

## ORIGINAL CONTRIBUTION

## 139 Physician awareness of elevated cholesterol

MICHAEL B. CLEARFIELD, DO; STEVE FEDORKO, PhD; MARK E. MCKINNEY, PhD

This study investigates fundamental levels of physician clinical recognition and awareness of elevated cholesterol. Assessments were made before and after a redefinition of the clinically normal range of serum cholesterol and the presentation of a continuing medical education lecture on hypercholesterolemia. The study also considered the influence of patient age, sex, severity of elevated cholesterol, and primary diagnosis on heightening physicians' awareness.

## CLINICAL PRACTICE

## 145 Facilitated positional release

STANLEY SCHIOWITZ, DO

This article introduces an indirect method that is an effective, nontraumatic, efficient approach toward the treatment of somatic dysfunction.

## SPECIAL COMMUNICATION

## 157 War, politics, and osteopathic medicine

MURRAY GOLDSTEIN, DO, MPH

The author provides a historical view of manipulative treatment and the evolution from *osteopathy* to *osteopathic medicine*, from *osteopathy* to *osteopathic physician*, and from local to national acceptance of DOs.

## MEDICAL PRACTICE

## 160 General practice residency training and the osteopathic profession: Trends and issues for the 1990s

ANTHONY D. AQUILINA, DO

Developing the best possible training programs in general practice is essential to the osteopathic medical profession. This article reviews the changes under way in these programs and predicts their beneficial effects.

*continued on page 100*

JAOA—THE JOURNAL OF THE AMERICAN OSTEOPATHIC ASSOCIATION (USPS 469-110) is published monthly by the AMERICAN OSTEOPATHIC ASSOCIATION  
142 East Ontario Street, Chicago, IL 60611-2864. Telephone 312/280-5800

ISSN 0098-6151

©1990, AMERICAN OSTEOPATHIC ASSOCIATION. All rights reserved under international conventions.

This publication is available in microform.

University Microfilms International, 300 North Zeeb Road, Ann Arbor, MI 48106 U.S.A.

## Subscription Rates

US \$10.00 per year, single copy, \$1.00

Canada and foreign, \$25.00 per year; single copy, \$2.50.

Second-class postage paid at Chicago, IL  
and at additional mailing offices.

## Postmaster

Send form 3579 to JAOA—The Journal of the  
American Osteopathic Association  
142 East Ontario Street, Chicago, IL 60611-2864.

## Change of Address

Six to eight weeks prior to moving, please clip the mailing  
label from the most recent issue, and send it along with  
your new address (including ZIP code) to the department  
designated below.

DOs and osteopathic students: direct changes to the atten-  
tion of the MEMBERSHIP DEPARTMENT. All other  
subscribers: direct changes to the attention of the CIR-  
CULATION DEPARTMENT.



## CASE REPORTS

- 179 **Transient acantholytic dermatosis treated with isotretinoin**  
ANGELO MANCUSO, DO; EDWIN H. COHEN, DO  
In the case reported, treatment of transient acantholytic dermatosis (Grover's disease) with isotretinoin resulted in resolution of lesions and associated pruritus.

## LETTERS

- 106 **All patients deserve respect as human beings**

## EDITORIALS

- 128 **Correcting the misperceptions surrounding osteopathic medicine,**  
THOMAS WESLEY ALLEN, DO  
128 **Mandatory in-flight medical equipment earns high marks,** GEORGE W. NORTHUP, DO

## DEPARTMENTS

- 104 Instructions to authors  
108 Medi-notes  
113 Home CME certification form  
124 Editorial comments  
185 New members  
186 CME quiz discussion  
187 CME quiz  
188 Advertisers' index

## COVER

In the study beginning on page 139, Michael B. Clearfield, DO, Steve Fedorko, PhD, and Mark E. McKinney, PhD, assess physician awareness of an elevated serum cholesterol level among patients at a university-affiliated, 200-bed community hospital. Criteria for awareness included any notation in the patient's chart indicating the physician's recognition of the abnormal cholesterol level or prescribing dietary or pharmacologic therapeutic intervention. (The test tube lipid precipitate is rendered as an airbrushed painting after slide 2, "Risk Factors for Coronary Heart Disease," from *Hypertension, Cholesterol, and Coronary Heart Disease: Comprehensive Slide/Lecture Guide*, written by Antonio M. Gotto, Jr, MD, DPhil, and produced through an education grant from Pfizer Laboratories.) Cover design by Barry and Wayne Lau of Design Two, Ltd.

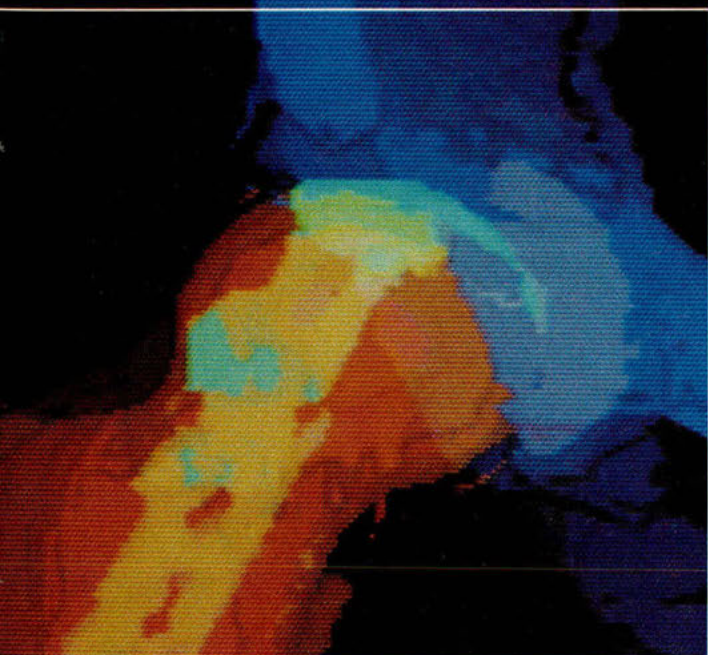
All opinions expressed in JAOA are those of the authors and not necessarily those of the editors, the AOA, or the institution with which the authors are affiliated, unless expressly stated. JAOA is indexed by *Index Medicus*, *Excerpta Medica*, *Current Contents (Clinical Practice)*, *Biological Abstracts*, and *Chemistry Abstracts*.

No part of the JAOA may be reprinted or reproduced in any form without written permission of the editor.



IN CHRONIC OSTEOARTHRITIS AND RHEUMATOID ARTHRITIS

# NAPROSYN<sup>®</sup> (NAPROXEN) CONCENTRATES HERE...



3-D MRI of osteoarthritic hip showing osteonecrosis with core decompression. Supplied by David W. Stoller, MD, Philipp Lang and Dimensional Medicine, Inc.

**Your experience and hundreds  
of clinical studies confirm:**

- Proven G.I. tolerability<sup>1,2\*</sup>
- An excellent renal and hepatic profile<sup>3,4\*\*</sup>
- #1 NSAID brand prescribed for elderly patients<sup>†,††</sup>

**CONCENTRATES IN THE JOINT—LOW RISK TO KEY ORGANS\***

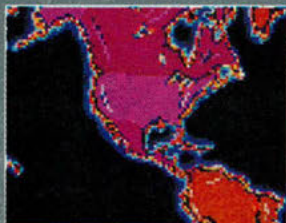
## **NAPROSYN<sup>®</sup> B.I.D.**

**(NAPROXEN)** 250/375/500 mg tablets  
Also available in suspension 125 mg/5 mL

\*The most frequent complaints are gastrointestinal. See "Warnings" and "Precautions" sections of prescribing information.  
\*\*As with other NSAIDs, rare hepatic and renal reactions have been reported. Please see "Precautions" section of prescribing information. †It is prudent to use the lowest effective dose in the elderly.

Please see adjacent page for brief summary of prescribing information and references.





# TRUST YOUR EXPERIENCE WITH NAPROSYN® (NAPROXEN): #1 IN THE U.S.\*

- 13 years of U.S. clinical experience
- #1 choice of rheumatologists and orthopaedic surgeons\*\*
- Over 7.5 billion patient therapy days worldwide

## Wide range of strengths and forms:



250 mg  
tablets



375 mg  
tablets



500 mg  
tablets



Suspension  
125 mg/5 mL  
(supplied in 16 oz  
unit-of-use bottles)

CONCENTRATES IN THE JOINT—LOW RISK TO KEY ORGANS

# NAPROSYN® B.I.D.

(NAPROXEN) 250/375/500 mg tablets  
Also available in suspension 125 mg/5 mL

1. Naprosyn prescribing information. 2. Geczy M, Peltier L, Wolbach R: Naproxen tolerability in the elderly: A summary report. *J Rheumatol* 1987;14:348-354. Data on file, Syntex Laboratories, Inc., Document #90669-2. 3. Corwin HL, Bonventre JV: Renal insufficiency associated with nonsteroidal anti-inflammatory agents. *Am J Kidney Dis* 1984;4:147-152. 4. Turner R: Hepatic and renal tolerability of long-term naproxen treatment in patients with rheumatoid arthritis. *Semin Arthritis Rheum* 1988;17(3)(suppl 2):29-35. \*\*Leading industry audits for 12 months ending December 1988. Data available upon request from Syntex Laboratories, Inc., Document #90669-B. \*\*Leading industry audit. A representative sample of 50 U.S. rheumatologists and 100 U.S. orthopaedic surgeons were asked which NSAID they prescribe most often. In 1988 Naprosyn was named by 57% of rheumatologists and 28% of orthopaedic surgeons in this survey, which is conducted annually by an independent market research firm. Data available upon request from Syntex Laboratories, Inc., Document #90669-C.

### Brief Summary:

**Contraindications:** Patients who have had allergic reactions to NAPROSYN, ANAPROX or ANAPROX DS or in whom aspirin or other NSAIDs induce the syndrome of asthma, rhinitis, and nasal polyps. Because anaphylactic reactions usually occur in patients with a history of such reactions, question patients for asthma, nasal polyps, urticaria, and hypotension associated with NSAIDs before starting therapy. If such symptoms occur, discontinue the drug. **Warnings:** Serious GI toxicity such as bleeding, ulceration, and perforation, can occur at any time, with or without warning symptoms, in patients treated chronically with NSAIDs. Remain alert for ulceration and bleeding in such patients even in the absence of previous GI tract symptoms. In clinical trials, symptomatic upper GI ulcers, gross bleeding or perforation appear to occur in approximately 1% of patients treated for 3-6 months, and in about 2-4% of patients treated for one year. Inform patients about the signs and/or symptoms of serious GI toxicity and what steps to take if they occur. Studies have not identified any subset of patients not at risk of developing peptic ulceration and bleeding. Except for a prior history of serious GI events and other risk factors known to be associated with peptic ulcer disease, such as alcoholism, smoking, etc., no risk factors (e.g., age, sex) have been associated with increased risk. Elderly or debilitated patients seem to tolerate ulceration or bleeding less well than others and most spontaneous reports of fatal GI events are in this population. In considering the use of relatively large doses (within the recommended dosage range), sufficient benefit should be anticipated to offset the potential increased risk of GI toxicity. **Precautions:** DO NOT GIVE NAPROSYN (NAPROXEN) CONCOMITANTLY WITH ANAPROX (NAPROXEN SODIUM) OR ANAPROX DS (NAPROXEN SODIUM) SINCE THEY CIRCULATE IN PLASMA AS THE NAPROXEN ANION. Acute interstitial nephritis with hematuria, proteinuria, and nephrotic syndrome has been reported. Patients with impaired renal function, heart failure, liver dysfunction, patients taking diuretics, and the elderly are at greater risk of overt renal decompensation. If this occurs, discontinue the drug. Use with caution and monitor serum creatinine and/or creatinine clearance in patients with significantly impaired renal function. Use caution in patients with baseline creatinine clearance less than 20 mL/minute. Use the lowest effective dose in the elderly or in patients with chronic alcoholic liver disease or cirrhosis. With NSAIDs, borderline elevations of liver tests may occur in up to 15% of patients. They may progress, remain unchanged, or be transient with continued therapy. Elevations of SGPT or SGOT occurred in controlled clinical trials in less than 1% of patients. Severe hepatic reactions, including jaundice and fatal hepatitis, have been reported rarely. If liver disease develops or if systemic manifestations occur (e.g., eosinophilia or rash), discontinue therapy. If steroid dosage is reduced or eliminated during therapy, do so slowly and observe patients closely for adverse effects, including adrenal insufficiency and exacerbation of arthritis symptoms. Determine hemoglobin values periodically for patients with initial values of 10 grams or less who receive long-term therapy. Peripheral edema has been reported. Therefore, use with caution in patients with fluid retention, hypertension or heart failure. The drug's antipyretic and anti-inflammatory activities may reduce fever and inflammation, diminishing their diagnostic value. Conduct ophthalmic studies if any change or disturbance in vision occurs. For patients with restricted sodium intake, note that the suspension contains 8 mg/mL of sodium. **Information for Patients:** Side effects of NSAIDs can cause discomfort and, rarely, there are more serious side effects, such as GI bleeding, which may result in hospitalization and even fatal outcomes. Physicians may wish to discuss with patients the potential risks and likely benefits of NSAID treatment, particularly when they are used for less serious conditions where treatment without NSAIDs may be an acceptable alternative. Patients should use caution for activities requiring alertness if they experience drowsiness, dizziness, vertigo or depression

during therapy. **Laboratory Tests:** Because serious GI tract ulceration and bleeding can occur without warning symptoms, follow chronically treated patients for signs and symptoms of these and inform them of the importance of this follow-up. **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:** Simple doses of 2.5-5 mg/kg, with total daily dose not exceeding 15 mg/kg/day, are safe in children over 2 years of age. **Adverse Reactions:** In a study, GI reactions were more frequent and severe in rheumatoid arthritis patients on 1,500 mg/day than in those on 750 mg/day. In studies in children with juvenile arthritis, rash and prolonged bleeding times were more frequent, GI and CNS reactions about the same, and other reactions less frequent than in adults. Incidence Greater Than 1%: Probable Causal Relationship: 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 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: agranulocytosis, 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: aplastic anemia, hemolytic anemia. CNS: cognitive dysfunction. Dermatologic: epidermal necrolysis, erythema multiforme, Stevens-Johnson syndrome, urticaria. GI: non-peptic GI ulceration, ulcerative stomatitis. Cardiovascular: vasculitis. General: angioneurotic edema, hyperglycemia, hypoglycemia. **Overdosage:** May have drowsiness, heartburn, indigestion, nausea, vomiting. Empty stomach and use usual supportive measures. In animals 0.5 g/kg of activated charcoal reduced plasma levels of naproxen. **Caution:** Federal law prohibits dispensing without prescription. See package insert for full Prescribing Information.

\*Incidence of reported reaction 3%-9%. Where unmarked, incidence less than 3%.

U.S. patent nos. 3,904,682, 3,998,966 and others.

© 1989 Syntex Puerto Rico, Inc.



Rev. 37  
October 1988



# THE JOURNAL OF THE AMERICAN OSTEOPATHIC ASSOCIATION

Thomas Wesley Allen, DO, FACOI  
*Editor in Chief*

George W. Northup, DO, FAAO  
*Editor Emeritus*

Gilbert E. D'Alonzo, Jr., DO  
*Contributing Editor*

Michael M. Patterson, PhD  
*Contributing Editor*

## EDITORIAL ADVISORY BOARD

Leonard H. Calabrese, DO  
Anthony G. Chila, DO

William L. Johnston, DO  
Ronald V. Marino, DO

Felix J. Rogers, DO  
Gary L. Slick, DO

## EDITORIAL STAFF

Sandra M. Williamson  
*Executive Editor*  
Andrea M. Dzik  
*Associate Editor*  
Leslie M. Huzyk  
*Associate Editor, Publications Design*

Karen Bjorkman Stipp  
*Managing Editor*  
Margaret Reich  
*Senior Staff Editor*  
Helen Samonte-Shippy  
*Staff Editor*

Rose Gainer  
*Editorial Assistant*  
Lurita J. Washington  
*Manuscript typist*

## EDITORIAL BOARD

Michael I. Abraham, DO, FACOS  
Gene P. Barbour, DO, FAOCPR  
John W. Becher, Jr., DO  
Anthony G. Chila, DO, FAAO  
Arthur B. Calabrese, DO  
Carl Jon Denbow, PhD  
Arthur A. Greenfield, DO, FACN  
Charles G. Hughes, DO  
Neil M. Kantor, DO  
Ferdinand L. Manlio, DO

A. A. Mannarelli, DO, FAOCA, FACOS  
Marc Morganstine, DO  
Daniel Morrison, DO, FAOAO  
Augustine L. Perrotta, DO, FACOI  
Felix J. Rogers, DO, FACOI  
Nicholas S. Sellas, DO  
Donald F. Stanton, DO  
Johannes C. Steenkamp, DO, MPH  
David L. Wolf, DO

## AMERICAN OSTEOPATHIC ASSOCIATION

William H. Voss, DO, FACOI  
*President*  
Mitchell Kasovac, DO, FACGP  
*President Elect*  
John P. Perrin  
*Executive Director*

*Committee on Editorial Policy*  
William C. Anderson, DO, FACOS  
*Chairman*  
T. Eugene Zachary, DO, FACGP  
*Vice Chairman*  
Mary Burnett, DO, FACGP  
S. Tim Coleridge, DO, COL, MC, USA  
*Members*

## PUBLICATIONS STAFF

Julie Shaw  
*Production Manager*  
Susan C. Baird  
*Circulation Manager*

## ADVERTISING SALES

James L. Motter  
*National Sales Manager*  
142 East Ontario Street  
Chicago, IL 60611  
(312) 280-5860  
Randall Roash  
*Eastern Sales Manager*  
437 Cedar Lane  
Mickleton, NJ 08056  
(609) 423-4751

## EDITORIAL CONSULTANTS

A list of consultants who have reviewed manuscripts of JAOA in the previous year is printed in each December issue.