

The section devoted to the treatment of trigger points is not as developed as that found in the book *Myofascial Pain & Dysfunction: The Trigger Point Manual* by Janet G. Travell and David G. Simons (Williams & Wilkins, 1983). However, I found the abbreviated format presented here to be an advantage to the physician who is looking for a more rapid, easily read summary. In my opinion, Editor Rachlin was not trying to replace Travell and Simons' work; rather, he was trying to make more accessible the information on the trigger point form of myofascial pain management.

Part 3 largely focuses on the noninvasive forms of treatment, with an emphasis on muscle deficiency, manual therapeutic approaches, massage, electrical treatment modalities, and the ergonomic considerations in the prevention and treatment of myofascial pain. Any DO who uses osteopathic manipulative treatment (OMT) will be interested in the presentation on manual treatment, made in this book by Brian Miller, a physical therapist. Little here will surprise the osteopathic physician who has even a modicum of OMT skills.

However, I found interesting the degree of influence that osteopathic medical ideas have had in the approaches that physical therapists are currently using. Such influence may not be known to many osteopathic physicians. Often, this influence is incorporated without physical therapists realizing the origins of the techniques. In this instance, however, Mr Miller quotes the research of Philip E. Green-

man, DO, Robert C. Ward, DO, and Irvin M. Korr, PhD.

What is surprising is that many persons outside the osteopathic medical profession who are interested in manual medical approaches sometimes independently discover techniques that we have been using for more than a century. Yet, on second thought, the fact that the history of manual medicine precedes Hippocrates makes such independent "discoveries" less unusual. As such, I think that it is worth our effort to investigate the work of other persons, regardless of their profession, who have similar interests to our own regarding manual medicine.

Osteopathic medical philosophy emphasizes the wholeness of the patient, the importance of structure and function, and the self-regulatory, self-healing nature of the body's interacting systems. We have often said that these principles are common sense approaches, even somewhat self-evident. It is rewarding to find this philosophy well-distributed throughout a text such as this, where the authors emphasize that the ultimate key to the myofascial problem may *not* be at the site where the patient complains of feeling the most pain.

This very emphasis makes *Myofascial Pain and Fibromyalgia* an excellent addition to the bookshelf of any physician who treats patients in pain.

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Joslin's Diabetes Mellitus

Edited by C. Ronald Kahn and Gordon C. Weir. Pp 1027, with illus. Lea & Febiger, Inc, Malvern, PA 19355-9725, 1994, \$125.

The first edition of this book was written in 1916 when Joslin began his work on diabetes. Subsequent editions have predominantly relied on Joslin's colleagues as contributors. However, this latest edition draws on an international roster of more than 100 authors. Their names read like a list from "Who's Who in Diabetes:" Richard S. Beaser, MD, C. Ronald Kahn, MD, Leo P. Krall, MD, Harold E. Lebovitz, MD, Rachmiel Levine, MD, Kenneth S. Polonsky, MD, and Roger H. Unger, MD. Despite the large number of contributors, the book maintains an integrated feel. It is also so up to date that the section on insulin therapy includes a discussion on the diabetes control and complications trial (DCCT), a noteworthy accomplishment in the often dated-before-it-appears-in-print world of publishing.

Organized in seven major sections, this edition covers basic mechanisms; definition of diabetes and its pathogenesis; obesity and lipoprotein disorders; treatment of diabetes mellitus; onset of diabetes complications; clinical aspects of complications; and hypoglycemia. Each of these sections is further broken down by the specific aspects of the disease. Readers can easily access these aspects by perusing the outline at the beginning of each chapter.

Usually, the primary care physi-

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Lorcet® 10/650

Each tablet contains: 10 mg hydrocodone bitartrate (Warning: May be habit-forming) and 650 mg acetaminophen.

Reference:

1. Data on file, Forest Laboratories, New York, NY.

INDICATIONS AND USAGE:

For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS:

Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS: Respiratory Depression:

At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing.

Head Injury and Increased Intracranial Pressure:

The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions:

The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS: Special Risk Patients:

As with any narcotic analgesic agent, Lorcet® 10/650 should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. The usual precautions should be observed and the possibility of respiratory depression should be kept in mind.

Cough Reflex:

Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when Lorcet® 10/650 is used postoperatively and in patients with pulmonary disease.

Drug Interactions:

Patients receiving other narcotic analgesics, antipsychotics, anxiolytic agents, or other CNS depressants (including alcohol) concomitantly with Lorcet® 10/650 may exhibit an additive CNS depression. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Use in Pregnancy:

Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. Lorcet® 10/650 should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects:

Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose. There is no consensus on the best method of managing withdrawal. Chlorpromazine 0.7 to 1 mg/kg q6h, and paregoric 2 to 4 drops/kg q4h, have been used to treat withdrawal symptoms in infants. The duration of therapy is 4 to 28 days, with the dosage decreased as tolerated.

Labor and Delivery:

As with all narcotics, administration of Lorcet® 10/650 to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

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 potential for serious adverse reactions in nursing infants from Lorcet® 10/650, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use:

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

The most frequently observed adverse reactions include lightheadedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

Central Nervous System:

Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence, mood changes.

Gastrointestinal System:

The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of Lorcet® 10/650 may produce constipation.

Genitourinary System:

Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression:

Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

DRUG ABUSE AND DEPENDENCE:

Lorcet® 10/650 is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, Lorcet® 10/650 should be prescribed and administered with caution. However, psychic dependence is unlikely to develop when Lorcet® 10/650 is used for a short time for the treatment of pain.

OVERDOSAGE: Acetaminophen: Signs and Symptoms:

In acute acetaminophen overdose, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Hydrocodone: Signs and Symptoms:

Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdose, apnea, circulatory collapse, cardiac arrest and death may occur.

DOSAGE AND ADMINISTRATION:

Dosage should be adjusted according to the severity of the pain and the response of the patient. However, it should be kept in mind that tolerance to hydrocodone can develop with continued use and that the incidence of untoward effects is dose related. The usual adult dosage is one tablet every four to six hours as needed for pain. The total 24 hour dose should not exceed 6 tablets.

CAUTION:

Federal law prohibits dispensing without prescription. A Schedule III Controlled Substance. Manufactured by: MIKART, INC. ATLANTA, GA 30318 Manufactured for: UAD Laboratories Division of Forest Pharmaceuticals, Inc. St. Louis, MO 63045 Rev. 6/94 Code 558A00

books (continued)

cian does not have time for subspecialty books, let alone a book that deals exclusively with one disease. *Joslin's Diabetes Mellitus* is really the exception. Primary care physicians see so many patients with this disease in its many forms and with its many ramifications that this book is a necessity. Furthermore, diabetes is one of the most expensive health problems in medicine today. Therefore, it behooves us primary care physicians to have on hand the latest comprehensive information on this disease entity.

Even if readers are members of the American Diabetes Association and read *Diabetes Care*, among other publications, a complete reference such as *Joslin's Diabetes Mellitus* serves as a valuable addition to the library of any physician who treats patients with this common disease.

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Correction

The article, "Vaginal infections: A diagnostic and therapeutic approach," in the September Supplement to the *JAOA*, includes *incorrect* biographical information. The article originated from the Department of Obstetrics and Gynecology, Philadelphia College of Osteopathic Medicine, Philadelphia, Pa, where Drs Forstein and Martinez are chief residents, and Dr Jeck is residency program director. As originally published, Germantown Hospital and Medical Center was incorrectly given as the place of origin.

JAOA

medi-notes

THOMAS WESLEY ALLEN, DO
Editor in Chief

Cognitive effects of ERT in older women

The authors studied the relationship between estrogen hormone replacement therapy and the recall of proper names and words in cognitively intact older women.

From a group of 278 older (age range, 55 to 93 years) community-dwelling women volunteers for memory research, 72 older women taking estrogen replacement therapy were matched on age and education with a group of 72 women not taking estrogen.

Proper name recall was significantly better in those receiving estrogen than in those not receiving estrogen. There was also significantly greater variance in the name recall scores of the group taking estrogen than in the group not taking estrogen. For word recall, there was no significant difference between those subjects taking estrogen and those not taking estrogen.

Estrogen use was associated with enhanced recall of proper names. Previous failures to find differences associated with estrogen use may reflect the memory measures used or an increased inter-individual variability of the estrogen-taking group, as was observed in the present study. Interpretation of these results should be tempered by their retrospective nature.

Robinson D, Friedman L, Marcus R, et al: Estrogen replacement therapy and memory in older women. *J Am Geriatr Soc* 1994; 42:919-922.



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