

# SELF-ASSESSMENT IN FAMILY PRACTICE

Series Editor: Robert B. Taylor, MD

Compiled by Merle Pennington, MD, Associate Professor, Department of Family Practice, Oregon Health Sciences University School of Medicine, Portland, Oregon.

*This section of the Journal is designed to present clinical problems that focus on patient management, problem solving, and other elements integral to family medicine. The intent of this section is aimed more at teaching and learning than at self-assessment as an evaluation or scoring device. Reinforcement of major teaching points is therefore included through the further discussion and supplemental references that appear on the following pages. Critical comments relating to these self-assessment materials are invited and should be submitted as letters to the Editor.*

## Questions 1-5 each contain four suggested answers. Choose one or more of the four responses.

*Mr. W. G. is a 33-year-old, white, married carpenter who presents to your office for the first time with a sprained ankle of two days' duration. He says he stepped off a curb, turning his ankle, but had little pain or swelling until the next day. The right ankle is markedly swollen and ecchymotic about the lateral malleolus and the lateral portion of the dorsum of the foot. He can bear weight on the foot only if the foot and heel are flat on the floor and externally rotated, and this effort produces sharp pain in the area of the lateral malleolus. His blood pressure is 168/90 mmHg. His hands show a slight tremor.*

1. Which of the following would you do at this time?

- A. Order and personally examine x-ray films of the ankle, lower fibula, and midfoot.
- B. Recheck blood pressure and inquire about a history of high blood pressure in the patient and his family.
- C. Draw blood for chemistry screen and free thyroxine (T4).
- D. Obtain and record resting pulse.

*There is no x-ray evidence of fracture. The blood pressure is 160/88 mmHg and 164/90 mmHg and nearly the same in both arms. The pulse is consistently 100 to 108 beats per minute on three different checks. The patient does not think he has ever had elevated blood*

*pressure before, and there is no family history of hypertension.*

*There is a fine hand tremor, the palms are warm and moist, and there is no protuberance of eyes nor lid lag. You put on a well-padded short leg cast, arrange for crutches, and ask the patient to return in one week for the application of a walking heel.*

*Your patient returns as directed. You add a walking heel and take his blood pressure, which is 172/88 mmHg and 170/90 mmHg; the pulse is repeatedly over 100 beats per minute.*

2. Which of the following would be appropriate?

- A. Instruct the patient on gradually resuming weight bearing and have him return in one week.

*Continued on page 185*

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For symptomatic relief of nasal congestion, runny nose, sneezing, itchy nose or throat, and itchy and watery eyes as may occur with the common cold or in allergic rhinitis (e.g., hay fever).

N.B.: A final determination has not been made on the effectiveness of this drug combination in accordance with efficacy requirements of the 1962 Amendments to the Food, Drug and Cosmetic Act.

**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 over-dosage 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.

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N.B.: A final determination has not been made on the effectiveness of this drug combination in accordance with efficacy requirements of the 1962 Amendments to the Food, Drug and Cosmetic Act.

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**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.

## SELF-ASSESSMENT

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B. Start the patient on an antihypertensive drug regimen.

C. Obtain a limited social history.

D. Question the patient about his drinking habits.

*The queries reveal recent family discord, several minor injuries in the past five years, and some job instability, which is blamed on the construction slowdown. When asked about drinking, his response is "a couple of beers in the evening."*

3. Which of the following statements are true regarding alcoholism?

A. The prevalence of alcoholism in the general population in the United States is thought to be between 5 and 12 percent.

B. In stable, middle-class patient populations the percentage of alcoholics is less than 3 percent.

C. Alcoholics are usually friendly and outgoing, and rarely have other emotional problems.

D. The selection of the appropriate management technique is a strong determinant of outcome in the treatment of alcoholism.

4. Which of the following approaches would you recommend?

A. Deal only with the ankle problem.

B. Offer support and counseling regarding the marital discord in the hope of uncovering other information that would lead to patient realization and acceptance of alcohol as a problem.

C. Use a strong confrontational approach with referral to an outpatient alcohol program or to Alcoholics Anonymous (AA).

D. Give a calm summation of the inconsistencies regarding the injury, the persistent elevation of blood pressure and pulse, and the tremor and sweating. Express your desire to pursue these further, including blood tests, and since alcohol could also logically explain the findings, his filling out and returning a questionnaire in this area would be most helpful in providing appropriate diagnosis and management. You suggest that he, with the assistance of his wife, fill out the questionnaire and both come in in a week.

*Despite the expressed skepticism, he and his wife return. The ankle is doing well. The Self-Administered Alcoholism Screening Test (SAAST) indicates a number of alcohol-related problems and a familial tendency. The couple indicate a number of episodes of depression in the past. The family discord and job problems have been largely related to drinking.*

5. Which of the following would you do next?

A. Refer him to AA.

B. Arrange for the patient's admission to an inpatient alcoholism treatment program.

C. Refer him to a behavioralist specializing in alcohol rehabilitation.

D. Set up a one-hour counseling session by you for husband and wife to be continued with regular follow-up.

## Answers and Discussion

1. A, B, and D are all necessary. C would probably not be helpful at this time. The story of the injury and absence of early pain are inconsistent with the marked swelling and ecchymosis. The elevation of blood pressure on a single reading may not be significant but, coupled with other findings, might suggest an alcohol relationship.<sup>1</sup> The tendency of physicians to overlook alcohol as a contributing factor to illnesses and injuries has been repeatedly documented.<sup>2,3</sup>

2. A, C, and D are all correct. A alone would mean ignoring the possibility of alcohol as an etiologic factor in the presenting complaint. Kaim et al<sup>4</sup> point out that elevated blood pressure, tachycardia, moist palms, and fine tremor in the absence of hyperthyroidism suggest recent excessive intake of alcohol. B would be inappropriate, since an etiology for the elevated blood pressure and tachycardia cannot be assumed at this time.

3. A is rather generally accepted, though difficult to determine precisely.<sup>3</sup> B, C, and D are common misconceptions unsupported by critical evaluation. A study of Mayo Community Internal Medicine Clinic providing care to a local, middle-class adult population found that 7 to 8 percent of adult patients could be identified as alcoholic or having alcohol-related problems.<sup>4</sup> Ramsay et al<sup>3</sup> in Burlington, Vermont, by very conservative criteria, found about 30 percent of individuals with emotional problems also had problems with alcohol; other studies have indicated an even higher relationship with depression. Skinner et al<sup>1</sup> cited several studies suggesting that different forms of treatment seem to produce very similar levels of success, at least for those individuals who have advanced to the later stages of alcohol abuse.

4. There is no absolutely correct

answer. A is the equivalent of giving iron to an anemic 55-year-old man and not looking for a source of blood loss. B may be justified in a tentative physician-patient relationship. C may be effective in dealing with some individuals. D is very straightforward and honest. The Michigan Alcoholism Screening Test (MAST)<sup>5</sup> and the Self-Administered Alcoholism Screening Test (SAAST)<sup>6</sup> are excellent tools for the detection of alcoholism and alcohol-related problems and for placing the individual on the continuum between social drinking and end stage alcoholism. The National Council on Alcoholism (NCA) criteria<sup>7</sup> are too heavily weighted to the severely degenerative end of the scale to be of much help in early detection and prevention.

5. Any or all may be correct. However, the review article by Skinner et al<sup>1</sup> makes a good case for the primary physician to provide comprehensive assessment with limited counseling and follow-up, especially for individuals in the earlier stages of excessive drinking.

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# TRINSICON<sup>®</sup> Capsules

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## Brief Summary of Prescribing Information

## DESCRIPTION

Each capsule contains—  
 Special Liver-Stomach Concentrate, (containing Intrinsic Factor) ..... 240 mg  
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 Folic Acid ..... 0.5 mg  
 with other factors of Vitamin B Complex present in the Liver-Stomach Concentrate.

**Usual dosage:** One Trinsicon Capsule twice a day.

## INDICATIONS AND USAGE

Trinsicon<sup>®</sup> (hematinic concentrate with intrinsic factor) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia. Therapeutic quantities of hemopoietic factors that are known to be important are present in the recommended daily dose.

## CONTRAINDICATIONS

Hemochromatosis and hemosiderosis are contraindications to iron therapy.

## PRECAUTIONS

**General Precautions**—Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

Folic acid *alone* is unwarranted in the treatment of pure vitamin B<sub>12</sub> deficiency states, such as pernicious anemia. Folic acid may obscure pernicious anemia in that the blood picture may revert to normal while neurological manifestations remain progressive.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiologic doses of vitamin B<sub>12</sub>. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B<sub>12</sub> may be necessary for adequate treatment of the patient. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic clinical and laboratory studies are considered essential and are recommended.

**Usage in Pregnancy**—*Pregnancy Category C*—Animal reproduction studies have not been conducted with Trinsicon. It is also not known whether Trinsicon can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Trinsicon should be given to a pregnant woman only if clearly needed.

**Nursing Mothers**—It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Trinsicon is administered to a nursing woman.

**Usage in Children**—Safety and effectiveness in children below the age of 10 have not been established.

## ADVERSE REACTIONS

Rarely, iron in the therapeutic doses produces gastrointestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects in the iron-sensitive patient.

In extremely rare instances, skin rash suggesting allergy has been noted following the oral administration of liver-stomach material. Allergic sensitization has been reported following both oral and parenteral administration of folic acid.

## OVERDOSAGE

**Symptoms**—Those of iron intoxication, which may include pallor and cyanosis, vomiting, hematemesis, diarrhea, melena, shock, drowsiness, and coma.

**Treatment**—For specific therapy, exchange transfusion and chelating agents. For general management, gastric and rectal lavage with sodium bicarbonate solution or milk, administration of intravenous fluids and electrolytes, and use of oxygen.

## HOW SUPPLIED

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Literature Revised October, 1983.

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# Self-Assessment in Family Practice

Series Editor: Robert B. Taylor, MD

Compiled by Anita D. Taylor, MA, Ed, Department of Public Health and Preventive Medicine, The Oregon Health Sciences University, Portland, Oregon.

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**Questions 1-5 each contain four suggested answers. Choose one or more of the four responses.**

*Mr. and Mrs. H.J., both in their early 40s, have been your patients for four years. You suspect that Mrs. J. may be seriously ill, and refer her to a consultant for further testing. Mr. J. telephones and says, "If the results are not good, I don't want you to tell her. I'll decide what's best for her." The results confirm your worse fears, and she is found to have metastatic cancer. Her life expectancy is measured in months. She is scheduled to return today to discuss the results of her tests. Do you tell her the truth or follow her husband's wishes?*

1. Which of the following are true of seriously ill patients?

- A. They do not want to be told the truth.
- B. If not told, they never become aware of the truth.

- C. They often have family members who request that the truth be withheld.
- D. They are harmed by telling the truth.

2. At your visit with Mrs. J. you should

- A. Include important family members
- B. Ask for Mrs. J.'s opinion as to what is happening
- C. Avoid using the word "cancer"
- D. Discuss only those therapeutic approaches that are scientifically accepted

3. Mr. J. feels that their 6-year-old son should not be told about his mother's illness or her grim prognosis because he will not understand. What advice should you give?

- A. "I agree, your son cannot understand the meaning of death."
- B. "Tell him, but be prepared to see some behavioral changes."

C. "It is important for your son to participate in the family's sadness."

D. "You may tell him about her illness, but when she dies just say she's gone away for awhile and will return."

4. A few weeks later, Mrs. J. asks you about drawing up a living will. What is true of a living will?

- A. It takes the place of a regular will.
- B. It has been recognized by all 50 states.
- C. It must be signed by two witnesses.
- D. It can be witnessed by you, the physician.

5. What areas would you consider to best assess Mrs. J.'s need for psychological support?

- A. Her previous reaction to stress
- B. Her level of denial
- C. Her expressions of anxiety
- D. Her level of fear

## Answers and Discussion

1. C is true; A, B and D are false. Most patients with serious illnesses want to be told the truth,<sup>1</sup> and most dying patients, even if not told, are aware of their diagnosis.<sup>2</sup> The fear that the truth will "harm" the patient is sometimes expressed by family members who wish to protect their loved one from depression or even suicide<sup>3</sup> or is an expression of the physician's own uneasiness about discussing death and dying issues.<sup>4</sup>

2. A and B are true; C and D are false. By including family members in this important visit, all will hear the same information about the diagnosis and plans for treatment. Asking Mrs. J. for her belief about what is happening may provide clues to her level of awareness and acceptance of the diagnosis. It will also allow her husband to hear her feelings about her illness.

It is important to use the word "cancer" early so as not to mislead the patient. Other words, such as "tumor" or "malignancy" can be used in future discussions. Address the issue of unproven cancer treatments, emphasizing your continued support of the patient, even if she chooses to try an alternative treatment.<sup>5</sup>

3. B and C are correct; A and D are incorrect. Children can understand the meaning of death earlier than

people realize. It is unfair to allow the child to believe that his mother will return when she will not—this would only postpone his understanding of her death and undermine his trust of other family members.

When the child sees family members sad, he needs to understand why. He needs their support to express his own feelings of grief, which might manifest themselves in a dread of illness and in separation anxiety.<sup>6</sup>

4. The correct answer is C. A living will is a document giving the physician directions concerning medical treatment while the person is dying. It does not replace a legal will, which is effected after death and concerns material possessions. The living will in various forms has been recognized by 22 states as representing the preferences of the patient,<sup>7</sup> and while not legally binding, offers help for the clinician and the family when the patient can no longer state his or her wishes. The document needs to be signed by two witnesses, neither of whom can be related to the declarer by blood or marriage, be entitled to a part of the declarer's estate, have a claim against the declarer's estate, be the declarer's attending physician or employees of the physician, or the employee of a health facility (hospital or nursing home) in which the declarer is a patient.<sup>3</sup>

5. A is the correct answer. By asking the patient and family about previous reactions to stress, you will have your best indicator as to how he or she will cope with the present illness.<sup>8</sup>

All patients will have some level of denial, but it is often unconscious and, therefore, not measurable. In the same manner, anxiety and fear about death may not be expressed openly. The patient may sense a physician's uneasiness about death and not reveal his feelings. It is up to the physician to elicit these emotions from the patient so that they can be discussed.<sup>9</sup>

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# Self-Assessment in Family Practice

Series Editor: Robert B. Taylor, MD

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*You are seeing a new patient, a 30-year-old, gravida 2, para 1 woman, who is now 12 weeks pregnant. She brings her medical records with her, revealing that she had a cesarean section done for cephalopelvic disproportion. This was necessitated by failure to progress at 6-cm dilatation, despite hard contractions, in the face of a "borderline" pelvis on pelvimetry. She was delivered using a low transverse incision. She now wishes to discuss with you a future vaginal delivery.*

1. Which of the following are contraindications to a trial of labor for vaginal delivery following a cesarean section?

- A. Breech presentation with current pregnancy
- B. Multiple gestation
- C. Patient refusal
- D. Low transverse incision

2. With respect to pelvic size and

x-ray pelvimetry, which of the following are true?

- A. Pelvimetry is a fairly reliable predictor of route of delivery.
- B. Pelvimetry is rarely helpful in predicting route of delivery.
- C. Pelvic size by pelvimetry is significantly different in women delivered by cesarean section for cephalopelvic disproportion when compared with those who successfully deliver vaginally.
- D. Pelvimetry can be harmful.

3. In order to foster patient education, you and the patient discuss the risks of the various delivery options. Which of the following are true?

- A. A trial of labor is extremely risky to both mother and baby.
- B. The chance of the previous scar completely rupturing is approximately 5 percent.
- C. The chance of rupture of the previous cesarean section scar is less than the likelihood of a prolapsed cord.
- D. The risk of a rupture with a low transverse incision is only slightly greater than with a classical incision.

4. In the United States, which of the following are true?

- A. The rate of repeat cesarean section is 75 percent.
- B. The rate of repeat cesarean section is 99 percent.
- C. The maternal mortality for cesarean delivery is two to four times higher than the mortality for vaginal delivery.
- D. The rate of cesarean section done because of previous cesarean section has increased.

5. If a trial of vaginal delivery is chosen by this patient, which of the following are true?

- A. The likelihood of vaginal delivery being accomplished is greater than 50 percent.
- B. It is absolutely contraindicated to consider oxytocin (Pitocin) augmentation in this patient.
- C. Oxytocin augmentation is unlikely to improve the likelihood for a successful vaginal delivery.
- D. The chance of uterine rupture is significantly greater if oxytocin is used.

*Continued on page 474*

## Antihypertensive therapy that does not increase cholesterol

### Brief Summary

Before prescribing, consult the complete package circular.

**Indications and Usage:** Treatment of hypertension, alone or in combination with a thiazide diuretic.

**Contraindication:** Known sensitivity to the drug.

**Precautions:** 1. Sedation: Causes sedation or drowsiness in a large fraction of patients. When used with centrally acting depressants, e.g., phenothiazines, barbiturates and benzodiazepines, consider potential for additive sedative effects. 2. Patients with vascular insufficiency: Like other antihypertensives use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease, or severe hepatic or renal failure. 3. Rebound: Sudden cessation of therapy with central alpha agonists like Wyensin may rarely result in "overshoot" hypertension and more commonly produces increase in serum catecholamines and subjective symptomatology.

**INFORMATION FOR PATIENTS:** Advise patients on Wyensin to exercise caution when operating dangerous machinery or motor vehicles until it is determined they do not become drowsy or dizzy. Warn patients that tolerance for alcohol and other CNS depressants may be diminished. Advise patients not to discontinue therapy abruptly.

**LAB TESTS:** In clinical trials, no clinically significant lab test abnormalities were identified during acute or chronic therapy. Tests included CBC, urinalysis, electrolytes, SGOT, bilirubin, alkaline phosphatase, uric acid, BUN, creatinine, glucose, calcium, phosphorus, total protein, and Coombs' test. During long-term use there was small decrease in serum cholesterol and total triglycerides without change in high density lipoprotein fraction. In rare instances occasional nonprogressive increase in liver enzymes was observed, but no clinical evidence of hepatic disease.

**DRUG INTERACTIONS:** Wyensin was not demonstrated to cause drug interactions when given with other drugs, e.g., digitalis, diuretics, analgesics, anxiolytics, and antiinflammatory or antineoplastic agents, in clinical trials. However, potential for increased sedation when given concomitantly with CNS depressants should be noted. **DRUG/LAB TEST INTERACTIONS:** No lab test abnormalities were identified with Wyensin use.

**CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY:** No evidence of carcinogenic potential emerged in rats during a two-year oral study with Wyensin at up to 9.5 mg/kg/day, i.e., about 10 times maximum recommended human dose. In the Salmonella microsome mutagenicity (Ames) test system, Wyensin at 200-500 mcg per plate or at 30-50 mg/ml in suspension gave dose-related increases in number of mutants in one (TA 1537) of five *Salmonella typhimurium* strains with or without inclusion of rat liver microsomes. No mutagenic activity was seen at doses up to those which inhibit growth in the eukaryotic microorganism, *Schizosaccharomyces pombe*, or in Chinese hamster ovary cells at doses up to those lethal to the cells in culture. In another eukaryotic system, *Saccharomyces cerevisiae*, Wyensin produced no activity in an assay measuring induction of repairable DNA damage. Reproductive studies showed a decreased pregnancy rate in rats given high oral doses (9.6 mg/kg), suggesting impairment of fertility. Fertility of treated males (9 mg/kg) may also have been affected, as suggested by decreased pregnancy rate of mates, even though females received drug only during last third of pregnancy.

**PREGNANCY:** Pregnancy Category C. WYENSIN® MAY HAVE ADVERSE EFFECTS ON FETUS WHEN ADMINISTERED TO PREGNANT WOMEN. A teratology study in mice indicated possible increase in skeletal abnormalities when Wyensin is given orally at doses 3 to 6 times maximum recommended human dose of 1.0 mg/kg. These abnormalities, principally costal and vertebral, were not noted in similar studies in rats and rabbits. However, increased fetal loss has been observed after oral Wyensin given to pregnant rats (14 mg/kg) and rabbits (20 mg/kg). Reproductive studies in rats have shown slightly decreased live-birth indices, decreased fetal survival rate, and decreased pup body weight at oral doses of 6.4 and 9.6 mg/kg. There are no adequate, well-controlled studies in pregnant women. Wyensin should be used during pregnancy only if potential benefit justifies potential risk to fetus.

**NURSING MOTHERS:** Because no information is available on Wyensin excretion in human milk, it should not be given to nursing mothers.

**PEDIATRIC USE:** Safety and effectiveness in children less than 12 years of age have not been demonstrated, use in this age group cannot be recommended.

**Adverse Reactions:** Incidence of adverse effects was ascertained from controlled clinical studies in U.S. and is based on data from 859 patients on Wyensin for up to 3 years. There is some evidence that side effects are dose-related. Following table shows incidence of adverse effects in at least 5% of patients in study comparing Wyensin to placebo, at starting dose of 8 mg b.i.d.

Adverse Effect	Placebo (%) n = 102	Wyensin (%) n = 109
Dry mouth	7	28
Drowsiness or sedation	12	39
Dizziness	7	17
Weakness	7	10
Headache	6	5

In other controlled clinical trials at starting dose of 16 mg/day in 476 patients, incidence of dry mouth was slightly higher (38%) and dizziness was slightly lower (12%), but incidence of most frequent adverse effects was similar to placebo-controlled trial. Although these side effects were not serious, they led to discontinuation of treatment about 15% of the time. In more recent studies using an initial dose of 8 mg/day in 274 patients, incidence of drowsiness or sedation was lower, about 20%. Other adverse effects reported during clinical trials but not clearly distinguishable from placebo effects and occurring with frequency of 3% or less: Cardiac—chest pain, edema, arrhythmias, palpitations. Gastrointestinal—nausea, epigastric pain, diarrhea, vomiting, constipation, abdominal discomfort. Central nervous system—anxiety, ataxia, depression, sleep disturbances. ENT disorders—nasal congestion. Eye disorders—blurring of vision. Musculoskeletal—aches in extremities, muscle aches. Respiratory—dyspnea. Dermatologic—rash, pruritus. Urogenital—urinary frequency, disturbances of sexual function. Other—gynecomastia, taste disorders.

**Drug Abuse and Dependence:** No dependence or abuse has been reported.

**Overdosage:** Accidental ingestion caused hypotension, somnolence, lethargy, irritability, miosis, and bradycardia in two children aged one and three years. Gastric lavage and pressor substances, fluids, and oral activated charcoal resulted in complete and uneventful recovery within 12 hours in both. Since experience with accidental overdosage is limited, suggested treatment is mainly supportive while drug is being eliminated and until patient is no longer symptomatic. Vital signs and fluid balance should be carefully monitored. Adequate airway should be maintained and, if indicated, assisted respiration instituted. No data are available on Wyensin dialyzability.

**Dosage and Administration:** Individualize dosage. A starting dose of 4 mg b.i.d. is recommended, whether used alone or with a thiazide diuretic. Dosage may be increased in increments of 4 to 8 mg/day every one to two weeks, depending on response. Maximum dose studied has been 32 mg b.i.d., but doses this high are rarely needed.

**How Supplied:** Wyensin (guanabenz acetate) Tablets, 4mg, bottles of 100 and 500, 8mg, bottles of 100.

Wyeth Laboratories  
Philadelphia, Pa 19101

## SELF-ASSESSMENT IN FAMILY PRACTICE

Continued from page 471

### Answers and Discussion

1. A, B, C. Currently, breech presentation, multiple gestation, and patient refusal are considered to be contraindications to a trial of vaginal delivery following cesarean section.<sup>1</sup>

A low transverse incision at the time of the previous cesarean section is considered a requirement to permit a safe trial of labor and vaginal delivery in a subsequent pregnancy.<sup>2</sup>

2. B, D. Pelvimetry rarely alters clinical management and is not reliable as a predictor of delivery outcome.<sup>3</sup> In a recent study it was reported that in 98 percent of patients, use of pelvimetry caused no change in clinical management plan.<sup>4</sup> Pelvimetry poses a radiation hazard with potential oncogenic risk to the newborn.<sup>3</sup> In addition, the trip to the radiology department makes observation and monitoring of the patient more difficult and increases the risk for a delivery in a suboptimal setting.<sup>3</sup> In a recent series no significant differences were found in pelvic diameter by pelvimetry between women experiencing vaginal delivery vs cesarean section.<sup>3</sup>

3. C. Acute fetal distress from an umbilical cord prolapse is much more frequent than fetal distress from a ruptured previous scar.<sup>1</sup> The current literature demonstrates the safety of a trial of labor in a woman who has had prior delivery by low transverse cesarean section.<sup>1,2,5,6</sup>

The chance of a rupture of the previous cesarean section scar is less than 1 percent—in a recent series of over 200 patients there were no ruptures.<sup>1</sup>

4. B, C, D. In the United States today, 99 percent of births after cesarean section are by repeat cesarean section.<sup>1,6</sup> This is true despite the report of the National Consensus Development Conference in recommending a trial of labor for vaginal delivery.<sup>6</sup> In the current literature, there have been no maternal deaths and only one fetal death due to a uterine incision

rupture in a monitored labor.<sup>1</sup> The maternal mortality rate for a cesarean section is two to four times higher than for vaginal delivery.<sup>2,6,7</sup> Previous cesarean birth as a cause for cesarean section has increased despite these facts.<sup>6</sup>

5. A. A recent series studied patients delivered after primary cesarean section for cephalopelvic disproportion and found that 67.3 percent were delivered vaginally.<sup>1</sup> In addition, in the same study, 94 patients out of 230 received oxytocin to augment their labors. There was no significant morbidity or mortality.<sup>1</sup> The successful rate of vaginal delivery was significantly increased in this study and in one other that allowed the liberal use of oxytocin.<sup>1,2</sup> All labors were monitored internally to assure appropriate intrauterine pressure of approximately 50 mmHg. There is no reason to believe that a given pressure achieved by augmentation is any more dangerous to a uterine scar than the same pressure achieved without augmentation.<sup>1</sup>

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# Self-Assessment in Family Practice

Series Editor: Robert B. Taylor, MD

Compiled by David R. Martin, MD, Resident, Department of Family Medicine, Oregon Health Sciences University School of Medicine, Portland, Oregon.

*This section of the Journal is designed to present clinical problems that focus on patient management, problem solving, and other elements integral to family medicine. The intent of the section is aimed more at teaching and learning than at self-assessment as an evaluation or scoring device. Reinforcement of major teaching points is therefore included through the further discussion and supplemental references that appear on the following pages. Critical comments relating to these self-assessment materials are invited and should be submitted as letters to the Editor.*

**Questions 1-5 each contain four suggested answers. Choose one or more of the four responses.**

*A 12-month-old male infant presents to your office for his fifth well-child visit. The visits at 2 weeks of age, and 2, 4, and 6 months of age were routine. The mother has no specific concerns. The child continues appropriate progression along the growth curves, and the physical examination is normal for his age.*

1. Which of the following conditions would prompt you to obtain a screening hematocrit as part of the well-child examination?

- A. The infant has been exclusively breast-fed since birth.
- B. The family is of low socioeconomic status.
- C. The infant was born at 35 weeks' gestation and had intrauterine growth retardation.
- D. The neonatal hematocrit (in a term delivery) was 43 percent by volume of packed red blood cells.

2. Which of the following statements regarding the tests used to establish the presence of iron-

deficiency anemia are correct?

- A. The most commonly used screening test is the capillary hematocrit.
- B. Venous hematocrit is significantly more accurate than capillary and is more reliably indicative of an iron-deficiency state.
- C. A Coulter complete blood count is more useful in screening than is a simple spun hematocrit.
- D. The "gold standard" in diagnosing iron-deficiency anemia is the free erythrocyte protoporphyrin.

3. Appropriate statements regarding the numerical values of screening hematocrits include:

- A. A hematocrit of 35 percent indicates that the individual should be considered a candidate for iron supplementation.
- B. The appropriate value is not 35 percent but 33 percent.
- C. Black infants have a lower average hematocrit than do white infants.
- D. The value of the hematocrit at which both blacks and whites should be treated is the same.

4. Which of the following are appropriate methods of treating or of preventing iron deficiency?

- A. Breast-fed infants should begin to receive iron supple-

mentation by 4 to 6 months of age.

B. All infants on long-term formula feedings should receive an iron-fortified formula or should receive iron supplementation.

C. Cereals formulated specifically for infants are fortified with iron in a form optimized for absorption.

D. An appropriate method of treating presumed iron deficiency is 3 mg/kg of body weight each day of elemental iron as ferrous sulfate given one-half hour before a feeding.

5. Which of the following are true of the effects of iron deficiency and of iron supplementation?

A. There is considerable evidence that iron deficiency in the first years of life is associated with subnormal mental development.

B. There is evidence that this effect is independent of malnutrition and socioeconomic status.

C. Other clinical findings of iron deficiency include thin, brittle, or spooned nails, as well as decreased absorption of fat, vitamin A, and xylose.

D. There has been some evidence that excessive iron intake predisposes the infant to infection.



## Answers and Discussion

1. All responses are true. The prevalence of iron-deficiency anemia reaches its peak between the ages of 6 months and 2 years.<sup>1</sup> The overall prevalence varies widely depending on diagnostic criteria and the population screened. Estimates of from 1 to 5 percent and 5 to 20 percent are common, with the latter being more typical.<sup>1,2,3</sup> Some studies have shown a greater than 60 percent prevalence in low-income groups.<sup>3</sup> Although there is not a consensus as to whether screening should be performed routinely in all 1-year olds, there is general agreement that those at high risk should be screened.

Premature and low-birth-weight infants are at high risk because of a low "iron endowment" at birth and because of increased growth rates. Iron endowment can be decreased by early cord clamping, perinatal blood loss, or anything else that decreases the neonatal hematocrit or total red cell mass.

2. A, B, and C are true. D is false. In one survey, 84 percent of 142 practicing family physicians screened their 1-year-old patients with capillary blood hematocrit determinations.<sup>4</sup> The capillary hematocrit has the advantage that it is easy to obtain; however, there is a clear-cut difference in accuracy as compared with venous samples. In one study, 10 percent of 70 paired Coulter hemoglobin measurements showed at least 1 g/dL difference and a mean hemoglobin difference of 0.5 g/dL.<sup>3</sup> In contrast,

no paired venous EDTA tube Coulter hemoglobin measurements showed greater than 0.4 g/dL difference, and the mean hemoglobin difference between paired venous samples was 0.6 g/dL.

Coulter hematocrit determinations were 0.4 to 0.5 percent lower than spun hematocrits in a series where the mean hematocrit was about 35.5 percent.<sup>3,4</sup> This difference may be expected to widen with increased severity of hypochromic anemia secondary to plasma trapping between the centrifuged microcytic red cells. However, for screening purposes, the two methods have been found equally useful when hematocrit alone is examined. One major advantage of Coulter analysis is that the mean corpuscular volume (MCV) is determined as well. As the MCV can be low, indicating possible iron deficiency in the presence of a normal hematocrit, Coulter analysis increases the sensitivity of the test in predicting responders to treatment.<sup>3,4</sup>

It is this response to treatment, rather than any single laboratory test, that is the "gold standard" in diagnosing iron deficiency. Blood studies should be repeated 3 to 4 months after initiation of therapy. A response of 0.6 g/dL is significant, but the generally accepted increase indicative of a "physiologically relevant" response is 1.0 g/dL.<sup>3</sup>

3. A is false. B, C, and D are true. The goal of screening for iron deficiency at 1 year of age is to identify

as many individuals as possible who will have a hemoglobin response to iron treatment while minimizing the number of unresponsive infants who might be treated unnecessarily. It has been shown that this means treating not only those classically considered anemic (Hct < 31 percent or Hgb < 11.0 g/dL) but also the "low normal" population (with Hct to 33 percent or Hgb to 11.5 g/dL).<sup>3,4</sup> If the screening criteria are further broadened to include all those with Hgb < 11.5 g/dL or MCV < 72 fL, then the number of total responders identified is almost doubled, and yet the response rate is stable at about 50 percent.<sup>3,4</sup>

Blacks normally have somewhat lower hemoglobins (0.3 to 0.8 g/dL) than Caucasians. However, identical screening criteria have been determined by response to therapeutic trials.<sup>5</sup>

4. All responses are true. The most recent recommendations of the American Academy of Pediatrics' (AAP) Committee on Nutrition regarding mineral supplement needs in normal children state that there is no evidence that breast-fed infants require iron supplements in the first 4 to 6 months.<sup>6</sup> After that time, the diet should be supplemented with iron-fortified cereal, standard infant formulas with iron, or iron drops. For about the last decade infant cereals have been fortified with iron of small particle size for improved absorption. Any infant started on commercial for-

*Continued on page 82*

# Norgesic<sup>®</sup> Forte TABLETS

(orphenadrine citrate, 50 mg; aspirin,  
770 mg; caffeine, 60 mg)

## Stops the pain, not the patient.

### Brief Summary

#### Indications:

1. Symptomatic relief of mild to moderate pain of acute musculo-skeletal disorders.
2. The orphenadrine component is indicated as an adjunct to rest, physical therapy, and other measures for the relief of discomfort associated with acute painful musculo-skeletal conditions.

The mode of action of orphenadrine has not been clearly identified, but may be related to its analgesic properties. Norgesic and Norgesic Forte do not directly relax tense skeletal muscles in man.

#### Contraindications:

Because of the mild anticholinergic effect of orphenadrine, Norgesic or Norgesic Forte should not be used in patients with glaucoma, pyloric or duodenal obstruction, achalasia, prostatic hypertrophy or obstructions at the bladder neck. Norgesic or Norgesic Forte is also contraindicated in patients with myasthenia gravis and in patients known to be sensitive to aspirin or caffeine.

The drug is contraindicated in patients who have demonstrated a previous hypersensitivity to the drug.

#### Warnings:

Norgesic Forte may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; ambulatory patients should therefore be cautioned accordingly.

Aspirin should be used with extreme caution in the presence of peptic ulcers and coagulation abnormalities.

#### Usage in Pregnancy:

Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

#### Usage in Children:

The safe and effective use of this drug in children has not been established. Usage of this drug in children under 12 years of age is not recommended.

#### Precautions:

Confusion, anxiety and tremors have been reported in few patients receiving propoxyphene and orphenadrine concomitantly. As these symptoms may be simply due to an additive effect, reduction of dosage and/or discontinuation of one or both agents is recommended in such cases.

Safety of continuous long term therapy with Norgesic Forte has not been established; therefore, if Norgesic Forte is prescribed for prolonged use, periodic monitoring of blood, urine and liver function values is recommended.

#### Adverse Reactions:

Side effects of Norgesic or Norgesic Forte are those seen with aspirin and caffeine or those usually associated with mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness and rarely, urticaria and other dermatoses. Infrequently an elderly patient may experience some degree of confusion. Mild central excitation and occasional hallucinations may be observed. These mild side effects can usually be eliminated by reduction in dosage. One case of aplastic anemia associated with the use of Norgesic has been reported. No causal relationship has been established. Rare G.I. hemorrhage due to aspirin content may be associated with the administration of Norgesic or Norgesic Forte. Some patients may experience transient episodes of light-headedness, dizziness or syncope.

#### Caution:

Federal law prohibits dispensing without prescription. NG-7

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## SELF-ASSESSMENT

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mula feedings in the first six months of life should receive iron-fortified formula or else should receive iron supplementation at a dosage of 1 mg/kg/d of elemental iron—starting no later than 4 months of age for term infants and earlier at higher doses for low-birth-weight infants.

Administering the iron between meals increases the amount absorbed and avoids reducing the antibacterial properties of breast milk, which occurs with increasing lactoferrin saturation.<sup>1,7</sup>

5. All responses are true. There is considerable evidence that iron deficiency in the first years of life is associated with a number of neurochemical changes as well as with poor performance on a variety of developmental and IQ scales.<sup>1,3</sup> In a controlled study conducted by Lozoff et al,<sup>8</sup> there is some evidence that this effect is independent of malnutrition and socioeconomic status.

There is a variety of evidence that excessive iron administration may impair specific host defenses and may predispose to the development of infection.<sup>1,2</sup> However, the AAP's Committee on Nutrition,<sup>7</sup> as well as other authorities,<sup>3</sup> believe that there is no evidence that iron supplementation or ther-

apy as currently recommended increases the risk of infection. It is felt that the benefits of iron administration in the recommended manner outweigh the risks as we currently understand them.

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## Self-Assessment in Family Practice

Series Editor: Robert B. Taylor, MD

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*This section of the Journal is designed to present clinical problems that focus on patient management, problem solving, and other elements integral to family medicine. The intent of this section is aimed more at teaching and learning than at self-assessment as an evaluation or scoring device. Reinforcement of major teaching points is therefore included through the further discussion and supplemental references that appear on the following pages. Critical comments relating to these self-assessment materials are invited and should be submitted as letters to the Editor.*

**Questions 1-4 each contain four suggested answers. Choose one or more of the four responses.**

*S.T. is a 15-year-old girl brought to the emergency room by her parents. She attempted suicide with overdosing. The family have been patients of yours for about six months, having recently moved from another town. When S.T. is medically stable, you talk with her and her parents. The parents express surprise at their daughter's action and explain that she and her boyfriend recently broke up. The patient says she's been despondent because of the loss of her boyfriend and she's now embarrassed and wants to return home.*

1. What considerations are the most important for you at this time, and what plan of action should you take?

- A. Discharge to home
- B. Hospitalize the patient
- C. Determine seriousness of suicide intent
- D. Make decisions for the child and parents and take action

2. When you suggest follow-up counseling to involve the family, the parents insist the problem occurred because the patient's boyfriend "broke up" with her and only she needs help. You should:

- A. Agree with the family
- B. Insist the parents see a therapist with the patient

C. Keep the child in the hospital until parents agree to counseling  
D. Start antidepressant medication

3. What are the signs to look for in assessing suicide potentiality?

- A. Violent or rebellious behavior
- B. Symptoms of depression
- C. Illegal behavior
- D. Running away

4. Which of the following can be related to adolescent suicide?

- A. Family communication
- B. Perinatal influences
- C. Siblings
- D. Social contact with peers

*Continued on page 174*

## Brief Summary

### Tavist® (clemastine fumarate) tablets, USP 2.68 mg

**INDICATIONS:** TAVIST Tablets 2.68 mg are indicated for the relief of symptoms associated with allergic rhinitis such as sneezing, rhinorrhea, pruritus, and lacrimation. TAVIST Tablets 2.68 mg are also indicated for the relief of mild, uncomplicated allergic skin manifestations of urticaria and angioedema.

**CONTRAINDICATIONS:** *Use in Nursing Mothers:* Because of the higher risk of antihistamines for infants generally and for newborns and premature infants in particular, antihistamine therapy is contraindicated in nursing mothers.

*Use in Lower Respiratory Disease:* Antihistamines should not be used to treat lower respiratory tract symptoms including asthma. Antihistamines are also contraindicated in the following conditions:

Hypersensitivity to TAVIST (clemastine fumarate) or other antihistamines of similar chemical structure.

Monoamine oxidase inhibitor therapy (see Drug Interaction Section).

**WARNINGS:** Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction, symptomatic prostatic hypertrophy, and bladder neck obstruction.

*Use in Children:* Safety and efficacy of TAVIST have not been established in children under the age of 12.

*Use in Pregnancy:* Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

*Use with CNS Depressants:* TAVIST has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

*Use in Activities Requiring Mental Alertness:* Patients should be warned about engaging in activities requiring mental alertness such as driving a car or operating appliances, machinery, etc.

*Use in the Elderly (approximately 60 years or older):* Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

**PRECAUTIONS:** TAVIST (clemastine fumarate) should be used with caution in patients with: history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, and hypertension.

*Drug Interactions:* MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

**ADVERSE REACTIONS:** Transient drowsiness, the most common adverse reaction associated with TAVIST (clemastine fumarate), occurs relatively frequently and may require discontinuation of therapy in some instances.

*Antihistaminic Compounds:* It should be noted that the following reactions have occurred with one or more antihistamines and, therefore, should be kept in mind when prescribing drugs belonging to this class, including TAVIST. The most frequent adverse reactions are underlined.

1. *General:* Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

2. *Cardiovascular System:* Hypotension, headache, palpitations, tachycardia, extrasystoles.

3. *Hematologic System:* Hemolytic anemia, thrombocytopenia, agranulocytosis.

4. *Nervous System:* Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

5. *GI System:* Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

6. *GU System:* Urinary frequency, difficult urination, urinary retention, early menses.

7. *Respiratory System:* Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

**DOSAGE AND ADMINISTRATION:** DOSAGE SHOULD BE INDIVIDUALIZED ACCORDING TO THE NEEDS AND RESPONSE OF THE PATIENT.

**TAVIST Tablets 2.68 mg:** The maximum recommended dosage is one tablet three times daily. Many patients respond favorably to a single dose which may be repeated as required, but not to exceed three tablets daily.

**HOW SUPPLIED:** TAVIST Tablets: 2.68 mg clemastine fumarate. White, round compressed tablet, embossed "78/72" and scored on one side, "TAVIST" on the other. Packages of 100.

**CAUTION:** Federal law prohibits dispensing without prescription.

## SELF-ASSESSMENT

## Answers and Discussion

*Continued from page 172*

1. Answer C is the most important consideration; however, answers A, B, and D may be correct in other situations. How serious was the suicide attempt? What were the circumstances of discovery and the possibility of completion? Is this a cry for help or did the child truly intend to end her life? What degree of hopelessness or helplessness is present in the child and in the parents? Answers to these questions will help you determine the seriousness of the attempt.

The child should be returned home to the support of the family if at all possible. Hospitalization will be needed if further medical treatment is necessary that can be provided only in a hospital or if support systems at home do not allow for the child's return.<sup>1</sup> The child has lost control of her situation and life; these parents show a degree of control by bringing S.T. to you. However, an assessment of their ability to maintain enough control to protect S.T. will be necessary. In many situations the parents will be detached or noncommunicative and other support may be needed.

2. B is correct. In some instances D may be indicated. A and C are false. Drugs may be needed in some cases to treat depressive symptoms; however, follow-up counseling is a necessity, and should involve the parents as well as the child. This is where the real problem lies.<sup>1</sup> If parents continue to refuse to attend with the child, then have the child seen alone. Family therapy is best, but it is important that the child's extreme method of communication not be ignored. The parents may agree to be seen occasionally for guidance to better understand their child's

problems or to develop improved communication skills.<sup>2</sup>

In families with poor interpersonal relationships, an adolescent will cling more desperately to outside relationships and be more devastated by their loss. Another underlying problem may be conflict with the parents. When parents are absent, noncommunicative, detached, or alienated from the child, the presence or absence of other supportive resources as patient substitutes should be elicited.<sup>3</sup>

3. All responses are true. Depending on the child's age and maturity you may want to look for all these signs. In most suicidal attempts one can find a history of emotional disturbance.<sup>4</sup> The older adolescent will generally display symptoms of depression, such as social withdrawal, loss of initiative and self-esteem, sadness, sleep disturbances, or a radical personality change. Younger children manifest symptoms of acting out behavior, hostility, aggressiveness, or delinquency.<sup>5,6</sup> Illegal behavior or an act that causes the child to be arrested may be a way of forcing others to act for him.<sup>1</sup>

4. A, B, and D are true. C is false. Studies have demonstrated a connection between adolescent suicide and patterns of family communication and interaction.<sup>1,3,8</sup> Alienation or social isolation may be related to the lack of a secure relationship with the parents, so that it affects the child's ability to establish long-term relationships with others.

When looking at communication systems within the family, ask yourself the following: how does the child or family handle loss and



have many losses occurred recently? An individual or family that denies the importance of a loss is unable to complete the grief process and functioning may be decreased. A family that openly discusses losses and understands needs for bereavement is more apt to pull together.

Siblings have not been mentioned as a cause in the literature, but they may have similar problems to the patient within the family system.

Salk and others<sup>9</sup> studied "the possible relationship between falling perinatal mortality and rising rates of adolescent suicide" and found that three factors have a correlation: respiratory distress for more than one hour at birth, lack of antenatal care before 20 weeks of pregnancy, and chronic disease of the mother during pregnancy. They summarize that "whatever environmental conditions might precipitate suicide, those individuals whose early life experience included adverse perinatal conditions are more vulnerable during adolescence."

Ask the teenager about family conflicts, such as divorce, abusive behavior, chronic illness of a family member, or a family history of suicide. Ask about social and economic changes, relocation, financial difficulties, peer pressure, and parent-child estrangement.<sup>5</sup> Jacobs and Teicher suggest using a life history chart to clarify the longitudinal dynamics.<sup>7</sup>

1. First Phase: Numerous behavior problems and dissensions within the family from childhood to onset of adolescence.

2. Escalation Phase: Onset of adolescence with its yearning for autonomy and personal authority leads to even stricter discipline and

personal restrictions on child by parents.

3. Final Phase: Alienated from the family, the child desperately latches onto boy- or girlfriend with an intensity that not only alienates others from the child but also makes the eventual dissolution of that single relationship almost inevitable.

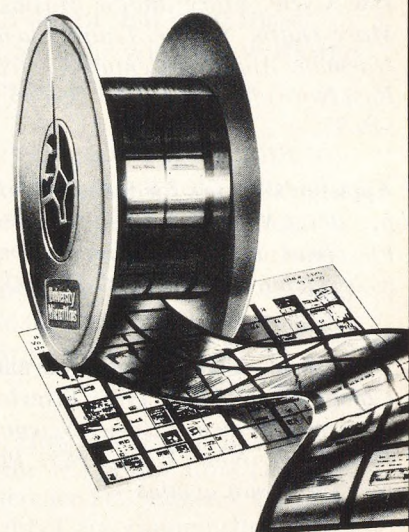
4. Suicide Phase: All social attachments gone, the adolescent feels the only legitimate solution is suicide.

This approach shows the child to be using a problem-solving method, exhausting all options before attempting suicide.

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# Self-Assessment in Family Practice

Series Editor: Robert B. Taylor, MD

Compiled by Larry E. Davis, MD, Department of Family Practice, The Oregon Health Sciences University School of Medicine, Portland, Oregon.

*This section of the Journal is designed to present clinical problems that focus on patient management, problem solving, and other elements integral to family medicine. The intent of this section is aimed more at teaching and learning than at self-assessment as an evaluation or scoring device. Reinforcement of major teaching points is therefore included through the further discussion and supplemental references that appear on the following pages. Critical comments relating to these self-assessment materials are invited and should be submitted as letters to the Editor.*

**Questions 1-5 each contain four suggested answers. Choose one or more of the four responses.**

*As part of your local hospital's continuing medical education program, a seminar dealing with hand injuries is presented. You attend and participate in presentations dealing with injuries occurring at home, at work, and during sports activities. Representative questions during the post-test examination include the following:*

1. Fingertip amputations or avulsions are among the most common hand injuries encountered by physicians who provide primary care. Which of the following are true with respect to operative (grafting) and nonoperative management of these injuries?

A. With operative management, time loss from work is usually less.

B. Operative management results in fingertips that have poorer sensation, increased cold sensitivity, depressed appearance, and often unsightly pigmentary changes.

C. With nonoperative management, most injuries will heal within four to six weeks with better two-point discrimination and appearance than in grafted fingertips.

D. Excellent cosmetic and functional results have been reported with nonoperative management in children, even when the distal phalanx was involved.

2. A 22-year-old patient suffers a 4-cm palm laceration while repairing a window. Which of the following are true?

A. A general anesthetic or axillary block is usually necessary in order to provide adequate anesthesia for hemostasis and adequate exposure to evaluate the wound.

B. Combined ulnar and median nerve blocks at the wrist will provide adequate anesthesia.

C. A blood-pressure cuff maintained at 250 mmHg on the upper arm may not provide adequate hemostasis unless the hand and arm are first compressed by application of an eschmark bandage.

D. Flexor tendon repair performed later than eight hours after injury usually is associated with poor outcome.

3. According to the *AMA Guides to the Evaluation of Permanent Impairment*, the following are true:

A. Permanent disability is a purely medical condition, which the physician considers stable or nonprogressive at the time evaluation is made, as is any anatomic or functional loss or abnormality after maximal medical rehabilitation has been achieved.

B. Amputation of the index finger at the metacarpal-phalangeal (MCP) joint is considered to cause more impairment than a similar injury of the long finger or thumb.

C. To determine restriction of

joint motion, two measurements are necessary.

D. The goniometer is primarily a research tool used to measure degree of joint swelling in rheumatoid arthritis of the hands.

4. Which of the following psychomotor tests of hand function are defined correctly?

A. Hand Dynamometer test: measures the eye-hand coordination and wrist-finger speed.

B. Tapping test: measures ability to make skillful, controlled manipulation of tiny objects.

C. O'Connor Finger Dexterity test: measures hand strength.

D. Minnesota Rate of Manipulation test: measures manual dexterity of arm-hand unit and consists of five subtests.

5. With respect to work-related injuries, which of the following are true?

A. Hand injuries account for approximately one third of the more than one million persons who make a claim for workers' compensation yearly.

B. A recent study showed that family physicians frequently fail to document either work status or exposures and their possible relationship to health status.

C. Malingering, psychiatric factors, and the physician's own feelings toward the patient may affect a disability evaluation.

D. Occupational health services are often six-sided relationships.

## Answers and Discussion

1. A is false; B, C, and D are true. A nonoperative technique has been described that eliminates many of the disadvantages of operative management and has superior results.<sup>1</sup> The wound is cleansed and debrided, then the defect is covered by an occlusive aluminum foil dressing (available as packaging for scalpel blades or Xeroform gauze). Dressing changes are performed on the third, fifth, and seventh days, then weekly. If initial bleeding is a problem, Gelfoam may be applied, then the foil dressing begun in 24 hours. The dressing is occlusive, does not stick to the wound and is comfortable. This eliminates the expense and time loss involved in grafting procedures.

2. B and C are true; A and D are false. Combined ulnar and median nerve blocks will provide adequate anesthesia, so that axillary block or general anesthesia are usually not necessary in this type of injury unless the patient refuses a wrist block. Venous oozing may flood the site of injury, obscuring exploration unless the extremity is compressed prior to application of the tourniquet. Flexor tendon repair may be performed at a later date if necessary due to absence of a qualified surgeon at initial evaluation or concerns about infection.

3. C is true; A, B, and D are false. The definition of permanent im-

pairment (not disability) is given in A. Permanent disability is not a purely medical condition. A patient is permanently disabled when his actual or presumed ability to engage in useful activity is reduced or absent because of "impairment," which, in turn, may or may not be combined with other factors. The percentage of impairment for finger amputations at the MCP joint are: thumb, 22 percent, index, 14 percent, long, 11 percent, ring, 5 percent, little, 3 percent.<sup>2</sup> The goniometer is an inexpensive, simple-to-operate device, which is necessary to measure the limits of flexion and extension of interphalangeal joints of the fingers. If the patient is capable of assuming the prescribed neutral position for each motion, then the degree of motion can be determined.

4. A, B, and C are defined incorrectly. Only D is defined correctly. The Hand Dynamometer test measures hand strength. The Tapping test measures eye-hand coordination and wrist-finger speed. It consists of a page with 300 circles, each 1.3 cm diameter. The subject is given 60 seconds with each hand to place three marks in each circle with a pencil and proceed as rapidly as possible across the rows without skipping any circles. The O'Conner Finger Dexterity test measures the ability to make skillful, controlled manipulation of tiny

objects involving primarily the fingers.<sup>3</sup>

5. All responses are true. Stein and Franks<sup>4</sup> reported in *The Journal of Family Practice* on a questionnaire study of 362 patients at a family medicine center and 38 percent described current health problems related to work. One hundred of these patients' charts were evaluated, and 41 of these had no documentation of job title, place of work, type of company, length of employment, or job duty. Occupational health services are often six-sided relationships involving a physician, patient, employer, government agency, workers' compensation carrier, and union.

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## Self-Assessment in Family Practice

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*This section of the Journal is designed to present clinical problems that discussion and supplemental references that appear on the following pages. family medicine. The intent of this section is aimed more at teaching and learning than at self-assessment as an evaluation or scoring device. Reinforcement of major teaching points is therefore included through the further discussion and supplemental references which appear on the following pages. Critical comments relating to these self-assessment materials are invited and should be submitted as Letters to the Editor.*

**Questions 1-4 each contain four suggested answers. Choose one or more of the four responses.**

*A 39-year-old gravida 1, para 0, woman presents to your office for prenatal care. Routine prenatal history and physical, prenatal laboratory studies, genetic counseling, and referral for genetic amniocentesis are performed.*

1. Which of the following patients

is at increased risk in regard to age and parity?

- A. 16-year-old G1, P0
- B. 22-year-old G1, P0
- C. 26-year-old G2, P1
- D. 39-year-old G1, P0

2. Which of the following conditions occur more frequently in the "elderly" primiparous woman?

- A. Pregnancy-induced hypertension
- B. Premature rupture of membranes
- C. Breech presentation
- D. Gestational diabetes

3. Which of the following is useful in screening for gestational diabetes?

- A. Hemoglobin A<sub>1c</sub>
- B. Fasting serum glucose
- C. One-hour glucose screen
- D. Three-hour glucose tolerance test

4. Which of the following studies assess the functional status of the placenta?

- A. Oxytocin contraction test
- B. Real-time ultrasound study
- C. Breast self-stimulation test (BSST)
- D. Non-stress test



## Answers and Discussion

1. A, B, C, and D are correct. Over the past ten years, utilization of risk assessment systems has been introduced into prenatal care.<sup>1,2,3</sup> These systems are based on a multifactorial analysis of a wide range of prenatal conditions and their association with obstetric outcome. In such systems, both age and parity have been identified as having a low, but definite, predictive value in terms of obstetric risk. Specifically, age less than 17 years or greater than 35 years and nulliparity or grand multiparity have been identified as risk factors. It should be noted that risk factors are cumulative in terms of predicting risk so that a 36-year-old G1, P0, woman is at greater risk than a 36-year-old G2, P1, woman.<sup>2</sup>

2. A, B, and D are correct. It has been a precept that "the elderly, primiparous patient" is at increased risk, but there is relatively little literature on this subject, and the available reports are somewhat contradictory. However, several conditions appear to occur more frequently in the elderly, primiparous patient: pregnancy-induced hypertension, gestational diabetes, and pre-term delivery often associated with premature rupture of membranes.<sup>4,5,6</sup> Perinatal mortality, but importantly not neonatal mortality, also appear to be increased in several studies. In these studies, this increase is associated with a higher incidence of placental abruption, particularly in patients who have pregnancy-induced hypertension.

3. C is correct. Gestational diabetes occurs in approximately 5 percent of pregnancies and is particularly associated with a positive family history of a first-degree relative with type II diabetes mellitus, a previous obstetric history of a large for gestational age (LGA) in-

fant (greater than 4,500 g), or maternal age greater than 25 years at the time of pregnancy. Hemoglobin A<sub>1c</sub>, which in theory would seem to be an ideal study for assessing long-term glucose intolerance, even in the setting of the dramatic physiologic changes in carbohydrate metabolism that occur during pregnancy, is not yet a useful test simply because normative values during pregnancy do not yet exist. A single fasting glucose tolerance test is not predictive of a pregnant patient's response to a carbohydrate load and, therefore, is an inadequate study. A three-hour glucose tolerance test remains the gold standard for diagnosing diabetes of any form, yet is too time consuming and expensive to be utilized as a simple screen. The one-hour glucose screen has gained increasing acceptance in the obstetric literature as the screening study of choice for gestational diabetes. In this procedure, 50 g of carbohydrate is administered to a fasting patient and the serum glucose is assessed one hour following the carbohydrate load. If the value is greater than 130-135 mg/dL, the patient may be glucose intolerant and a full three-hour glucose tolerance test is indicated. The optimal time to screen is at the point of maximal insulin demand during pregnancy or at approximately 26-30 weeks. Any patient who demonstrates an early pattern of rapid and excessive weight gain should also be screened.<sup>7</sup>

4. A, C, and D are correct. The earliest standard for assessing placental function was the oxytocin contraction test, a study designed to mimic the physiologic stress of labor.<sup>8</sup> During the past 10 years, this test has been largely replaced by the non-stress test, which does not entail the administration of Pitocin. While the non-stress ap-

pears to be a good predictor of fetal well-being, it does not necessarily predict placental function.<sup>9</sup> Recently, interest has centered on the breast self-stimulation test, or BSST.<sup>10</sup> The BSST is performed by asking the patient to perform nipple stimulation while being monitored in the fashion of a non-stress test. The nipple stimulation causes endogenous release of oxytocin, which in turn produces uterine contractions. Fetal heart rate response during contractions can then be interpreted in a manner analogous to the oxytocin challenge test. Ultrasound, while useful for defining location and occasionally separation of the placenta, is not helpful in assessing placental function.

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