

# VALIUM<sup>®</sup> diazepam/Roche

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

**Indications:** Management of anxiety disorders, or short-term relief of symptoms of anxiety; 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 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 anti-depressants 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.

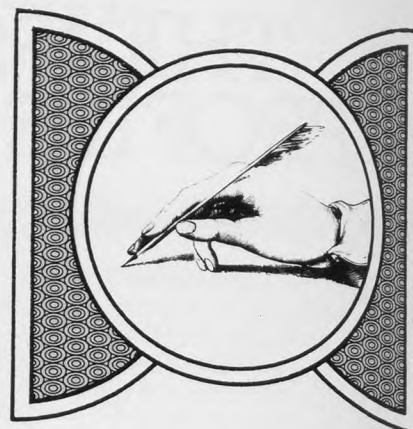
**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Anxiety disorders, symptoms of anxiety, 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.

 Roche Laboratories  
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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.

### Hemophilus Vaginalis Vaginitis in Children—Two Cases

To the Editor:

I recently saw two unrelated girls, both aged 3½ years, who presented with symptoms and signs of vaginitis, namely, perineal itching, vaginal discharge, and mild dysuria. Both symptoms had been present approximately one to two weeks. In both children the urinalysis was negative, but physical examination revealed a creamy vaginal discharge, and perineal erythema. The rest of the physical examination was negative in both cases, and the hymenae were intact. Vaginal swabs were taken.

On subsequent questioning it was learned that both children bathed with their mothers, and each family shared their towels among individual members. The parents were advised in each case to bathe the child alone, each day, and to use separate towels.

Return of the culture results in both cases showed a pure growth of *Hemophilus Vaginalis*, 3+, which worried us as this is supposed to be a sexually transmitted disease.

Both parents, in each case, returned again with each child and were found to be normal, with normal family interactions. Physical examination was normal at this

time, and the symptoms had resolved in less than one week in each case. Both mothers denied vaginal infection, or vaginal discharge, and were not examined.

It was felt that sexual abuse was not relevant here. Repeat cultures have not yet been done.

As it is unlikely that the culture results were incorrect, or mistaken with another patient's in both cases, it remains to suspect that infection resulted from contact in bathing, or through the use of the same towels.

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### Primary Care Access and Reimbursement

To the Editor:

I was especially pleased to see *The Journal of Family Practice* for July. The editorial on trends in emergency room utilization (*Geyman JP: Trends and Concerns in Emergency Room Utilization. J Fam Pract 11:23, 1980*) and the article by Dr. Hilditch (*Hilditch JR: Changes in Hospital Emergency Department Use Associated with Increased Family Physician Availability. J Fam Pract 11: 91,*

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# LOMOTIL<sup>®</sup>

brand of diphenoxylate hydrochloride  
with atropine sulfate

## LETTERS TO THE EDITOR

**IMPORTANT INFORMATION:** This is a Schedule V controlled substance by federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage, treatment is similar to that for meperidine or morphine intoxication (with prolonged and careful monitoring). Respiratory depression may occur as late as 30 hours after ingestion and may recur in spite of initial response to narcotic antagonists. A sub-therapeutic amount of atropine sulfate is present to discourage deliberate overdosage. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. KEEP THIS MEDICATION OUT OF REACH OF CHILDREN.

**Indications:** For adjunctive therapy in management of diarrhea.

**Contraindications:** In children less than 2 years due to decreased margin of safety in younger age groups, in patients hypersensitive to diphenoxylate HCl or atropine, in patients with obstructive jaundice, and in diarrhea associated with pseudomembranous enterocolitis.

**Warnings:** Use with special caution in young children because of variable response. Dehydration may cause variability of response. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Lomotil should not be used in diarrhea associated with organisms that penetrate the intestinal mucosa.

Patients with acute ulcerative colitis should be carefully observed and Lomotil therapy discontinued if abdominal distention or other untoward symptoms develop.

Concurrent use of Lomotil with monoamine oxidase inhibitors may precipitate hypertensive crisis.

Use with extreme caution in patients with advanced hepatorenal disease or abnormal liver function since hepatic coma may occur.

Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol.

**Precautions:** Use with caution in children since signs of atropinism may occur even with recommended doses, particularly in patients with Down's syndrome.

Addiction to diphenoxylate HCl is possible at high doses.

The use of any drug during pregnancy, lactation, or in women of childbearing age requires that the potential benefits of the drug be weighed against any possible hazard to the mother and child.

Diphenoxylate HCl and atropine are excreted in breast milk of nursing mothers.

**Adverse Reactions:** Atropine effects, such as dryness of the skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention may occur, especially in children. Other adverse reactions reported with Lomotil use are: anorexia, nausea, vomiting, abdominal discomfort, paralytic ileus, toxic megacolon, pruritis, swelling of gums, giant urticaria, angioneurotic edema, dizziness, drowsiness/sedation, headache, malaise/lethargy, restlessness, euphoria, depression, respiratory depression, coma, numbness of extremities.

**Overdosage:** Keep the medication out of reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include dryness of the skin and mucous membranes, flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, and respiratory depression that may occur 12 to 30 hours after overdose. Induce vomiting, evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist without agonist activity should be used in respiratory depression. Observation should extend over at least 48 hours.

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1980) struck a very responsive chord in me.

After a dozen years in a busy hospital emergency room I realized that people simply needed, in 90 percent of the cases, an easy access to good care. I joined the hospital-based (or free-standing) movement and I have been thrilled with the response of the community and the physicians who practice here. A great paradox exists, however, and that concerns third party reimbursement. The insurance industry grew up protecting against hospital costs, but now it's so easy to prove that ambulatory care centers are so much more cost effective, and yet the insurance companies are slow to embrace that view. The free-standing units that are hospital sponsored and have the billing done by the hospital business office get paid very well but the free enterprise physician who goes out on his own does not fare as well.

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### Family Practice in the Predoctoral Curriculum

To the Editor:

In a recent article in this journal (Boulger JG: Family Practice in the Predoctoral Curriculum: A Model for Success. *J Fam Pract* 10:453, 1980), it was pointed out that 55 percent of students who began their medical education at the University of Minnesota, Duluth, School of Medicine, selected family practice residencies. The involvement of family physicians in the curriculum, admissions processes, and general

goal setting for the institution was described. This report updates the data included in that article.

National Residency Matching Program (NRMP) results for the entering class of 1976 were released in mid-March 1980; again, the prime residency selection for Duluth students was family medicine. Remarkably, the proportion of students from Duluth selecting this specialty was 65 percent. In contrast, the national proportion of the 1980 graduating class continued to hover around 13 percent—a figure which has remained quite stable over the past few years.

This extremely high proportion of students electing family medicine graduate programs is, to our knowledge, unique in the annals of modern medical education. The average, over the first five graduating classes, is now 58 percent based on NRMP data. Follow-up of graduates indicates that attrition from this figure (ie, students who switched to other types of residency following an initial NRMP match to family medicine) is more than balanced by the number entering family practice residencies following a "flexible" first year of graduate training.

We believe the success of the program will continue. Shortages of family physicians will be present for the foreseeable future; it is apparent that this program is dedicated toward—and has been successful in—helping to alleviate those shortages.

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**SEARLE**