

(Continued from preceding page)

**Nursing Mothers:** Captopril is secreted in human milk. Exercise caution when administering captopril to a nursing woman, and, in general, nursing should be interrupted.

**Pediatric Use:** Safety and effectiveness in children have not been established although there is limited experience with use of captopril in children from 2 months to 15 years of age. Dosage, on a weight basis, was comparable to that used in adults. Captopril should be used in children only if other measures for controlling blood pressure have not been effective.

**ADVERSE REACTIONS:** Reported incidences are based on clinical trials involving about 4000 patients.

**Renal**—One to 2 of 100 patients developed proteinuria (see WARNINGS). Renal insufficiency, renal failure, polyuria, oliguria, and urinary frequency in 1 to 2 of 1000 patients.

**Hematologic**—Neutropenia/agranulocytosis occurred in about 0.3% of captopril treated patients (see WARNINGS). Two of these patients developed sepsis and died.

**Dermatologic**—Rash (usually mild, maculopapular, rarely urticarial), often with pruritus and sometimes with fever and eosinophilia, in about 10 of 100 patients, usually during the 1st 4 weeks of therapy. Pruritus, without rash, in about 2 of 100 patients. A reversible associated pemphigoid-like lesion, and photosensitivity have also been reported. Angioedema of the face, mucous membranes of the mouth, or of the extremities in about 1 of 100 patients—reversible on discontinuance of captopril therapy. One case of laryngeal edema reported. Flushing or pallor in 2 to 5 of 1000 patients.

**Cardiovascular**—Hypotension in about 2 of 100 patients. See WARNINGS (Hypotension) and PRECAUTIONS (Drug Interactions) for discussion of hypotension on initiation of captopril therapy. Tachycardia, chest pain, and palpitations each in about 1 of 100 patients. Angina pectoris, myocardial infarction, Raynaud's syndrome, and congestive heart failure each in 2 to 3 of 1000 patients.


**Dysgeusia**—About 7 of 100 patients developed a diminution or loss of taste perception; taste impairment is reversible and usually self-limited even with continued drug use (2 to 3 months). Gastric irritation, abdominal pain, nausea, vomiting, diarrhea, anorexia, constipation, aphthous ulcers, peptic ulcer, dizziness, headache, malaise, fatigue, insomnia, dry mouth, dyspnea, and paresthesias reported in about 0.5 to 2% of patients but did not appear at increased frequency compared to placebo or other treatments used in controlled trials.

**Altered Laboratory Findings:** Elevations of liver enzymes in a few patients although no causal relationship has been established. Rarely cholestatic jaundice and hepatocellular injury with secondary cholestasis have been reported. A transient elevation of BUN and serum creatinine may occur, especially in volume-depleted or renovascular hypertensive patients. In instances of rapid reduction of longstanding or severely elevated blood pressure, the glomerular filtration rate may decrease transiently, also resulting in transient rises in serum creatinine and BUN. Small increases in serum potassium concentration frequently occur, especially in patients with renal impairment (see PRECAUTIONS).

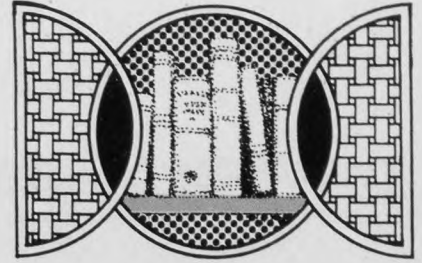
**OVERDOSAGE:** Primary concern in correction of hypotension. Volume expansion with an I.V. infusion of normal saline is the treatment of choice for restoration of blood pressure. Captopril may be removed from the general circulation by hemodialysis.

**DOSAGE AND ADMINISTRATION:** CAPOTEN should be taken one hour before meals. Dosage must be individualized; see DOSAGE AND ADMINISTRATION section of package insert for detailed information regarding dosage in hypertension and in heart failure. Because CAPOTEN (captopril) is excreted primarily by the kidneys, dosage adjustments are recommended for patients with impaired renal function. **Consult package insert before prescribing CAPOTEN (captopril).**

**HOW SUPPLIED:** Available in tablets of 25, 50, and 100 mg in bottles of 100, and in UNIT-MATIC® unit-dose packs of 100 tablets.

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Princeton, NJ 08540 524-501  
Issued: January 1984

## Book Reviews



**Archives of Family Practice (Volume 3, 1982).** John P. Geyman (ed). Appleton-Century-Crofts, East Norwalk, Connecticut, 1982, 349 pp., \$38.50.

This book is unique in family practice literature in that it focuses exclusively on the educational, clinical, and research developments in family practice as a specialty in its own right and in its own setting. It is the third of a continuing annual series and in contrast to the first two volumes is heavily weighted toward clinical advances in the field.

The book has an international flavor, drawing upon work by authors from the United States, Canada, the United Kingdom, Israel, and Australia. This volume of the *Archives* is divided into three sections: (1) Clinical Research in Family Practice, (2) Quality Care Assessment, and (3) Continuing Education in Family Practice. The contents include 34 original papers by outstanding authors involved in family practice/general practice from around the world. The book also contains 73 well-condensed and superbly written abstracts of articles published in various international journals by physicians whose primary interest is family practice.

This volume of the *Archives* is a solid indication of the progress of the specialty in establishing its own area of clinical medicine, in its contributions to medical education, and probably most important of all, at this time, its own area of clinical research.

*Archives of Family Practice* is certainly of interest and value to those family physicians involved in academic medicine and with this volume becomes increasingly valuable to the clinician. Not only are the *Archives* valuable in keeping abreast of advances in the field, they also offer evidence of the growing stature of family medicine.

George E. Burket, Jr, MD  
University of Kansas  
School of Medicine  
Kingman, Kansas

**Clinical Dermatology: Diagnosis and Therapy of Common Skin Diseases.** P. Vasarinsh. Butterworth, Boston, 1982, 744 pp., \$49.95.

*Clinical Dermatology* by Vasarinsh is one of the few textbooks of dermatology specially dedicated to the practicing primary care physi-

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- References:** 1. Kales J et al: *Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. 2. Kales A et al: *Clin Pharmacol Ther* 18:356-363, Sep 1975. 3. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 4. Kales A et al: *Clin Pharmacol Ther* 32:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 6. Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. 7. Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. 8. Greenblatt DJ et al: *Sleep* 5 (Suppl 1):S18-S27, 1982. 9. Kales A et al: *Pharmacology* 26:121-137, 1983. 10. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. 11. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 12. Amrein R et al: *Drugs Exp Clin Res* 9(1):85-99, 1983.

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Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

**Contraindications:** Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided, with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

**Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.

## BOOK REVIEWS

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It has the clarity and evenness possible only in a single-authored text; moreover, the author happens to be a dermatologist who has extensive experience teaching and relating to family practice residents and practicing primary care physicians. The lucidity of his writing reveals an honest appreciation of those dermatologic problems frequently encountered by the non-specialist.

The author avoids the internal medicine bias of many dermatology texts. It was a pleasure to note the integration of pediatric and obstetric and gynecological considerations into the various topics. Patient instruction sheets are available for acne, atopic dermatitis, and chronic hand eczema. The continued advocacy for comedo extraction (despite little or no acceptance by most physicians and their patients) does not reflect the reality of primary care. However, reasonable management options have been presented in all cases.

The text is palatable and easily digestible. The organization is by clinical group with a special chapter devoted to regional dermatology. Pathogenesis is emphasized in all chapters. Treatment recommendations are generic with occasional omission of dosage ranges, frequency of dosing, and treatment durations. This information would be helpful in providing realistic expectations in terms of treatment response. Perhaps, Kenneth Arndt's *Handbook of Dermatologic Therapy* (Little, Brown) would serve as the perfect companion volume.

The photographs are black-and-white but very representative and effective. The line drawings, which are generously employed, are also outstanding.

We would recommend this text

to all practicing family physicians and to residents who desire a dermatologic text that fills the void between the major tomes and the pocket atlases. This volume will not gather dust but will become a frequently used reference book.

Jimmy H. Hara, MD  
Wm. MacMillan Rodney, MD  
University of California  
Los Angeles, California

**Diagnosis and Management of Obstetrical Emergencies.** Hossam Fadel (ed). Addison-Wesley Publishing Company, Menlo Park, California, 1982, 324 pp., \$26.95.

A volume devoted to the complications of pregnancy is extremely useful to the practicing physician, particularly the family physician who may need a quick review of the subject and a checklist to make sure that the latest thinking and treatment are incorporated in his management of his own patient. The goal of this book is to give the primary obstetrical caregiver an opportunity to recognize the early signs of developing problems. The book also indicates which problems will lead to more potential morbidity and mortality and thus allows consultation and referral should it become necessary. All obstetrical emergencies are not covered, but many significant obstetrical emergencies are, with stress on the diagnosis and management of those conditions. The book is divided into five parts, including early pregnancy complications, late pregnancy complications, intrapartum, postpartum, and associated medical and surgical problems. There is an attempt to begin each chapter

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## New Pump!

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(flunisolide) nasal solution  
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### Brief Summary

**Description:** Each bottle contains flunisolide in a solution of propylene glycol, polyethylene glycol 3350, citric acid, sodium citrate, butylated hydroxyanisole, edetate disodium, benzalkonium chloride, and purified water, with NaOH and/or HCl added to adjust the pH. It contains no fluorocarbons.

**Indications:** For relief of the symptoms or seasonal or perennial rhinitis when effectiveness of or tolerance to conventional treatment is unsatisfactory.

Improvement is usually apparent within a few days after starting Nasalide but may take as long as 2 weeks in some patients. Although systemic effects are minimal at recommended doses, Nasalide should not be continued beyond 3 weeks in the absence of significant symptomatic improvement. Nasalide should not be used in the presence of untreated localized infection involving nasal mucosa.

**Contraindications:** Hypersensitivity to any ingredients.

**Warnings:** Patients transferred from systemic steroid therapy to Nasalide should be monitored to avoid acute adrenal insufficiency in response to stress. Since some patients may experience symptoms of withdrawal, attention must be given to patients previously treated for prolonged periods with systemic corticosteroids, particularly those with associated asthma or other clinical conditions where too rapid a decrease in systemic corticosteroids may cause a severe exacerbation of symptoms. Nasalide should be used with caution in patients on alternate-day prednisone for any disease.

**Precautions: General:** Localized *Candida albicans* infections of the nose and pharynx occurred only rarely in clinical studies, but if such an infection presents, treatment with appropriate local therapy or discontinuation of Nasalide treatment may be required.

Flunisolide is absorbed into the circulation. Systemic effects have been minimal with recommended doses but larger doses should be avoided since excessive doses may suppress hypothalamic-pituitary-adrenal function.

Nasalide should be used with caution in patients with active or quiescent tuberculosis infections of the respiratory tract; untreated fungal, bacterial, or systemic viral infections; or ocular herpes simplex.

In patients who have experienced recent nasal septal ulcers, recurrent epistaxis, nasal surgery, or trauma, a nasal corticosteroid should be used with caution until healing has occurred.

**Information for Patients:** Nasalide should be used as directed at the prescribed dosage. Nasal vasoconstrictors or oral antihistamines may be needed until the effects of Nasalide are fully manifested. The patient should follow the Patient Instructions carefully and should contact a physician if symptoms do not improve, if the condition worsens, or if sneezing or nasal irritation occurs.

**Carcinogenesis:** While no evidence of carcinogenicity was found in a 22-month study in Swiss-derived mice, there was a slight increase in the incidence of pulmonary adenomas which was well within the range of spontaneous adenomas previously reported for untreated Swiss-derived mice.

**Impairment of Fertility:** Female rats receiving high doses of flunisolide (200 mcg/kg/day) showed some evidence of impaired fertility. Reproductive performance in low and mid dose groups was comparable to controls.

**Pregnancy:** Pregnancy Category C. The drug has been shown to be teratogenic and fetotoxic in rabbits and rats. The drug should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:** Because other corticosteroids are excreted in human milk, caution should be exercised when the drug is administered to nursing women.

**Adverse Reactions:** The most frequent complaints were mild transient nasal burning and stinging (reported in approximately 45% of patients). These complaints do not usually interfere with treatment; in only 3% of patients was it necessary to decrease dosage or stop treatment because of those symptoms.

Incidence of 5% or less: nasal congestion, sneezing, epistaxis and/or bloody mucus, nasal irritation, watery eyes, sore throat, nausea and/or vomiting, headaches and loss of sense of smell and taste. In rare instances, nasal septal perforations were observed during the studies but a causal relationship with Nasalide was not established.

Systemic corticosteroid side effects were not reported during the controlled clinical trials. If recommended doses are exceeded, or if individuals are particularly sensitive, symptoms of hypercorticism could occur.

**Dosage and Administration:** Full therapeutic benefit requires regular use and is usually evident within a few days, but up to 3 weeks may be required for some patients to achieve maximum benefit. Patients should use a decongestant and clear their nasal passages of secretions prior to use. Recommended starting dose in adults: 2 sprays in each nostril b.i.d. If needed, increase to 2 sprays t.i.d.

Recommended starting dose in children (6-14 years): 1 spray in each nostril t.i.d. or 2 sprays in each nostril b.i.d. Not recommended for use in children less than 6 years old.

Total daily doses: not to exceed 8 sprays in each nostril for adults and 4 sprays in each nostril for children.

Maintenance dose: smallest amount necessary to control symptoms.

**How Supplied:** Each 25 ml Nasalide<sup>®</sup> (flunisolide) nasal solution spray bottle (NDC 0033-2906-40) contains 6.25 mg (0.25 mg/ml) of flunisolide and is supplied with a nasal pump unit with dust cover, and patient instructions.



Syntex Laboratories, Inc.  
Palo Alto, CA 94304

## BOOK REVIEWS

Continued from page 646

with an overview. The use of marginal notes to allow for skimming the material is innovative. There are significant attempts to make the book not only readable but also accessible to rapid review of the specific problem.

Each chapter has listed associated references that touch on the areas mentioned in the chapters. There is a sparing use of illustrations. These are for the most part line drawings with occasional photographs that give emphasis to the text. There is judicious use of nomograms and algorithms. As previously mentioned, there is a deliberate limitation on the scope of the text, but there is coverage of quite a wide number of complications, including a section on emergency anesthesia for obstetric complications, management of the unexpected cesarean section, and an excellent chapter on resuscitation of the newborn. Complications of the acute abdomen in pregnancy, diabetes, cardiac emergencies, and embolic disease are covered in the section on associated complications. An appendix lists frequently used drugs in obstetric emergencies. The class of agent and the appropriate medications under each class are listed.

Designed for the primary care physician in the active practice of obstetrics, this compact reference would serve well as a text for residents and students in family practice or obstetrics. Easily readable, it can be skimmed for the essentials of each chapter. It would also be a useful review text for allied health professionals and nurse midwives.

Any attempt to produce a book on complications must be frustrating because of the strenuous selectivity necessary. Common compli-

cations are included here in detail with a specific format to allow easy review in those emergency situations where such knowledge may not be readily available to the practicing physician. No brief is made for extensive in-depth presentation, but sufficient direction to obtain more information is given with each chapter. All in all, the family physician who, in the middle of the night, finds himself presented with an obstetrical complication he has not seen in the past five years would appreciate the ability to pick up a small volume and review the latest information on that complication, and this book fulfills that need in an exemplary fashion.

*Richard C. Barnett, MD  
Family Practice Program  
Santa Rosa, California*

**Clinical Epidemiology—The Essentials.** Robert H. Fletcher, Suzanne W. Fletcher, Edward H. Wagner. Williams & Wilkins, Baltimore, 1982, 223 pp., \$16.00 (paper).

This excellent work is suitable reading material for anyone needing information about clinical epidemiology, research design, or interpretation of clinical scientific literature. The text is written in an understandable manner using appropriate clinical examples to illustrate the issues under discussion. The book would be appropriate for beginning students taking an orientation course in epidemiology or would be useful review for any clinician committed to scholarly work.

Explanations of such concepts as normality, outcome measures, bias, validity, reliability, normal distribution, sensitivity, specific-

ity, predictive value, medicine, prevalence, risk, and chance are well done. The book goes beyond some works in epidemiology in addressing such issues as diagnostic strategies, prognoses, and treatments.

Some of the tables and figures are difficult to understand largely because of complexity and failure to define symbols. Most, however, are well done and appropriate to the task at hand. The authors are at times iconoclastic. For instance, it is refreshing to see a concept such as the "normal distribution curve" placed in its real historical perspective as an accident that seems to fit many clinical situations.

The final chapter sums up using the oft-maligned University Group Diabetes Program study to illustrate many of the points previously discussed. The book does its job well and will impart to the reader the essentials of epidemiology.

William C. Fowkes, Jr, MD  
San Jose Health Center  
San Jose, California

**Quick Reference to Clinical Neurology.** Carl H. Gunderson. J.B. Lippincott, Philadelphia, 1982, 451 pp., price not available.

The author of this text on clinical neurology has skillfully succeeded in developing a concise and readable text on this topic. He avoided the pitfall of focusing undue attention on the rare and the exotic. The only major shortcoming is the unfortunate avoidance of a not-so-rare group of problems—those involving the autonomic nervous system.

Although the author states that the book is intended for use by medical students and house officers, it also seems useful as a quick

office reference for any practicing physician not specializing in the field of neurology. The book is highly recommended for practitioners and students alike, and especially for those practitioners who are involved in teaching either medical students or residents.

Raymond Y. Demers, MD  
Wayne State University  
Detroit, Michigan

**Foot and Ankle Pain (2nd Edition).** Rene Cailliet. F. A. Davis Company, Philadelphia, 1983, 200 pp., \$11.95 (paper).

Dr. Cailliet's book, *Foot and Ankle Pain*, provides valuable information for the physician in general and family practice as well as the resident training in family practice. This well-organized book allows the practicing physician to approach multiple foot problems in a systematic way. The book's excellent illustrations help explain the functional anatomy associated with many foot problems and also help clarify many of the recommended therapeutic regimens.

Over the years, I have found that I was inadequately prepared to approach the full spectrum of foot and ankle problems that present to the primary care physician. I have found this volume to be quite helpful as a reference in evaluating and treating these patients.

My only criticism of the book is that in some controversial areas the controversy is not acknowledged, such as in the aggressive treatment of congenital flat feet and metatarsus varus in the newborn infant. Also, I would consider the use of injectable steroids in achilles tendonitis to be somewhat controversial. All in all, however, the book is

a helpful and interesting addition to the physician's library.

George H. Hess, MD  
Carson City, Nevada

**Pediatric Emergencies: A Practical Guide to Acute Pediatrics.** Tom Lissauer. Appleton-Century-Crofts, East Norwalk, Connecticut, 1982, 328 pp., \$22.50.

In this book, Dr. Lissauer aims to provide a practical guide to help junior physicians manage the important acute pediatric problems they are likely to encounter. The author achieves his aim, but to a limited degree.

The chapters are well organized with succinct discussions of etiology, clinical examination, investigations, and management for each problem. The text is written in a very readable style that facilitates quick review of the pertinent points with very little extraneous material. Illustrations and tables are used liberally to provide details not covered in the text, such as laboratory investigations warranted, calculations of fluid deficits, and abbreviated treatment algorithms. Photographs of x-ray films and patients are also included as complements to the written descriptions.

One of the major strengths of the book is the section on practical procedures. This section provides practical guidelines, illustrations, and photographs for obtaining arterial and venous blood samples, starting and maintaining intravenous infusions, and performing lumbar punctures and suprapubic aspirations of urine. Also included is an extensive table of drug dosages for children of different ages.

This book is appropriate for third- and perhaps fourth-year med-



ical students, but is of limited value for house officers. Despite its length, the volume does not provide the details that senior students or residents may require. In addition, hurried house officers may be frustrated by the absence of clearly outlined steps for evaluating and managing the emergencies. In this regard, the *Manual of Pediatric Therapeutics* published by Little, Brown (\$14.95) is far superior. Furthermore, the *Manual of Pediatric Therapeutics* covers some emergencies barely mentioned in *Pediatric Emergencies*, eg, drug abuse, drowning, heat stroke, and cold injury.

For the price difference, I would tend to recommend the *Manual of Pediatric Therapeutics* over *Pediatric Emergencies*.

John C. Rogers, MD  
New Brunswick, New Jersey

**Genetic Counseling (3rd Edition).**  
Walter Fuhrmann, Friedrich Vogel.  
Springer-Verlag, New York, 1983,  
188 pp., \$15.95 (paper).

A general background in genetics is necessary for the family physician, who is often asked questions regarding the chances of having a malformed child or, if one has already been born, the chances of further children manifesting the same or similar abnormality. There are also frequent questions regarding prenatal diagnosis of biochemical diseases, mutagenic problems from radiation exposure, and teratogenic effects of illnesses or medication during early pregnancy. These questions are becoming more frequent as the general public becomes more aware of the field of genetic counseling.

The third edition of *Genetic Counseling* has been revised to reflect current practice, and the au-

thors believe that an interested and informed family physician can give fully adequate counsel in some cases.

The authors present some highly complex material in a readable fashion by first going over the basics: the family medical history or pedigree, and a description of the autosomal dominant and recessive modes of inheritance, sex-linked modes in inheritance, chromosomal aberrations, and new mutations and nonhereditary cases. There are separate chapters on prenatal diagnosis, genetic abnormalities and diseases, mental retardation and mental illness, genetic prognosis for a consanguineous marriage, exposure to mutagenic noxae, teratogenic effects during early pregnancy, and psychological and social considerations of genetic counseling.

Of special interest to the family physician are discussions of indication for chromosomal analysis and amniocentesis in a chapter on prenatal diagnoses.

There are 50 illustrations that are of excellent quality and supplement the text.

I believe this book would be of benefit to the practicing physician and to residents in family practice training programs. It will help the family physician give adequate counsel in some cases and, just as important, recognize the limits of his knowledge and consult with a genetic specialist in these instances. Even when consultation is needed, the physician will have gained information from this book that will help him understand the nature of the problem and allow him to aid the specialist in gathering relevant information.

Lawrence L. Perry, MD  
University of Kansas  
Kansas City, Kansas

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**DOSAGE AND ADMINISTRATION:** One capsule daily or as directed by the physician.

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