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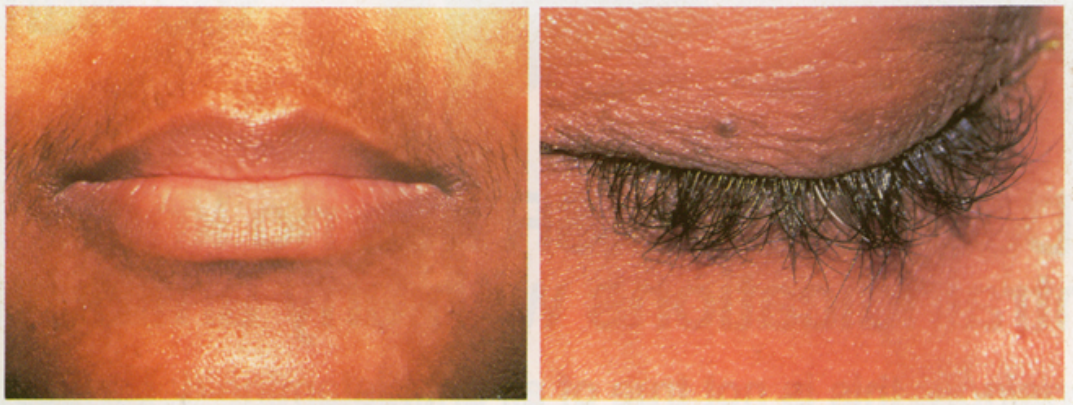

See Special Selection, page 747.

TRACKING THE CHANGES IN PHYSICIAN PRACTICE SETTINGS

COMBINED METHOTREXATE AND MISOPROSTOL FOR EARLY INDUCED ABORTION

CLINICAL REVIEW: SOMATIZATION

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American Medical Association
Physicians dedicated to the health of America

included in a multivariate model, nonatopic children who had not been breast-fed had three times the odds of wheezing recurrently (odds ratio, 3.03; confidence interval, 1.06 to 8.69). Eleven percent of recurrent wheeze among nonatopic children could be attributed to not breast-feeding.

Conclusions: Recurrent wheeze at age 6 years is less common among nonatopic children who were breast-fed as infants. This effect is independent of whether the child wheezed with a lower respiratory tract illness in the first 6 months of life.

(1995;149:758-763) Anne L. Wright, PhD, et al, Department of Pediatrics, University Medical Center, Tucson, AZ 85724.

Breast-feeding in a Low-Income Population: Program to Increase Incidence and Duration

Objective: To evaluate the efficacy of an intervention program to increase breast-feeding in a low-income, inner-city population.

Design: A randomized, nonblinded clinical control trial. Patients were followed up through pregnancy, delivery, and the first year of the infant's life or until the time of weaning from the breast, whichever came first.

Setting: The ambulatory care center for prenatal and pediatric care and the inpatient maternity unit of a primary care center that serves a low-income, inner-city population.

Patients: There were a total of 108 patients: 51 were randomized to the intervention group that received prenatal and postnatal lactation instruction from a lactation consultant, and 57 were randomized to the control group that received the standard of care at the institution. Patients in the control group were not seen by the lactation consultant. The two groups were similar demographically.

Intervention: This program consisted of individual prenatal lactation consultation, daily rounds by the lactation consultant on the postpartum unit, and outpatient follow-up at 48 hours after discharge, at the time that the infant was 1 week of age, and at all future health supervision visits for infants up to 1 year of age.

Main Outcome Measures: The incidence and duration of breast-feeding.

Results: There was a markedly higher incidence of breast-feeding in the intervention group, as compared with that of the control group (61% vs 32%, respectively; $P=.002$). The duration of breast-feeding was also significantly longer in the intervention group ($P=.005$).

Conclusions: This lactation program increased the incidence and duration of breast-feeding in our low-income cohort. We suggest that similar efforts that are applied to analogous populations may increase the incidence and duration of breast-feeding in low-income populations in the United States.

(1995;149:798-803) Nancy B. Brent, MD, IBCLC, et al, The Mercy Hospital of Pittsburgh, Department of Pediatrics, Mercy Children's Medical Center, 1400 Locust St, Pittsburgh, PA 15219.

Clinical Pearl

For tinea pedis, use over-the-counter miconazole, followed by prescription antifungals only if miconazole does not work (this is less expensive overall than starting with the prescription). (*JAMA*. 1994;272:1922-1925).

DIAGNOSIS: Acantholytic acanthoma.

DISCUSSION

The solitary acantholytic acanthoma is a benign cutaneous tumor probably seen much more commonly than is reported. First described by Brownstein[1] in 1985, his review of 31 cases in 1988[2] highlight certain clinical features. The lesion is most commonly a solitary, usually hyperkeratotic papule with occasional crusting. Most often asymptomatic, pruritus was present in several of his cases. There is a truncal predilection, and the palms, soles, face, and mucous membranes are usually spared. Most patients are over 50 years of age; men are more commonly affected (ratio, 2:1). The most frequent clinical diagnosis is seborrheic keratosis or actinic keratosis, although lesions can resemble basal cell carcinomas. The central umbilication seen in this case has not been previously noted, and the clinical similarity to a lesion of molluscum contagiosum is evident.

Histologically, prominent acantholysis is the characteristic feature. It most commonly involves all the layers of the epidermis, but some cases may show acantholysis confined to the granular layer or suprabasilar region. Hyperkeratosis, papillomatosis, and acanthosis are variably present. Mild dyskeratosis with occasional grains in the granular layer can be seen. Prominent dyskeratosis is not a feature, and, if present, would favor the diagnosis of a warty dyskeratoma or papular acantholytic dyskeratosis of the genitalia.[3-5] A mild perivascular lymphohistologic infiltrate with occasional eosinophils is often present in the superficial papillary dermis. Prominent acantholysis can be a feature of Grover's disease, the pemphigus group, and Hailey-Hailey disease, but these are easily differentiated clinically from the solitary, usually hyperkeratotic acantholytic acanthoma.

The opinions contained herein are the private views of the authors and are not to be construed as official or as reflecting the views of the Department of the Navy or the Department of Defense.

Selected from Arch Dermatol. *1995;131:211-216. Off-Center Fold.*

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Safe Discontinuation of Antihypertensive Therapy

The clinical review article by Kirk and Johnson[1] in the March issue of the ARCHIVES is excellent, educational, and timely and emphasizes the dangers of antihypertensive withdrawal syndrome (AWS). I read it with great interest and concur strongly that such review teaches family practitioners how to prevent and manage AWS. Their article contained a table listing antihypertensive therapies that cause AWS. To this list should be added minoxidil,[2] topical minoxidil,[3] hydralazine,[4] and guanethidine. In a report from Mexico, a patient was described who suffered a hypertensive crisis following withdrawal of topical minoxidil.[3] Abrupt discontinuation of therapy with direct vasodilators, minoxidil, or the ganglionic blocker guanethidine also results in AWS.[5] Antihypertensive withdrawal syndrome has been reported in a patient with renovascular hypertension treated with hydralazine.[4] Finally, the angiotensin-converting enzyme inhibitor lisinopril has been implicated as the cause of AWS in the literature.[6] Because the use of angiotensin-converting enzyme inhibitors is widespread with expanding indications, many patients could be at risk of such rebound hypertension (AWS). Therefore, these agents should be tapered off slowly, too.

This brief communication is intended to complement their review, which I believe is an extremely educational and timely article.

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1. Kirk JK, Johnson SH. Safe discontinuation of antihypertensive therapy. *Arch Fam Med.* 1995;4:266-270.
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In reply

We agree with Dr Ahmad's additions to the table of the other potential antihypertensive agents that can cause AWS and thank him for his comments. However, there is reference to one case of AWS occurring with the angiotensin-converting enzyme inhibitor, lisinopril. This class of agents has not been abundantly reported to be associated with a withdrawal syndrome. Although the single case cited is convincing, this is not enough evidence to associate angiotensin-converting enzyme inhibitors as agents that routinely cause AWS. The addition of one case report of AWS with lisinopril is noted, and the recommendation to slowly taper off administration of this class of antihypertensives is most likely not an inappropriate suggestion, especially in patients with a history of angina or coronary heart disease. As pointed out in the case cited, enalapril maleate is available in an intravenously administered formulation that could be used if necessary in specific situations.

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Clinical Pearl

Estrogen use in elderly women is associated with better verbal memory. (*Obstet Gynecol.* 1994;83:979-982).

more than 90% of the subjects found the procedure and its associated bleeding and side effects acceptable, and they would prefer it to a surgical procedure in the future. The results of the questionnaire may be skewed because of the lack of randomization and likely selection bias of subjects who participated and may have had negative experiences or feelings about surgical abortion.

The procedure appears suitable for primary care practitioners relying on clinical criteria for pregnancy dating, access to laboratory facilities, and surgical backup from a gynecologist. Vaginal ultrasound was not used uniformly owing to the additional expense and its general unavailability to many practitioners. In the future, however, ultrasound may become readily available to primary care practitioners. To avoid the inconvenience and cost of an additional office visit, home administration of a compounded misoprostol vaginal suppository was successfully used with acceptable side effects. The suppositories are not generally available, making this aspect of the protocol difficult to implement. In the protocol of Creinin and Vittinghoff,[14] physician placement of misoprostol tablets in the vagina was used. (See **Table 5** for a summary of various protocols for medically induced abortions.)

Further studies are needed to simplify this procedure. We are currently evaluating the substitution of misoprostol vaginal tablets with an applicator for the misoprostol vaginal suppository, and whether one visit at 2 weeks and a home pregnancy test at 4 weeks are sufficient to document a complete abortion in uncomplicated cases. Additional research questions include (1) How will mifepristone compare with methotrexate or the combination of mifepristone and methotrexate for later 8- and 9-week gestations when the medications are less effective? (2) What is the upper limit of gestational age at which methotrexate and misoprostol treatment provides acceptable success and complication rates? and (3) Are other intravaginal prostaglandin preparations that are already on the market as effective as misoprostol?

We conclude that treatment with methotrexate and misoprostol is effective at inducing early abortion. The medications are well tolerated with acceptable side effects. Methotrexate has the additional advantage of treating early ectopic pregnancy. Most women can be evaluated clinically and followed up with β-hCG determinations without ultrasound. Because of its low cost, availability, and ease of use, methotrexate and misoprostol have the potential to increase access for women seeking an early abortion in the United States.

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Clinical Pearl

Traveler's diarrhea: a single 500-mg dose of ciprofloxacin hydrochloride (Cipro) works well. (*Lancet.* 1994;344:1527-1529.)