

... too valuable to keep in reserve

Macrochantin®

(nitrofurantoin macrocrystals)

Capsules: 25, 50, 100mg

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 If these reactions occur, the drug should be withdrawn and appropriate measures should be taken.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 Hemolysis ceases when the drug is withdrawn.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.

Hepatitis, including chronic active hepatitis, has been observed rarely. Fatalities have been reported. The mechanism appears to be of an idiosyncratic hypersensitive type.

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 child-bearing 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 eruption, pruritus, urticaria, and angioedema.

Other hypersensitivity reactions: Anaphylaxis, asthmatic attack in patients with history of asthma, cholestatic jaundice, hepatitis, including chronic active hepatitis, 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.

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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.

Post-Abortion Attitudes and Patterns of Birth Control

To the Editor:

I am quite disturbed by the verbiage expended in the article by Abrams et al, "Post-Abortion Attitudes and Patterns of Birth Control" (*J Fam Pract* 9:593, 1979).

Just reading the summary leads one to believe the article contains worthwhile and valid information regarding women's behavior and feelings after abortion. In fact, over one third sampled felt better able to cope with problems in life in general. Could one ask for anything more?

In the discussion, the authors report that a large number of the women surveyed showed "a high degree of commitment to family planning," and further that "these data support the concept that the decision for abortion . . . is rarely regretted." Later the authors state that the crisis of abortion was positively resolved with no serious reactions.

The authors admit that "data in the current study were based on a questionnaire which elicited a high response rate, probably because of the careful preparation of the participants, all of whom were personally canvassed for permission before questionnaires were sent." Discerning readers should ask whether this statement might color the data and prejudice the conclusions? Out of 450 patients from June through November 1974, the

investigators selected 83, of whom 81 agreed to participate. The authors admit this is not a random sampling but they do not enlighten us as to the techniques of sampling used. Instead, using much statistical folderol, they proceed to reach all manner of totally invalid and unwarranted conclusions.

This article might have been acceptable as an interesting "Letter to the Editor," or as a jumping off point for a randomly sampled study to produce something of statistical validity. Its use as a major article in an important family practice journal is rather insulting, unless the plan is to incorporate it as a bad example in study design for a class in elementary statistics.

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The preceding letter was referred to Ms. Abrams who responds as follows:

Burton Hillis once said, "There's a mighty big difference between good, sound reasons and reasons that sound good." Dr. Nacht, in his unremitting enthusiasm to be critical of our article on "Post Abortion Attitudes and Patterns of Birth Control" (Abrams M, DiBiase V, Sturgis S: *J Fam Pract* 9:593, 1979), has demon-

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VALIUM®

diazepam/Roche

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

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders, athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

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: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 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 in trays of 10.



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strated his capacity to be caustic and to misinterpret the written word.

We stated explicitly at the outset, that "this was not a random sampling." Furthermore, the first paragraph spoke of the "feelings and attitudes [one year later] of a *selected* [italics mine] group of women who have had first trimester abortions"; if the selectivity offended Dr. Nacht, he could have stopped right there.

In the interest of space, the "Methods" section was compressed, but I am delighted to restate the sampling methods and problems. The records of 450 sequential patients were reviewed, because prior permission to be included in a study had not been obtained. In each case, indications of need for or requests for confidentiality were honored. Many of these subjects were eliminated from the study because they had not informed their parents, roommates, or husbands or boyfriends of the abortion. Among the remaining, one year after abortion, a large number had moved, had incorrect telephone numbers, or could not be reached after three attempts. The process of "personally" canvassing all subjects was done painstakingly to avoid embarrassment of the women, with no messages left, and no identification of the source of the telephone call until the subject herself was reached. I suspect that Dr. Nacht might agree that this kind of consideration for human subjects involved in such a study is reasonable and necessary.

Dr. Nacht was correct in singling out the phrase "careful preparation of participants"; in retrospect, its ambiguity is apparent. This was meant to refer to the contact prior to mailing the questionnaire in

order to obtain the necessary permission.

The facts are, in spite of Dr. Nacht's dismay, that in this "selected" group—selected in sequence in the only humane manner suitable—there was a "high degree of commitment to family planning" . . . (78 percent using an acceptable method of birth control one year after abortion) and the decision for abortion was "rarely regretted."*

Dr. Nacht implies that we have tried to draw global inferences and that these methods might "color the data" and "prejudice the conclusions." In the article we were careful to state that "only tentative conclusions can be drawn from this pilot study."

For his information, let me emphasize again that it was a pilot study and that we are engaged presently in a study using a larger sample, in which permission was obtained for inclusion at the time of abortion. There will never be a fully randomized, unselected group of women available because permission is essential. Nevertheless, studies of women after abortion are intrinsically important for what light they shed even among a "selected" group.

In an area in which the data remain meager, it is encouraging that other significant studies support the "tentative" conclusions of our study.

Marilyn Abrams
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*Two tables were omitted from the printed article which show respondents' answers to: Reasons Given for Abortion, and Feelings About Abortion—At the Time of Abortion and One Year Later. These are available by writing to the authors.