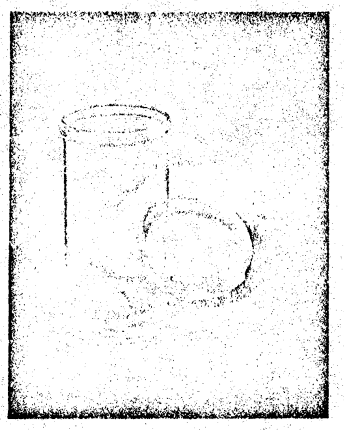
The undermedicated society

one rewards the patient for his complaints of pain. As for narcotics, they should be avoided in patients with chronic pain—except those with malignant disease. In such cases the narcotic ought to be given at fixed



intervals and in sufficient doses to provide a steady level of *adequate* analgesia."

Physicians are often overcautious in treating some childhood disorders, says Dr. Sydney Gellis, chairman of pediatrics at New England Medical Center and author of a widely used pediatric textbook.

"Take salicylates for rheumatoid arthritis," he says. "Doctors are afraid of salicylate toxicity, but treatment may require doses as high as 1 gr/lb of body weight daily to be effective. For assurance, blood levels should be taken, aiming at a serum level between 25 and 30 mg/100 ml.

"Meningitis is another example. Antibiotic doses ought to be calculated according to the child's body weight, but often aren't. Instead, suboptimal doses are given."

Another frequently underused drug in children, says Dr. Gellis, is prednisone (Delta-Dome, Deltasone, Meticorten, Orasone, Sterapred, et al). "The full dose is 2 mg/kg daily, and it should be given for severe asthmatic attacks or severe cases of poison ivy or hives. But we often see family practitioners using doses of 0.25 mg or 0.5 mg/kg for these conditions, and that's not adequate. If the condition is severe enough to justify corticosteroids, they should be given adequately. Otherwise, they shouldn't be given at all.

"Phenobarbital (Eskabarb, Hypnette, Luminal, Solfoton) is underdosed, too. Perhaps an eighth of a grain is used for an infant instead of the more appropriate quarter grain. Rather than quiet the child down, this only makes him more excitable."

Finally, notes Dr. Gellis, there's the much discussed problem of patient noncompliance with antibiotic regimens. "Physicians tend to blame the parents if a child doesn't complete the full 10 days of treatment in strep throat or otitis media, for example. But I suspect it's sometimes the doctor's fault for insufficiently impressing parents with the importance of compliance. He should do so not only verbally, but in written instructions. And he should make a point of telling parents that there's a way to get around the problem if their child refuses to take the oral preparation: They must bring him in for an injection of long-acting antibiotic."

Another physician who finds family practitioners sometimes erring on the side of caution is Harry M. Robinson Jr., chief of dermatology at the University of Maryland Hospital.

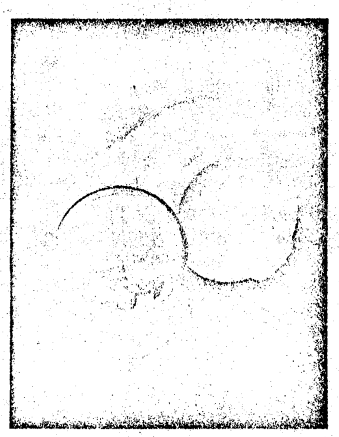
"Many times we've seen cases of one of the reactive erythemas, such as erythema multiforme, in which we've really had to slug the patient with a huge dose of prednisone to overcome the basic problem. Their doctors had been using 10 to 15 mg a day, and we've had to triple or quadruple the dose—in fact, we've used as much as 100 to 150 mg a day.

"The same thing happens with severe cases of bullous pemphigoid, pemphigus foliaceus, pemphigus vulgaris, and systemic lupus erythmatosus. We've had patients come in completely denuded from some of these disorders, because they didn't receive a sufficiently high dosage of prednisone.

"Let's face it," continues Dr. Robinson, "when it comes to cases like these, some of the FDA-approved dosage recommendations are almost homeopathic. You can't send a boy to do a man's work."

Depression

No help at all is what too many physicians give for depression, says psychiatrist Nathan S. Kline. In fact, Dr. Kline went so far as to call depression "the most undertreated of all major diseases" in a 1974 JAMA article (227:1158, 1974). "The percentage of nonpsychiatrists attempting to treat depression is discouragingly small," Dr. Kline wrote, "and frequently



treatment is not done well." An example he cited was underdosing—using less than 25 mg of a tricyclic tid or qid [or less than 5 mg of nortriptyline HCl (Aventyl) tid or qid], or using whatever dose of a tricyclic for