

A Married Man Seropositive for Human Immunodeficiency Virus

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JOHAN G. PRICHARD, MD (*Assistant Professor, Departments of Family Medicine and Internal Medicine*): Today's case involves issues likely to be increasingly encountered by family physicians; thus it is propitious for this conference. As there are difficult legal, clinical, and ethical components, I have asked several colleagues to discuss each area in some detail. I begin by presenting the patient's history and clinical findings.

CASE PRESENTATION

A 47-year-old married father of two was seen in consultation because of a positive serological test for human immunodeficiency virus (HIV). He had obtained the test, on his own initiative, at an alternate test site. He complained only of difficulty in falling asleep during the previous three months. He denied weight loss, fever, cough, dyspnea, symptoms referable to the gastrointestinal tract, or new skin lesions. He denied sensory changes, memory deficits, or difficulties with calculations. His past medical history was remarkable for an appendectomy at age 7 years and multiple fractures resulting from a skiing injury at age 28 years. He otherwise has enjoyed good health and has continued to be a vigorous skier, sailor, and tennis player. He does not smoke, consumes 1 to 3 oz of alcohol daily, and takes no medications. He is employed as a senior geologist for an oil exploration company, and he travels extensively in the Middle East, Europe, and Latin America. In the past ten years, during lengthy travels abroad, he engaged in a number of homosexual affairs. He nonetheless considers his marriage to be very stable and is committed to its continuance. His family and friends are unaware of his bisexual behavior, and he is adamant regarding confidentiality of his medical record. Two sons attend high school.

A physical examination revealed a muscular, anxious man who appeared somewhat younger than his age. Height was 72 inches and weight, 172 pounds. Findings on examination of the ears, eyes, nose, and throat were unremarkable. Multiple, greater than 1-cm nodes were palpable in the supraclavicular fossa bilaterally, in both axillae, and in both femoral regions. These nodes were soft, nontender, and nonfixed. Bilateral epitrochlear nodes were palpable. An examination of his skin disclosed no abnormalities. The chest was clear to percussion and auscultation. Cardiovascular and genitourinary tract examinations were normal. There was no hepatomegaly, no masses or tenderness on palpation of the abdomen; however, the spleen tip was palpable 2 cm below the left costal margin. Findings on detailed neurological examination were normal.

Laboratory studies disclosed a white cell count of $4 \times 10^6/L$ ($4000/mm^3$) with a normal differential. The hemoglobin was 101 g/L (10.1 g/dL), and the platelets were $72 \times 10^9/L$ ($72 \times 10^3/mm^3$). The serum ferritin level was elevated, the serum iron and iron-binding capacities were diminished. The sedimentation rate was 42 mm/h. The reticulocyte count was 0.013 (1.3 percent). The red cell indices and peripheral blood smear were normal. Results of a 20-item chemistry panel, which included measurements of renal and hepatic function, were within normal limits. Findings on chest x-ray film were unremarkable. A VDRL was nonreactive, and a serological study for HIV was positive by Western blot.

On a return visit to discuss the results of laboratory tests, he denied any new symptoms. He refused to discuss the HIV seropositivity with his spouse. He wished to continue being seen at this institution but forbade any discussion of his illness with anyone other than himself. The patient stated that he felt he could maintain a relationship with his spouse without continuing to expose her to the virus. Further diagnostic studies were recommended but declined for the present.

I have asked Dr. Morris to begin the discussion by identifying some legal issues raised by the case—particularly regarding confidentiality and the duty the physician might have toward the patient's spouse.

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LEGAL ISSUES

DR. MORRIS (*Assistant Professor, Department of Family Medicine*): A major issue of legal importance in this case is whether a physician may be held liable for unauthorized disclosure of confidential information. More specifically, we are concerned with whether the physician may disclose the patient's seropositivity to his wife or any third party.

Confidentiality is central to each physician-patient encounter. Its importance in our daily activities has been emphasized since the Hippocratic oath, is still emphasized in ethics manuals, and is currently addressed in statutory law. On the federal level, the Federal Drug Abuse and Treatment Act has provisions for maintaining confidentiality. State licensing statutes usually contain provisions against unprofessional or dishonorable conduct as well as provisions regarding confidentiality.

There are at least four legal theories under which a physician may incur liability for unauthorized disclosure of confidential information. The first is violation of a statute. In one case involving a statutory licensing provision, it was held that unauthorized disclosure of confidential information by a physician would give rise to a civil action for the damages naturally arising from such a wrong.¹ In another case involving a licensing statute, it was held that the standards set out in the statute were merely administrative provisions and did not give the patient a right to recover for an alleged wrongful disclosure of medical information.² Hence, a court's interpretation of relevant statutory provisions may vary from state to state.

The second theory of liability is invasion of privacy. In one case involving unauthorized disclosure of confidential information by a physician to an insurance company, the court stated:

The preservation of the patient's privacy is no mere ethical duty on the part of the doctor, but is a legal duty as well, so that the unauthorized revelation of medical secrets, or any confidential communication given in the course of treatment is tortious conduct which may be the basis for an action in damages.³

An important factor to be considered, however, is the person to whom disclosure was made. In a case in which the physician discussed his patient's condition with the patient's wife, it was held that there was no invasion of privacy, as it was a reasonable disclosure to persons who had a legitimate interest.⁴ In the present case, although unauthorized disclosure of confidential material could expose the physician to liability, there may be some protection if the disclosure were only to the patient's spouse.

The third theory under which a physician may be held liable for unauthorized disclosure is breach of the physician-patient confidential relationship. Though not recognized in some jurisdictions, disclosure without consent may be seen as a breach of a fiduciary relationship, giving rise to a cause of action.⁵

The fourth theory under which a physician may incur liability is that of professional negligence or malpractice. Malpractice is defined as "any professional misconduct, unreasonable lack of skill or fidelity in professional or fiduciary duties, evil practice, or illegal or immoral conduct."⁶ There are basically four elements, each of which must be proven to establish malpractice. Only two are pertinent in this case. First, there must exist a fiduciary relationship that creates a responsibility, or duty, on the part of the physician to conduct himself professionally. This duty is inherent once the physician-patient relationship is established. Second, there must be some breach of this duty or deviation from an accepted standard of care. There is precedent to support a physician's disclosure of information about a patient to others, even if such disclosure is unauthorized. In *Tarasoff v Regents of the University of California*,⁷ which involved a therapist who did not disclose information to a third party, the court stated:

. . . once a therapist does in fact determine or . . . should have determined, that the patient poses a serious danger . . . to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger.

Clearly our patient poses a potential danger to his wife. This precedent offers some guidance as well as support for the argument that one would be protected from liability for unauthorized disclosure of confidential information.

Legal defenses to suits for unauthorized disclosure of confidential information include the following: disclosure in the public interest, disclosure only to those with legitimate interests, duty to disclose imposed by law, and absence of malice. In one case involving disclosure of a mistaken diagnosis of syphilis, the court stated:

Where a physician makes a disclosure of information imparted by a patient to secure treatment, believing that such disclosure is necessary to prevent the spread of disease, and the physician acts in good faith, with reasonable grounds for his diagnosis and without malice, he cannot be held liable in damages by his patient, even though he is mistaken in his diagnosis.¹

The defense that disclosure is required by law may become relevant, in some jurisdictions, in light of proposed communicable disease reporting statutes that might require that HIV seropositivity be a reportable condition.

In summary, unauthorized disclosure of confidential information arising during a physician-patient encounter may expose a physician to liability. There exists, however, some protection against liability if the disclosure is shown to be in the public interest, is disclosed only to the patient's spouse, or is required by law.

ETHICAL ISSUES

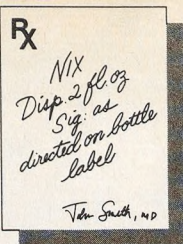
EARL E. SHELPS, PhD (*Assistant Professor of Medical Ethics, Department of Community Medicine; Fellow, Theology and Medical Ethics, Institute of Religion*): When

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Nix FOR LICE®

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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.

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1. Davies J, Dedhia H, Morgade C, et al: Lindane poisonings, *Arch Dermatol* 1983;119:142-144.
2. Taplin D, Meinking T, Castillero P, et al: Permethrin 1% creme rinse for the treatment of pediculus humanus var capitis infestation. *Pediatr Dermatol* 1986;3:344-348.
3. Taplin D, Meinking T: Pyrethrins and pyrethroids for the treatment of scabies and pediculosis. *Semin Dermatol* 1987;6:125-135.



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faced with a difficult decision that is not strictly medical in nature, clinicians tend to seek the guidance of either statutory or case law. As the legal overview just provided indicates, however, the law doesn't always provide clear answers. Ethics and moral instruction have a long history of providing guidance for human conduct and, at least in theory, serve as a foundation for laws governing human interaction.

The contribution that ethics provides to the practice of the healing arts is reflected in the Hippocratic writings, including the Hippocratic oath, that are often referenced as the moral charter documents for scientific medicine. Over the centuries a series of principles and rules of conduct have evolved to guide medical practitioners in their pursuit of knowledge and in their efforts to benefit patients.⁸ These principles and rules, at times, may appear to conflict, thus placing a physician in a situation of not being certain about the right course to follow. The most obvious conflict that the physician faces in this case stems from a desire to respect a patient's request for confidentiality and a sense of duty to protect the patient's wife from possible harm, more specifically, HIV infection. It should be noted that the duty of physicians toward individuals who are not their patients is a relatively new concept in the history of medicine. The Tarasoff opinions are landmarks articulating this individual-specific duty. Prior to Tarasoff, however, a physician's duty to protect people who are not the physician's patients was directed more toward the public's welfare.

The conflict implicit in the present case is not novel from a moral point of view. It is analogous to conflicts regarding confidentiality involving other sexually transmitted diseases. Physicians and medical ethicists, prior to the appearance of HIV, debated whether a breach of confidentiality regarding a sexually transmitted disease was justified. We are now faced with the question of whether the rules of confidentiality change when the secret is HIV infection. Given the particularly sensitive nature of this information, it should also be asked whether there are practical strategies a physician may adopt to avoid the sort of conflicts apparent in the present case.

The patient's presumption is that whatever a physician learns during a clinical encounter will be kept secret unless a patient consents to specific disclosures. There are two types of moral justifications for the rule of medical confidentiality. A deontological justification is, simply, that it is right to keep promises. The promise of secrecy may be implicit or explicit to the patient-physician relationship and should be kept unless there are overriding reasons not to do so. A consequentialist justification is that a patient's forthright and honest communication promotes the ability of physicians to benefit patients individually or as a class. Thus, it can be morally argued that confidentiality ought not to be breached unless a patient consents or is required by law.⁹ Neither exception applies in the present circumstance.

In this case, the physician reasonably could ask what action is morally permissible. The moral principle of beneficence states that moral agents should do good, or when it is not possible to achieve a good, do that which will prevent or lessen harm. As a general guide to conduct, the principle of beneficence provides a valuable instructive service.¹⁰

There are several goods that might deserve protecting in the present case: keeping promises, maintaining a patient-physician relationship, maintaining a patient's trust, and protecting the patient's wife from potential HIV infection. Among the possible evils or harms to be avoided or lessened are infection of the wife by the husband with HIV, loss of the individual patient's trust, undermining of the public trust in the medical profession, loss of the patient-physician relationship, and a breach of an implicit or explicit promise. The good selected to be pursued or harm to be avoided will reflect the values of the person choosing. Thus, whether the physician in the present case decides to respect confidentiality or decides to disregard the patient's request, the choice will carry a price of risking certain harms or sacrificing certain goods.

Based upon this analysis, two recommendations are offered: (1) Physicians should not make implicit or explicit promises that cannot or will not be kept; (2) with respect to information derived from HIV antibody testing, clinicians should recognize the sensitive nature of the test result and should order the test only with appropriate counseling and consent, making certain that the patient understands how the physician intends to handle the test result.

DR. PRICHARD: Thus far we have developed some of the legal and ethical issues that the present case illuminates. I have asked Dr. Goolishian to discuss an approach toward this and similar conflicts from his perspective as a family therapist.

A FAMILY THERAPIST'S PERSPECTIVE

DR. HAROLD GOOLISHIAN (*Clinical Professor, Department of Family Medicine; Director, Galveston Family Institute*): We can spend a good deal of time on the issues of confidentiality, right and duty to inform, and legal malpractice issues. Certainly these are cogent and important issues that deserve attention.

On the other hand one could also think of this case from the perspective of a patient who is having difficulty disclosing. From this perspective the problem is the patient's, and the question we then ask is in what way can the physician intervene in such a way that the issue of disclosure ceases to represent a problem.

Insofar as possible, we should operate on the premise that the best people to solve problems are those who have them. We must try to understand and position ourselves

within such a framework so that we can be consultants to the patients' work rather than doing it for them.¹¹

In the practice of medicine and other healing arts, it is often necessary to make a distinction between social control and treatment. Social control is the mandating and enforcing of conduct and behavior. Treatment is an expert consultative process that permits individuals to change themselves. Control limits behavior, while treatment optimizes the opportunity for changing behavior. As healers, treatment and consultation are always preferable to control, provided of course that the option is open to us. Sometimes the choice is determined by the questions we ask, such as in this case. Whose problem with disclosure is it?

There are a myriad of details regarding the social, psychological, family, community, church, business, and other contexts in this patient's life that must be assessed to understand clearly how we might intervene so that disclosure is no longer a problem for the patient discussed today, and he may do what, I think, he knows he must do. It is imperative that we understand his reasons, his anxieties, and our role in being able to assist him with his difficult task. In problems of this sort, as in many others, our attitudes, fears, concerns, and values can complicate our task. To enter into a therapeutic conversation regarding this man's dilemma, we must have the capacity to respect and understand his concerns and his style.¹² We can then promote the opportunity for him to solve his problem rather than for us to do it for him. In matters of urgency we sometimes move too fast. With a problem such as the one presented today, it is urgent that we proceed as slowly as time permits.

The patient, in this instance, is obviously a man of high intelligence and accomplishment. He enjoys a high status in his career, community, church, and family. He is accustomed to controlling his life and making his own decisions. These are all strengths that one could use to make the problem truly his. In the final analysis he is the person with the problem of disclosure, not the physician. This is, it seems, still a matter of treatment, not a matter of control.

DR. PRICHARD: We have had an opportunity to meet with this gentleman on two subsequent occasions. Our approach was similar to that outlined by Dr. Goolishian. We were able to discuss his personal fears and concerns for his family and allow enough time for him to formulate his own plan of management. He has since disclosed the nature of his illness to his wife, explaining its origin as a consequence of a distant, no longer extant, heterosexual affair. We are currently providing medical and supportive therapy for both him and his wife. We have obtained an HIV assay as part of her evaluation. Results are not currently available, though it is important to note that seropositivity is not necessarily to be expected.¹³ Though the patient's risk of developing acquired immunodeficiency syndrome will increase with time,¹⁴ at least for the present,

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Warnings: Cyclobenzaprine is closely related to the tricyclic antidepressants, e.g., amitriptyline and imipramine. In short-term studies for indications other than muscle spasm associated with acute musculoskeletal conditions, and usually at doses somewhat greater than those recommended for skeletal muscle spasm, some of the more serious central nervous system reactions noted with the tricyclic antidepressants have occurred (see **Warnings**, below, and **Adverse Reactions**). FLEXERIL may interact with monoamine oxidase (MAO) inhibitors. Hyperpyretic crisis, severe convulsions, and deaths have occurred in patients receiving tricyclic antidepressants and MAO inhibitor drugs. Tricyclic antidepressants have been reported to produce arrhythmias, sinus tachycardia, prolongation of the conduction time leading to myocardial infarction and stroke. FLEXERIL may enhance the effects of alcohol, barbiturates, and other CNS depressants.

Precautions: *General:* Because of its atropine-like action, FLEXERIL should be used with caution in patients with a history of urinary retention, angle-closure glaucoma, increased intraocular pressure, and in patients taking anticholinergic medication.

Information for Patients: FLEXERIL may impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle.

Drug Interactions: FLEXERIL may enhance the effects of alcohol, barbiturates, and other CNS depressants. Tricyclic antidepressants may block the antihypertensive action of guanethidine and other similarly acting compounds.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In rats treated with FLEXERIL for up to 67 weeks at doses of approximately 5 to 40 times the maximum recommended human dose, pale, sometimes enlarged, livers were noted and there was a dose-related hepatocyte vacuolation with lipidosis. In the higher dose groups this microscopic change was seen after 26 weeks and even earlier in rats which died prior to 26 weeks; at lower doses, the change was not seen until after 26 weeks. Cyclobenzaprine did not affect the onset, incidence or distribution of neoplasia in an 81-week study in the mouse or in a 105-week study in the rat. At oral doses of up to 10 times the human dose, cyclobenzaprine neither adversely affected the reproductive performance or fertility of male or female rats, nor demonstrated mutagenic activity in the male mouse at dose levels of up to 20 times the human dose.

*Pregnancy: Pregnancy Category B—*Reproduction studies have been performed in rats, mice and rabbits at doses up to 20 times the human dose, and have revealed no evidence of impaired fertility or harm to the fetus due to FLEXERIL. 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 cyclobenzaprine is closely related to the tricyclic antidepressants, some of which are known to be excreted in human milk, caution should be exercised when FLEXERIL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness of FLEXERIL in children below the age of 15 have not been established.

Adverse Reactions: The following list of adverse reactions is based on the experience in 473 patients treated with FLEXERIL in controlled clinical studies, 7607 patients in the post-marketing surveillance program, and reports received since the drug was marketed. The overall incidence of adverse reactions among patients in the surveillance program was less than the incidence in the controlled clinical studies.

The adverse reactions reported most frequently with FLEXERIL were drowsiness, dry mouth and dizziness. The incidence of these common adverse reactions was lower in the surveillance program than in the controlled clinical studies:

	Clinical Studies	Surveillance Program
drowsiness	39%	16%
dry mouth	27%	7%
dizziness	11%	3%

Among the less frequent adverse reactions, there was no appreciable difference in incidence in controlled clinical studies or in the surveillance program. Adverse reactions which were reported in 1% to 3% of the patients were: fatigue/tiredness, asthenia, nausea, constipation, dyspepsia, unpleasant taste, blurred vision, headache, nervousness, and confusion.

Incidence Less Than 1 in 100: The following adverse reactions have been reported at an incidence of less than 1 in 100—*Body as a Whole:* Syncope; facial edema; malaise. *Cardiovascular:* Tachycardia; arrhythmia; vasodilatation; palpitation; hypotension. *Digestive:* Vomiting; anorexia; diarrhea; gastrointestinal pain; gastritis; thirst; flatulence; edema of the tongue; abnormal liver function and rare reports of hepatitis, jaundice, and cholestasis. *Musculoskeletal:* Local weakness. *Nervous System and Psychiatric:* Ataxia; vertigo; dysarthria; tremors; hypertonia; convulsions; muscle twitching; disorientation; insomnia; depressed mood; abnormal sensations; anxiety; agitation; abnormal thinking and dreaming; hallucinations; excitement; paresthesia. *Skin:* Sweating; skin rash; urticaria. *Special Senses:* Ageusia; tinnitus. *Urogenital:* Urinary frequency and/or retention.

Causal Relationship Unknown: Other reactions reported rarely for FLEXERIL under circumstances where a causal relationship could not be established or reported for other tricyclic drugs are listed to serve as alerting information to physicians: *Body as a Whole:* Chest pain; edema. *Cardiovascular:* Hypertension; myocardial infarction; heart block; stroke. *Digestive:* Paralytic ileus; tongue discoloration; stomatitis; parotid swelling. *Endocrine:* Inappropriate ADH syndrome. *Hematic and Lymphatic:* Purpura; bone marrow depression; leukopenia; eosinophilia; thrombocytopenia. *Metabolic, Nutritional, and Immune:* Elevation and lowering of blood sugar levels; weight gain or loss. *Musculoskeletal:* Myalgia. *Nervous System and Psychiatric:* Decreased or increased libido; abnormal gait; delusions; peripheral neuropathy; Bell's palsy; alteration in EEG patterns; extrapyramidal symptoms. *Respiratory:* Dyspnea. *Skin:* Pruritus; photosensitization; alopecia. *Urogenital:* Impaired urination; dilatation of urinary tract; impotence; testicular swelling; gynecomastia; breast enlargement; galactorrhea.

Drug Abuse and Dependence: Pharmacologic similarities among the tricyclic drugs require that certain withdrawal symptoms be considered when FLEXERIL is administered, even though they have not been reported to occur with this drug. Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

Overdosage: The acute oral LD₅₀ of FLEXERIL is approximately 338 and 425 mg/kg in mice and rats, respectively.

Treatment is symptomatic and supportive. Empty the stomach as quickly as possible by emesis, followed by gastric lavage. After gastric lavage, activated charcoal may be administered. Twenty to 30 g of activated charcoal may be given every four to six hours during the first 24 to 48 hours after ingestion. An ECG should be taken and close monitoring of cardiac function must be instituted if there is any evidence of dysrhythmia. Maintenance of an open airway, adequate fluid intake, and regulation of body temperature are necessary. The intravenous administration of 1 to 3 mg of physostigmine salicylate is reported to reverse symptoms of poisoning by atropine and other drugs with anticholinergic activity. Physostigmine may be helpful in the treatment of cyclobenzaprine overdose. Because physostigmine is rapidly metabolized, its dosage should be repeated as required, particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage. Because physostigmine itself may be toxic, it is not recommended for routine use.

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some of the psychological and social morbidity attendant to HIV infection may have been obviated.

References

1. Simenson v Swenson, 104 Nev 224, 177 NW 831 (1920)
2. Quarles v Sutherland, 215 Tenn 651, 389 SW 2d 249 (1965)
3. Hammonds v Aetna Casualty and Surety Co, 237 Fed Suppl 96, 3 Ohio Misc 83, 31 Ohio Ops 2d 174 (Applying Ohio Law) (ND Ohio, 1965)
4. Mikel v Abrams, 541 F Supp 591, Affd without op (Ca 8 Mo) 716 F 2d 907 (WD Mo, 1982)
5. Annotation, Physicians' Tort Liability for Unauthorized Disclosure of Confidential Information About Patients, 48 ALR 4th 688, 693
6. Black HC (ed): Black's Law Dictionary, ed 5. St. Paul, Minn, West Publishing, 1979
7. Tarasoff v Regents of The University of California, 17 Cal 3d 425
8. Jonsen AR, Siegler M, Winslade WJ: Clinical Ethics. New York, Macmillan, 1982.
9. Gastin L, Curran WJ: AIDS screening, confidentiality, and the duty to warn. Am J Public Health 1987; 77:361-365
10. Shelp EE (ed): Beneficence and Health Care. Holland, Dordrecht & Reidel, 1982
11. Anderson H, Goolishian H: Systems consultation with agencies dealing with domestic violence. In Wynne L, McDaniel S, Weber T (eds): Systems Consultation: A New Perspective for Family Therapy. New York, Guilford Press, 1986
12. Goolishian H, Anderson H: Human systems: Some ideas about the problems they present and our work with them. In Reiter L, Brunner J, Reiter-Theil S (eds): Von Der Familientherapie Zur Systemischen Therapie. Heidelberg, Springer-Verlag, forthcoming
13. Fischl MA, Dickinson GM, Scott GB, et al: Evaluation of heterosexual partners, children and household contacts of adults with AIDS. JAMA 1987; 257:640-644
14. Holtzman RS, Walsh CM, Karparkin S: Risk for the acquired immunodeficiency syndrome among thrombocytopenic and non-thrombocytopenic homosexual men seropositive for the human immunodeficiency virus. Ann Intern Med 1987; 106:383-386