

gastrointestinal tract, the patient is given antispasmodic medication. We are still far from viewing man as an integrated unit.

Some argue that the body is so complex that it is difficult to view in its entirety. It is this school of thinking that has encouraged the growth of specialization. Too often we revert to the Greek Cnidian days, when the diagnosis and classification of disease were detached from the human organism. Even today, we are sometimes guilty of viewing disease solely as a sort of malevolent intruder that destroys the health of man. It is particularly noteworthy that many of us in the osteopathic profession speak of the need to approach man and his diseases from a unified standpoint, yet when we examine and treat the musculoskeletal system, we violate some of our own basic principles. Structural diagnosis and manipulative treatment sometimes are limited to only the part of the musculoskeletal system that is painful.

Another cornerstone of osteopathic theory is the healing power of nature. The concept that the body has its own built-in healing units was considered to be relatively radical at its inception. However, the idea has been brought into sharper focus since the discovery of endogenous chemicals that have a profound effect on the body and its healing mechanisms.

These discoveries lend support to some of the basic philosophies of osteopathic medicine. In the summer of 1984, the First International Symposium on Endocoids convened at the Texas College of Osteopathic Medicine in Fort Worth. The proceedings of this conference have recently been published under the editorship of Harbans Lal, Frank LaBella, and John Lane. (Drs. Lal and Lane are at the Department of Pharmacology at TCOM, and Dr. LaBella is at the Department of Pharmacology at the University of Manitoba in Winnipeg, Canada.) The significance of the conference and its relationship to osteopathic medicine is apparent.

"The concept of endocoids finds its origin in ancient history where our forefathers talked about the body's own medicines, i.e., *vis medicatrix naturae*," write the editors in the preface. "Hygeia and Hippocrates wrote of these substances. Claude Bernard proposed the concept of the *milieu interieur*. In the 20th century, Andrew T. Still, the founder of osteopathic medicine, adopted the concept of endocoids as one of the important pillars of medical practice. He wrote, 'The body of man was God's drugstore and had in it all liquids, drugs, lubricating oils, opiates, acids, and antacids, and every sort of drug that the wisdom of God thought necessary for human happiness and health.' He further suggested that, 'man should study and use the drugs

compounded in his own body.'"

The book responds to this challenge to study the healing power of our own bodies. It describes clinical research that translates these ancient mandates into a new scientific discipline. We must not adopt the somewhat myopic viewpoint that the principles of osteopathic medicine have already been accepted and achieved. Rather, we are now in the midst of a new emergence of scientific discoveries that support the Hippocratic and Still view of health maintenance and the prevention and treatment of disease.

Our revolution in the practice of medicine is dawning. There is an ever-increasing interest in structural diagnosis and manipulative therapy as it applies to the disorders of the musculoskeletal system and its relationship to other body functions. Both M.D. and D.O. physicians and surgeons, physical therapists, and representatives of other allied health fields are eagerly seeking information concerning this modality. Unfortunately, much of the information sought is being dissociated from the basic concepts of osteopathic medicine. This isolation from the rest of medical science violates the very principles of osteopathic medicine. Structural diagnosis and manipulative treatments must become a part of total medical care and not merely an interesting appendage.

The philosophy of osteopathic medicine continues to take hold, but its time has not fully come.

GEORGE W. NORTHUP, D.O., FAAO

Prescription drug abuse

Perhaps at no time in American history has there been more talk and rightful concern about the growing drug problem in our country. The discussions, seminars, and legislative actions are mushrooming. Much governmental attention has been paid to the illicit drug traffic, and rightfully so. However, the professions of medicine need to address themselves more vigorously to one further area of abuse—the prescription drug problem.

In 1981, the American Medical Association appointed an informal steering committee on prescription drug abuse. This voluntary coalition of government agencies and professional organizations includes representatives from the American Osteopathic Association. Its objectives are to achieve a national consensus on the nature of the problem and potential solutions, to develop workable programs for combating prescription drug diversion, and to help states to implement those programs as part of a comprehensive approach.

A report that appeared in the *Detroit News* on



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Information for Patients: Patients should use caution for activities requiring alertness if they experience drowsiness, dizziness, vertigo or depression during therapy.

Drug Interactions: Use caution when giving concomitantly with coumarin-type anticoagulants; a hydantoin, sulfonamide or sulfonylurea; furosemide; lithium; beta-blockers; probenecid; or methotrexate.

Drug/Laboratory Test Interactions: The drug may decrease platelet aggregation and prolong bleeding time or increase urinary values for 17-ketogenic steroids. Temporarily stop therapy for 72 hours before doing adrenal function tests. The drug may interfere with urinary assays of 5HIAA.

Carcinogenesis: A 2-year rat study showed no evidence of carcinogenicity.

Pregnancy: Category B. Do not use during pregnancy unless clearly needed. Avoid use during late pregnancy.

Nursing Mothers: Avoid use in nursing mothers.

Pediatric Use: Indications and dosage have not been established.

Adverse Reactions: Incidence Greater Than 1%: GI: The most frequent complaints related to the GI tract: constipation, heartburn, abdominal pain; nausea; dyspepsia, diarrhea, stomatitis. CNS: headache, dizziness, drowsiness, light-headedness, vertigo. Dermatologic: itching (pruritus), skin eruptions, ecchymoses, sweating, purpura. Special Senses: tinnitus, hearing disturbances, visual disturbances. Cardiovascular: edema, dyspnea, palpitations. General: thirst. *Incidence of reported reaction 3%-9%. Where unmarked, incidence less than 3%. Incidence Less Than 1%: Probable Causal Relationship: GI: abnormal liver function tests, GI bleeding and/or perforation, hematemesis, jaundice, melena, peptic ulceration with bleeding and/or perforation, vomiting. Renal: glomerular nephritis, hematuria, interstitial nephritis, nephrotic syndrome, renal disease. Hematologic: eosinophilia, granulocytopenia, leukopenia, thrombocytopenia. CNS: depression, dream abnormalities, inability to concentrate, insomnia, malaise, myalgia and muscle weakness. Dermatologic: alopecia, photosensitive dermatitis, skin rashes. Special Senses: hearing impairment. Cardiovascular: congestive heart failure. Respiratory: eosinophilic pneumonitis. General: anaphylactoid reactions, menstrual disorders, pyrexia (chills and fever). Causal Relationship Unknown: Hematologic: agranulocytosis, aplastic anemia, hemolytic anemia. CNS: cognitive dysfunction. Dermatologic: epidermal necrolysis, erythema multiforme, Stevens-Johnson syndrome, urticaria. GI: ulcerative stomatitis. Cardiovascular: vasculitis. General: angioneurotic edema, hyperglycemia, hypoglycemia.

Overdosage: May have drowsiness, heartburn, indigestion, nausea, vomiting. Empty stomach and use usual supportive measures. Prompt administration of 5 grams activated charcoal may reduce drug absorption.

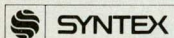
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October 10, 1982, highlights the situation. The article chronicled the life of a Ms. X, who had 397 prescriptions filled during the last two years of her life. Twenty-seven different doctors supplied her with drugs, with one physician rendering his services on 79 separate occasions. One hundred and fourteen of her prescriptions were filled at the same pharmacy, and costs were reimbursed by Medicaid. Ms. X died from a drug overdose at age 22. At the time of death, her body contained near-toxic levels of diazepam, phenobarbital, barbiturates, tranquilizers, opiates, and cocaine.

The AMA estimates that, nationally, three percent of the population misuses or abuses drugs. The AMA also quotes federal surveys showing that 60 to 70 percent of patients who receive treatment for or die of drug-related medical problems do so while abusing prescription drugs. Whereas drug abusers in the past turned to prescription products only when "street" drugs were scarce, today's sophisticated drug users often prefer prescription drugs because of their predictable potency, cheaper price, and lighter penalty for use.

These are sobering statements for those of us engaged in daily medical practice. It is easy to become part of the problem because of misapplied compassion. Some patients are very convincing, but the physician should always be acutely aware of the possibility of drug abuse. The ready availability of blank prescription pads also contributes to the problem. It is common knowledge that these pads are sometimes stolen from offices, and even taken to a printer under the guise of ordering new tablets. Printing establishments should be warned against printing such orders unless they are first confirmed by a reliable person in the physician's office.

Prescription abuse is an important part of the larger drug crisis that physicians can indeed do something about. All of us, whether or not we have been responsible for some of the problem, must be active in the cure.

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