

Entex[®] LA

PHENYLPROPANOLAMINE HCl 75 mg
GUAIFENESIN 400 mg

IN A SPECIAL BASE TO PROVIDE A PROLONGED THERAPEUTIC EFFECT

OR

Entex[®] LIQUID

Each 5 ml (one teaspoonful) contains:
PHENYLEPHRINE HYDROCHLORIDE 5 mg
PHENYLPROPANOLAMINE HYDROCHLORIDE 20 mg
GUAIFENESIN 100 mg
ALCOHOL 5%

Before prescribing or administering, see package circular for full product information. The following is a brief summary.

INDICATIONS AND USAGE: Entex is indicated for the symptomatic relief of sinusitis, bronchitis, pharyngitis, and coryza when these conditions are associated with nasal congestion and viscous mucus in the lower respiratory tract.

CONTRAINDICATIONS: Entex is contraindicated in individuals with known hypersensitivity to sympathomimetics, severe hypertension, or in patients receiving monoamine oxidase inhibitors.

WARNINGS: Sympathomimetic amines should be used with caution in patients with hypertension, diabetes mellitus, heart disease, peripheral vascular disease, increased intraocular pressure, hyperthyroidism, or prostatic hypertrophy.

PRECAUTIONS: Information for Patients: Do not crush or chew Entex LA tablets prior to swallowing.

Drug Interactions: Entex should not be used in patients taking monoamine oxidase inhibitors or other sympathomimetics.

Drug/Laboratory Test Interactions: Guafenesin has been reported to interfere with clinical laboratory determinations of urinary 5-hydroxyindoleacetic acid (5-HIAA) and urinary vanilmandelic acid (VMA).

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

Nursing Mothers: It is not known whether the drugs in Entex are excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants, a decision should be made whether to discontinue nursing or to discontinue the product, taking into account the importance of the drug to the mother.

Pediatric Use: Entex LA: Safety and effectiveness of Entex LA tablets in children below the age of 6 have not been established.

Entex Liquid: Safety and effectiveness of Entex Liquid in children below the age of 2 have not been established.

ADVERSE REACTIONS: Possible adverse reactions include nervousness, insomnia, restlessness, headache, nausea, or gastric irritation. These reactions seldom, if ever, require discontinuation of therapy. Urinary retention may occur in patients with prostatic hypertrophy.

OVERDOSAGE: The treatment of overdosage should provide symptomatic and supportive care. If the amount ingested is considered dangerous or excessive, induce vomiting with ipecac syrup unless the patient is convulsing, comatose, or has lost the gag reflex, in which case perform gastric lavage using a large-bore tube. If indicated, follow with activated charcoal and a saline cathartic. Since the effects of Entex may last up to 12 hours, treatment should be continued for at least that length of time.

DOSE AND ADMINISTRATION: Entex LA: Adults and children 12 years of age and older — one tablet twice daily (every 12 hours); children 6 to under 12 years — one-half (1/2) tablet twice daily (every 12 hours). Entex LA is not recommended for children under 6 years of age. Tablets may be broken in half for ease of administration without affecting release of medication but should not be crushed or chewed prior to swallowing.

Entex Liquid: All dosage should be administered four times daily (every 6 hours).

Children:
2 to under 4 years 1/2 teaspoonful (2.5 ml)
4 to under 6 years 1 teaspoonful (5.0 ml)
6 to under 12 years 1 1/2 teaspoonfuls (7.5 ml)

Adults and children 12 years of age and older:
2 teaspoonfuls (10.0 ml)

HOW SUPPLIED: Entex LA is available as a blue, scored tablet imprinted with "ENTEX LA" on the smooth side. **Entex Liquid** is available as an orange-colored, pleasant-tasting liquid.

Entex LA
NDC 0149-0436-01 bottle of 100
NDC 0149-0436-05 bottle of 500

Entex Liquid
NDC 0149-0414-16 16 FL OZ (1 Pint) bottle

CAUTION: Federal law prohibits dispensing without prescription.

LQ-B55/LA-B58

REVISED JULY 1985 (Entex LA)

REVISED SEPTEMBER 1985 (Entex Liquid)

Norwich Eaton

Norwich Eaton Pharmaceuticals, Inc.
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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.

BLACKMARKET STEROIDS COMPLICATE ACNE THERAPY

To the Editor:

This letter was prompted by a telephone call to the Drug Information Service at the University of Utah Health Sciences Center from a concerned parent seeking identification and information regarding a bottle of pills she had found in her teenage son's room. The handwritten label on the bottle indicated it contained methandrostenalone. The woman wanted to verify that this was the same medication prescribed for her son's acne.

She was informed that the medication in question was a well-known anabolic steroid used by many athletes to increase muscle mass, and that the drug carries the risk of many adverse effects, including acne. Nevertheless, she was relieved that her son was not on "hard drugs." She was also advised to discuss the use of this illicit medication with her son as well as the physician treating his acne.

It has been documented that at least 1 million athletes are using anabolic steroids,¹ most of which are easily obtained through blackmarket sources.² Very little, if any, drug education is connected with anabolic steroids obtained in this fashion. This lack of education is in part responsible for most illicit users exceeding the recommended therapeutic dosages by several times.² Certainly, education regarding their efficacy and side effects is a key in reducing their use in healthy individuals.

Young athletes may seek medical treatment for acne induced by anabolic steroids. Physicians unaware of anabolic steroid abuse may embark on a therapeutic regimen that includes systemic medications such as tetracycline and isotretinoin (Accutane). Both of these medications can cause hepatotoxicity, as can anabolic steroids.³ The concomitant use of any

of these medications may increase the risk of hepatic injury. While isotretinoin decreases sebaceous gland activity, the anabolic steroid stimulates this activity, thus confusing the clinical picture of the acne patient.

In conclusion, we believe that physicians should routinely query young athletes concerning anabolic steroid abuse prior to initiating acne therapy, especially systemic therapy. If abuse is discovered, discontinuing the anabolic steroid is the first step in the treatment of the athlete's acne and an important step in reducing the individual's risk of liver dysfunction,³ liver cancer,³ coronary artery disease,⁴ testicular dysfunction,³ gynecomastia,³ and abnormalities of skeletal muscle tissue.⁵

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References

1. Taylor WN: Hormonal Manipulation: A New Era of Monstrous Athletes. Jefferson, NC, McFarland & Co, 1985
2. Strauss RH, Wright JE, Finerman GA, et al: Side effects of anabolic steroids in weight-trained men. *Phys Sports Med* 1983; 11:86-98
3. McEvoy GK (ed): Drug Information '86. Bethesda, Md, American Society of Hospital Pharmacists, 1986, pp 279, 1528-1814
4. Cohen JC, Faber WM, Beneade AJ, Noakes TD: Altered serum lipoprotein profiles in male and female powerlifters ingesting anabolic steroids. *Phys Sports Med* 1986; 14:131-136
5. Rogozkin V: Metabolic effects of anabolic steroid on skeletal muscle. *Med Sci Sports* 1979; 11:160-163

ECG IN AMBULATORY CARE

To the Editor:

I agree with the article by Robert Nissan and Maria Encarnacion, "Clinical Value of the Electrocardiogram in Ambulatory Care" (*J Fam Pract* 1987; 24:361-363), that routine periodic screening of all adults with electrocardiogram (ECG) is unjustified. I believe the case for selective

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screening, though, is far more complex than presented.

First, while only two of the authors' cases required immediate treatment, many of the other diagnoses listed suggested the need for further workup and treatment. More follow-up on the other abnormal cases would be required to define truly whether 0.5 percent, 30.3 percent, or something in between represents the "true positive" rate for ECGs. For a test that is totally benign and fairly inexpensive, even low positive rates should be acceptable. A cost-benefit analysis would be interesting; I suspect ECG would compare favorably with other screening procedures such as sigmoidoscopy.

Second, the authors question the usefulness of the baseline ECG based on a single study¹ that examined its usefulness in deciding whether to admit a patient with chest pain. Clearly in the emergency room the past ECG is of minimal help; it can be much more useful in the hospitalized patient with atypical pain and nonspecific ECG changes. In this context it helps gauge the physician's index of suspicion and may alter the course of further, more invasive testing.

Third, in hypertension the presence of left ventricular hypertrophy (LVH) can suggest not only the duration of disease, but also the adequacy of control, ie, the average daily blood pressure.² Following potentially reversible changes of hypertension such as LVH³ may be a better indicator of treatment efficacy than a single office blood pressure reading. In this setting the ECG may actually be underutilized.

Finally, the authors cite the anxiety induced by performing an ECG on a patient. My experience more often is the opposite: the patient is relieved when told that his ECG is fine. Abnormal ECGs in themselves do not provoke anxiety; rather, the physician who presents the interpretation can provoke undue anxiety, appropriate concern, or reassurance. We need to realize the limitations of the tests, rather than just stop ordering them.

I believe the authors' data represent a liberal but appropriate use of the ECG. While not a screening test for

the general population, selective screening of high-risk groups and liberal use in symptomatic patients are certainly justified in a society increasingly geared toward the prevention and early detection of disease.

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References

1. Rubenstein L, Greenfield S: The baseline ECG in the evaluation of acute cardiac complaints. *JAMA* 1980; 244:2536-2539
2. Sokolow M, Werdegar D, Kain HK, Hinman AT: Relationship between level of blood pressure measured casually and by portable recorders and severity of complications in essential hypertension. *Circulation* 1966; 34:279
3. Rowlands DB, Glover DR, Ireland MA, et al: Assessment of left ventricular mass and its response to antihypertensive treatment. *Lancet* 1982; 1:467

HYPONATREMIA RESULTING FROM PELVIC ULTRASOUND PREPARATION

To the Editor:

Even noninvasive testing may be associated with unappreciated hazards. The following case illustrates the infrequently reported,¹ and often overlooked, problem of hyponatremia resulting from free water intoxication associated with pelvic ultrasound preparations.

A 64-year-old woman was admitted to the hospital for severe lower back pain, of one week's duration, radiating to the left buttock. The patient had well-compensated thyroid disease, but no history of diuretic usage, renal disease, adrenal disease, liver disease, or congestive heart failure. Vital signs were as follows: temperature 37 °C, pulse 96 beats per minute, blood pressure 150/80 mmHg, and respirations 18/min. Physical examination was remarkable for tenderness over the left sciatic notch and a grade 2/6 systolic heart murmur localized to the aortic region. There were no signs of dehydration or edema. Admission laboratory studies disclosed the following values: serum sodium 138 mmol/L (138 mEq/L); potassium 4.3 mmol/L (4.3 mEq/L); and chloride 108 mmol/L

NIX FOR LICE®

CREME RINSE

permethrin 1%

PEDICULICIDAL/OVICIDAL ACTIVITIES: *In vitro* data indicate that permethrin has pediculicidal and ovicidal activity against *Pediculus humanus var. capitis*. The high cure rate (97-99%) of Nix in patients with head lice demonstrated at 14 days following a single application is attributable to a combination of its pediculicidal and ovicidal activities and its residual persistence on the hair which may also prevent reinfestation.

INDICATIONS AND USAGE: Nix is indicated for the single-application treatment of infestation with *Pediculus humanus var. capitis* (the head louse) and its nits (eggs). Retreatment for recurrences is required in less than 1% of patients since the ovicidal activity may be supplemented by residual persistence in the hair. If live lice are observed after at least seven days following the initial application, a second application can be given.

CONTRAINDICATIONS: Nix is contraindicated in patients with known hypersensitivity to any of its components, to any synthetic pyrethroid or pyrethrin, or to chrysanthemums.

WARNING: If hypersensitivity to Nix occurs, discontinue use.

PRECAUTIONS:

General: Head lice infestation is often accompanied by pruritus, erythema, and edema. Treatment with Nix may temporarily exacerbate these conditions.

Information for Patients: Patients with head lice should be advised that itching, redness, or swelling of the scalp may occur after application of Nix. If irritation persists, they should consult their physician. Nix is not irritating to the eyes; however, patients should be advised to avoid contact with eyes during application and to flush with water immediately if Nix gets in the eyes. In order to prevent accidental ingestion by children, the remaining contents of Nix should be discarded after use.

Combing of nits following treatment with Nix is not necessary for effective treatment. However, patients may do so for cosmetic or other reasons. The nits are easily combed from the hair treated with Nix after drying.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Six carcinogenicity bioassays were evaluated with permethrin, three each in rats and mice. No tumorigenicity was seen in the rat studies. However, species-specific increases in pulmonary adenomas, a common benign tumor of mice of high spontaneous background incidence, were seen in the three mouse studies. In one of these studies there was an increased incidence of pulmonary alveolar-cell carcinomas and benign liver adenomas only in female mice when permethrin was given in their food at a concentration of 5000 ppm. Mutagenicity assays, which give useful correlative data for interpreting results from carcinogenicity bioassays in rodents, were negative. Permethrin showed no evidence of mutagenic potential in a battery of *in vitro* and *in vivo* genetic toxicity studies.

Permethrin did not have any adverse effect on reproductive function at a dose of 180 mg/kg/day orally in a three-generation rat study.

Pregnancy: Teratogenic Effects: Pregnancy Category B: Reproduction studies have been performed in mice, rats, and rabbits (200-400 mg/kg/day orally) and have revealed no evidence of impaired fertility or harm to the fetus due to permethrin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy 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 and because of the evidence for tumorigenic potential of permethrin in animal studies, consideration should be given to discontinuing nursing temporarily or withholding the drug while the mother is nursing.

Pediatric Use: Nix is safe and effective in children two years of age and older. Safety and effectiveness in children less than two years of age have not been established.

ADVERSE REACTIONS: The most frequent adverse reaction to Nix is pruritus. This is usually a consequence of head lice infestation itself, but may be temporarily aggravated following treatment with Nix. 5.9% of patients in clinical studies experienced mild temporary itching; 3.4% experienced mild transient burning/stinging, tingling, numbness, or scalp discomfort; and 2.1% experienced mild transient erythema, edema, or rash of the scalp.

DOSAGE AND ADMINISTRATION:

Adults and Children: Nix is intended for use after the hair has been washed with shampoo, rinsed with water and towel dried. Apply a sufficient volume of Nix to saturate the hair and scalp. Nix should remain on the hair for 10 minutes before being rinsed off with water. A single treatment is sufficient to eliminate head lice infestation. Combing of nits is not required for therapeutic efficacy, but may be done for cosmetic or other reasons.

SHAKE WELL BEFORE USING.

HOW SUPPLIED: Nix (Permethrin) 1% (wt./wt.) Creme Rinse is supplied in plastic squeeze bottles that contain 2 fl. oz. weighing 56 g. (NDC-0081-0780-81)

Store at 15°-25°C (59°-77°F).

1 DiNapoli J, Austin R, Englander S, et al: Eradication of lice with a single treatment (unpublished data, 1987). 2 Taplin D, Meiniking T, Castillero P, et al: Permethrin 1% cream rinse for the treatment of pediculus humanus var capitis infestation. *Pediatr Dermatol* 1986; 3:434-448. 3 Davies J, Dedhia H, Morgade C, et al: Lindane poisonings. *Arch Dermatol* 1983; 119:142-144.

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3030 Cornwallis Road
Research Triangle Park, NC 27709

(108 mEq/L). Results of other tests, including bicarbonate, blood urea nitrogen, creatinine, glucose, urinalysis, complete blood count, thyroid function, and a chemistry panel, were all within normal limits.

Medications on admission were carisoprodol-aspirin (Soma Compound), ibuprofen (Motrin), oxycodone-acetaminophen (Tylox), and L-thyroxine (Synthroid). The patient received one injection of dexamethasone (Decadron) the day of admission. On the second day of hospitalization, pelvic ultrasonography was ordered. In preparation for the echogram, the patient drank 1,350 mL of water over one to two hours. Upon returning from the examination, the patient complained of severe weakness. Two hours later, a nurse found the patient disoriented and aphasic. Laboratory test results included serum sodium 123 mmol/L (123 mEq/L), 93 mmol/L chloride (93 mEq/L), and potassium 3.5 mmol/L (3.5 mEq/L). Serum osmolarity was 249 mmol/L (249 mOsm/L). Calcium, glucose, magnesium, and complete blood count were normal. The patient was given an intravenous solution of 3 percent saline, followed by 5 percent glucose in normal saline. Six hours later the sodium was 129 mmol/L (129 mEq/L). Within 14 hours the patient's serum osmolarity, electrolytes, and mental status were back to normal.

Subsequent workup was pertinent for L-4 and L-5 disc disease. There were no further electrolyte abnormalities or neurological deficits noted during hospitalization or subsequently as an outpatient.

Although pelvic ultrasound is commonly considered a "benign examination," this woman's course is an example of how an ultrasound preparation can result in symptomatic hyponatremia. Even though a normal individual may drink up to 15 liters of water without a change in serum sodium levels,² far less water may dilute the serum sodium in elderly individuals and patients whose ability to excrete free water is impaired. In this case, a documented oral intake of 1,350 mL resulted in hyponatremia. Clinicians should be

aware of this potential side effect if a patient develops confusion after an ultrasound examination.

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References

1. Christenson LL, Scott D: Acute water intoxication following pelvic ultrasound examination. *Postgrad Med* 1985; 77:161-162
2. Barlow ED, DeWardnere HE: Compulsive water drinking. *Q J Med* 1959; 28:235-258

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The wart medicine you can recommend with complete confidence.

Because you know the importance of preventing autoinoculation as well as the transmittance of the wart virus, you may wish to recommend Compound W.[®] Compound W contains Salicylic Acid 17% (the maximum strength your patients can buy) in a flexible collodion vehicle which has been classified safe and effective to remove warts.* Compound W, in liquid and gel, is an economical way for your patients to eliminate infectious and embarrassing warts. For the past 25 years, Compound W has been an effective and safe wart remedy. You can recommend it with complete confidence.

*FDA Tentative Final Monograph On Wart Remover Drug Products For Over-The-Counter Human Use, The Federal Register, (Vol. 47, No. 172), pgs. 39102-39105, Sept. 3, 1982.



LIQUID AND GEL

Maximum Strength Compound W

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BRIEF SUMMARY

DESCRIPTION: LOZOL (indapamide) is an oral antihypertensive/diuretic.

INDICATIONS AND USAGE: LOZOL is indicated for the treatment of hypertension, alone or in combination with other antihypertensive drugs.

LOZOL is also indicated for the treatment of salt and fluid retention associated with congestive heart failure.

Usage in Pregnancy: (see PRECAUTIONS).

Contraindications: Anuria, hypersensitivity to indapamide or other sulfonamide-derived drugs.

WARNINGS: Hypokalemia occurs commonly with diuretics, and electrolyte monitoring is essential. In general, diuretics should not be given concomitantly with lithium.

PRECAUTIONS: GENERAL: 1. *Hypokalemia and Other Fluid and Electrolyte Imbalances:* Periodic determinations of serum electrolytes should be performed at appropriate intervals. In addition, patients should be observed for clinical signs of fluid or electrolyte imbalance, such as hyponatremia, hypochloremic alkalosis, or hypokalemia. Electrolyte determinations are particularly important in patients who are vomiting excessively or receiving parenteral fluids, in patients subject to electrolyte imbalance (including those with heart failure, kidney disease, and cirrhosis), and in patients on a salt-restricted diet. The risk of hypokalemia secondary to diuresis and natriuresis is increased when large doses are used, when the diuresis is brisk, when severe cirrhosis is present and during concomitant use of corticosteroids or ACTH. Interference with adequate oral intake of electrolytes will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis, such as increased ventricular irritability. Dilutional hyponatremia may occur in edematous patients; the appropriate treatment is restriction of water rather than administration of salt, except in rare instances when the hyponatremia is life threatening. However, in actual salt depletion, appropriate replacement is the treatment of choice. Any chloride deficit that may occur during treatment is generally mild and usually does not require specific treatment except in extraordinary circumstances as in liver or renal disease. 2. *Hyperuricemia and Gout:* Serum concentrations of uric acid increased by an average of 1.0 mg/100 ml in patients treated with indapamide, and frank gout may be precipitated in certain patients receiving indapamide (see ADVERSE REACTIONS). Serum concentrations of uric acid should therefore be monitored periodically during treatment. 3. *Renal Impairment:* Renal function tests should be performed periodically during treatment with indapamide. 4. *Impaired Hepatic Function:* Indapamide, like the thiazides, should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. 5. *Glucose Tolerance:* Latent diabetes may become manifest and insulin requirements in diabetic patients may be altered during thiazide administration. Serum concentrations of glucose should be monitored routinely during treatment with indapamide. 6. *Calcium Excretion:* Calcium excretion is decreased by diuretics pharmacologically related to indapamide. Indapamide may decrease serum PBI levels without signs of thyroid disturbance. 7. *Interaction With Systemic Lupus Erythematosus:* Thiazides have exacerbated or activated systemic lupus erythematosus.

DRUG INTERACTIONS: 1. *Other Antihypertensives:* LOZOL (indapamide) may add to or potentiate the action of other antihypertensive drugs. 2. *Lithium:* See WARNINGS. 3. *Post-Sympathectomy Patient:* The antihypertensive effect of the drug may be enhanced in the post-sympathectomized patient. 4. *Norepinephrine:* Indapamide may decrease arterial responsiveness to norepinephrine, but this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. **CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY:** Both mouse and rat life-time carcinogenicity studies were conducted. There was no significant difference in the incidence of tumors between the indapamide-treated animals and the control groups.

PREGNANCY/TERATOGENIC EFFECTS: PREGNANCY CATEGORY B. Diuretics are known to cross the placental barrier and appear in cord blood. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. If use of this drug is deemed essential, the patient should stop nursing.

ADVERSE REACTIONS: Most adverse effects have been mild and transient. In long-term controlled clinical studies, equal to or greater than 5% cumulative adverse reactions are headache, dizziness, fatigue, weakness, loss of energy, lethargy, tiredness, or malaise; muscle cramps or spasms, or numbness of the extremities; nervousness, tension, anxiety, irritability, or agitation; and less than 5% cumulative adverse reactions are lightheadedness, drowsiness, vertigo, insomnia, depression, blurred vision, constipation, nausea, vomiting, diarrhea, gastric irritation, abdominal pain or cramps, anorexia, orthostatic hypotension, premature ventricular contractions, irregular heart beat, palpitations, frequency of urination, nocturia, polyuria, rash, hives, pruritus, vasculitis, impotence or reduced libido, rhinorrhea, flushing, hyperuricemia, hyperglycemia, hyponatremia, hypochloremia, increase in serum urea nitrogen (BUN) or creatinine, glycosuria, weight loss, dry mouth, tingling of extremities. Clinical hypokalemia occurred in 3% and 7% of patients given indapamide 2.5 mg and 5.0 mg, respectively.

OVERDOSEAGE: Symptoms include nausea, vomiting, weakness, gastrointestinal disorders and disturbances of electrolyte balance. In severe instances, hypotension and depressed respiration may be observed. If this occurs, support of respiration and cardiac circulation should be instituted. There is no specific antidote. An evacuation of the stomach is recommended by emesis and gastric lavage after which the electrolyte and fluid balance should be evaluated carefully.

HOW SUPPLIED: White, round film-coated tablets of 2.5 mg in bottles of 100, 1,000, 2,500, and in unit-dose blister packs, boxes of 100 (10 x 10 strips).

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

See product circular for full prescribing information.

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LETTERS TO THE EDITOR

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PATIENT SATISFACTION

To the Editor:

The article in your April issue by Paula Cowan, "Patient Satisfaction With an Office Visit for the Common Cold" (*J Fam Pract* 1987; 24:412-413), raises a poignant question for all of us in primary care.

The crux of the issue, I feel, is the successful interaction of the expectations, needs, and communication skills of both the patient and the physician,¹ and not just the receipt of a prescription.

I believe in my practice a large number of people expect some written prescription for their expense. I find it surprising that 36 percent were satisfied with reassurance only. Were the patients fee-for-service, capitation, or gratis? Cowan's article alludes to the pressure we all feel to give the patient something. Unfortunately, in my experience, many patients see the drugs received as a rite of passage into the world of recognition or confirmation of their illness. They also may be expected to receive medication by loved ones, employers, and other interested peers.

Many people today are under enormous external and internal pressure not to be sick and to get better at whatever the cost. Of course, the physician is always placed in the role of determining what is at stake, in terms of behavioral issues.

What I feel health care providers are faced with today is patient reeducation on a grand scale. These captains may find themselves sailing against the tide of old drug-prescribing habits.

Cowan's research can serve to promote discussion about the difficult process of simultaneously giving the patient something appropriate, effective, and satisfying. In our system most people feel satisfied if they get something.

She unfortunately did not examine the impact of all the items received during the office transaction. It is important to point out that the physician himself or herself is a drug. We are always giving something; we are giving ourselves.

Eric J. Cassell² also shows the power of information as a therapeutic tool. The something we are giving (implied agreement) may be educational, eg, what to look for if the viral infection becomes bacterial; our agreeing to be available for any new problems provides engagement, and our input, counseling, points out and helps patients with the conflict of getting better at any cost. The visit itself may satisfy the patient by providing an avenue for disclosure and insight, thereby avoiding taking an unnecessary medication (about which both physician and patient may feel good).

There is so much happening at the time of visit in both the open and hidden agenda. Cannot today's visit for the common cold set the stage for tomorrow's consultation on hypertension or marital discord, for example?

Recently the question of patient satisfaction and behavioral science education was raised.³ The authors concluded, "The findings that significant differences in patient satisfaction exist on the 'art of care' scale and in the predicted direction certainly points to the importance of the behavioral sciences for patient care and overall residency education."

Although Dr. Cowan's sample is small, her article contributes to that fund of information in family practice skills that sets us apart from the mainstream of medicine. Would the same conclusions hold true for all systems of health care delivery including health maintenance organizations? I hope we will see more research in this direction.

Lawrence I. Silverberg, DO
West Friendship, Maryland

References

1. Balint M: *The Doctor, His Patient and the Illness*, ed 2. Surrey, UK, Unwin Brothers, The Gresham Press, 1971
2. Cassell EJ: *Talking With Patients*, vol 2, Clinical Technique. Cambridge, Mass, MIT Press, 1985
3. Amos SP, Teter K: Behavioral science education and patient satisfaction: Is there a link? *Fam Med* 1987; 19:144-145