

Valium[®] (V) 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 (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 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.

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.

Pediatric Training in Family Practice

To the Editor:

I read with interest the two articles, "Pediatric Training in Family Medicine Residency Programs" (*Rabinowitz HK, Hervada AR. J Fam Pract 11:575, 1980*) and "School Health Education in Family Medicine and Pediatrics" (*Collins TR, Graham D. J Fam Pract 11:583, 1980*), and Dr. Geyman's editorial (*Pediatric Training in Family Practice Residencies. J Fam Pract 11: 531, 1980*) in the October issue of *The Journal of Family Practice*.

I would agree that our training in "areas of developmental disorders and learning problems of childhood" is woefully lacking. So it was in my recent residency tenure. I am happy to see this weakness pointed out.

However, I see two problems in implementation of change. The first is specific and logistical: if pediatric training only occupies about one fourth of our training time, this being taken up largely by learning in areas of general inpatient and outpatient pediatrics and neonatal care, where shall we squeeze in a new segment? As a recent residency graduate, I readily attest to the fact that my three years were quite full as it was.

Secondly, a broader problem occurs to me as I think back and recall the lack of facility with which my pediatric colleagues in my particu-

lar university program handled the "school referral clinic" and other related areas. I have the distinct feeling that they may have completed their own residency years feeling nearly as uncomfortable as I did dealing with these problems. Put another way, are there, in truth, any residency graduates (pediatric or otherwise) who feel really well trained in these comprehensive areas?

Notwithstanding, let us admit our shortcomings, and address and redress them as is possible.

James L. Fletcher, Jr, MD
Sparta, Tennessee

Family Practice Residents and OB/Gyn Clerkship

To the Editor:

I enjoyed reading the article by Vontver et al in the December issue of *The Journal of Family Practice* (*Impact of family practice residents on obstetrics and gynecology basic clerkship: Medical students' perceptions. J Fam Pract 11:10, 1980*). This kind of educational research will help us determine the role of family practice in the overall medical education process. On initial reading, I was concerned to see that 22 percent of medical students responded that the presence of family practice residents had a negative effect on their obstetrics and gynecology clerkship; however, it

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Roche Laboratories
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Broad-spectrum antifungal

Mycelex®

1% Cream
1% Solution (clotrimazole)

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

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

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

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

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

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

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

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

How Supplied: Mycelex Cream 1% is supplied in 15 g and 30 g tubes, and 90 g package (2 x 45 g tube).

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

Store between 35° and 86°F.

Manufactured by Schering Corporation, Kenilworth, NJ 07033, for Miles Pharmaceuticals, Division of Miles Laboratories, Inc.

References: 1. Spiekermann PH, Young MD: Clinical evaluation of clotrimazole: A broad-spectrum antifungal agent. *Arch Dermatol* 112:350-352, 1976. 2. Duhm B, et al: The pharmacokinetics of clotrimazole ¹⁴C. *Postgrad Med J*, July suppl, 1974, pp 13-16.

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should be noted that the question was asked in a highly narrow and limited fashion. The student had no opportunity to elaborate on the question or to give intermediate responses. The question was asked simply, "Viewed from an overall perspective, was the presence of the family practice resident helpful, harmful, or of no effect to your clerkship?"

It would seem that in order to accurately measure the impact of family practice residents on student obstetrics and gynecology clerkships, attitudes toward family practice residents would have to be compared either with attitudes prior to their rotation or with attitudes toward obstetrics and gynecology residents and/or residents from other services rotating on obstetrics and gynecology.

I believe that the authors should repeat the study attempting to ask the question, "How did the presence of family practice residents influence your experience in obstetrics-gynecology?" Furthermore, the appropriate control groups should be included before any conclusions are drawn from these data.

Charles W. Smith, Jr., MD
Director, Family Health Center
The Miami Valley Hospital
Dayton, Ohio

The preceding letter was referred to Dr. Vontver, who responds as follows:

I would like to thank Dr. Smith for his comments and suggestions regarding the study of family practice residents on an obstetrical and gynecological clerkship. The central question in our study, "viewed

from an overall perspective was the family practice resident helpful, harmful or of no effect to your clerkship?"—provides for three responses, all of which are stated in accordance with accepted standards for measuring attitudes. Responses predictably were scattered between these three possibilities. Although 22 percent of students felt the family practice residents hindered, Dr. Smith neglected to note that 48 percent of the students felt family practice residents were helpful on the clerkship. The latter data are emphasized in both the abstract and the conclusion of the paper. We did allow students to comment specifically as to which areas they felt the residents were helpful or harmful, and these comments were described in the article. Helpful aspects of family practice residents' presence included their broad perspective on patient care, sensitivity to patient needs, and patience in teaching. Harmful aspects were most often associated with competition for hands-on experience in deliveries. As stated in our discussion, from an overall perspective students felt family practice residents were more helpful than harmful to their learning experience on the clerkship, although their effect can be highly variable. Information gathered by the questionnaire was useful to us in providing feedback to faculty and residents. This in turn improved the relationship between family practice residents and obstetrics and gynecology students, which was our ultimate goal.

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