

Management of Labor in Which Epidural Anesthesia Is Used

EA is a significant intervention about which patients should be well informed. Ideally, education should occur prior to the onset of labor so that the patient can be knowledgeable about her options during labor and delivery.

Because of the strong association with need of oxytocin augmentation after EA,^{2,4} consideration should be given to placing an intrauterine pressure catheter early in the course of labor to measure contraction strength if EA is to be used.

If avoidance of instrumental delivery is desired, allowing the degree of anesthesia to decrease^{5,11} or using a lighter level of anesthesia as described by Potter and MacDonald⁹ should be considered. Another recommendation to avoid rotational forceps is to allow the woman to remain on her side for up to one hour after complete cervical dilation before beginning pushing. It may be more considerate of the mother and fetus to question the use of EA for pain-free labor and delivery than to accept the complications associated with EA. Although there are methodologic problems with many studies of

epidural anesthesia, it does appear that it may significantly alter the course and management of labor and delivery.

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Binge Eating, Vomiting, and Weight Fear in a Female High School Population

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Bulimia nervosa is an eating disorder characterized by alternating episodes of binge eating and rigid dieting and is frequently associated with self-

induced vomiting following binges.^{1,2} Another determining characteristic is a morbid fear of fat. These behaviors are often found in patients with anorexia nervosa, although the latter disorder involves less frequent bingeing behavior. Furthermore, anorexia nervosa involves self-induced loss of weight with severe emaciation and persistent amenorrhea.²

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This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dose as determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be re-evaluated as conditions in each patient warrant.

INDICATIONS AND USAGE: MINIZIDE (prazosin hydrochloride polythiazide) is indicated in the treatment of hypertension. (See box warning.)

CONTRAINDICATIONS: RENESSE (polythiazide) is contraindicated in patients with anuria, and in patients known to be sensitive to thiazides or to other sulfonamide-derived drugs.

WARNINGS: MINIPRESS (prazosin hydrochloride) may cause symptoms with sudden loss of consciousness. In most cases this is observed to occur on progressive and/or hypertensive effect, although occasionally the syncope episode has been preceded by a bout of severe tachycardia with heart rates of 120-150 beats per minute. Syncope episodes have usually occurred within 30 to 90 minutes of the initial dose of the drug. The episodes have been reported in association with rapid dosage increases or the introduction of another antihypertensive drug. The regimen of a patient taking high doses of MINIPRESS. 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 drug into the patient's regimen with caution. (See DOSAGE AND ADMINISTRATION.) Hypertension 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 symptomatically 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 be warned that the 1 mg capsules of MINIPRESS. The 2 mg and 5 mg capsules are not indicated for initial therapy. Major common side effects of this drug are the symptoms often associated with lowering of the blood pressure, namely, dizziness and orthostatic hypotension. 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 therapy.

RENESSE: RENESSE should be used with caution in renal disease. Thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be avoided in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Thiazides may be additive or synergistic with the action of other antihypertensive drugs.

Retention of calcium may aggravate or precipitate osteoporosis, osteoarthritis, and/or osteomalacia. Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

In patients receiving thiazide therapy, should be observed for clinical signs of fluid or electrolyte imbalance, namely, hypokalemia, hypochloremic alkalosis, and hypotension. Serum and urine electrolyte determinations are particularly important when the patient is receiving a diuretic. Major electrolyte disturbances are also influenced by other drugs. Warning signs, irrespective of cause, are: weakness, fatigue, drowsiness, restlessness, muscle aches or cramps, muscular fatigue, hyposthenia, anorexia, headache, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any potent diuretic, especially with initial diuresis, when severe orthostasis is present, or during concomitant use of corticosteroids or ACTH.

Hypokalemia with adequate oral potassium intake will also contribute to hypokalemia. Digitalis therapy may exaggerate the metabolic effects of hypokalemia, especially with concurrent thiazide therapy.

Anti-hypertensive generally indicated usually does not require special treatment except under extraordinary circumstances (as in the case of renal disease). Hypotension may occur in debilitated patients in too weakly, appropriate therapy is water restriction rather than intravenous salt. Severe hypotension when the hypotension is life-threatening, intravenous fluid depletion appropriate replacement to the therapy if it occurs.

Hypertension may occur in some patients who are treated with certain antipsychotics receiving thiazide therapy. Usual requirements in debilitated patients may be further increased, decreased, or unchanged. Latent diabetes mellitus may become manifest during thiazide administration.

Thiazide drug may increase responsiveness to digitalis glycosides. The antihypertensive effect of the drug may be diminished in the presence of digitalis glycoside.

Thiazides may obscure or mask hypotension in hypotensive patients. This combination is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

In hypotensive state (low blood pressure), as indicated by a rising prothrombin time or a fall in blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withdrawal or discontinuation of thiazide therapy.

Thiazides may decrease serum sodium, potassium levels without signs of the electrolyte imbalance.

PRECAUTIONS: Contraception, Fertility, and Pregnancy: No contraceptive or mutagenic studies have been conducted with MINIZIDE (prazosin hydrochloride polythiazide). However, acute uterine contraction was demonstrated in 16-month studies in rats with MINIPRESS (prazosin hydrochloride) and RENESSE (polythiazide) at doses 40 times the usual maximum human doses. MINIPRESS was not mutagenic in three genetic toxicology studies.

MINIZIDE produced no impairment of fertility in male or female rats of 50 and 25 mg/kg/day of MINIPRESS and RENESSE, respectively, in uterine studies in the year or more of MINIPRESS or in uterine studies. Fetal changes consisting of atrophy and necrosis occurred at 25 mg/kg/day (50 times the usual maximum recommended human dose). No fetal changes were seen in rats or dogs at 5 mg/kg/day (10 times the usual maximum recommended human dose). In view of the fetal changes observed in animals, 100 patients on long-term MINIPRESS therapy were monitored for fetal abnormalities and no changes including a drug effect were observed. In addition, 27 women on MINIPRESS therapy for 2 to 12 months showed no changes in breast morphology suggestive of drug effect.

Use in Pregnancy: Pregnancy category B. MINIZIDE was not teratogenic in either rats or rabbits when administered at doses 40 times the usual maximum human dose. Studies in rats indicated that the combination of RENESSE (40 times the usual maximum recommended human dose) and MINIPRESS (10 times the usual maximum recommended human dose) produces a greater number of stillbirths, a low offspring survival rate, and decreased survival of pups to weaning than that caused by MINIPRESS alone. There are no adequate and well-controlled studies in pregnant women. Therefore, MINIZIDE (prazosin hydrochloride polythiazide) should be used in pregnancy only if the potential benefits justify the potential risks to the fetus.

Lactation: Nursing Mothers: It is not known whether MINIPRESS (prazosin hydrochloride) or RENESSE (polythiazide) are excreted in human milk. Thiazides are known to be excreted in milk. The usual nursing infant should be monitored for possible drug effects.

ADVERSE REACTIONS: MINIPRESS: The most common reactions associated with MINIPRESS therapy are: dizziness, 0.2%, headache, 0.2%, drowsiness, 0.2%, rapid therapy, 0.2%, weakness, 0.2%, anorexia, 0.2%, orthostatic hypotension, 0.2%, tachycardia, 0.2%. In most instances side effects have disappeared with continued therapy or have been treated with the usual measures of symptomatic relief.

The following reactions have been associated with MINIPRESS (prazosin hydrochloride) in some instances causal relationships have not been established:

- Headache, dizziness, drowsiness, orthostatic hypotension, abnormal electrocardiogram.
 - Orthostatic hypotension, weakness, fatigue, depression, anorexia.
 - Central Nervous System: depression, vertigo, depression, anorexia.
 - Dermatologic: rash, conjunctivitis, itching, skin pruritus.
 - Cardiovascular: tachycardia, palpitations, orthostatic hypotension, hypotension, dizziness, drowsiness, depression.
 - Eye: blurred vision, edema, conjunctivitis, conjunctivitis, dry mouth, nasal congestion.
 - Other: hypotension.
- Some reports of congestive heart failure and edema associated with a few reports of breast development in this population have been reported. In these instances, the exact causal relationship has not been established. These side effects have been reported frequently in patients.

When used with other antihypertensive drugs, which included sodium beta-blockers, diuretics, and/or other antihypertensive agents, the following reactions have been reported:

- RENESSE: orthostatic hypotension, dizziness, weakness, drowsiness, depression, anorexia, orthostatic hypotension, tachycardia, conjunctivitis, conjunctivitis, dry mouth, nasal congestion, orthostatic hypotension, dizziness, weakness, drowsiness, depression, anorexia, orthostatic hypotension, tachycardia, conjunctivitis, conjunctivitis, dry mouth, nasal congestion.
- Other: hypotension, dizziness, orthostatic hypotension, weakness, drowsiness, depression, anorexia, orthostatic hypotension, tachycardia, conjunctivitis, conjunctivitis, dry mouth, nasal congestion.

OVERDOSE: MINIPRESS: Accidental ingestion of 100 mg (20 times the usual maximum recommended human dose) resulted in a profound bradycardia and hypotension. Overdose cases of 100 mg (20 times the usual maximum recommended human dose) were reported. Recovery was uneventful.

Should overdose lead to hypotension, support of the cardiovascular system is of first importance. Restoration of blood pressure and normalization of heart rate may be accomplished by keeping the patient in the supine position. If this measure is inadequate, shock should be treated with volume expanders. If necessary, vasopressors should then be used. Renal function should be monitored and supported as needed. Laboratory data indicate that MINIPRESS is not dialyzable because it is protein bound.

RENESSE: Should overdose with RENESSE occur, electrolyte balance and adequate hydration should be maintained. Gastric lavage is recommended, followed by supportive treatment. Where necessary, this may include intravenous dextrose and saline with potassium and other electrolyte therapy, administered with caution as indicated by laboratory testing at appropriate intervals.

DOSAGE AND ADMINISTRATION: MINIZIDE (prazosin hydrochloride polythiazide): Dosage as determined by individual titration of MINIPRESS (prazosin hydrochloride) and RENESSE (polythiazide). (See box warning.)

Usual MINIZIDE dosage is one capsule two or three times daily, the strength depending upon individual requirement following titration. The following is a general guide to the administration of the individual components of MINIZIDE:

MINIPRESS: 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: In the presence of a diuretic or other antihypertensive agent, the dose of MINIPRESS should be reduced to 1 mg or 2 mg three times a day and titration then carried out as usual.

RENESSE: The usual dose of RENESSE for antihypertensive therapy is 2 to 4 mg daily.

STRENGTH	COMPONENTS	COLOR	CAPSULE CODE	PKG. SIZE
MINIZIDE 1	1 mg prazosin + 0.5 mg polythiazide	Blue-Green	430	100's
MINIZIDE 2	2 mg prazosin + 0.5 mg polythiazide	Blue-Green/Pink	432	100's
MINIZIDE 5	5 mg prazosin + 0.5 mg polythiazide	Blue-Green/Blue	436	100's



BINGE EATING, VOMITING, AND WEIGHT FEAR

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Bulimia nervosa has been called a dangerous disorder because it may lead to potassium depletion and other physical complications, such as swollen salivary glands and deterioration of tooth enamel. Psychological complications may include anxiety, depression, and interference with daily functioning caused by obsessional thoughts of food and vomiting.²

Data now suggest that bulimia nervosa, considered rare until recently, may be widespread among college undergraduates, particularly women.^{1,3} Although several sources suggest that the onset of binge eating occurs in adolescence,^{4,5} there has been no known report on the prevalence of bulimia nervosa symptoms in a high school population. Therefore, investigating younger adolescent populations would be a useful step in providing a greater understanding of the development of the disorder.

Methods

The Eating Attitudes Test (EAT) is a 40-item questionnaire that has been shown to identify accurately anorexic patients.⁶ Although validated on an anorexic population, the measure provides information on the bulimia symptoms of binge eating, vomiting after eating, and fears of weight gain. Moreover, the frequency of amenorrhea is reflected on the EAT. This item may serve to identify anorexics as opposed to bulimics, since the latter population would be more likely to continue menses. The present study involved the administration of the EAT to a female adolescent population in an attempt to determine the prevalence of symptoms often associated with bulimia nervosa.

A total of 151 girls from the only two public high schools in a small northwest Georgia community (population, 40,000) were assessed. As the assessment involved only girls, home economics classes, in which few male students were enrolled, were evaluated. Furthermore, the seven home economics classes assessed represented all such classes composed of tenth graders. As a result,

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Table 1. Responses to Specific Items Related to Eating Binges, Vomiting After Eating, and Fear of Weight Gain

Item	Frequency			Percentage of Sample
	Always	Very often	Often	
Have gone on uncontrollable eating binges	4	2	19	16.6
Vomit after I have eaten	4	3	3	6.6
Terrified of being overweight	37	10	18	43.1
Preoccupied with a desire to be thinner	30	14	15	39.1
Preoccupied with the thought of having fat on my body	26	18	9	35.1

these data were considered a fairly comprehensive and representative sample of the town's tenth-grade girls.

Permission was obtained from school officials to administer the EAT to a group of female subjects. The voluntary nature of completing the EAT was emphasized and the reasons for administering the questionnaire were explained to the subjects before completion of the questionnaire.

Results

Given the nature of this study, only descriptive statistics were used in analysis. Scores of 30 or above on the EAT have been demonstrated to effectively identify anorexic populations. A total of 18 (11.9 percent) of the subjects scored 30 or above. Importantly, only four of these subjects reported the absence of regular menstrual periods, an essential diagnostic criterion for anorexia nervosa. Therefore, only these four could be considered true anorexia nervosa subjects.

To further evaluate the data, specific items related to bulimia nervosa were isolated (Table 1). A total of 25 (16.6 percent) subjects reported frequent eating binges, while 10 (6.6 percent) reported frequent vomiting episodes after eating. The results for items related to fear of weight gain indicated that 65 (43.1 percent) subjects were ter-

rified of being overweight, 59 (39.1 percent) were preoccupied with a desire to be thinner, and 53 (35.1 percent) were preoccupied with the thought of having fat on their bodies. The results suggest that the symptoms of bulimia nervosa are found in a significant percentage of female high school students. It would appear that a conservative estimate of the frequency of bulimia nervosa in this population would be 6 to 7 percent on the basis of self-induced vomiting, and it may go as high as 16 to 17 percent on the basis of a binge-eating criterion. Using the criterion of irregular menstrual periods, less than 3 percent of these subjects might also be considered anorexic.

Comment

These results are interesting, since bulimic behaviors were considered rare only a few years ago. There are several possible reasons for such a change. The data may simply reflect an increase in public awareness of the problem. Binge eating and self-induced vomiting are usually performed in a secretive manner. Only recently have the specific patterns of behavior associated with bulimia nervosa come to public attention and, thereby, possibly become less clandestine. On the other hand, the findings of increased incidence may be real. Such increases might be due to changes in societal

expectations and the emphasis on thinness in women.⁷ Regardless of the reasons, it is quite apparent that these symptoms are much more prevalent than originally suspected.

It would behoove medical professionals to screen carefully for bulimia nervosa in their young female patients. Once these individuals are identified, treatment should be attempted. Limited evidence suggests that bulimia nervosa patients may respond favorably to behavioral psychological approaches.⁸ Although the successfully treated cases justify guarded optimism, further controlled research is needed prior to the complete advocacy of these or other treatment approaches.

In conclusion, bulimia nervosa appears to be a prevalent disorder, and further research is needed at the levels of assessment, diagnosis, and treatment. It is hoped that physicians will appreciate the implications of the present study, and that it

will aid them in identifying and assisting patients with the symptoms of bulimia nervosa.

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The Clinical Dietitian in Family Practice Residency Programs

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There is increasing emphasis on nutrition education throughout medical education. The American Academy of Family Physicians recently added education in nutrition to its revised special requirements for family practice residency training, which were effective July 1, 1983.¹ How programs will meet this requirement has not been examined. Physicians with a strong background in nutrition may be suitable to teach nutrition, but their scar-

city may have been a compelling force behind this new requirement. The clinical dietitian may appropriately assume this role; however, as yet the scope of the dietitian's involvement has not been established.

The purpose of this study was to define the current role of dietitians in family practice residencies. Specifically, their numbers, educational degrees, and functions were investigated to identify their participation in resident nutrition education.

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Methods

In November 1982 a written questionnaire was mailed to the 385 program directors listed in *The*