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Osteopathic graduate medical education programs *must* be maintained

To the Editor:

In his letter, Ronald Kienitz, DO, (JAOA 1995;95:155) advises that the American Osteopathic Association (AOA) should "phase out the training and certification of specialists." On behalf of its membership, the American College of Osteopathic Internists (ACOI) Board of Directors considers his comments to be ill-advised and unrealistic. Osteopathic internists are distinctive from their allopathic counterparts, both in the osteopathic medical training programs and clinical practice. Much needed studies are under way to identify and quantify these differences.

Without osteopathic medical specialty training programs, we think that our profession will cease to have a separate identity and would lose the basis for our heritage. The osteopathic distinctiveness is essential for the continued existence of osteopathic hospitals and colleges. Rather than relegate the contribution of the osteopathic medical profession solely to the American Academy of Osteopathy, the ACOI believes that this contribution must be integrated into every specialty's philosophy and practice. This goal can only be accomplished by developing first-rate training programs with a distinctive osteopathic medical emphasis, as well as maintaining existing osteopathic medical specialty training programs. The draft proposal outlining the osteopathic postdoctoral training institutions (OPTI) is designed to provide such guidelines. The OPTI proposal was approved at the Board of Trustees meeting in July in Chicago.

At a time when medical economics and viability is being determined by managed care programs with an increased emphasis on the role

of the primary care physician, the ACOI believes that the osteopathic model of primary and specialty care may be more marketable and competitive than its allopathic counterparts *if* our distinctiveness can be identified, quantitated, and perpetuated. Within our generation, we have seen the development of excessive numbers of specialists and generalists. Meanwhile, the demand for physicians has declined as the use of more cost-effective paramedic personnel becomes more common. In such a medical-political future, the only way the osteopathic medical profession can continue to exist is to maintain our distinctive and needed contributions. Rather than discontinue osteopathic specialty training and certification programs, we must strengthen and support them.

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To the Editor:

With true concern, I read the letter by Ronald Kienitz, DO, "Time to abolish most osteopathic graduate medical education programs" (JAOA 1995;95:155). I wonder whether Dr Kienitz is cognizant that the DO degree he holds and the privilege of practicing medicine that it conveys exist only because of the distinctiveness of the philosophy and principles and practice of osteopathic medicine.

After earning the near-universal respect of patients, the military, federal and state governments, and third-party payers, why would the osteopathic medical profession give up the very educational programs,

board-certification system, and distinctive approach to healthcare delivery that brought it that respect? The osteopathic medical education system gave us our degree, not the allopathic medical education system, or the Accreditation Council on Graduate Medical Education (ACGME), which Dr Kienitz thinks should now set the standard for DO training programs. Perhaps, Dr Kienitz should familiarize himself with the ACGME requirements for all specialties before suggesting that osteopathic residency programs should seek ACGME accreditation. Actually, most osteopathic residency programs would *not* be eligible for such accreditation. For the most part, osteopathic medical residency program directors are not eligible to be included under ACGME criteria. Most of the osteopathic medical institutions could not meet the ACGME training requirements for programs, faculty, and minimum training class size. More importantly, however, why should the osteopathic medical profession cast aside a system that has resulted in quality programs that successfully meet the needs of today's trainees?

Osteopathic specialty colleges monitor closely their training programs, often upgrading the curriculum standards. Programs accredited by the American Osteopathic Association (AOA) are under close scrutiny by outside accrediting agencies and are meeting these agencies' standards. Osteopathic specialty board-certification programs, such as those of the American Osteopathic Board of Internal Medicine, compare equally with allopathic specialty boards in their standards as well as the number of physicians who pass the board-certification examinations.

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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, anti-anxiety 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.

Usage 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: Urteral 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 overdosage, 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 overdosage, 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 CIII 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

letters

(continued)

Osteopathic graduate medical education programs and the specialty boards that confer board-certification status represent the heart, soul, and future of the practice of osteopathic medicine. We DOs who are proud of our heritage and degree will continue to teach the distinctive benefits of osteopathic medicine to students, interns, and residents, and to encourage them to seek osteopathic board-certification status. Fortunately, some 3200 interns and residents in AOA-approved programs felt the same way last year, too.

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Correct treatment for accidental epinephrine auto-injector-induced digital ischemia

To the Editor:

The article "Accidental epinephrine auto-injector-induced digital ischemia reversed by phentolamine digital block" (*JAOA* 1995;95:377-378), by Drs Hardy and Agostini makes several references to epinephrine and levaterenol as α -adrenergic blocking agents, a description that properly refers to α -adrenergic receptor antagonists, such as phentolamine. The article also incorrectly implies that reports of the use of levaterenol to treat accidental injection of epinephrine began to appear in 1989. In fact, the reports refer to the use of phentolamine for reversal of epinephrine-induced ischemia. The authors correctly identify and describe the use of phentolamine at other points in the article, but students may be confused by these inaccuracies. The case reported in their arti-

cle provides a useful illustration of the digital block technique for phentolamine administration, although a discussion of the subject by Hinterberger and Kintzi (*Arch Fam Med* 1994;3:193-195) suggest that local infiltration of phentolamine at the site of the epinephrine injection may be the most prudent route of administration in that it allows phentolamine direct access to the affected alpha-receptors, whereas the digital block technique may allow phentolamine to diffuse proximal to the affected region. Moreover, the inclusion of lidocaine as used by Drs Hardy and Agostini may interfere with the clinical assessment of sensation once blood flow has returned, according to Hinterberger and Kintzi. ♦

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