

BULLETIN

of the
MAHONING COUNTY
MEDICAL SOCIETY

Volume LIII

OCTOBER, 1983

Number 7



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7. Physician consent for settlement of claim prior to judgement	YES	_____
8. Legal defense services provided only by specialists in defendant medical professional liability insurance suits	YES	_____
9. No pre-paid legal expense	YES	_____
10. Refusal to pay nuisance claims	YES	_____
11. Premiums to surplus ratio of less than 2-1	YES	_____
12. "Clean" opinion from auditors	YES	_____
13. Steady growth in surplus, claims reserves, and operating profits	YES	_____
14. Physician decisions on claims and underwriting matters	YES	_____
15. Official endorsement by the OSMA	YES	_____

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1983 - MAHONING COUNTY MEDICAL SOCIETY MEETINGS - 1983

Tuesday	Tuesday	Tuesday	Tuesday	Tuesday	Tuesday
Jan. 18	Mar. 15	May 17	Sept. 20	Nov. 15	Dec. 20

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From the Desk of the President



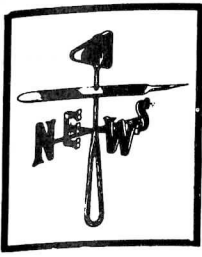
At St. Elizabeth's Medical Staff Meeting in September a member of the hospital's financial team attempted to explain the regulations establishing D.R.G. reimbursement. St. Elizabeth, as most hospitals, accepts assignment and receives approximately 40% of its revenue from Medicare; the implementation of D.R.G., therefore, could affect the hospital's finances in a dramatic fashion. Discussion of the advisability of the hospital administration's accepting such a far-reaching program was unfortunately curtailed by the meeting's presiding officer, although some strong opinions were expressed by the physicians present that the hospital should not abide by the new D.R.G. policy. Hopefully, this issue will be added to the agenda for discussion in the near future.

The pitfalls of accepting reimbursement from third parties are manifest. The motivation behind such plans are mainly cost containment and care curtailment, rather than quality assurance. The purpose of D.R.G. is to shift expenses from the insurer (The government-HHS in the case of Medicare) to the hospital under the ruse of inspiring greater hospital efficiency and creating cost competitiveness. D.R.G. does not have the best interest of our patients as its inspiration — it is purely economic and it will result in curtailment of services and eventual rationing of medical care. Poor quality medicine will be the logical result; medical judgment in patient care will be replaced by what third parties feel is necessary and for which they will pay. In the New Jersey experience with D.R.G., patient census and hospital income dropped to the point of bankrupting some of those very institutions that embraced the program.

One staff physician asked at what point in time the hospital will elect to leave the government apron strings, and do that which is going to be increasingly more difficult but necessary to preserve good medical care for our community: spurn the dictates of third party payees thereby preserving private personal patient relationships. When medical judgments are dictated by those third parties whose main concern is cost containment, when the individual patient and his disease are lumped into tidy diagnostically related categories, when a rigid number of days and dollars are statistically allocated for a patient's unique disease, then individuality is truly lost and independent personally-tailored medical care is sacrificed for the faceless, impersonal, inept, imperative of a bureaucracy.

Physicians must recognize that they act as an ombudsmen for their patients and they must, in conscience, advise any facility offering a place

(Continued on Page 186)



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of the Mahoning County Medical Society

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OCTOBER, 1983

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The opinions and conclusions expressed herein do not necessarily represent the views of the Editorial staff nor the official views of the Mahoning County Medical Society.

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Robert B. Blake

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Editorial

PAIN

Everyone has had to deal with pain sometime in life, whether personally or in someone else, professionally or non-professionally.

Managing the troublesome entity has taxed the ingenuity, patience, and endurance of all professionals plus families and friends of victims. Addiction is a "cancer" crying for a cure.

What is pain? Everyone has a different definition or description which means something to that person, but can only be suggestive to others. Some sufferers can be stoic martyrs even to severe discomfort while others are belligerent bellyachers even to mild interferences with normal routines.

On September 1, 1983 Robert Addison, M.D., Director of the Pain Center at the Rehabilitation Institute of Chicago, delivered a sensible and practical talk for YHA's Family Practice All-Division's meeting on the "Management of Low Back Pain". Dr. Addison reiterated exhortations we all remember from medical school — do a good history and physical examination before proceeding on a course of therapy. Consider the patient's real needs carefully. Which exercises, if any, could be helpful? Is bed rest necessary? Should surgery be considered? What and how much medication should be used? Could the endorphin-released placebo response prove helpful? What about job re-training as an alternative? Heat, massage, manipulation are other considerations. Most important, however, is the prevention of a chronic outcome which may be intractable. Intense preventive measures should be instituted within three months.

The August 26, 1983 issue of JAMA has an interesting review article by Richard A. Deyo, M.D., MPH, in which he tries to distinguish useful from useless therapy in low back pain. Limited research and inadequate evaluation procedures have not resulted in enlightened management, generally.

Since we have conquered many disease entities and now are addressing the newer AIDS and toxic shock syndromes and other glamour problems, shouldn't we pause to reflect on and meet head on the age-old but still aggravating problem of pain, realistically?

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Richard W. Juvancic, M.D.

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PROCEEDINGS OF COUNCIL

Sept. 13, 1983

The regular meeting of the Council of the Mahoning County Medical Society was held Tuesday, Sept. 13, 1983 at the Youngstown Club.

The meeting was called to order by vice-president Glenn J. Baumbblatt at 7:33 p.m. The minutes of the June 14, 1983 meeting having been read, were approved.

The treasurer's report included a recap of total income to date from dues and other sources. The bill list was read and a motion made, seconded and passed to pay each bill.

The following applications were presented by the censors:

ACTIVE: Stanley Goldstein, M.D.

ASSOCIATE: Malcolm R. S. Arnold, M.D. Prasad B. Guttikonda, M.D.

Bimleshwar Dayal, M.D. Bee Min Lim, M.D.

Thomas P. Fogarty, D.O. James Paul Moore, M.D.

Donald W. Fox, D.O. Niranjana N. Patel, M.D.

Norton I. German, M.D. Robert G. Spratt, M.D.

Kim Goldenberg, M.D. Donald J. Tamulonis, M.D.

The applications were approved. The applicants will become members of the Mahoning County Medical Society in the voted category 15 days after publication of the names in the *Bulletin* unless objection is filed in writing with the executive director before that time.

Communications included: A letter from the Youngstown Community Action Council concerning assignment of a physician to the East Side Medical Center by the Public Health Service; Information about the AMA Awards Program; A letter about the Auxiliary Masquerade Dance; Notes of thanks from Mrs. William Flynn, Dr. John Goldcamp and Dr. John Rogers.

Committee reports included: A report from the MCMS Foundation that six loans of \$1,000 each were made to medical students in July; a report from the Canfield Fair Committee; a report from the Constitution Committee on a proposed by-law change that suggested approval of notifying the membership of new member applications by publication in the minutes and not waiting for *Bulletin* publication; a report from the Nominating Committee that named the following committee members— Drs. Mahar, Kiskaddon, B. P. Bruccoli, McGowen, Friedrich and Brandmiller, who will meet Oct. 18; a report on the San Antonio Medical Executives Conference from the executive director.

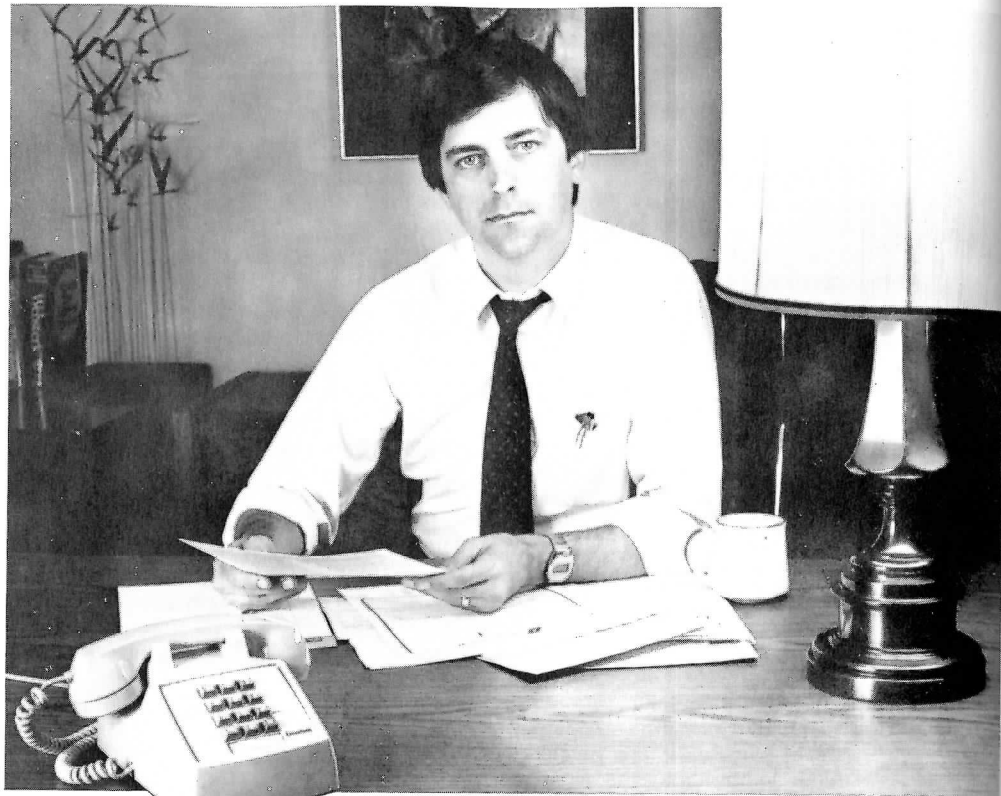
Sixth District Councilor Dr. Anderson gave an interesting and enlightening review of the recent State Council meeting in Columbus. He spoke on pending legislation and the possible impact on the enactment of legislation now in force.

Dr. Sovik, OSMA legislative committee member, spoke about matters discussed in a recent meeting of his committee.

Under unfinished business it was noted a letter has been sent to the proper person in support of the concept of the East Side Medical Center and the services it provides for persons on welfare, ADC and ADCU programs.

In response to a request for a speaker to talk about cost containment in the health care field as they are implemented by physicians, a motion was made, seconded and passed that the executive director work in cooperation with any willing physician to provide a program on the topic requested.

The subject of publishing a pictorial directory of the Society was brought up and discussed. A motion was made, seconded and passed that some samples of directories and cost figures for publishing a directory be presented at the October meeting of Council.



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A motion was made, seconded and passed that the president of the Medical-Dental Bureau be requested to attend the next Council meeting, with a technician if needed, to explain why the service is not what it should be.

Announcements included: Old Fashioned Society meeting at the Youngstown Maennerchor at 6 p.m. Sept. 20; a seminar on DRG reimbursement systems from 2 - 5 p.m. Sept. 21 in Columbus; conference on Impaired Physicians being held Oct. 15 - 16 in Columbus; Academy of Medicine of Columbus Ski Trip and 10 hour CME program to Steamboat Springs, Jan. 14.

The meeting adjourned at 9:40.

Robert B. Blake
Executive Director

T. E. F. R. A.

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THE SOARING COST OF MEDICAL CARE?

Introduction

"Health care costs now consume 10.5 per cent of the gross national product" and "health costs continue to rise faster than the general rate of inflation" are repeatedly quoted.

I can accept these as correct.

I shall analyze facts — not statistics.

Data Base

What is included in "health costs" (sometimes expressed as "medical costs")?

It contains the costs of increasing government regulations, the overhead of health insurance companies, malpractice insurance, defensive medicine.

Also included are stomach stapling for obesity, cosmetic plastic surgery, extraordinary life saving procedures, substance abuse programs, sex therapies, wellness programs, preventive services, holistic medicine, second surgical opinions, peer review, diet programs, megavitamin therapy, medical fads, research, equipment.

What is not included? I could not determine: are over the counter medications, vitamins, the large number of non-physicians (podiatrists, chiropractors, optometrists, psychologists, nurse practitioners, physician assistants, para-medics, mid wives, technicians, physiotherapists) independently providing services, hospices, the many single disease interest groups, construction of hospitals and clinics, included?

The data base for "health care cost" is never specifically stated.

The Rise in Health Care Cost

Inflation has entered every part of living. "Health care cost" should not and cannot be considered in isolation from inflation.

The increase in physicians' fees in four of the past five years has been lower than the all services component of the consumer price index.

Hospital room rates include a large number of services and expenses— not only bed, food, and nursing care. Modern diagnostic and therapeutic equipment with needed personnel is one source of the increase in hospital rates. Hospitals must pay for the effects of inflation in salaries, food, utilities, maintenance, insurances. Hospital care costs have risen slightly more than the general inflation rate.

Physicians, hospitals, pharmaceutical companies, sick people and their families all agree in their desire and demand for quality, quantity, availability of health care. These add to cost — without price tags.

The quantity of care has increased. People tend to overlook that life-saving and life-prolonging measures (for example, for heart disease and hypertension, cancer therapies, surgical skills and techniques) add to costs. Death ends some health care costs. The quantity of care could be reduced by immoral and unethical mandatory birth control and euthanasia.

The increase in cost directly related to the increasing over sixty five age group has been repeatedly documented.

The increase in population, not only the aged, has led to increased cost.

It is impossible to estimate the added costs of first-dollar insurance coverage, the expectation that the health care system keep healthy people well and cure the sick, excessive payment for remaining ill.

Possible Solution

Proper solutions to the "soaring costs of health care" must start with the correct identification of problems.

What specific services are considered to be "health care"?

Inflation has caused and remains the largest increase in whatever is included as "health care".

Personal and private care, quality, quantity, availability do not have specific prices. Curtailing and limiting these may reduce costs immediately and probably would increase costs over an extended period of time.

Bureaucratic decisions (for example DRG), HMO, PPO, free standing clinics will have little effect in reducing the total cost of the treatment of disease and injury.

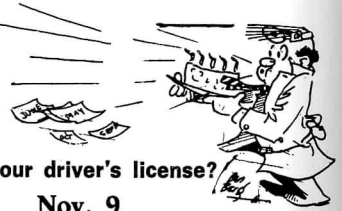
These plans, other proposals, quoting statistics without stating precisely what is included, imply that the present system of health care is outdated and that physicians, hospitals, pharmaceutical companies are causes of "soaring" or "escalating" health care costs.

I gratefully acknowledge that much of the material was obtained from "Psychiatric Annals", June 1983 and particularly from "Health Costs" — a National Noncrisis" by John K. Layle, M.D.

Frank Gelbman, M.D.

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Nov. 3
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Nov. 5
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Nov. 6
L. O. Gregg

Nov. 8
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Nov. 9
J. B. Birch

Nov. 10
N. K. Badjatia
J. C. Melnick

Nov. 13
Mahoning County
Medical Society

Nov. 14
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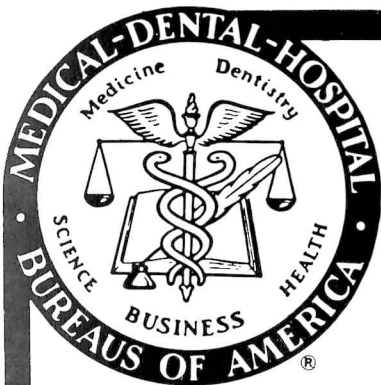
Nov. 15
J. S. Gregori
R. W. Juvancic
J. P. Kalfas

From the Desk of the President

(Continued from Page 178)

where medical care is rendered, when that facility is stepping upon the slippery slope toward poor quality health care. The facility so advised must then make its choice to act in the patient's best interest or to act in regard to its own immediate financial best interest, knowing what result must necessarily follow. Let us, therefore, speak clearly for uncompromised high quality medical care. Let us condemn this new scheme for rationed poor quality health care dictated by third parties unwilling to pay for first rate medicine.

P. J. Mahar, Jr., M.D.



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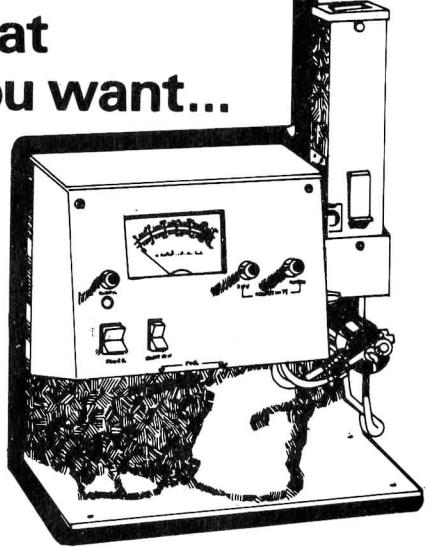
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From the Bulletin

FIFTY YEARS AGO — OCTOBER 1933

Schools were closed because of the polio epidemic. The Medical Society Council recommended that the Health Department pool all the blood donations received from convalescent cases and make the serum available to the doctors. The epidemic waned and nothing came of the proposal.

A course of eight lectures in hematology by Drs. Doan and Wiseman of Ohio State University started that month. Fee for the course, three dollars.

Dr. G. B. Kramer held a "Clinico-Pathological Conference" at the South Side Unit. It was a new thing and more were planned. Doctors were invited to attend.

FORTY YEARS AGO — OCTOBER 1943

Dr. John Tucker of the Cleveland Clinic told the members that the new Penicillin was the most powerful anti-bacterial agent known.

The honor roll of doctors and nurses in the armed services took up four pages in the *Bulletin*. There were many letters:

Joe Colla in one year had been in Fort Sam Houston, thn Camp Bowie, Texas, then the dispensary at the Pentagon in Washington. From there he went on a special mission to South America, North Africa and Canada. He wrote from a camp in Virginia which he was not allowed to name where there were swimming pools, a golf course, and a horse for each officer. John Noll was at Jefferson Barracks, Mo. Brack Bowman was at Laguna Beach near Los Angeles. Barclay Brandmiller was at Monterey, the old capital of California. Luke Reed was at Monroe, California. E. M. Chalker was at Las Vegas, Nevada. Herman Zeve was at Trinidad, B.W.I. Walter Tims was still in England, promoted to Major.

McKelvey's store celebrated its 60th Anniversary by launching a project to sell \$300,000 worth of bonds to buy a bomber to be named "The Spirit of Mahoning County".

THIRTY YEARS AGO — OCTOBER 1953

Physicians were concerned about the proposal to include them in Social Security. Disapproval was expressed by the A.M.A. House of Delegates, the American Bar Association, and the American Dental Association.

President Goodwin reported on a local survey of hospital expense. The report showed that only 16½ of the hospital days were paid by the individual. The rest was paid by Insurance, Workmen's Compensation, state or city, and Community Chest.

Editor Reese sounded off about doctors who have their secretaries put through calls to other doctors and make them wait on the line until the caller is ready to talk. He said it was a breach of common courtesy.

At the September meeting a vote was taken to decide whether Wednesday or Thursday afternoon should be the official "afternoon off" for doctors. The vote was 113 to 64 in fayor of Thursday.

TWENTY YEARS AGO — OCTOBER 1963

The Sixth-District Post-Graduate Day was held at Packard Hall in Warren on the twenty-third. The program was most attractive and the place was jammed.

There were seventeen outstanding speakers from twelve great medical centers like McGill, Harvard, Jefferson, Michigan, Cleveland, Pittsburgh, Minnesota, and Columbus.

Dr. Thomas Lander died. He was a prominent family physician doing a great deal of Obstetrics. He has been greatly missed.

Leonard Blum, John Buchanan, Pat Kennedy and Harry Zeve were elected to honorary membership.

Seventy thousand persons visited the Health Exhibit at the Canfield Fair. The supervision was done by Harlan McGregor, Clyde Walter, Jack Schreiber, Robert Fisher, and Fred Resch.

New members were: Glen J. Baumblatt, Leonard N. Green, John C. Melnick, Rafael Tarnopolsky, Frank Tiberio and John Werning.

It was a good month. Ninety-two members attended our business meeting and that's a quorum. Warren put on a great Post-Graduate Day. We had a cultural program going for doctors at Youngstown University. Six desirable new members were added. The Society gave \$100.00 to the good ship "Hope".

TEN YEARS AGO — OCTOBER 1973

President Ed Pichette editorialized about the various methods proposed for recertification and relicensure of practicing physicians. He reported that 93% of those responding to a questionnaire were not in favor of requiring evidence of CME for relicensure.

Editor Bill Moskalik reflected on some of the injustices in the world, like recalling automobiles for mechanical problems, yet ignoring the defects of the drivers who cause 90% of the accidents.

The Medical Assistants dinner was held October 3rd at the Ramada Inn. Dr. George Deitz was Chairman of the affair, and he presented twenty-seven door prizes, including two oil paintings. There were 270 girls in attendance and each received a favor at her plate.

The Womens' Auxiliary held a picnic cook-out "under the oaks" at the Friedrich Farm. Sally Hernandez was Chairman. The Auxiliary also visited more than 200 physicians' offices to pick up drug samples which they planned to send to Detroit for the World Medical Relief, Inc.

The Florence Crittenton Home celebrated its 70th year of service to the community.

New active members were Norma Hazelbaker, M.D., Chandler Kohli, M.D., Paul Mahar, M.D., Nicholas Pappas, M.D. and V. G. Raghavan, M.D.

New associate members were: N. K. Badjatia, M.D., Taiji Kawatu, M.D., J. Louis Pecora, M.D., Fred R. Pruitt, M.D., and G. D. Sangvai, M.D.

The Medical Society was still debating on how to vote on PSRO

—Robert R. Fisher, M.D.

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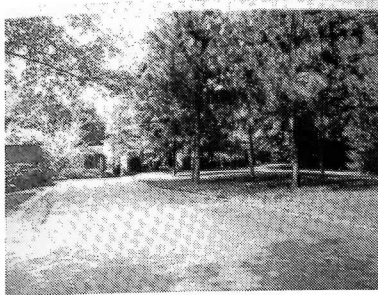
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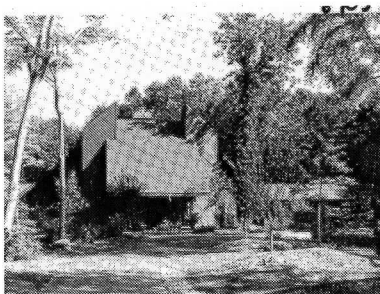
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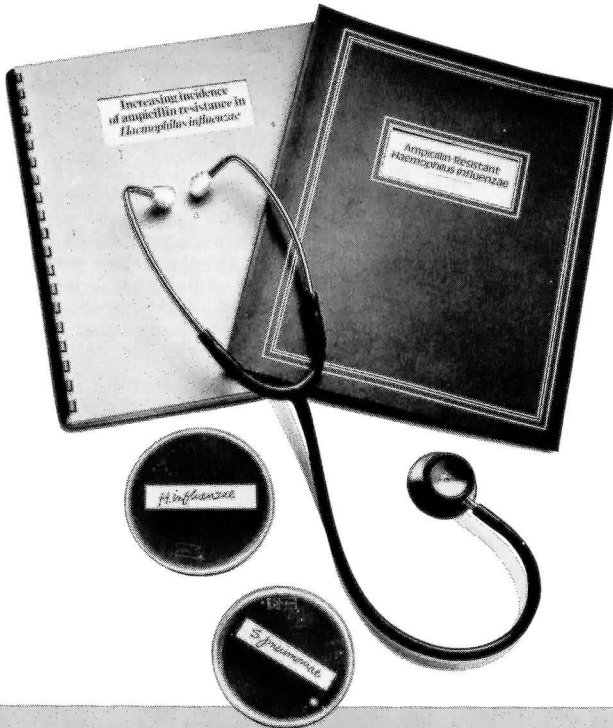
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See adjoining column for
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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor™ (cefadroxil, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.
Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococcus).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY; THEREFORE, THE RISK OF ALLERGIC REACTIONS OF VARYING DEGREE OF CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomonas colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomonas colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomonas colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: **General Precautions**—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing if newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Lilly's solutions and also with Grinflex® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Use in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.16, 0.20, 0.21, and 0.16 mcg/ml at one, two, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Use in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70). Symptoms of pseudomonas colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported in 1 percent of patients.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthralgia/rhealgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematologic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). (061782Z)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice for the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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8. Principles and Practice of Infectious Diseases (edited by G.L. Mandel, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

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