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.

Errors in Recorded Birthweights

To the Editor:

Birthweight is a critical variable in many studies of infants. Data on birthweight are frequently obtained from patient records and are assumed to be valid because of the source of the information. During the data-collection phase of a study on morbidity patterns in Canadian Indian and non-Indian children,[1] we discovered that this assumption was not correct. The study subjects were children born to women attending two family medical centers in Southern Ontario.

Birthweight was recorded in patient records at the time of the infant's first visit, usually at ages two to six weeks. In many instances, birthweight obtained from records at the medical center did not agree with the birthweight from hospital records. We report these discrepancies to alert clinicians and researchers to the possibility of errors in birthweight.

Birthweight was not recorded on the chart at the medical center for 13.4 percent (51 of 382) of the children. For the remaining 331 children, birthweight was recorded primarily using metric units on hospital charts and imperial units on center records.

Recorded weights from the two sources were equal for 63 children (19 percent). Sixty-four percent (213) of the weights were within 28 g (rounding error in the conversion from metric to imperial units).

In 28 cases (8.5 percent), however, center birthweights exceeded hospital birthweights by 29 to 570 g; for 18 infants this difference was more than 114 g. For 27 children (8.2 percent) hospital birthweights were 35 to 1,074 g higher than center birthweights; the difference was over 114 g for 17 of these cases.

Birthweight recorded on the child's chart is frequently obtained by asking the mother. Thus, three explanations are possible for observed differences in weights. First, patient recall may be poor. Second, the mother may be misinformed. Finally, there may be an incorrect transformation from metric to imperial units.

Patient recall may be the most important source of error for the cases in which hospital birthweights were more than 28 g over center birthweights. The mother may recall the discharge weight of the child rather than the birthweight.

There were 35 cases with an absolute difference in excess of 114 g (4 oz) between center and hospital birthweights. Physicians and researchers using birthweight as a baseline measurement in the assessment of child growth are advised to obtain the data from hospital records or discharge summaries rather than rely on patient records.

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Reference

1. Evers SE, Rand CG: Morbidity in Canadian Indian and non-Indian children in the first year of life. Can Med Assoc J 126:249, 1982

Behavioral Science in Family Practice

To the Editor:

In his August editorial, "Public Perceptions of Psychosocial Problems and Roles of the Family Physician" *(J Fam Pract 15:225, 1982)*, Geyman calls for a "reassessment" of current behavioral sciences training in family practice residencies. Specifically, he advocates continuing "broad content" areas while limiting training in skills such as crisis intervention and brief counseling. In support of this, he cites articles which show that many patients do not perceive the family physician as a major resource for treating psychosocial ills.

Reflecting on these studies, Geyman then calls for a "more limited" role for the family physician in dealing with some such problems. While maintaining sensitivity to psychosocial issues, he argues, the family physician may be less involved in the actual management of some of the problems. A "more realistic" approach might be for family physicians to work

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Pediazole®

erythromycin ethylsuccinate and sulfisoxazole acetyl for oral suspension

BRIEF SUMMARY:
Please see package enclosure for full prescribing information.

Indication
For treatment of ACUTE OTITIS MEDIA in children caused by susceptible strains of *Hemophilus influenzae*.

Contraindications
Known hypersensitivity to either erythromycin or sulfonamides.
Infants less than 2 months of age.
Pregnancy at term and during the nursing period, because sulfonamides pass into the placental circulation and are excreted in human breast milk and may cause kernicterus in the infant.

Warnings
Usage in Pregnancy (SEE ALSO: CONTRAINDICATIONS): The safe use of erythromycin or sulfonamides in pregnancy has not been established. The teratogenic potential of most sulfonamides has not been thoroughly investigated in either animals or humans. However, a significant increase in the incidence of cleft palate and other bony abnormalities of offspring has been observed when certain sulfonamides of the short, intermediate and long-acting types were given to pregnant rats and mice at high oral doses (7 to 25 times the human therapeutic dose).
Reports of deaths have been associated with sulfonamide administration from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving sulfonamides.
The frequency of renal complications is considerably lower in patients receiving the most soluble sulfonamides such as sulfisoxazole. Urinalysis with careful microscopic examination should be obtained frequently in patients receiving sulfonamides.

Precautions
Erythromycin is principally excreted by the liver. Caution should be exercised in administering the antibiotic to patients with impaired hepatic function. There have been reports of hepatic dysfunction, with or without jaundice occurring in patients receiving oral erythromycin products.
Recent data from studies of erythromycin reveal that its use in patients who are receiving high doses of theophylline may be associated with an increase of serum theophylline levels and potential theophylline toxicity. In case of theophylline toxicity and/or elevated serum theophylline levels, the dose of theophylline should be reduced while the patient is receiving concomitant erythromycin therapy.
Surgical procedures should be performed when indicated.
Sulfonamide therapy should be given with caution to patients with impaired renal or hepatic function and in those patients with a history of severe allergy or bronchial asthma. In the presence of a deficiency in the enzyme glucose-6-phosphate dehydrogenase, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and renal stone formation.

Adverse Reactions
The most frequent side effects of oral erythromycin preparations are gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting and diarrhea occur infrequently with usual oral doses. During prolonged or repeated therapy, there is a possibility of overgrowth of nonsusceptible bacteria or fungi. If such infections occur, the drug should be discontinued and appropriate therapy instituted. The overall incidence of these latter side effects reported for the combined administration of erythromycin and a sulfonamide is comparable to those observed in patients given erythromycin alone. Mild allergic reactions such as urticaria and other skin rashes have occurred. Serious allergic reactions, including anaphylaxis, have been reported with erythromycin.
The following untoward effects have been associated with the use of sulfonamides:
Blood dyscrasias: Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.
Allergic reactions: Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.
Gastrointestinal reactions: Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis.
C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia.
Miscellaneous reactions: Drug fever, chills and toxic nephrosis with oliguria or anuria. Periarteritis nodosa and L.E. phenomenon have occurred.
The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents.
Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration
PEDIAZOLE SHOULD NOT BE ADMINISTERED TO INFANTS UNDER 2 MONTHS OF AGE BECAUSE OF CONTRAINDICATIONS OF SYSTEMIC SULFONAMIDES IN THIS AGE GROUP.
For Acute Otitis Media in Children: The dose of Pediazole can be calculated based on the erythromycin component (50 mg/kg/day) or the sulfisoxazole component (150 mg/kg/day to a maximum of 6 g/day). Pediazole should be administered in equally divided doses four times a day for 10 days. It may be administered without regard to meals.
The following approximate dosage schedule is recommended for using Pediazole:
Children: Two months of age or older.

Weight	Dose—every 6 hours
Less than 8 kg (less than 18 lb)	Adjust dosage by body weight
8 kg (18 lb)	½ teaspoonful (2.5 ml)
16 kg (35 lb)	1 teaspoonful (5 ml)
24 kg (53 lb)	1½ teaspoonfuls (7.5 ml)
Over 45 kg (over 100 lb)	2 teaspoonfuls (10 ml)

How Supplied
Pediazole Suspension is available for teaspoon dosage in 100-ml (**NDC** 0074-8030-13), 150-ml (**NDC** 0074-8030-43) and 200-ml (**NDC** 0074-8030-53) bottles, in the form of granules to be reconstituted with water. The suspension provides erythromycin ethylsuccinate equivalent to 200 mg erythromycin activity and sulfisoxazole acetyl equivalent to 600 mg sulfisoxazole per teaspoonful (5 ml).

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more closely with a psychologist or social worker in selected cases.

As a family physician already practicing closely with a family therapist, I applaud the latter suggestion. But I object to Geyman's argument, for it may be used to downgrade the impact of the behavioral sciences on our still-developing discipline.

Patients' attitudes do not exist in a vacuum. They emerge in response to social forces, not the least of which (when it comes to medical care) being the physician's own attitude.

Traditionally, physicians have rejected a psychosocial perspective, a fact which contemporary family medicine is earnestly challenging through its concern with the broader dimensions of illness and illness behavior.

Because patients' attitudes are shaped by traditional medicine, one would expect them to look elsewhere for treatment for their psychological problems. Most patients today have been urged to seek out specialist care for each problem. But to use such attitudes as a basis for re-examining the role of the behavioral sciences in family medicine is circular reasoning. It assumes that because such attitudes exist, they somehow ought to exist and cannot be changed.

Clearly, patients' attitudes can be molded. One might argue instead, then, for further efforts by family medicine to educate the public about its field's potential.

The family physician's role may not require "sharper definition" now. This role appears to be in considerable evolution; the field simultaneously embraces older family physicians and younger ones, those who do surgery and those who do not, those who counsel and those who do not, and so on. Rather than curtail behavioral science training, it might be wiser to recognize what is in fact already happening: Different schools are developing programs that emphasize different aspects of family medicine. Some deal more with psychosocial issues, some less. Let young physicians choose the approach that most appeals to them. The field will thus evolve. Geyman seems to be pressing for premature closure to a highly controversial question: the role of behavioral insight in the development of family practice.

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Educational Pelvic Examination

To the Editor:

I, too, am a woman physician and found Dr. Leonie Gordon's letter to the editor *(Educational pelvic examination, letter. J Fam Pract 15:410, 1982)* offensive. I totally disagree with the objections she raised to the article by Dr. Gabriel Smilkstein, "The Educational Pelvic Examination" *(J Fam Pract 13: 932, 1981)*.

Patient education is not inappropriate. Her concerns that patients would be embarrassed and have more anxiety than usual are unfounded. Furthermore, her statement that "the educational pelvic examination is probably non-cost-effective, time consuming, and inappropriate" is also unfounded.

A former resident at the Uni-

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Diabinese
(chlorpropamide)
Tablets 100 mg and 250 mg
A proven regimen... continue it with confidence.

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, thiazides, phenylbutazone, salicylates, probenecid, dicoumarol or MAO inhibitors. Adequate dietary intake should be assured in all patients using Diabinese.
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. HERE, INSULIN IS INDISPENSABLE.
HYPOGLYCEMIA, IF IT OCCURS, MAY BE PROLONGED. (SEE ADVERSE REACTIONS.) IN INSTANCES OF CONCOMITANT USE WITH INSULIN, PATIENTS SHOULD BE CAREFULLY MONITORED.
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, skin eruptions rarely progressing to erythema multiforme and exfoliative dermatitis, and probably depression of formed elements of the blood. They occur characteristically during the first six weeks of therapy. With a few exceptions, these manifestations have been mild and readily reversible on the withdrawal of the drug. The more severe manifestations may require other therapeutic measures, including corticosteroid therapy. 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 INCIPIENT 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 sulfonylureas, 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 total daily dosage is generally taken at a single time each morning with breakfast. Occasionally, cases of gastrointestinal intolerance may be relieved by dividing the daily dosage. A LOADING OR PRIMING DOSE IS NOT NECESSARY AND SHOULD NOT BE USED. 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 sulfonylurea 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.

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Leaders in Oral Diabetic Therapy

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versity of Iowa Department of Family Practice, Dr. Ronald Feldmann, conducted a research project in his third year of residency to address some of these issues. In short, he found (1) no significant difference in relaxation or comfort level between the control and study groups; (2) the educational pelvic examination took about 1.25 minutes longer than the routine pelvic examination; (3) physician-patient communication was greater in the study group as reflected by more questions asked and answered during the examination; and (4) most women in the study group wanted to use a hand-held mirror during future examinations and all would recommend it to a friend.

Ignorance is not bliss. Patient education should be encouraged in all aspects of medicine, including the pelvic examination.

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Telephone Prescriptions

To the Editor:

In their article, "Patient Care Telephone Calls Received in Family Practice Offices," Jackie McGee Brown et al (*J Fam Pract 14:527, 1982*) document once again the extensive use physicians make of the telephone in handling drug prescriptions. Research indicates that from 7 to 11 percent of all prescriptions to adults are issued via the telephone. For children the range is even higher, 10 to 29 percent.[1] This seems to be unique to North American medicine, as comparable figures from European centers are much lower.

Although Brown et al did not mention which drugs were prescribed or renewed over the telephone in their study, in a paper published in this journal in 1980,[2] I found evidence that the most common telephone repeat prescriptions were for psychotropic drugs. This class of drugs represented 27 percent of all telephone prescription renewals, but only 14 percent of office prescriptions. Furthermore, the recipients of these prescriptions were demographically distinct in that they were more likely to be female patients, have more psychosocial problems, and were viewed by the prescribing physician in a significantly more negative light than a group of patients receiving prescriptions in the office. This raises serious questions about the desirability and appropriateness of repeat telephone prescriptions. It suggests that some of these are symptomatic of a compromised physician-patient relationship.

Brown et al indicate in their study that 80 percent of the calls handled by the clinical phamacist were for prescription repeats. They mention that a follow-up office visit was recommended in about one half of all medication-related calls, but no mention is made of the level of compliance with this request. Under these circumstances it would seem to me that, in the interests of high-quality medical care, the role of the clinical pharmacist in handling telephone repeat prescriptions must, at least, be clearly defined and, at best, be very limited.

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References

1. Kohn R, White K: Health Care: An Internation Study. London, Oxford University Press, 1976
2. Freeman T: A study of telephone prescriptions in family practice. J Fam Pract 10:857, 1980