Prelicensure Training

Recently the content and duration of prelicensure training for physicians has been debated extensively in Ontario. One suggestion considered was that all interns, irrespective of specialty programs, should be required to have 1 month of training in family practice to gain awareness of the problems managed by physicians in community practices.

Because of our concern about the availability of family physician supervisors if such a requirement is pursued, we mailed a questionnaire to part-time faculty members in the Department of Family Medicine at McMaster University asking whether they would supervise interns for 1 month of prelicensure training in their practices.

A 99% response rate was obtained (98 of 99). Forty-eight of the part-time faculty were willing to act as supervisors, 46 would not, and four were undecided.

If the results of our survey apply to the part-time family physicians in the other four Ontario departments of family medicine, then there are certainly enough supervisors willing to accept interns for 1-month training positions in their practices. The question now becomes one of desirability, and not feasibility.

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Stuttering

I was pleased to see the article on stuttering by Boberg and Webster in the June 1990 issue of Canadian Family Physician. Boberg and Webster note that the origin of stuttering is probably neurological, ie, medical. Recognition of this origin has been slow in coming, although most people first turn to their family doctor for help in dealing with the problem.

Boberg and Webster and their co-workers have achieved worldwide recognition for their research and treatment of stuttering, a problem that continues to plague a considerable number of children and adults. Present-day treatment is fairly effective if followed by a consistent, disciplined maintenance program to reinforce new patterns of speech learned in the speech clinics. We can hope that researchers will continue their efforts to firmly establish the cause (or causes) of stuttering and to modify and improve treatment.

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Reference


Doing Our Part to Prevent Pollution

Especially in these environmentally conscious times, I am dismayed by physicians’ passivity toward junk mail and unwanted magazines.

Canadian physicians probably discard about 1 000 000 kg of unsolicited mail and journals each year after reading very little from them. They also receive many more calendars, date books, note pads, etc, than can possibly be used.

Whether it is recycled or not, this constant barrage of paper products represents a tremendous consumption of trees and energy that is...
Naprosyn Suspension contains sodium chloride (20 mg/mL). This should be considered in patients whose overall intake of sodium must be restricted. As with other drugs used with the elderly or those with impaired liver function it is prudent to use the lowest effective dose. Severe hepatic reactions including jaundice, and cases of fatal hepatitis have been reported with NSAIDs. The prescriber should be alert to the fact that the anti-inflammatory, analgesic and antipyretic effects of Naprosyn may mask the usual signs of infections. Periodic liver function tests and ophthalmologic studies are recommended for patients on chronic therapy. Caution should be exercised by patients whose activities require alertness if they experience drowsiness, dizziness, vertigo or depression during naproxen therapy. Naprosyn may displace other albumin-bound drugs from their binding sites and may lead to drug interactions or interfere with certain laboratory tests. See Product Monograph for specific examples.

ADVERSE REACTIONS – (1) Denotes incidence of reported reaction between 3% and 9%. (2) Denotes incidence of reported reactions between 1% and 3%. See Product Monograph for reactions occurring in less than 1% of patients. Gastrointestinal: Heartburn (1), constipation (1), abdominal pain (1), nausea (1), diarrhea (2), dyspepsia (2), stomatitis (2), diverticulitis (2). Rectal burning (1) has been reported occasionally with the use of naproxen suppositories. Central Nervous System: Headache (1), dizziness (1), drowsiness (3), lightheadedness (2), vertigo (2), depression (2), and fatigue (2). Skin: Pruritus (1), ecchymoses (1), skin eruptions (1), sweating (2), and purpura (2). Cardiovascular: Dyspnea (1), peripheral edema (1), and palpitations (2). Special senses: Tinnitus (1), and hearing disturbances (2). Others: Thirst (2).

DOSE AND ADMINISTRATION – Adult: Oral: The usual total daily dosage for osteoarthritis, rheumatoid arthritis and ankylosing spondylitis is 500 mg (20 mL, 4 teaspoons) a day in divided doses. It may be increased gradually to 750 or 1000 mg or decreased depending on the patient’s response. Patients with rheumatoid arthritis or osteoarthritis maintained on a dose of 750 mg/day in divided doses can be switched to a once daily dose of Naprosyn SR 750 mg. The single daily dose of Naprosyn SR should not be exceeded and can be administered in the morning or evening. Naprosyn SR tablets should be swallowed whole. Rectal: Naprosyn Suppositories (500 mg) can replace one of the oral doses in patients receiving 1000 mg of Naprosyn daily. Juvenile Rheumatoid Arthritis: The recommended daily dose is approximately 10 mg/kg in two divided doses.

AVAILABILITY – Naprosyn is available as: 125 mg, 250 mg, 375 mg, and 500 mg Tablets, as 750 mg Sustained-Release Tablets and 500 mg Suppositories. Suspension: Each 5 mL contains 125 mg of naproxen. Shake bottle gently before use. Pharmacists are to provide the Naprosyn Patient Information leaflet when dispensing this drug. Product Monograph available to health professionals upon request. References

Naprosyn (naproxen) should not be used concurrently with the related drug Anaprox (naproxen sodium) since they both circulate in plasma as the naproxen anion. GI system: If peptic ulceration is suspected or confirmed, or if gastrointestinal bleeding or perforation occurs Naprosyn should be discontinued, and appropriate treatment instituted. Renal effects: Patients with impaired renal function, extracellular volume depletion, sodium restrictions, heart failure, liver dysfunction, those taking diuretics, and the elderly are at greatest risk of developing overt renal decompensation. Assessment of renal function in these patients before and during therapy is recommended. Naprosyn and its metabolites are eliminated primarily by the kidneys, and therefore, a reduction in daily dosage should be anticipated to avoid the possibility of drug accumulation in patients with significantly impaired renal function. Peripheral edema has been observed, consequently, patients with compromised cardiac function should be kept under observation when taking Naprosyn.

particularly gallbladder because the pulp and paper industry is Canada’s most polluting economic activity. This waste also contributes to higher drug costs for our patients, as most junk mail is financed either directly or indirectly by pharmaceutical companies.

Rather than discarding it all, I suggest that physicians instruct office personnel to “return to sender” unwanted mail and to ask publishers to stop sending unwanted magazines. We can hope that those responsible for this disgrace will soon get our message, as the situation is getting totally out of hand.

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Correction
The News section of the July 1990 issue (Canadian Family Physician 1990;36:1265) contained an error. The paper, “The Ecology of Medical Care” was written by Kerr White, not Carl White, as printed.

Canadian Family Physician apologizes for any embarrassment or inconvenience this error may have caused Dr Kerr White or Dr Carl White.

Correction
The Letters section of the August 1990 issue (Canadian Family Physician 1990;36:1373) contained an error. The sole author of the Letter to the Editor entitled “Sick or Sinner? Comment” was Dr Raymond H. Feiera- bend, Jr.

Canadian Family Physician apologizes for any embarrassment or inconvenience the error may have caused Dr Feierabend.