literature." The report by Chodak and Passaro (239:225, 1978) is a case in point (Gastroenterology 12:879-883, 1949), although the error is not important.

The point is that an author can never tell how many cases of any entity have previously been reported: no amount of library research will permit more than a rough guess. If the point he is making has to do with an intangible, such as an approach to therapy, there is no way even to look it up for precedence.

If an author is to do the minimum to locate previously published cases of, for example, a specific pathological entity (to make it easy), he must do the following:

1. Assemble all of the terms possibly used in the present and in the past to name the entity (and he will miss some because of nomenclature errors of the past, forgotten classifications, and other problems).

2. Then, using these terms, he must consult in detail the following sources: (a) Index Catalogue of the Library of the Surgeon General's Office, volume by volume, from inception in the mid-19th century to cessation of publication in the mid-20th century; (b) the Index Medicus, volume by volume, from its start to finish; (c) the Cumulative Index, volume by volume, from its start to the present; and (d) the great classical sources that so often contain references missed by the other sources. Henke and Lubarsch's Handbuch (1924 edition) is the most important of the latter, although in this country too few libraries have all one hundred or so volumes.

3. Every paper on the subject located by these sources along with its bibliography must be scrutinized; errors must be recognized; and cases must be accepted only after critical evaluation. Many previously published compilations will be found in error, sometimes because cases have been accepted from the titles of papers alone, especially papers written in difficult languages, and sometimes because previous compilers have freely accepted the compilations of even earlier compilers.

After this study the author must understand that he will have missed all the cases that have been published in the following sources: (1) all of the textbooks and monographs that have appeared since the beginning of medical writing, especially the cases reported in the thousands of paperback monographs published throughout central Europe during the end of the 19th century up to World War II; (2) all of the governmental reports (towns, districts, counties, states) from all countries (sometimes these include in a simple listing some cases of the entity the author is seeking, and sometimes they relate good case details); (3) all of the literally millions of published doctoral theses which often can be found only in the library of the parent university, the only place where they are indexed (the most valuable doctoral theses are found in South America, Scandinavia, and, of course, throughout Europe); (4) the many case reports that appear in the letters-to-the-editor section of many journals since the journals began; and (5) others, including all those that have been missed by the indexers.

Of course, the author also must understand that, as important as the entity seems to him, others who have dealt with similar cases only rarely have bothered to write them up.

We should mention that in JAMA, letters to the editor are indexed. —Ed.

No Opium for Pain
To the Editor.—This letter is an update of my COMMENTARY "Medical Preparedness—A Must!" (228:1171, 1975) and my editorial "No Opium for Pain—A Threatening Medical Crisis" (N Engl J Med 291:1411, 1974), both of which detail the fact that the painkiller medicinal opium stockpile in the United States is woefully inadequate for use in the event of a grave national emergency. Recent events indicate that this stockpile will soon be much more depleted. It is important to preface this worrisome prediction with several facts. First, there is no synthetic medicine that combines the potent pain-relieving and tranquilizing effect of morphine, the medicinal drug extracted from the opium poppy flower. Second, there is no synthetic medicine that combines the painkilling, cough-relieving, and sedative effect of codeine, also extracted from the opium poppy flower. Third, the pharmaceutical industry and academic sources are not optimistic about their ability, within the foreseeable future, to replace these medicinal opiate drugs. Meperidine hydrochloride, which is possibly the most widely used synthetic drug in the United States for the relief of severe pain, falls short in that it does not relieve the anxieties so frequently present with pain.

It is estimated that our present medicinal opium stockpile is less than 20,000 kg, not barely enough to meet the normal demands of the civilian population in a nonepidemic environment. Factually, on the other hand, the US requirement of medicinal opium for the year 1978 is estimated to be at least 51,750 kg, and this will continue to soar upward yearly with improved medical care and population increases. Furthermore, all this medicinal opium must be imported.

Despite the obvious need for an adequate inventory of medicinal opium in our strategic materials stockpile, the federal government banned on June 2, 1977, the commercial growth in our country of the poppy plant known as the "great scarlet poppy" or Papaver bracteatum. This poppy is unique in that codeine, the most widely used of medicinal opium drugs, can be easily extracted from it, while it is almost impossible to extract the highly addictive drug heroin from the great scarlet poppy. This ban destroyed the hope of ever making our nation independent of outside sources. Now this already sadly depleted inventory of medicinal opium is being further threatened. The Carter administration announced on Oct 7, 1977, that it will start legislation to ask congressional permission to sell more medicinal opium from the strategic stockpile in the current fiscal year ending next Sept 30.

For all these reasons, the specter of no opium for pain in the United States is indeed well founded. A critical shortage of medicinal opium drugs in this country could easily cause a medical catastrophe. In the event of a grave national emergency, physicians would be as useful as a fleet of new ambulances with no gasoline in their tanks. This grim observation is indisputable!

Leonard B. Greenhale, MD
Columbus, Ohio

Abuse of Pentazocine and Tripelennamine
To the Editor.—Pentazocine abuse is commonly believed to be largely confined to the medical community and to patients iatrogenically addicted. We would like to call attention to the widespread and increasing abuse of pentazocine among "street" addicts. In this situation the user most often crushes pentazocine tablets and combines this with crushed tripelennamine (Pyribenzamine). The mixture is then dissolved in water.

Continued on p 1612.
Polymyalgia Rheumatica in Blacks

To the Editor.—Polymyalgia rheumatica (PMR) has been reported to have a predilection for whites. It was also stated, "There are no known occurrences in blacks, Orientals or American Indians." Two reports have since appeared describing the condition in a black woman and in an American Indian. More recently, Sanford and Berney described five cases of PMR appearing in blacks. The occurrence of PMR and biopsy-proven temporal arteritis in blacks is even less common. To our knowledge, six cases have been reported in the literature.

Over a six-year period in a large urban hospital where a large proportion of the patients are blacks, we have treated three black patients with PMR associated with temporal arteritis. The clinical and laboratory features (Table), including the response to corticosteroid therapy, are similar to those reported in white subjects. We concur with others that this disorder can occur in nonwhites but is less prevalent in these racial groups.

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Clinical and Laboratory Features of Black Patients With Polymyalgia Rheumatica

<table>
<thead>
<tr>
<th>Patient/Age, yr/SEX</th>
<th>1/71/M</th>
<th>2/71/F</th>
<th>3/71/F</th>
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<tbody>
<tr>
<td>Fever</td>
<td>No</td>
<td>No</td>
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</tr>
<tr>
<td>Symptoms of temporal arteritis</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Visual symptoms</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Jaw pain</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Weight loss, malaise</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Synovitis</td>
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<td>Yes</td>
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</tr>
<tr>
<td>Anemia</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Sedimentation rate (Wintrobe)</td>
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<td>51</td>
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<tr>
<td>Antinuclear antibodies</td>
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<tr>
<td>Rheumatoid factor</td>
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<td>No</td>
</tr>
<tr>
<td>Temporal artery biopsy specimen</td>
<td>Arteritis; no giant cells</td>
<td>Arteritis; no giant cells</td>
<td>Giant cell arthritis</td>
</tr>
<tr>
<td>Response to prednisone therapy</td>
<td>Good</td>
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</table>

Dying at Home

To the Editor.—I wish to add several points to the article "Dying at Home" (228:2405, 1977).

First, the physician is indispensable as a guide in helping patient and family to cope with the program. The physician must be honest about the terminal state as well as about the prognosis at all stages of the illness to retain the confidence of the family.

There are families who do not want to know the truth or do not want the patient to know the truth. The contract is between physician and patient, and the patient should always be informed of the truth. Family wishes can be listened to but only rarely honored. In addition, the physician can tactfully gain the confidence of the family members to guide them to the reality of the situation, especially by explaining that the contract is between physician and patient. Beliefs in unreal approaches are usually unsuccessful and end uncomfortably.

Although accessory personnel such as nurses and volunteers, can be used, the physician should be the perceived leader at all stages, especially when discussing death. If he carries the program through successfully, the need for others may actually be minimal. Families and patients are often concerned lest someone die in the presence of children, thinking that children would not be able to handle feelings or might be scarred in some way. I am unaware of any substantiation of this idea. Reassurance of the naturalness of the matter often is enough to assure family and patient concerns. However, I would not strongly resist hospitalizing the patient at the time of death. Families are accurate in observing and predicting closeness to death. Hospitalization during the last 24 to 48 hours sometimes can be comforting to all.

Methadone for pain may be given only once every 24 hours and perhaps even less often, along with other drugs, if severe liver disease is present, as drugs usually have longer half-life then. Families can learn to give injections of narcotics and anti-emetics to those patients who cannot swallow.

It is realistic to be concerned about the cost of terminal care. I previously pointed out in a letter to the editor several years ago the tremendous cost of dying in a hospital, especially when physicians have unrealistic expectations or try too many last-ditch measures. The cost has run as high as $20,000 to $30,000 for inappropriate terminal care. It is self-evident that the economy cannot tolerate such a pattern.

Some attempts at home care will be unsuccessful. An unsuccessful experience, however, should not dissuade the physician from subsequent attempts.

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