

# 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.

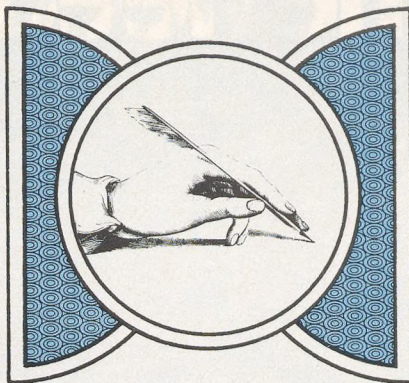
## Psychological Medicine Insights

To the Editor:

This letter is to introduce *Psychological Medicine Insights* (PMI) to your readers. PMI is a brief educational newsletter I have developed for our family practice residents and faculty. The purpose of this one-page educational piece is "to provide family physicians with practical ways of dealing with common medical-psychological problems seen in family practice."

The newsletter is distributed once a month. Among the topics included in the first seven issues are "Reassurance Therapy" (dealing with patients with psychosomatic symptoms), "How To Find The Real Problem" (determining patient's reasons for coming), "School Phobia", "Stress Evaluation" (via the Personal Stress Inventory), "Time-Limited Counseling By Family Physicians", "What Is A Psychological Problem?" and "Nocturnal Enuresis." These articles draw upon the literature of family practice, psychology, psychiatry, internal medicine, and pediatrics. References are provided with each article. Resident and faculty response to *Psychological Medicine Insights* has been for the most part positive.

If any of your readers are interested in receiving this newsletter,



they should address their inquiries to me at the Department of Family Practice, University of Minnesota, Box 381 Mayo, Minneapolis, MN 55455, (612) 373-7684.

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## Occupational Illness in Family Practice

To the Editor:

The recent article by Campbell and Nicolle describing the occurrence of environmental and occupational disease (Occupational and environmental disease in family practice," *J Fam Pract* 13:118, 1981) was both timely and interesting. Both practitioners and researchers are paying progressively more attention to the effects of the environment and the work place on the health of people.

The study, however, has a shortcoming that results from the nature of its design. What the authors have done is survey the perceptions of 325 physicians, not the actual occurrence of occupational or environmental disease in the practitioner's office as is implied in the study. What these physicians are responding to is a function of their recall capacities, their training, their existing interests in occupa-

tional and environmental related disease, and their value systems. A more objective account of the degree to which physicians consider and pursue occupational and environmental exposures as disease risk factors is needed.

Additionally, educational interventions must begin in order to bring occupational and environmental diseases to the forefront of consciousness of practicing physicians so that they may be more aware of their existence in day-to-day practice.

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## Nutrition Instruction in a Clerkship

To the Editor:

The Brown University Program in Medicine requires 18 clock hours of nutrition instruction in the second year of training. Until one year ago, no further instruction in nutrition was offered. A curriculum was designed to instruct community medicine/family medicine clerks in nutrition, particularly focusing on nutrition assessment in a primary care practice.

A study was conducted to examine the effectiveness of nutrition instruction within the format of a clerkship. A nonequivalent control group design was employed. The study was initiated in February 1980 and ended in July 1981. Eight clerks rotate through the clerkship every six weeks. Four students go to a site where no nutrition instruction is offered and the other four rotate through a site where a full-time nutritionist is employed. Clerks were pre- and posttested together during orientation and debriefing sessions on campus. A total of 88

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# Diet & Diabinese®

(chlorpropamide) Tablets  
100 mg and 250 mg

**References:** 1. Craig JW: Clinical implications of the new diabetes classification. *Postgrad Med* 68 (No. 4):122-133, October 1980. 2. Yalow RS, Berson SA: Immunoassay of endogenous plasma insulin in man. *J Clin Invest* 39:1157-1175, July 1960.

## BRIEF SUMMARY

### DIABINESE® (chlorpropamide) Tablets

**Contraindications:** Diabinese is not indicated in patients having juvenile or growth-onset diabetes mellitus, severe or unstable "brittle" diabetes, and diabetes complicated by ketosis and acidosis, diabetic coma, major surgery, severe infection, or severe trauma. Diabinese is contraindicated during pregnancy. Serious consideration should be given to the potential hazard of its use in women of childbearing age who may become pregnant.

Diabinese is contraindicated in patients with serious impairment of hepatic, renal, or thyroid function.

**Precautions:** Use chlorpropamide with caution with barbiturates, in patients with Addison's disease or in those ingesting: alcohol, antibacterial sulfonamides, phenylbutazone, salicylates, probenecid, dicoumarol or MAO inhibitors.

**Warnings:** DIABINESE (CHLORPROPAMIDE) SHOULD NOT BE USED IN JUVENILE DIABETES OR IN DIABETES COMPLICATED BY ACIDOSIS, COMA, SEVERE INFECTION, MAJOR SURGICAL PROCEDURES, SEVERE TRAUMA, SEVERE DIARRHEA, NAUSEA AND VOMITING, ETC. HYPOGLYCEMIA, IF IT OCCURS, MAY BE PROLONGED.

**Adverse Reactions:** Usually dose-related and generally respond to reduction or withdrawal of therapy. Generally transient and not of a serious nature and include anorexia, nausea, vomiting and gastrointestinal intolerance; weakness and paresthesias.

Certain untoward reactions associated with idiosyncrasy or hypersensitivity have occasionally occurred, including jaundice (rarely associated with severe diarrhea and bleeding), skin eruptions rarely progressing to erythema multiforme and exfoliative dermatitis, and probably depression of formed elements of the blood. With a few exceptions, these manifestations have been mild and readily reversible on the withdrawal of the drug. Diabinese should be discontinued promptly when the development of sensitivity is suspected.

Jaundice has been reported, and is usually promptly reversible on discontinuance of therapy. THE OCCURRENCE OF PROGRESSIVE ALKALINE PHOSPHATASE ELEVATION SHOULD SUGGEST THE POSSIBILITY OF INCIPENT JAUNDICE AND CONSTITUTES AN INDICATION FOR WITHDRAWAL OF THE DRUG.

Leukopenia, thrombocytopenia and mild anemia, which occur occasionally, are generally benign and revert to normal, following cessation of the drug.

Cases of aplastic anemia and agranulocytosis, generally similar to blood dyscrasias associated with other sulfonilureas, have been reported.

BECAUSE OF THE PROLONGED HYPOGLYCEMIC ACTION OF DIABINESE, PATIENTS WHO BECOME HYPOGLYCEMIC DURING THERAPY WITH THIS DRUG REQUIRE CLOSE SUPERVISION FOR A MINIMUM PERIOD OF 3 TO 5 DAYS, during which time frequent feedings or glucose administration are essential. The anorectic patient or the profoundly hypoglycemic patient should be hospitalized.

Rare cases of phototoxic reactions have been reported. Edema associated with hyponatremia has been infrequently reported. It is usually readily reversible when medication is discontinued.

**Dosage:** The mild to moderately severe, middle-aged, stable diabetic should be started on 250 mg daily. Because the geriatric diabetic patient appears to be more sensitive to the hypoglycemic effect of sulfonilurea drugs, older patients should be started on smaller amounts of Diabinese, in the range of 100 to 125 mg daily.

After five to seven days following initiation of therapy, dosage may be adjusted upward or downward in increments of 50 to 125 mg at intervals of three to five days. Patients who do not respond completely to 500 mg daily will usually not respond to higher doses. Maintenance doses above 750 mg daily should be avoided.

**Supply:** 100 mg and 250 mg, blue, 'D'-shaped, scored tablets.

More detailed professional information available on request.

**Pfizer** LABORATORIES DIVISION  
PFIZER INC.

Leaders in Oral Diabetic Therapy

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clerks were tested in the 17-month period. Of this total, 27 clerks' scores were used in the study. The remaining 61 sets of scores were incomplete and had to be dropped because of missing pretest or posttest values.

Results of statistical analysis showed a highly significant increase ( $P < .005$ ) in the posttest score mean of the experimental group. The mean control group posttest score did not increase significantly. Pretest score mean analyzed in the two groups had no significant difference. The mean experimental group posttest score was significantly higher ( $P < .025$ ) than the mean control group posttest score. Control group posttest scores actually decreased. Speculation is that student interest in taking the posttest without having any instruction sharply declined, which could have resulted in casual answering of test questions. Possible explanations for the improved posttest scores of the experimental group are (1) possible self-selection (students interested in nutrition choosing the site in which they know nutrition instruction is offered) and (2) possible additional learning that might have come about through consultation with the nutritionist regarding patients seen at the site.

The study suggests that including structured nutrition instruction in a clerkship setting can provide effective cognitive learning. Medical students at this level of training appear to be highly motivated to learn about nutrition as it applies to medical practice in a clinical environment. Because of the positive results of the study and positive feedback from students receiving the instruction, the curriculum has become a permanent part of the

clerkship and is offered to students at both sites.

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## Conversion Code from ICHPPC-2 to ICD-9-CM

To the Editor:

It has recently come to our attention that the US Department of Social and Health Services (DSHS) has started to require that diagnosis codes be submitted to the fourth digit using ICD-9-CM.

We recently published an article addressing the issue of using ICHPPC-2 for reimbursement purposes. The conversion code to ICD-9-CM was presented only to the third digit, which was what DSHS required at that time.

We would like to make available to interested readers an expanded conversion that is compatible with ICD-9-CM for reimbursement needs. [Copies are available upon request from Dr. Schneeweiss at the address below.] This conversion has been run through the DSHS computer programs and passed the edits they use for diagnosis code acceptability.

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Ronald Schneeweiss, MD  
Department of Family Medicine  
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Seattle, Washington

## Reference

1. Froom J, Schneeweiss R: Use of the international classification of health problems in primary care (ICHPPC-2) for reimbursement. *J Fam Pract* 11:609, 1980