

tal course. More important than the mortality group, however, is the surviving group. Data here support the fact that patients who survive the initial insult progress to rehabilitation. Acute-care hospitalization among patients in the survival group is long and resource-intensive. Such a situation is likely to tax the resources of nontrauma centers.

Our experience at MIEMSS supports other study conclusions, namely, that outcome from a major traumatic injury is best managed in specially designated trauma centers.

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Response

To the Editor:

We are grateful for Dr Gerold's comments and appreciate the opportunity to respond to them. First, the limitations of the Glasgow Coma Score (GCS) are well known and generally accepted. However, using the GCS is helpful in stratifying the patients relative to the severity of injury.

As Dr Gerold notes, the GCS does have use in the prediction of the patient's outcome. Our patients' outcomes correlated well with their initial GCS. The survivors' scores averaged 9.6, com-

pared with an average GCS of 4.1 among nonsurviving patients.

Dr Gerold criticizes the fact that the GCS imparts no information concerning the extent or type of injury; however, this information is provided in the text of our article. Furthermore, because our study was not intended to be a multifactorial analysis of cranial gunshot wounds, we elected not to include several factors that Dr Gerold noted were absent (shock, coagulopathy, caliber, or number of wounding projectiles).

He is captious of our "failure to consider functional outcome...." However, our article clearly states that 57% of the patients who survived their injuries were classified as good or mildly disabled according to the Glasgow Outcome Scale of Jennett and Bond.

On another point, Dr Gerold contends that our data "contradict a national experience that demonstrates traumatic morbidity and mortality are reduced when patients are cared for in designated trauma centers." Yet, our article compares mortality and morbidity data from major centers throughout the country with mortality and morbidity rates from our small patient population. Our results compare favorably, if not slightly better, in both categories with the other cited studies.

Similarly, Dr Gerold's data from the Maryland Institute for Emergency Medical Services System (MIEMSS) does not discredit our results. The mortality figure of 73.6% he cites, adjusted to 62.6% when the 10 patients who died of cardiac arrest on admis-

sion to the trauma center are considered, is higher than the mortality rate of 43% in our population.

His results merely reflect the discharge GCS measurements and the fact that the majority of surviving patients were discharged to home, another acute-care hospital, or a rehabilitation facility. Dr Gerold's data does not indicate a functional outcome level as does our data; therefore, a comparison is not possible. Nonetheless, even if we were to assume that all of the 24 patients (26.4%) who survived had a satisfactory recovery, this statistic is lower than the 12 patients (57%) in our study who made good functional recovery or had only mild disability.

We completely agree with Dr Gerold's comment that cranial gunshot wounds can be devastating injuries with high morbidity and mortality. At the time our study was conducted, no regional trauma center service system existed in the Philadelphia area; patients were routinely taken to the closest medical facility for treatment.

We believe our article is important because it demonstrates that patients with cranial gunshot wounds can indeed be treated in a community hospital setting and do as well, if not better, than the statistics from designated trauma centers would indicate. We make this statement with the understanding that a community hospital intending to provide such care must make the appropriate commitment to do so.

Our comments are not meant to take anything away from the

(continued on page 430)

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C I B A

See next page for brief summary of Prescribing Information.

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BRIEF SUMMARY (FOR FULL PRESCRIBING
INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE

Transderm Scop is indicated for prevention of nausea and vomiting associated with motion sickness in adults. The disc should be applied only to skin in the postauricular area.

Clinical Results: Transderm Scop provides antiemetic protection within several hours following application of the disc behind the ear. In 195 adult subjects of different racial origins who participated in clinical efficacy studies at sea or in a controlled motion environment, there was a 75% reduction in the incidence of motion-induced nausea and vomiting. Transderm Scop provided significantly greater protection than that obtained with oral dimenhydrinate.

CONTRAINDICATIONS

Transderm Scop should not be used in patients with known hypersensitivity to scopolamine or any of the components of the adhesive matrix making up the therapeutic system, or in patients with glaucoma.

WARNINGS

Transderm Scop should not be used in children and should be used with special caution in the elderly. See **PRECAUTIONS**.

Since drowsiness, disorientation, and confusion may occur with the use of scopolamine, patients should be warned of the possibility and cautioned against engaging in activities that require mental alertness, such as driving a motor vehicle or operating dangerous machinery.

Potentially alarming idiosyncratic reactions may occur with ordinary therapeutic doses of scopolamine.

PRECAUTIONS

General

Scopolamine should be used with caution in patients with pyloric obstruction, or urinary bladder neck obstruction. Caution should be exercised when administering an antiemetic or antimuscarinic drug to patients suspected of having intestinal obstruction.

Transderm Scop should be used with special caution in the elderly or in individuals with impaired metabolic, liver, or kidney functions, because of the increased likelihood of CNS effects.

Information for Patients

Since scopolamine can cause temporary dilation of the pupils and blurred vision if it comes in contact with the eyes, patients should be strongly advised to wash their hands thoroughly with soap and water immediately after handling the disc.

Patients should be advised to remove the disc immediately and contact a physician in the unlikely event that they experience symptoms of acute narrow-angle glaucoma (pain in and reddening of the eyes accompanied by dilated pupils).

Patients should be warned against driving a motor vehicle or operating dangerous machinery. A patient brochure is available.

Drug Interactions

Scopolamine should be used with care in patients taking drugs, including alcohol, capable of causing CNS effects. Special attention should be given to drugs having anticholinergic properties, e.g., belladonna alkaloids, antihistamines (including meclizine), and antidepressants.

Carcinogenesis, Mutagenesis, Impairment of Fertility

No long-term studies in animals have been performed to evaluate carcinogenic potential. Fertility studies were performed in female rats and revealed no evidence of impaired fertility or harm to the fetus due to scopolamine hydrobromide administered by daily subcutaneous injection. In the highest-dose group (plasma level approximately 500 times the level achieved in humans using a transdermal system), reduced maternal body weights were observed.

Pregnancy Category C

Teratogenic studies were performed in pregnant rats and rabbits with scopolamine hydrobromide administered by daily intravenous injection. No adverse effects were recorded in the rats. In the rabbits, the highest dose (plasma level approximately 100 times the level achieved in humans using a transdermal system) of drug administered had a marginal embryotoxic effect. Transderm Scop should be used during pregnancy only if the anticipated benefit justifies the potential risk to the fetus.

Nursing Mothers

It is not known whether scopolamine is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Transderm Scop is administered to a nursing woman.

Pediatric Use

Children are particularly susceptible to the side effects of belladonna alkaloids. Transderm Scop should not be used in children because it is not known whether this system will release an amount of scopolamine that could produce serious adverse effects in children.

ADVERSE REACTIONS

The most frequent adverse reaction to Transderm Scop is dryness of the mouth. This occurs in about two thirds of the people. A less frequent adverse reaction is drowsiness, which occurs in less than one sixth of the people. Transient impairment of eye accommodation, including blurred vision and dilation of the pupils, is also observed.

The following adverse reactions have also been reported on infrequent occasions during the use of Transderm Scop: disorientation; memory disturbances; dizziness; restlessness; hallucinations; confusion; difficulty urinating; rashes and erythema; acute narrow-angle glaucoma; and dry, itchy, or red eyes.

Drug Withdrawal: Symptoms including dizziness, nausea, vomiting, headache and disturbances of equilibrium have been reported in a few patients following discontinuation of the use of the Transderm Scop system. These symptoms have occurred most often in patients who have used the systems for more than three days.

OVERDOSAGE

Overdosage with scopolamine may cause disorientation, memory disturbances, dizziness, restlessness, hallucinations, or confusion. Should these symptoms occur, the Transderm Scop disc should be immediately removed. Appropriate parasympathomimetic therapy should be initiated if these symptoms are severe.

DOSAGE AND ADMINISTRATION

Initiation of Therapy: One Transderm Scop disc (programmed to deliver 0.5 mg of scopolamine over 3 days) should be applied to the hairless area behind one ear at least 4 hours before the antiemetic effect is required. Only one disc should be worn at any time.

Handling: After the disc is applied on dry skin behind the ear, the hands should be washed thoroughly with soap and water and dried. Upon removal of the disc, it should be discarded, and the hands and application site washed thoroughly with soap and water and dried, to prevent any traces of scopolamine from coming into direct contact with the eyes. (A patient brochure is available.)

Continuation of Therapy: Should the disc become displaced, it should be discarded, and a fresh one placed on the hairless area behind the other ear. If therapy is required for longer than 3 days, the first disc should be discarded, and a fresh one placed on the hairless area behind the other ear.

The system should be stored between 59°-86°F (15°-30°C).

CAUTION

Federal law prohibits dispensing without prescription.

Dist. by:

CIBA Consumer Pharmaceuticals
Div. of CIBA-GEIGY Corp.
Summit, NJ 07901

C88-5 (Rev. 2 88)

C I B A

References:

1. Price N et al: *Clin Ther* 1979;2:258-262. Studies at sea that demonstrated a 75% mean reduction in the incidence of nausea and vomiting associated with motion sickness with Transderm Scop, compared to 50% with Dramamine* ($P > 0.05$).
2. Dahl E: *Clin Pharmacol Ther* 1984;36:116-120. A study of mild motion sickness in a laboratory setting in which Transderm Scop* demonstrated a significantly greater reduction in the incidence of nausea and vomiting than 25 mg meclizine ($P = 0.01$) and placebo ($P = 0.003$).

letters

(continued)

importance of trauma care. However, many patients may not have access to regionalized trauma center care. Yet, many neurosurgeons practice in community hospital settings. Our intent was to provide data demonstrating that inherent limitations of community hospitals do not, by themselves, doom patients with cranial gunshot wounds to inferior care or unsatisfactory outcomes. We believe our data support this claim.

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Clarifying physicians' liability when notifying third parties of HIV risk

To the Editor:

In "Lose a piece of the rock: Physician liability for failing to notify private third parties of HIV risk" (*JAOA* 1991;91:45-50), Drs Isaacman and Closen conclude, "A physician who fails to disclose a patient's HIV infection to identified or reasonably identifiable sexual or needle-sharing partners (or both) may become embroiled in a negligence claim based on failure to warn."

I would like to clarify this point, at least as it pertains to the Florida state law 455.2416, (continued on page 436)