the People's Doctor

A MEDICAL NEWSLETTER FOR CONSUMERS by Robert S. Mendelsohn, MD

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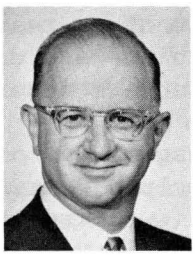

Dr. Robert Mendelsohn

I dearly wish that someday a drug would come onto the market which cured the condition for which it was prescribed and which had no side effects or adverse reactions. But unfortunately, as I learned long ago, when chemicals are put into the human body, there is no free lunch. A medication that acts on one system will usually affect other systems as well, and while one disease condition may be ameliorated by use of a drug, another disease condition may be activated.

The first portion of this month's Newsletter deals with Tagamet (cimetidine), a new medication which is being given to ever-increasing numbers of ulcer patients. And, as with all new drugs, as more and more patients take it, more and more of the side effects are becoming known. What needs to be understood by any patient who is put on a new medication is that that drug was probably given to only a few thousand people before FDA approval was given for widespread use. Thus, anyone who takes a new drug becomes a guinea pig who is unwittingly helping to write the medical literature. Each of you must remember that it is you, the patient, who must weigh the risks of taking a drug against the benefits that may derive from its use. And, until that drug has been on the market for a substantial period of time, no-one can tell just what all those risks are.

In the second part of this Newsletter, I continue with a subject I began last month--interference with the natural process of childbirth. The kind of interference I am talking about in this issue is surgical interference--the burgeoning use of Caesarean sections. I hope that you'll read this information closely and will understand what the implications of one C-section for every four babies are, not just for yourselves, but for your children and grandchildren as well.

Q

Please write about Tagamet. I'm taking this new drug for duodenal ulcer. I had been taking Motrin and Naprosyn for arthritis, and I developed severe stomach cramps while taking them. Could that have caused the ulcer?--Worried

A

Ulcers and Tagamet

I want to give you the exact words used in the prescribing information for Upjohn's Motrin: "The most frequent type adverse reaction occuring with Motrin (ibuprofen) is gastrointestinal. In premarketing studies, the percent of patients reporting one or more gastrointestinal complaints ranged from 4 to 15.9 percent. Specific complaints reported include abdominal distress; cramps or pain; indigestion, epigastric pain and heartburn; bloating, flatulence and fullness of the G.I. tract; nausea and vomiting; constipation and diarrhea. A few cases of ulceration, including some complicated by bleeding and perforation, have occurred."

Next, let me give you the words of an article in the March 21, 1977 issue of the Journal of the American Medical Association about Syntex's Naprosyn: "The most frequent gastrointestinal effects are dyspepsia, heartburn, epigastric or abdominal pain, nausea, vomiting, and constipation. . . . However, during premarketing clinical trials, gastrointestinal bleeding, which was sometimes severe, and ulceration occurred in a few patients. . ."

Now, let me give you the verbatim information on Naprosyn taken from an ad in a recent medical journal: "Adverse reactions related to the gastrointestinal tract were reported in approximately 1 in 7 patients . . . Among 737 patients treated with Naprosyn during the course of clinical trials in the United States (256 treated for more than two years), 15 cases of peptic ulceration were reported. . . . Although most of the patients with serious bleeding were receiving concomitant therapy and had a history of peptic ulcer disease, it should be kept in mind that Naprosyn also has the potential for causing gastrointestinal bleeding on its own. In foreign marketing experience, there have been a number of fatalities due to gastrointestinal bleeding in patients who were receiving Naprosyn."

I have a hunch that you and all the rest of my readers can easily understand the above words, even though physicians and drug companies claim that the information contained in the package insert is too complicated for the patient.

The prescribing information on SK&F's Tagamet is not much more difficult to understand: The side effects include diarrhea, muscular pains, dizziness, rash and mild gynecomastia (swelling of the male breast). In addition, even though this drug is new, a variety of abnormal findings on blood tests already have been identified. Furthermore, the prescribing information states that lack of experience to date precludes recommending this drug for pregnant women, nursing mothers, women of childbearing potential and children under age 16. If you do decide to use this new drug for the treatment of the ulcers that may have been caused by your previous medication, then I hope you will start it quickly, since one of the aphorisms of modern medicine is to always use a new drug right away before its potential dangers are known. Otherwise, I expect to receive a future letter from you asking me to write about another new drug that was prescribed for you to counter the effects of the last new drug that was prescribed for you to counter . . .

Last November, I was put on Tagamet to relieve an esophageal ulcer. Because this drug almost completely relieved my pain, I followed no diet at all.

In February, I began to experience some peculiar sensations--fast pulse, feelings of being all alone on the edge of a cliff, all my nerves seeming to be racing even though I was lying still or sitting still.

Eventually this condition became so bad that my fellow employees had to rush me to a hospital when I could no longer control my limbs and my head was bobbing from side to side. At the hospital, an EKG proved negative, my pulse was 115 and my blood pressure 150/90. I was given an injection of Valium and allowed to rest for 45 minutes before I was released.

The next day, I went to see my personal physician who informed me that I was experiencing the side effects of Tagamet. Could this be true?--M.P.

Tagamet and mental confusion

The brief list of adverse reactions contained in Tagamet's (cimetidine) prescribing literature do not include the condition you mention. However, the same week that you wrote your letter (February 23, 1979), an article appeared in the Journal of the American Medical Association which associated this new drug with mental confusion in two critically ill patients who had been treated with cimetidine after open heart surgery. The article concluded that "cimetidine may induce stupor in critically ill patients." Previously, the July 21, 1978 issue of JAMA reported cases of mental confusion among older people treated with cimetidine. In this report, Dr. Shashi K. Agarwal drew attention to visual hallucinations which he linked to the possibly adverse effects of cimetidine therapy.

Your report again serves to show that, in the absence of long-term observations of patients who are taking new drugs, each patient every day is helping to write medical history.

I recently had a Caesarean section delivery which I'm not sure was really necessary. Is a repeat C-section absolutely essential? What kind of anesthetic do you feel is the least dangerous? What medication, if any, is essential to a sectioned mother's delivery and recovery (e.g., antibiotic to avoid infection)? Do you feel there is any danger in waiting until labor begins before a C-section is performed?--Mrs.H.G.

Once a Caesarean, always a Caesarean?

In olden times (the 1960's), when only one baby out of 20 was delivered by Caesarean section, your question would have been of only limited interest. But now, in the "enlightened" 1970's, when in many places one in four American babies evades the vaginal route, your questions take on widespread significance.

The conventional education of medical students has perpetuated the slogan, "Once a C-section, always a C-section." However, it ain't necessarily so. As far back as 1963, Drs. R. Gordon Douglas, Stanley J. Birnbaum and Frances A. MacDonald, from the Department of Obstetrics and Gynecology at Cornell Medical College (Cornell, according to Time Magazine, March 27, 1978, now has a 22 percent C-section rate), wrote the following in the American Journal of Obstetrics and Gynecology: "Our policy of allowing post-Caesarean section patients to be delivered vaginally has not contributed to maternal mortality. On the contrary, it tends to keep it at a lower rate by eliminating the hazards of abdominal surgery." These doctors' statistics indicated that more than one-half of post-Caesarean patients can be delivered vaginally, and their conclusion was, "The dictum, 'Once a Caesarean, always a Caesarean' does not apply to current obstetric practices."

Since then, this view and other reservations about Caesarean sections has been echoed by others in the field. Thus, in 1977, Drs. John R. Evrard and Edwin M. Gold compared maternal death rates and found "a risk factor 26 times greater for Caesarean section than for vaginal deliveries." On the nine deaths in the C-section group studied by these researchers, the procedure itself was found to be responsible for the deaths of four of the nine.

Some doctors will defend "routine, prophylactic" antibiotics. Since you asked my opinion, I put myself on the side of (among others) Dr. William J. Ledger of the University of Southern California Medical Center in Los Angeles, who rejects the use of routine prophylactic antibiotics in Caesarean sections, and who says this practice is specifically contraindicated in all obstetrical-gynecological surgery.

Far from being dangerous to wait for labor to begin spontaneously, I concur with those physicians who prefer to wait for labor to begin spontaneously before performing a C-section, in order to reduce the hazards of atelectasis (an airless state of the lungs) and hyaline membrane disease (an often fatal lung condition) in small infants.

Finally, as the Time article stated, "Doctors often use only local anesthesia (in Caesareans), letting the mother see the newborn baby almost immediately." Thus, any doctor using general or spinal anesthesia in childbirth must be ready to defend this practice.

As long as we're on the subject, I might add another danger that you did not mention--multiple vaginal examinations by obstetricians, residents, medical students and nursing personnel during labor. This is one of the major causes of infection during childbirth--Caesarean delivery or otherwise.

As mounting technologic intervention threatens to change pregnancy from a natural process into a nine-month disease that can only be "cured" surgically, it is vital for each pregnant woman to add one more question to her list as she interviews prospective obstetricians--namely, "What is your Caesarean-section rate?"

Since my child was born by Caesarean section in January of this year, I was very interested in your recent advice on C-sections. Here in the Atlanta area, the doctors we have contacted tell us, "Once a C-section, always a C-section."

I was told that my section resulted from my baby's being in the breech position. After planning a Lamaze delivery, I was very disappointed when my doctor would not even attempt to deliver my baby in a normal way. Any help you can give me would be appreciated--Georgia Reader

Natural delivery after C-section?

Dr. Berkely S. Merrill and C. E. Gibbs of the Robert B. Green Hospital in San Antonio, Texas, reported in a recent issue of Obstetrics and Gynecology that one-half of 526 women who had given birth to their first child by Caesarean section safely delivered their next child vaginally.

You might wish to contact these gentlemen for a referral to a similar-thinking physician in the Atlanta area. For the names of physicians around the country who are expert in delivering post-Caesarean babies vaginally as well as delivering breech babies vaginally, I recommend you contact either David Stewart, Ph.D., president of the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC) P.O.Box 267, Marble Hill, Missouri 63764, or Gregory White, M.D., president of the American College of Home Obstetrics, 2821 Rose St., Franklin Park, Illinois 60131.

Doctor-induced hyaline membrane disease

A recent study conducted by a team of physicians at the neonatal intensive care unit of the Milton S. Hershey Medical Center in Hershey, Pennsylvania, has shown that doctor-induced hyaline membrane disease (a serious lung condition of babies) could be reduced at least 15 percent if obstetricians scheduled Caesarean sections and other kinds of induced delivery more carefully.

The report states that at least 6,000 of the estimated 40,000 cases of hyaline membrane disease which occur annually in the United States

could be prevented if doctors did not induce delivery until they were sure the fetus was mature enough to leave the womb. The study concludes that "a reassessment of current practices with regard to the artificial termination of pregnancy seems appropriate."

I consider that quite an understatement!

Q

TO THE EDITOR, SAN FRANCISCO CHRONICLE: Having just read Dr. Robert Mendelsohn's column in my morning paper, I certainly would appreciate your giving me some information about this doctor.

First of all, you are printing a medical column read by thousands in which this doctor advocates the "safe and effective support of close relatives" in lieu of pain-killing anesthesia for women in childbirth. In other words, right back to the Old Testament's prophecy of pain and suffering for women.

I would like to know this man's religion. And what about his political persuasion? Is he a "right-to-lifer"? Is it his belief that the infant's birth is more important than the mother's health or even her life? Does he believe that a pregnancy should never be terminated, even if the birth were to result in the woman's death?

Just what does he base his views on? Is it a male emotional viewpoint rather than a view based on the "continuing accumulation of scientific evidence and the accumulated experience of mothers"? As for the latter, we have thousands of years of experience to tell us that childbirth is indeed a painful experience.

The Chronicle has a wide readership. I don't believe that political viewpoints should be introduced in a medical column. I have four children, three of whom are daughters, and I think we women deserve better medical advice than we are getting from Dr. Mendelsohn.--G.T.

A

William German, managing editor of the San Francisco Chronicle, sent the above letter to me.

A doctor's ethics

I believe this reader made an extremely important point, i.e., that every doctor treats patients according to his own standards of values. These values are derived from his own historical background, including cultural, religious and familial influences, as well as from the action of contemporary social forces. Thus, being an observant Jew influences my attitudes on abortion. A practicing Catholic who is a physician has attitudes on contraception that would almost certainly be at variance with those of physicians who call themselves "humanists." Physicians who espouse "situational ethics" have views on euthanasia that often conflict with traditional systems of ethics. And physicians who claim to make NO value judgments are ipso facto making the biggest value judgment of all. Thus, while some might consider the questions raised as impertinent, I regard them as appropriate, not only for a reader to ask me, but for all patients to consider in their selection of a physician.

Since a physician's ethical values affect his advice and case management, patients must be aware of the congruence, or lack thereof, between their own principles and those of their doctors. Furthermore, it is just as important for the doctor to be fully conscious of the sources of his own value judgments so that he can identify those areas in which his behavior may be in conflict with his patient's belief system. Sir Thomas More may have been A Man for All Seasons, but no physician is A Doctor for All Patients.

Potpourri

Breast cancer

A biologist from the Massachusetts Institute of Technology, Maurice S. Fox, Ph.D., has published (Journal of American Medical Association, February 2, 1979) a landmark article on the diagnosis and treatment of breast cancer which deserves the widest publicity. On the basis of careful studies carried out at the Harvard School of Public Health, Dr. Fox reaches the following conclusions:

1) Radical mastectomy offers no greater benefit than simple mastectomy followed by x-ray therapy.

2) The incidence of diagnosed breast cancer showed an 18 per cent increase between 1935 and 1965, and a 50 per cent increase between 1965 and 1975. Yet the mortality rate in breast cancer has remained unchanged for at least the past 40 years.

3) There appear to be two almost equally divided basic classes of women with breast cancer; about 40 per cent die regardless of the treatment, and the other 60 per cent show mortality rates little different from that of women without cancer.

4) Some cancers appear malignant under the microscope but, as far as the patient is concerned, behave in a relatively benign fashion.

5) Although nearly all patients with breast cancer are treated one way or another, those who die rapidly show a mortality rate similar to untreated patients in the nineteenth century.

6) Careful studies of groups of women screened for breast cancer vs. similar groups who went unscreened show that the reduction in breast cancer mortality in the first group is not substantially different from the reduction in general mortality exhibited by that group. Furthermore, the group that refused to be screened experienced both a lower incidence of breast cancer and a substantially lower mortality from breast cancer.

7) The striking acceleration of the incidence of diagnosed breast cancer, beginning around 1965, presumably reflects the increasing detection of early disease. Nevertheless, there is no evidence of benefit of this early detection in terms of breast cancer mortality, even 10 years later.

8) "It remains possible that much of the occult or early disease detected by screening would never manifest itself as malignant disease in a normal lifetime," says Dr. Fox. He continues, "My interpretation of the existing evidence raises questions regarding the wisdom of routine periodic surveys of asymptomatic women."

Dr. Fox expressed his puzzlement as to why so many physicians continue to select the more radical forms of intervention. I must confess to being similarly puzzled during the last two decades, often having thought that the reason women's breasts are removed so frequently lies in their easy accessibility to the surgeon's knife (similar to tonsils) and to the comparative simplicity of this surgery as compared to other operations.

On the basis of this biologist's work (which deserves to be reprinted in newspapers throughout the country), all women visiting doctors either for screening or treatment of breast cancer should be sure that their physicians can answer the questions Dr. Fox has raised.

"Dark disease"

Gloomy headlines have informed us that many babies in Naples, Italy, are dying from a mysterious condition called "the dark disease." Soldiers and military equipment have been ordered into the city to disinfect streets, schools, and public buildings. Doctors from all over the world have been flown into Italy to try to determine the cause and treatment of this condition. Some of these experts have implicated a certain germ labelled "respiratory syncytial virus" as the cause, and, although this

virus has been found all over the world (including the United States), these scientists have blamed slum living conditions, apparently peculiar to Naples, for the current epidemic. Naturally, scientists are working hard to produce a vaccine which will fight this mysterious virus.

However, in the dozens of newspaper reports I have read, not one physician or scientist has referred to the well-established evidence that RS virus, which hits practically only infants, has something to do with the way babies are fed. The British Medical Journal of July 31, 1976, contained an article from the Department of Child Health and Virology, University of Newcastle upon Tyne entitled "Breastfeeding Protects against Respiratory Syncytial Virus Infections."

This article reports that only eight of 115 infants with RSV infection hospitalized during an epidemic in Great Britain had been breastfed, and none of these eight children still were being breastfed at the time of the RSV illness. An examination of 21 specimens of human colostrum (early breast milk) showed that all contained RSV-neutralizing activity. Of course, this is just one example of the well-documented evidence that human milk protects babies from a large variety of infectious diseases, regardless of the parents' social class.

I hope the following questions will soon be answered:

1) What is the incidence of breastfeeding in the poverty-stricken area of Naples?

2) What is the illness and mortality rate of breastfed babies compared to bottlefed babies? (interestingly enough, it was a Naples social worker, Amalia Cocozza, not a physician, who noticed that most of the sick and dying babies were bottlefed.)

Since there is no particular reason to believe that Naples is much different from large cities throughout the world, the answers to these questions should lead to an immediate effort to promote breast-feeding. This simple, effective measure should make unnecessary the presence of troops, the airlifting of physician-experts, and the search for vaccines. It also should remove the Dark Disease from the list of "mysterious" conditions.

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Your questions about the medical problems that trouble you most will be answered by Dr. Mendelsohn. Please send your questions to: The People's Doctor, 664 N. Michigan Ave., Suite 720, Chicago, Ill. 60611.

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Another View

by Marian Tompson
President, La Leche League International

Two letters about Caesarean deliveries recently crossed my desk, and I was startled by what they implied. The first was brief and indignant: The letter writer wanted to know why I referred to such deliveries as C-sections instead of C-births. "You're giving the impression," she scolded, "that the only kind of natural birth is a vaginal delivery."

The second letter was from my friend Jan. She recently had returned to the nursing profession after a hiatus while her children were growing up. Upon being assigned to the maternity floor, Jan discovered she was the only nurse on the floor who had not had her babies by Caesarean section. "A Caesarean is considered a perfectly natural way to have a baby around here," she wrote in some amazement.

My immediate reaction was to wonder how anyone could consider an operation a natural procedure. But, on reflection, I realized that we've been doing this kind of thing for a long time--putting acceptable labels on procedures which might otherwise not be so acceptable. How else could we justify the wholesale feeding of cow's milk to human babies or the insensitive handling of human births? For years we accepted these as the natural, or at least normal, way of doing things.

The other evening, at my father-in-law's 85th birthday party, Dad Tompson began reminiscing about the home births of my husband and his two brothers. Dad told how Doc Rublee, who had attended the births, opposed the birth of babies in hospitals. Doc said that the trouble with hospitals was that a baby was taken away from its mother and put into a nursery. If it got hungry, a nurse fed it a bottle, and if it needed a diaper change, another nurse probably took care of that. Under those circumstances, Doc said, how was a baby to know its real mother?

Today we know that damage to mothers and babies goes beyond the initial anxiety of separation, but listening to my father-in-law renewed my appreciation of that native wisdom we seem to have lost touch with. Or maybe it's just that we've been educated out of believing in it. That would explain the problem we created for ourselves when be began looking to experts for advice on child care, even when the advice they gave us conflicted with our children's obvious needs. We let experts separate us from our babies at birth, and then once we were home, we obeyed their admonition never to take our babies into bed with us. As an adult, I've always slept more comfortably with my husband at my side and yet, in some strange way, I expected that my children were more independent and were capable of being in a room off by themselves. This same kind of non-thinking (or is it non-feeling?) enabled hospitals for so many years to get away with restricted visiting hours in the pediatric wards while we parents dutifully left the room whenever something medical was going to be done.

I've wandered somewhat from where I began, but I want to make the point that natural means true to our nature, and we have to get back to appreciating what that really means. For the sake of the babies and parents involved, I wish that a C-birth had the same kind of physiological and psychological outcome as a natural delivery. But it doesn't, and changing the label won't make it so.