Reviews

Reviews of books for this section are welcomed from osteopathic physicians and from faculty members in osteopathic medical institutions. Interested individuals will be sent information on format on request. A certain number of reviews are invited for books supplied to JAOA by publishers; persons wishing to be a part of this program should write to the editors, giving background and areas of interest.

The Medical Interview: A Primer for Students of the Art


Much discussion has taken place concerning physicians' failure to remember the patient in today's maze of high-technology medicine. This book puts the human side of medicine on the level that it deserves. Students are commonly told that history-taking and communicating with the patient comes with experience. To some extent this may be true; however, the authors have developed an approach to effective communication, which they teach to the reader.

Interview excerpts with patients enable the reader to extract pearls of wisdom quickly. Using such techniques, the authors cover the basic skills necessary for history-taking as well as conducting a physical examination. An excellent section on writing up the patient's medical record is included here as well.

This second edition features new material covering pediatrics, geriatrics, and dealing with difficult patients. A very timely chapter detailing the ethics of patient interviewing can be found here as well.

No "cookbook" on history-taking, The Medical Interview: A Primer for Students of the Art should interest—and help—students and house staff alike. If other physicians share my reaction, this book should enhance physicians' caring for patients.

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Professor of Medicine
Chicago College of Osteopathic Medicine
Chicago, III

Painful Cervical Trauma

Edited by C. David Tollison and John R. Satterthwaite. Pp 492, with illus. Williams & Wilkins, 428 E Preston St, Baltimore 21202, 1992, $80.

Primary care physicians see patients with painful cervical trauma often. At one end of the spectrum, the urgency of the traumatic injury may be readily apparent, with directions for acute management immediately set in motion. At the other extreme, is a patient with chronic cervical pain whose case file already fills a volume as thick as the text currently being reviewed. This second patient has seen many specialists, yet still represents one discouraging data point for the outcome studies frequently referenced in Painful Cervical Trauma.

The editors are a director and a consulting anesthesiologist at Pain Therapy Centers in Greenville, SC. They have compiled a text whose content is logically sectioned into diagnostic foundations, therapeutic techniques, treatment of selected disorders, and medical-legal issues. These four sections, particularly the latter, present a comprehensive picture of painful trauma medicine in today's practice environment.

Yet, with seven to ten contributing authors in each of these clinical sections, the editors have allowed frequent duplication of some very straightforward material. This material includes routine procedures such as history-taking and physical examinations; conceptual anatomic considerations; and tissue injury and treatment. Many of these topics are repeated in a perfunctory manner. Such overlapping dilutes the impact of the authors' individual contributions.

Several chapters that deal with the critical aspects of major injuries provide a valuable reference for all physicians. In addressing this acute care, the authors carefully present the diagnostic tests and criteria used for assessing and managing the injured patients. Physical examination in acute traumatic injury; radiologic imaging of structural changes; clinical stability/instability of the spinal motion segment; functional integrity of the neural elements; and presence of cognitive deficits are included here. These components prove critical to decisions made concern-

(continued on page 538)
PINPOINTS.
PENDRATES.
PREVAILS.

Full-course antibiotic therapy in half the usual time

NEW Zithromax™
AZITHROMYCIN
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Zithromax™ (azithromycin) is targeted to sites of bacterial infection.

Zithromax distributes rapidly from serum to a wide variety of tissues.\(^1\)\(^2\)

Additionally, Zithromax is taken up extensively by phagocytes, part of the body’s own defenses, and is transported to infected tissue, which may further enhance drug levels.\(^3\)\(^4\)
**PENETRATES**

Zithromax penetrates and concentrates infected tissue.\(^1,3-5\)

In three animal models, Zithromax demonstrated higher concentrations in infected tissues.

Zithromax concentrations were measured in infected and noninfected tissues.\(^4\) (Data on file.\(^1\))

Concentrations in animal tissues do not relate directly to concentrations in humans. Tissue concentrations may not be quantitatively related to efficacy, however, Zithromax's extensive tissue distribution may be relevant to clinical activity.

**NEW**

**Zithromax**

**ONCE DAILY FOR 5 DAYS**

(AZITHROMYCIN) 250-mg capsules

Please see brief summary of prescribing information on last page of this advertisement.
Sustained tissue levels observed

Zithromax™ (azithromycin) concentrations in human tonsillar tissue following 1-day dosing. (Adapted from Foulds.6)

Projected tissue and serum levels of 5-day dosing

The above projected tissue and serum concentrations were generated using pharmacokinetic modeling. The observed tissue levels from 1-day dosing were used in the model to project tissue concentrations for 5-day dosing.1
Once-daily dosing for 5 days provides full-course antibiotic therapy in half the usual time

<table>
<thead>
<tr>
<th>Zithromax (qd x 5 days)</th>
<th>VS</th>
<th>amoxicillin/clavulanate (tid x 10 days)</th>
<th>30 doses</th>
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<tr>
<td></td>
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<td>cefaclor (tid x 10 days)</td>
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<td>ciprofloxacin (bid x 7–14 days)</td>
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<td>clarithromycin (bid x 7–14 days)</td>
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<td>erythromycin (bid-qid x 10 days)</td>
<td>20-40 doses</td>
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Please see brief summary of prescribing information on last page of this advertisement.
The efficacy you want — with once-daily dosing for just 5 days

Indicated for patients 16 years of age and older with mild to moderate infections, including acute bacterial exacerbations of COPD (chronic bronchitis) due to Haemophilus influenzae, Moraxella catarrhalis, or S pneumoniae.

In a study of Acute bacterial exacerbations of COPD (chronic bronchitis)

<table>
<thead>
<tr>
<th></th>
<th>Zithromax™ (azithromycin)</th>
<th>cefaclor</th>
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<tbody>
<tr>
<td>5 days/ 5 doses</td>
<td>100%</td>
<td>92%</td>
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<tr>
<td>10 days/ 30 doses</td>
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Excellent bacteriologic eradication†

<table>
<thead>
<tr>
<th></th>
<th>Zithromax (75/86 isolates) 87%</th>
<th>cefaclor (23/30 isolates) 90%</th>
</tr>
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<tbody>
<tr>
<td>S pneumoniae (p=ns)</td>
<td>Zithromax (9/9 isolates) 100%</td>
<td>cefaclor (4/4 isolates) 100%</td>
</tr>
<tr>
<td>H influenzae (p=ns)</td>
<td>Zithromax (19/21 isolates) 90%</td>
<td>cefaclor (6/9 isolates) 67%</td>
</tr>
</tbody>
</table>

Clinical response (%)*

- Cured: 33% (n=64)
- Improved: 67% (n=64)
- Cured: 20% (n=25)
- Improved: 72% (n=25)

* Clinical response at the end of therapy was defined as: cured, based upon complete resolution of signs and symptoms; improved, based upon improvement but not complete resolution of signs and symptoms; or failed, based upon no improvement in signs and symptoms.
† Bacteriologic response at the end of therapy was classified as: eradication, if the susceptible pathogen present at baseline was eradicated; persistent, if the susceptible pathogen was still present.

Adapted from Dark7; Data on file.
Indicated for community-acquired, outpatient pneumonia due to *S. pneumoniae* and *H. influenzae*. Azithromycin should not be used in patients with pneumonia who are judged to be inappropriate for outpatient oral therapy because of moderate to severe illness or risk factors such as any of the following: patients with nosocomially-acquired infections; patients with known or suspected bacteremia; patients requiring hospitalization; elderly or debilitated patients; or patients with significant underlying health problems that may compromise their ability to respond to their illness (including immunodeficiency or functional asplenia).

## In a Study of Pneumonia

<table>
<thead>
<tr>
<th></th>
<th>Zithromax</th>
<th>Cefaclor</th>
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<tbody>
<tr>
<td><strong>5 days/5 doses</strong></td>
<td><em>94%</em></td>
<td><em>94%</em></td>
</tr>
<tr>
<td><strong>10 days/30 doses</strong></td>
<td><em>100%</em></td>
<td><em>100%</em></td>
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### Excellent Bacteriologic Eradication

<table>
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<th>Pathogen</th>
<th>Zithromax</th>
<th>Cefaclor</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>H. influenzae</em></td>
<td>(9/10 isolates) <em>90%</em></td>
<td>(13/15 isolates) <em>87%</em></td>
</tr>
<tr>
<td><em>S. pneumoniae</em></td>
<td>(11/13 isolates) <em>85%</em></td>
<td>(16/17 isolates) <em>94%</em></td>
</tr>
</tbody>
</table>

*Clinical response at the end of therapy was defined as: cured, based upon complete resolution of signs and symptoms; improved, based upon improvement but not complete resolution of signs and symptoms; or failed, based upon no improvement in signs and symptoms.*

* Bacteriologic response at the end of therapy was classified as: eradication, if the susceptible pathogen present at baseline was eradicated; persistent, if the susceptible pathogen was still present.

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NEW

**Zithromax™**

Once Daily for 5 Days

(AZITHROMYCIN) 250-mg capsules

Please see brief summary of prescribing information on last page of this advertisement.
Improved potential for patient compliance with convenient dosing

- 5 once-daily doses for respiratory tract and skin infections: 500-mg single dose on day 1; 250 mg once daily on days 2 through 5. Total dose is 1.5 g.

- Zithromax™ (azithromycin) should be given at least 1 hour before or 2 hours after a meal.

- A favorable safety profile with a low discontinuation rate due to side effects.† In multidose trials, the most common side effects were diarrhea/loose stools (5.0%), nausea (3.0%), and abdominal pain (3.0%).†

![Graph showing patient discontinuation due to side effects](image)

Please see brief summary of prescribing information on last page of this advertisement.
Note: Azithromycin should not be used in patients with pneumonia who were infected with M. pneumoniae or with evidence of Mycoplasma infection.

Pseudomembranous colitis has also been reported in patients with no known exposure to azithromycin. In general, patients with pseudomembranous colitis should be managed initially with fluid and electrolyte repletion and broad-spectrum antimicrobial therapy. The use of vancomycin or metronidazole is recommended, and treatment should be continued for at least 7 to 10 days. For patients who are toxic or have evidence of significant dehydration, surgical consultation should be obtained.

Special Populations

Pediatric Patients

No studies have been conducted in children. Use of azithromycin in children is based on adult studies, age-related differences in elimination, and age-related differences in pharmacokinetics.

Hypersensitivity Reactions

Hypersensitivity reactions may occur and may range in severity from mild to severe. If an allergic reaction occurs, discontinue azithromycin and institute appropriate therapy. Antihistamines may be prescribed for mild cutaneous reactions such as urticaria.

Adverse Effects

The following adverse reactions have been reported with the use of azithromycin:

Gastrointestinal:

Diarrhea, abdominal pain, nausea, vomiting, flatulence.

Respiratory:

Cough, pharyngitis, and lower respiratory tract infection.

Dermatological:

Rash, photosensitivity, and pruritus.

Central Nervous System:

Dizziness, headache, and somnolence.

Other:

Arthralgia, allergic reaction, and hypoglycemia.


due to the use of azithromycin in a large number of patients, the overall incidence of these reactions may be underestimated.

References


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The most common adverse reactions associated with the use of azithromycin are:

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Other:

Arthralgia, allergic reaction, and hypoglycemia.


due to the use of azithromycin in a large number of patients, the overall incidence of these reactions may be underestimated.
records, their ability to carry out a full spectrum of normal activities. They do cite separate statistics indicating that 40% to 70% of patients with this general “functional recovery” retain some intermittent, distracting discomfort that occasionally proves intolerable.

This same chapter includes manipulation as “the most controversial” treatment in a long list of options for whiplash victims. Although the authors do not perform manipulation, they do refer to thrust adjustments as the best known form of manipulation and express concerns about its use. Some readers may feel that the chapter on chiropractic manipulation by Preston B. Fitzgerald, DC, although well-presented, feeds the aforementioned concern. Dr Fitzgerald covers some palpatory examination principles and procedures, eventually focusing on the site where the patient perceives the pain.

Spinal evaluation for structural and neuromuscular integrity and for normal muscle tone includes examination of anterior and posterior cervical musculature, interspinous spaces, and related areas. In his examination techniques, Dr Fitzgerald rules out structural, arterial, and neurologic damage before considering manipulation. Increased range of movement is the major treatment goal here.

For patients with acceleration/deceleration injuries, Dr Fitzgerald includes in his treatment local application of ice, then high-voltage galvanic stimulation, and after 72 hours, ultrasound. This regimen is followed by traction/distraction forms of treatment that prepare the patient for mobilization and manipulation.

A 12-week course of chiropractic treatment begins with mobilization daily for 2 weeks, then every other day for 4 to 6 weeks. This mobilization continues weekly for 1 month. “Specific, short-levered high-velocity thrust” manipulative techniques are generally performed.

Dr Fitzgerald’s use of the theoretical models by J. Dvorak, MD, for vertebral position and malposition seems appropriate for thrust technique. However, many readers may find that thrust technique will not necessarily be the appropriate choice for treating a posttraumatic condition.

The author recognizes other methods of manipulative technique, but when he refers to the research of Irvin M. Korr, PhD, done in the 1940s and 1950s, he does not discuss the impact of Dr Korr’s research on modern manipulative technique. As our knowledge of the neurophysiologic mechanisms of spinal motor function has grown, other established methods besides thrust have gained favor. Choice of technique becomes an important clinical decision.

Included in this book is a well-illustrated chapter discussing ergonomic considerations. It includes good examples of poor work habits and poor personal posture habits, and their potential for accidental injury and physical stress on the body mechanics. The authors provide constructive
It's on its way to your office.

Allergic rhinitis season is here. Expect to see patients complaining of rhinorrhea, nasal congestion, sneezing and watery eyes. Symptoms Bromfed can easily tame. That's because Bromfed contains an effective decongestant and a well-tolerated antihistamine. Together they help spell the end of allergic rhinitis attacks. Bromfed is also available as Bromfed-PD® Timed-release Capsules.

Please see adjacent page for brief summary of prescribing information.
suggestions for addressing these habits, both in personal living space and in work space design. They use a “human performance profile,” testing capabilities such as strength, mobility, and alertness. The profile permits a constructive evaluation of an individual’s functional capacity, that is, one’s ability to work, rather than an individual’s chronic functional disorder as seen by the clinician.

Most of the contributors in this book comment on the psychologic overtones of the patient in chronic pain, but contributor Benjamin L. Crue, Jr, MD, brings this issue into focus. He outlines concepts of existing pain in terms of the peripheralist and the centralist. The former emphasizes continuing nociceptor input from the injured area. The latter emphasizes the central “memory” of pain within the sensory networks of the central nervous system. This memory continues after the injured area has healed. As a centralist, Dr Crue separates the term psychosomatic (chronic central pain) from the somatopsychic (chronic peripheral pathologic condition with nociceptive input and recurrent acute pain).

He carefully references the development of his own approach to chronic pain. He outlines his 4-week team pain unit program, which is structured for intensive, all-day outpatient interaction. Essential to this plan is preparing patients to participate in this concentrated program. To that end, an informative 18-page appendix has been included.

As for when the patient should enter this 4-week program, it is not clear how the director makes the initial assumption that the injured area is healed. Is time the only criterion?

Clinical tests are not described to support the clinical reasoning for a now-healed cervical region. Again, an objective baseline is missing for expressions such as healed and the awkward phrase nothing in the periphery (in the region of the painful previously injured cervical spine) that needs fixing.

Many adjunctive therapeutic aspects in this program address the chronic-pain patient’s general condition. Biofeedback, exercise and movement, relaxation and occupation techniques, and nutrition represent some of these modes of therapy. Dr Crue describes a very thoughtful approach to the control of medication as well.

Insight psychotherapy remains the focus throughout all aspects of this program, with treatment based on learning theory. Patients are taught that six common causes of unresolved emotional conflicts—grief, anger, depression, fear, guilt, and shame—lead to chronic pain. Of these, unresolved grief is the most common, writes Dr Crue. This aspect of therapy clearly concerns itself with disturbed characteristics of the individual’s general psyche and how they may contribute to the individual’s pain pattern.

As evidenced by this review, Painful Cervical Trauma covers a broad range of topics in this complex medical (and often legal) encounter. As such it accomplishes a distinct service. However, when
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Rx Pedia-Profen®
Ibuprofen Suspension
100 mg/5 ml

Provides 6 to 8 hours of fever relief

• Effective fever relief is achieved with 2 levels of dosing:
  — 5 mg/kg for fevers under 102.5°F
  — 10 mg/kg for fevers 102.5°F and higher

• Pleasant tasting and easy to swallow

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McNEIL McNeil Consumer Products Company
Division of McNeil-PPC, Inc.
Fort Washington, PA 19034  U.S.A.

the editors attempt to be interdisciplinarily with a well-qualified list of contributors, they fall short of their goal. For example, although the list includes two DO contributors (R. Michael Gallagher and Frederick G. Freitag), they have been asked to contribute chapters on muscle relaxant medications and headache following cerebral trauma, respectively.

Throughout this discipline, the book of osteopathic medicine does not emerge. Authors give little consideration to whole body concepts, such as the relationship of the cerebral cortex to the structural base of body support; reflex somatic input to the cerebral spine from other spinal regions; or visceral afferent input from other body systems. Osteopathic medicine recognizes that other impediments may limit the body's ability to stabilize cerebral motor function. In some individuals, these impediments may be just as important to persisting pain as the unresolved emotional conflicts Dr Crue recognizes.

Considerations of relevant osteopathic medical literature are missing, too. This void seems particularly noticeable when one considers descriptions of musculoskeletal tests. Osteopathic palpatory tests of tissue and motion are objective, especially when the procedures and criteria for positive findings are carefully described. They do not rely necessarily on the patient's subjective report of pain for interpretation. Especially when the examiner is not an emergency, time must be spent to determine not only the cerebral region mobility and its limitations, but the cerebral segmental motion and its dysfunction. In this manner, positive signs on physical examination would prompt a diagnostic process for justifying judgments in osteopathic manipulative management and an evaluating mechanism for monitoring response to treatment.

In my opinion, a baseline of objective tests of cerebral motor function has not been presented in this book. It provides no other functional standard on which to constructively plan caring for the patient with less acute trauma and the chronic peripheral pathologic condition with nociceptive input and recurrent acute pain.

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