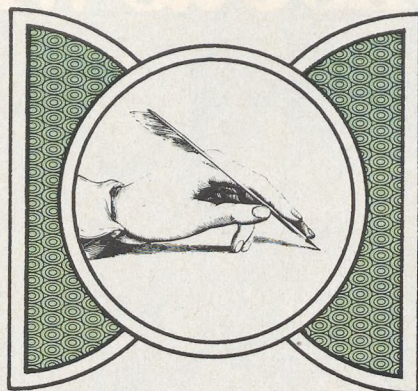


Letters to the Editor



The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Outpatient Failed Appointments

To the Editor:

A challenge for many family practice clinics is to provide patients efficient access to their physician. However, high no-show rates prevent timely access to care by displacing available appointment times into the future. The result is long waiting times for appointments. Furthermore, acute problems are deferred or managed inappropriately (ie, by emergency room visits) if a schedule appears completely "booked" when in fact there is available space once no-shows are taken into account.

I commend Drs. Barry and Daniels (Barry SP, Daniels AA: *Effecting Change in Outpatient Failed Appointments. J Fam Pract* 1984; 18:739-742) for their efforts in trying to demonstrate whether an introductory video tape can reduce the number of failed appointments. Their preliminary findings of success using video taping are encouraging, but many factors that could confound their results were

not addressed. For example, since physician continuity affects no-show rates, the authors did not state whether the randomization process resulted in an equal spread of educational interventions among first-, second-, and third-year residents. This is important, since third-year residents have more clinics available for patient care. One could speculate that these residents might follow their patients more frequently and thereby establish greater physician continuity than would first- or second-year residents. In fact we are left with no sense of the effectiveness of the randomization process.

Another factor which could confound the results of this study is the effect that frequency of cancellation of clinics by residents has on failed appointments. Our experience has shown that patients expect to have their appointments rescheduled because of so frequent cancellation of clinics by residents. The impact of cancellation and re-

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Foreword written by Howard Spiro,
famous gastroenterologist!

FLEXIBLE SIGMOIDOSCOPY RONALD M. KATON, M.D., EMMET B. KEEFFE, M.D., AND CLIFFORD S. MELNYK, M.D.

The need for literature on flexible sigmoidoscopy aimed at the primary care practitioner has been met by *Flexible Sigmoidoscopy*, the first comprehensive treatise on this subject. This book emphasizes the *why* and *how* of flexible sigmoidoscopy. A thorough description of the technique of fiberoptic sigmoidoscopy points out pitfalls and gives hints for successfully mastering the procedure.

Experienced and knowledgeable authors address significant topics on sigmoidoscopy in the text's eleven chapters. Principles of fiberoptics, and the mechanical operation and care of fiberscopes are included. A consumer's guide to the many different model flexible sigmoidoscopes is included, and comparative studies between flexible (60-cm) sigmoidoscopy and rigid (25-cm) sigmoidoscopy, or the short flexible (35-cm) sigmoidoscopy are reviewed. Pertinent differences are highlighted. A detailed description of various colorectal disorders and a color atlas are also included.

February 1985, 176 pp., \$34.50
ISBN: 0-8089-1701-3, Order Code: 792251

IRRITABLE BOWEL SYNDROME

Edited by
NICHOLAS W. READ, M.D.

This book is based on the June 1983 symposium on the irritable bowel syndrome held in Droitwich, U.K.

This authoritative text is divided into four parts. The first section, nomenclature and diagnosis, is largely concerned with definition, classification, and the need to establish a positive symptomatic diagnosis. The next portion, pathogenesis, includes important and new contributions regarding the roles of psychological stress, the gastrocolonic response, intestinal secretion, and an illuminating discussion on whether a disorder in colonic motility specific to IBS, really exists. Disease mechanisms, the third part, contains new data on constipation, abdominal pain, food intolerance as a cause of diarrhoea and anorectal disorders. The final section on treatment contains important assessments of the role of dietary fibre, and drug psychotherapy in the management of IBS, with detailed practical advice on how to carry out psychotherapy and design therapeutic trials.

January 1985, 288 pp., \$34.50
ISBN: 0-8089-1669-6, Order Code: 793529

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Contraindications: Hypersensitivity to either ingredient; concurrent MAO inhibitor therapy; severe hypertension; lower respiratory tract conditions, including asthma; coronary artery disease; stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. Children under 12, nursing mothers.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Warn patients of possible additive effects of alcohol and other CNS depressants.

Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, hypertension, prostatic hypertrophy, hyperthyroidism, diabetes. Patients taking this medication should be cautioned not to take simultaneously other products containing phenylpropanolamine HCl or amphetamines.

Use in Children: In infants and children, antihistamines in overdose may cause hallucinations, convulsions, or death. As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

Use in Pregnancy: Use in pregnant women only when clearly needed in the judgment of the physician.

Use in the Elderly (approximately 60 or older): The risk of dizziness, sedation, and hypotension is greater in the elderly patient.

Adverse Reactions: Excessive dryness of nose, throat, or mouth; headache, rash, weakness, angina pain, palpitations, hypertension; hypotension; thrombocytopenia; leukopenia; hemolytic anemia; agranulocytosis; drowsiness; nervousness or insomnia; dizziness; irritability; incoordination; tremor; convulsions; visual disturbances; nausea; vomiting; epigastric distress; diarrhea; abdominal pain; anorexia; constipation; difficulty in urination; dysuria; tightness of chest.

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Contraindications: Hypersensitivity to either component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease. Do not use "Tuss-Ornade" Spansule capsules in children under 12 years of age.

Warnings: Warn vehicle or machine operators of possible drowsiness. Warn patients of possible additive effects of alcohol and other CNS depressants.

Precautions: Use with caution in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, thyroid disease or diabetes, and in patients in whom productive cough is desirable to clear excessive secretions from bronchial tree. Patients taking this medication should be cautioned not to take simultaneously other products containing phenylpropanolamine HCl or amphetamines.

Usage in Pregnancy: Do not use in pregnancy, nursing mothers, or women of childbearing potential unless the anticipated benefits outweigh the potential risks.

Adverse Reactions: Drowsiness; nervousness; insomnia; nausea, constipation, diarrhea; dizziness; weakness; tightness of chest; angina pain; irritability; palpitations; headache; incoordination; tremor; difficulty in urination; hypertension, hypotension; anorexia; visual disturbances; dysuria; gastrointestinal upset.

Supplied: "Tuss-Ornade" Spansule capsules, in bottles of 50 and 500.

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scheduling of clinics on no-show rates has received no mention in the literature. Residents having a greater rescheduling rate might anticipate a greater no-show rate. Possibly future studies will reveal the importance of this factor on no-show rates in family practice centers.

*T. Rich McNabb, MD, MPH
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Throat Cultures

To the Editor:

I believe that the conclusions reached by J.C. Shank and T.A. Powell in their article "A Five-Year Experience with Throat Cultures" (*J Fam Pract* 1984; 18:857-863) are not justified by their data.

They found that cultures were positive for streptococci in 18 percent of children aged 6 to 15 years who were clinically diagnosed as being viral. From this they conclude that clinical diagnosis is inaccurate despite the fact that they quote a carrier rate of 15 to 20 percent in prior studies. In the absence of titers, one can not conclude that a clinical diagnosis of viral was inaccurate given the high carrier rate. The clinician may elect to treat these children as having an active infection, but he can not conclude that the positive culture represents a true infection.

They also concluded that there was no evidence that physicians could be taught to increase their diagnostic accuracy. In their study,

4 faculty members did 413 cultures over a five-year period—an average of 20 cultures per year per physician. It would be difficult to improve clinical acumen when a procedure is done so infrequently. Moreover, the guidelines they used in making a clinical diagnosis of streptococcal pharyngitis are known to be imprecise. Their decision to not include an equivocal category prevented participants from limiting their diagnosis of streptococcal pharyngitis to cases that had a high probability of being streptococcal.

Finally, they do not comment on the significance of the 9 percent false-negative rate found in control cultures. The existence of false negatives means that cases clinically diagnosed as being streptococcal but considered to be viral on the basis of a negative culture may have indeed been streptococcal.

When carrier rates, false negatives, and the effect of an equivocal category are considered, the case for clinical diagnosis is much better than the authors have concluded.¹

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Reference

1. Forsyth RA: Selective utilization of clinical diagnosis in treatment of pharyngitis. *J Fam Pract* 1975; 2:173-177

Diagnosis of Candida Vaginitis

To the Editor:

There are several problems with the recent article by Bergman, et al. (*Bergman JJ, Berg AO, Schneeweis R, Heidrich FE: Clini-*

cal comparison of microscopic and culture techniques in the diagnosis of *Candida vaginitis*. *Journal of Family Practice* 1984; 18:549-552). These problems limit the usefulness of their recommendations for the laboratory evaluation of women with symptoms of vaginitis.

The first problem is that the study population included patients with a variety of reasons for a pelvic examination. While a majority of these patients (65 percent) complained of "vaginal symptoms," what percentage presented to the office specifically for evaluation of these complaints? This consideration is especially important for studies of *Candida vaginitis* because whether the presence of the organism is synonymous with the "disease" is unclear. Is *C albicans* always a pathogen and does it therefore always require treatment? It is also unclear how clinicians should best respond to the asymptomatic patient who is incidentally found to have genitourinary candida. By mixing the patient populations, the authors have made it impossible to use their sensitivity and specificity values in determining the test predictive values for the everyday clinical situation of the symptomatic patient.

The second major problem with this study is the shockingly low rate of positive KOH slides. We believe that a major reason for this could be the specimen collection technique that was used. In the study, a single swab was used to collect the specimen from the lateral vaginal wall. This single swab was then used for four different tests. One fourth of the swab surface was used for each test. This obviously limits the quantity of material available for the microscopic study and is equivalent to taking a single loop full of urine and plating three cul-

tures and then using the remaining urine on the loop for the microscopic examination of the specimen. We recommend using two, 6-inch cotton swabs and obtaining a large quantity of vaginal secretions from wherever they pool in the vagina.¹ This is usually in the vaginal vault, beneath the cervix. The specimen is then suspended into a small quantity of normal saline in a centrifuge tube and taken to the laboratory for examination. It is our belief that this technique enhances the sensitivity of a wet mount preparation.

Finally, the authors suggest that the poor results of their KOH testing could be due to either inadequate time taken in examining the specimen or inadequate test training. It is our experience that clinicians are frequently not trained and are excessively casual in performing this test. Failure to perform a test properly is an avoidable cause for a low test sensitivity.

The KOH examination can be a rapid and inexpensive test with a high specificity. Further research will be needed to identify the test sensitivity and to clarify the pathogenicity of the candida organism.

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Reference

1. Fischer PM, Addison LA, Curtis P, Mitchell JM: The Office Laboratory. Appleton-Century-Crofts, East Norwalk, Conn, 1983

(Continued from adjacent 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 100 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).**

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