and utility. That it has improved with age is a testimonial to its editors and authors. Their careful work has made substantial contributions to both family practice and primary care.

Arthur D. Nelson, MD  
Scottsdale Memorial Hospital  
Scottsdale, Arizona

**Family and Marital Therapy: A Transactional Approach.** James E. Lantz. Appleton-Century-Crofts, New York, 1978, 215 pp., \$9.75 (paper).

The author of this volume states his hope that it will serve as a theoretical framework and practi-

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**NOVAFED® Capsules**pseudoephedrine hydrochloride  
Controlled-Release Decongestant

**DESCRIPTION:** Each capsule contains 120 mg. of pseudoephedrine hydrochloride in specially formulated pellets designed to provide continuous therapeutic effect for 12 hours. About one half of the active ingredient is released soon after administration and the rest slowly over the remaining time period.

**ACTIONS:** Pseudoephedrine is an orally effective nasal decongestant with peripheral effects similar to epinephrine and central effects similar to, but less intense than, amphetamines. It has the potential for excitatory side effects. At the recommended oral dosage, it has little or no pressor effect in normotensive adults. Patients have not been reported to experience the rebound congestion sometimes experienced with frequent, repeated use of topical decongestants.

**INDICATIONS:** Relief of nasal congestion or eustachian tube congestion. May be given concomitantly with analgesics, antihistamines, expectorants and antibiotics.

**CONTRAINDICATIONS:** Patients with severe hypertension, severe coronary artery disease, and patients on MAO inhibitor therapy. Also contraindicated in patients with hypersensitivity or idiosyncrasy to sympathomimetic amines which may be manifested by insomnia, dizziness, weakness, tremor or arrhythmias.

Children under 12: Should not be used by children under 12 years.

Nursing Mothers: Contraindicated because of the higher than usual risk for infants from sympathomimetic amines.

**WARNINGS:** Use judiciously and sparingly in patients with hypertension, diabetes mellitus, ischemic heart disease, increased intraocular pressure, hyperthyroidism or prostatic hypertrophy. See, however, Contraindications. Sympathomimetics may produce central nervous stimulation with convulsions or cardiovascular collapse with accompanying hypotension.

Do not exceed recommended dosage.

**Use in Pregnancy:** Safety in pregnancy has not been established.

**Use in Elderly:** The elderly (60 years and older) are more likely to have adverse reactions to sympathomimetics. Overdosage of sympathomimetics in this age group may cause hallucinations, convulsions, CNS depression, and death. Safe use of a short-acting sympathomimetic should be demonstrated in the individual elderly patient before considering the use of a sustained-action formulation.

**PRECAUTIONS:** Patients with diabetes, hypertension, cardiovascular disease and hyper-reactivity to ephedrine.

**ADVERSE REACTIONS:** Hyper-reactive individuals may display ephedrine-like reactions such as tachycardia, palpitations, headache, dizziness or nausea. Sympathomimetics have been associated with certain untoward reactions including fear, anxiety, tenseness, restlessness, tremor, weakness, pallor, respiratory difficulty, dysuria, insomnia, hallucinations, convulsions, CNS depression, arrhythmias, and cardiovascular collapse with hypotension.

**DRUG INTERACTIONS:** MAO inhibitors and beta adrenergic blockers increase the effects of pseudoephedrine. Sympathomimetics may reduce the antihypertensive effects of methyldopa, mecamylamine, reserpine and veratrum alkaloids.

**DOSAGE AND ADMINISTRATION:** One capsule every 12 hours. Do not give to children under 12 years of age.

**CAUTION:** Federal law prohibits dispensing without prescription.

**HOW SUPPLIED:** Brown and orange colored hard gelatin capsules, monogrammed with the Dow diamond followed by the number 104. Bottle of 100 capsules (NDC 0183-0104-02).



DOW PHARMACEUTICALS  
The Dow Chemical Company  
Indianapolis, IN 46268



Only 1 tablet b.i.d.

# Gantanol DS

sulfamethoxazole/Roche

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

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

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

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

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

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

**Dosage:** Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis). Usual adult dosage: 2 Gm (2 DS tabs or 4 tabs or 4 teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

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

## BOOK REVIEWS

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cal guide for the beginning family therapist. As an introductory text it has numerous shortcomings which reduce its utility.

Lantz labels his theoretical approach "transactional," meaning that individual disturbance can be best understood as resulting from repetitive dysfunctional transactions or patterns of communication. The therapist's task is to reshape those transactional processes within the family. This is hardly a new insight; Lantz borrows liberally from prior work. The result is neither a new synthesis nor a clarifying restatement, but a hodgepodge of concepts, jargon, and techniques from very different sources forced uncomfortably together. The beginner in this field would do much better to go directly to the very readable primary sources, eg, Virginia Satir, Jay Haley, and Eric Berne.

The author's presentation of technique similarly lacks cohesion. Various intervention strategies are briefly presented at different points in the book, often with very little elaboration on how to use them or what to expect when they are introduced into a family therapy session. Lantz states that his book should not be used to replace competent professional supervision, but "how to" books are inevitably used in precisely that manner. The neophyte therapist "trying out" these techniques is likely to wind up in situations with which he or she is ill prepared to deal. A section of particular interest to family physicians, on decreasing somatic and physician complaints, is so lacking in detail as to be of almost no assistance to the clinician looking for direction in this vital area.

This book is not likely to be of much use to the necessarily pragmatic family physician. The style of intervention required more allocation of time than most primary care physicians are able to make, and this is a far less than ideal primer in any case.

Christopher Carstens, MD  
Family Medical Center  
Davenport, Iowa

**Obstetric Emergencies (2nd edition),** Denis Cavanagh, Ralph E. Woods, Timothy C. F. O'Connor. Harper & Row Publishers, Hagerstown, Md, 1978, 437 pp., \$19.50.

This book is written in the style of the shorter British text revealing the origins of two of its authors who have attempted to provide rapidly available guidance to those of us who have the misfortune to deal with obstetric emergencies. They point out that "there is little time for thought and often only the prompt and appropriate intervention of an alert doctor or nurse averts catastrophe."

The book is intensely practical. The first section likely to be consulted is the index, which is clearly laid out, allowing easy access to the information in the book. Terms such as "toxemia" and "eclampsia" are indexed with page numbers, avoiding the annoying necessity to thumb through the index.

The chapters are brief, logically laid out, and nicely subdivided. The subheadings are easily identified, and the information is presented in succinct form, often as a "laundry list" of steps. Illustrations, where they are used, are line drawings but all are clear and adequate for the purpose intended.

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



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The authors make extensive use of diagrams and tables, which seem to be appropriately chosen to support the text. There are occasional photographs or x-rays throughout the book and these are well reproduced, particularly taking into account the modest cost of the book.

This volume achieves its objective extremely well. It presents a great deal of information in a highly concentrated but easily retrievable form. It is comprehensive, up-to-date, and intensely practical. In short, it is a very good, handy reference manual for the family physician who practices obstetrics, for the family practice or obstetric resident, for the medical student, or obstetric nurse. It succeeds admirably in its purpose and I shall guard my copy jealously.

Peter G. Coggan, MD  
Southern Illinois University  
Springfield

**Immediate Care of the Sick and Injured Child.** Shiv K. Dube (ed); Sophie H. Pierog (assoc ed). CV Mosby Company, St. Louis, Missouri, 1978, 384 pp., \$17.50 (paper).

"The entrance of a pediatric patient and his parents into an emergency room is the final stage of a process in which the child and parents have been engaged....In bringing the child to an emergency room, the parents are acknowledging their own inability and failure to meet the child's needs" (page 6). This sensitive insight sets the opening tone of a guide to pediatric urgencies and emergencies that is technically valuable, and occa-

sionally family oriented. I only wish that the family orientation were maintained throughout the book. The technical value of this book does not rest on any claim to be the latest and most thorough update of pediatric emergencies. On the contrary, the book is simple—sometimes to an extreme, but exceptionally well organized and readable. The first major section presents common problems; the second, surgical and medical emergencies; and the third section is an appendix of childhood laboratory values, drug dosages, and procedures.

In the first section, the authors deal with common, but urgent problems of sick children. Seventeen common problems, such as vomiting, diarrhea, noisy breathing, and fever are discussed clearly under headings of etiology, work-up, and management. Potentially serious signs and symptoms are put under a diagnostic alert heading at the beginning of each chapter, and serve as a guide for emergency admissions. In the etiology section, most chapters present boxed areas of common and uncommon causes for each of the problems. While the work-up is divided into the typical history, physical examination, and laboratory investigations that appear overly simplified and "cookbookish," the management section presents concise operations for ambulatory as well as initial inpatient therapy.

I found the second section on medical management and surgical emergencies useful, with some important topics packed with a wealth of insights and data, but marred by minor inconsistencies that I wish were not part of a manual otherwise so sensitive to behavioral management. For instance, the

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Brief Summary of Prescribing Information  
Benlyn® Cough Syrup

**Each 5 ml contains:**  
Benadryl® (diphenhydramine hydrochloride) . . . . . 12.5mg  
Alcohol . . . . . 5%  
Also contains, as inactive ingredients, sugar; water; glucose liquid; glycerin; ammonium chloride; sodium citrate; raspberry imitation flavor; sodium saccharin; citric acid; caramel; menthol; FD&C Red 40; and D&C Red 33.

**INDICATIONS.** Benlyn Cough Syrup is indicated as an antitussive for the control of cough due to colds or allergy.

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified this indication as follows:

There is a lack of substantial evidence that this fixed combination drug has the effect purported. Final classification of the less-than-effective indication requires further investigation.

**CONTRAINDICATIONS.** Use in Newborn or Premature Infants: This drug should not be used in newborn or premature infants.

**Use in Nursing Mothers:** Because of the higher risk of antihistamines for infants generally, and for newborns and premature infants in particular, antihistamine therapy is contraindicated in nursing mothers.

**Use in Lower Respiratory Disease:** Antihistamines should NOT be used to treat lower respiratory-tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions:

Hypersensitivity to diphenhydramine hydrochloride and other antihistamines of similar chemical structure.

Monoamine oxidase inhibitor therapy (See Drug Interaction section).

**WARNINGS.** Antihistamines should be used with considerable caution in patients with narrow-angle glaucoma, stenosing peptic ulcer, symptomatic prostatic hypertrophy, bladder-neck obstruction, or pyloroduodenal obstruction.

**Use in Children:** In infants and children, especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, antihistamines may produce excitation.

**Use in Pregnancy:** Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

**Use with CNS Depressants:** Diphenhydramine hydrochloride has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

**Use in Activities Requiring Mental Alertness:** Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

**Use in the Elderly (approximately 60 years or older):** Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

**PRECAUTIONS.** Diphenhydramine hydrochloride has an atropine-like action and, therefore, should be used with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, or hypertension.

**DRUG INTERACTIONS.** MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

**ADVERSE REACTIONS.** The most frequent adverse reactions are underscored:

1. *General:* Urticaria; drug rash; anaphylactic shock; photosensitivity; excessive perspiration; chills; dryness of mouth, nose, and throat
2. *Cardiovascular System:* Hypotension, headache, palpitations, tachycardia, extrasystoles
3. *Hematologic System:* Hemolytic anemia, thrombocytopenia, agranulocytosis
4. *Nervous System:* Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, parosmias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions
5. *GI System:* Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation
6. *GU System:* Urinary frequency, difficult urination, urinary retention, early menses
7. *Respiratory System:* Thickening of bronchial secretions; tightness of chest and wheezing, nasal stuffiness

**OVERDOSAGE.** Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms—dry mouth; fixed, dilated pupils; flushing; and gastrointestinal symptoms may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic or one-half isotonic saline is the lavage solution of choice. Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and, therefore, are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

**HOW SUPPLIED.** Benlyn Cough Syrup is supplied in 4-oz., 1-pt, and 1-gal bottles, and unit-dose bottles of 5 ml and 10 ml.

May 1978

**PARKE-DAVIS**  
PARKE-DAVIS  
Division of Warner-Lambert Company  
Morris Plains, NJ 07950

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