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138 TRIBUTE TO THE UNKNOWN REVIEWERS
Her stuffy nose and ears are bad enough.

Why make her drowsy, too?

Single-entity SUDAFED® (pseudoephedrine HCl) Syrup works without antihistamines—so it opens the nose without closing the eyes. Can't cause antihistamine 'overdry' either.

SUDAFED Syrup also helps to decongest the sinuses and to restore eustachian tube patency for easier drainage in otitis media. Orally effective, SUDAFED Syrup reaches areas drops and sprays can't. Avoids the rebound problem, too.

SUDAFED Syrup. Available on your Rx or recommendation.

It has the taste children like.

PRESCRIPTION INDICATIONS: • acute coryza • vasomotor rhinitis • acute eustachian salpingitis • aerotitis (barotitis) media • serous otitis media with eustachian tube congestion

In the following conditions, adjunctive therapy with analgesics, antihistamincs, antibiotics, expectorants and other measures may be employed with Sudafed brand Pseudoephedrine Hydrochloride for optimum results: • allergic rhinitis • asthma • croup • acute otitis media • acute and subacute sinusitis • acute tracheobronchitis

PRECAUTION: Although pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertensives.

SIDE EFFECTS: While the great majority of patients will experience no side effects, those particularly sensitive to sympathomimetic drugs may note mild stimulation.

decongestion without drowsiness

SUDAFED pseudoephedrine HCl

30mg/5cc Syrup
5 reasons why you should recommend Debrox® Drops to your patients

1. A recent survey of physicians shows more Debrox Drops recommendations for in-home use than all other non-Rx brands combined! (Data available on request.)

2. Debrox Drops provides a safe, non-irritating method of softening and removing earwax.

3. Debrox Drops cleanses ear with sustained microfoam without causing earwax to swell.

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5. Debrox Drops is safe. It is clinically effective and chemically stable. (Contains carbamide peroxide 6.5% in specially prepared anhydrous glycerol.)
Chloromycetin (chloramphenicol) must be used only in those serious infections for which less potentially dangerous drugs are ineffective or contraindicated. However, Chloromycetin may be chosen to initiate antibiotic therapy on the clinical impression that Hemophilus influenzae meningitis is believed to be present.

Among diseases of the central nervous system, *H. influenzae* meningitis is one of the most severely threatening. Chloromycetin can be particularly useful in this condition. Chloromycetin may be used in the treatment of *H. influenzae* meningitis when the patient has known—or suspected—allergy to penicillin.
Chloramphenicol is an antibiotic that is commonly used to treat a variety of infections, including those caused by bacteria. It is active against many Gram-negative and Gram-positive bacteria, as well as some fungi and mycoplasma. Chloramphenicol is often used in the treatment of meningitis, typhoid fever, and other infections caused by bacteria that are not responsive to other antibiotics. It is also used in the treatment of plague, scrub typhus, and other infections caused by bacteria that are resistant to other antibiotics. Chloramphenicol is typically given intravenously or by injection, and it is usually given in combination with other antibiotics to prevent the development of resistance. It is important to note that chloramphenicol can cause significant toxicity, including bone marrow suppression, and it should be used with caution in patients who are at risk for these complications. Chloramphenicol is not recommended for use in pregnant women or in children under the age of 12 years, and it should be used with great caution in patients with a history of bone marrow suppression or hepatic impairment. Chloramphenicol is also contraindicated in patients who are allergic to it or to other members of the tetracycline family.

Chloramphenicol is a member of the tetracycline family of antibiotics, and it is active against a wide range of Gram-positive and Gram-negative bacteria. It is also active against some viruses and mycoplasmas. Chloramphenicol is used to treat a variety of infections, including those caused by bacteria that are resistant to other antibiotics. It is typically given intravenously or by injection, and it is usually given in combination with other antibiotics to prevent the development of resistance. It is important to note that chloramphenicol can cause significant toxicity, including bone marrow suppression, and it should be used with caution in patients who are at risk for these complications. Chloramphenicol is not recommended for use in pregnant women or in children under the age of 12 years, and it should be used with great caution in patients with a history of bone marrow suppression or hepatic impairment. Chloramphenicol is also contraindicated in patients who are allergic to it or to other members of the tetracycline family.

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A CURRENT issue of Pediatrics should be consulted for general style. Three complete copies of the manuscript (including tables and illustrations) must be supplied. All material (including tables and references) should be double-spaced and typed on white 8½ × 11-inch bond paper with margins at least 1½ inches wide. Single-spaced material will be returned for retyping. Number pages consecutively.

Manuscripts should include a clear introductory statement of purpose; a historical review when desirable; a description of the technique and the scope of the experiments or observations (previously published procedures require only references to the original); a full presentation of the Results obtained; a brief Comment or Discussion on the significance of the findings and any correlation with those of other workers; a paragraph headed Speculation and Relevance, or Implications; and a Summary, in brief, logical résumé which may include conclusions.

The author's style will be respected; however, writing should conform to acceptable English usage and syntax. Titles should be concise and clear, subtitles avoided. Terminology should follow Standard Nomenclature of Diseases and Operations. Give authors' full names and professional degrees, principal author's address, and name of institution(s) where work was done; omit departmental appointments unless necessary for special reasons. Slang, medical jargon, obscure abbreviations, and abbreviated phrasing should be avoided. Mathematical terms, formulas, abbreviations, and units of measurement must conform to usage in Pediatrics, based on standards in Science, 120:1078, 1954. The metric system will be used; equivalent measurement in the English system may be included in parentheses. Name of chemical compounds—not formulas—should be given. Proprietary names, if unavoidable, will be indicated by capitalization of the first letter. Conversions to accepted standards and terms should be made before the manuscript is submitted.

References must be numbered consecutively according to order of appearance in the text. They must conform to the style employed in Pediatrics and be keyed in the text. Abbreviations for journals should be those listed in Index Medicus. References to books should contain the authors' names, title of book, volume, edition, and city and state, name of publisher, year of publication, and page numbers of reference. Foreign references should be carefully checked for accents, capitalization, and spelling.

Authors are requested to furnish (in addition to the full title) a condensed title for the cover, not exceeding 60 spaces, and a running foot of not more than 35 spaces. Original articles should be accompanied by an Abstract, prepared by the author in 200 words or less, as well as up to five key words under which the paper should be indexed and an alphabetical list of any unusual abbreviations used, with meanings.

Illustrations—Photographs of line drawings and any other figure which is not composed simply of letters, numerals, and routine symbols must be furnished. Do not send original artwork or printed forms. A reasonable number of black-and-white illustrations will be printed from black-and-white glossies or film without cost, but the cost of color illustrations and other special processing is usually borne by the author. Manuscripts containing such materials will not be accepted until arrangements for payment, on the basis of estimated prices, are made. Color work requires one month longer for production and authors will be expected to pay for the extra expenses involved.

Illustrations must be identified by number, author’s name, and “top.” They should be keyed in the text. If unessential, their omission may be requested. The prints should not be stapled, clipped together, mounted or trimmed. Details to be emphasized or crop marks should be indicated on a tissue overlay, not on the illustration itself. Illustrations of poor quality may be returned for improvement. Photographs of patients should be submitted only when parental permission has been obtained. It is the responsibility of the authors to obtain this permission and to keep it in their files. Use cardboard inserts to protect illustrations in the mail. Legends for figures are to be a separate sheet.

Tables must be comprehensible to the reader without reference to the text, typed (double-spaced) rather than photographed, and accompanied by headings. Care should be taken to make tables as concise and brief as possible.

Revised, December 1974


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BPA Membership Applied for, November 1978
**Neosporin™ Ointment**

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum q.s.; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

**PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.
SPECIAL ARTICLE


ARTICLES


42. Longitudinal Evaluation of Neonatal Nosocomial Infections: Association of Infection with a Blood Pressure Cuff—Martin G. Myers

46. The Value of Pulsus Paradoxus in Assessing the Child With Status Asthmaticus—Stanley P. Galant, Charles E. Gronicy, and Kathryn C. Shaw

52. Idiopathic Atrial Flutter in Infancy: A Review of Eight Cases—Thomas W. Rowland, Rajamath Mathew, Leon Chameides, and John F. Keane

57. Candida albicans Meningitis in a Premature Neonate Successfully Treated With 5-Fluorocytosine and Amphotericin: A Case Report and Review of the Literature—Lawrence D. Lilien, Rajam S. Ramamurthy, and Rosita S. Pildes


68. Acetaminophen: Report of an Unusual Poisoning—Jay M. Arena, Malcolm H. Rourke, Jr., and Corry D. Sibrack

73. Myocardial Necrosis Following General Anesthesia in Hemoglobin SC Disease—Alan S. Rockoff, Diane Christy, Norman Zeldis, Ding-Joe Tsai, and Robert A. Kramer

77. Blood Glucose and Plasma Amino Acid Concentrations in Infants of Diabetic Mothers—Gyula Soltesz, Károly Schultz, Julius Mestyán, and Imre Horváth

83. Wegener’s Granulomatosis in the Pediatric Age Group—James P. Orloski, John D. Clough, and Paul G. Dyment


94. Nafcillin-Induced Neutropenia in Children—Gerald R. Greene and Eddie Cohen

98. Tetracycline Photo-onycholysis—Alan E. Lasser and Matthew M. Steiner
This asthmatic isn't worried about his
high theophylline for effective around-the-clock therapy
Quibron may give the asthmatic up to eight hours of bronchodilation with each dose and provides the high dosages of theophylline which are now believed necessary to keep patients free of acute attacks and chronic wheezing.

100% free theophylline
Quibron helps achieve high serum theophylline levels with minimal dosage volume...delivers 100% free theophylline in comparison to many other compounds which contain from 47% to 91% effective theophylline.

individualized theophylline dosage schedule
Today’s more efficient usage of theophylline includes individualizing dosage and monitoring serum theophylline levels. The usual recommended dosages of Quibron are: Adults — 1 to 2 capsules or tablespoonfuls every 6 to 8 hours; dosage may be cautiously adjusted upward to a maximum of 2000 mg theophylline per 24 hours. Children under 12 — 3 to 5 mg theophylline per kg/body weight every 6 to 8 hours; dosage may be cautiously adjusted up to 7 mg/kg every 6 hours and in exceptional circumstances up to 9 or 10 mg/kg.

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.
Dosage: Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls every 6-8 hours. Children 6-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.
Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20 µg/ml.
How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100. Elixir in bottles of 1 pint and 1 gallon.
SCHEDULE OF MEETINGS

ANNUAL MEETINGS

1978
Palmer House
Chicago
October 21 to 26

1979
San Francisco Hilton
St. Francis Hotel
San Francisco
October 13 to 18

1980
Detroit Plaza Hotel
Detroit
October 25 to 30

1981
New Orleans
October 31 to Nov. 5

1982
New York Hilton
Americana Hotel
New York City
October 23 to 28

1983
San Francisco
October 22 to 27

Note: All Annual Meetings start on Saturday
A consistent in vivo response

Septra outperformed cephalexin

In a study of 148 patients with recurrent urinary tract infections, bacteriologic response rate on day 14 of therapy was 99% with Septra, compared to 94% with cephalexin. This superiority of response to Septra occurred in spite of a built-in “handicap”: Infecting organisms had to be susceptible in vitro to cephalexin, but not necessarily to Septra. Drug regimens consisted of either two Septra tablets b.i.d. or one 250 mg cephalexin pulvule q.i.d.

Results derived from urine cultures done at the midpoint of a 28-day study, since recommended duration of Septra therapy is 14 days.

Septra outperformed ampicillin

In a study of 156 patients with recurrent urinary tract infections, clear culture was maintained four days after therapy ended in 81% of patients treated with Septra, compared to 76% of those treated with ampicillin. These results gain added significance considering that causative organisms not susceptible in vitro to ampicillin were excluded, but no such advantage was afforded Septra. Drug regimens consisted of either two Septra tablets b.i.d. or one 500 mg ampicillin capsule q.i.d.

Criterion for infection: 100,000 or more organisms/ml urine; criterion for clear culture: 1000 or fewer organisms/ml urine.

Septra outperformed nitrofurantoin (macrocryystals)

In a study of 289 patients treated for 14 days for recurrent urinary tract infections, bacteriologic response (measured eight days after therapy ended) to Septra was 94%, compared to 90% with nitrofurantoin. Drug regimens consisted of either two Septra tablets b.i.d. or one 100 mg capsule of nitrofurantoin macrocrystals q.i.d.

Criterion for infection: 100,000 or more organisms/ml urine; criterion for clear culture: 1000 or fewer organisms/ml urine.

In vitro antibacterial action
well balanced by clinical success

Septra DS

Each tablet contains: 160 mg trimethoprim and 800 mg sulfamethoxazole in recurrent urinary tract infections due to susceptible organisms

It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.

Artist's conception of major uropathogens.
See next page for prescribing information.
In recurrent urinary tract infections due to susceptible organisms*

**Septra DS Tablets**
Each tablet contains:
160 mg trimethoprim and 800 mg sulfamethoxazole

**Septra Suspension**
Each teaspoonful (5 ml) contains:
40 mg trimethoprim and 200 mg sulfamethoxazole

**In vitro antibacterial action well balanced by clinical success**
- convenient b.i.d. dosage schedule helps insure patient compliance
- pleasantly flavored cherry suspension available for children

**Rx guidelines**
- during therapy, maintain adequate fluid intake and perform frequent urinalyses with careful microscopic examination
- contraindicated in children under two months old
- Septra and Septra DS now available in new small-size tablets
- see prescribing information for complete guidelines

*It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.

---

**Septra**
Tablets and Suspension

**Indications and Usage:** Urinary Tract Infections: Urinary tract infections due to susceptible strains of the following organisms: Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.

**NOTE:** The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections.

The recommended quantitative disc susceptibility method (Federal Register 37, 1962) 1972 may be used to estimate bacterial susceptibility to Septra. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Septra therapy. "Intermediate susceptibility" also indicates that response is likely and "Resistant" that response is unlikely.

**Contraindications:** Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period. Infants less than two months of age.

**Warnings:** Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombocytopenia with purpura in elderly patients on certain diuretics, primarily thiazides.

Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBCs are recommended; therapy should be discontinued if a significant reduction in the count of any formed blood element is noted.

**Precautions:** Use with caution in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur (frequently dose-related). During therapy, maintain adequate fluid intake and perform frequent urinalyses with careful microscopic examination and renal function tests, particularly where there is impaired renal function.

**Adverse Reactions:** All major reactions to sulfonamides and trimethoprim are included, even if not reported with Septra. Blood Dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypersplenism, hemoglobinuria and methemoglobinemia. Allergic Reactions: Urticaria, rash, lymphadenitis, desquamation, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. Gastrointestinal Reactions: Glositis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. C.N.S. Reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. Miscellaneous Reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Penicillins prevent and L. E. phenomenon have occurred. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiadizides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia; cross-sensitivity may exist with these agents. In rats, long-term administration of sulfonamides has produced thyroid malignancies.

**Dosage and Administration:** Not recommended for use in infants less than two months of age.

**Adults:** The usual adult dosage for the treatment of urinary tract infections is one double strength tablet or two regular tablets or four teaspoonfuls (20 ml) every 12 hours for 10 to 14 days. Shake suspension well before using.

**Children:** Recommended dose is 6 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, given in two divided doses for 10 days. The following table is a guideline for the attainment of this dosage using Septra Tablets or Suspension.

<table>
<thead>
<tr>
<th>Weight (lb)</th>
<th>Dosage (ml)</th>
<th>Tablets</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>1 (5 ml)</td>
<td>½</td>
</tr>
<tr>
<td>40</td>
<td>2 (10 ml)</td>
<td>1</td>
</tr>
<tr>
<td>60</td>
<td>3 (15 ml)</td>
<td>1½</td>
</tr>
<tr>
<td>80</td>
<td>4 (20 ml)</td>
<td>2</td>
</tr>
</tbody>
</table>

For patients with renal impairment:

<table>
<thead>
<tr>
<th>Creatinine Clearance (ml/min)</th>
<th>Recommended Dosage Regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above 30</td>
<td>Usual Standard Regimen</td>
</tr>
<tr>
<td>15-30</td>
<td>Half of the usual Dosage Regimen</td>
</tr>
<tr>
<td>Below 15</td>
<td>Use Not Recommended</td>
</tr>
</tbody>
</table>

**Supplied:** Septra DS (Double Strength) tablets containing 160 mg trimethoprim and 800 mg sulfamethoxazole — bottles of 50 tablets and unit dose packs of 100. Septra tablets containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 40, 100, 500, and 1000 tablets and strip packages of 100 individually packed tablets. Oral suspension, containing the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole in each teaspoonful (5 ml), cherry flavored — bottles of 450 ml.

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159 Diagnosis of Neonatal Subarachnoid Hemorrhage: Other Laboratory Methods—Docteur Brossard Y.

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A strong *in vitro* record

**E. coli**

**Septra 95%**

- **Cephalosporin 79%**
  - of 358025 isolates
- **Ampicillin 74%**
  - of 351311 isolates
- **Nitrofurantoin 95%**
  - of 338756 isolates

**Proteus sp**

**Septra 91%**

- **Cephalosporin 81%**
  - of 106281 isolates
- **Ampicillin 77%**
  - of 104437 isolates
- **Nitrofurantoin 13%**
  - of 100829 isolates

*Indicated in approved drug information for *Proteus mirabilis* only.

**Enterobacter**

**Septra 87%**

- **Cephalosporin 32%**
  - of 14986 isolates
- **Ampicillin 15%**
  - of 14036 isolates
- **Nitrofurantoin 66%**
  - of 14219 isolates

*Not indicated in approved drug information.

**Klebsiella pneumoniae**

**Septra 87%**

- **Cephalosporin 85%**
  - of 76898 isolates
- **Ampicillin 5%**
  - of 76026 isolates
- **Nitrofurantoin 68%**
  - of 72030 isolates

*Not indicated in approved drug information.

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*In vitro activity does not necessarily imply a correlation with *in vivo* results.*
A consistent in vivo response

Septra outperformed cephalexin
In a study of 148 patients with recurrent urinary tract infections, bacteriologic response rate on day 14 of therapy was 99% with Septra, compared to 94% with cephalexin. This superiority of response to Septra occurred in spite of a built-in "handicap": Infecting organisms had to be susceptible in vitro to cephalexin, but not necessarily to Septra. Drug regimens consisted of either two Septra tablets b.i.d. or one 250 mg cephalexin pulvule q.i.d.

Septra outperformed ampicillin
In a study of 10-day therapy in 156 patients with recurrent urinary tract infections, clear culture was maintained four days after therapy ended in 81% of patients treated with Septra, compared to 76% of those treated with ampicillin. These results gain added significance considering that causative organisms not susceptible in vitro to ampicillin were excluded, but no such advantage was afforded Septra. Drug regimens consisted of either two Septra tablets b.i.d. or one 500 mg ampicillin capsule q.i.d.

Septra outperformed nitrofurantoin (macrocrystals)
In a study of 289 patients treated for 14 days for recurrent urinary tract infections, bacteriologic response (measured eight days after therapy ended) to Septra was 94%, compared to 90% with nitrofurantoin. Drug regimens consisted of either two Septra tablets b.i.d. or one 100 mg capsule of nitrofurantoin macrocrystals q.i.d.

In vitro antibacterial action well balanced by clinical success

Septra DS
Each tablet contains: 160 mg trimethoprim and 800 mg sulfamethoxazole in recurrent urinary tract infections due to susceptible organisms

It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.

Artist's conception of major uropathogens.
See next page for prescribing information.
A strong in vitro record

**E. coli**
**Septra 95%**
95% of 220517 isolates

**Cephalosporin 79%**
of 358025 isolates
**Ampicillin 74%**
of 351311 isolates
**Nitrofurantoin 95%**
of 338756 isolates

**Proteus sp**
**Septra 91%**
91% of 66163 isolates

**Cephalosporin 81%**
of 106281 isolates
**Ampicillin 77%**
of 104437 isolates
**Nitrofurantoin 13%**
of 100829 isolates

*Indicated in approved drug information for Proteus mirabilis only.

**Enterobacter**
**Septra 87%**
87% of 9896 isolates

**Cephalosporin 32%**
of 14986 isolates
**Ampicillin 15%**
of 14036 isolates
**Nitrofurantoin 66%**
of 14219 isolates

*Not indicated in approved drug information.

**Klebsiella pneumoniae**
**Septra 87%**
87% of 46279 isolates

**Cephalosporin 85%**
of 76898 isolates
**Ampicillin 5%**
of 76026 isolates
**Nitrofurantoin 68%**
of 72030 isolates

*Not indicated in approved drug information.

*In vitro activity does not necessarily imply a correlation with in vivo results.*
The rhythm band cough.

Get ‘em back on the beat with Novahistine DH. The effective antitussive action of codeine controls a wide range of coughs. At the same time, the decongestant plus antihistamine in Novahistine DH relieves congestion associated with upper respiratory infections.

NOVAHISTINE DH
Antitussive-Decongestant-Antihistamine

Each 5 ml. teaspoonful contains codeine phosphate 10 mg. (Warning: May be habit forming). phenylpropanolamine hydrochloride 18.75 mg., chlorpheniramine maleate 2 mg., and alcohol 5%.

DOW PHARMACEUTICALS
THE DOW CHEMICAL COMPANY
INDIANAPOLIS, INDIANA 46268
Introducing children's TYLENOL® tablets

As effective as aspirin...but safer*

Relieves fever and pain
Clinical investigators have consistently shown that TYLENOL acetaminophen is equipotent to aspirin as an analgesic/antipyretic. 1,2,4

Avoids aspirin complications
TYLENOL Chewable tablets are unlikely to cause the stomach upset, 1,2 allergic reactions, 1,2 or postoperative bleeding 1,3 associated with aspirin. In addition, TYLENOL products do not produce the toxic reactions 2,7 that may occur with therapeutic doses of aspirin. 1,2 This is of special importance in infants and young children, especially when they're dehydrated (due to fever, diarrhea or vomiting).

Precautions and Adverse Reactions:
If a rare sensitivity reaction occurs, administration of the drug should be stopped. TYLENOL acetaminophen at recommended doses has rarely been found to produce any side effects.

Easy-to-administer chewable tablets
New pleasant-tasting fruit flavor in the dosage form many mothers prefer for their children.

Chewable tablets: 80 mg. acetaminophen
Also available:
Elixir: 120 mg. acetaminophen per 5 ml. (alcohol 7%)
Drops: 60 mg. acetaminophen per 0.6 ml. (one-calibrated dropperful) (alcohol 7%)

*when used at recommended dosages

References:

McNEIL Laboratories, Inc.
Fort Washington, Pa. 19034
The unceremonial cough.

Kiss it goodbye with Novahistine Expectorant. Novahistine Expectorant provides effective antitussive action, plus a decongestant and an expectorant.

NOVAHISTINE® EXpectorant
Antitussive-Decongestant-Expectorant

Dow

Dow Pharmaceuticals
The Dow Chemical Company
Indianapolis, Indiana 46268

Each 5 ml. teaspoonful contains codeine phosphate 10 mg., (Warning: May be habit forming), phenylpropanolamine hydrochloride 18.75 mg., guaifenesin 100 mg., and alcohol 7.5%.
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The oral antipruritic that controls itching... while you treat the cause.

TEMARIL®
trimeprazine tartrate syrup

Each 5 ml. teaspoonful contains trimeprazine tartrate equivalent to 2.5 mg. of trimeprazine and alcohol, 5.7%.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

**Indications**

Based on a review of this drug by the National Academy of Sciences—National Research Council and other information, FDA has classified the indications as follows:

Effective: For symptomatic relief of pruritic symptoms in urticaria.

Possibly effective: For relief of pruritic symptoms in neurodermatitis, allergic dermatitis, contact dermatitis, atopic dermatitis, chickenpox, pruritus ani and vulvae.

**Final classification of the less-than-effective indications requires further investigation.**

**Contraindications**: Comatose patients; presence of large amounts of C.N.S. depressants, bone marrow depression, disopyramide or hypersensitivity to this drug or other phenothiazines; in newborn or premature children; in nursing mothers; in acutely ill or dehydrated children.

**Warnings**: May impair mental and/or physical ability required for potentially hazardous tasks (driving vehicles, operating machinery). May impair mental alertness in children. Concomitant use with alcohol or other C.N.S. depressants may have additive effect. Warn patients accordingly.

Use with extreme caution in patients with asystolic attack, narrow-angle glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, bladder neck obstruction, patients receiving MAO inhibitors.

Do not use in women of childbearing potential. There are reported instances of jaundice and prolonged extrapyramidal symptoms in infants whose mothers received phenothiazines during pregnancy.

Use with caution in children, as administration may result in excitation; overdosage may produce hallucinations, convulsions, sudden death.

Elderly patients (60 or older) are more prone to develop the following phenothiazine side effects: hypotension, syncope, toxic confusional states, extrapyramidal symptoms (especially parkinsonism), excessive sedation.

**Precautions**: May increase, prolong or intensify sedative action of C.N.S. depressants (when administered concomitantly), narcotic or barbiturate dosage should be reduced to 1/4 or 1/3. Lead to restlessness and motor hyperactivity in patient with pain being treated with narcotics; block or reverse the pressor effect of epinephrine. Use cautiously in persons (particularly children) with acute or chronic respiratory impairment; it may suppress cough reflex, in persons with cardiovascular disease, liver function impairment, or history of ulcer disease. The drug's slight antiemetic action may obscure signs of intestinal obstruction, brain tumor, toxic drug overdose.

**Adverse Reactions**: (Note: May produce adverse reactions attributable to both phenothiazines and antihistamines, although not all the following have been reported with 'Temaril'. There have been occasional reports of sudden death in patients receiving phenothiazine derivatives chronically.) Drowsiness, extrapyramidal reactions (opisthotonos, dystonia, akathisia, dyskinesia, parkinsonism), particularly with high doses, hyperreflexia in newborn (when used during pregnancy), dizziness, headache, lassitude, tinnitus, incoordination, fatigue, blurred vision, euphoria, diplopia, nervousness, insomnia, tremors, ataxia, and/or grand mal seizures, excitation, catatonic-like states, neuritis and hysteria, oculogyric crises, disturbing dreams/nightmares, pseudoschizophrenia, intensification and prolongation of action of C.N.S. depressants, atropine, heat, organophosphorus insecticides.

Also postural hypotension, reflex tachycardia, Bradycardia, faintness, cardiac arrest, ECG changes, anorexia, nausea, vomiting, epigastric distress, diarrhea, constipation, dry mouth, increased appetite and weight gain, urinary frequency and dysuria, urinary retention, early menses, induced lactation, gynecomastia, decreased libido, inhibition of ejaculation, false positive pregnancy tests, thickening of bronchial secretions, tightness of chest, wheezing, nasal stuffiness, urticaria, dermatitis, asthma, laryngeal edema, angioneurotic edema, photosensitivity, lupus erythematosus-like syndrome, anaphylactoid reactions, leukopenia, agranulocytosis, pancytopenia, hemolytic anemia, elevation of plasma cholesterol levels, thrombocytopenic purpura, jaundice, erythema, peripheral edema, stomatitis, high or prolonged glucose tolerance curves, glycosuria, elevated spinal fluid proteins, reversed epinephrine effects.

After prolonged phenothiazine administration at high dosage, the following have occurred: skin pigmentation; ocular changes (the appearance of lenticon and cornal opacities, epithelial keratocones, pigmented retinopathy). Vision may be impaired.

**Drug Interactions**: MAO inhibitors and thiazide diuretics prolong and intensify anticholinergic effects. Combined use of MAO inhibitors and phenothiazines may result in hypertension and extrapyramidal reactions. Phenothiazines potentiate C.N.S. depressant and antiseptic effects of narcotics. Phenothiazine effects may be potentiated by oral contraceptives, progesterone, reserpine, nydramine HCl.

**Supplied**: Syrup — in 4 fl oz bottles. Spanseule® capsules (not for use in children 6 and under) — Each capsule contains trimeprazine tartrate equivalent to 5 mg. of trimeprazine, in bottles of 50. Tablets — Each tablet contains trimeprazine tartrate equivalent to 2.5 mg. of trimeprazine, in bottles of 100 and 1000. Tablets and 'Spanseule' capsules also available in Single Unit Packages (SUP) of 100, intended for institutional use only.

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Can you pick the virus that caused the last cold you treated?

Even an expert virologist wouldn't find it easy. To check your virology-quotient, see answers printed upside down below.
For the interchangeable symptoms of over 100 different viruses

Physician’s number one choice for relieving the drip and congestion common to most virus colds — the elixir with the great grape taste.

Dimentapp Elixir®

Each 5 ml teaspoonful contains:
Brompheniramine Maleate, NF...4 mg.
Phenylephrine Hydrochloride, USP...5 mg.
Phenypropanolamine Hydrochloride, NF...7 mg.
Alcohol 2.9%.

INDICATIONS
Based on a review of this drug by the National Academy of Sciences - National Research Council and/or other information, FDA has classified the following indications as ‘probably effective’ for Dimentapp Elixir: The symptomatic treatment of seasonal and perennial allergic rhinitis and vasomotor rhinitis and ‘lacking substantial evidence of effectiveness as a fixed combination’ for the following indications: They symptomatic relief of upper respiratory infection, acute sinusitis, nasal congestion, pharyngitis, bronchitis, and otitis.

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy. PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient’s response has been determined, he should be cautioned against engaging in operations which require alertness. SIDE EFFECTS: Hypersensitivity reactions including skin rashes, urticaria, hypertension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. DOSAGE: Adults — 1 to 2 teaspoonfuls 3 or 4 times daily. Children (1 to 6 months) — ¼ teaspoonful 3 or 4 times daily; (7 months to 2 years) — ½ teaspoonful 3 or 4 times daily; (2 to 4 years) — ¾ teaspoonful 3 or 4 times daily; (4 to 12 years) — 1 teaspoonful 3 or 4 times daily. Rev. July 1976.

A. H. ROBINS COMPANY RICHMOND, VA 23220

Member of Certified Medical Representatives Institute
For the symptomatic relief of Bronchial Asthma Pulmonary Emphysema Chronic Bronchitis...

the growing Somophyllin®
(theophylline/aminophylline) family.

*Somophyllin® is indicated for the symptomatic relief of bronchial asthma, pulmonary emphysema, chronic bronchitis, and other pulmonary diseases associated with bronchospasm. Please see brief summary of prescribing information which follows.
Mean Serum Theophylline Levels in Patients Receiving Somophyllin* Capsules.

New Somophyllin® Capsules
theophylline, U.S.P. anhydrous: 100 mg, 200 mg, 250 mg
A new dosage form in three convenient strengths.
Liquid-filled capsules . . . for prompt, sustained blood levels.
• dye free
• single entity
• corn-starch free
• well tolerated

Somophyllin® Oral Liquid
aminophylline 105 mg providing 90 mg theophylline base/5 ml
The preferred liquid form.
Concentrated, aqueous solution . . .
in line with current concepts in theophylline therapy:
• higher dosage and individual patient titration.
• therapeutic blood levels within 30 minutes
• alcohol free
• sugar free
• small dosage volume
• palatable
• economical

Somophyllin® Rectal Solution
aminophylline 300 mg providing 255 mg theophylline base/5 ml
for prompt blood levels in patients with intermittent or acute asthma associated with coughing and vomiting, and other specific clinical situations.

. . . when accuracy of theophylline dosage is important to you.
Somophyllin®... when accuracy of theophylline dosage is important to you.

BRIEF SUMMARY
Oral Liquid: Each 5 ml (teaspoonful) contains aminophylline 105 mg (equivalent to 90 mg theophylline anhydrous) in an aqueous vehicle.
Each 15 ml (tablespoonful) contains aminophylline 315 mg (equivalent to 270 mg theophylline).
Capsules: Supplied in three strengths: 100 mg, 200 mg, and 250 mg of theophylline U.S.P., anhydrous.
Rectal Solution: Each 5 ml contains aminophylline 300 mg (equivalent to 255 mg theophylline anhydrous) as a concentrated aqueous solution for rectal administration with the Rectal Ject Syringe.

Contraindications: Somophyllin is contraindicated in those patients who have shown hypersensitivity to theophylline or theophylline derivatives.

Warning and precautions: Use with caution in the presence of severe hypertension, and in infants and young children. Other formulations containing theophylline or its derivatives should not be administered concomitantly. Metabolism of theophylline may be impaired in patients with severe pulmonary, cardiovascular, renal, or hepatic disease.

Adverse reactions: Toxicity of theophylline and its derivatives may manifest as nausea, vomiting, peripheral vascular collapse, reactivation of peptic ulcers, intestinal bleeding, albuminuria, palpitation, nervousness, insomnia, and, with excessively high dosages, convulsions.

NOTE: The metabolism of theophylline is a major factor in the observed interpatient serum level variability. Ideally, all individuals should have serum theophylline levels measured and a theophylline half-life calculated which would enable doses and dosing regimens to be tailored to each patient to maintain a serum theophylline level within the recommended therapeutic range (10-20 μg/ml), which insures optimal clinical response and avoidance of toxicity.

How supplied:
Oral Liquid: Bottles of 8 fl. oz.
Capsules: 100 mg, 200 mg, and 250 mg, in white, imprinted soft gelatin capsules, in bottles of 100.
Rectal Solution: in non-breakable bottles of 3 fl. oz. and 5 fl. oz. with accompanying rectal syringe, plastic applicator tips and patient instructions.

Fisons Corporation, Bedford, Mass. 01730

A28

TO THE PRACTICING PEDIATRICIAN

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A comprehensive review will be presented by acknowledged experts in the field of clinical immunologic and allergic diseases relevant to your practice needs — bronchial asthma, urticaria, middle ear effusion, allergic rhinitis, eczema, and immunodeficiency diseases — along with an update on new trends in diagnostic and treatment programs for these and other common allergic problems. This 5½-day program will focus on physician participation with:

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only one shot
vaccinates
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Indications: ATTENUVAX® (Measles Virus Vaccine, Live, Attenuated, MSD)—Active immunization against measles (rubella) in children 15 months of age or older.

BIAVAX® (Rubella and Mumps Virus Vaccine, Live, MSD)—Simultaneous immunization against rubella and mumps in children 15 months of age to puberty. May be given as early as 12 months if that offers greater convenience in scheduling.

MERSUVA® (Rubella Virus Vaccine, Live, MSD)—Immunoablation against rubella (German measles) in children 15 months of age to puberty. May be given as early as 12 months if that offers greater convenience in scheduling. May be useful for postpartum males to prevent or control rubella outbreaks in circumcised population groups. In postpubertal females vaccination must not be undertaken unless the woman is not pregnant; is susceptible to rubella (as shown by Hemagglutination Inhibition test), understands it is imperative not to become pregnant for the next three months and will follow a medically acceptable method for pregnancy prevention (also in immediate postpartum period), and is informed of frequent occurrence of self-limited arthralgia and possible arthritis beginning two to four weeks after vaccination.

M-M-R® (Measles, Mumps and Rubella Virus Vaccine, Live, MSD)—Simultaneous immunization against measles, mumps, and rubella in children 15 months of age to puberty.

M-M-R VAX® (Measles and Rubella Virus Vaccine, Live, MSD)—Simultaneous immunization against measles (rubella) and rubella (German measles) in children 15 months of age to puberty.

MUMPISVAX® (Mumps Virus Vaccine, Live, MSD)—Immunoablation against mumps for children 15 months of age or older. May be given as early as 12 months if that offers greater convenience in scheduling.

Contraindications: Pregnancy or the possibility of pregnancy within three months following vaccination. Hypersensitivity to neomycin, in patients hypersensitive to chicken or duck eggs or chicken or duck eggs or feathers. Rubella vaccination should be deferred for at least three months following birth. Children in monovalent vaccines or administration of more than 0.02 ml human serum globulin per pound of body weight. Rubella vaccine may be given in the immediate postpartum period to those nonimmune women who have received anti-Rho (D) immune globulin humanum without interfering with vaccine effectiveness.

Attenuated measles, mumps, and rubella virus vaccines live, given separately, may result in a temporary depression of tuberculin skin sensitivity. If a tuberculin test is to be done, it should be done before or simultaneously with any of these virus vaccines.

Measles Containing Vaccines—Due caution should be employed in children to prevent a history of feeble convulsions, cerebral injury or any other condition in which stress due to fever should be avoided. The physician should be kept abreast of the temperature elevation which may occur 5 to 12 days after vaccination. The occurrence of thrombocytopenia and purpura has been extremely rare.

Rubella-Containing Vaccines—Excretion of live attenuated rubella virus from the throat has been determined in the majority of susceptible individuals administered rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Adverse Reactions: To date, clinical evaluation of the combination vaccines has revealed those adverse reactions expected to follow administration of the monovalent vaccines given separately.

Measles Containing Vaccines—Occasionally, moderate fever (101-102°F), less common, high fever (above 103°F), rarely, feeble convulsions. Infrequently, rash, usually minimal without generalized distribution. Reactions at injection site: Local reactions characterized by marked swelling, redness, and vesication at the injection site of attenuated live measles virus vaccines have occurred in children who received killed measles vaccine previously. The combination vaccines were not given under this condition in clinical trials.

Experience from more than 80 million doses of all live measles vaccines given in the U.S. through 1975 indicates that significant central nervous system reactions such as encephalitis and encephalopathy, occurring within 30 days after vaccination, have been temporally associated with measles vaccine approximately once for every million doses. In no case has it been clearly shown that reactions were actually caused by vaccine. The Centers Disease Control has pointed out that "a certain number of cases of encephalitis may be expected to occur in a large childhood population in a defined period of time even when no vaccines are administered." However, the data suggest the possibility that some of these cases may have been caused by measles vaccines. The risk of such serious neurological disorders associated with live measles virus vaccine administration remains far less than that for encephalitis and encephalopathy with natural measles (one person per thousand reported cases).

There have been reports of subacute sclerosing panencephalitis (SSPE) in children who did not have a history of natural measles but did receive measles vaccine. Some of these cases may have resulted from unrecognized measles in the first year of life or possibly from the measles vaccine. Based on estimated nationwide measles vaccine distribution, the association of SSPE cases to measles vaccine is about one case per million vaccine doses distributed, far less than the 5:10 cases of SSPE per million cases of natural measles.

Rubella-Containing Vaccines—Adverse reactions may include fever and rash; mild local reactions such as erythema, induration, tenderness, and regional lymphadenopathy: thrombocytopenia and purpura, allergic reactions such as urticaria, and arthralgia, and arthritis, polyarthritis and polyarthralgia.

Moderate fever (101-102°F) occurs occasionally and high fever (103°F) occurs less commonly. Rash occurs infrequently and is usually minimal without generalized distribution. Encephalitis and other nervous system reactions have occurred rarely.

Transient arthritis, arthralgia, and polyarthritis may occur in children treated with rubella vaccine. These symptoms are usually minor and self-limited; however, in rare instances, the arthritis has been more persistent, greater in severity, and more widespread than that observed in patients with uncomplicated rubella. Rarely, arthritis persists in a subacute form for months or years after infection. The occurrence of such chronic arthritis is not expected to be more frequent in recipients of rubella vaccine than expected in recipients of other vaccines. The occurrence of such arthritis is not expected to be more frequent in recipients of rubella vaccine than expected in recipients of other vaccines.

Mumps-Containing Vaccines—During shipment, to ensure that there is no loss of potency the vaccine must be maintained at a temperature of 10°C (50°F) or less. Before reconstitution, store vaccines at 2-8°C (35.6-46.4°F) and protect from light. Use only diluted supplied to reconstitute vaccines. If not used immediately, store reconstituted vaccines in a dark place at 2-8°C (35.6-46.4°F) and discard if not used within eight hours.

Color change: The usual color of the vaccine when reconstituted is pinkish to red due to the presence of phenol. A yellow or brownish coloration in the vaccine may not be detrimental to the vaccine's potency. The vaccine should be stored in the cold, but when reconstituted for use, it should be allowed to warm up to room temperature before use.

How Supplied: ATTENUVAX® (Measles Virus Vaccine, Live, MSD)—Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID50 (tissue culture infectious doses) of measles virus vaccine expressed in terms of the assigned titer of the FDA Reference Measles Virus, and approximately 25 mcg neomycin.

BIAVAX® (Rubella and Mumps Virus Vaccine, Live, MSD)—Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID50 of rubella virus vaccine, live, and 5,000 TCID50 of mumps virus vaccine, live, expressed in terms of the assigned titer of the FDA Reference Rubella and Mumps Viruses, and approximately 25 mcg neomycin.

MERSUVA® (Rubella Virus Vaccine, Live, MSD)—Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID50 of rubella virus vaccine, expressed in terms of the assigned titer of the FDA Reference Rubella Virus, and approximately 25 mcg neomycin.

M-M-R® (Measles, Mumps and Rubella Virus Vaccine, Live, MSD)—Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID50 of measles virus vaccine, live, attenuated, 5,000 TCID50 of mumps virus vaccine, live, and 1,000 TCID50 of rubella virus vaccine, live, expressed in terms of the assigned titer of the FDA Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin.

M-M-R VAX® (Measles and Rubella Virus Vaccine, Live, MSD)—Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 TCID50 of measles virus vaccine, live, attenuated, and 1,000 TCID50 of rubella virus vaccine, live, expressed in terms of the assigned titer of the FDA Reference Measles and Rubella Viruses, and approximately 25 mcg neomycin.

MUMPISVAX® (Mumps Virus Vaccine, Live, MSD)—Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 5,000 TCID50 of mumps virus vaccine, expressed in terms of the assigned titer of the FDA Reference Mumps Virus, and approximately 25 mcg neomycin.

Each of these vaccines is supplied as a single-dose vial packed with a disposable syringe containing diluent and fitted with a 25-gauge, ½” needle, and as a box of 10 single-dose vials with an accompanying box of 10 diluent containing disposable syringes with affixed needles.

For more detailed information, consult your MSD representative or see full prescribing information.
THE NATIONAL QUALIFYING EXAMINATION FOR PEDIATRIC NURSE PRACTITIONERS AND ASSOCIATES

will be offered

Friday, April 14, 1978.

This voluntary certification examination is sponsored by the NATIONAL BOARD OF PEDIATRIC NURSE PRACTITIONERS AND ASSOCIATES. Member organizations of the Board are the National Association of Pediatric Nurse Associates and Practitioners and the American Academy of Pediatrics.

The National Qualifying Examination evaluates entry-level competence in the pediatric nurse practitioner/associate role.

Brochures and applications may be obtained from:

Mary Kaye Willian, R.N., P.N.A.
Executive Director
National Board of Pediatric Nurse Practitioners and Associates
P.O. Box 1034
Evanston, Illinois 60204

TEDRAL®/TEDRAL® SUSPENSION
TEDRAL® Elixir

Description. Tedral: each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.
Tedral Suspension: each 5 ml teaspoonful of suspension contains 65 mg theophylline, 12 mg ephedrine hydrochloride, and 4 mg phenobarbital.
Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; alcohol content is 15%.

Indications. Tedral, Tedral Suspension and Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal and perennial asthma.

Tedral Suspension and Tedral Elixir are convenient for persons who may have difficulty in swallowing tablets.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications. Sensitivity to any of the ingredients, porphyria.

Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation may be reported.

Average Dosage. Prophylactic or Therapeutic.

Tedral. Adults—One or two tablets every 4 hours. Children—(Over 60 lb) one-half the adult dose.

Tedral Suspension. Note: One teaspoonful is equivalent to one-half Tedral tablet.

Adults—two to four teaspoonfuls every 4 hours. Children—One teaspoonful per 60 lb body weight, every 4-6 hours unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution.

SHAKE BOTTLE WELL.

Tedral Elixir. Note: One teaspoonful is equivalent to one-quarter Tedral tablet. Children—One teaspoonful per 30 lb body weight, every 4-6 hours unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution.

Adults—One to two tablespoonfuls every four hours.

Supplied. Tedral. White, uncoated scored tablets in bottles of 24 (N 0047-0230-24) 100
(N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral Suspension: Yellow, licorice-flavored suspension in bottles of 237 ml (8 fl oz) (N 0047-0237-08) and 474 ml (16 fl oz) (N 0047-0237-16).

Tedral Elixir: Dark red and cherry-flavored in 474 ml (16 fl oz) bottles (N 0047-0242-16).

STORE BETWEEN 59°-86° F (15°-30° C).

Full information is available on request.

WARNER/CHILCOTT
Div. Warner-Lambert Company
Morris Plains, N.J. 07950
THE GIFT OF AIR.

Tedral means air... so children with asthma can be children.

Once symptoms have begun, Tedral can reduce bronchospasm and help to relieve dyspnea and wheezing. And, it may be used prophylactically to reduce the frequency and severity of asthmatic attacks.

Either way, Tedral can help young asthmatics lead more active, normal lives.

Available in three convenient dosage forms for children: a cherry-flavored elixir, a licorice-flavored suspension, and tablets.

Tedral® Elixir
Each 5 ml teaspoonful contains:
32.5 mg theophylline,
6 mg ephedrine hydrochloride,
and 2 mg phenobarbital;
the alcohol content is 15%.

Tedral®
Each tablet contains:
130 mg theophylline,
24 mg ephedrine hydrochloride,
and 8 mg phenobarbital

ASTHMA THERAPY A CHILD CAN LIVE WITH

See preceding page for prescribing information.
(personal communications). None of these patients apparently had anomalies of the lower extremities. Lowry\(^1\) described craniosynostosis and bilateral fibular aplasia in male siblings of a second cousin marriage. These children also exhibited cryptorchidism, multiple skeletal defects, and abnormalities of the palate. All of these patients are compared in the Table; our patient and that of Herrman et al.\(^2\) have all the major malformations exhibited by both types of patients with either radial or fibular aplasia.

Do all of these patients represent a variable expression of the same malformation syndrome or, indeed, does each type represent an entirely separate condition? The extensive overlap of anomalies among the children suggests a common origin, but there are sufficient and consistent differences between them to derive three types of conditions. If we assume the position of the “splitters,”\(^1\): then our patient and that of Herrman et al.\(^2\) must represent a distinct malformation syndrome.

Chromosome studies in our patient and that of Herrman et al. as well as in all others have revealed no apparent abnormality. In all of the cases, parents appeared normal and in two reports matings were consanguinous, i.e., second cousins in one and third cousins in another. Thus, the conditions may be inherited as autosomal-recessive traits.

In addition to a thorough physical examination, a skeletal survey including skull roentgenograms may be justified in any patient with one, or any combination, of these major manifestations—craniosynostosis, radial/fibular aplasia, cleft lip/palate—to evaluate the range of associated anomalies. Accumulation of these clinical data will be necessary to adequately define the range of expression of these conditions.

REFERENCES


AMERICAN BOARD OF PEDIATRICS

The 1978 written examination will be given September 15, 1978. The fee is $300 with the initial application. Applications may be obtained by writing to the American Board of Pediatrics, Children’s Hospital of Philadelphia, 34th Street and Civic Center Boulevard, Philadelphia, PA 19104. The deadline for receipt of applications is January 31, 1978.
child's bid

_Mandatory bid to child_ (event sampled): directive, prohibition

Child behaviors

_Vocalization_ (time sampled): non-distress vocalization, comprehensible or incomprehensible

_Fussing_ (time sampled): fuss/cry

_Negative responsiveness_ (time sampled): fuss/cry, hit, throw, prohibit, reject caregiver bid

_Bid to caregiver_ (event sampled): Request for help or information, or give, reach, point, share (may be verbal, gestural, or both)

Reciprocal behaviors between caregiver and child

_Caregiver verbalizes contingently to child_ (time sampled): caregiver responds contingently to child's vocalization with positive verbalization more than a simple imitation, "hmm," or "what?"

Reciprocal positive attentiveness between caregiver and child (time sampled): either member of the dyad responds positively to positive behavior of other (e.g., question and answer, vocalize contingently to other's vocalization, vocalize imitatively, caregiver stance positive to child's bid, child complies with caregiver's nonmandatory bid)

Intense positive attentiveness between caregiver and child (time sampled): both members of the dyad emit two or more positive behaviors within the same 15-second interval

Caregiver's stance positive towards child (event sampled): caregiver responds to child's bid in a positive manner by permitting, giving, helping, accepting, vocalizing contingently, etc.

Child's compliance to caregiver (event sampled): child complies with caregiver's mandatory bid

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**AMERICAN ACADEMY OF PEDIATRICS RESIDENCY FELLOWSHIPS STIPULATIONS**

To enable young physicians to complete their pediatric training, the American Academy of Pediatrics will grant a small number of fellowships of $500 to $2,500 each to pediatric interns and residents for the year beginning July 1. Candidates must meet the following requirements:

1. Be legal residents of the United States or Canada;
2. Have completed, or will have completed by July 1, a qualifying approved internship (PL-0) or have completed a PI-1 program, and have made a definite commitment for a first year pediatric residency (PI-1 or PI-2) acceptable to the American Board of Pediatrics; or
3. Be pediatric residents (PI-1, PI-2, or PI-3) in a training program and have made a definite commitment for another year of residency in a program acceptable to the American Board of Pediatrics;
4. Have real need of financial assistance; and
5. Support their application with a letter from the Chief of Service substantiating the above requirements; if a change in residency training program is contemplated (i.e., moving to another institution), a letter from the chief of this service certifying acceptance to this program will also be necessary.

The fellowships have been provided through grants to the American Academy of Pediatrics by Mead Johnson Laboratories and the Gerber Products Company.

Although the fellowship awards are intended primarily for the support of first and second year pediatric residents, it is also recognized that some physicians may desire a third or fourth year of pediatric residency. Up to 25% of the fellowships may be awarded to persons in this category. Consideration will be given to geographic spread of awards, and preference will be exhibited for well-qualified but smaller training centers which perhaps have fewer resources for residents in training than do some of the larger centers.

The Committee on Residency Fellowships of the American Academy of Pediatrics will make final decision on the granting of the Awards. Those interested in applying may write to Jean D. Lockhart, M.D., Department of Committees, American Academy of Pediatrics, P.O. Box 1034, Evanston, Illinois 60204, for application forms.

The deadline for the receipt of applications will be March 1.
NEW for kids 6 to 9* who tell you they’re ‘too old’ for syrup

10MG ALUPENT® tablets
[metaproterenol sulfate]
Bronchodilator

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**ZOSTER IMMUNE GLOBULIN AND VARICELLA-ZOSTER IMMUNE GLOBULIN**

Since January 1972, the Center for Disease Control has provided the investigational drug zoster immune globulin (ZIG) to more than 1,000 immunodeficient children within 72 hours of exposure to varicella (chickenpox). Preliminary data suggest that ZIG, which is prepared from the plasma of healthy donors convalescing from herpes zoster infection (shingles) or varicella, is effective in preventing or modifying varicella infection in immunodeficient patients if it is administered shortly after exposure.

Unfortunately, the supply of ZIG has been intermittent because the number of plasma donors has been insufficient to meet the increasing number of requests. In an attempt to meet this increasing demand, CDC has contracted with the Sidney Farber Cancer Institute and State Laboratory Institute of Massachusetts State Department of Public Health to provide and distribute a supply of varicella-zoster immune globulin (VZIG), prepared from pooled plasma containing high titers of varicella antibody.

VZIG is also an investigational drug, and the supply of it is likewise limited. Unnecessary use can be minimized, where feasible, by routine screening of children with immunodeficiency, leukemia, or lymphoma for VZ virus antibody.

Both ZIG and VZIG have been available at no cost as of November 1, 1977, for use in patients meeting the following criteria:

1. One of the following underlying illnesses or conditions
   - Leukemia or lymphoma
   - Congenital or acquired immunodeficiency
   - Receiving immunosuppressive medication
   - Newly born of mother with varicella
2. One of the following types of exposure to varicella or zoster patient
   - Household contact
   - Playmate contact (more than one hour of play indoors)
   - Hospital contact (in same two- to four-bed bedroom or adjacent beds in a large ward)
   - Newborn contact (newborn whose mother contracted varicella, within four days before delivery or within 48 hours after delivery)
3. Negative or unknown prior disease history
4. Age of less than 15 years
5. The request for treatment must be initiated within 72 hours of exposure

A physician who desires treatment for such a patient should contact the Division of Clinical Microbiology, Sidney Farber Cancer Institute, 44 Binney Street, Boston, Massachusetts; telephone (617) 732-3121. Although former ZIG consultants and the Immunization Division of CDC will no longer have responsibility for distribution of ZIG, they will be available for consultation regarding alternative modes of therapy.

the parent or guardian requesting that the school district comply with the physician’s order.

3. Medication should be brought to school in a container appropriately labeled by the pharmacy or physician.

4. One member of the staff should be designated to handle this task, ideally the health personnel if available.

5. A locked cabinet should be provided for the storage of medication.

6. Opportunities should be provided for communication between the parent, school personnel, and physician regarding the efficacy of the medication administered during school hours.

7. A designated member of the school staff should notify the parent or guardian as quickly as possible after an emergency occurs. The parent’s current telephone number should be available in the student’s record specifically for this purpose.

Nonprescription medication, e.g., aspirin, ointments, cold tablets, should not be given without prior written permission of parent or guardian.

There should be close cooperation between学校 officials and the child’s physician so that the medical program can be modified as warranted by changes in the student’s condition.

School districts that assume the responsibility for giving medication during school hours should provide liability coverage for the staff, including the nurse, teachers, athletic staff, principal, superintendent, and school board.

COMMITTEE ON SCHOOL HEALTH, 1976-1977

Members: Donald E. Cook, M.D., Chairman; Karl W. Hess, M.D.; Samuel R. Leavitt, M.D.; Norman B. Schell, M.D.; Ned W. Smull, M.D.; J. Ward Stackpole, M.D.; Casper E. Wiggins, M.D.

Liaison Representatives: Lauren M. Brown, M.D., American Academy of Family Physicians; Stephen J. Jerrick, Ph.D., American School Health Association; William H. Carlyon, Ph.D., American Medical Association

REFERENCES


MEDICAL COSTS SOARING EVERYWHERE

The French government is desperately seeking more means of reducing social security expenditure combined. It is common for a patient in a teaching hospital with mild abdominal pain to have full gallbladder and bowel x-rays in addition to the full battery of blood and urine tests which means that each patient in a Paris teaching hospital now costs Social Security nearly 600 francs a day ($200). As Mr. Barre states, “we are heading for disaster,” something will have to be done about it.

At a recent meeting on the cost to France of chronic renal failure, Professor Sournia, chief medical advisor to Social Security, stated that 7,000 patients were now being treated and were costing 1,000 million francs yearly, i.e. 1% of the whole Social Security budget. Considerable economy would be obtained if more kidney donors were available for transplantation and if more patients could undergo dialysis at home which costs about half that of a specialized unit. The Social Security are even prepared to pay for the telephone to be installed, but many patients who have tried home dialysis return to hospital because of the emotional strain for their families. According to Professor Sournia only 15% of patients with chronic renal failure in France undergo home dialysis as against 29% in Germany and 65% in Britain.

patient when indicated by the judgment of the attending physician who, in consultation with the radiologist, can determine the examination protocol.

All physicians who request and conduct radiologic examinations should familiarize themselves with the pertinent radiologic information. The attending physician should carefully consider the need for the examination and record the decision in the patient's record. And, the x-ray consultation request should carry a notation that the matter of potential or actual pregnancy has been taken into account in the decision to request the examination.

Committee on Radiology

1978 PEDIATRIC ENDOCRINOLOGY EXAMINATION

The Subspecialty Committee of Pediatric Endocrinology of the American Board of Pediatrics will administer its first certifying examination on Friday, October 6, 1978. The following criteria must be met to be eligible to sit for the exam:

1. Certification by the American Board of Pediatrics;
2. Two years of full-time graduate training in pediatric endocrinology completed by September 1, 1978; or five years in the clinical practice of pediatric endocrinology completed by September 1, 1978; or a combination of fellowship and practice to total five years of experience completed by September 1, 1978: (a) for fellowships of less than 12 months, one month of fellowship equals one month of practice; (b) for fellowships of 12 to 23 months, one month of fellowship equals two months of practice;
3. Letters of recommendation from individuals able to attest to the applicant's training or clinical practice.

Each application will be considered individually and must be acceptable to the Subspecialty Committee of Pediatric Endocrinology.

Registration for this exam will extend from January 1, 1978, to April 30, 1978. Requests for applications received prior to the opening of registration will be held on file until that date, at which time application materials will be sent to those who have requested them.

The application fee is $450 ($150 registration and $300 examination). Candidates who are not approved to take the examination will be refunded the $300 exam fee. The registration fee will be retained.

Please direct inquiries to the American Board of Pediatrics, Children's Hospital, 34th Street and Civic Center Boulevard, Philadelphia, PA 19104; telephone (215) 349-8500.

Members: Alvin Felman, M.D., Chairman; Norman Glazer, M.D.; William McSweeney, M.D.; William Northway, MD.; Leonard Swischuk, M.D.; Herman Grossman, M.D., Advisor

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