Our osteopathic uniqueness needs nurturing

To the Editor:

The idea of an osteopathic physician having to integrate osteopathic principles into practice should be ridiculous. Unfortunately it is not, and your editorial, "Practicing what we teach: Integrating osteopathic principles into practice (*JAOA* 1990;90:893-894), is appropriate.

The majority of DOs do not use manipulation. Many of those physicians who do so, use it primarily for treating musculoskeletal complaints. They do not use manipulation for its homeostatic benefits to the body's physiology. It would be wonderful if every osteopathic physician could experience the miracles possible when patient care includes some indicated, efficient, well-directed osteopathic manipulative treatment (OMT) along with the indicated medications or surgical care, or both.

I firmly believe that the patients have been the saviors of osteopathic medicine. They do not forget its benefits. They ask for OMT, and they seek physicians who effectively use this treatment in their medical management programs.

Whether or not patients' demand for OMT has affected students' attitudes cannot be scientifically proved. Nonetheless, I have seen a change in osteopathic medical students' attitudes over the past 10 years. Most of them want true osteopathic medical training. They are asking good questions about osteopathic medicine in general and its philosophy. They are researching answers to these questions as well as looking for a method to support the body's homeostatic mechanisms in the management of various patients. With the studies of Sato[1,2] and other scientists, we are now able to explain and predict scientifically most of the clinical results that occur when OMT is used.

You alluded to the lost generation of DOs trained in the 1950s and 1960s, when the main emphasis was "to be as good as" our allopathic colleagues so that we could obtain an unlimited practice license. We did not want to emphasize our uniqueness. We did a good job, got our license, and almost forgot how to effectively and efficiently use osteopathic medicine in all its depth and completeness.

During that time, the colleges of osteopathic medicine (COMs) felt it was essential to have a group of osteopathic physicians responsible for preserving, unifying, and teaching osteopathic principles, theory, and manipulative treatment techniques and management. In the 1950s, many osteopathic physicians in general practice, obstetrics, dermatology, endocrinology, and internal medicine were instructors in OMT or osteopathic principles and practice (OPP) laboratories. In fact, many of these instructors at the Kirksville College of Osteopathic Medicine were my mentors.

But as each college delegated the teaching of OPP and OMT to a group of physicians, it became apparent that terms, techniques, treatment protocols, and the like were becoming individualized and territorial. Such "distinctive osteopathic teaching" made it almost impossible for a DO from one college to communicate with a DO from another college; even professors within any one college could not agree on terms. Not surprisingly, it was nearly impossible to communicate our research findings or treatment success with anyone outside of the osteopathic medical profession.

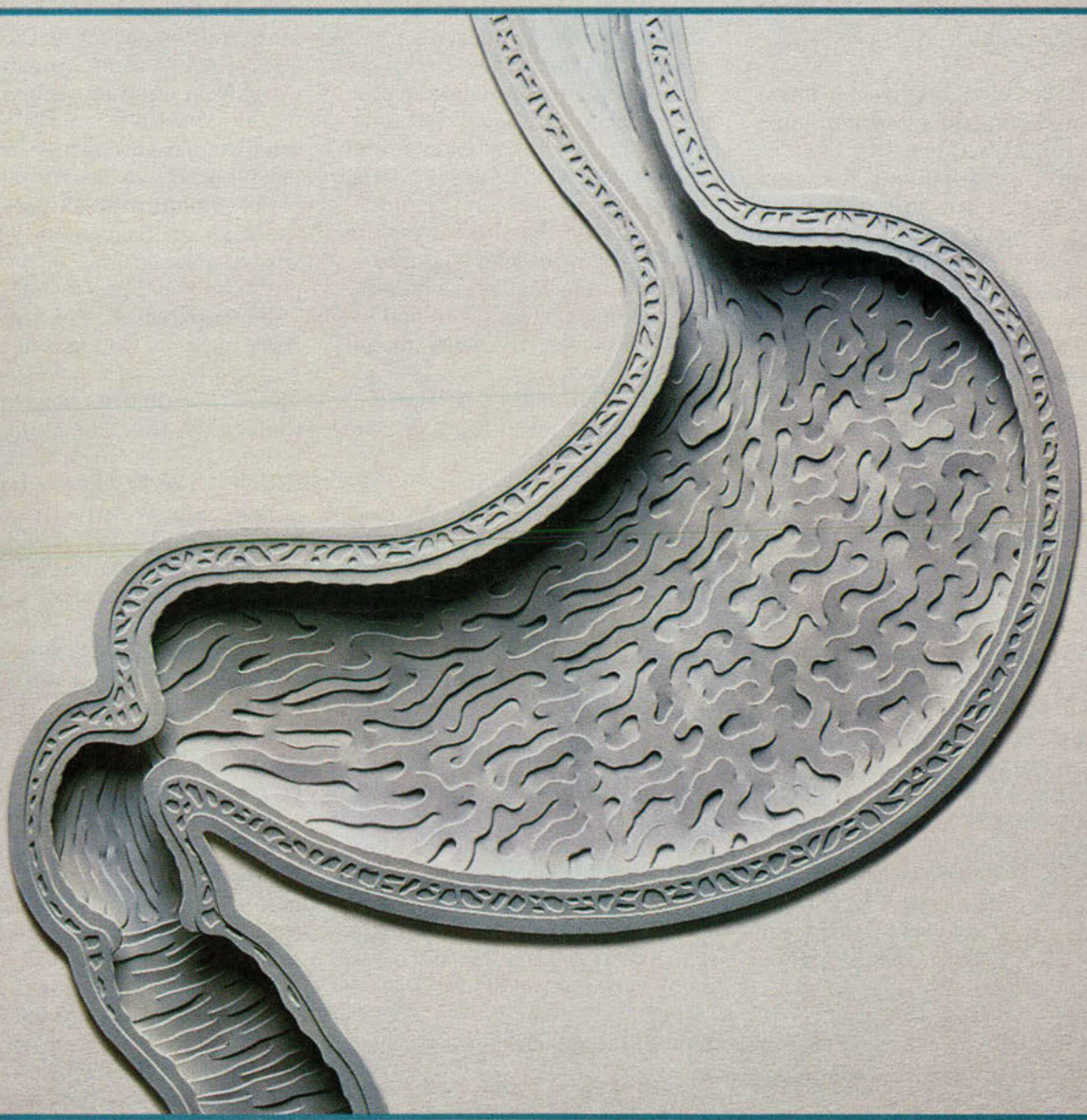
For this reason, the American Association of Colleges of Osteopathic Medicine formed and financed, with the assistance of the COMs, the Education Committee on Osteopathic Principles (ECOP). The ECOP is composed of one representative from each of the college's OPP/OMT department. In 1981, the first glossary of osteopathic terminology, prepared by the committee, was published in the *JAOA*. The ECOP continues to meet at least every year to discuss osteopathic philosophy as well as to ensure unified teaching of osteopathic terms, principles, techniques, and management.

This unity has enabled the completion of a work called *Osteopathic Principles Core Curriculum*. An osteopathic textbook, financed by the American Osteopathic Association, is now in the making as well. This kind of progress could not have occurred without a concerted effort. It would have been impossible for physicians working individually across the country in their respective fields to have done so on their own.

(continued on page 121)

In arthritis therapy:

Because you're concerned about G.I. reactions...



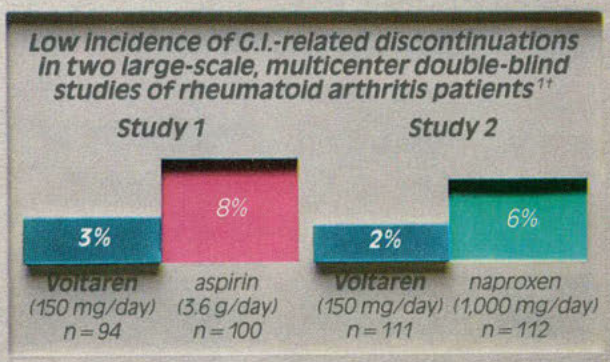
*Contraindicated in patients hypersensitive to aspirin, other NSAIDs, or Voltaren. As with other NSAIDs, the most frequent complaints relate to the G.I. tract. In patients treated chronically with NSAID therapy, serious G.I. toxicity such as bleeding, ulceration, and perforation can occur. Elevations of SGOT and/or SGPT, some significant, have been reported in association with Voltaren treatment; as with other NSAIDs, cases of severe hepatic reactions have rarely been reported.

†No statistically significant difference between treatment groups; some patients discontinued trial due to more than one adverse effect. The dosages used in Study 2 represent the most commonly used RA dosage levels for diclofenac sodium and for naproxen. In clinical studies of RA patients involving diclofenac sodium and naproxen at lower dosage levels than those used in Study 2, no significant differences were observed with regard to adverse reactions or patient discontinuation rates.

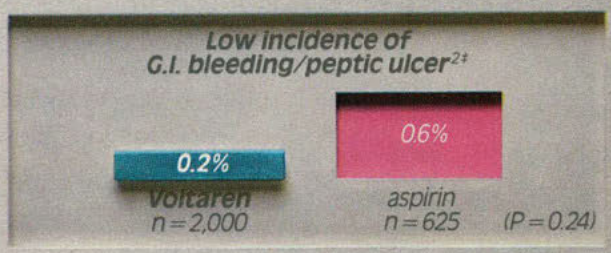
‡Incidence measured during the first 30 days of treatment; between-treatment values not statistically significant.

*NSAIDs may adversely affect the hematologic, hepatic, renal, and gastrointestinal systems. Because G.I. reactions occur most frequently, they are of particular concern when you choose arthritis therapy. Voltaren offers your patients a time-proven G.I. profile, with a low rate of G.I.-related discontinuations,[1] a low incidence of G.I. bleeding/peptic ulcer,[2] and an established record of G.I. tolerability.**

Voltaren. It relieves joint pain and helps restore function in your arthritis patients. And its time-proven G.I. profile helps relieve your concern about G.I. reactions.



Adapted from Kolodny AL.[1]



25·50·75-MG TABLETS

Voltaren®

diclofenac sodium

An established record of G.I. tolerability.

Please see following page for brief summary of Prescribing Information and references.

Voltaren. Helping your patients come to grips with arthritis.

Voltaren®
diclofenac sodium

Enteric-Coated Tablets

Brief Summary (See full Prescribing Information)

INDICATIONS AND USAGE
Voltaren is indicated for acute and chronic treatment of the signs and symptoms of rheumatoid arthritis, osteoarthritis, and ankylosing spondylitis.

CONTRAINDICATIONS
Patients with hypersensitivity to it, in whom Voltaren, aspirin, or other nonsteroidal anti-inflammatory drugs induce asthma, urticaria, or other allergic-type reactions.

WARNINGS
Gastrointestinal Effects
Risk of G.I. ulcerations, bleeding and perforation with nonsteroidal anti-inflammatory therapy: Serious G.I. toxicity can occur at any time, with or without warning symptoms, during chronic treatment. The occurrence is about 1% after 3-6 months, 2-4% after a year. Patients should be informed of signs and symptoms of serious G.I. toxicity and what to do if it occurs. No subset of patients not at risk has been identified. Prior history of serious G.I. events and other risk factors of peptic ulcer disease, e.g., alcoholism, smoking, etc., have been associated with increased risk. The elderly and debilitated tolerate ulceration and bleeding less well than other individuals and most spontaneous reports of fatal G.I. events are in this population. G.I. ulceration and bleeding can occur without warning symptoms and chronically treated patients should be followed. It is recommended that patients be maintained on the lowest dose of diclofenac sodium possible consistent with achieving a satisfactory therapeutic response.
Hepatic Effects
As with other nonsteroidal anti-inflammatory drugs, elevations of one or more liver tests may occur during Voltaren therapy. These laboratory abnormalities may progress, may remain unchanged, or may be transient with continued therapy. Borderline elevations, (i.e., 1.2-3 times the upper limit of normal [ULN]), or greater elevations of transaminases occurred in about 15% of Voltaren-treated patients. The SGPT (ALT) test is probably the most sensitive indicator of liver injury. In clinical trials, meaningful elevations (i.e., more than 3 times the ULN) of SGOT (SGPT was not measured in all studies) occurred in about 2% of approximately 5700 patients at some time during Voltaren treatment. In a large, open, controlled trial, meaningful elevations of SGOT and/or SGPT occurred in about 4% of 3700 patients treated for 2-6 months, including marked elevations (i.e., more than 8 times the ULN) in about 1% of the 3700 patients. In that open-label study, a lower incidence of borderline (1.2-3 times the ULN), moderate (3-8 times the ULN), and marked (>8 times the ULN) elevations of SGOT or SGPT was observed in patients randomized to other NSAIDs. Transaminase elevations were seen more frequently in patients with osteoarthritis than in those with rheumatoid arthritis (see ADVERSE REACTIONS).

Transaminase elevations were reversible on cessation of therapy, and among 51 patients in all studies with marked elevations, signs and symptoms of liver disease occurred in only 3 cases, and only 1 patient developed jaundice. Most patients with borderline elevations did not have therapy interrupted; transaminase elevations in most of these cases disappeared or did not progress. There were no identifying features to distinguish those patients who developed marked elevations from those who did not.

In addition to the enzyme elevations seen in clinical trials, rare cases of severe hepatic reactions, including jaundice and fatal fulminant hepatitis, have been reported.

Because severe hepatotoxicity may develop without a prodrome of distinguishing symptoms, physicians should measure transaminases periodically in patients receiving long-term therapy with Voltaren. The optimum times for making the first and subsequent transaminase measurements are not known. In the largest U.S. trial (open-label), which involved 3700 patients monitored first at 8 weeks and 1200 patients monitored again at 24 weeks, almost all meaningful elevations in transaminases were detected before patients became symptomatic. In 42 of the 51 patients in all trials who developed marked transaminase elevations, abnormal tests occurred during the first 2 months of therapy with Voltaren. Based on this experience the first transaminase measurement should be made no later than 8 weeks after the start of Voltaren treatment. As with other NSAIDs, if abnormal liver tests persist or worsen, if clinical signs and/or symptoms consistent with liver disease develop, or if systemic manifestations occur (e.g., eosinophilia, rash, etc.), Voltaren should be discontinued.

To minimize the possibility that hepatic injury will become severe between transaminase measurements, physicians should inform patients of the warning signs and symptoms of hepatotoxicity (e.g., nausea, fatigue, lethargy, pruritus, jaundice, right upper quadrant tenderness and "flu-like" symptoms), and the appropriate action to take should these signs and symptoms appear.

PRECAUTIONS
Allergic Reactions: As with other nonsteroidal anti-inflammatory drugs, allergic reactions including anaphylaxis, have been reported.

Fluid Retention and Edema: Fluid retention and edema have been observed in some patients taking Voltaren.

Renal Effects: Cases of significant renal failure in patients receiving Voltaren have been reported from postmarketing experience, but were not observed in over 4,000 patients in clinical trials during which serum creatinines and BUNs were followed serially. Since Voltaren metabolites are eliminated primarily by the kidneys, patients with significantly impaired renal function should be more closely monitored than subjects with normal renal function.

Porphyria: The use of diclofenac in patients with hepatic porphyria should be avoided.

Drug Interactions
Aspirin: Concomitant administration of Voltaren and aspirin is not recommended.

Anticoagulants: NSAIDs affect platelet function as well, concurrent therapy with all NSAIDs, including Voltaren, and warfarin requires close monitoring of patients to be certain that no change in their anticoagulant dosage is required.

Digoxin, Methotrexate, Cyclosporine: Voltaren, like other NSAIDs, through effects on renal prostaglandins, may cause increased toxicity of digoxin, methotrexate, and cyclosporine.

Lithium: Voltaren decreases lithium renal clearance and increases lithium plasma levels. In patients taking Voltaren and lithium concomitantly, lithium toxicity may develop.

Oral Hypoglycemics: Physicians should consider the possibility that diclofenac may alter a diabetic patient's response to insulin or oral hypoglycemic agents.

Diuretics: Voltaren and other NSAIDs can inhibit the activity of diuretics. Concomitant treatment with potassium-sparing diuretics may be associated with increased serum potassium levels.

Other Drugs: In small groups of patients (7-10/interaction study), the concomitant administration of azathioprine, gold, chloroquine, D-penicillamine, prednisolone, doxycycline, or digitoxin did not significantly affect the peak levels and AUC values of Voltaren.

Drug/Laboratory Test Interactions
Effect on Blood Coagulation: Voltaren increases platelet aggregation time but does not affect bleeding time, plasma thrombin clotting time, plasma fibrinogen, or factors V and VII to XII.

Pregnancy Category B
There are no adequate and well-controlled studies in pregnant women. Voltaren should be used during pregnancy only if the benefits to the mother justify the potential risk to the fetus. Because of the known effects of prostaglandin-inhibiting drugs on the fetal cardiovascular system (closure of ductus arteriosus), use of Voltaren during late pregnancy should be avoided.

Labor and Delivery
The effects of Voltaren on labor and delivery in pregnant women are unknown. However, as with other nonsteroidal anti-inflammatory drugs, it is possible that Voltaren may inhibit uterine contraction.

Nursing Mothers
Voltaren has been found in the milk of nursing mothers. As with other drugs that are excreted in milk, Voltaren is not recommended for use in nursing women.

Pediatric Use
Dosage recommendations and indications for use in children have not been established.

ADVERSE REACTIONS
The incidence of common adverse reactions (greater than 1%) is based upon controlled clinical trials in 1543 patients treated up to 13 weeks. By far the most common adverse effects were gastrointestinal symptoms, most of them minor, occurring in about 20%, and leading to discontinuation in about 3%, of patients. Peptic ulcer or G.I. bleeding occurred in clinical trials in less than 1% of approximately 1800 patients during their first 3 months of diclofenac treatment and in less than 2% of approximately 800 patients followed for 1 year. Comparative rates were 0.2% for peptic ulcer or G.I. bleeding in approximately 2000 diclofenac-treated patients and 0.6% in approximately 600 aspirin-treated patients.

In double-blind trials there were fewer minor gastrointestinal complaints in 1227 patients treated with Voltaren than in 721 patients treated with aspirin, 22% vs 33% (compared to 13% on placebo).

The following adverse reactions were reported in patients treated with Voltaren:
Incidence Greater Than 1% (All derived from clinical trials.)
Body as a Whole: Abdominal pain or cramps*, headache*, fluid retention, abdominal distention.
Digestive: Diarrhea*, indigestion*, nausea*, constipation*, flatulence, liver test abnormalities, PUB, i.e., peptic ulcer, with or without bleeding and/or perforation, or bleeding without ulcer (see above and also WARNINGS).
Nervous System: Dizziness.
Skin and Appendages: Rash, pruritus.
Special senses: Tinnitus.
*Incidence, 3% to 9% (incidence of unmarked reactions is 1-3%)

Incidence Less Than 1%—Causal Relationship Probable (Adverse reactions reported only in the literature, not seen in clinical trials, are considered rare and are italicized.)
Body as a Whole: Malaise, swelling of lips and tongue, photosensitivity, *anaphylaxis,* anaphylactoid reactions.
Cardiovascular: Hypertension, congestive heart failure.
Digestive: Vomiting, jaundice, melena, aphthous stomatitis, dry mouth and mucous membranes, bloody diarrhea, hepatitis, appetite change, pancreatitis with or without concomitant hepatitis, *colitis.*
Hemic and Lymphatic: Hemoglobin decrease, leukopenia, thrombocytopenia, *hemolytic anemia, aplastic anemia, agranulocytosis,* purpura, *allergic purpura.*
Metabolic and Nutritional Disorders: Azotemia.
Nervous System: Insomnia, drowsiness, depression, diplopia, anxiety, irritability.
Respiratory: Epistaxis, asthma, laryngeal edema.
Skin and Appendages: Alopecia, urticaria, eczema, dermatitis, *bullous eruption, erythema multiforme major,* angioedema, *Stevens-Johnson syndrome.*
Special Senses: Blurred vision, taste disorder, reversible hearing loss, scotoma.
Urogenital: *Nephrotic syndrome,* proteinuria, *oliguria, interstitial nephritis, papillary necrosis, acute renal failure.*

Incidence Less Than 1%—Causal Relationship Unknown (Adverse reactions reported only in the literature, not seen in clinical trials, are considered rare and are italicized.)
Body as a Whole: Chest pain.
Cardiovascular: Palpitations, *flushing,* tachycardia, premature ventricular contractions, myocardial infarction.
Digestive: Esophageal lesions.
Hemic and Lymphatic: *Bruising.*
Metabolic and Nutritional Disorders: Hypoglycemia, *weight loss.*
Nervous System: Paresthesia, memory disturbance, nightmares, tremor, tic, *abnormal coordination,* convulsions, *disorientation, psychotic reaction.*
Respiratory: Dyspnea, hyperventilation, edema of pharynx.
Skin and Appendages: Excess perspiration, *exfoliative dermatitis.*
Special Senses: Vitreous floaters, night blindness, amblyopia.
Urogenital: Urinary frequency, nocturia, hematuria, impotence, vaginal bleeding.

C90-36 (Rev. 7/90)

References:
1. *Kolodny AL. Two double blind trials of diclofenac sodium with aspirin and with naproxen in the treatment of patients with rheumatoid arthritis.* J Rheumatol. *1988;15:1205-1211.*
2. *Data on file, CIBA-GEIGY Pharmaceuticals.*

Geigy
GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, NY 10502

388-11587-A

Dr Allen, you are writing about the ideal. Of course, all osteopathic physicians have had training in structural diagnosis and manipulative treatment. All of them should be able to provide this special treatment to any of their patients. Each osteopathic general/family practitioner and OMT specialist also should be demonstrating the advantages of OMT to the students who rotate through his or her office. In reality, such is not the case.

By their second year in a COM, students are prepared to use the techniques they have learned in the classroom on actual patients. Despite this eagerness to practice what they have learned on a variety of patients, students complain that many times they are prevented from doing so by the practicing DO who does not use his or her unique osteopathic abilities.

Some COMs have adopted the model that you outline in your editorial. Such a model does give osteopathic physicians who want more OMT training a chance to teach in OPP/OMT laboratories. In so doing they would become better able to use manipulation in their specialty. However, I think it makes more sense to conduct individual classes for physicians who want to refine their osteopathic skills. Within their specialty, then, they could be preceptors in addition to treating office and hospital patients. It would be less confusing for students to learn the unified principles and terms taught by a preceptor who is responsible for teaching these very principles in the classroom.

Having specialists in OMT also makes good sense. We have all been trained in all fields of medicine, but we cannot be experts in all areas. The manipulative expertise of one DO may not be sufficient to help every patient with mechanical problems.

Sometimes an osteopathic practitioner may need help in determining how best to use manipulation to support the homeostatic mechanisms of a particular medical problem. In such instances, referring the patient to an "osteopathic specialist in manipulation" would help the patient. The referring physician would not need to worry whether the patient would go to the specialist for all of his or her medical care. Referring patients to such OMT specialists makes more sense than referring them to a physical therapist or a chiropractor, neither of whom shares our osteopathic management philosophy.

Each of us chose to pursue osteopathic medicine because of its inherent virtues. If we osteopathic physicians support each other and our own profession by promoting and providing osteopathic medical care to our patients and the country at large, our profession would be strengthened and our unique abilities would remain unbeatable.

We have something worth preserving, improving, and promoting. Let's work together to ensure that we do just that. We should not wait until some other profession rediscovers and uses what we have had all along but failed to nurture. Let's use our resources and energies to be leaders.

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Kirksville College of Osteopathic Medicine
Kirksville, Mo

1. Sato A and Schmidt RF: The modulation of visceral functions by somatic afferent activity. *Jpn J Physiol* 1987;37:1-17.

2. Sato A: The somatosympathetic reflexes: Their physiologic and clinical significance, in Goldstein M (ed): *The Research Status of Spinal Manipulative Therapy*. US Department of Health, Education and Welfare, Bethesda, Md, 1975, pp 163-172.

Correction

In Table 5 of the article, "Osteopathic postdoctoral education," by Helen H. Baker, PhD, and Janice Wachtler, BA, appearing in the November 1990 issue of *JAOA* (90:1010-1019), part of the heading was inadvertently omitted. The heading for Table 5 (page 1014) should read: "Table 5: Osteopathic Residency Statistics, *Based on Contracts Received by October 1 of Each Year*" (italics indicate omission). Data in the table are current only as of that cutoff date.

Nathan Freed, DO, program director of hematology and oncology, University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine, has informed the authors that the UMDNJ/SOM hematology/oncology program has had a resident every year since that program's inception in 1982.