

(erythromycin ethylsuccinate)

INDICATIONS: *Streptococcus pyogenes* (Group A beta hemolytic streptococcus): Upper and lower respiratory tract, skin, and soft tissue infections of mild to moderate severity.

Injectable benzathine penicillin G is considered by the American Heart Association to be the drug of choice in the treatment and prevention of streptococcal pharyngitis and in long-term prophylaxis of rheumatic fever.

When oral medication is preferred for treatment of the above conditions, penicillin G, V, or erythromycin are alternate drugs of choice.

When oral medication is given, the importance of strict adherence by the patient to the prescribed dosage regimen must be stressed. A therapeutic dose should be administered for at least 10 days.

Alpha-hemolytic streptococci (viridans group): Although no controlled clinical efficacy trials have been conducted, oral erythromycin has been suggested by the American Heart Association and American Dental Association for use in a regimen for prophylaxis against bacterial endocarditis in patients hypersensitive to penicillin who have congenital heart disease, or rheumatic or other acquired valvular heart disease when they undergo dental procedures and surgical procedures of the upper respiratory tract. Erythromycin is not suitable prior to genitourinary or gastrointestinal tract surgery. **NOTE:** When selecting antibiotics for the prevention of bacterial endocarditis the physician or dentist should read the full joint statement of the American Heart Association and the American Dental Association.

Staphylococcus aureus: Acute infections of skin and soft tissue of mild to moderate severity. Resistant organisms may emerge during treatment.

Streptococcus pneumoniae (Diplococcus pneumoniae): Upper respiratory tract infections (e.g., otitis media, pharyngitis) and lower respiratory tract infections (e.g., pneumonia) of mild to moderate degree.

Mycoplasma pneumoniae (Eaton agent, PPL0): For respiratory infections due to this organism.

Hemophilus influenzae: For upper respiratory tract infections of mild to moderate severity when used concomitantly with adequate doses of sulfonamides. (See sulfonamide labeling for appropriate prescribing information). The concomitant use of the sulfonamides is necessary since not all strains of *Hemophilus influenzae* are susceptible to erythromycin at the concentrations of the antibiotic achieved with usual therapeutic doses.

Treponema pallidum: Erythromycin is an alternate choice of treatment for primary syphilis in patients allergic to the penicillins. In treatment of primary syphilis, spinal fluid examinations should be done before treatment and as part of follow-up after therapy.

Corynebacterium diphtheriae: As an adjunct to antitoxin, to prevent establishment of carriers, and to eradicate the organism in carriers.

Corynebacterium minutissimum: For the treatment of erythrasma.

Entamoeba histolytica: In the treatment of intestinal amebiasis only. Extraenteric amebiasis requires treatment with other agents.

Listeria monocytogenes: Infections due to this organism.

Bordetella pertussis: Erythromycin is effective in eliminating the organism from the nasopharynx of infected individuals, rendering them non-infectious. Some clinical studies suggest that erythromycin may be helpful in the prophylaxis of pertussis in exposed susceptible individuals.

Legionnaires' Disease: Although no controlled clinical efficacy studies have been conducted, *in vitro* and limited preliminary clinical data suggest that erythromycin may be effective in treating Legionnaires' Disease.

CONTRAINDICATIONS: Erythromycin is contraindicated in patients with known hypersensitivity to this antibiotic.

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.

Areas of localized infection may require surgical drainage in addition to antibiotic therapy.

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.

Usage during pregnancy and lactation: The safety of erythromycin for use during pregnancy has not been established.

Erythromycin crosses the placental barrier. Erythromycin also appears in breast milk.

ADVERSE REACTIONS: The most frequent side effects of 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.

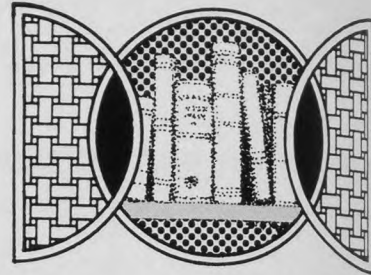
Allergic reactions ranging from urticaria and mild skin eruptions to anaphylaxis have occurred.

There have been isolated reports of reversible hearing loss occurring chiefly in patients with renal insufficiency and in patients receiving high doses of erythromycin.



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Book Reviews



The Injured Athlete. Daniel N. Kulund. JB Lippincott, Harper & Row, Philadelphia, 1982, 526 pp., \$42.50.

The Injured Athlete will serve well the physician who finds sports medicine of major interest. Moreover, all physicians encountering patients who engage in athletics of any type should be able to rely on this volume as a handy reference to training, injury evaluation, and rehabilitation. The text has smooth readability and delivers an organization exactly as promised by the author in his preface: to serve the physician over a wide spectrum of involvement with athletes.

The author's approach to the athlete is consistent with the comprehensive quality of care provided by the family physician. Effective warm-up and training technique and the prevention of injuries are emphasized, as is the importance of the mandatory, thorough preparticipation history and physical evaluation.

From a practical standpoint, an extensive part of this selection deals systematically with athletic injuries, often sports specific, employing a methodical format leading the reader to successful patient management: mechanism of injury, anatomical defect, immediate therapy, and rehabilitation.

With the addition of numerous helpful illustrations and the com-

prehensive index, *The Injured Athlete* strikes me as an exceptionally valuable text for office reference.

James J. Bergman, MD
Seattle, Washington

Eyes Only. Kenneth B. Kauver. Appleton-Century-Crofts, E. Norwalk, Connecticut, 1982, 195 pp., \$6.95.

The author developed this book from written descriptions of various eye problems that he used to supplement and clarify the information he gave his patients orally. It was not the author's intent to provide a manual for self-diagnosis and treatment but to give an overview of the care of the eyes and some of the conditions that can adversely affect the vision. The book lies somewhere between the usual patient information booklet and a text for general physicians in understanding eye problems.

Eyes Only is readable and understandable from the physician's standpoint; however, it may be a little too detailed for understanding by the average patient. On the other hand, the text is not sufficiently detailed to be a reference text for a family physician, as this was not the author's intention.

The book is organized into nine

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BRIEF SUMMARY

MINIPRESS® (prazosin hydrochloride) CAPSULES For Oral Use
INDICATIONS: MINIPRESS® (prazosin hydrochloride) is indicated in the treatment of hypertension. As an antihypertensive drug, it is mild to moderate in activity. It can be used as the initial agent or it may be employed in a general treatment program in conjunction with a diuretic and/or other antihypertensive drugs as needed for proper patient response.

WARNINGS: MINIPRESS (prazosin hydrochloride) may cause syncope with sudden loss of consciousness. In most cases this is believed to be due to an excessive postural hypotensive effect, although occasionally the syncope episode has been preceded by a bout of severe tachycardia with heart rates of 120-160 beats per minute. Syncope episodes have usually occurred within 30 to 90 minutes of the initial dose of the drug; occasionally they have been reported in association with rapid dosage increases or the introduction of another antihypertensive drug into the regimen of a patient taking high doses of MINIPRESS (prazosin hydrochloride). The incidence of syncope episodes is approximately 1% in patients given an initial dose of 2 mg or greater. Clinical trials conducted during the investigational phase of this drug suggest that syncope episodes can be minimized by limiting the initial dose of the drug to 1 mg, by subsequently increasing the dosage slowly, and by introducing any additional antihypertensive drugs into the patient's regimen with caution (see **DOSAGE AND ADMINISTRATION**). Hypotension may develop in patients given MINIPRESS who are also receiving a beta-blocker such as propranolol.

If syncope occurs, the patient should be placed in the recumbent position and treated supportively as necessary. This adverse effect is self-limiting and in most cases does not recur after the initial period of therapy or during subsequent dose titration.

Patients should always be started on the 1 mg capsules of MINIPRESS (prazosin hydrochloride). The 2 and 5 mg capsules are not indicated for initial therapy.

More common than loss of consciousness are the symptoms often associated with lowering of the blood pressure, namely, dizziness and lightheadedness. The patient should be cautioned about these possible adverse effects and advised what measures to take should they develop. The patient should also be cautioned to avoid situations where injury could result should syncope occur during the initiation of MINIPRESS (prazosin hydrochloride) therapy.

Usage in Pregnancy: Although no teratogenic effects were seen in animal testing, the safety of MINIPRESS (prazosin hydrochloride) in pregnancy has not been established. MINIPRESS (prazosin hydrochloride) is not recommended in pregnant women unless the potential benefit outweighs potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of MINIPRESS (prazosin hydrochloride) in children.

ADVERSE REACTIONS: The most common reactions associated with MINIPRESS (prazosin hydrochloride) therapy are: dizziness 10.3%, headache 7.8%, drowsiness 7.6%, lack of energy 6.9%, weakness 6.5%, palpitations 5.3%, and nausea 4.9%. In most instances side effects have disappeared with continued therapy or have been tolerated with no decrease in dose of drug.

The following reactions have been associated with MINIPRESS (prazosin hydrochloride), some of them rarely. (In some instances exact causal relationships have not been established.)

Gastrointestinal: vomiting, diarrhea, constipation, abdominal discomfort and/or pain.

Cardiovascular: edema, dyspnea, syncope, tachycardia.

Central Nervous System: nervousness, vertigo, depression, paresthesia.

Dermatologic: rash, pruritus, alopecia, lichen planus.

Genitourinary: urinary frequency, incontinence, impotence, priapism.

EENT: blurred vision, reddened sclera, epistaxis, tinnitus, dry mouth, nasal congestion.

Other: diaphoresis.

Single reports of pigmentary mottling and serous retinopathy, and a few reports of cataract development or disappearance have been reported. In these instances, the exact causal relationship has not been established because the baseline observations were frequently inadequate.

In more specific slit-lamp and funduscopic studies, which included adequate baseline examinations, no drug-related abnormal ophthalmological findings have been reported.

DOSAGE AND ADMINISTRATION: The dose of MINIPRESS (prazosin hydrochloride) should be adjusted according to the patient's individual blood pressure response. The following is a guide to its administration:

Initial Dose: 1 mg two or three times a day. (See Warnings.)

Maintenance Dose: Dosage may be slowly increased to a total daily dose of 20 mg given in divided doses. The therapeutic dosages most commonly employed have ranged from 6 mg to 15 mg daily given in divided doses. Doses higher than 20 mg usually do not increase efficacy; however, a few patients may benefit from further increases up to a daily dose of 40 mg given in divided doses. After initial titration some patients can be maintained adequately on a twice daily dosage regimen.

Use With Other Drugs: When adding a diuretic or other antihypertensive agent, the dose of MINIPRESS (prazosin hydrochloride) should be reduced to 1 mg or 2 mg three times a day and retitration then carried out.

HOW SUPPLIED: MINIPRESS (prazosin hydrochloride) is available in 1 mg (white #431), 2 mg (pink and white #437) capsules in bottles of 250, 1000, and unit dose institutional packages of 100 (10 x 10's); and 5 mg (blue and white #438) capsules in bottles of 250, 500 and unit dose institutional packages of 100 (10 x 10's).

More detailed information available on request.

References: 1. O'Conner DJ, Preston RA, Sasso EH: Renal perfusion changes during treatment of essential hypertension: Prazosin versus propranolol. *J Cardiovasc Pharmacol* 1(suppl):S38-S42, 1979. 2. Falase AO, Salako LA: The effect of prazosin combined with a diuretic, polythiazide, in hypertensive Africans. *Curr Ther Res* 25:10-15, 1979. 3. Okun R, Maxwell M: Long-term antihypertensive therapy with prazosin plus a diuretic. *J Cardiovasc Pharmacol* 1(suppl):S21-S27, 1979. 4. Kirkendall WM, Hammond JJ, Thomas JC, et al: Prazosin and clonidine for moderately severe hypertension. *JAMA* 240 (23): 2553-2556, December 1, 1978. 5. Harter HR, Delmez JA: Effects of prazosin in the control of blood pressure in hypertensive dialysis patients. *J Cardiovasc Pharmacol* 1(suppl):S43-S55, 1979. 6. Leren P, Foss PO, Helgeland A, et al: Effect of propranolol and prazosin on blood lipids: The Oslo study. *Lancet*: 4-6, July 5, 1980. 7. Lowenstein J, Neusy A-J: The biochemical effects of antihypertensive agents and the impact on atherosclerosis. *J Cardiovasc Pharmacol* 4 (suppl 2):S262-S264, 1982. 8. Kokubu T, Itoh I, Kurita H, et al: Effect of prazosin on serum lipids. *J Cardiovasc Pharmacol* 4 (suppl 2):S228-S232, 1982. 9. Velasco M, Silva H, Morillo J, et al: Effect of prazosin on blood lipids and on thyroid function in hypertensive patients. *J Cardiovasc Pharmacol* 4 (suppl 2):S225-S227, 1982.

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chapters including sections on caring for your eyes, understanding your visual problems, conditions of the extraocular muscles, conditions of the front of the eye, conditions of the back of the eye, general eye problems, undergoing eye surgery, new procedures and techniques of eye care, and an eye care checklist.

Informative contents of these chapters deal with common misconceptions about eye care, emergency procedures, and prevention of injury, which would be good common knowledge for all patients and physicians. The text is supplemented by illustrations of the eye anatomy and instruments used in the examination of the eyes.

This book would be appropriate for an intelligent patient desiring to learn more about the problems affecting vision and some of the reasoning an ophthalmologist uses in selecting an appropriate treatment of the specific visual problem.

I believe the book would be of benefit to family physicians, residents, and such allied health professionals in family practice as family nurse practitioners. The book may be used as a source of information in teaching patients about specific visual problems and from that standpoint may be a valuable addition to the physician's library.

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A Manual of Neonatal Intensive Care. N.R.C. Robertson. Appleton-Century-Crofts, E. Norwalk, Connecticut, 1982, 278 pp., \$19.95 (paper).

Most family physicians will probably have only two or three complicated newborns in a given year. Those who practice in dedicated rural locales will have to provide

all care for the child. Regardless of the availability of neonatal consultation, these family physicians have to be able to stabilize and support a sick newborn through the first several hours or days of its life.

A Manual of Neonatal Intensive Care contains all the information one needs to help with this care. In 280 pages it presents the author's philosophy regarding newborn care, including temperature control, feeding, fluid and electrolyte balance, resuscitation and initial care of the newborn, and a wide range of altered physiologic states, diseases, and abnormalities of all organ systems. The book is highly readable, and its format lends itself to a speedy review of any area of concern.

The chapter "Resuscitation and Initial Care of the Newborn" is very well written. It in itself makes the volume a worthwhile investment. All chapters begin with a discussion of the physiology relevant to the organ system under discussion, followed by brief but concise discussions of pathologic conditions and their management.

A 29-page index (10 percent of the book's content) is complete and easy to use. There is a ten-page listing of procedures and their pitfalls. There is a listing of approximately 50 commonly used drugs and their dosages. Most of the literature references are to pre-1980 publications, and most are readily available in U.S. medical libraries.

Whereas I have a moderate aversion to "pocket manuals" (a family physician's pockets could not begin to hold all the manuals needed), I think this small book would be a useful addition to the library.

Douglas D. Pile, MD
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Sports Medicine in Primary Care.

Robert C. Cantu. *The Collamore Press, D.C. Heath & Company, Lexington, Massachusetts, 1982, 229 pp., \$16.95 (paper).*

Prescribing sports as medicine is a growing part of the family physician's practice. Patients are demanding that physicians respond in a knowledgeable and sensitive manner to questions about sports training and injuries. Since most practicing physicians have little more than anecdotal information on sports medicine to supplement their basic medical training, there is a place for a practical reference textbook.

Sports Medicine in Primary Care by Dr. Robert C. Cantu is a reference book that will respond to most of the physician's questions on sports in medicine, such as "How do I evaluate and prescribe for patients who wish to initiate a physical fitness program?" Within the section entitled "Well-Patient Sports Medicine," the author effectively covers a range of issues that most frequently concern patients: "Is my heart ready for exercise?" "What will happen to my body when I exercise?" "What should I eat?" "How can I maintain my exercise program?" "How should I choose my sport?" "After I choose my sport, how far, how fast, and how long should I exercise?"

The last question in this list pertains to the exercise prescription. Although most aspects of the exercise prescription are well covered by Cantu, I have problems with the convoluted exercise program the author prescribes. It seems to me that a sure way to discourage exercise is to recommend a 15- to 25-step exercise protocol. Since no one has shown an advantage of a complex exercise protocol over a

simple walk, run, or swim, the question must be asked, "Why make the exercise process so complicated?" This same criticism applies to the many words and illustrations given over to stretching exercises. The absence of any definitive studies showing the worth of these various stretching maneuvers over specific sporting activities raises the question "Why bother?"

I am impressed with the success that Cantu and his contributors, Means, Micheli, Siegel, and Vinger, have achieved in treating the full scope of sports injuries—prevention, diagnosis, treatment, and rehabilitation. If family physicians are to become recognized as part of the sports medicine scene, it is imperative that they become involved in the prevention and rehabilitation of sports injuries. Care of the athlete is incomplete if the program limits attention only to diagnosis and treatment. The athlete wants to know how to prevent recurrences of the injury and how to become involved in the rehabilitation program that will result in a rapid but safe return to play.

Sports Medicine and Primary Care is a well written and illustrated book for all those in family practice who are interested in sports medicine. It may be used as a textbook for medical students and resident physicians or as a reference book for practicing physicians.

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Drug Use in Pregnancy. Jennifer R. Niebyl (ed). *Lea & Febiger, 1982, Philadelphia, 194 pp., \$18.50 (USA), \$22.50 (Canada).*

This multiauthored book is a successful approach to a very important topic. Three broad categories of drug use are discussed.

First, several chapters are devoted to drugs commonly prescribed for conditions unrelated to pregnancy such as antibiotics and anticoagulants. The second category, a discussion of nonprescription drug use, includes caffeine, narcotics, and mild analgesics. The book is worth getting if only for the excellent reviews on alcohol use and cigarette smoking. The third group of drugs are those used specifically for problems of pregnancy: drugs for nausea of pregnancy, treatment and prevention of premature labor, and corticosteroids for prevention of respiratory distress syndrome.

The first chapter discusses the difficult issue of assessment of the teratogenic risks of drugs. In this area decisions must be based on incomplete evidence. As the author points out, for many reasons the conclusions drawn from animal tests are unreliable.

A book such as this cannot possibly deal with all drugs that could conceivably be used in pregnancy, but most of the common and important drugs are included. The authors were chosen because of their expertise and interest in the particular drugs discussed.

Many drugs pose risks to the unborn child during the first trimester of pregnancy, even before the woman knows that she is pregnant. For this reason, I highly recommend this book, not only for physicians who include obstetrics as part of their practices, but for all physicians who care for women in the childbearing years. The book will not only help the physician in his choice of drugs for the pregnant patient but also provide valuable information for preconception counseling.

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