

Diet & 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 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 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.

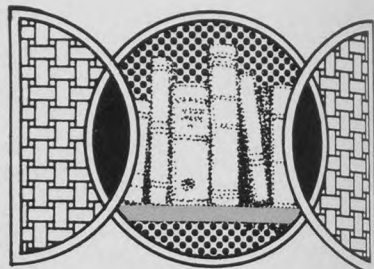
After five to seven days following initiation of therapy, dosage may be adjusted upward or downward in increments of 50 to 125 mg at intervals of three to five days. PATIENTS WHO DO NOT RESPOND COMPLETELY TO 500 MG DAILY WILL USUALLY NOT RESPOND TO HIGHER DOSES. Maintenance doses above 750 mg daily should be avoided.

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

More detailed professional information available on request.

Pfizer LABORATORIES DIVISION
PFIZER INC
Leaders in Oral Diabetic Therapy

Book Reviews



Pictorial Manual of Neurologic Tests. Maurice W. Van Allen, Robert L. Rodnitzky. Year Book Medical Publishers, Chicago, 1981, 227 pp., \$19.95.

To any family physician, a reference text that covers one organ system can be very useful if it is neither too brief nor too wordy. Many reference texts go into worthwhile reviews of differential diagnoses and treatments of various disorders. Other reference texts are of limited value because of the way the material is covered or because of their approach.

As a reference resource, the *Pictorial Manual of Neurologic Tests* by Allen and Rodnitzky is much less a pictorial manual than a descriptive guide to performing and interpreting a neurologic examination that can be carried out in an office or in the hospital. The title alone is insufficient to give appropriate information to a prospective buyer as to what the book is about. The text does cover neurologic testing. There is only a very cursory statement about symptoms that might cause abnormal test responses, and it does not go into any treatment modality. Thus as a reference text, it is probably better for medical students, allied health personnel, or residents who are reviewing exactly how to perform a

neurologic examination, not how to interpret abnormal testing evaluation. It may also be useful to family physicians in reviewing their understanding of some basic neurologic tests. It is, however, not so useful in my opinion for the majority of practicing family physicians.

There are certain problems with the book. It is a very unusual size (6.25 inches high by 9.25 inches across) and would stick out or not fit easily on many bookcases or shelves. Although the book is described as a pictorial manual, there are proportionately few pictures, and these are drawings of approaches to doing some neurologic evaluation or some abnormal responses. In addition, the text has very small type, especially for a book of this size; this took some getting used to at first. It therefore does not offer the reader quickly visible test information.

The first chapter of the text, a good review of the basic neurologic examination, would be of benefit to anyone. The subsequent chapters are compressed and slightly disorganized. Although the neurologic system may not lend itself easily to compartmentalization, one chapter on abnormal signs and syndromes

Continued on page 1205

Continued from page 1192

covers everything from cranial nerves to dyskinesias, signs of meningitis, root compression syndromes, peripheral nerve paralysis, neurocutaneous syndrome, to rectal and pelvic examinations. This is a very disjointed approach to the neurologic system and abnormal neurologic responses. The chapter does cover all of the subjects involved, but again at a very cursory level. It seems almost as if this chapter were added to expand the scope of the book beyond simply offering a text on how to do a neurologic examination and how to interpret neurologic findings. The book certainly does not seem like the kind of reference text that would be utilized frequently, but

there do seem to be some portions that could be useful on a limited basis.

Ross R. Black II, MD
Akron, Ohio

Training for General Practice. *Dennis J. Pereira Gray. Macdonald & Evans, Limited, Plymouth, England, 1981, 310 pp., \$9.95.*

Postgraduate training in family medicine has developed quite differently on each side of the Atlantic. The British apprenticeship system of training in a physician's office is a sharp contrast to the American residency clinic.

Dr. D. J. Pereira Gray's book describes the development of training for general practice in the

United Kingdom from the perspective of one who has been intimately concerned with its history and current organization. Dr. Gray has written the book for trainers and trainees and for the large numbers of others involved in health care delivery who are part of, or who support, educational programs in general practice.

Without a detailed knowledge of training in the United Kingdom, it is difficult to provide an adequate opinion of the book's value to its intended readership. It is certainly clearly written and contains many references to decisions and documents that have been crucial to the implementation of the current vocational training programs. To an American with little appreciation of the political and cultural differ-

The AUTOMATIC. The ANSWER.

Your young patients and their parents look to you for the best in health care. The TA-5A Automatic Impedance Audiometer from Teledyne Avionics helps you provide that care.

Simple, accurate and easy to use, the TA-5A is an important tool in management of middle ear pathology. A hand-held probe is placed against the ear, not inserted, for maximum comfort.

Tympanometry requires 3.5 seconds per ear and complete testing only a total of 12 seconds.

For more information and a demonstration of "The Automatic"—

contact:

 **TELEDYNE AVIONICS**

P.O. Box 6400 • Charlottesville, VA 22906 • 804/973-3311

ences, Dr. Gray's account is fascinating, although of little relevance here.

Several chapters do have international appeal, particularly those dealing with teaching methods, the trainer-trainee relationship, and the curriculum of courses for trainees. Many of the issues addressed in these chapters will be familiar to many American family physicians, and it is a great shame that, because of the stated goal of the book to concentrate on general principles, we are not treated to greater detail.

I put the book down feeling that it provided an excellent summary of the philosophy and direction of teaching in general practice in the United Kingdom, but it would be of little direct value in the United States, except to provoke thought on other methods of training that might be more practical or economical than our present system.

*Peter Coggan, MD
Seattle, Washington*

Principles of Biomedical Ethics.

Tom L. Beauchamp, James F. Childress. Oxford University Press, New York, 1979, 314 pp., \$15.95 (cloth), \$8.95 (paper).

There are two broad categories of books on medical ethics available to the interested clinician or teacher. The first type focuses on the analysis of clinical cases, usually with one or more medical authors who are clinicians. The approach in this type is to understand the ethical issues embedded in the traditional approach to managing clinical problems. The second type, typified by this book, comes from the liberal arts community and is frequently written by medical ethi-

cists with a background in sociology, philosophy, or religion. The authors of this book are a philosopher and a professor of religious studies.

The book is aimed at health care professionals such as physicians and nurses, research investigators, and policy makers, as well as philosophers, theologians, and students interested in medical ethics. The authors presuppose a minimum acquaintance with philosophy, theology, and medicine. The book deals with moral and ethical theory and then touches in detail on some fundamental ethical principles, such as autonomy, nonmaleficence, beneficence, and justice. Chapters are also included on the professional-patient relationship (including confidentiality and truth telling), and on philosophical notions of ideals, virtues, and integrity (including conscience). Appendices include case studies and a summary of the various medical codes of ethics. The book is complemented by a fairly short selected bibliography of books.

In teaching medical ethics, clinicians who have conducted ethical analyses on a number of typical day-to-day cases begin to look for a more detailed discussion of the general ethical principles that lie behind any systematic approach to understanding ethical dilemmas. This book provides a very readable and useful overview of this level of ethical analysis. It is a helpful reference book for teachers of ethics, and the treatment of ethical issues is lucid and balanced. It will not be of immediate value to the practicing clinician faced with an issue in his practice but would be the kind of text that he might eventually consult.

*Tom Taylor, MD
Seattle, Washington*

As an adjunct to rest and physical therapy
ROBAXIN®-750
(Methocarbamol Tablets, USP), 750 mg
ROBAXISAL®
Methocarbamol, USP, 400 mg/Aspirin, USP, 325 mg

INDICATIONS: Robaxin-750 and Robaxisal are indicated as adjuncts to rest, physical therapy, and other measures for the relief of discomfort associated with acute, painful musculoskeletal conditions.

The mode of action of methocarbamol has not been clearly identified, but may be related to its sedative properties. Methocarbamol does not directly relax skeletal muscles in man.

CONTRAINDICATIONS: Hypersensitivity to methocarbamol or aspirin.

WARNINGS: Since methocarbamol may possess a general central nervous system depressant effect, patients receiving Robaxin-750 or Robaxisal should be cautioned about combined effects with alcohol and other CNS depressants.

PRECAUTIONS: Products containing aspirin should be administered with caution to patients with gastritis or peptic ulceration, or those receiving hypoprothrombinemic anticoagulants.

Methocarbamol may cause a color interference in certain screening tests for 5-hydroxyindoleacetic acid (5-HIAA) and vanilmandelic acid (VMA).

Pregnancy: Safe use of Robaxin-750 and Robaxisal has not been established with regard to possible adverse effects upon fetal development. Therefore, Robaxin-750 or Robaxisal should not be used in women who are or may become pregnant and particularly during early pregnancy unless in the judgment of the physician the potential benefits outweigh the possible hazards.

Nursing Mothers: It is not known whether methocarbamol is secreted in human milk; however, aspirin does appear in human milk in moderate amounts. It can produce a bleeding tendency either by interfering with the function of the infant's platelets or by decreasing the amount of prothrombin in the blood. The risk is minimal if the mother takes the aspirin just after nursing and if the infant has an adequate store of vitamin K. As a general rule, nursing should not be undertaken while a patient is on a drug.

Pediatric Use: Safety and effectiveness in children 12 years of age and below have not been established.

Use in Activities Requiring Mental Alertness: Robaxisal may rarely cause drowsiness. Until the patient's response has been determined, he should be cautioned against the operation of motor vehicles or dangerous machinery.

ADVERSE REACTIONS: The most frequent adverse reaction to methocarbamol is dizziness or lightheadedness and nausea. This occurs in about one in 20-25 patients. Less frequent reactions are drowsiness, blurred vision, headache, fever, allergic manifestations such as urticaria, pruritus, and rash.

Adverse reactions that have been associated with the use of aspirin include: nausea and other gastrointestinal discomfort, gastritis, gastric erosion, vomiting, constipation, diarrhea, angio-edema, asthma, rash, pruritus, urticaria.

Gastrointestinal discomfort may be minimized by taking Robaxisal with food.

DOSAGE AND ADMINISTRATION: Robaxin-750: Adults: Initial dosage, 2 tablets q.i.d.; maintenance dosage, 1 tablet q.4h. or 2 tablets t.i.d. Six grams a day are recommended for the first 48 to 72 hours of treatment. (For severe conditions 8 grams a day may be administered.) Thereafter, the dosage can usually be reduced to approximately 4 grams a day.

Robaxisal: Adults and children over 12 years of age: Two tablets four times daily. Three tablets four times daily may be used in severe conditions for one to three days in patients who are able to tolerate salicylates. These dosage recommendations provide respectively 3.2 and 4.8 grams of methocarbamol per day.

OVERDOSAGE: Toxicity due to overdosage of methocarbamol is unlikely; however, acute overdosage of aspirin may cause symptoms of salicylate intoxication.

Treatment of Overdosage: Supportive therapy for 24 hours, as methocarbamol is excreted within that time. If salicylate intoxication occurs, especially in children, the hyperpnea may be controlled with sodium bicarbonate. Judicious use of 5% CO₂ with 95% O₂ may be of benefit. Abnormal electrolyte patterns should be corrected with appropriate fluid therapy.

HOW SUPPLIED: Robaxin-750 is supplied as white capsule-shaped tablets in bottles of 100 (NDC 0031-7449-63) and 500 (NDC 0031-7449-70) and Dis-Co® Unit Dose Packs of 100 (NDC 0031-7449-64).

Robaxisal is supplied as pink and white laminated compressed tablets in bottles of 100 (NDC 0031-7469-63) and 500 (NDC 0031-7469-70) and Dis-Co® Unit Dose Packs of 100 (NDC 0031-7469-64).

Rev. May 1980

A.H. ROBINS

A.H. Robins Company, Richmond, Va. 23220