

Keflex®
cephalexin

Brief Summary. Consult the package literature for prescribing information.

Indications: Keflex is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Respiratory tract infections caused by *Streptococcus (Diplococcus) pneumoniae* and group A beta-hemolytic streptococci (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. Keflex is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of Keflex in the subsequent prevention of rheumatic fever are not available at present.)

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

Contraindication: Keflex is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflex.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Precautions: Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflex occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflex may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Keflex should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflex, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Adverse Reactions: *Gastrointestinal*—The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Nausea, vomiting, dyspepsia, and abdominal pain have also occurred.

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Keflex.

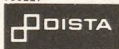
Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Eosinophilia, neutropenia, and slight elevations in SGOT and SGPT have been reported.

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Additional information available to the profession on request from Dista Products Company, Division of Eli Lilly and Company, Indianapolis, Indiana 46285.

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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.

Lymphadenopathy Incidence To the Editor:

In the January issue of *The Journal of Family Practice* the first two articles both quote incidence rates. I understand the meaning and use of the incidence of bacteremia¹ in a hospital but not the annual incidence of enlarged lymph nodes² given as 0.5 percent of the study population and derived from encounter records. How was this calculated? What would it mean if the "incidence" were twice as high next year? If a practice in Des Moines recorded 1.5 percent, what would a comparison between Des Moines and Cedar Rapids tell us?

S. J. Kilpatrick, PhD
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References

1. Wilson CB, Jones T, Shane L: Bacteremia in a small non-urban community hospital. *J Fam Pract* 12:37, 1981
2. Allhiser JN, McKnight TA, Shank JC: Lymphadenopathy in a family practice. *J Fam Pract* 12:27, 1981

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

Dr. Kilpatrick has raised a reasonable question. In our article, we present a figure of 0.5 percent annual incidence for enlarged lymph nodes in our study population. It is emphasized that the study population was the active practice of the Cedar Rapids Family Practice Residency Program at the midpoint of the two-year study. This rate was calculated from 80 cases of lym-

phadenopathy per 7,483 active patients per two-year study period. It was made clear that our incidence rate applies only to our study population, which we can characterize, and not to the general population of our community.

We believe our qualified definition of incidence is within the guidelines provided by the "Glossary for Primary Care"¹ and in Howie's recent monograph.² We believe it would be of interest to compare incidence rates for a problem such as lymphadenopathy in different defined study populations. For example, we could compare the incidence of lymphadenopathy in the Cedar Rapids Family Practice Residency patient population with that of other family practice residency practices. Any differences noted should raise appropriate curiosities and beg for explanation.

We respect Dr. Kilpatrick's concern that we not be casual in our use of the important epidemiologic term *incidence*. In its traditional sense, this applies to much larger population studies. Despite this, we believe with the qualification of stating our study population, this term can still be useful for more limited family practice research endeavors.

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References

1. Glossary for primary care. *J Fam Pract* 7:129, 1978
2. Howie JGR: Research in General Practice, London, Croom Helm, 1979, p 367