...too valuable to keep in reserve

Macrodantin®

(nitrofurantoin macrocrystals)

Capsules: 25, 50, 100mg

INDICATIONS Macrodantin is indicated for the treatment of urinary tract infections when due to susceptible strains of *Escherichia coli* enterococci *Staphylococcus aureus* (it is not indicated for the treatment of associated renal cortical or perinephric abscesses), and certain susceptible strains of *Klebsiella* species *Enterobacter* species and *Proteus* species

NOTE: Specimens for culture and susceptibility testing should be obtained prior to and during drug administration

CONTRAINDICATIONS Anuria oliguria or significant impairment of renal function (creatinine clearance under 40 ml per minute) are contraindications to therapy with this drug Treatment of this type of patient carries an increased risk of toxicity because of impaired excretion of the drug For the same reason this drug is much less effective under these circumstances

The drug is contraindicated in pregnant patients at term as well as in infants under one month of age because of the possibility of hemolytic anemia due to immature *enzyme* systems (glutathione instability)

The drug is also contraindicated in those patients with known hypersensitivity to Macrodantin. Furadantin® (nitrofurantoin), and other nitrofurantoin preparations

WARNINGS Acute subacute and chronic pulmonary reactions have been observed in patients treated with nitrofurantoin products If these reactions occur the drug should be withdrawn and appropriate measures should be taken

An insidious onset of pulmonary reactions (diffuse interstitial pneumonitis or pulmonary fibrosis or both) in patients on long-term therapy warrants close monitoring of these patients

There have been isolated reports giving pulmonary reactions as a contributing cause of death (See Hypersensitivity reactions)

Cases of hemolytic anemia of the primaquine sensitivity type have been induced by Macrodantin The hemolysis appears to be linked to a glucose-6-phosphate dehydrogenase deficiency in the red blood cells of the affected patients This deficiency is found in 10 percent of Negroes and a small percentage of ethnic groups of Mediterranean and Near-Eastern origin Any sign of hemolysis is an indication to discontinue the drug Hemolysis ceases when the drug is withdrawn

Pseudomonas is the organism most commonly implicated in superinfections in patients treated with Macrodantin

Hepatitis including chronic active hepatitis has been observed rarely Fatalities have been reported The mechanism appears to be of an idiosyncratic hypersensitive type

PRECAUTIONS. Peripheral neuropathy may occur with Macrodantin therapy this may become severe or irreversible Fatalities have been reported Predisposing conditions such as renal impairment (creatinine clearance under 40 ml per minute) anemia diabetes, electrolyte imbalance vitamin B deficiency and debilitating disease may enhance such occurrence

Usage in Pregnancy: The safety of Macrodantin during pregnancy and lactation has not been established Use of this drug in women of childbearing potential requires that the anticipated benefit be weighed against the possible risks

ADVERSE REACTIONS **Gastrointestinal** reactions: Anorexia, nausea and emesis are the most frequent reactions: abdominal pain and diarrhea occur less frequently These dose-related toxicity reactions can be minimized by reduction of dosage especially *in* the female patient Hepatitis occurs rarely

Hypersensitivity reactions: Pulmonary sensitivity reactions may occur which can be acute subacute or chronic

Acute reactions are commonly manifested by fever chills, cough, chest pain dyspnea pulmonary infiltration with consolidation or pleural effusion on x-ray and eosinophilia The acute reactions usually occur within the first week of treatment and are reversible with cessation of therapy Resolution may be dramatic

In subacute reactions fever and eosinophilia are observed less often Recovery is somewhat slower perhaps as long as several months If the symptoms are not recognized as being drug related and nitrofurantoin is not withdrawn symptoms may become more severe

Chronic pulmonary reactions are more likely to occur in patients who have been on continuous nitrofurantoin therapy for six months or longer The insidious onset of malaise dyspnea on exertion cough and altered pulmonary function are common manifestations Roentgenographic and histologic findings of diffuse interstitial pneumonitis or fibrosis or both are also common manifestations Fever is rarely prominent

The severity of these chronic pulmonary reactions and the degree of their resolution appear to be related to the duration of therapy after the first clinical signs appear Pulmonary function may be permanently impaired even after cessation of nitrofurantoin therapy This risk is greater when pulmonary reactions are not recognized early

Dermatologic reactions Maculopapular erythematous or eczematous eruption pruritus urticaria and angioedema

Other hypersensitivity reactions Anaphylaxis asthmatic attack in patients with history of asthma cholestatic jaundice hepatitis including chronic active hepatitis drug fever and arthralgia

Hematologic reactions Hemolytic anemia granulocytopenia leukopenia eosinophilia and megaloblastic anemia Return of the blood picture to normal has followed cessation of therapy

Neurological reactions Peripheral neuropathy headache dizziness nystagmus and drowsiness

Miscellaneous reactions Transient alopecia As with other antimicrobial agents superinfections by resistant organisms may occur With Macrodantin however these are limited to the genitourinary tract because suppression of normal bacterial flora elsewhere in the body does not occur

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Loss of sexual interest among compulsive gamblers

Q ***Is compulsive gambling a displaced sexual interest or sex-substitute?***

A To those of us who work with compulsive gamblers, pathological gambling would seem to be a pure addiction. Most active gamblers with appropriate sexual partners seem to continue normal sexual behavior up to the point at which the addiction takes control of the whole life-style, a point at which sex like other basic social responses is crowded out by the preoccupation and urge to gamble. Gambling is not displaced sexual interest; gambling displaces sex as well as all normal interests such as work, family, health, and spiritual life. The traditional literature on compulsive gambling is meager, heavily Freudian, and unproductive of effective therapy. Psychiatry and the behavioral sciences have much to offer in the treatment of the compulsive gambler, with newer techniques and theories stressing the present situation, the nature of the addictive behavior itself, and corrective techniques. Much emphasis is placed on peer group support in the form of group therapy, therapeutic community, and Gamblers Anonymous. Normal sexual function and the capacity to love are usually fully restored when the addiction is arrested and personal growth in all areas of social living again becomes possible.

JULIAN I. TABER, Ph.D.

Julian I. Taber is Coordinator, Compulsive Gamblers Treatment Program, Cleveland VA Medical Center (Brecksville Division) Ohio.

Androgens and sexual potency

Q ***Will exogenous androgens increase the sexual capability of hypogonadal men? Will they increase the potency of normal (eugonadal) men?***

A Androgen has been used extensively in the treatment of hypogonadal males, but its efficacy in restoring sexual behavior had not been scientifically established until recently. In an appropriately controlled double blind study, it was shown that the administration of exogenous androgen (testosterone enanthate) restored sexual performance. Frequency of erections, including nocturnal erections, and coitus showed significant dose-related responses to androgen treatment which closely followed fluctuations in circulating testosterone levels. This is not to say, however, that all hypogonadal males will respond to androgen treatment. There may be factors such as age or coincident diseases such as diabetes with subsequent neuropathy which may preclude effective androgen treatment for sexual disabilities.

On the other hand, there is no evidence in intact normal men or any other species examined that circulating androgen levels are correlated with sexual capability or performance. Individuals with relatively low androgen levels may be very sexually active while those with comparatively high androgen concentrations may be fairly inactive. One's sexual performance cannot be predicted on the basis of circulating androgen levels within the normal range. There are no data to suggest that the administration of androgen to eugonadal men will increase potency and/or libido. The lack of correlation between androgen levels and sexual behavior in the most extensively studied species, the rat, is due to the fact that the androgen threshold for the maintenance of sexual behavior is well below the levels seen in normal individuals. It is reasonable to assume that this is probably true in men.

ERLA R. SMITH, Ph.D.

Erla R. Smith is Research Associate, Department of Physiology, Stanford University School of Medicine, California.

Lesbian mothers

Q ***Is it common for lesbian women to want to be mothers, or does this orientation usually include nonmaternal leanings?***

A There is no reason to believe that lesbians are any more or any less likely than other women to want to bear and raise children. In actuality, however, lesbians are probably less likely to follow through on their maternal leanings.

Research indicates that many les-

bians are involved in heterosexual relationships prior to adopting a lesbian lifestyle. It is not uncommon for lesbians to have been married and have children. Other lesbians may decide to bear a child outside of marriage, and individual women are now exploring approaches such as artificial insemination.

A major concern for many lesbian mothers concerns losing custody of their children following a divorce. Very little is currently known about the children of lesbian mothers. Preliminary findings from a study being conducted at UCLA comparing children of lesbian mothers and single heterosexual mothers indicate few differences in the psychological development of children in the two groups. Unfortunately, unenlightened and misinformed courts have often viewed lesbianism in and of itself as a sufficient reason for denying a woman custody of her children.

LETITIA ANNE PEPLAU, Ph.D.

Letitia Anne Peplau is Associate Professor of Psychology, University of California, Los Angeles.

Chlamydial infections

Q ***What is the most common symptom of chlamydial infection, and how is it distinguished on clinical presentation from other genital infections?***

A The commonest clinical presentation of chlamydial genital infection is nongonococcal urethritis (NGU); in the U.S. and in Western Europe C. *trachomatis* is responsible for 30-50% of cases of NGU. A man with NGU complains of urethral irritation, dysuria, or urethral discharge, or a combination of these symptoms. On examination, a mucoid or mucopurulent discharge can be seen in most patients; the diagnosis of NGU is made by establishing the presence of urethritis and excluding infection by N. *gonorrhoeae* by microscopy and culture of urethral specimens. Although some large-scale studies have indicated that the discharge of chlamydial NGU is more purulent than that of nonchlamydial NGU, it is impossible to make a firm clinical diagnosis of chlamydial urethritis unless cell-culture facilities are available, which is usually not the case.

A less common but important presentation of chlamydia! infection in men is acute epididymitis. In men under the age of 30, *C. trachomatis* is probably the cause of over 50% of epididymitis.

In women, the overall prevalence of chlamydial infections is uncertain, but they are common in exposed groups such as women attending VD clinics. At least one third of female contacts of men with NGU have cervical infections with C. *trachomatis.* This infection may cause no apparent disease, but most women show evidence of cervicitis. Chlamydial cervicitis cannot be differentiated clinically from cervicitis due to other causes such as N. *gonorrhoeae. C. trachomatis* is also responsible for some cases of infection of Bartholin's glands and of the urethral syndrome (symptoms of bacterial cystitis in a woman with negative urinary cultures), and it is unquestionably an important cause of acute salpingitis. In neonates, infection by chlamydiae derived from the maternal genital tract may cause inclusion blennorrhea, afebrile pneumonia, and other diseases.

Unfortunately, an accurate clinical diagnosis of chlamydial infection is impossible. However, if men with NGU, their sexual contacts, and women with cervicitis of uncertain etiology were all thoroughly treated with a tetracycline (erythromycin in pregnancy), a great amount of infection would be eliminated.

J. D. ORIEL, M.D.

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Psychological vs. physiological causes of menopausal symptoms

Q ***Are menopausal symptoms purely on a hormonal basis, or are life events and emotions also responsible?***

A The only menopausal symptoms which have been established as clearly due to a hormonal basis are hot flashes, night sweats, and the mucosal and skin changes which sometimes lead to some discomfort in intercourse. All the others appear to be unrelated to hormonal changes but are responses to life events, emotions, and particularly the feelings a woman may have about reaching middle age and menopause based on the individual significance of these experiences for her.

Role changes, family events, reactions to changes in husbands and children are important midlife experiences for women. Many of these may not coincide with the actual menopause, although they may be attributed to it.

MALKAH T. NOTMAN, M.D.

Malkah T. Notman is Associate Clinical Professor of Psychiatry, Harvard Medical School, and Obstetrics-Gynecology Liaison Psychiatrist, Beth Israel Hospital, Boston.

Best contraceptive method for adolescents

Q ***Which birth control method is best for unmarried adolescents? Can most girls be counted on to take the pill or to use a diaphragm consistently? Are boys more trustworthy with regard to condoms?***

A There is no one birth control method which is best for unmarried (which I assume also means nulliparous) adolescents. For each patient, the decision must be individualized. The risks and benefits of each method must be weighed, remembering that for adolescents, particularly those under 15 years, pregnancy itself poses a health risk.

Compliance with the prescribed birth-control method in our clinic population of adolescents, with either oral contraceptives, diaphragm, or intrauterine device, was only 45%.[1] Interestingly, however, those patients who had come to the clinic specifically for birth control were compliant in 75% of cases, compared with a low 15% compliance rate among those for whom contraception was the physician's suggestion. Other factors found to be associated with good compliance included frequent intercourse (more than once a week), and making and paying for one's own appointment.

The use of condoms has been studied by Finkel and Finkel.[2] They found that although 28% of high-school stu-