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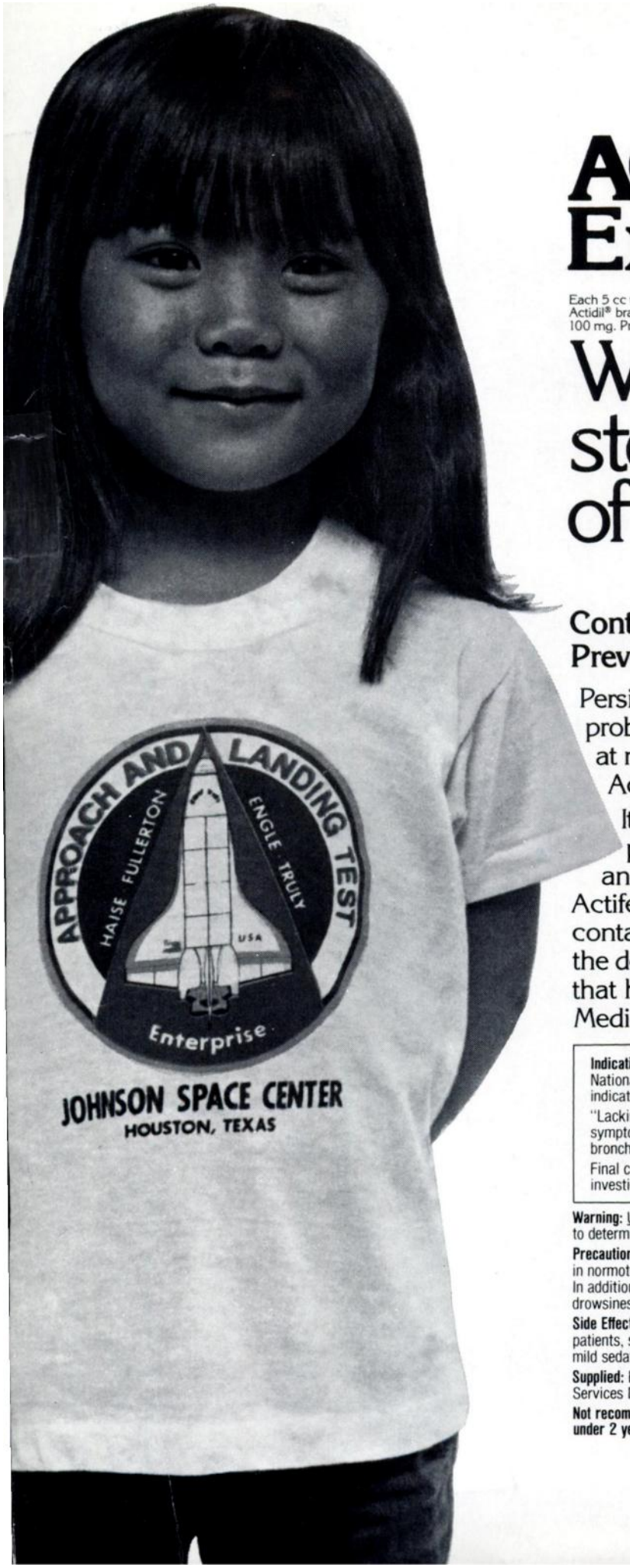

ACTIFED-C® Expectorant ℞

Each 5 cc teaspoonful contains: codeine phosphate 10 mg (Warning—may be habit-forming); Actidil® brand triprolidine HCl 2 mg; Sudafed® brand pseudoephedrine HCl 30 mg; guaifenesin 100 mg. Preservatives are methylparaben 0.1% and sodium benzoate 0.1%.

With the cough-stopping power of codeine.

Controls Excessive Coughing Without Preventing Productive Expectoration

Persistent, repetitive, dry coughs can be a problem in the pediatric patient, particularly at night when it often disturbs sleep. Actifed-C is made for this type of cough.

It contains codeine to reduce severity and persistence plus guaifenesin to liquefy and ease the expulsion of mucus. Moreover, Actifed-C is the only cough medication that contains triprolidine and pseudoephedrine... the decongestant/antihistamine combination that has been part of the NASA Space Medicine Kit since 1968.

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 indications as follows:

"Lacking substantial evidence of effectiveness as a fixed combination": For the symptomatic relief of cough in conditions such as: the common cold, acute bronchitis, allergic asthma, bronchiolitis, croup, emphysema, tracheobronchitis.

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

Warning: Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Precautions: Although pseudoephedrine hydrochloride causes virtually no pressor effect in normotensive patients, it should be used with caution in patients with hypertension. In addition, even though triprolidine hydrochloride produces only a low incidence of drowsiness, appropriate precautions should be observed.

Side Effects: The great majority of patients will not have any side effects. Only certain patients, sensitive to one or another of the ingredients, may note mild stimulation or mild sedation.

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Not recommended for use in children under 2 years of age.

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Effective, fast-acting sore throat relief.

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*See Physicians' Desk Reference for full prescribing information.

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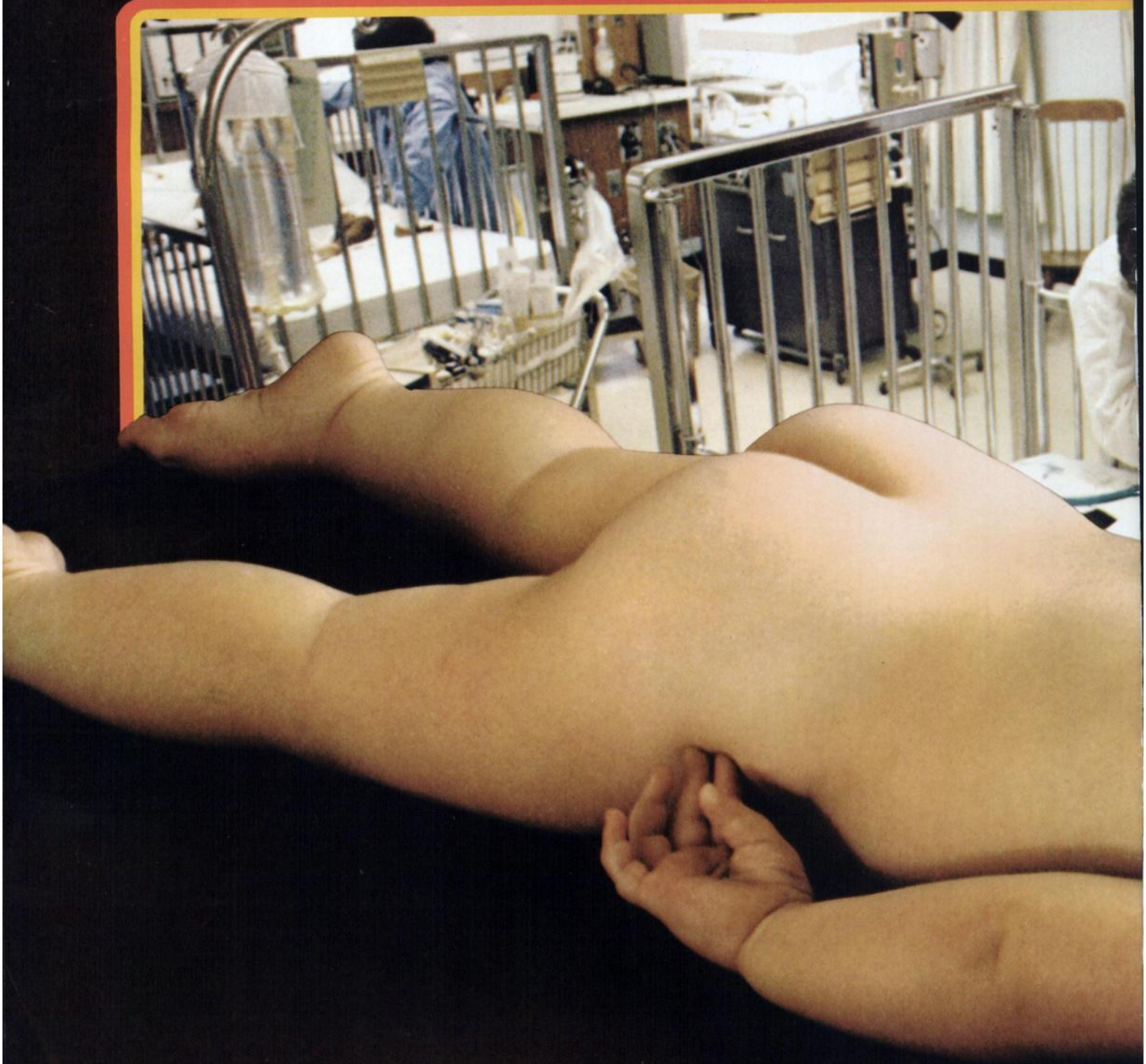
CHLOROMYCETIN®

(chloramphenicol) Sodium Succinate for injection

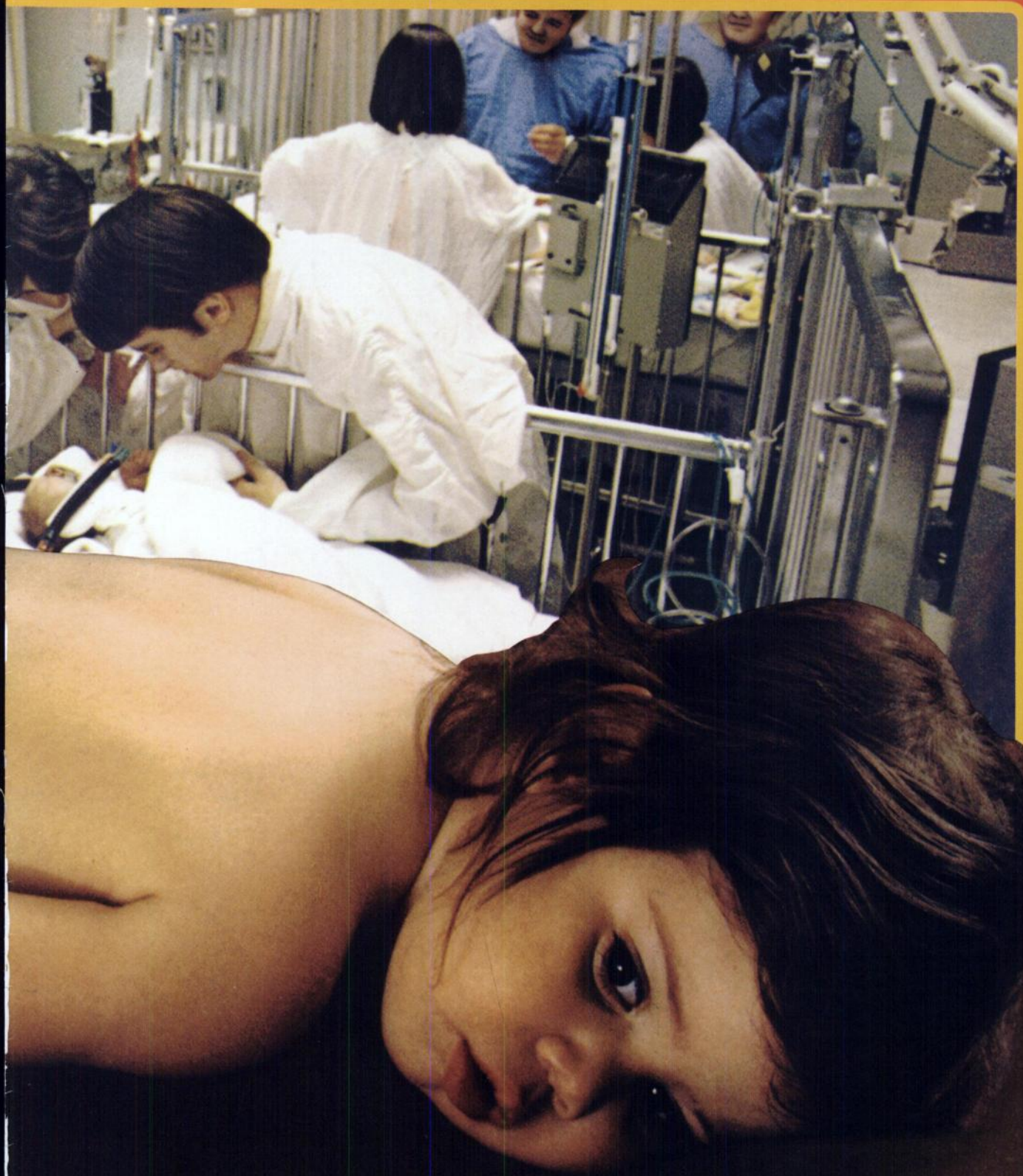


Chloromycetin (chloramphenicol) must be used only in those serious infections for which less potentially dangerous drugs are ineffective or contraindicated. However, Chloromycetin may be chosen to initiate antibiotic therapy on the clinical impression that *Hemophilus influenzae* meningitis is believed 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.

for H influenzae meningitis



Please see next page for complete prescribing information.

PARKE-DAVIS

Prescribing Information
Chloromycetin Sodium Succinate
(chloramphenicol sodium succinate for injection, USP)
For intravenous administration

WARNING

Serious and fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, and granulocytopenia) are known to occur after the administration of chloramphenicol. In addition, there have been reports of aplastic anemia attributed to chloramphenicol which later terminated in leukemia. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Chloramphenicol must not be used when less potentially dangerous agents will be effective, as described in the Indications section. *It must not be used in the treatment of trivial infections or where it is not indicated, as in colds, influenza, infections of the throat; or as a prophylactic agent to prevent bacterial infections.*

Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia, reticulocytopenia, or granulocytopenia, before they become irreversible, such studies cannot be relied on to detect bone marrow depression prior to development of aplastic anemia. To facilitate appropriate studies and observation during therapy, it is desirable that patients be hospitalized.

IMPORTANT CONSIDERATIONS IN PRESCRIBING INJECTABLE CHLORAMPHENICOL SODIUM SUCCINATE

CHLORAMPHENICOL SODIUM SUCCINATE IS INTENDED FOR INTRAVENOUS USE ONLY. IT HAS BEEN DEMONSTRATED TO BE INEFFECTIVE WHEN GIVEN INTRAMUSCULARLY.

1. Chloramphenicol sodium succinate must be hydrolyzed to its microbiologically active form and there is a lag in achieving adequate blood levels compared with the base given intravenously.
2. The oral form of chloramphenicol is readily absorbed and adequate blood levels are achieved and maintained on the recommended dosage.
3. Patients started on intravenous chloramphenicol sodium succinate should be changed to the oral form as soon as practicable.

DESCRIPTION

Chloramphenicol is an antibiotic that is clinically useful for, *and should be reserved for,* serious infections caused by organisms susceptible to its antimicrobial effects when less potentially hazardous therapeutic agents are ineffective or contraindicated. Sensitivity testing is essential to determine its indicated use, but may be performed concurrently with therapy initiated on clinical impression that one of the indicated conditions exists (see Indications section).

Each gram (10 ml of a 10% solution) of chloramphenicol sodium succinate contains approximately 52 mg (2.25 mEq) of sodium.

ACTIONS AND PHARMACOLOGY

In vitro chloramphenicol exerts mainly a bacteriostatic effect on a wide range of gram-negative and grampositive bacteria and is active *in vitro* against rickettsias, the lymphogranuloma-psittacosis group, and *Vibrio cholerae.* It is particularly active against *Salmonella typhi* and *Hemophilus influenzae.* The mode of action is through interference or inhibition of protein synthesis in intact cells and in cell-free systems.

Chloramphenicol administered orally is absorbed rapidly from the intestinal tract. In controlled studies in adult volunteers using the recommended dosage of 50 mg/kg/day, a dosage of 1 g every six hours for eight doses was given. Using the microbiological assay method, the average peak serum level was 11.2 mcg/ml one hour after the first dose. A cumulative effect gave a peak rise to 18.4 mcg/ml after the fifth dose of 1 g. Mean serum levels ranged from 8 to 14 mcg/ml over the 48-hour period. Total urinary excretion of chloramphenicol in these studies ranged from a low of 68% to a high of 99% over a three-day period. From 8% to 12% of the antibiotic excreted is in the form of free chloramphenicol; the remainder consists of microbiologically inactive metabolites, principally the conjugate with glucuronic acid. Since the glucuronide is excreted rapidly, most chloramphenicol detected in the blood is in the microbiologically active free form. Despite the small proportion of unchanged drug excreted in the urine, the concentration of free chloramphenicol is relatively high, amounting to several hundred mcg/ml in patients receiving divided doses of 50 mg/kg/day. Small amounts of active drug are found in bile and feces. Chloramphenicol diffuses rapidly, but its distribution is not uniform. Highest concentrations are found in liver and kidney, and lowest concentrations are found in brain and cerebrospinal fluid. Chloramphenicol enters cerebrospinal fluid even in the absence of meningeal inflammation, appearing in concentrations about half of those found in the blood. Measurable levels are also detected in pleural and in ascitic fluids, saliva, milk, and in the aqueous and vitreous humors. Transport across the placental barrier occurs with somewhat lower concentration in cord blood of newborn infants than in maternal blood.

INDICATIONS

In accord with the concepts in the Warning Box and this Indications section, chloramphenicol must be used only in those serious infections for which less potentially dangerous drugs are ineffective or contraindicated. However, chloramphenicol may be chosen to initiate antibiotic therapy on the clinical impression that one of the conditions below is believed to be present; *in vitro* sensitivity tests should be performed concurrently so that the drug may be discontinued as soon as possible if less potentially dangerous agents are indicated by such tests. The decision to continue use of chloramphenicol rather than another antibiotic when both are suggested by *in vitro* studies to be effective against a specific pathogen should be based upon severity of the infection, susceptibility of the pathogen to the various antimicrobial drugs, efficacy of the various drugs in the infection, and the important additional concepts contained in the Warning Box above.

1. Acute infections caused by *S typhi**
   It is not recommended for the routine treatment of the typhoid carrier state.
2. Serious infections caused by susceptible strains in accordance with the concepts expressed above.
   a) *Salmonella* species
   b) *H influenzae,* specifically meningeal infections
   c) Rickettsia
   d) Lymphogranuloma-psittacosis group
   e) Various gram-negative bacteria causing bacteremia, meningitis, or other serious gram-negative infections
   f) Other susceptible organisms which have been demonstrated to be resistant to all other appropriate antimicrobial agents
3. Cystic fibrosis regimens

*In the treatment of typhoid fever, some authorities recommend that chloramphenicol be administered at therapeutic levels for 8 to 10 days after the patient has become afebrile to lessen the possibility of relapse.

CONTRAINDICATIONS

Chloramphenicol is contraindicated in individuals with a history of previous hypersensitivity and/or toxic reaction to it. *It must not be used in the treatment of trivial infections or where it is not indicated, as in colds, influenza, infections of the throat; or as a prophylactic agent to prevent bacterial infection.*

PRECAUTIONS

1. Base line blood studies should be followed by periodic blood studies approximately every two days during therapy. The drug should be discontinued upon appearance of reticulocytopenia, leukopenia, thrombocytopenia, anemia, or any other blood study findings attributable to chloramphenicol. However, it should be noted that such studies do not exclude the possible later appearance of the irreversible type of bone marrow depression.
2. Repeated courses of the drug should be avoided if at all possible. Treatment should not be continued longer than required to produce a cure with little or no risk of relapse of the disease.
3. Concurrent therapy with other drugs that may cause bone marrow depression should be avoided.
4. Excessive blood levels may result from administration of the recommended dose to patients with impaired liver or kidney function, including that due to immature metabolic processes in the infant. The dosage should be adjusted accordingly or, preferably, the blood concentration should be determined at appropriate intervals.
5. There are no studies to establish the safety of this drug in pregnancy.
6. Since chloramphenicol readily crosses the placental barrier, caution in use of the drug is particularly important during pregnancy at term or during labor because of potential toxic effects on the fetus (gray syndrome).
7. Precaution should be used in therapy of premature and full-term infants to avoid gray syndrome toxicity. (See Adverse Reactions.) Serum drug levels should be carefully followed during therapy of the newborn infant.
8. Precaution should be used in therapy during lactation because of the possibility of toxic effects on the nursing infant.
9. The use of this antibiotic, as with other antibiotics, may result in an overgrowth of nonsusceptible organisms, including fungi. If infections caused by nonsusceptible organisms appear during therapy, appropriate measures should be taken.

ADVERSE REACTIONS

1. Blood Dyscrasias

The most serious adverse effect of chloramphenicol is bone marrow depression. Serious and fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, and granulocytopenia) are known to occur after the administration of chloramphenicol. An irreversible type of marrow depression leading to aplastic anemia with a high rate of mortality is characterized by the appearance weeks or months after therapy of bone marrow aplasia or hypoplasia. Peripherally, pancytopenia is most often observed, but in a small number of cases only one or two of the three major cell types (erythrocytes, leukocytes, platelets) may be depressed.

A reversible type of bone marrow depression, which is dose-related, may occur. This type of marrow depression is characterized by vacuolization of the erythroid cells, reduction of reticulocytes, and leukopenia, and responds promptly to the withdrawal of chloramphenicol.

An exact determination of the risk of serious and fatal blood dyscrasias is not possible because of lack of accurate information regarding (1) the size of the population at risk, (2) the total number of drug-associated dyscrasias, and (3) the total number of nondrug-associated dyscrasias.

In a report to the California State Assembly by the California Medical Association and the State Department of Public Health in January 1967, the risk of fatal aplastic anemia was estimated at 1:24,200 to 1:40,500 based on two dosage levels.

There have been reports of aplastic anemia attributed to chloramphenicol which later terminated in leukemia.

Paroxysmal nocturnal hemoglobinuria has also been reported.

2. Gastrointestinal Reactions

Nausea, vomiting, glossitis and stomatitis, diarrhea and enterocolitis may occur in low incidence.

3. Neurotoxic Reactions

Headache, mild depression, mental confusion, and delirium have been described in patients receiving chloramphenicol. Optic and peripheral neuritis have been reported, usually following long-term therapy. If this occurs, the drug should be promptly withdrawn.

4. Hypersensitivity Reactions

Fever, macular and vesicular rashes, angioedema, urticaria, and anaphylaxis may occur. Herxheimer reactions have occurred during therapy for typhoid fever.

5. "Gray Syndrome"

Toxic reactions including fatalities have occurred in the premature and newborn; the signs and symptoms associated with these reactions have been referred to as the gray syndrome. One case of gray syndrome has been reported in an infant born to a mother having received chloramphenicol during labor. One case has been reported in a 3-month-old infant. The following summarizes the clinical and laboratory studies that have been made on these patients:

a) In most cases, therapy with chloramphenicol had been instituted within the first 48 hours of life.
b) Symptoms first appeared after three to four days of continued treatment with high doses of chloramphenicol.
c) The symptoms appeared in the following order:
   (1) abdominal distention with or without emesis;
   (2) progressive pallid cyanosis;
   (3) vasomotor collapse, frequently accompanied by irregular respiration;
   (4) death within a few hours of onset of these symptoms.
d) The progression of symptoms from onset to exitus was accelerated with higher dose schedules.
e) Preliminary blood serum level studies revealed unusually high concentrations of chloramphenicol (over 90 mcg/ml after repeated doses).
f) Termination of therapy upon early evidence of the associated symptomatology frequently reversed the process with complete recovery.

ADMINISTRATION

Chloramphenicol, like other potent drugs, should be prescribed at recommended doses known to have therapeutic activity. Administration of 50 mg/kg/day in divided doses will produce blood levels of the magnitude to which the majority of susceptible microorganisms will respond.

As soon as feasible, an oral dosage form of chloramphenicol should be substituted for the intravenous form because adequate blood levels are achieved with chloramphenicol by mouth.

The following method of administration is recommended:

Intravenously as a 10% (100 mg/ml) solution to be injected over at least a one-minute interval. This is prepared by the addition of 10 ml of an aqueous diluent such as water for injection or 5% dextrose injection.

DOSAGE

Adults

Adults should receive 50 mg/kg/day in divided doses at six-hour intervals. In exceptional cases, patients with infections due to moderately resistant organisms may require increased dosage up to 100 mg/kg/day to achieve blood levels inhibiting the pathogen, but these high doses should be decreased as soon as possible. Adults with impairment of hepatic or renal function or both may have reduced ability to metabolize and excrete the drug. In instances of impaired metabolic processes, dosages should be adjusted accordingly. (See discussion under Newborn Infants.) Precise control of concentration of the drug in the blood should be carefully followed in patients with impaired metabolic processes by the available microtechniques (information available on request).

Children

Dosage of 50 mg/kg/day divided into four doses at six-hour intervals yields blood levels in the range effective against most susceptible organisms. Severe infections (eg, bacteremia or meningitis), especially when adequate cerebrospinal fluid concentrations are desired, may require dosage up to 100 mg/kg/day; however, it is recommended that dosage be reduced to 50 mg/kg/day as soon as possible. Children with impaired liver or kidney function may retain excessive amounts of the drug.

Newborn Infants
(See section titled Gray Syndrome under Adverse Reactions.)

A total of 25 mg/kg/day in four equal doses at six-hour intervals usually produces and maintains concentrations in blood and tissues adequate to control most infections for which the drug is indicated. Increased dosage in these individuals, demanded by severe infections, should be given only to maintain the blood concentration within a therapeutically effective range. After the first two weeks of life, full-term infants ordinarily may receive up to a total of 50 mg/kg/day equally divided into four doses at six-hour intervals. *These dosage recommendations are extremely important because blood concentration in all premature infants and full-term infants under two weeks of age differs from that of other infants.* This difference is due to variations in the maturity of the metabolic functions of the liver and the kidneys.

When these functions are immature (or seriously impaired in adults), high concentrations of the drug are found which tend to increase with succeeding doses.

Infants and Children with Immature Metabolic Processes

In young infants and other children in whom immature metabolic functions are suspected, a dose of 25 mg/kg/day will usually produce therapeutic concentrations of the drug in the blood. In this group particularly, the concentration of the drug in the blood should be carefully followed by microtechniques. (Information available on request.)

HOW SUPPLIED

N 0071-4057-3 (Steri-Vial® No. 57)
Chloromycetin Sodium Succinate (chloramphenicol sodium succinate for injection, USP) is supplied as a dried powder in Steri-Vials (rubber-diaphragm-capped vials). When reconstituted as directed, each vial contains a sterile solution equivalent to 100 mg of chloramphenicol per milliliter (1 g/10 ml). Available in packages of 10 vials.

CHLOROMYCETIN, brand of chloramphenicol. Reg US Pat Off RJ

PD-JA-1281-2-P(12-77)

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Send all manuscripts to Jerold F. Lucey, MD, Editor, Pediatrics Editorial Office, Mary Fletcher Hospital, Colchester Avenue, Burlington, VT 05401.

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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.

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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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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 a 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.

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Pediatrics

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Dosage: Treatment should be initiated at 150 mg theophylline every 6 hours for adults and 4 mg/kg every 6 hours for children. The usual recommended dosages are *Adults:* 1-2 capsules or 1-2 tablespoons (15 ml) liquid every 6-8 hours. *Children 9 to 12:* 4-5 mg theophylline/kg bodyweight every 6-8 hours. *Children under 9:* 4-6 mg theophylline/kg bodyweight every 6-8 hours. When necessary, to achieve greater efficacy theophylline dosage may be cautiously adjusted upward. Serum theophylline determinations are helpful in monitoring therapeutic progress. When dosages exceed the usual recommended ranges serum determinations are essential. In the absence of side effects, the dosage may be titrated upward cautiously by increments of no more than 25% of previous dose, increasing the dose no more than every third day until the desired clinical response is obtained. If nausea, vomiting or other evidence of toxicity occurs, omit one dose and resume treatment at a lower dose.
Warnings: 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 compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e., clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. 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 is not usually a problem at serum theophylline levels below 20 mcg/ml.
How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Liquid in bottles of 1 pint and 1 gallon.
See package insert for complete prescribing information.

Mead Johnson PHARMACEUTICAL DIVISION

AMERICAN ACADEMY OF PEDIATRICS

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Oct 31 to Nov 5

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

1983
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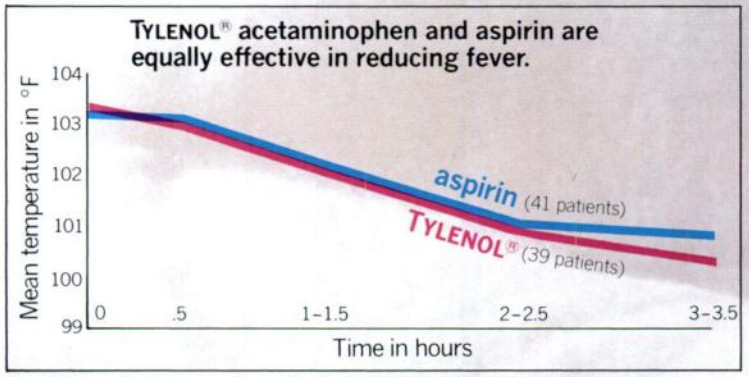
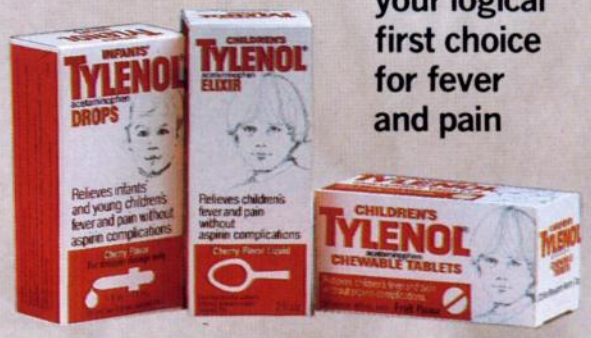
acetaminophen

Clinical evidence:



Adapted from Tarlin,L., et al: Am J Dis Child 124:880-882 (Dec.) 1972.



your logical first choice for fever and pain

McNEIL

McNeil Consumer Products Company
Fort Washington, Pa. 19034

PEDICULOSIS.

THE ONLY DISEASE YOU CAN CURE IN FOUR MINUTES.

A single, four-minute lathering with Kwell Shampoo is generally all it takes to eliminate head and pubic lice fast–and completely![1] Just about 100% effective,[2] nonsensitizing and nonirritating to the skin, it's as easy to use as any ordinary shampoo.[1,2] For lice on less hirsute areas of the body, and for scabies, Kwell is also available in lotion form.

Available on prescription as Kwell Shampoo and Lotion in 2 and 16 fl. oz. bottles, and as Kwell Cream in 2 oz. and 1 lb. jars. Patient instruction pads in English and Spanish are available on request. See package insert for complete prescribing information.

REFERENCES: 1. Wexler, L.: Am. J. Nurs. 69:3, March, 1969. 2. Patient Care 7:94, Nov. 1, 1973.

WARNING: KWELL SHOULD BE USED WITH CAUTION ESPECIALLY IN INFANTS, CHILDREN AND IN PREGNANCY. GAMMA BENZENE HEXACHLORIDE PENETRATES HUMAN SKIN AND HAS THE POTENTIAL FOR CNS TOXICITY. STUDIES INDICATE THAT POTENTIAL TOXIC EFFECTS OF TOPICALLY APPLIED LINDANE ARE GREATER IN THE YOUNG. Seizures have been reported after the use of gamma benzene hexachloride but a cause and effect relationship has not been established. Simultaneous application of creams, ointments or oils may enhance the percutaneous absorption of gamma benzene hexachloride.

PRECAUTIONS: If accidental ingestion occurs, prompt institution of gastric lavage will rid the body of large amounts of the toxicant. However, since oils favor absorption, saline cathartics for intestinal evacuation should be given rather than oil laxatives. If central nervous system manifestations occur, they can be antagonized by the administration of pentobarbital, or phenobarbital.

If accidental contact with the eyes occurs flush with water. If irritation or sensitization occurs discontinue this product and consult a physician.

ADVERSE REACTIONS: Eczematous eruptions due to irritation from this product have been reported.

The unsurpassed standard for the treatment of pediculosis and scabies.

Kwell®

Gamma Benzene Hexachloride

SHAMPOO/LOTION/CREAM

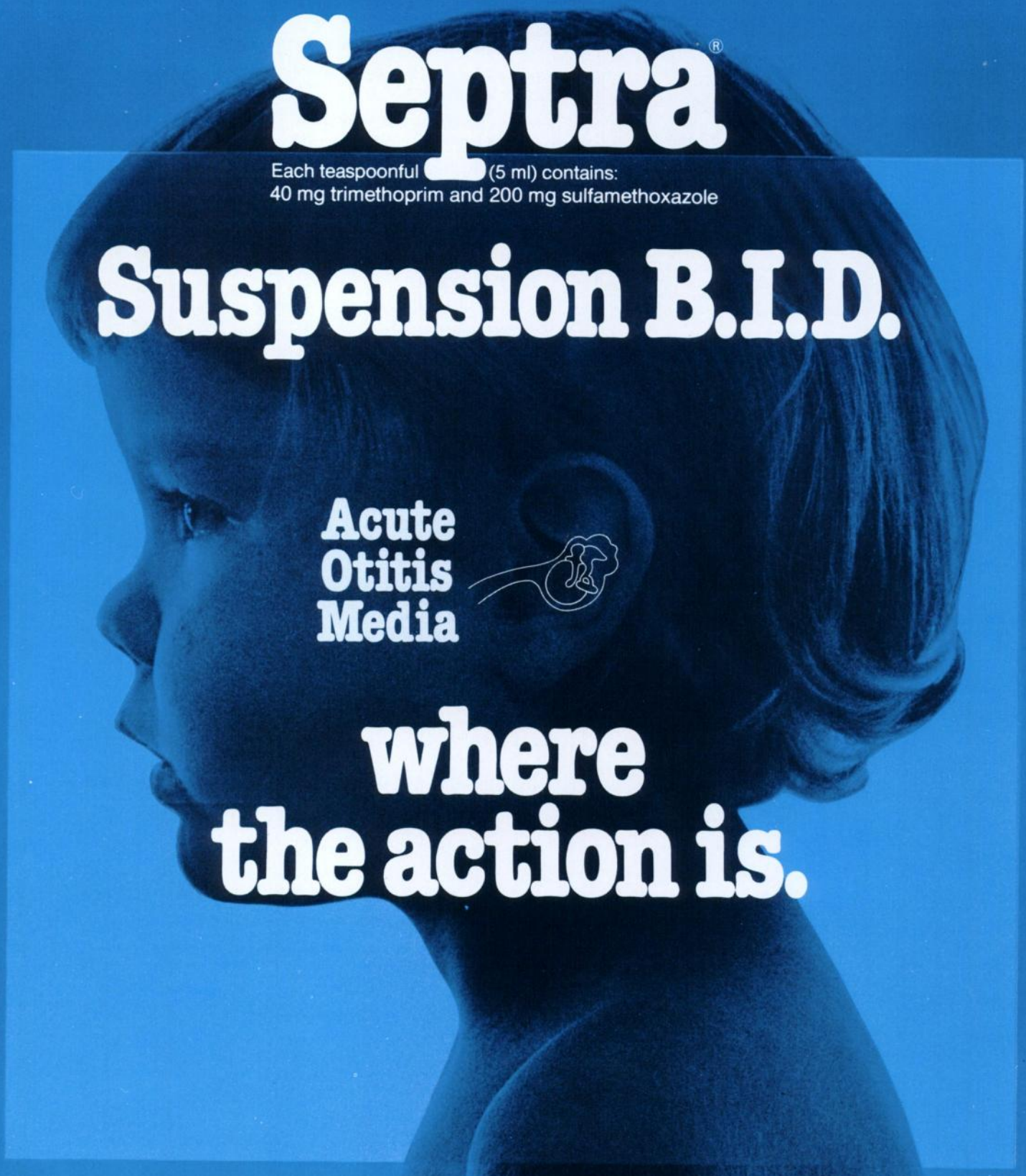
Reed & Carnrick/Kenilworth, New Jersey 07033

In pediatric infections

Septra®

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

Suspension B.I.D.



Acute Otitis Media

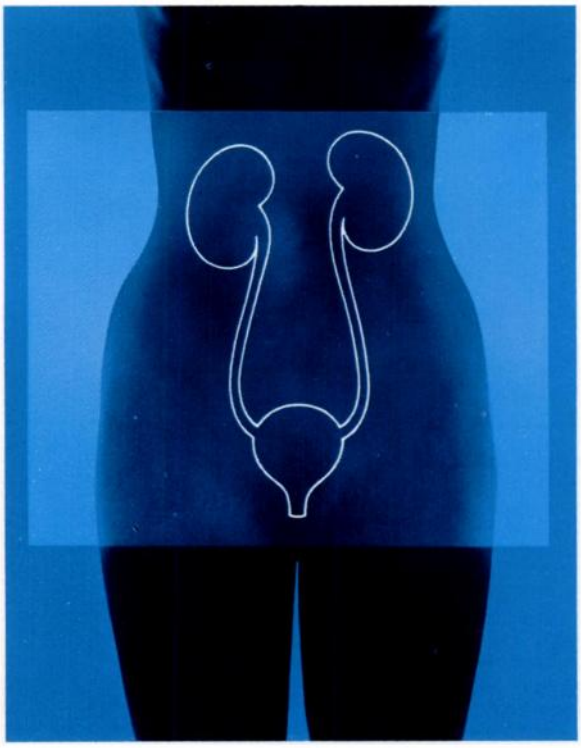
where the action is.

In acute otitis media

Septra Suspension provides effective antibacterial action against susceptible strains of H influenzae and S pneumoniae (D pneumoniae), the pathogens most likely to cause acute otitis media in children.

Septra Suspension is useful in many patients, but especially in those with penicillin allergy or with infections caused by ampicillin-resistant H influenzae. Limited clinical data are presently available on the effectiveness of treatment of acute otitis media with Septra when the infection is due to H influenzae resistant to ampicillin. However, in vitro data is highly favorable; when over 200 strains of ampicillin-resistant H influenzae were tested, all proved susceptible to TMP/SMX.*

And unlike most other antibacterials for the treatment of acute otitis media, Septra Suspension is administered on a convenient b.i.d. dosage schedule. The cherry-flavored suspension is well accepted by children.



In recurrent urinary tract infections

Septra Suspension provides effective antibacterial action in urine and blood against susceptible strains of E coli, Klebsiella-Enterobacter and Proteus. Whether the infection centers in the kidneys or bladder, Septra Suspension maintains effective levels at the site of the infection with just two doses a day.

Adequate fluid intake should be maintained and frequent urinalyses with careful microscopic examination performed during Septra therapy. Septra is contraindicated in infants under two months of age.

*In vitro data do not necessarily correlate with clinical results. Data on file, Burroughs Wellcome Co.
NOTE: Septra should not be used in the treatment of streptococcal pharyngitis.

Please see prescribing information on next page.

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Septra® Suspension B.I.D.

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

Septra® DS B.I.D.

Each tablet contains: 160 mg trimethoprim and 800 mg sulfamethoxazole

Septra® DS Tablets Double Strength
Septra® Tablets
Septra® Suspension

INDICATIONS AND USAGE:
URINARY TRACT INFECTIONS: **For the treatment of 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: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of these urinary tract infections.

ACUTE OTITIS MEDIA: **For the treatment of acute otitis media in children due to susceptible strains of** *Haemophilus influenzae* **or** *Streptococcus pneumoniae* **when in the judgment of the physician Septra offers some advantage over the use of other antimicrobial agents. Limited clinical information is presently available on the effectiveness of treatment of otitis media with Septra when the infection is due to** *Haemophilus influenzae* **resistant to ampicillin. To date, there are limited data on the safety of repeated use of Septra in children under two years of age. Septra is not indicated for prophylactic or prolonged administration in otitis media at any age.**

SHIGELLOSIS: **For the treatment of enteritis caused by susceptible strains of** *Shigella flexneri* **and** *Shigella sonnei* **when antibacterial therapy is indicated.**

PNEUMOCYSTIS CARINII **PNEUMONITIS: For the treatment of documented** *Pneumocystis carinii* **pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.**

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

WARNINGS: SEPTRA SHOULD NOT BE USED IN THE TREATMENT OF STREPTOCOCCAL PHARYNGITIS.

Clinical studies have documented that patients with Group A β-hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with Septra than do those patients treated with penicillin as evidenced by failure to eradicate this organism from the tonsillopharyngeal area.

Deaths associated with administration of sulfonamides have been reported 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 thrombopenia 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.

Since Septra may prolong prothrombin time in patients on warfarin, coagulation time should be reassessed when Septra is given.

ADVERSE REACTIONS: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Septra. *Blood Dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic Reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal Reactions:* Glossitis, 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. Periarteritis nodosa and L. E. phenomenon have occurred.

Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) 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.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: The usual adult dosage for the treatment of urinary tract infections is two tablets or four teaspoonfuls (20 ml) every 12 hours for 10 to 14 days. An identical daily dosage is used for 5 days in the treatment of shigellosis.

Children: The recommended dose for children with urinary tract infections or acute otitis media is 8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, given in two divided doses every 12 hours for 10 days. An identical daily dosage is used for 5 days in the treatment of shigellosis. The following table is a guideline for the attainment of this dosage using Septra Tablets or Suspension.

Children: Two months of age or older:

Weight		Dose —every 12 hours	
lb	kg	Teaspoonfuls	Tablets
22	10	1 (5 ml)	½
44	20	2 (10 ml)	1
66	30	3 (15 ml)	1½
88	40	4 (20 ml)	2 (or 1 DS tablet)

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual Standard Regimen
15-30	Half of the usual dosage regimen
Below 15	Use Not Recommended

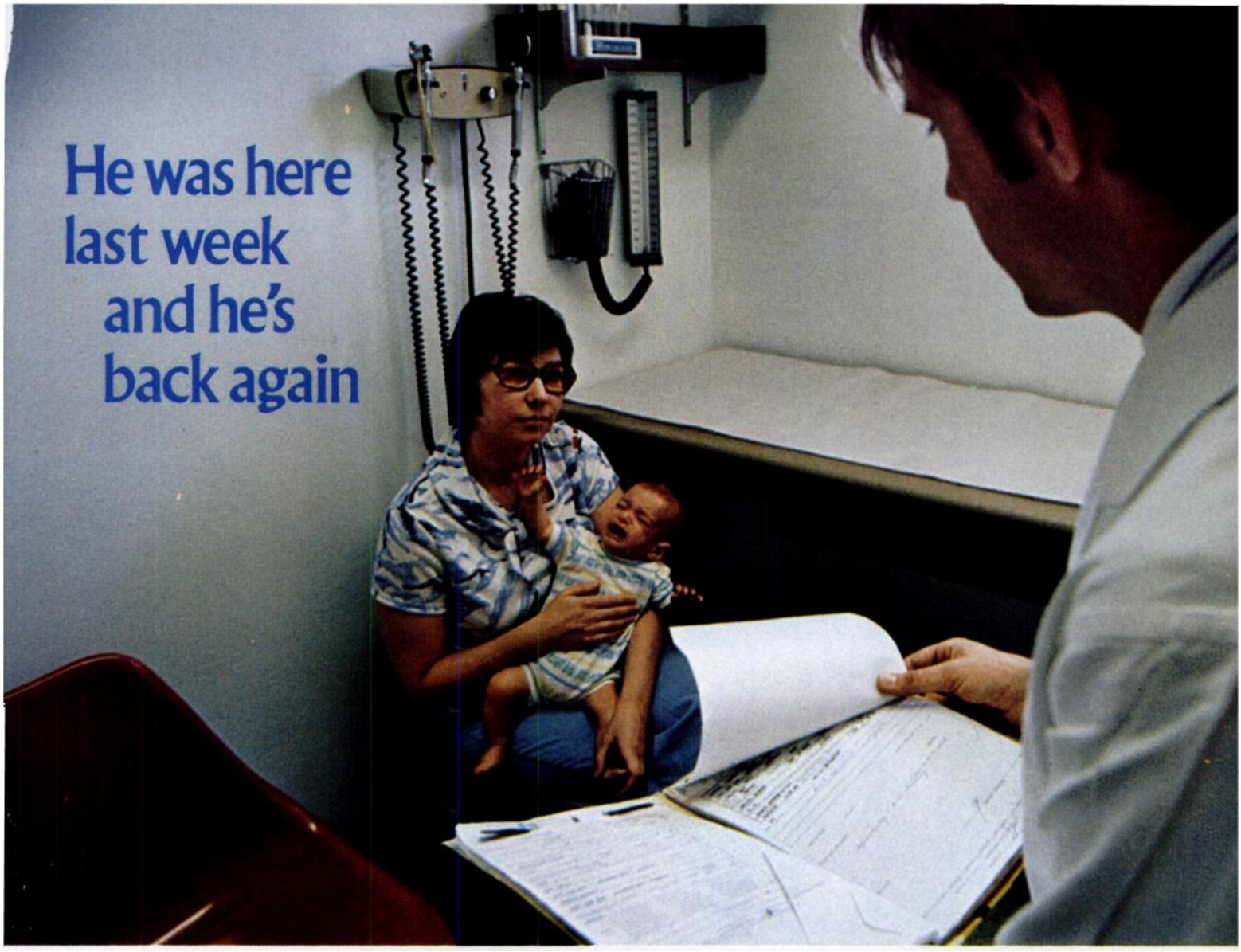
PNEUMOCYSTIS CARINII **PNEUMONITIS:**
The recommended dosage for patients with documented *Pneumocystis carinii* pneumonitis is 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours given in equally divided doses every 6 hours for 14 days. The following table is a guideline for the attainment of this dosage in children.

Weight		Dose —every 6 hours	
lb	kg	Teaspoonfuls	Tablets
18	8	1 (5 ml)	½
35	16	2 (10 ml)	1
53	24	3 (15 ml)	1½
70	32	4 (20 ml)	2 (or 1 DS tablet)

HOW SUPPLIED: TABLETS, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 40, 100, 500 and 1000 tablets; unit dose pack of 100.

ORAL SUSPENSION, containing the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole in each teaspoonful (5 ml), cherry flavored—bottle of 450 ml. Also available in double strength, oval-shaped, pink, scored tablets containing 160 mg trimethoprim and 800 mg sulfamethoxazole—Compliance™ Pak of 20, bottle of 60 and unit dose pack of 100.

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709



Have you ruled out cow-milk sensitivity?

The physical symptoms are many and varied: diarrhea, colic, eczema, asthma, vomiting, bronchitis, rhinitis. They can be coupled with behavioral symptoms: repeated refusal of the nursing bottle . . . general fussiness.[1-3]

Alone or together, the manifestations of milk sensitivity are an unnecessary burden for the infant . . . and parents. More important, if unchecked the allergic syndromes can lead to failure to thrive and other serious health problems.[4]

With Isomil® Soy Protein Formula you can avoid the symptoms of milk sensitivity and help confirm your initial diagnosis.

Moreover, Isomil promotes normal growth.[2,5] It looks like milk, it pours like milk and has a pleasant aroma, which help insure acceptability. Unlike milk, Isomil is lactose free. It avoids the possibility of prolonged or recurring diarrhea caused by lactose intolerance.

Consider the possibility of milk sensitivity when associated symptoms are presented. "A high index of suspicion" is essential to its prompt detection.[2,6]

References: 1. Rapp, D. J.: Milk Allergy — From Birth to Old Age. Consultant 14:120, 1974. 2. Cowan, C.C., Brownlee, R.C., DeLoache, W.R., Jackson, H.P., and Matthews, J.P.: A Soy Protein Isolate Formula in the Management of Allergy in Infants and Children. South. Med. J. 62:389, 1969. 3. Clein, N.W.: Cow's Milk Allergy in Infants and Children. Int. Arch. Allergy, 13:245, 1958. 4. Goldman, A.S., Anderson, D.W., Sellars, W.A., Saperstein, S., Kniker, W.T., Halpern, S.R.: Milk Allergy. 1. Oral Challenge with Milk and Isolated Milk Proteins in Allergic Children. Ped. 32:425, 1963. 5. Jung AL, Carr SL: A soy protein formula and a milk-based formula. Clin.Ped. 16:982, 1977. 6. Frier, S. and Kletter, B.: Milk Allergy in Infants and Young Children. Clin. Ped. 9:449, 1970.

Switch first to ISOMIL®

Soy Protein Formula

when the baby can't take milk

ROSS LABORATORIES
COLUMBUS, OHIO 43216
Division of Abbott Laboratories, USA

208-B169

St. Joseph.®
For over thirty years we've been helping you relieve the symptoms of a child's common cold.

Introduced 1947

St. Joseph Aspirin For Children

No other Children's Antipyretic/Analgesic has such a long record of efficacy and tolerance.

- more than a quarter century of proven efficacy and tolerance
- first to provide the desirable children's dosage
- first with pure orange flavor
- first with safety lock cap
- chewy, creamy texture.

FORMULA: Aspirin 1-1/4 grain per tablet
SUPPLIED: In bottles of 36 tablets

St. Joseph Cold Tablets For Children

Effective nasal decongestant, Antipyretic and Analgesic in one 2-layer tablet.

- combines the effective decongestant Phenylpropanolamine HCl with the same aspirin that's in St. Joseph Aspirin for Children
- chewable • pleasant orange flavor • exact children's dosage

FORMULA: Aspirin 1-1/4 gr. (81 mg.) Phenylpropanolamine HCl (3.125 mg.)
INDICATIONS: To decongest stuffed up nose, to ease breathing, reduce fever, relieve aches and pain of colds and flu.
SUPPLIED: In bottles of 30 tablets

Introduced 1975

Introduced 1953

St. Joseph Cough Syrup For Children

An effective Antitussive for physicians who prefer single medication therapy.

- contains no antihistamines • contains no narcotics
- contains a single active ingredient (d-Methorphan Hydrobromide 7.5 mg. per 5cc.)
- suppresses cough impulses, gives relief and controls coughs up to 8 hours • pleasant cherry flavor

FORMULA: Active ingredient: d-Methorphan Hydrobromide (7.5 mg. per 5cc.).
INDICATIONS: To relieve coughs due to colds and flu. Suppresses cough impluses. Controls coughs up to 8 hours.
SUPPLIED: 2 oz. and 4 oz. bottles.

St. Joseph Decongestant Nose Drops

Specially Formulated for Children Ages 2-5 years

St. Joseph Decongestant Nasal Spray

For Children Ages 6 years and Over

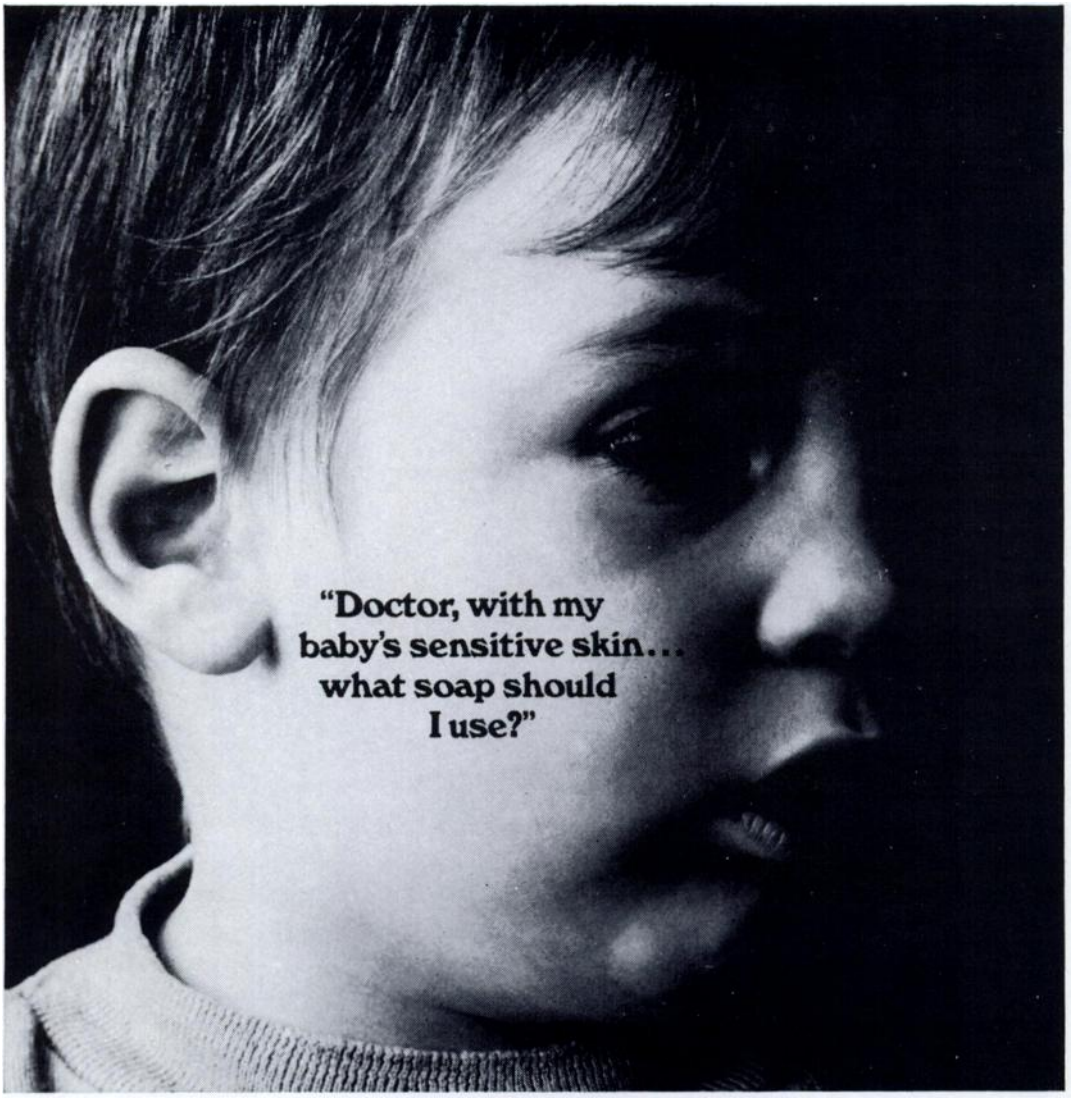
Only one application gives relief all day or all night. Each form contains Oxymetazoline Hydrochloride.

- gives rapid relief
- available in spray form for children 6 and over
- available in drops, specially formulated for children 2 through 5

INDICATIONS: Fast temporary relief of nasal congestion due to colds, sinusitis, and hay fever. Relieves up to 12 hours.
SUPPLIED: Drops, in 2/3 oz. bottles
Spray, in 1/2 oz. bottles

FORMULA: Drops: Oxymetazoline HCl 0.025% / Spray: Oxymetazoline HCl 0.05%

Introduced 1977



Pure mild Ivory is one of the safest possible soaps you can recommend for sensitive skin. More doctors recommend Ivory than any other soap.

It makes sense. Ivory's absence of many extra ingredients helps minimize chances of irritation.

Thirty-eight years of laboratory testing—including patch tests and arm immersion experiments—confirm that Ivory is one of the mildest, least irritating soaps you can recommend.

And 89 years of safe consumer use support this clinical experience.

Ivory may safely be used as an adjunct to treatment of cradle cap, scabies, impetigo and seborrhea.

THE R.A.U. PATIENT.

CAN THE PROBLEMS IN HIS MOUTH BE LINKED TO THE PROBLEMS ON HIS MIND?

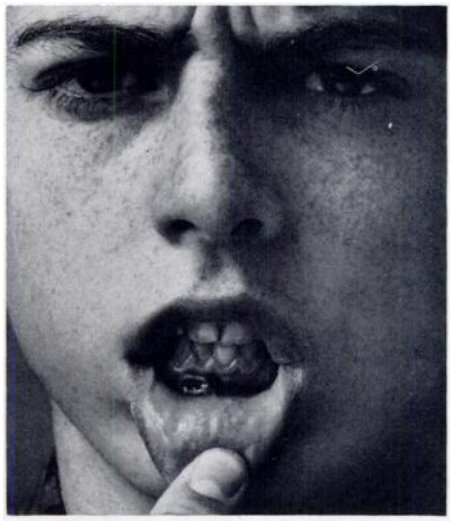
Twenty years of research are now shedding an entirely different light on the canker sore, or as physicians now call it–recurrent aphthous ulceration (R.A.U.). Because the apparently arbitrary exacerbations and remissions that characterize R.A.U. may actually be linked to the presence of emotional stress.[1-5]

R.A.U.—how to recognize it

The aphthous ulcer appears out of nowhere and usually disappears without incident. So most patients dismiss it as little more than a bothersome fact of life. But R.A.U. is actually a complex medical syndrome. It is characterized by single or multiple lesions of 2-20 mm in diameter that appear repeatedly on any of the moist mucous membranes of the mouth. A positive history of recurrences, the healthy appearance of surrounding tissue and the absence of associated systemic disorders will distinguish it from any other oral disease, including a herpetic infection.[4]

Extremely high incidence seen in students under stress

Ship et al[5] uncovered the most extensive evidence of the relationship between R.A.U. and stress in a major study of medical, dental, nursing and veterinary students in the University of Pennsylvania area. Of over 1700 students, 55% suffered from R.A.U. Furthermore, the medical histories of 64% of the students revealed that the group with R.A.U. reported significantly more emotional problems than those without the disease—problems that were in fact related to the frequency of each attack.



Correlation between R.A.U. and other ulcerative syndromes

Naturally a highly-selected population survey should be interpreted with caution. But additional findings by Ship in a subsequent investigation[4] suggest that the connection between R.A.U. and the mind under stress is more than coincidental: for the typical R.A.U. patient, the problem of ulcers doesn't stop in the oral cavity. Gastrointestinal and/or vulvovaginal ulcers plus a variety of other disorders, especially allergies, are often present as well.

Treatment remains palliative

No one knows the precise etiology of R.A.U. Its high incidence in environments notorious for intense pressure and mental strain, and its correlation with disorders long known to be at least partly psychogenic, strongly implicate stress as a leading factor. But until we can positively discern and treat the primary cause of R.A.U., treatment is still centered on debriding the lesion and relieving the pain.

Proxigel: to cleanse and help soothe minor oral inflammations

Proxigel is the ideal antiseptic to recommend for the R.A.U. patient in your practice and is also useful as adjunctive therapy in gingivitis, periodontitis, stomatitis, Vincent's infection and denture irritation.

Its unique viscous base adheres to affected areas—for longer debriding action on necrotic or pathological tissue.

Proxigel also helps to inhibit odor-causing bacteria. It is bactericidal against pathogens and other microorganisms which may be found in the oral cavity.

And Proxigel helps soothe painful tissue and thus aids in healing.

References: **1.** Francis, T.: Recurrent aphthous stomatitis and Behcet's disease, *Oral Surg. 30*:476, October 1970. **2.** Greenfield, D.S. and Fasciano, R.W.: Oral ulcerative disease in young adults: diagnosis and management, *J. Am. Coll. Health Assoc. 23*:167, December 1974. **3.** McCarthy, P. and Shklar, G.: *Diseases of the Oral Mucosa*, McGraw-Hill Book Company, New York, 1964, p. 192-200. **4.** Ship, I.I.: Epidemiologic aspects of recurrent aphthous ulcerations, *Oral Surg. 33*:400, March 1972. **5.** Ship, I.I., Morris, A.L., Durocher, R.T. *et al:* Recurrent aphthous ulcerations and recurrent herpes labialis in a professional school student population, *Oral Surg. 13*:1191, 1317,1438, Oct. 1960, Nov. 1960, Dec. 1960.

Proxigel Active Ingredient: Carbamide peroxide 11% in a water-free gel base.

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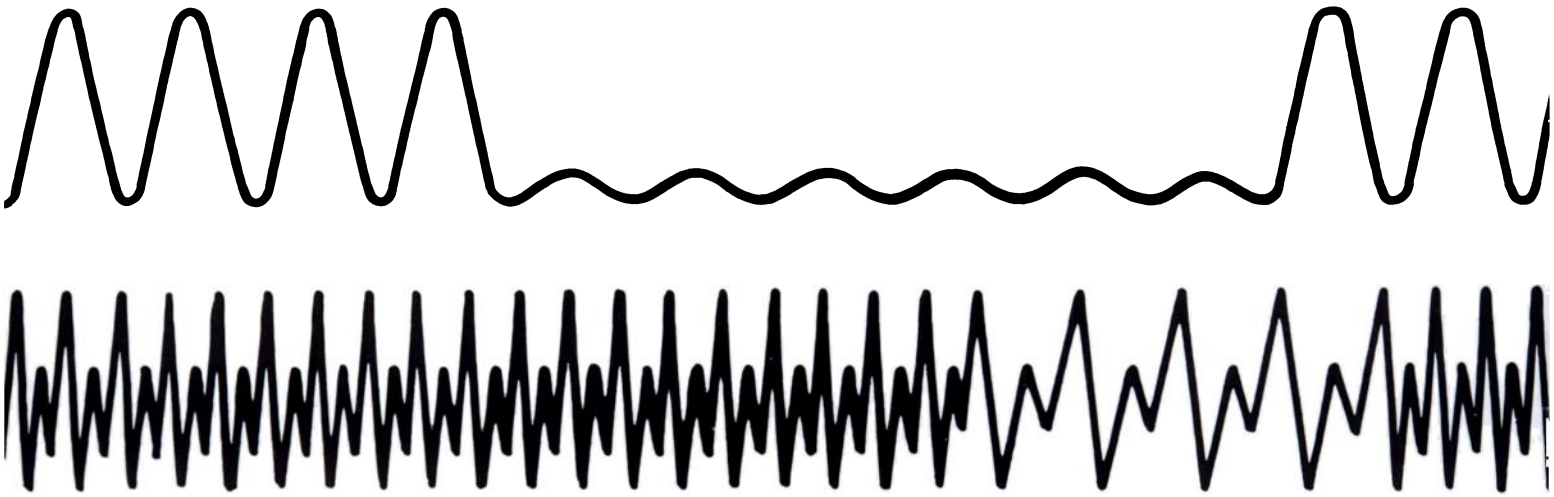
PROXIGEL®

Oral Antiseptic & Cleanser

Adjunctive therapy for R.A.U.



The PCG™ Pneumo-CardioGram Recording: An advanced technique for detecting and quantitating periods of apnea and/or bradycardia.

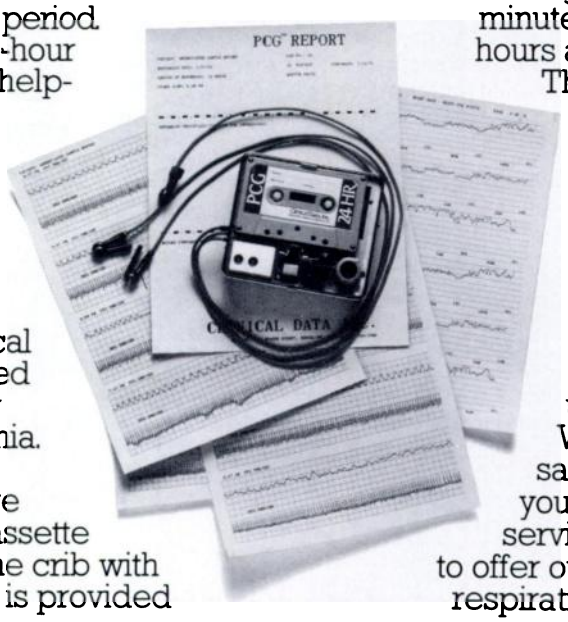
Two years ago Clinical Data introduced the Pediatric Pneumogram[1] – a continuous recording of respiration.

Now we introduce the Pneumo-CardioGram – an advanced technique for recording respiration and ECG simultaneously for a 12 or 24 hour period.

The timeliness of a 12-hour recording is especially helpful in evaluating and documenting the effectiveness of pharmacological intervention, such as theophylline or caffeine. A 24-hour recording provides more data to analyze the clinical significance of suspected apneic periods and any accompanying arrhythmia.

The recording is performed using a miniature battery-operated FM cassette recorder which sits in the crib with the infant. The recorder is provided at no capital expense, and provides continuous data over a 12 or 24 hour period.

To speed the processing of the data, we offer you a Telephone Transmission Unit (TTU™) which transmits the data to our reviewing and reporting center in minutes. Our facilities operate 24 hours a day, seven days a week. There, trained medical personnel using a proprietary computer-assisted playback system review the entire recording, and identify apneic episodes and arrhythmia. A verbal report is telephoned to you immediately and a printed report follows, usually within 24 hours. We'll gladly send you a sample PCG Report to show you how helpful this unique service can be. (We continue to offer our PPG™ recording for respiration only.) Call us toll free 800-225-9180.



Clinical Data, Inc.

1371 Beacon Street, Brookline, Massachusetts 02146

1. **Stein IM, et al**: The Pediatric Pneumogram: *A New Method for Detecting and Quantitating Apnea in Infants. Pediatrics 55: No. 5, 1975.*

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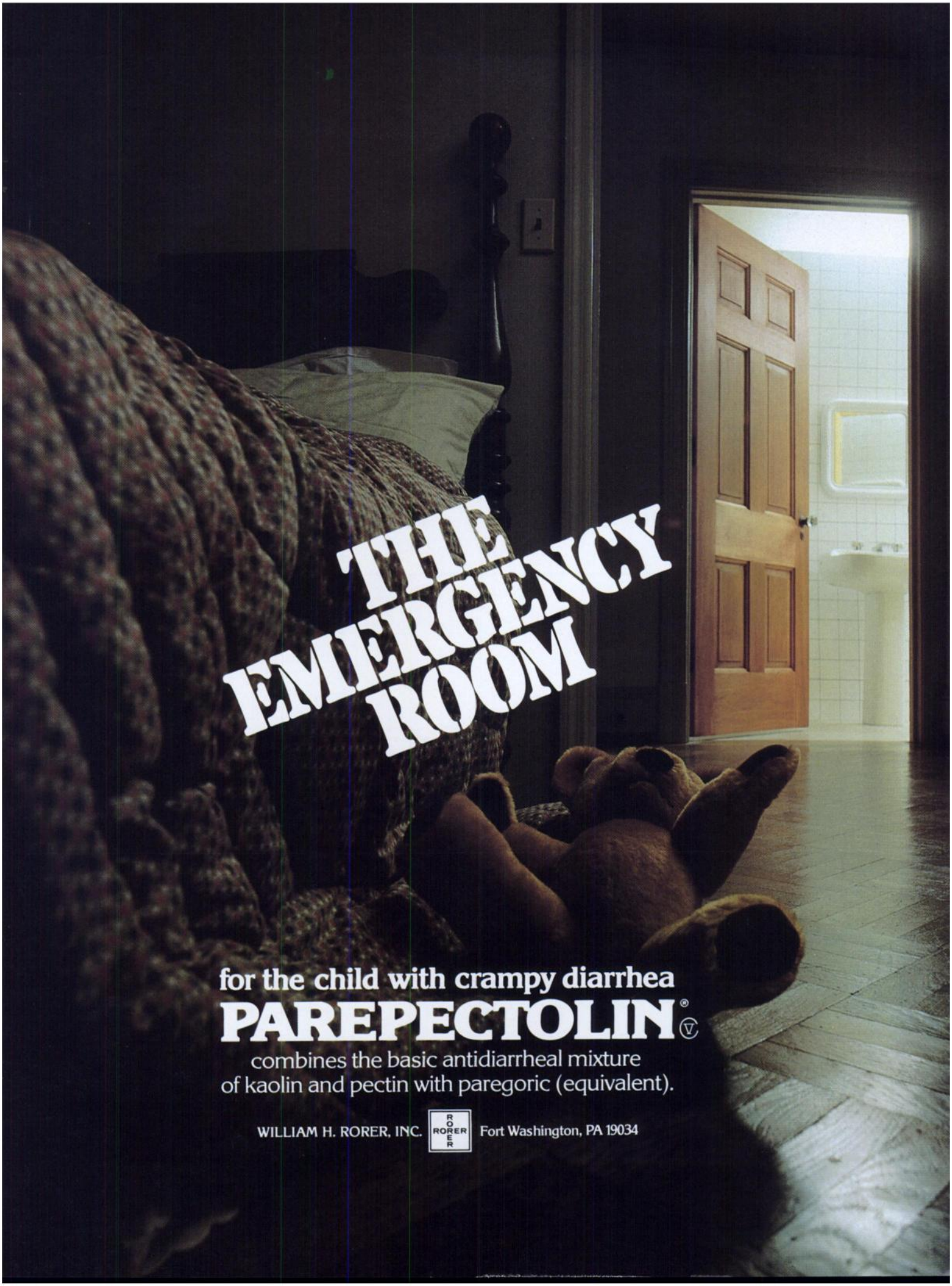
THE EMERGENCY ROOM
for the child with crampy diarrhea
PAREPECTOLIN®
combines the basic antidiarrheal mixture
of kaolin and pectin with paregoric (equivalent).
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SAFETY ACCURACY CONVENIENCE

Advanced Display

Operating status, alarm conditions, set up procedure errors and internal malfunction are instantly identified on the Liquid Crystal Display Panel. When the "Infusion Complete" legend appears, the 960 automatically reverts to a 1 ml/hr. "keep open" rate, eliminating restarts due to clotting. The clearly defined read-out allows a situation to be easily understood and dealt with. A visual track on the panel moves relative to infusion rate.

IMED'S Proven Accuset

The Imed 960 Volumetric Infusion Pump is designed to utilize the different types of Imed Accuset disposables. Recognized throughout the world for its dependable accuracy and safety, the Accuset is the heart of the 960's pumping and metering functions.

A Protective Door

If the Accuset is incorrectly affixed to the cassette nest, the door will not close and the pump will not operate. The closed door insures that the cassette and tubing in the air detector remain firmly in place.

IMED'S 960

imed VOLUMETRIC

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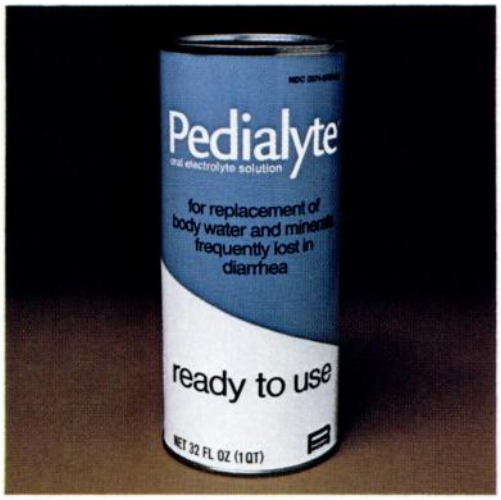
Do they belong here?

for replacement and maintenance of body water and minerals lost in diarrhea

Soft drinks, gelatins, and sports beverages — they may not be the safest or wisest course of therapy for diarrhea.[1-3]



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1. Scanlon JW: Electrolyte content of commercial gelatin products and sweetened liquid mixtures in treatment of diarrhea. *Clin Pediatr* 9:508-509, 1970.
2. *Acute Diarrhea in Infants and Children*. Columbus, Ohio, Ross Laboratories, publication F180, January 1978.
3. Gatorade and other oral electrolyte solutions. *Med Lett Drugs Ther* 11:71-72, 1969.

Specify

Pedialyte®

oral electrolyte solution

specifically formulated for infants and young children

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COLUMBUS, OHIO 43216
Division of Abbott Laboratories, USA

B198/9711

This is the vitamin-fluoride combination that lets you accurately adjust dosage.

NEW 1979 REVISED DOSAGE FOR FLUORIDE SUPPLEMENTATION*
Reference: American Academy of Pediatrics Committee on Nutrition, Pediatrics 63:150-2, Jan., 1979.

And it costs your patients less!

The only way to accurately prescribe a systemic fluoride is to adjust the dosage to each patient's drinking water and age. Fixed-dose combination vitamin/fluoride supplements do not allow you to do this without altering desired vitamin intake. This is an important reason why vitamin/fluoride combination products are not recognized by dental authorities.

But adjustable-dose Luride® drops is Accepted by the American Dental Association.

By recommending vitamins without fluoride, in combination with Luride drops, you can be assured that your young patients get the optimal dosage of both vitamins and fluoride.

And because Luride drops cost 8¢-9¢ less per dose than vitamin/fluoride combinations, Luride and vitamins can be purchased separately and *still cost less* than vitamin/fluoride combination products.

Clinical studies have shown fluoride supplements, like Luride drops, to be as effective as fluoridated water in preventing caries when used on a consistent and continuous basis.[1,2] Caries reductions of up to 80% have been reported when used on a regular, daily basis.[3] And you can titrate dosage to the nearest 0.125 (1/8) mg.

Consider adjustable-dose Luride drops—*it lets you prescribe fluoride and vitamins more accurately.* And Luride is free of sugar and saccharin unlike many vitamin/fluoride combination products.

Luride® (sodium fluoride) **drops and Lozi-Tabs® tablets**

DESCRIPTION: LURIDE Drops—Each drop from the dropper bottle contains approximately 0.125 (1/8) mg. fluoride (from 0.275 sodium fluoride). CONTRAINDICATIONS: LURIDE Drops are contraindicated where the drinking water exceeds 0.7 ppm F. PRECAUTION: Recommended dosage should not be exceeded since prolonged over-dosage may result in dental fluorosis.

* ADMINISTRATION and DOSAGE:

F-Content of Drinking Water	Daily Dosage		
	Birth to Age 2	Age 2 to 3	Age 3 and over
Less than 0.3 ppm	2 drops	4 drops	8 drops
0.3 to 0.7 ppm	1 drop	2 drops	4 drops
Over 0.7 ppm	Fluoride dietary supplements contraindicated		

HOW SUPPLIED: Peach flavored. 30 ml. drop-delivery plastic bottles. Also available: LURIDE Lozi-Tabs tablets in 1.0 mg. F, 0.5 mg. F, 0.25 mg. F, and SF (Special Formula containing no artificial colors or flavors) formulations.

[1]Report of Joint Committee of American Academy of Pediatrics and The American Society of Dentistry for Children: Dental Caries and a Consideration of the Role of Diet in Prevention. *Pediatrics 23*:400, 1959. [2]Arnold, F.A., Jr., McClure, F.J., and White, C.L. (NIH): Sodium Fluoride Tablets for Children, *Dental Progress 1*:3, 1960. [3]Aasenden, R. and Peebles, T.C.: Effects of Fluoride Supplementation from Birth on Human Deciduous and Permanent Teeth, *Arch. Oral Biol. 23*:111, 1978.

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Get them on their feet again!

When winter colds are at their worst, Naldecon® is at its best!

(antihistamine/decongestant)

Winter colds can get even the best of sports down. But Naldecon® (antihistamine/decongestant) can get them up and going again with fast symptomatic relief!

With balanced formulation for maximum relief and minimum side effects.

Naldecon combines antihistamines from two chemical classes, as well as two decongestants, to offer prompt symptomatic relief and minimize side effects. That's why it's the ideal choice for busy, active patients who aren't going to let a cold stop them.

An ethanolamine for long-lasting antihistamine activity

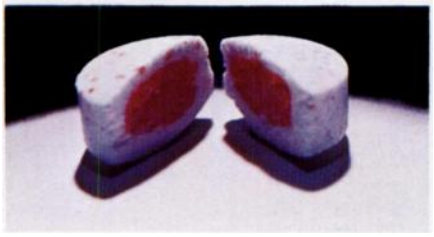
An alkylamine for minimal antihistamine drowsiness

Phenylpropanolamine for prolonged decongestant effectiveness

Phenylephrine for additional decongestant action with little or no C.N.S. stimulation.

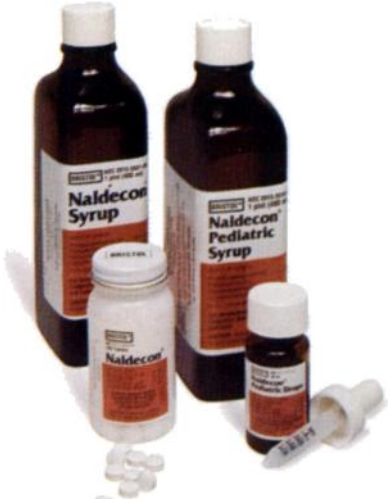
With a unique tablet designed for easy titrating and hours of sustained relief.

With Naldecon tablets, adjusting dosage without losing the convenience of sustained relief is a snap! The unique Naldecon tablet is scored so that just a little thumb pressure on each half of the tablet breaks it neatly in two. Half tablet or whole, the outer layer rapidly dissolves for prompt effectiveness and the slow-release inner core provides additional hours of relief.



With enough dosage forms to keep the entire family skiing.

Naldecon's full line of forms for all ages includes "kid-tested and flavor-approved" pediatric liquids.



- Adult tablets and syrup.
- Pediatric syrup for infants and children, 6 months to 12 years old.
- Pediatric drops for infants and children, 3 months to 6 years old.

Naldecon® salutes the world's best.

XIII OLYMPIC WINTER GAMES LAKE PLACID 1980

The world's best winter athletes gather in Lake Placid this year for the quadrennial spectacle of the Olympic Winter Games. Bristol Laboratories takes great pride in having Naldecon designated Official Supplier to these XIII Olympic Winter Games.
We salute the splendid amateur athletes whose memorable feats are once again an inspiration to all of us who have trouble staying on our feet in the winter.

Naldecon®

(antihistamine/decongestant)

BRISTOL™

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PLEASE SEE NEXT PAGE FOR FULL PRESCRIBING INFORMATION.

Naldecon®
(antihistamine/decongestant)

Official Supplier to the XIII Olympic Winter Games in Lake Placid, New York.

Only Naldecon® offers the winter cold sufferer the effectiveness of *two* antihistamines and *two* decongestants, proportioned to minimize their undesirable side effects.

Naldecon® has:

- **Staying power.** Sustained release: an outer layer for immediate relief, an inner core for hours more.
- **Flexibility.** Dosage forms for all ages and a unique scored tablet for fractionalized dosage, without losing the sustained release.
- **Balance.** Formulated to provide maximum effectiveness with minimum side effects.

NALDECON® Tablets, Syrup, Pediatric Drops, and Pediatric Syrup For Oral Use Only

5600DIMO-11 1/78

DESCRIPTION:

Each sustained-action tablet contains:	For immediate action	For delayed action	Total content
Phenylpropanolamine hydrochloride	20.0 mg.	20.0 mg.	40.0 mg.
Phenylephrine hydrochloride	5.0 mg.	5.0 mg.	10.0 mg.
Phenyltoloxamine citrate	7.5 mg.	7.5 mg.	15.0 mg.
Chlorpheniramine maleate	2.5 mg.	2.5 mg.	5.0 mg.

Each teaspoonful (5 ml.) of syrup contains:	
Phenylpropanolamine hydrochloride	20.0 mg.
Phenylephrine hydrochloride	5.0 mg.
Phenyltoloxamine citrate	7.5 mg.
Chlorpheniramine maleate	2.5 mg.

Each pediatric formulation contains the following ingredients:	Pediatric Syrup each 5 ml. contains:	Pediatric Drops each 1-ml. dropper contains:
Phenylpropanolamine hydrochloride	5.0 mg.	5.0 mg.
Phenylephrine hydrochloride	1.25 mg.	1.25 mg.
Phenyltoloxamine citrate	2.0 mg.	2.0 mg.
Chlorpheniramine maleate	0.5 mg.	0.5 mg.

ACTIONS: Naldecon is useful for the relief of nasal congestion associated with pollen allergy and minor infections of the upper respiratory tract (the common cold, nasopharyngitis, acute and chronic sinusitis). Naldecon tablets are compounded with half of each ingredient in the outer layer for immediate action and the remainder in the slowly disintegrating core for a sustained effect.

The actions and uses of individual ingredients in the formulation are as follows:

Phenylpropanolamine Hydrochloride

Phenylpropanolamine hydrochloride[1] acts similarly to ephedrine. It is effective orally for the symptomatic control of allergic manifestations, such as perennial hay fever and bronchial asthma. Its action is more prolonged than that of ephedrine, and it is not so apt to produce anxiety complex as is ephedrine.

Phenylephrine Hydrochloride

Phenylephrine hydrochloride[2] is a more powerful vasoconstrictor than synephrine tartrate. When administered orally, it is a vasopressor and relatively nontoxic. The pressor and anti-allergic effects of the drug are produced by oral administration. Therefore, this route may be employed in the treatment of orthostatic hypotension and allergic disorders. The comparatively larger doses required for effective oral treatment are only rarely accompanied by mild gastrointestinal symptoms. These may be avoided by administering the drug after meals.

Phenyltoloxamine Citrate

Phenyltoloxamine citrate[3] is a,β-dimethylaminoethyl ether of orthobenzylphenol; as such it belongs to the group of antihistaminics exhibiting the aminoalkyl ether structure. The incidence of side effects is low, at recommended doses, soporific effects occur in less than 7% of patients.

Chlorpheniramine Maleate

Chlorpheniramine maleate[4] has good therapeutic efficacy and low incidence of side effects. It is comparable in therapeutic efficacy to other antihistaminics although administered in very low dosage.

INDICATIONS: Relief of distressing symptoms of colds and other upper respiratory infections, acute and chronic sinusitis, hay fever, and other pollen allergies:

Rhinorrhea	Lacrimation
Postnasal drip	Sneezing
Nasal congestion	Itching of eyes and nose
Sinus congestion	Head stuffiness

CONTRAINDICATIONS: Sensitivity to any of the ingredients.

PRECAUTIONS: This preparation may cause drowsiness. The patient should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Do not exceed the recommended dose unless directed by a physician. Individuals with high blood pressure, heart disease, diabetes mellitus, thyroid disease, glaucoma, peripheral vascular disease or prostatic hypertrophy should use only as directed by a physician.

DOSAGE: This chart represents single dosages for the products listed below. Usual dosage schedule for Naldecon Pediatric Drops, Naldecon Pediatric Syrup and Naldecon Syrup is every 3 to 4 hours, not to exceed four doses in a 24-hour period. For sustained-action Naldecon Tablets, doses should be administered on arising, in midafternoon, and at bedtime.

Single Dosage for...	Pediatric Drops	Pediatric Syrup	Syrup	Tablets
3 to 6 months	1/4 ml.			
6 to 12 months	1/2 ml.	1/2 teaspoonful		
1 to 6 years	1 ml.	1 teaspoonful		
6 to 12 years		2 teaspoonfuls	1/2 teaspoonful	1/2 tablet
over 12 years			1 teaspoonful	1 tablet

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4. New and Nonofficial Drugs 1959

SUPPLY:

NDC 0015-5600—Naldecon Tablets
NDC 0015-5601—Naldecon Syrup
NDC 0015-5615—Naldecon Pediatric Drops
NDC 0015-5616—Naldecon Pediatric Syrup

For information on package sizes available, refer to the current price schedule.

BRISTOL™

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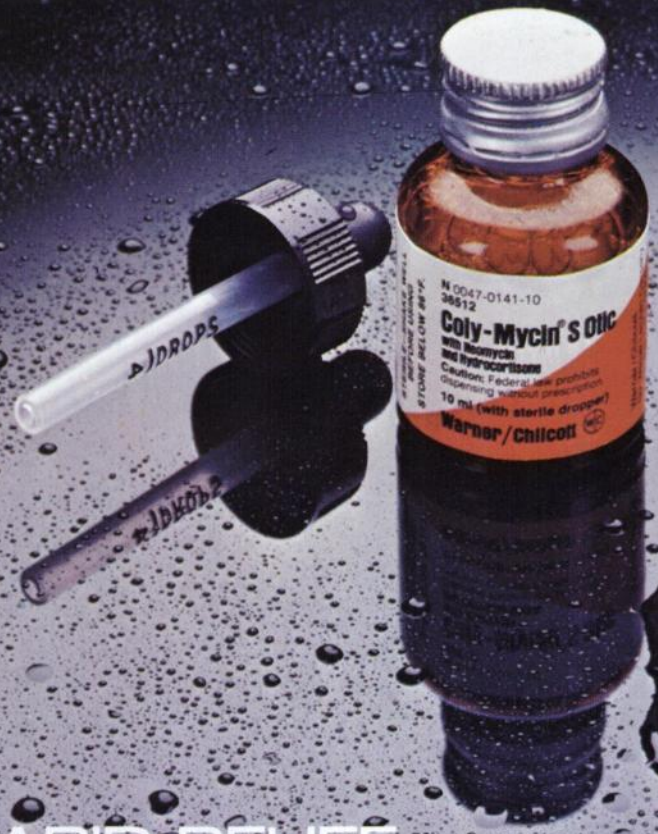
WHEN INFECTION, AND ITS PAIN, ARE A MATTER OF FACT



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- prompt relief of inflammation, pain, swelling and itching — Hydrocortisone Acetate
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plus, dosage versatility:
5 ml size—often sufficient therapy for unilateral infection; 10 ml size—may be preferable for more severe cases, or bilateral involvement.

See preceding page for prescribing information.

VOLUME 65 • MARCH 1980 • NUMBER 3

Pediatrics

Early Intervention for Infants with Down Syndrome: A Controlled Trial

Martha C. Piper, PhD, and I. B. Pless, MD

From the School of Physical and Occupational Therapy and Department of Epidemiology and Health, McGill University, Montreal

ABSTRACT. The mental development of 37 infants with Down syndrome, allocated either to an experimental or control group, was assessed over a six-month period by an independent evaluator. The experimental group participated in biweekly therapy sessions designed to stimulate normal development while the control group received no intervention. The Griffiths Mental Developmental Scales were used to assess changes in the developmental status in the two groups, which were shown to be equal initially on a variety of variables. No statistically significant differences in mental development between the experimental and control groups were found. The early intervention regimen investigated in this study was not efficacious in altering the pattern of mental development in those Down syndrome infants participating in the program. *Pediatrics* 65:463-468, 1980; *Down syndrome, early intervention, infants, mental development.*

Infant stimulation and training programs have been developed as means to ameliorate the severity of the mental handicap associated with Down syndrome. Unfortunately, the influence of such programs on the mental functioning of Down syndrome children remains uncertain in spite of the fact that infants with Down syndrome are easily identified at birth, thereby permitting early intervention within the first months of life.

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Reprint requests to (M.C.P.) School of Physical and Occupational Therapy, McGill University, 3654 Drummond St, Montreal, Quebec H3G 1Y5.

The contribution of early intervention programs in deterring mental retardation in children defined as being "at risk" for retardation at some later date has been established.[1-3] However, it is still unclear whether early intervention remediates retardation when applied to children with diagnosed forms of mental retardation, such as Down syndrome. The distinction between these two populations of children, those "at risk" for mental retardation and those defined as mentally retarded, although essential when discussing the effect of early intervention, is often overlooked.

Historically, the positive effect of early intervention for children with Down syndrome was inferred from comparisons of the development of institutionalized children with that of children reared in the home.[4-9] However, the interpretation of these studies is extremely difficult since selective factors may have produced comparison groups that are biased.[10] Although more recent evaluations of early intervention programs for these children report positive findings, similar difficulties arise regarding the comparison groups used in several of these investigations.[11-13] To date, only two evaluations of early intervention for children with Down syndrome have employed adequate control groups; but aside from matching subjects on age, sex, and mental age, neither study focused attention on other potential factors that might influence development.[14-15] Moreover, the effect of intervention during infancy was not evaluated in spite of evidence that measured intelligence declines as the child with Down syndrome grows older.[9,16,17]

The purpose of this study was to evaluate the

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ENDORPHINS AND SHOCK

B endorphin is likely released during shock states and may contribute to hypotension. Naloxone, in an animal model, rapidly reverses endotoxin-induced hypotension and also prevents its occurrence. The same findings are noted in experimental hypovolemic shock. The low toxicity of naloxone and its effect on shock in experimental animals makes it an attractive agent. Naloxone may be efficacious in septic shock and in hypovolemic shock.

Comment: Animals only, so far, but these are fantastic data and raise wonderful possibilities. The soon to come primate data will be exciting to see.

R.H.R.

Abstracted from J. W. Holaday et al: Naloxone reversal of endotoxin hypotension suggests role of endorphins in shock (*Nature* 275:450, 1978); A. I. Faden, et al: Opiate antagonists: A role in the treatment of hypovolemic shock (*Science* 205:317, 1979).

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ANNOUNCEMENT OF 1980 EXAMINATION OF THE AMERICAN BOARD OF MEDICAL TOXICOLOGY

The 1980 Examination of the American Board of Medical Toxicology will be administered on Monday, August 4, 1980 in Minneapolis, Minnesota in conjunction with the annual meeting of the American Academy of Clinical Toxicology and the Association of Poison Control Centers.

Application material for the certifying examination of the Board is available throughout the year by writing to the Board Office at the address below. The completed application material of those applicants who wish to be considered for the 1980 Board Examination must be postmarked by May 1, 1980.

Frederick H. Lovejoy, Jr, MD, Chairman
American Board of Medical Toxicology
300 Longwood Ave
Boston, MA 02115

However, in selected patients the CT scan may detect intracerebral infection at an early stage. The choice of antibiotics should be based on suspect organisms identified at other sites or with broad spectrum coverage normally used in the treatment of brain abscess. *Staphylococcus aureus* sepsis (in particular endocarditis),[10] *Haemophilus influenzae* leptomeningeal infections,[11] and *Listeria monocytogenes* infections in renal transplant patients[12] are clinical conditions in which cerebritis may occur. Success in therapy can then be monitored with sequential CT scans and surgical intervention performed when indicated by clinical course. Prognosis for this approach will depend upon mutual cooperation among various subspecialities within each medical center.

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MYCOPLASMA PNEUMONIAE

Infection due to *Mycoplasma pneumoniae* (MP) may be recurrent. The majority of MP infections are upper respiratory. Rates of pneumonia incidence with MP are greatest at ages 5 to 9 years, whereas total pneumonia incidence is greatest in the 0 to 5-year age group. MP infection has a cyclic pattern with epidemic peaks. No seasonal influence is noted. Approximately one third of all pneumonia in the group aged 5 to 9 is MP. Annually 8% of age group 5 to 9 are infected with MP; 6% of 15 to 19-year-olds are infected. Of 5 to 9 years olds with MP infection 10% have pneumonia; 22% of 15 to 19-year-olds with MP have pneumonia.

R.H.R.

Abstracted from H. M. Foy, et al: Long-term epidemiology of infections with mycoplasma pneumoniae (*J Infect Dis* 139:681, 1979).

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BREAST CANCER AFTER EXPOSURE OF ADOLESCENTS TO IONIZING RADIATION

Further analysis of data from Hiroshima and Nagasaki, 1950 to 1974, revealed that adolescents who were 10 to 19 years of age when exposed to the atomic bomb, are now experiencing a greater frequency of breast cancer than are women who were older at the time of the bomb (ATB). The risk for these women is more than twice the risk for women who were 20 to 29 years old ATB. Data are not yet sufficient to evaluate the risk in women who were under 10 years of age ATB. The data make clear that the excess in breast cancer lies latent until the atomic-bomb survivors reach the usual age for the occurrence of this neoplasm.

Robert H. Miller, MD
National Cancer Institute-NIH, Bethesda, MD

Abstracted from M. Tokunaga et al (*J Natl Cancer Inst* 62:1347–1359, June 1979).

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PHILOSOPHY OF SCIENCE

. . .Science [is distinguished by]. . . its method of inquiry. I have already noted that every special finding of science, whether it be general or particular in form, may require reconsideration because of fresh evidence that seems to challenge it. No question raised for study is ever settled beyond the possibility of its being reopened, for no proposed answer is indubitable. Indeed, when one surveys the history of science, the impermanence of nearly all of its comprehensive theories is most impressive. As I see it, it is the method of science that is relatively stable and permanent, rather than the answers to questions accepted at various times. It is certainly the case that the alleged certainty of scientific knowledge derives from the intellectual method by which the findings of inquiry are warranted.

Submitted by Student

From Nagel E: *Teleology Revisited and Other Essays in The Philosophy and History of Science.* New York, Columbia University Press 1979.

lems with apparently contaminated cultures. However, the experimental data and technique to support the micro-blood culture method comes from the work of Jennings et al[4] and Fisher et al.[5]

Two basic questions arise: (1) Are small volumes of blood (0.2 ml) adequate for cultures? (2) May they be obtained from a peripheral site (ie, heel stick)?

Fisher et al[5] made adult rabbits bacteremic with 2×10^7 *Escherichia coli*. Serial arterial blood cultures of 0.1 and 0.2 ml were obtained and revealed that 0.2 ml of arterial blood was adequate for culture if more than five organisms per milliliter were present.

Jennings et al[4] extended the experimental *E coli* model to adult dogs and monkeys and used not only arterial cultures of 0.1 and 0.2 ml but also 0.14 ml of capillary blood. The results demonstrated that capillary specimens of 0.14 ml were as accurate as arterial samples of 0.1 and 0.2 ml if more than ten organisms per milliliter were present.

In addition, the study of neonatal *E coli* sepsis by Dietzman et al[7] demonstrated that bacteremia was rarely found with less than five organisms per milliliter and not uncommonly exceeded 10^3 bacteria per milliliter.

Our data demonstrate that small volume blood cultures obtained from a heelstick are as sensitive as those obtained from a venous site. Those cultures which were positive by heelstick and negative in venous blood can be explained. Skin contamination is always a potential problem, but we believe a better explanation may relate to pooling of blood in the periphery thereby increasing the number of bacteria present in the sample. The heelstick blood culture technique is safe, simple, and above all accurate in diagnosing neonatal sepsis and bacteremia.

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MALNUTRITION

In 1967, the support of the Field Foundation allowed a medical team to range throughout the country to identify those areas where malnutrition was prevalent. It became clear that a number of sections of the nation were involved, with practically every ethnic group—white, black, Chicano, Puerto Rican, Indian, Eskimo, Aleut—represented. By our best estimates, over 20 million Americans were hungry, malnourished, and far too poor to afford the $106 a month the Agriculture Department estimated would feed a family of four a minimally adequate diet. The worst off were those who are always the most vulnerable: infants and young children, pregnant and nursing women, and the elderly.

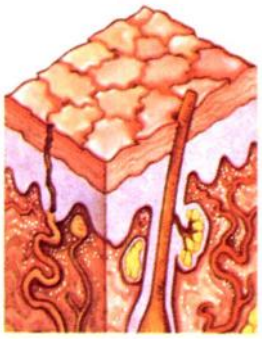
Last year, the Field Foundation again sent a team, many of them the same physicians, to retrace their steps of a decade ago: This spring they reported to the Congress that while the facts of poverty in the areas surveyed had not changed, they no longer could find cases of medically demonstrable malnutrition in any of the counties where malnutrition had been found previously to be prevalent. They concluded that "in the area of food there is a difference." They went on: "The Food Stamp Program, the nutritional component of Head Start, school lunch and breakfast programs, and to a lesser extent the Women-Infant-Children feeding programs have made the difference."

Submitted by Student

From Mayer J: Warning to youths: Futility's unwarranted. *New York Times* August 26, 1979.

Hydrocortisone and hydration

When hyperkeratosis intervenes, an emollient base with 10% urea can make a difference. The added hydration helps soften and soothe the skin without mineral oil, lanolin or preservatives. Especially useful for the inflammatory manifestations of atopic dermatitis.



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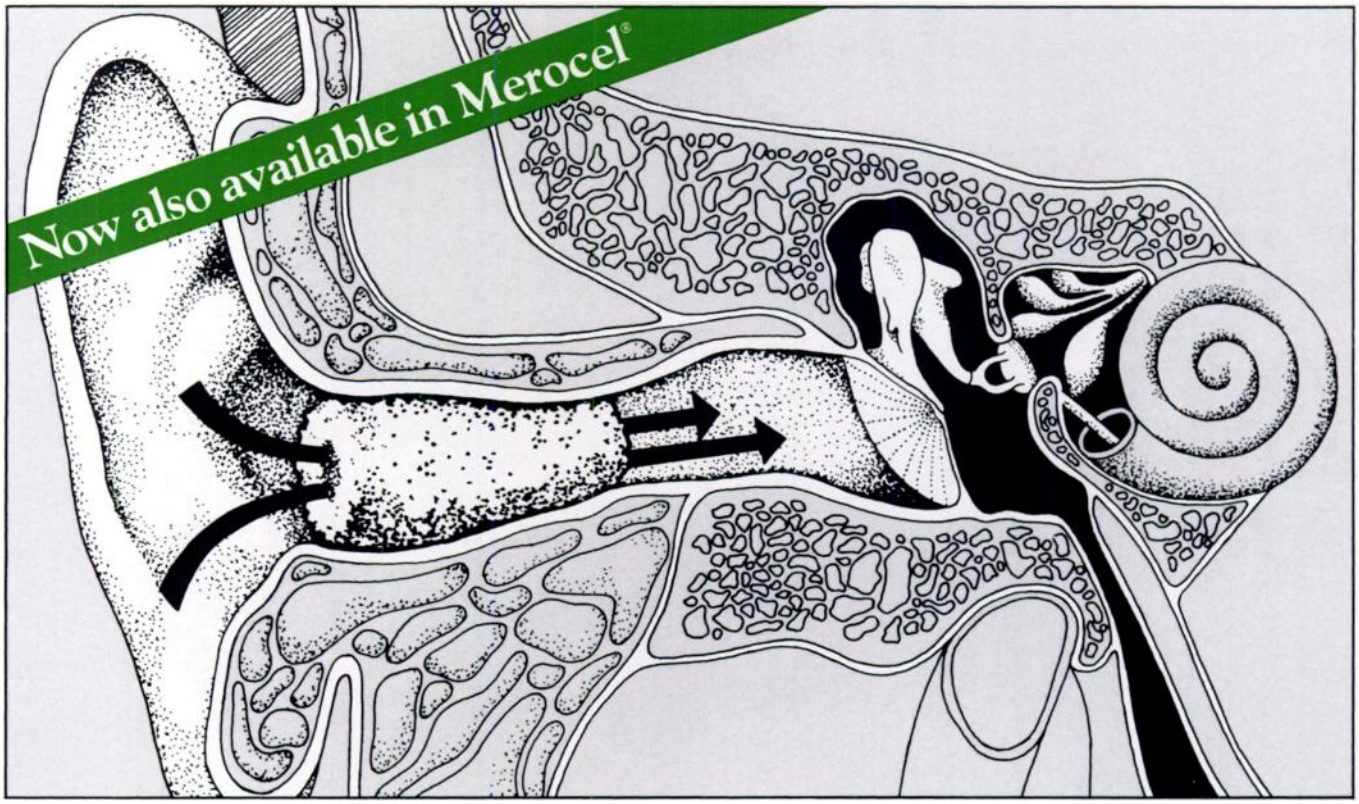
POPE OTO-WICK™

The preferred medication vehicle for otitis externa.



The Pope Oto-Wick,™ designed by a physician for physicians, is a remarkable development in the treatment of otitis externa. Made of highly compressed hydrocellulose or Merocel, it expands when moistened with aqueous solutions and serves as a vehicle for applying medication evenly throughout the ear canal. When glycol-based solutions are used, the Oto-Wick* should be expanded first with sterile water. It has become the preferred wick for these reasons:

- Provides immediate relief from discomfort
- Allows even distribution of medication
- Remains moist with medication for prolonged periods of time
- Applies even, soothing pressure to inflamed canal tissue
- Hollow center facilitates hearing during treatment
- Oto-Wick won't fall out as edema subsides
- Easily inserted

Availability:
Merocel — Sterile singles (XO-0108); and bulk 100's (XO-0109)
Hydrocellulose — Sterile 5's (XO-0106); and bulk 200's (XO-0107)

Designed by T. Pope, M.D., Durham, North Carolina
**U. S. Patent Nos. 4,034,759 and 4,159,719*
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"The Microsurgery Company"

RONDEC-DM™ Syrup ℞

(carbinoxamine maleate, 4 mg; pseudoephedrine HCl, 60 mg; dextromethorphan HBr, 15 mg; less than 0.6% alcohol per 5 ml)

for adults, teenagers, and children 18 months of age and older

RONDEC-DM™ Drops ℞

(carbinoxamine maleate, 2 mg; pseudoephedrine HCl, 25 mg; dextromethorphan HBr, 4 mg; less than 0.6% alcohol per ml)

for infants to 18 months of age

BRIEF SUMMARY: please see package enclosure for complete prescribing information.

INDICATIONS

RONDEC-DM is indicated for the following disorders:

- nasopharyngitis with postnasal drip
- common cold
- bronchitis and bronchial cough
- recurrent cough due to recurrent respiratory infection

CONTRAINDICATIONS

There are no known contraindications for the use of **RONDEC-DM™** Drops and **RONDEC-DM™** Syrup.

PRECAUTIONS

Although pseudoephedrine has less pressor effect than ephedrine, use with caution in patients with hypertension.

Because of the antihistamine component, carbinoxamine maleate, patients should be cautioned to exercise care in driving or operating machinery until the possibility of drowsiness is determined.

If a sensitivity reaction or idiosyncrasy should occur, withdraw the drug.

Safety in pregnancy has not been determined. **RONDEC-DM** Drops and **RONDEC-DM** Syrup should be used in pregnant women only when the benefits outweigh the risks.

ADVERSE REACTIONS

Those patients particularly sensitive to pseudoephedrine, a sympathomimetic amine, may note mild central nervous system stimulation.

Like all antihistamines, sedation has been observed with the use of carbinoxamine maleate. However, it is generally mild, and tolerance appears to develop rapidly in most cases. Patients particularly sensitive to antihistamines may experience moderate to severe drowsiness.

Mild gastrointestinal disturbance and drowsiness have been observed among patients receiving dextromethorphan hydrobromide. These instances are rare, and no serious side effects have been reported.

Effective for adults

Contains dextromethorphan hydrobromide, a nonnarcotic antitussive that is as effective as codeine without its addictive properties or side effects.

Safe for children

Relieves congestion, sneezing and sniffles. Will not suppress respiration or ciliary activity.

One prescription for the family cold

Helps decrease the frequency and intensity of coughs to help minimize the spread of common cold viruses among family members.

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Barely out of kindergarten, but already veterans—
and already refractory
While some patients can be maintained indefinitely on a particular anticonvulsant, others in time become refractory. Or develop persistent side effects. It then becomes necessary to choose another effective anticonvulsant....
Yvonne—
Lennox-Gastaut syndrome
Marion—
myoclonic seizures
Chad—
akinetic seizures

How many anticonvulsants can give patients like these

all these advantages?

Established efficacy in akinetic/myoclonic seizures
Used alone or as an adjunct, Clonopin ® (clonazepam/Roche) —a benzodiazepine with specific and potent anticonvulsant properties—has proved clinically effective in reducing the frequency and/or severity of akinetic and myoclonic seizures and Lennox-Gastaut syndrome (petit mal variant). It also may be useful in absence seizures (petit mal) where succinimide therapy has failed.

Longer half-life (18 to 50 hours) for more flexible dosage
The longer half-life of Clonopin—more than twice that of valproic acid, for instance—produces a more flexible dosage regimen that may enhance patient compliance. It means, too, that "breakthrough" seizure activity is less likely with an inadvertently skipped dose.

Fewer G.I. upsets and appetite problems
Gastrointestinal problems are relatively uncommon with Clonopin, another factor that encourages patient compliance.

Proven safety with long-term administration
On Clonopin therapy, the most frequently noted side effects—drowsiness and ataxia—generally have been dose-related and could often be controlled by dosage adjustment. Behavior problems have been noted in some children. (For more detailed side effects and precautions, see prescribing information which appears on next page.)

And also:
- **Can be taken at bedtime**
- **Does not interact with anticoagulants or aspirin**
- **Can be used concomitantly with most other anticonvulsants ***
- **Is compatible with a ketogenic diet**

*Please see Precautions section of complete product information.

CLONOPIN® IV
clonazepam/Roche

For patients with minor motor seizures

ROCHE

Please see next page for complete product information.

CLONOPIN®
clonazepam/Roche

0.5-mg, 1-mg and 2-mg tablets

Complete Product Information:

Description: Chemically, clonazepam is 5-(2-chlorophenyl)-1,3-dihydro-7-nitro-2H-1,4-benzodiazepin-2-one. It is a light yellow crystalline powder. It has a molecular weight of 315.7.

Actions: In laboratory animals, Clonopin (clonazepam/Roche) exhibits several pharmacologic properties which are characteristic of the benzodiazepine class of drugs. Convulsions produced in rodents by pentylenetetrazol or electrical stimulation are antagonized, as are convulsions produced by photic stimulation in susceptible baboons. A taming effect in aggressive primates, muscle weakness and hypnosis are likewise produced by Clonopin. In humans it is capable of suppressing the spike and wave discharge in absence seizures (petit mal) and decreasing the frequency, amplitude, duration and spread of discharge in minor motor seizures.

Single oral dose administration of Clonopin to humans gave maximum blood levels of drug, in most cases, within one to two hours. The half-life of the parent compound varied from approximately 18 to 50 hours, and the major route of excretion was in the urine. In humans, five metabolites have been identified. In general, the biotransformation of clonazepam followed two pathways: oxidative hydroxylation at the C-3 position and reduction of the 7-nitro function to form 7-amino and/or 7-acetyl-amino derivatives.

Indications: Clonopin is useful alone or as an adjunct in the treatment of the Lennox-Gastaut syndrome (petit mal variant), akinetic and myoclonic seizures. In patients with absence seizures (petit mal) who have failed to respond to succinimides, Clonopin may be useful.

In some studies, up to 30% of patients have shown a loss of anticonvulsant activity, often within three months of administration. In some cases, dosage adjustment may reestablish efficacy.

Contraindications: Clonopin should not be used in patients with a history of sensitivity to benzodiazepines, nor in patients with clinical or biochemical evidence of significant liver disease. It may be used in patients with open angle glaucoma who are receiving appropriate therapy, but is contraindicated in acute narrow angle glaucoma.

Warnings: Since Clonopin produces CNS depression, patients receiving this drug should be cautioned against engaging in hazardous occupations requiring mental alertness, such as operating machinery or driving a motor vehicle. They should also be warned about the concomitant use of alcohol or other CNS-depressant drugs during Clonopin therapy (see Drug Interactions).

Usage in Pregnancy: The effects of Clonopin in human pregnancy and nursing infants are unknown.

Recent reports suggest an association between the use of anticonvulsant drugs by women with epilepsy and an elevated incidence of birth defects in children born to these women. Data are more extensive with respect to diphenylhydantoin and phenobarbital, but these are also the most commonly prescribed anticonvulsants; less systematic or anecdotal reports suggest a possible similar association with the use of all known anticonvulsant drugs.

The reports suggesting an elevated incidence of birth defects in children of drug-treated epileptic women cannot be regarded as adequate to prove a definite cause and effect relationship. There are intrinsic methodologic problems in obtaining adequate data on drug teratogenicity in humans; the possibility also exists that other factors, *e.g.*, genetic factors or the epileptic condition itself, may be more important than drug therapy in leading to birth defects. The great majority of mothers on anticonvulsant medication deliver normal infants. It is important to note that anticonvulsant drugs should not be discontinued in patients in whom the drug is administered to prevent seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life. In individual cases where the severity and frequency of the seizure disorder are such that the removal of medication does not pose a serious threat to the patient, discontinuation of the drug may be considered prior to and during pregnancy, although it cannot be said with any confidence that even mild seizures do not pose some hazards to the developing embryo or fetus.

These considerations should be weighed in treating or counseling epileptic women of childbearing potential.

Use of Clonopin in women of childbearing potential should be considered only when the clinical situation warrants the risk. Mothers receiving Clonopin should not breast-feed their infants.

In a two-generation reproduction study with Clonopin given orally to rats at 10 or 100 mg/kg/day, there was a decrease in the number of pregnancies and a decrease in the number of offspring surviving until weaning. When Clonopin was administered orally to pregnant rabbits at 0.2, 1.0, 5.0 or 10.0 mg/kg/day, a nondose-related incidence of cleft palates, open eyelids, fused sternebrae and limb defects was observed at the 0.2 and 5.0 mg/kg/day levels. Nearly all of the malformations were seen from one dam in each of the affected dosages.

Usage in Children: Because of the possibility that adverse effects on physical or mental development could become apparent only after many years, a benefit-risk consideration of the long-term use of Clonopin is important in pediatric patients.

Physical and Psychological Dependence: Withdrawal symptoms similar in character to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepine drugs. These symptoms include convulsions, tremor, abdominal and muscle cramps, vomiting and sweating. Addiction-prone individuals, such as drug addicts or alcoholics, should be under careful surveillance when receiving benzodiazepines because of the predisposition of such patients to habituation and dependence.

Precautions: When used in patients in whom several different types of seizure disorders coexist, Clonopin may increase the incidence or precipitate the onset of generalized tonic-clonic seizures (grand mal). This may require the addition of appropriate anticonvulsants or an increase in their dosages. The concomitant use of valproic acid and clonazepam may produce absence status.

Periodic blood counts and liver function tests are advisable during long-term therapy with Clonopin (clonazepam/Roche).

The abrupt withdrawal of Clonopin, particularly in those patients on long-term, high-dose therapy, may precipitate status epilepticus. Therefore, when discontinuing Clonopin, gradual withdrawal is essential. While Clonopin is being gradually withdrawn, the simultaneous substitution of another anticonvulsant may be indicated. Metabolites of Clonopin are excreted by the kidneys; to avoid their excess accumulation, caution should be exercised in the administration of the drug to patients with impaired renal function.

Clonopin may produce an increase in salivation. This should be considered before giving the drug to patients who have difficulty handling secretions. Because of this and the possibility of respiratory depression, Clonopin should be used with caution in patients with chronic respiratory diseases.

Adverse Reactions: The most frequently occurring side effects of Clonopin are referable to CNS depression. Experience to date has shown that drowsiness has occurred in approximately 50% of patients and ataxia in approximately 30%. In some cases, these may diminish with time; behavior problems have been noted in approximately 25% of patients. Others, listed by system, are:

Neurologic: Abnormal eye movements, aphonia, choreiform movements, coma, diplopia, dysarthria, dysdiadochokinesis, "glassy-eyed" appearance, headache, hemiparesis, hypotonia, nystagmus, respiratory depression, slurred speech, tremor, vertigo.

Psychiatric: Confusion, depression, forgetfulness, hallucinations, hysteria, increased libido, insomnia, psychosis, suicidal attempt (the behavior effects are more likely to occur in patients with a history of psychiatric disturbances).

Respiratory: Chest congestion, rhinorrhea, shortness of breath, hypersecretion in upper respiratory passages.

Cardiovascular: Palpitations.

Dermatologic: Hair loss, hirsutism, skin rash, ankle and facial edema.

Gastrointestinal: Anorexia, coated tongue, constipation, diarrhea, dry mouth, encopresis, gastritis, hepatomegaly, increased appetite, nausea, sore gums.

Genitourinary: Dysuria, enuresis, nocturia, urinary retention.

Musculoskeletal: Muscle weakness, pains.

Miscellaneous: Dehydration, general deterioration, fever, lymphadenopathy, weight loss or gain.

Hematopoietic: Anemia, leukopenia, thrombocytopenia, eosinophilia.

Hepatic: Transient elevations of serum transaminases and alkaline phosphatase.

Drug Interactions: The CNS-depressant action of the benzodiazepine class of drugs may be potentiated by alcohol, narcotics, barbiturates, nonbarbiturate hypnotics, antianxiety agents, the phenothiazines, thioxanthene and butyrophenone classes of antipsychotic agents, monoamine oxidase inhibitors and the tricyclic antidepressants, and by other anticonvulsant drugs.

Overdosage: Symptoms of Clonopin overdosage, like those produced by other CNS depressants, include somnolence, confusion, coma and diminished reflexes. Treatment includes monitoring of respiration, pulse and blood pressure, general supportive measures and immediate gastric lavage. Intravenous fluids should be administered and an adequate airway maintained. Hypotension may be combated by the use of levarterenol or metaraminol. Methylphenidate or caffeine and sodium benzoate may be given to combat CNS depression. Dialysis is of no known value.

Dosage and Administration: *Infants and Children:* Clonopin is administered orally. In order to minimize drowsiness, the initial dose for infants and children (up to 10 years of age or 30 kg of body weight) should be between 0.01 to 0.03 mg/kg/day but not to exceed 0.05 mg/kg/day given in two or three divided doses. Dosage should be increased by no more than 0.25 to 0.5 mg every third day until a daily maintenance dose of 0.1 to 0.2 mg/kg of body weight has been reached unless seizures are controlled or side effects preclude further increase. Whenever possible, the daily dose should be divided into three equal doses. If doses are not equally divided, the largest dose should be given before retiring.

Adults: The initial dose for adults should not exceed 1.5 mg/day divided into three doses. Dosage may be increased in increments of 0.5 to 1 mg every three days until seizures are adequately controlled or until side effects preclude any further increase. Maintenance dosage must be individualized for each patient depending upon response. Maximum recommended daily dose is 20 mg.

The use of multiple anticonvulsants may result in an increase of depressant adverse effects. This should be considered before adding Clonopin to an existing anticonvulsant regimen.

How Supplied: Scored tablets—0.5 mg, orange; 1 mg, blue; 2 mg, white—Prescription Paks of 100.

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About the only things they don't outgrow are stuffy noses, sneezes, and itchy eyes.

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Convenient b.i.d. dosage for children 6 and over. Long-acting symptomatic relief available without a prescription

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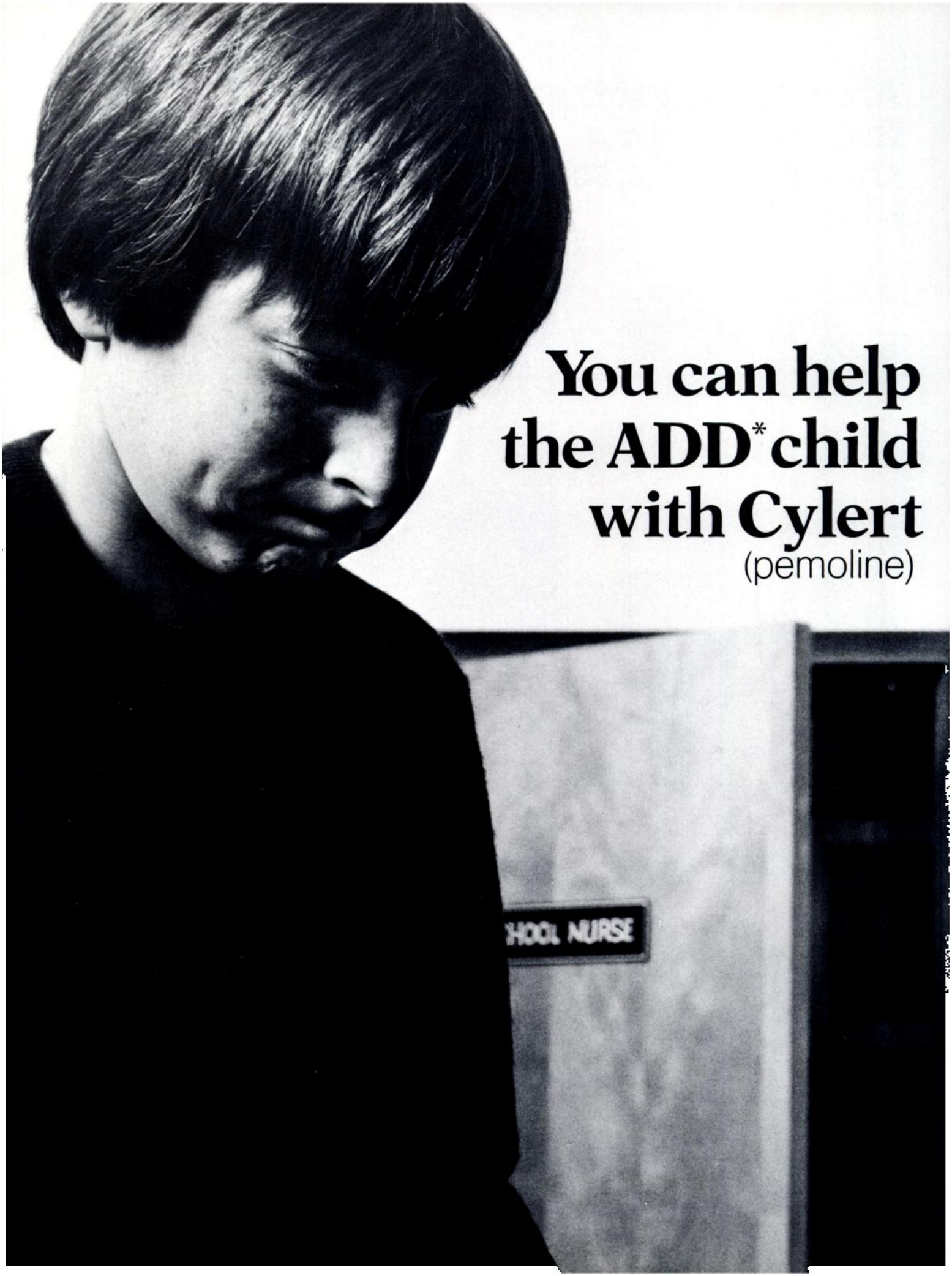

You can help the ADD* child with Cylert
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Day-long behavior therapy without dosing problems at school

Impressive all-day control.

Cylert works extremely well, given an adequate period of trial. Single daily doses are as effective for behavior control as multiple doses of methylphenidate or amphetamines. Blood levels are well sustained, without necessity for multidose administration.

No troublesome midday dose.

Cylert avoids problems of taking a drug at school. No involvement of school personnel. No peer teasing about noon-time dosing. The parents manage all medication, and the child carries no drugs. (And note that Cylert is Schedule IV, not II.)

Cylert® (pemoline) C IV

18.75, 37.5, 75 mg tablets; 37.5 mg chewables

Just once a day. At home.

*ADD: Attention Deficit Disorder (formerly called MBD, Minimal Brain Dysfunction), or the Hyperkinetic Syndrome. Please see next page for Brief Summary.

ABBOTT

9083319

Cylert® (pemoline)

DESCRIPTION: CYLERT (pemoline) is a central nervous system stimulant. Pemoline is structurally dissimilar to the amphetamines and methylphenidate.

It is an oxazolidine compound and is chemically identified as 2-amino-5-phenyl-2-oxazolin-4-one.

Pemoline is a white, tasteless, odorless powder, relatively insoluble (less than 1 mg/ml) in water, chloroform, ether, acetone, and benzene; its solubility in 95% ethyl alcohol is 2-2 mg/ml.

CYLERT (pemoline) is supplied as tablets for oral administration.

CLINICAL PHARMACOLOGY: CYLERT (pemoline) has a pharmacological activity similar to that of other known central nervous system stimulants; however, it has minimal sympathomimetic effects. Although studies indicate that pemoline may act in animals through dopaminergic mechanisms, the exact mechanism and site of action of the drug in man is not known.

There is neither specific evidence which clearly establishes the mechanism whereby CYLERT produces its mental and behavioral effects in children, nor conclusive evidence regarding how these effects relate to the condition of the central nervous system.

The serum half-life of pemoline is approximately 12 hours. Peak serum levels of the drug occur within 2 to 4 hours after ingestion of a single dose. Multiple dose studies in adults at several dose levels indicate that steady state is reached in approximately 2 to 3 days.

Metabolites of pemoline include pemoline conjugate, pemoline dione, mandelic acid, and unidentified polar compounds. CYLERT is excreted primarily by the kidneys; approximately 75% of an oral dose is recovered in the urine within 24 hours. Approximately 43% of pemoline is excreted unchanged.

CYLERT (pemoline) has a gradual onset of action. Using the recommended schedule of dosage titration, significant clinical benefit may not be evident until the third or fourth week of drug administration.

INDICATIONS: CYLERT is indicated as an integral part of a total treatment program which typically includes other remedial measures (psychological, educational, social) for a stabilizing effect in children with a behavioral syndrome characterized by the following group of developmentally inappropriate symptoms: moderate to severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity. The diagnosis of this syndrome should not be made with finality when these symptoms are only of comparatively recent origin. Nonlocalizing (soft) neurological signs, learning disability, and abnormal EEG may or may not be present, and a diagnosis of central nervous system dysfunction may or may not be warranted.

Attention Deficit Disorder and Hyperkinetic Syndrome are among the terms being used to describe the above signs and symptoms. In the past, a variety of terms has been associated with these signs and symptoms, including: Minimal Brain Dysfunction; Hyperkinetic Reaction of Childhood; Hyperkinetic Syndrome; Hyperactive Child Syndrome; Minimal Brain Damage; Minimal Cerebral Dysfunction; and Minor Cerebral Dysfunction.

CONTRAINDICATIONS: CYLERT (pemoline) is contraindicated in patients with known hypersensitivity or idiosyncrasy to the drug. (See ADVERSE REACTIONS.)

WARNINGS: CYLERT is not recommended for children less than 6 years of age since its safety and efficacy in this age group have not been established.

Clinical experience suggests that in psychotic children, administration of CYLERT may exacerbate symptoms of behavior disturbance and thought disorder.

Data are inadequate to determine whether chronic administration of CYLERT may be associated with growth inhibition; therefore, growth should be monitored during treatment.

PRECAUTIONS: Drug treatment is not indicated in all cases of the behavioral syndrome characterized by moderate to severe distractibility, short attention span, hyperactivity, emotional lability and impulsivity. It should be considered only in light of the complete history and evaluation of the child. The decision to prescribe CYLERT should depend on the physician's assessment of the chronicity and severity of the child's symptoms and their appropriateness for his/her age. Prescription should not depend solely on the presence of one or more of the behavioral characteristics.

When these symptoms are associated with acute stress reactions, treatment with CYLERT is usually not indicated.

Long-term effects of CYLERT in children have not been well established.

Liver function tests should be performed prior to and periodically during therapy with CYLERT. The drug should be discontinued if abnormalities are revealed and confirmed by follow-up tests. (See ADVERSE REACTIONS regarding reports of abnormal liver function tests and jaundice.)

CYLERT should be administered with caution to patients with significantly impaired hepatic or renal function.

The interaction of CYLERT with other drugs has not been studied in humans. Patients who are receiving CYLERT concurrently with other drugs, especially drugs with CNS activity, should be monitored carefully.

CYLERT failed to demonstrate a potential for self-administration in primates. However, the pharmacologic similarity of pemoline to other psychostimulants with known dependence liability suggests that psychological and/or physical dependence might also occur with CYLERT. There have been isolated reports of transient psychotic symptoms occurring in adults following the long-term misuse of excessive oral doses of pemoline. CYLERT should be given with caution to emotionally unstable patients who may increase the dosage on their own initiative.

Usage during Pregnancy and Lactation: The safety of CYLERT (pemoline) for use during pregnancy and lactation has not been established.

Studies in rats have shown an increased incidence of stillbirths and cannibalization when pemoline was administered at a dose of 37.5 mg/kg/day. Postnatal survival of offspring was reduced at doses of 18.75 and 37.5 mg/kg/day.

ADVERSE REACTIONS: Insomnia is the most frequently reported side effect of CYLERT. It usually occurs early in therapy, prior to an optimum therapeutic response. In the majority of cases it is transient in nature or responds to a reduction in dosage.

Anorexia with weight loss may occur during the first weeks of therapy. In the majority of cases it is transient in nature; weight gain usually resumes within three to six months.

Stomach ache, skin rashes, increased irritability, mild depression, nausea, dizziness, headache, drowsiness, and hallucinations have been reported.

Elevations of SGOT, SGPT, and serum LDH have occurred in patients taking CYLERT, usually after several months of therapy. These effects appear to be reversible upon withdrawal of the drug, and are thought to be manifestations of a delayed hypersensitivity reaction. There have also been a few reports of jaundice occurring in patients taking CYLERT; a causal relationship between the drug and this clinical finding has not been established.

The following CNS effects have been reported with the use of CYLERT: dyskinetic movements of the tongue, lips, face and extremities; nystagmus and nystagmoid eye movements; and convulsive seizures. A definite causal relationship between CYLERT and these reactions has not been established.

Mild adverse reactions appearing early during the course of treatment with CYLERT often remit with continuing therapy. If adverse reactions are of a significant or protracted nature, dosage should be reduced or the drug discontinued.

OVERDOSAGE: Signs and symptoms of acute CYLERT overdosage may include agitation, restlessness, hallucinations, dyskinetic movements and tachycardia. The treatment for an acute overdosage of pemoline is essentially the same as that for an overdosage of any CNS stimulant. Management is primarily symptomatic and may include induction of emesis or gastric lavage, sedation, and other appropriate supportive measures.

Results of studies in dogs indicate that extracorporeal hemodialysis may be useful in the management of CYLERT overdosage; forced diuresis and peritoneal dialysis appear to be of little value.

DOSAGE AND ADMINISTRATION: CYLERT (pemoline) is administered as a single oral dose each morning. The recommended starting dose is 37.5 mg/day. This daily dose should be gradually increased by 18.75 mg, at one week intervals until the desired clinical response is obtained. The effective daily dose for most patients will range from 56.25 to 75 mg. The maximum recommended daily dose of pemoline is 112.5 mg.

Clinical improvement with CYLERT is gradual. Using the recommended schedule of dosage titration, significant benefit may not be evident until the third or fourth week of drug administration.

Where possible, drug administration should be interrupted occasionally to determine if there is a recurrence of behavioral symptoms sufficient to require continued therapy.

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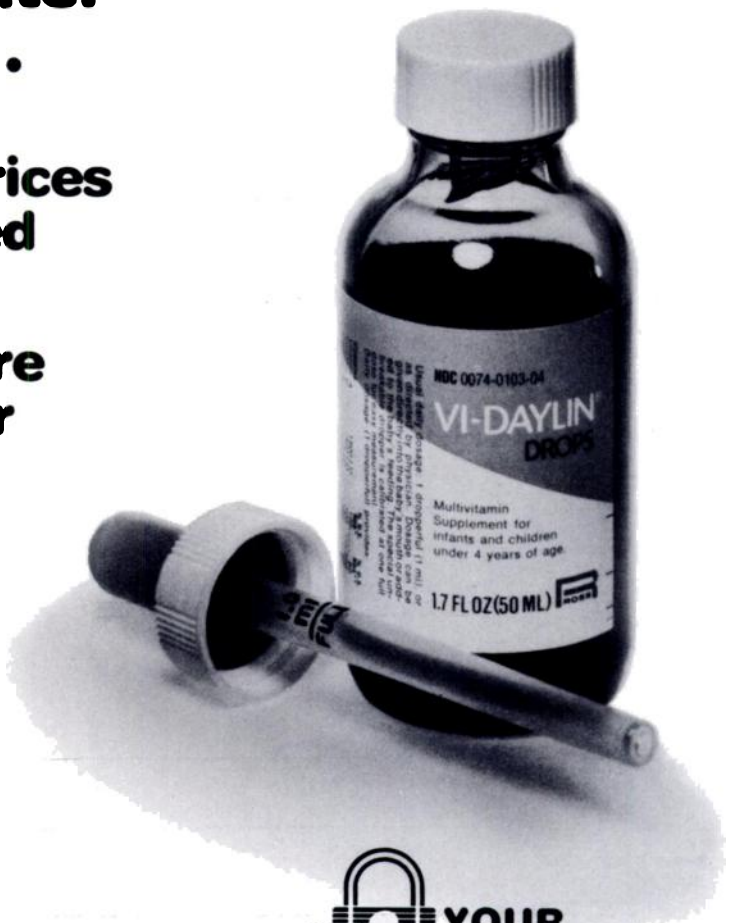

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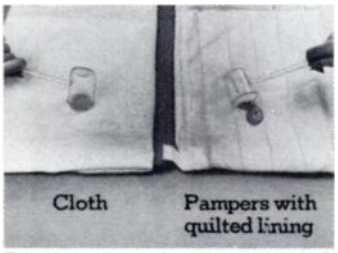
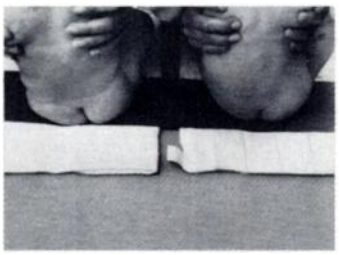
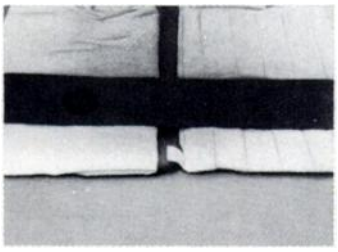
Proof you can see



Equal amounts of water are poured on a cloth diaper and a Pampers



After a minute's wait, a blotter is placed across both
Then two babies are set down on the blotter



When the babies are lifted up, the difference is clear!
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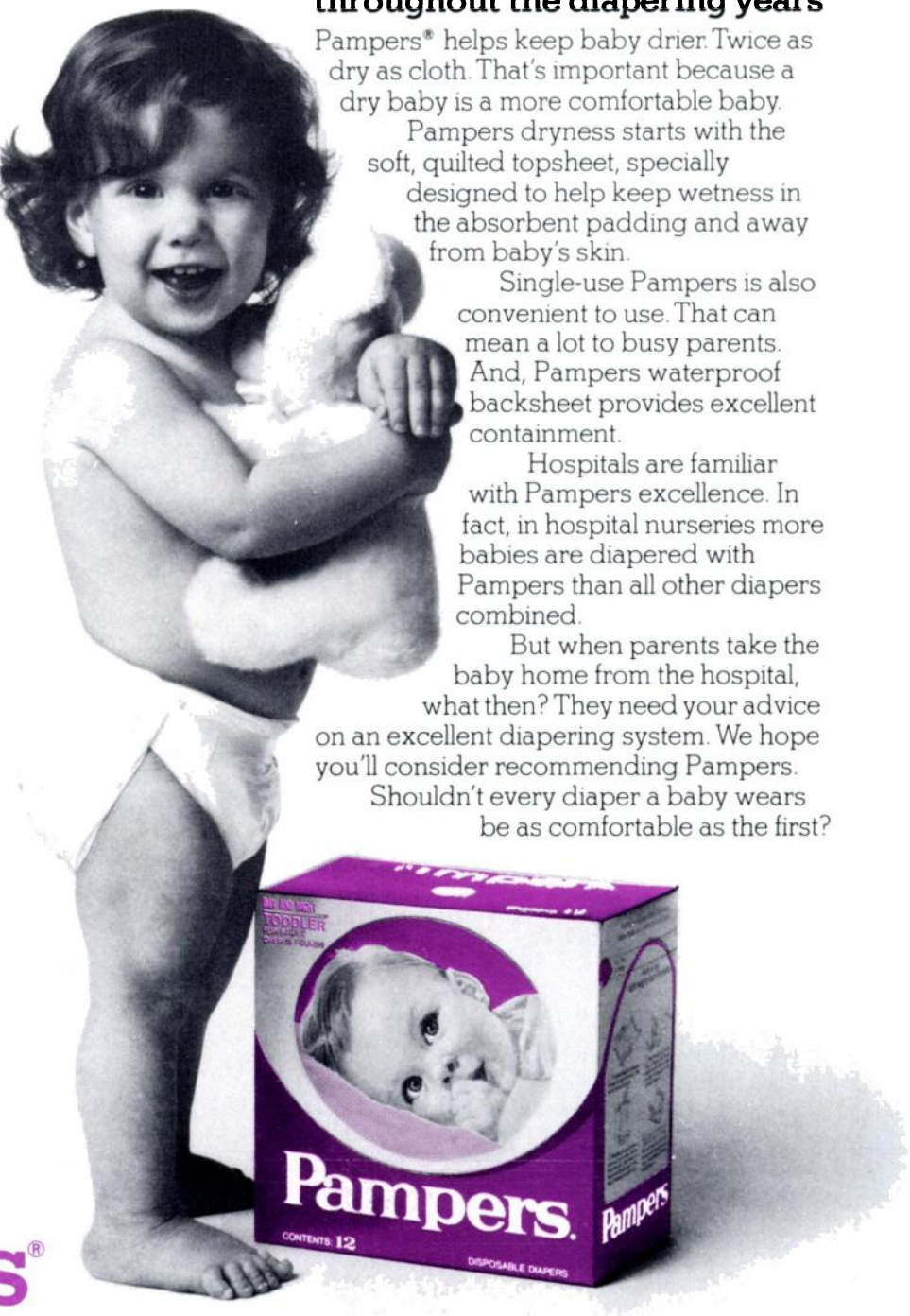
Hospitals are familiar with Pampers excellence. In fact, in hospital nurseries more babies are diapered with Pampers than all other diapers combined.

But when parents take the baby home from the hospital, what then? They need your advice on an excellent diapering system. We hope you'll consider recommending Pampers. Shouldn't every diaper a baby wears be as comfortable as the first?



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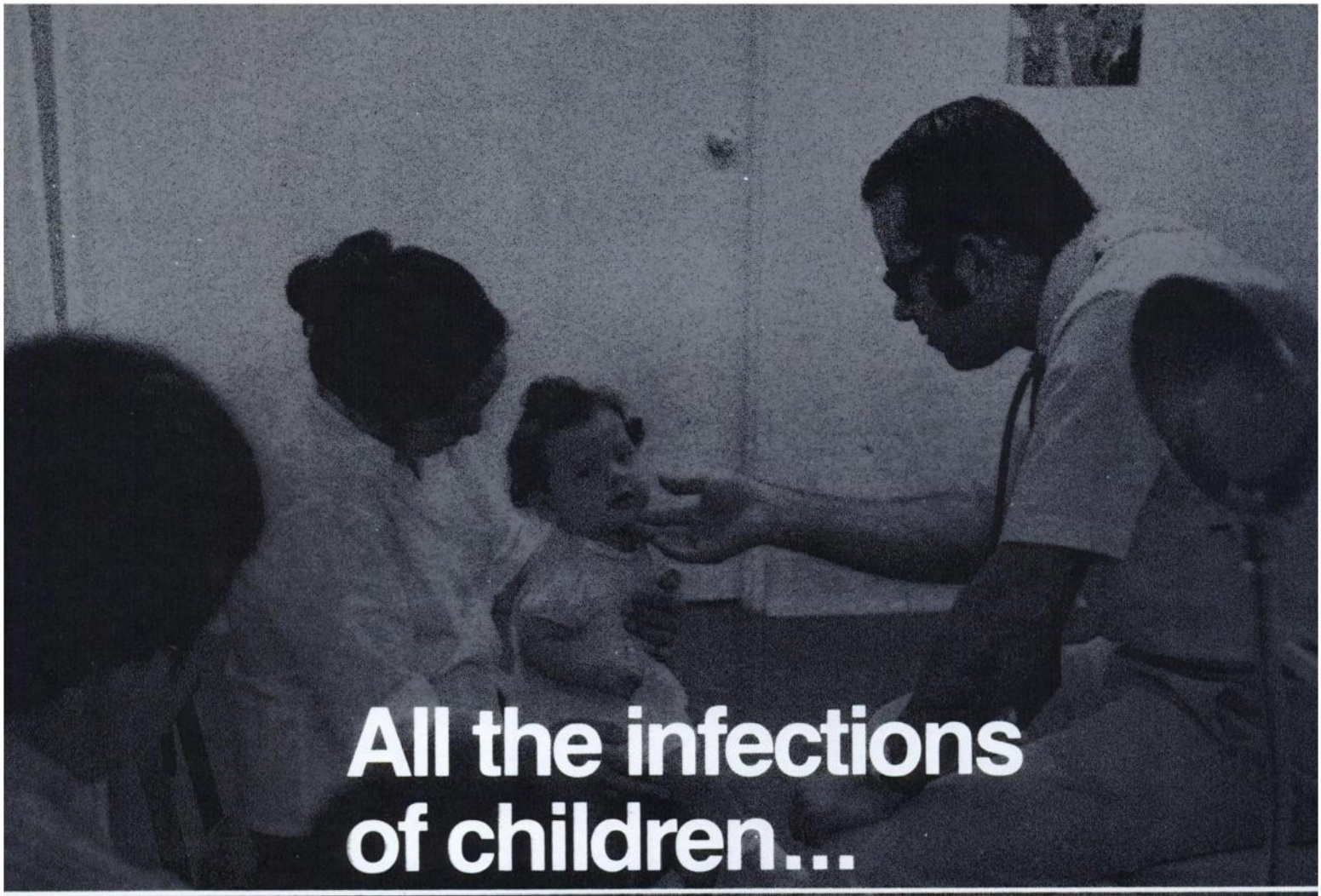

All the infections of children...

are described in detail in the "Red Book," officially known as the "Report of the Committee on Infectious Diseases." This succinct, up-to-date desk reference gives the etiology, epidemiology, incubation period, period of communicability, clinical forms and differential diagnosis, diagnostic procedures, treatment and control measures for more than 100 diseases from anaerobic infections to viral gastroenteritis. New sections of this edition include recommendations on otitis media, pneumococcal infections and opportunistic infections. The "Red Book" also provides comprehensive information on immunization and drug dosages. 1977 Indexed: 345 pages.

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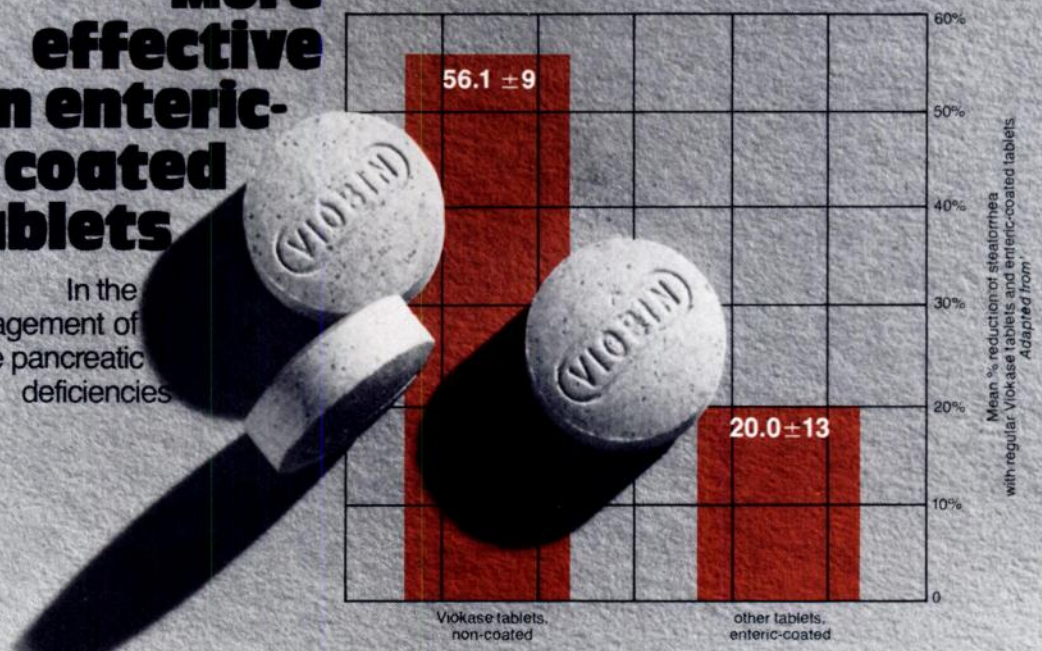
In the management of exocrine pancreatic deficiencies



VIOKASE®

Each 325 mg. Tablet contains: Lipase, N.F. Units 6,500; Protease, N.F. Units 32,000; Amylase, N.F. Units 48,000

CONSIDER THESE BENEFITS IN THE DIGESTIVE MANAGEMENT OF CYSTIC FIBROSIS

In a recent study, regular pancreatic enzyme tablets, such as Viokase, were found to be nearly three times as effective as enteric-coated tablets in correcting steatorrhea.[1] Theoretically, the enteric coating protects the enzymes from the stomach's acidity and releases them in the alkaline environment of the small intestine. But in patients with pancreatic insufficiency, the duodenum and upper jejunum are often acidic.[2] As a result, enteric coatings "...may reduce the clinical effectiveness of the pancreatic extracts".[1]

Another study reports that, "In the dosages used, neither enteric-coated enzymes nor supplemental neutralizing antacids were more effective than pancreatin alone in decreasing steatorrhea or improving duodenal enzyme delivery."[3] The authors tentatively conclude that "...acid-resistant enteric-coated preparations are helpful only in selected cases in which postprandial intragastric pH is uniformly low".[3] Thus, enteric-coated preparations appear to have limited usefulness in the treatment of exocrine pancreatic insufficiency, and when they are used, their effectiveness should be tested by determination of the response of steatorrhea.[1]

Viokase still costs less

Based on figures published in the 1979 *Drug Topic Redbook*, daily therapy with Viokase can cost your patients less than half the price of enteric-coated products...and the effectiveness of Viokase is confirmed by over 25 years of clinical experience.

VIOKASE® (pancreatin)

Description: VIOKASE is a pancreatic enzyme concentrate of porcine origin containing standardized amylase, protease and lipase activities plus esterases, peptidases, nucleases and elastase.

The enzyme potency of the tablets and powder are:

	Each 325 mg. Tablet	Each 0.75 gram (⅓ teaspoonful)
Lipase, N.F. Units	6,500	15,000
Protease, N.F. Units	32,000	75,000
Amylase, N.F. Units	48,000	112,500

Under conditions of the N.F. test method (in vitro) VIOKASE has the following total digestive capacity:

	Each 325 mg. Tablet	Each 0.75 g. Powder
Dietary Fat	23	53 grams
Dietary Protein	32	75 grams
Dietary Starch	48	112 grams

VIOKASE Tablets are not enteric coated.

Indications: As a digestive aid in cystic fibrosis and in exocrine pancreatic deficiencies usually due to chronic pancreatitis, pancreatectomy or obstruction in the pancreas caused by malignant growth.

Administration and Dosage:
Powder: Dosage to patients with cystic fibrosis: ⅓ teaspoon (0.75 grams) with meals.

Tablets: Dosage to patients with cystic fibrosis or chronic pancreatitis —1 to 3 tablets with meals. For aiding digestion in patients with pancreatectomy or gastrectomy—1 to 2 tablets taken at 2-hour intervals, or as directed by physician.

Caution: Federal law prohibits dispensing without prescription.

Warnings: Avoid inhalation of powder.

Precautions: Use with caution in patients known to be allergic to pork protein.

How Supplied:
Powder: Bottles of 4 ounces and 8 ounces
Tablets: Bottles of 100 and 500

Literature Available: Complete literature available upon request including information on BEEF VIOKASE DERIVED FROM BEEF PANCREAS FOR THOSE EXCEPTIONAL PATIENTS ALLERGIC TO PORK.

1. Graham, David Y., M.D. Enzyme Replacement Therapy of Exocrine Pancreatic Insufficiency in Man. N Engl J Med 296: 1314-1317, 1977.

2. Benn, A. and Cooke, W.T. Intraluminar pH of Duodenum and Jejunum in Fasting Subjects with Normal and Abnormal Gastric or Pancreatic Function. Scand J Gastroenterol 6: 313-317, 1971.

3. Regan, Patrick T., M.D., Malagelada, Juan-R, M.D., DiMagno, Eugene P., M.D., Glanzman, Scotty L. and Go, Vay Liang W., M.D. Comparative Effects of Antacids, Cimetidine and Enteric Coating on the Therapeutic Response to Oral Enzymes in Severe Pancreatic Insufficiency. N Engl J Med 297: 854-858, 1977.

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HISTORY OF OXYGEN THERAPY AND RETROLENTAL FIBROPLASIA

As medical technology improves and more patients survive conditions which once meant certain death, the demand for better treatment of problems which may afflict these survivors has increased. This is particularly true for infants who develop retrolental fibroplasia. It is now known that the administration of oxygen which saves the lives of numerous premature and low birthweight infants also causes the development of retrolental fibroplasia—in many instances leading to permanent blindness.

The Committee on Fetus and Newborn of the American Academy of Pediatrics strives to make conditions ideal for all newborn infants, and it has become increasingly concerned about the infants who develop retrolental fibroplasia. In an attempt to compress the work done by researchers throughout the world into one document—and thus more easily see possible causes and solutions as well as stimulate more research—the Committee prepared and wrote the History of Oxygen Therapy and Retrolental Fibroplasia. This document, which was published as a supplement to *Pediatrics,* is available to all persons involved with or interested in the treatment of newborn infants, especially infants who are at high risk for developing retrolental fibroplasia.

The sequence of events concerning the use of oxygen and the development of retrolental fibroplasia is given. Considerable attention has been paid to the historical background of modern care for premature infants, the status of medical practice when oxygen was first used on premature infants, and the process of dissemination of new research data. Included are the Academy's recommendations on the use of oxygen through the years, the current state regulations on the use of oxygen, and six pages of references which go back as far as 1862.

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American Academy of Pediatrics

Spring Session
April 19-24, 1980
Las Vegas, Nevada

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The American Academy of Pediatrics will hold its 1980 Spring Session in one of America's most dazzling cities—Las Vegas. No matter how many times you've been there, Las Vegas can still entice and surprise you. And if you've never played the Vegas casinos or seen its night club acts, you owe yourself this Las Vegas experience.

The Spring Session, April 19-24, offers an exciting program for you and your family. Some highlights:

For your family:

More than 16 tours and activities offer you the continuing excitement of Las Vegas. The offerings include:

- **Hoover Dam**—a ground tour right to the top of the $175 million giant;
- **Learn To Gamble**—a lesson from an expert on how to be a winner in the casino;
- **Valley Of Fire**—a tour of magnificent red sandstone rock formations dating back to 300 B.C.;
- **ESP And Beyond**—a professional showman demonstrates ESP on people in the audience;
- **Gourmet Cooking**—a class taught by the author of a famous cookbook;
- **Transactional Workshop**—a workshop conducted by an expert in this field;
- **House Tour**—a marvelous tour taking you through Las Vegas' residential areas and the Liberace Museum.

Several classes are being offered in the family program for those who like to combine leisure and learning. A seminar on Financial Planning will provide information on effective ways to manage your money. Another seminar will be conducted by a foremost authority speaking on Estate Planning for Wives.

To help Fellows and their families keep in shape while they enjoy the meeting and Las Vegas, the Academy has arranged a program of aerobic exercises.

For you:

A balanced scientific program covering topics of interest to all child health professionals, from acne to strabismus. The program features an increased number of seminars and round tables, and is accredited for 36 hours of Category 1 continuing medical education credit. In addition, many topics on the program are coordinated with the Academy's new comprehensive continuing education program, PREP. For details of the scientific sessions, consult your preliminary program, or write for a copy to:

American Academy of Pediatrics, Division M, 1801 Hinman Ave., Evanston, IL 60204.

See you in Las Vegas!

For a list of topics to be presented in the Seminars and Round Tables, please turn to pages

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- Unlike Povan†(pyrvinium pamoate), VERMOX® is not a dye; it will not stain underwear, bed linen, toilet bowls.
- Just one VERMOX® tablet eliminates pinworm, regardless of age†† and weight, unlike other products which require large dosages for adults.
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Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.
Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.
PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.
Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.
Dosage and Administration The VERMOX tablet may be chewed, swallowed or crushed and mixed with food. For control of pinworm (enterobiasis) a single tablet is administered orally, one time. If patient is not cured three weeks after treatment, a second course of treatment is advised.

† Registered trademark of Parke-Davis
†† Because VERMOX has not been extensively studied in children under two years of age, the relative benefit/risk should be considered before treating these children. VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

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*'Temaril' (brand of trimeprazine) has been evaluated as effective for symptomatic relief of pruritic symptoms in urticaria; possibly effective for relief of pruritic symptoms in atopic dermatitis. See brief summary.

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

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trimeprazine tartrate syrup

Relief that won't rub off

Avoids the discomfort and messiness of antipruritic ointments and creams

Use lowest effective dose. Do not use in children acutely ill and/or dehydrated.

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/or 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; idiosyncrasy or hypersensitivity to this drug or other phenothiazines; in newborn or premature children; in nursing mothers; in acutely ill and/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 asthmatic 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 ¼ or ½); lead to restlessness and motor hyperactivity in patients 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, as 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 and 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 lenticular and corneal opacities, epithelial keratopathies, pigmentary 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 analgesic effects of narcotics. Phenothiazine effects may be potentiated by oral contraceptives, progesterone, reserpine, nylidrin HCl.

Supplied: Syrup—in 4 fl. oz. bottles. Spansule® 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 'Spansule' capsules also available in Single Unit Packages (SUP) of 100, intended for institutional use only.

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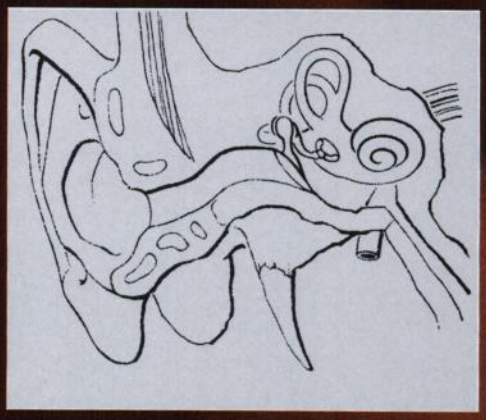
In otitis media due to H. influenzae...



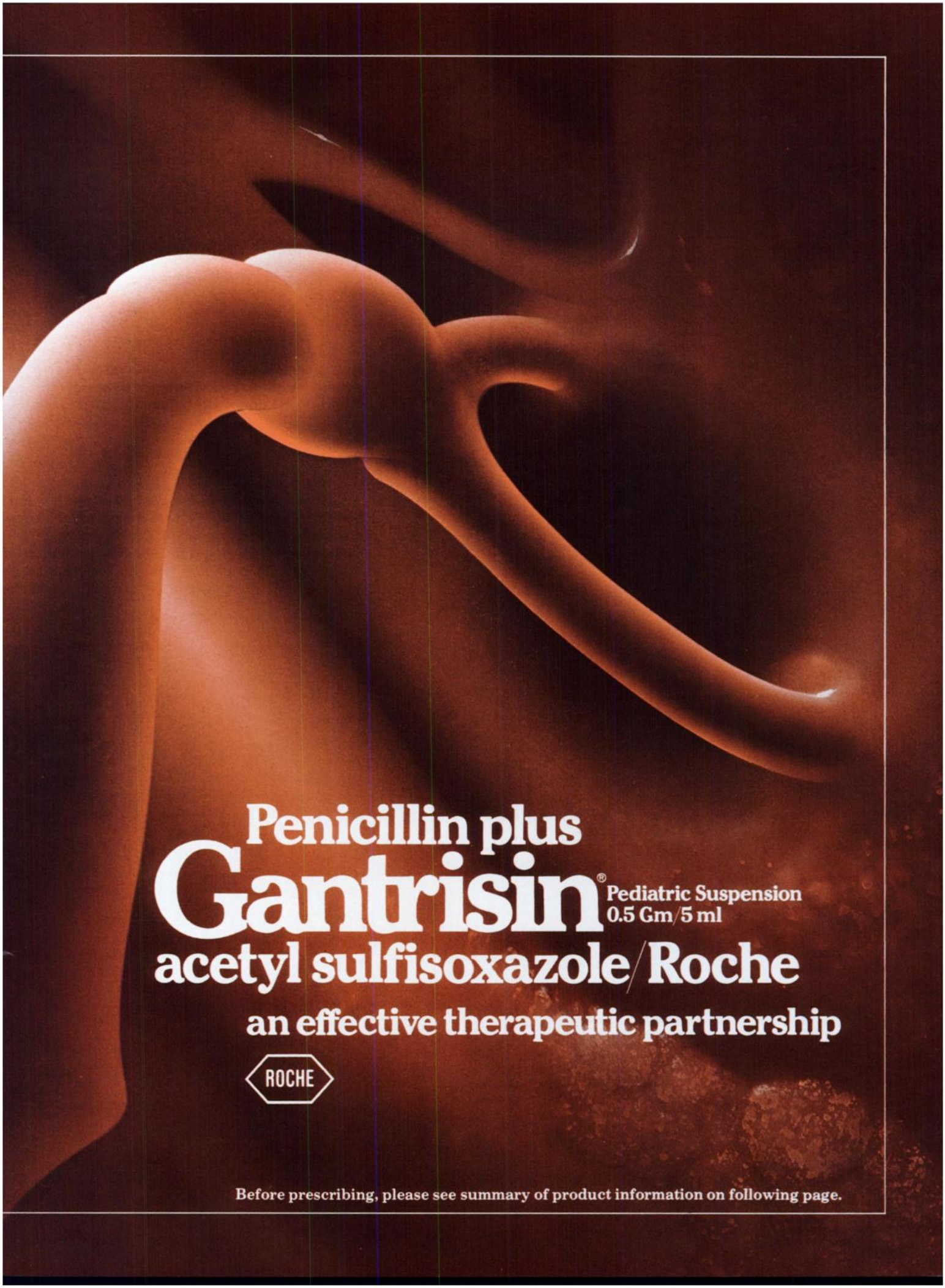
H. influenzae is commonly cultured from middle ear exudates in children under five—and may be a significant pathogen even in older children.*

try this:

Because of their combined effectiveness against *H. influenzae,* Gantrisin (sulfisoxazole) and penicillin make excellent "working partners" whenever the pathogen is implicated in acute otitis media. Gantrisin also has an impressively long record of safety. (As with all sulfonamides, adequate fluid intake should always be maintained and frequent CBC's and urinalyses performed.) And parents will appreciate the economy of Gantrisin therapy.

Usual dosage for young otitis media patients: Gantrisin—150 mg/kg/day in four to six divided doses to a maximum of 6 Gm; penicillin G—25,000 to 90,000 units/kg/day in four to six divided doses, not to exceed recommended adult dosage. Gantrisin should not be given to infants under 2 months of age.

*Schwartz R *et al.: JAMA 238*:1032-1033, Sept 5, 1977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American Academy of Pediatrics

Section On Pediatric Nephrology

The Section Committee cordially invites all FELLOWS with an interest in the field of pediatric nephrology to apply for Section Membership.

APPLICATIONS for Section Membership may be obtained from the Section Secretary at the address below.

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Each 5 ml teaspoonful contains
codeine phosphate 10 mg (Warning: may be habit forming.)
phenylpropanolamine hydrochloride 18.75 mg
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ZARONTIN Capsules
(ethosuximide capsules, USP)
ZARONTIN Syrup
(ethosuximide)
BRIEF SUMMARY OF PRESCRIBING INFORMATION AHFS Category 28:12

Indication: Zarontin is indicated for the control of absence (petit mal) epilepsy.

Contraindication: Ethosuximide should not be used in patients with a history of hypersensitivity to succinimides.

Warnings: Blood dyscrasias, including some with fatal outcome, have been reported to be associated with the use of ethosuximide; therefore, periodic blood counts should be performed.

Ethosuximide is capable of producing morphological and functional changes in the animal liver. In humans, abnormal liver and renal function studies have been reported.

Ethosuximide should be administered with extreme caution to patients with known liver or renal disease. Periodic urinalysis and liver function studies are advised for all patients receiving the drug.

Cases of systemic lupus erythematosus have been reported with the use of ethosuximide. The physician should be alert to this possibility.

Usage in Pregnancy: The effects of Zarontin in human pregnancy and nursing infants are unknown.

Recent reports suggest an association between the use of anticonvulsant drugs by women with epilepsy and an elevated incidence of birth defects in children born to these women. Data is more extensive with respect to phenytoin and phenobarbital, but these are also the most commonly prescribed anticonvulsants; less systematic or anecdotal reports suggest a possible similar association with the use of all known anticonvulsant drugs.

The reports suggesting an elevated incidence of birth defects in children of drug-treated epileptic women cannot be regarded as adequate to prove a definite cause and effect relationship. There are intrinsic methodologic problems in obtaining adequate data on drug teratogenicity in humans; the possibility also exists that other factors, eg, genetic factors or the epileptic condition itself, may be more important than drug therapy in leading to birth defects. The great majority of mothers on anticonvulsant medication deliver normal infants. It is important to note that anticonvulsant drugs should not be discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life. In individual cases where the severity and frequency of the seizure disorder are such that the removal of medication does not pose a serious threat to the patient, discontinuation of the drug may be considered prior to and during pregnancy, although it cannot be said with any confidence that even minor seizures do not pose some hazard to the developing embryo or fetus.

The prescribing physician will wish to weigh these considerations in treating or counseling epileptic women of childbearing potential.

Hazardous Activities: Ethosuximide may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as driving a motor vehicle or other such activity requiring alertness; therefore, the patient should be cautioned accordingly.

Precautions: Ethosuximide, when used alone in mixed types of epilepsy, may increase the frequency of grand mal seizures in some patients.

As with other anticonvulsants, it is important to proceed slowly when increasing or decreasing dosage, as well as when adding or eliminating other medication. Abrupt withdrawal of anticonvulsant medication may precipitate absence (petit mal) status.

Adverse Reactions

Gastrointestinal System: Gastrointestinal symptoms occur frequently and include anorexia, vague gastric upset, nausea and vomiting, cramps, epigastric and abdominal pain, weight loss, and diarrhea.

Hemopoietic System: Hemopoietic complications associated with the administration of ethosuximide have included leukopenia, agranulocytosis, pancytopenia, aplastic anemia, and eosinophilia.

Nervous System: Neurologic and sensory reactions reported during therapy with ethosuximide have included drowsiness, headache, dizziness, euphoria, hiccups, irritability, hyperactivity, lethargy, fatigue, and ataxia. Psychiatric or psychological aberrations associated with ethosuximide administration have included disturbances of sleep, night terrors, inability to concentrate, and aggressiveness. These effects may be noted particularly in patients who have previously exhibited psychological abnormalities. There have been rare reports of paranoid psychosis, increased libido, and increased state of depression with overt suicidal intentions.

Integumentary System: Dermatologic manifestations which have occurred with the administration of ethosuximide have included urticaria, Stevens-Johnson syndrome, systemic lupus erythematosus, and pruritic erythematous rashes.

Miscellaneous: Other reactions reported have included myopia, vaginal bleeding, swelling of the tongue, gum hypertrophy, and hirsutism. **TJ**

PARKE-DAVIS

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PD-JA-2153-1-P-(4-77) *Morris Plains, NJ 07950*

Zarontin®

(ethosuximide) SYRUP | (ethosuximide capsules, USP) CAPSULES

A drug of choice† to treat absence seizures (petit mal) as the child matures

---

***Absence seizure**

†**Note:** Periodic blood counts are advised in patients taking Zarontin. The physician should be alert to signs and symptoms of bone marrow depression of any type.

Reference: Livingston S: Comprehensive Management of Epilepsy in Infancy, Childhood and Adolescence. Springfield, IL, Charles C Thomas, 1972, p 237.

For brief summary of prescribing information, see adjacent page.

PAIN GONE

while the antibiotic gets going

An effective adjuvant to systemic antibiotic treatment, AURALGAN promptly relieves the pain and reduces the inflammation of acute otitis media, while the antibiotic of choice fights the infection.

AURALGAN contains the topical analgesic action of benzocaine and antipyrine plus glycerin dehydrated...a decongestant so hygroscopic that it "blots up" excess moisture through the tympanic membrane, for relief of pressure and pain in the middle ear.

BRIEF SUMMARY

OTITIS MEDIA (ACUTE): AURALGAN is indicated for relief of pain and reduction of inflammation in the congestive and serous stages of acute otitis media. It is effective adjuvant therapy when antibiotics or sulfonamides are administered systemically.

Administration: Otitis media (acute): Instill AURALGAN, permitting the solution to run along the wall of the canal until it is filled. Avoid touching ear with dropper. Then, moisten cotton pledget with AURALGAN and insert into the meatus. Repeat every one to two hours (or three or four times a day).

REMOVAL OF CERUMEN: AURALGAN facilitates the removal of excessive or impacted cerumen.

Administration for Removal of Cerumen: Instill AURALGAN three times daily for two days to help detach cerumen from wall of canal and facilitate removal of plug. Irrigate with warm water.

Note: Keep well closed. Do not rinse dropper after use.

SUPPLIED: No. 1000 - AURALGAN Otic Solution, in package containing 15 ml (1/2 fl oz.) bottle with separate dropper-screw cap attachment.

...in acute otitis media

Auralgan®

OTIC SOLUTION

Each ml contains:

Antipyrine	54.0 mg
Benzocaine	14.0 mg
Glycerin dehydrated q.s. to	1.0 ml

(contains not more than 1.0% moisture) (also contains oxyquinoline sulfate)

FULLY COMPATIBLE WITH SYSTEMIC ANTIBACTERIAL THERAPY. ON PRESCRIPTION ONLY.

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MEDICAL PROGRESS

Western industrialized society has achieved a high standard of physical health for most of its members, and the reality of medical progress goes almost unquestioned. Most dramatic of all have been the achievements based on bacteriological explanations of the etiology of disease. Hence, the identification of living organisms as agents of disease is conventionally regarded as the triumph of scientific medicine in the nineteenth century. Yet Louis Pasteur's theories seemed at the time, according to scientific criteria, to be anomalous. His claim that disease in an animal or plant was caused by another independent species, by means unknown, was contrary not only to the established trend of chemical explanation, but also to mainstream germ theory, since this development was based on advances made earlier in the century in the understanding of structure, growth, and differentiation. It looked not to independent living organisms, but to abnormal processes, for the agents in disease. If the bacteriological discoveries of the 1870s and 1880s are to be regarded as "scientific," then the complex biochemical and physiological explanations of disease characteristic of earlier decades can hardly be less so.

Submitted by Student

From Pelling M: *Cholera, Fever and English Medicine 1825–1865*. Oxford, Oxford University Press, 1978.

tions of greater than 50 mg/liter, experience with adults[9] would suggest that much lower levels may potentially be associated with seizure activity in neonates.

Dosing errors such as those responsible for the seizures in our cases unfortunately are all too common when drugs dispensed for use in adults are adapted for use in infants. Perlstein and co-workers[10] also warn us of this problem in their recent survey of the reliability of physician and nurse dosing calculations in newborns. We hope this report will increase awareness of the need for close monitoring of theophylline levels when this drug is used in neonatal nurseries.

ACKNOWLEDGMENT

We wish to express our gratitude to Rebecca L. Green, CMA-Ped for the preparation of this manuscript.

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A POPULAR CORDIAL PRESCRIBED IN 1896 FOR CHILDREN SUFFERING FROM DIARRHEA

Polypharmaceutical preparations were frequently prescribed for the treatment of children during the latter part of the nineteenth century. A popular prescription for children with diarrhea was the following (*Pediatrics* (NY) 1: 215, 1896).

Diarrhea Cordial—Spirit of camphor, 4 drams; compound fl. ext. blackberry, 1 ounce; compound tincture of cardamon, 1 ounce; chloroform, 2 drams; tincture capsicum, 2 drams; oil of peppermint, 1 dram; fl. ext. of catechu, 4 drams; sugar, 24 ounces; alcohol, 5 ounces; water, 13 ounces. Mix alcohol with 13 ounces of water; add camphor, fluid extracts, oils, etc., and filter; then dissolve sugar by cold percolation; add chloroform and shake thoroughly; then add sufficient simple syrup to make 32 ounces.

Noted by T.E.C., Jr, MD

ing the heterogenous nature of the underlying etiologies. Although delineation of the heterogeneity of hyperthyroidism is needed before definitive treatment recommendations based upon the natural history of the disease can be made, long-term therapy seems appropriate.

ACKNOWLEDGMENTS

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THE PHILOSOPHY OF KARL POPPER

"There is a basic conflict of intent between the *Critical Attitude*. . .and a desire for *Justification*. . .should the hypotheses we choose be criticized in the hope of improving them, or justified in the hope that we can show ourselves to have been as near correct as we could be? Being right is very attractive. Being obviously right, even more attractive. And being demonstratively right, most attractive of all. But the widely held hope to be able to demonstrate how right we are is at odds with the aim of improving our knowledge. So that skepticism ('Enquiry'; *Skeptomal* — 'I Examine'), despite its creative power, has never been widely acclaimed. Few people like to have their mistakes pointed out, and fewer admit to them gladly."

Submitted by Student

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ANNOUNCEMENT OF 1980 PEDIATRIC HEMATOLOGY-ONCOLOGY EXAMINATION

The Sub-Board of Pediatric Hematology-Oncology of the American Board of Pediatrics will administer its next certifying examination on Friday, October 10, 1980.

The following criteria must be met to be eligible to sit for the examination:

1. Certification by the American Board of Pediatrics.
2. Two years of full-time graduate training in pediatric hematology-oncology completed by September 1, 1980

   OR

   Five years in the clinical practice of pediatric hematology-oncology completed by July 1, 1978. THIS IS THE LAST EXAMINATION FOR WHICH CANDIDATES MAY APPLY VIA THE PRACTICE ROUTE.

   OR

   A combination of fellowship and practice to total five years of experience completed by September 1, 1980 (Note that no practice time may be accrued after July 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.

   THIS IS THE LAST EXAMINATION FOR WHICH CANDIDATES MAY APPLY VIA THE COMBINATION ROUTE.
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 Sub-Board of Pediatric Hematology-Oncology.

Registration for this examination will extend from FEBRUARY 1, 1980 to MAY 30, 1980. 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 examination fee. The registration fee will be retained.

Please direct inquires to: American Board of Pediatrics
Suite 402, NCNB Plaza
136 East Rosemary St
Chapel Hill, NC 27514
(919) 929-0461

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Encyclopedia of Pediatric Psychology. Logan Wright, Arelene B. Schaefer, and Gerald Solomons. Baltimore, University Park Press, 1979, $39.50, 933 pp.

Childhood Pathology and Later Adjustment, The Question of Prediction. Edited by Loretta K. Cass and Carolyn B. Thomas. Somerset, NJ, John Wiley & Sons, Inc, 1979, $16.95, 268 pp.

Psychopathological Disorders of Childhood. Edited by Herbert C. Quay and John S. Werry. Somerset, NJ, John Wiley & Sons, Inc, 1979, $18.95, 542 pp.

Bone Diseases of Children. Edited by Pierre Maroteaux. Philadelphia, JB Lippincott Co, 1979, $39, 435 pp.

Liver Disorders In Childhood. Alex P. Mowat. Woburn, MA, Butterworths and Co, 1979, $48.50, 407 pp.

Atlas of Rectoscopy and Colonoscopy. Peter Otto and Klaus Ewe, Secaucus, NJ, Springer-Verlag, 1979, $53.90, 110 pp.

Infants Born at Risk: Behavior and Development. Tiffany M. Field, Anita Miller Sostek, Susan Goldberg, and H. H. Shuman. Jamaica, NY, SP Medical & Scientific Books, 1979, $28.95, 498 pp.

The Treatment of Neurological Diseases. Roger M. Rosenberg. Jamaica, NY, SP Medical & Scientific Books, 1979, $45, 613 pp.

Real Time Ultrasound in Perinatal Medicine. R. Chef Charleroi. Basel, Switzerland, S Karger AG Publishers, 1979, $51.50, 159 pp.

Recent Advances in Cystic Fibrosis Research. M. H. Gotz and O. B. Stur. Basel, Switzerland, S Karger AG Publishers, 1979, $51.50, 159 pp.

Biting off the Bracelet: A Study of Children in Hospitals. Ann Hill Beuf. Philadelphia, University of Pennsylvania Press, 1979, $9.95 (cloth), 164 pp.

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TEXTBOOKS THAT DON'T EMBALM

For 30 years as a professor I've "given" assignment in textbooks and before that for 20 years "done" them as student. Not until this year, as I was writing my fourth textbook, did I realize what sort of creatures textbooks really are. . . .

They peddle the ideas, methods, principles and knowledge of authorities but abstracted and detached from the experience that generates them.

By their form, they imply that the discoveries spring full-blown in the heads of experts. . . .

Because textbooks betray none of the humanity of their authors or of the authorities whose work they merchandise, they unwittingly imply that their readers can never themselves become authorities.

Submitted by Student

From Macrorie K: Textbooks that don't embalm. New York *Times,* September 3, 1979.

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JUST CLONING AROUND

Oh, give me a clone
Of my own flesh and bone
With its Y chromosome changed to X;
And when it is grown,
Then my own little clone
Will be of the opposite sex.

Submitted by Student

From Garrett R: Just cloning around. New York *Times*, September 10, 1979.

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THE AMERICAN WAY OF TESTING

Developed first for the Army in World War I and widely used in World War II to test intelligence and ability, objective tests are gifts of war to civilian life. In the 25 years the S.A.T. (Scholastic Aptitude Test) has been dominant, American education has been revolutionized. The marketplace has overturned the traditional foundations of learning—reading and writing—more completely than the efforts of any mechanistic theorist. Most Americans are probably tested more that they are taught. Compositions, essay, questions, term papers—vigorous thinking—all have yielded to one right answer out of four, to boxes to be checked, blanks to be filled. Objective tests not only carry the prestige of being scientifically accurate—when they aren't—but also provide an easy way of handling the masses by machine. . . .

The American language—supple, imaginative and alive—has lost ground to the pretense of measurement.

Submitted by Student

From Wheeler TC: The American way of testing. *New York Times*, September 2, 1979.

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ANNOUNCEMENT OF 1980 PEDIATRIC ENDOCRINOLOGY EXAMINATION

The Subspecialty Committee of Pediatric Endocrinology of the American Board of Pediatrics will administer its next certifying examination on Friday, October 10, 1980.

The following criteria must be met to be eligible to sit for the examination:

1. Certification by the American Board of Pediatrics.
2. Two years of full-time graduate training in pediatric endocrinology completed by September 1, 1980

   OR

   Five years in the clinical practice of pediatric endocrinology completed by September 1, 1980

   OR

   A combination of fellowship and practice to total five years experience completed by September 1, 1980:
   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 examination will extend from FEBRUARY 1, 1980 to MAY 30, 1980. 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 examination fee. The registration fee will be retained.

Please direct inquiries to: American Board of Pediatrics
Suite 402, NCNB Plaza
136 East Rosemary St
Chapel Hill, NC 27514
(919) 929-0461

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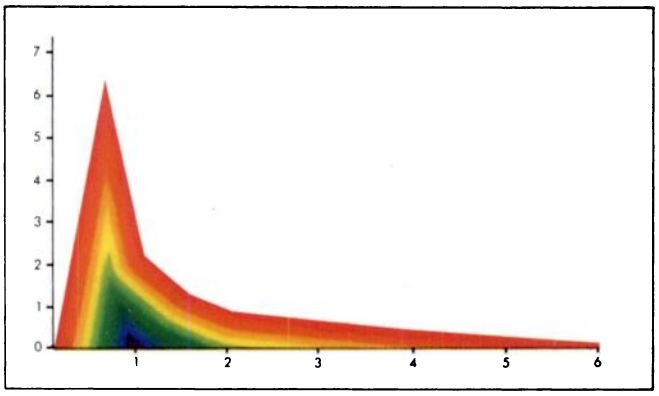
SOME OF OUR CUSTOMS

A great deal of the future health of man, depends on his organization and rise in the world. A child born of healthy parents; and being exposed to the different elements at or near its birth, that is of cold water or air, with other changes, such children generally bring into the world a system by nature formed to resist the cause of disease. The treatment of children among us Indians tends to secure this firmness of constitution, that becomes in some degree hereditary. To harden them against the inclemency of the weather we plunge our pappooses frequently under water, winter and summer and to preserve their shape, we tie them to a board for several months our children are frequently part naked and either bare footed or wear a kind of thin mockasin which is but little defence against water or cold, our wigwams part open and even some times without wigwams and the top of our heads are all ways open to the snow or rain, in this way our constitutions are prepared to stand the inclemency of the weather. In the time of plenty and in war and more especially in victory; we rise in victorious exercise and strike a lance; having little bells or beeds tied to our ancles and instruments in our hands to make a noise, and we parade around the fire in winter; and in summer around other objects over which we make motions as though we would tommahawk or scalp each other, and try our activity to see how near we can strike at another's head and still miss it, and every few rounds we always raise a shout and thus set our blood in a high state of circulation, our squaws always stand near one place in their dance and shuffle their feet having a number of deers hoofs and the like fastened near the bottom of their garments while they make a low and rather a coarse noise. Our squaws does the principal part of the hard work, this gives a firmness to their bodies and strength to their constitution, *their menses seldom begin to flow before they are eighteen years of age and cease before they are forty*; and they seldom marry till they are above twenty-five. During pregnancy our women are excused from the more laborious parts of their labor. Nature is their only midwife. Each woman is delivered in a private wigwam without so much as one of her own sex to attend her, and after washing herself in cold water, she returns in a few days to her own camp.

Submitted by S. E. Wheelock, MD

From Pocahontus Nonoquet in The Indian Guide to Health, Kentucky, 1812.

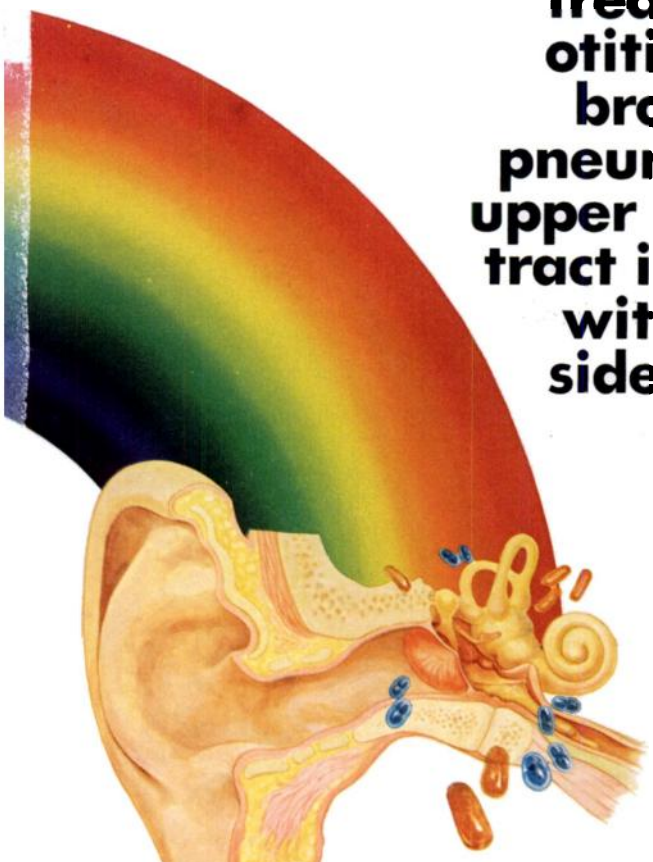
more than just spectrum

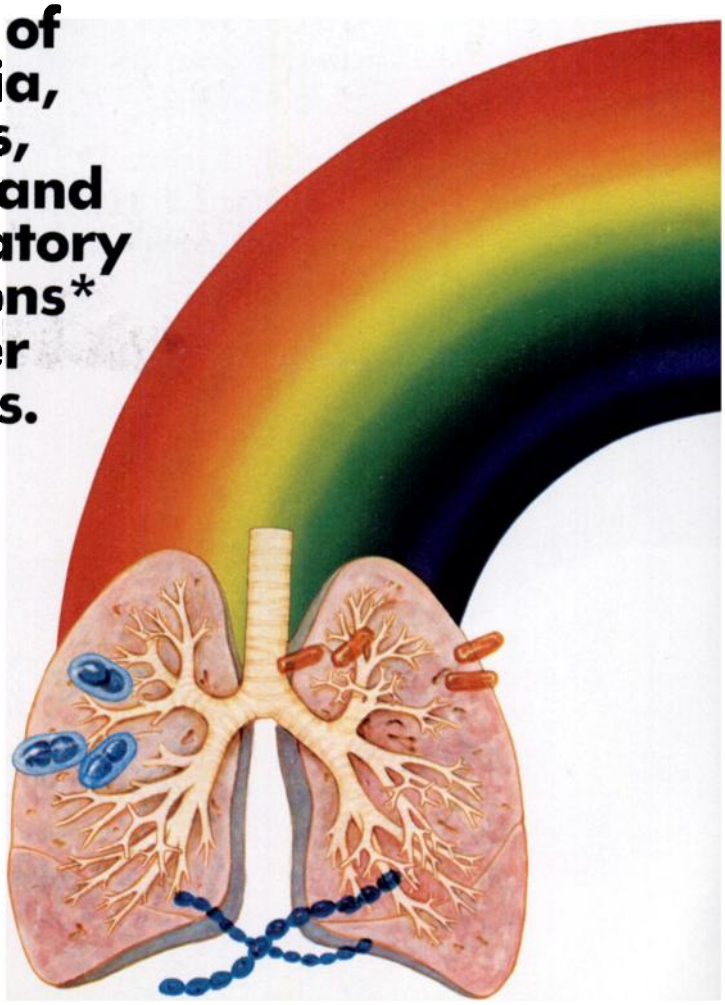


New CYCLAPEN®

(cyclacillin) Tablets/ Suspension

Efficacy proven in the treatment of otitis media, bronchitis, pneumonia and upper respiratory tract infections* with fewer side effects.





*Due to susceptible organisms

(See important information on last page.)

New CYCLAPEN®

(cyclacillin) Tablets/ Suspension

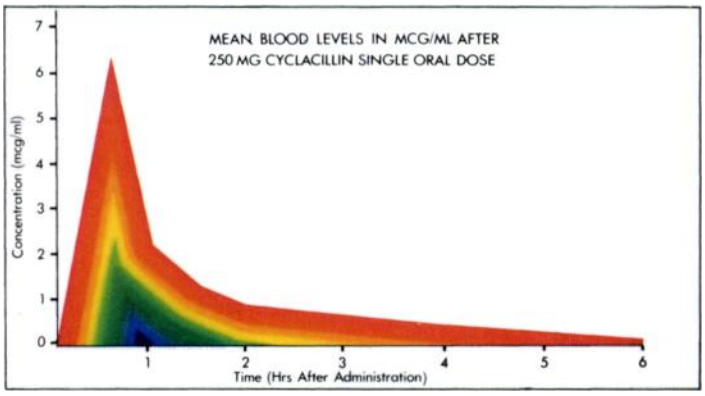
efficacy with fewer side ampicillin confirmed in studies of 2,581

Rapid, virtually complete absorption from GI tract

Rapid onset of action—mean peak serum levels within 30 minutes

Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)

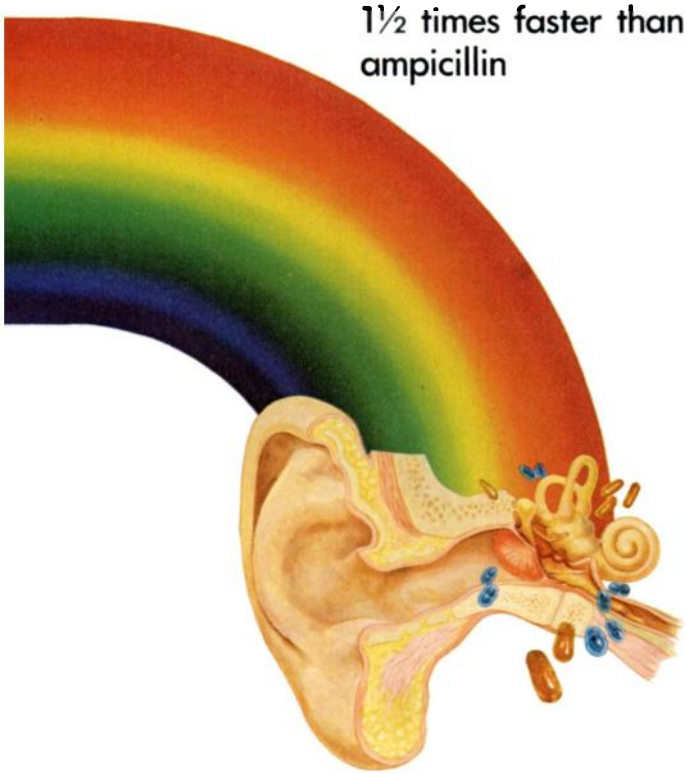
Rapidly excreted unchanged in the urine—1½ times faster than ampicillin



Clinical efficacy of CYCLAPEN® in otitis media†

Causative Organism		No. of Patients
S. pneumoniae	96	82
	95	
H. influenzae	88	96
	85	

% Clinical Response
% Bacterial Eradication

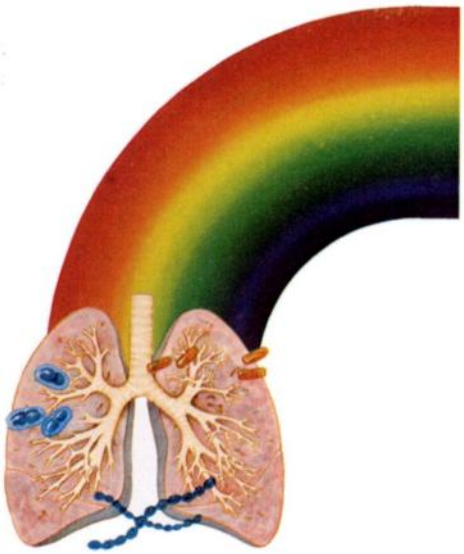


more than just spectrum in otitis media

*Includes all patients treated. 2,415 evaluated for safety; 1,819 evaluated for efficacy.

†Due to susceptible organisms.

effects than double-blind patients*



Fewer side effects with CYCLAPEN® in double-blind studies to date[1,2]

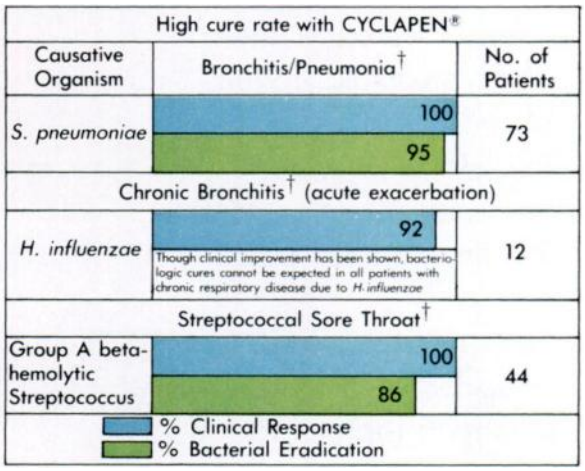
Total number of drug-related side effects in all patients	
CYCLAPEN®	128 of 1,286 (10%) of patients
ampicillin	202 of 1,129 (18%) of patients
Difference statistically significant (P <0.001)	

CYCLAPEN® (cyclacillin)
Effective for otitis media† in children

- Excellent clinical results in eliminating the two most common causative organisms in otitis media
- Significantly lower incidence of diarrhea and skin rash in children treated with CYCLAPEN® Suspension

	diarrhea	rash
CYCLAPEN	9.1%	2.1%
ampicillin	19.2%	5.8%
	P < 0.001	P < 0.03

In bronchitis, pneumonia and upper respiratory tract infections†



more than just spectrum

CYCLAPEN®

(cyclacillin) Tablets/ Suspension

1. Gold JA, Hegarty CP, Deitch MW, Walker BR: Double-blind clinical trials of oral cyclacillin and ampicillin, *Antimicrob Ag Chemother* 15:55-58, (Jan.) 1979.
2. Data on file, Wyeth Laboratories.

(See important information on next page.)

Wyeth Laboratories
Philadelphia, Pa 19101

New from Wyeth Laboratories

CYCLAPEN®
(cyclacillin) Tablets/ Suspension

Usual children's dosage: 50 to 100 mg/kg/day in equally spaced doses, depending on severity.

more than just spectrum in otitis media, bronchitis, pneumonia, and upper respiratory tract infections*

- Rapid, virtually complete absorption from GI tract
- Rapid onset of action—mean peak serum levels within 30 minutes
- Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)
- Rapidly excreted unchanged in the urine—1½ times faster than ampicillin
- Significantly fewer episodes of diarrhea and skin rash than reported with ampicillin in studies to date
- Excellent clinical response and outstanding bacterial eradication documented in double-blind studies involving 2,581 patients
- New CYCLAPEN® Suspension—great-tasting raspberry punch flavor

*Due to susceptible organisms.

How Supplied

CYCLAPEN® (cyclacillin) tablets:
250 mg scored tablets
500 mg scored tablets

Indications

Cyclapen® (cyclacillin) has less in vitro activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below.

Cyclapen® is indicated for the treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis* (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

Contraindications

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

Warnings

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS.

SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN.

ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Precautions

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

Adverse Reactions

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated hypersensitivity to penicillins or in those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS.)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

Dosage and Administration

CYCLAPEN® (cyclacillin) for oral suspension
125 mg per 5 ml:
100 ml and 200 ml bottles
250 mg per 5 ml:
100 ml and 200 ml bottles

INFECTION*	ADULTS	CHILDREN
		Dosage should not result in a dose higher than that for adults.
Respiratory Tract		
Tonsillitis & Pharyngitis**	250 mg q.i.d. in equally spaced doses	body weight ≤20 kg (44 lbs) 125 mg q.i.d. in equally spaced doses body weight >20 kg (44 lbs) 250 mg q.i.d. in equally spaced doses
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d. in equally spaced doses	50 mg/kg/day q.i.d. in equally spaced doses
Chronic Infections	500 mg q.i.d. in equally spaced doses	100 mg/kg/day q.i.d. in equally spaced doses
Otitis Media	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Skin & Skin Structures	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Urinary Tract	500 mg q.i.d. in equally spaced doses	100 mg/kg/day in equally spaced doses.

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or until evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure

Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended:

Patients with a creatinine clearance of >50 ml/min need no dosage interval adjustment.

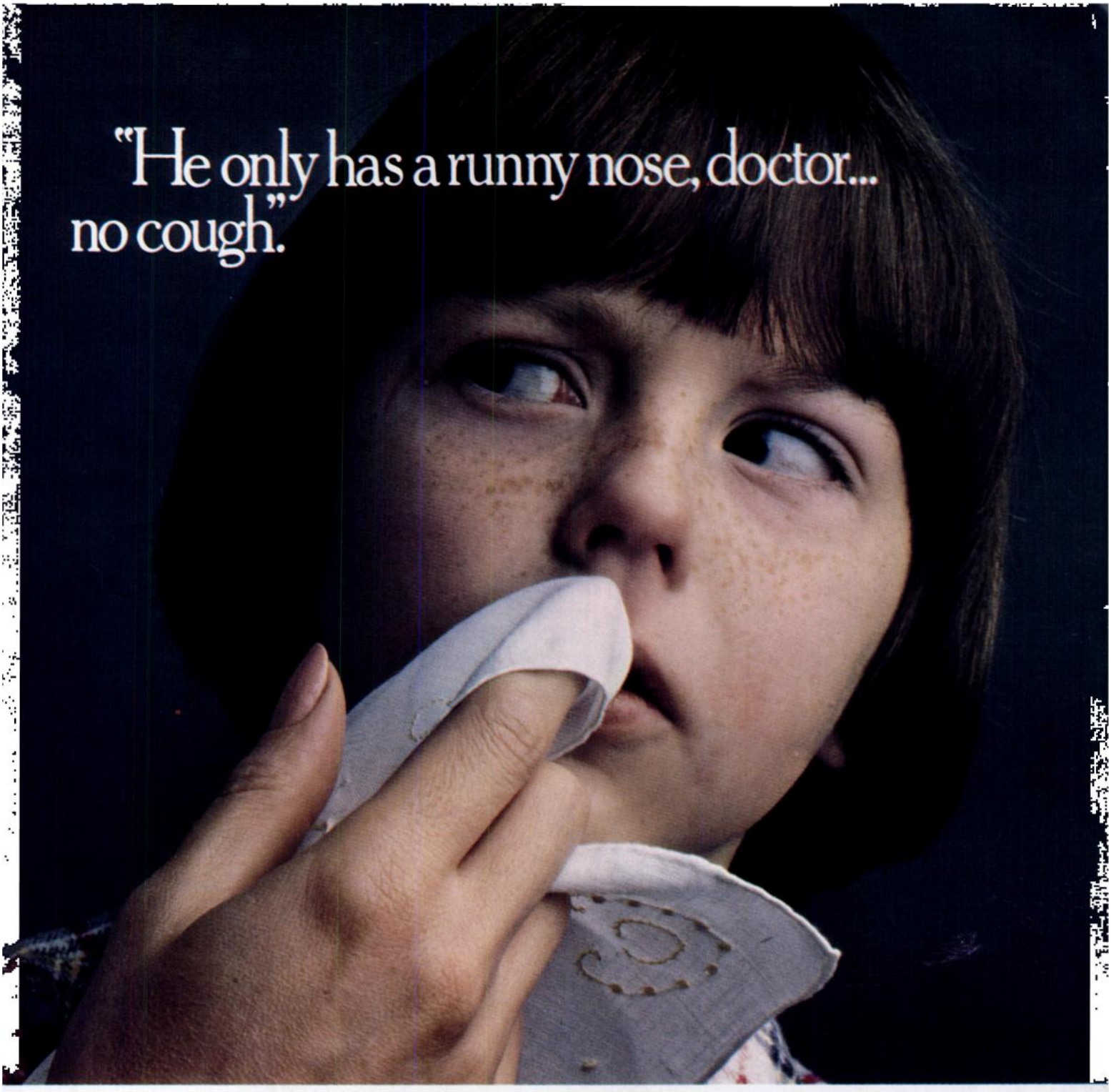
Patients with a creatinine clearance of 30-50 ml/min should receive full doses every 12 hours.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of ≤10 ml/min or serum creatinine values of >10 mg%, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency.

Wyeth Laboratories
Philadelphia, Pa. 19101



No need to treat more symptoms than he has. Now you can recommend SYMPTOM formulas from Parke-Davis and treat specific symptoms, singly or in combination.

- SYMPTOM formulas offer custom-tailored treatment for the symptoms of common colds: SYMPTOM 1™ for temporary relief of dry, hacking cough; SYMPTOM 2™ for nasal congestion; SYMPTOM 3™ for runny nose and hay fever allergies.
- MULTI-SYMPTOM™ formula combination can be used when *all* the symptoms are present.
- Safe, effective SYMPTOM formulas are nonnarcotic, pleasant-tasting liquids.
- ***Dye-free, saccharin-free,*** and available without prescription.
- Recommend SYMPTOM to your patients—the right medication for the right symptom.

SYMPTOM Formulas from PARKE-DAVIS

PARKE-DAVIS
Division of Warner-Lambert Company
Morris Plains, NJ 07950

PD-JA-2629-1-C (3-79)

NOW PETER

Attention Deficit Disorders* under control...
His natural abilities are coming through

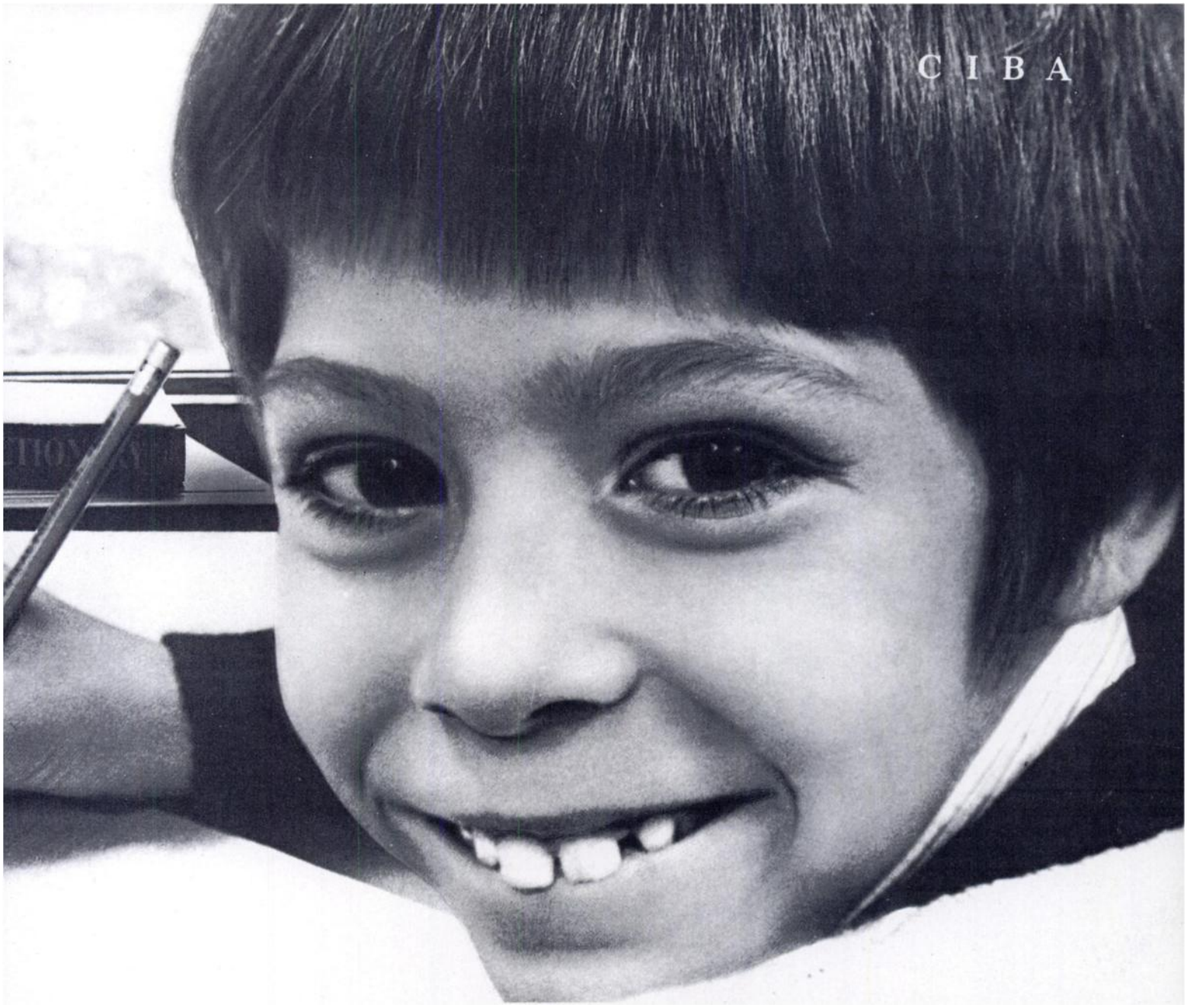
Now Peter's enjoying more things at play as well as in school. He works better with his teacher and classmates... likes doing things with his dad... gets more natural pleasure out of family and friends.

Now that his concentration is improved, his natural abilities are coming through. He's functioning better. Under a well-integrated program of treatment for Attention Deficit Disorders (ADD), hyperactivity and impulsiveness are markedly reduced.

Ritalin (methylphenidate) can be a vital part of his regimen. With adjunctive use of Ritalin, many ADD children are better able to control hyperkinetic behavior —act in a more natural and appropriate manner.

A 20-year record of proven efficacy

Over the years, Ritalin has become an established choice for pharmacotherapy of ADD. In a report by the



BEHAVES MORE NATURALLY.

National Council on Child Health,[1] Ritalin was described as among the most effective and best-documented agents for stimulant therapy in hyperkinetic children.

Reduces hyperactivity, impulsive behavior

Ritalin has a well-documented record of success in relieving the dominant symptoms of ADD. As it reduces distractibility, disorganized behavior and hyperactivity, improved school performance usually results,[2,3] as well as better peer interaction.[2]

Generally well tolerated

Although side effects may occur with Ritalin, they are generally not serious. During prolonged therapy, anorexia, weight loss, and insomnia are among the most frequently encountered adverse reactions. (See Adverse Reactions section of the prescribing information.) Even though most children require long-term treatment, there is little evidence of habituation.[1]

Therapy with Ritalin should be considered only after a medical diagnosis of ADD has been confirmed. Dosage can usually be interrupted during weekends and vacations. In some cases, these drug holidays reveal "stabilization" in the child's behavior without medication. They may permit a reduction in dosage and eventual discontinuation of drug therapy if warranted.

*Attention Deficit Disorders: new designation by the American Psychiatric Association; formerly called Minimal Brain Dysfunction (MBD) or Hyperkinetic Syndrome.

Ritalin . . . only when medication is indicated for Attention Deficit Disorders

Ritalin® C II
(methylphenidate)
as adjunctive therapy for ADD

Please turn page for brief prescribing information

Ritalin® C II (methylphenidate)

Only when medication is indicated

Ritalin® hydrochloride (methylphenidate hydrochloride USP) C II

TABLETS

INDICATIONS

Attention Deficit Disorders (previously known as Minimal Brain Dysfunction in Children). Other terms being used to describe the behavioral syndrome below include: Hyperkinetic Child Syndrome; Minimal Brain Damage; Minimal Cerebral Dysfunction; Minor Cerebral Dysfunction.

Ritalin is indicated as an integral part of a total treatment program which typically includes other remedial measures (psychological, educational, social) for a stabilizing effect in children with a behavioral syndrome characterized by the following group of developmentally inappropriate symptoms: moderate-to-severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity. The diagnosis of this syndrome should not be made with finality when these symptoms are only of comparatively recent origin. Nonlocalizing (soft) neurological signs, learning disability, and abnormal EEG may or may not be present, and a diagnosis of central nervous system dysfunction may or may not be warranted.

Special Diagnostic Considerations

Specific etiology of this syndrome is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.

Characteristics commonly reported include: chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity, minor neurological signs and abnormal EEG. Learning may or may not be impaired. The diagnosis must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these characteristics.

Drug treatment is not indicated for all children with this syndrome. Stimulants are not intended for use in the child who exhibits symptoms secondary to environmental factors and or primary psychiatric disorders, including psychosis. Appropriate educational placement is essential and psychosocial intervention is generally necessary. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.

CONTRAINDICATIONS

Marked anxiety, tension, and agitation are contraindications to Ritalin, since the drug may aggravate these symptoms. Ritalin is contraindicated also in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS

Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established.

Sufficient data on safety and efficacy of long-term use of Ritalin in children are not yet available. Although a causal relationship has not been established, suppression of growth (*ie*, weight gain, and or height) has been reported with the long term use of stimulants in children. Therefore, patients requiring long-term therapy should be carefully monitored.

Ritalin should not be used for severe depression of either exogenous or endogenous origin. Clinical experience suggests that in psychotic children, administration of Ritalin may exacerbate symptoms of behavior disturbance and thought disorder.

Ritalin should not be used for the prevention or treatment of normal fatigue states.

There is some clinical evidence that Ritalin may lower the convulsive threshold in patients with prior history of seizures, with prior EEG abnormalities in absence of seizures, and, very rarely, in absence of history of seizures and no prior EEG evidence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. In the presence of seizures, the drug should be discontinued.

Use cautiously in patients with hypertension. Blood pressure should be monitored at appropriate intervals in all patients taking Ritalin, especially those with hypertension.

Symptoms of visual disturbances have been encountered in rare cases. Difficulties with accommodation and blurring of vision have been reported.

Drug Interactions

Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors.

Human pharmacologic studies have shown that Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy

Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence

Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS

Patients with an element of agitation may react adversely; discontinue therapy if necessary.

Periodic CBC, differential, and platelet counts are advised during prolonged therapy.

Drug treatment is not indicated in all cases of this behavioral syndrome and should be considered only in light of the complete history and evaluation of the child. The decision to prescribe Ritalin should depend on the physician's assessment of the chronicity and severity of the child's symptoms and their appropriateness for his her age. Prescription should not depend solely on the presence of one or more of the behavioral characteristics.

When these symptoms are associated with acute stress reactions, treatment with Ritalin is usually not indicated.

Long-term effects of Ritalin in children have not been well established.

The Ritalin tablets (5 and 20 mg) contain FD&C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin hypersensitivity.

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. Toxic psychosis has been reported. Although a definite causal relationship has not been established, the following have been reported in patients taking this drug: leukopenia and or anemia; a few instances of scalp hair loss.

In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

DOSAGE AND ADMINISTRATION

Children (6 years and over)

Start with small doses (*eg*, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.

If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug.

Where possible, drug administration should be interrupted occasionally to determine if there is a recurrence of behavioral symptoms sufficient to require continued therapy. Improvement may be sustained when the drug is either temporarily or permanently discontinued.

Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.

HOW SUPPLIED

Tablets, 20 mg (peach, scored), bottles of 100 and 1000

Tablets, 10 mg (pale green, scored), bottles of 100, 500, 1000 and Accu-Pak® blister units of 100

Tablets, 5 mg (pale yellow), bottles of 100, 500 and 1000

Dispense in tight, light-resistant container (USP)

665382 C80-14 (1 80)

Consult complete product literature before prescribing

References

1. Kugel RB, Scherz RG, Seidel HM, et al: Council on Child Health: Medication for hyperkinetic children. *Pediatrics* 1975 (Apr.). **55**(4) 560-562.
2. Hoffman SP, Engelhardt DM, Margolis RA, et al: Response to methylphenidate in low socioeconomic hyperactive children. *Arch Gen Psychiatry* 1974 (Mar.). **30** 354-359.
3. MacKay MC, Beck L, Taylor R: Methylphenidate for adolescents with minimal brain dysfunction. *NY State J Med* 1973 (Feb.). **73** 550-554.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

175-01409-01

CIBA

Expressly for kids with colds that cough*

orange-pineapple flavored

Tuss-Ornade® cough/cold liquid

Each 5 ml. teaspoonful contains 5 mg. caramiphen edisylate; 2 mg. chlorpheniramine maleate; 15 mg. phenylpropanolamine hydrochloride; isopropamide iodide equivalent to 0.75 mg. of isopropamide; and alcohol, 7.5%.

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/or other information, FDA has classified the indications as follows:

Lacking in substantial evidence of effectiveness as a fixed combination: For relief from coughing, upper respiratory congestion and hypersecretion associated with the common cold, sinusitis, vasomotor rhinitis and allergic rhinitis.

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

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Do not use 'Tuss-Ornade' Liquid in children less than six months of age or under 15 lbs. in weight. Do not use 'Tuss-Ornade' *Spansule* capsules in children under 12 years of age.

Warnings: Warn vehicle or machine operators of possible drowsiness. Warn patients of possible additive effects of alcohol and other C.N.S. depressants.

Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards. An inhibitory effect on lactation may occur.

Effect on PBI Determination and I^{131} Uptake: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; use thyroid tests unaffected by exogenous iodides.

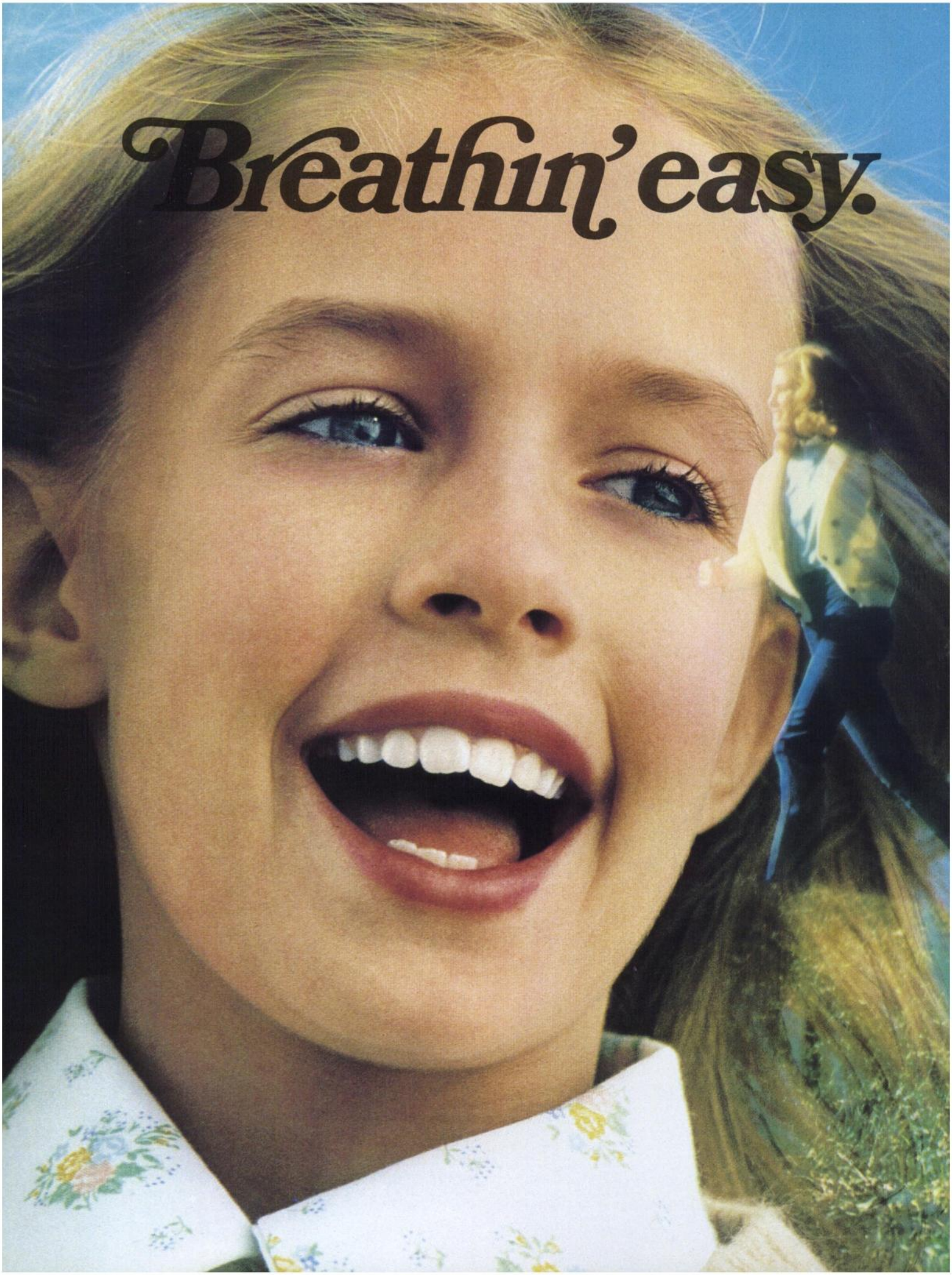
Precautions: Use with caution in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness, insomnia; nausea, vomiting, diarrhea; rash; dizziness; weakness; tightness of chest; angina pain; abdominal pain; irritability; palpitation; headache; incoordination; tremor; difficulty in urination; thrombocytopenia, leukopenia; convulsions; hypertension, hypotension; anorexia; constipation; visual disturbances; iodine toxicity (acne, parotitis); dysuria; epigastric distress.

Supplied: 'Tuss-Ornade' Liquid: An orange-pineapple flavored liquid in 16 fl. oz. bottles. For patients 12 years or older, 'Tuss-Ornade' *Spansule* capsules (each capsule contains 20 mg. caramiphen edisylate; 8 mg. chlorpheniramine maleate; 50 mg. phenylpropanolamine HCl; and isopropamide iodide equivalent to 2.5 mg. of isopropamide), in bottles of 50 and 500 capsules.

SK&F a SmithKline company

Smith Kline &French Laboratories
Div. of SmithKline Corp., Phila., Pa.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Predictable bronchodilation. Once optimum dosage of SLO-PHYLLIN® is determined, patients can usually be maintained long term without lessening of effect. As children grow, of course, dosage should be adjusted.

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SLO-PHYLLIN® GYROCAPS® timed release capsules of 100% theophylline (anhydrous) 60 mg., 125 mg., 250 mg.
Recommended for use b.i.d. in many adults and t.i.d. in children. (Conveniently filled with individual time-release pellets.)

SLO-PHYLLIN® Tablets 100 mg. and 200 mg.—100% theophylline (anhydrous)—scored, dye-free.

SLO-PHYLLIN®
(theophylline, anhydrous)

DOONER LABORATORIES, INC.

Subsidiary of:
William H. Rorer, Inc.
Fort Washington, PA 19034

(see next page for a brief summary of prescribing information)

SLO-PHYLLIN® (theophylline, anhydrous)
SYRUP, TABLETS,
GYROCAPS® (timed release capsules)

Indications: For relief and/or prevention of symptoms from asthma and reversible bronchospasm associated with chronic bronchitis and emphysema.

Contraindications: In individuals who have shown hypersensitivity to any of its components.

Warnings: Status asthmaticus is a medical emergency. Optimal therapy frequently requires additional medication including corticosteroids when the patient is not rapidly responsive to bronchodilators.

Excessive theophylline doses may be associated with toxicity and serum theophylline levels are recommended to assure maximal benefit without excessive risk. Incidence of toxicity increases at levels greater than 20 mcg/ml. Morphine, curare, and stilbamidine should be used with caution in patients with airflow obstruction since they stimulate histamine release and can induce asthmatic attacks. They may also suppress respiration leading to respiratory failure. Alternative drugs should be chosen whenever possible.

There is an excellent correlation between high blood levels of theophylline resulting from conventional doses and associated clinical manifestations of toxicity in (1) patients with lowered body plasma clearances (due to transient cardiac decompensation), (2) patients with liver dysfunction or chronic obstructive lung disease, (3) patients who are older than 55 years of age, particularly males.

There are often no early signs of less serious theophylline toxicity such as nausea and restlessness, which may appear in up to 50 percent of patients prior to onset of convulsions. Ventricular arrhythmias or seizures may be the first signs of toxicity.

Many patients who have higher theophylline serum levels exhibit a tachycardia. Theophylline products may worsen pre-existing arrhythmias.

Usage in Pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development, but neither have adverse effects on fetal development been established. This is, unfortunately, true for most antiasthmatic medications. Therefore, use of theophylline in pregnant women should be balanced against the risk of uncontrolled asthma.

Precautions: Mean half-life in smokers is shorter than non-smokers, therefore, smokers may require larger doses of theophylline. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, and in the elderly (especially males) and in neonates. Great caution should especially be used in giving theophylline to patients in congestive heart failure. Such patients have shown markedly prolonged theophylline blood level curves with theophylline persisting in serum for long periods following discontinuation of the drug.

Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to G.I. tract although gastrointestinal symptoms are more commonly central and associated with serum concentrations over 20 mcg/ml.

Adverse Reactions: The most consistent adverse reactions are usually due to overdose and are:

1. Gastrointestinal: nausea, vomiting, epigastric pain, hematemesis, diarrhea.
2. Central nervous system: headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.
3. Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, life threatening ventricular arrhythmias.
4. Respiratory: tachypnea.
5. Renal: albuminuria, increased excretion of renal tubular cells and red blood cells; potentiation of diuresis.
6. Others: hyperglycemia and inappropriate ADH syndrome.

Drug Interactions: Toxic synergism with ephedrine has been documented and may occur with some other sympathomimetic bronchodilators.

DRUG	EFFECT
Aminophylline with lithium carbonate	Increased excretion of lithium carbonate
Aminophylline with propranolol	Antagonism of propranolol effect
Theophylline with furosemide	Increased diuresis of furosemide
Theophylline with hexamethonium	Decreased hexamethonium – induced chromatropic effect
Theophylline with reserpine	Reserpine – induced tachycardia
Theophylline with chlordiazepoxide	Chlordiazepoxide – induced fatty acid mobilization
Theophylline with cyclamycin (TAO troleandomycin) erythromycin, lincomycin	Increased theophylline plasma levels

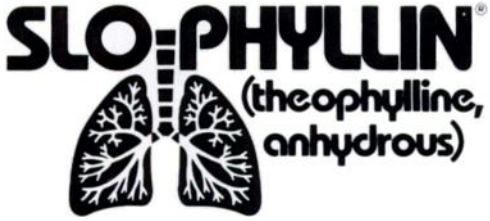
How Supplied:

Slo-Phyllin® 80 Syrup (80 mg. 15ml), 4 oz., pint, and gallon bottles, 5 ml. and 15 ml. unit dose bottles.

Slo-Phyllin® 100 mg. and 200 mg. Tablets, bottles of 100 and 1000, unit dose packages.

Slo-Phyllin® Gyrocaps® 60 mg., bottles of 100 and 1000.

Slo-Phyllin® Gyrocaps® 125 mg. and 250 mg., bottles of 100 and 1000, unit dose strip packages.



DOONER LABORATORIES, INC.

Subsidiary of:
William H. Rorer, Inc.
Fort Washington, PA 19034

Brief Summary of Prescribing Information
BENADRYL® (diphenhydramine hydrochloride)

INDICATIONS. Benadryl in the oral form is effective for the following indications

Antihistaminic: For perennial and seasonal (hay fever) allergic rhinitis, vasomotor rhinitis, allergic conjunctivitis due to inhalant allergens and foods, mild, uncomplicated allergic skin manifestations of urticaria and angioedema, amelioration of allergic reactions to blood or plasma, dermatographism, as therapy for anaphylactic reactions *adjunctive* to epinephrine and other standard measures after the acute manifestations have been controlled

Motion sickness: For active and prophylactic treatment of motion sickness

Antiparkinsonism: For parkinsonism (including drug-induced extrapyramidal reactions) in the elderly unable to tolerate more potent agents, mild cases of parkinsonism (including drug-induced) in other age groups, in other cases of parkinsonism (including drug-induced) in combination with centrally acting anticholinergic agents

CONTRAINDICATIONS. Use in Newborn or Premature Infants: This drug should *not* be used in newborn or premature infants

Use in Nursing Mothers: Because of the higher risk of antihistamines for infants generally, and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease: Antihistamines *should NOT* be used to treat lower respiratory tract symptoms including asthma

Antihistamines are also contraindicated in the following conditions

Hypersensitivity to diphenhydramine hydrochloride and other antihistamines of similar chemical structure

Monoamine oxidase inhibitor therapy (See Drug Interactions section)

WARNINGS. Antihistamines should be used with considerable caution in patients with narrow-angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction, symptomatic prostatic hypertrophy or bladder-neck obstruction

Use in Children: In infants and children, especially, antihistamines in *overdosage* may cause hallucinations, convulsions, or death

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus

Use with CNS Depressants: Diphenhydramine hydrochloride has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc)

Use in Activities Requiring Mental Alertness: Patients should be warned about engaging in activities requiring mental alertness such as driving a car or operating appliances, machinery, etc

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients

PRECAUTIONS. Diphenhydramine hydrochloride has an atropine-like action and, therefore, should be used with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension

DRUG INTERACTIONS. MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines

ADVERSE REACTIONS. The most frequent adverse reactions are underscored

1 *General* Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat

2 *Cardiovascular System* Hypotension, headache, palpitations, tachycardia, extrasystoles

3 *Hematologic System* Hemolytic anemia, thrombocytopenia, agranulocytosis

4 *Nervous System* Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions

5 *GI System* Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation

6 *GU System* Urinary frequency, difficult urination, urinary retention, early menses

7 *Respiratory System* Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness

OVERDOSAGE. Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms, dry mouth; fixed, dilated pupils; flushing, and gastrointestinal symptoms may also occur

If vomiting has not occurred spontaneously the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children

If vomiting is unsuccessful gastric lavage is indicated within 3 hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic or 1/2 isotonic saline is the lavage solution of choice.

Saline cathartics, as milk of magnesia, by osmosis draw water into the bowel and, therefore, are valuable for their action in rapid dilution of bowel content

Stimulants should *not* be used

Vasopressors may be used to treat hypotension

HOW SUPPLIED. Supplied in (as) 50 and 25 mg capsules, and Elixir 12.5 mg/5 ml with 14% alcohol

WL/YA

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Morris Plains, NJ 07950 USA

Advt. No. 1-79-9591 Prepared by LEWIS & GILMAN, INC., Philadelphia

The one pediatricians lean on...

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- relieves symptoms of allergic rhinitis
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- single oral dose produces maximum response in approximately one hour
- each 5 ml contains 12.5 mg diphenhydramine hydrochloride with 14% alcohol
- also available for oral administration as 25-mg capsules and 50-mg Kapseals®

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Morris Plains, NJ 07950 USA

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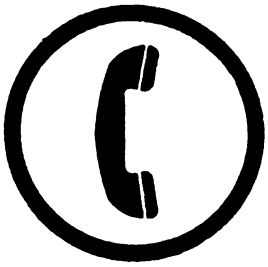

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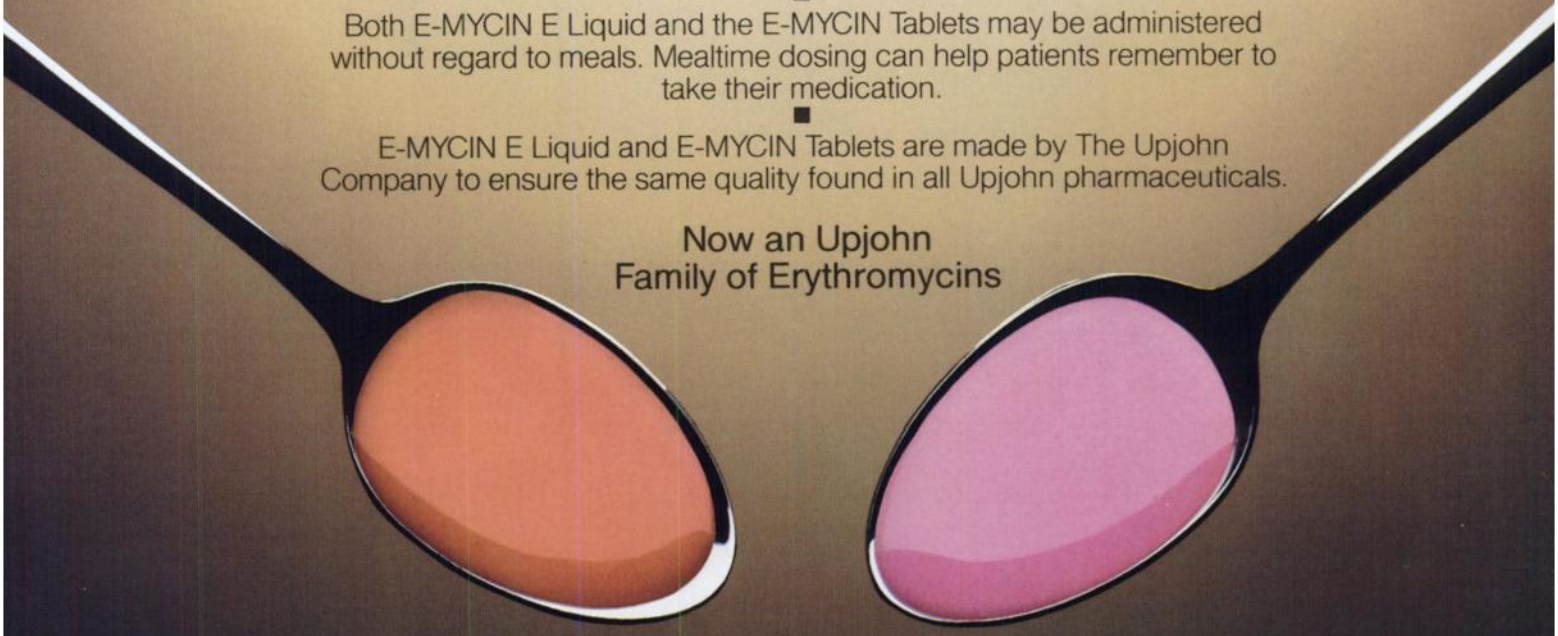

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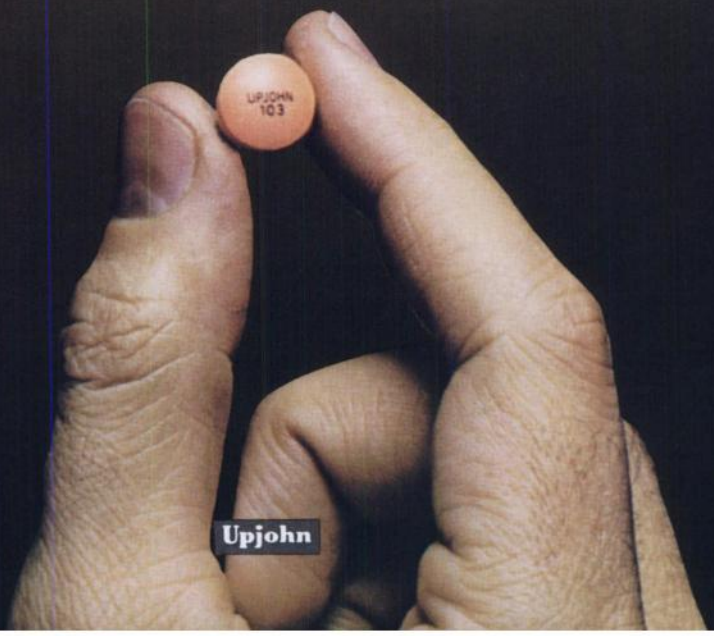

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†Due to susceptible organisms
‡Data on file at The Upjohn Company

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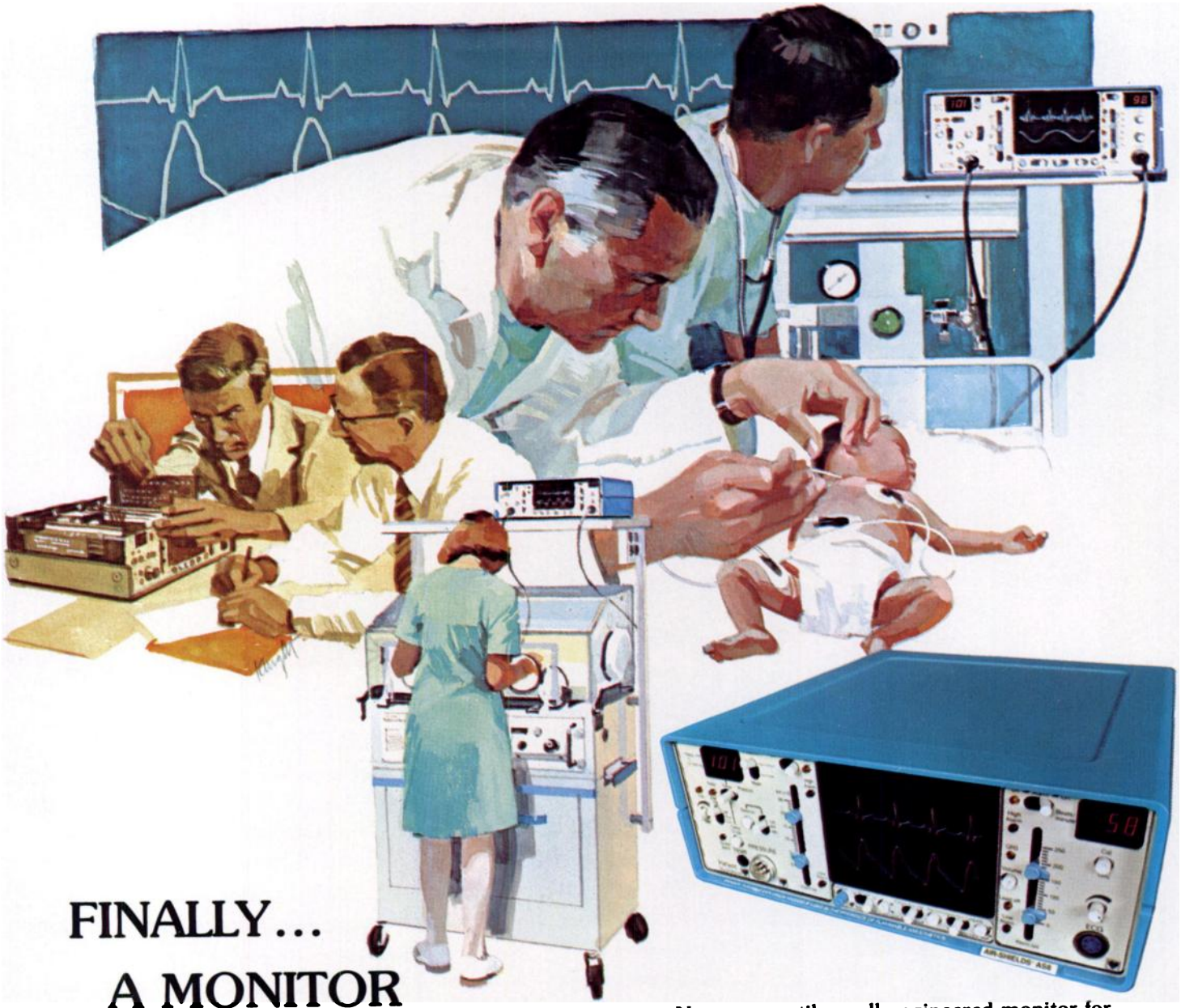

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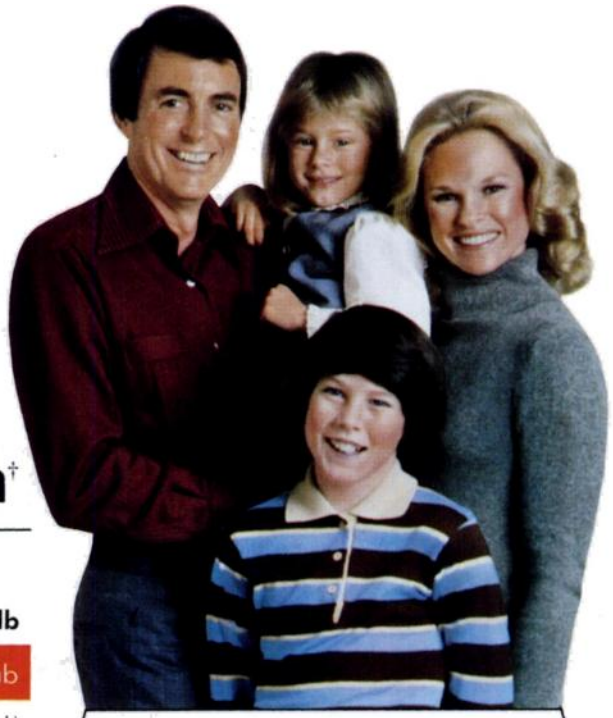
Eliminate pinworm without dosage calculations

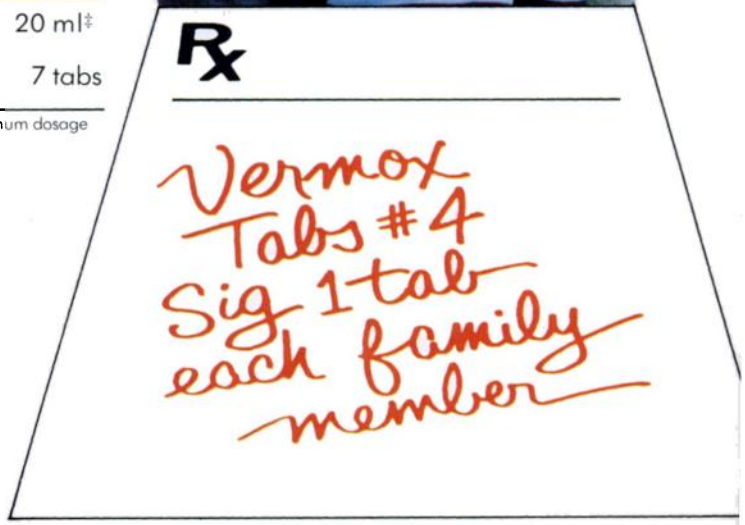


Compare: Vermox® vs Antiminth* and Povan†

Patient Weight

	40 lb	60 lb	80 lb	130 lb	150 lb	180 lb	200 lb
VERMOX	1 tab	1 tab	1 tab	1 tab	1 tab	1 tab	1 tab
Antiminth	4 ml	6 ml	8 ml	13 ml	15 ml	18 ml	20 ml‡
Povan Tablets	2 tabs	3 tabs	4 tabs	6 tabs	7 tabs‡	7 tabs	7 tabs

‡Maximum dosage



Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The VERMOX tablet may be chewed, swallowed or crushed and mixed with food. For control of pinworm (enterobiasis) a single tablet is administered orally, one time. If patient is not cured three weeks after treatment, a second course of treatment is advised.

* Registered trademark of Roerig.
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†† Because VERMOX has not been extensively studied in children under two years of age, the relative benefit/risk should be considered before treating these children. VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Just one tablet eliminates pinworm, regardless of patient age††and weight.

Vermox® TABLETS (mebendazole)

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JPI-022


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Choledyl®

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50 mg/5 ml

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- ☐ **Preferred to their previous medications by over 70% of asthmatic children in actual taste test***
- ☐ **More soluble than either aminophylline or theophylline**
- ☐ **Rapidly reaches therapeutic steady-state theophylline levels**
- ☐ **Contains no alcohol, sedatives or tartrazine dye**

*Data on file, Medical Affairs Dept, Parke-Davis
Please see following page for brief summary of prescribing information.

PARKE-DAVIS
Div of Warner-Lambert Co
Morris Plains, NJ 07950 USA

Choledyl® Pediatric Syrup (oxtriphylline) 50 mg/5 ml
Before prescribing, please consult full prescribing information.

A brief summary follows.

Caution: Federal law prohibits dispensing without prescription.

Indications. Choledyl (oxtriphylline) is indicated for relief of acute and chronic bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

Contraindications. Choledyl is contraindicated in individuals who have shown hypersensitivity to theophylline or to Choledyl (oxtriphylline) or any of its components.

Warnings. Status asthmaticus is a medical emergency. Optimal therapy frequently requires additional medication including corticosteroids when the patient is not rapidly responsive to bronchodilators.

Excessive theophylline doses may be associated with toxicity, and serum theophylline levels are recommended to assure maximal benefit without excessive risk; incidence of toxicity increases at levels greater than 20 mcg theophylline/ml. Morphine, curare, and stilbamidine should be used with caution in patients with airflow obstruction since they stimulate histamine release and can induce asthmatic attacks. These drugs may also suppress respiration leading to respiratory failure. Alternative drugs should be chosen whenever possible.

There is an excellent correlation between high blood levels of theophylline resulting from conventional doses and associated clinical manifestations of toxicity in patients with liver dysfunction or chronic obstructive lung disease.

There is excellent correlation between high serum levels of theophylline (over 20 mcg/ml) and the clinical manifestations of toxicity. Careful reduction of dosage and monitoring of serum levels are especially important in patients manifesting a decrease in total body theophylline clearance rate, including those with generalized debility, acute hypoxia, cardiac decompensation, hepatic dysfunction, or renal failure. Dosage reduction may also be necessary in patients who are older than 55 years of age, particularly males.

Serious toxic effects may occur suddenly and are not invariably preceded by minor adverse effects such as nausea, vomiting, and restlessness. Convulsions, tachycardia or ventricular arrhythmias may be the first sign of toxicity.

Children have a marked sensitivity to the CNS stimulant action of theophylline. Serious toxic effects, including fatalities, have been reported in children as well as adults.

Theophylline products may worsen pre-existing arrhythmias.

Usage in Pregnancy. Safe use of Choledyl (oxtriphylline) in pregnancy and lactation has not been established relative to possible adverse effects on fetal or neonatal development. Therefore Choledyl (oxtriphylline) should not be used in patients who are pregnant or who may become pregnant, or during lactation unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Precautions. Mean half-life in smokers is shorter than nonsmokers. Therefore, smokers may require larger doses of theophylline. Theophylline should not be administered concurrently with other xanthine medications or with xanthine-containing beverages or foods. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, or liver disease, and in the elderly (especially males) and in neonates. Great caution should especially be used in giving theophylline to patients in congestive heart failure. Such patients have shown markedly prolonged theophylline blood level curves with theophylline persisting in serum for long periods following discontinuation of the drug.

Use theophylline cautiously in patients with a history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly central and associated with serum theophylline concentrations over 20 mcg/ml.

Adverse Reactions. The most consistent adverse reactions are usually due to overdose and are:

1. Gastrointestinal: nausea, vomiting, epigastric pain, hematemesis, diarrhea.
2. Central nervous system: headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.
3. Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, life-threatening ventricular arrhythmias.
4. Respiratory: tachypnea.
5. Renal: albuminuria, increased excretion of renal tubular cells and red blood cells, diuresis.
6. Others: hyperglycemia and inappropriate antidiuretic hormone (ADH) syndrome.

Drug Interactions. Theophylline-containing preparations have exhibited interaction with the following drugs:

Drug	Effect
Lithium carbonate	Increased excretion of lithium carbonate
Propranolol	Antagonism of propranolol effect
Furosemide	Increased furosemide diuresis
Hexamethonium	Decreased hexamethonium-induced chronotropic effect
Reserpine	Reserpine-induced tachycardia
Chlordiazepoxide	Chlordiazepoxide-induced fatty acid mobilization
Troleandomycin, erythromycin or lincomycin	Increased theophylline plasma levels

How Supplied. N 0071-2217-23 Choledyl Pediatric Syrup (oxtriphylline) is a vanilla-mint flavored syrup supplied in bottles of 16 fl oz (1 pint) 474 ml.

Store between 59°-86°F (15°-30°C).

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Please note that Bactrim is not recommended for the treatment of streptococcal pharyngitis; it is contraindicated during pregnancy and lactation, in patients hypersensitive to its components and infants under 2 months of age. For adverse reactions, see summary of product information.

*To date, clinical information on the effectiveness of Bactrim against *H. influenzae* with *in vitro* resistance to ampicillin and *in vitro* sensitivity to Bactrim is limited.

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

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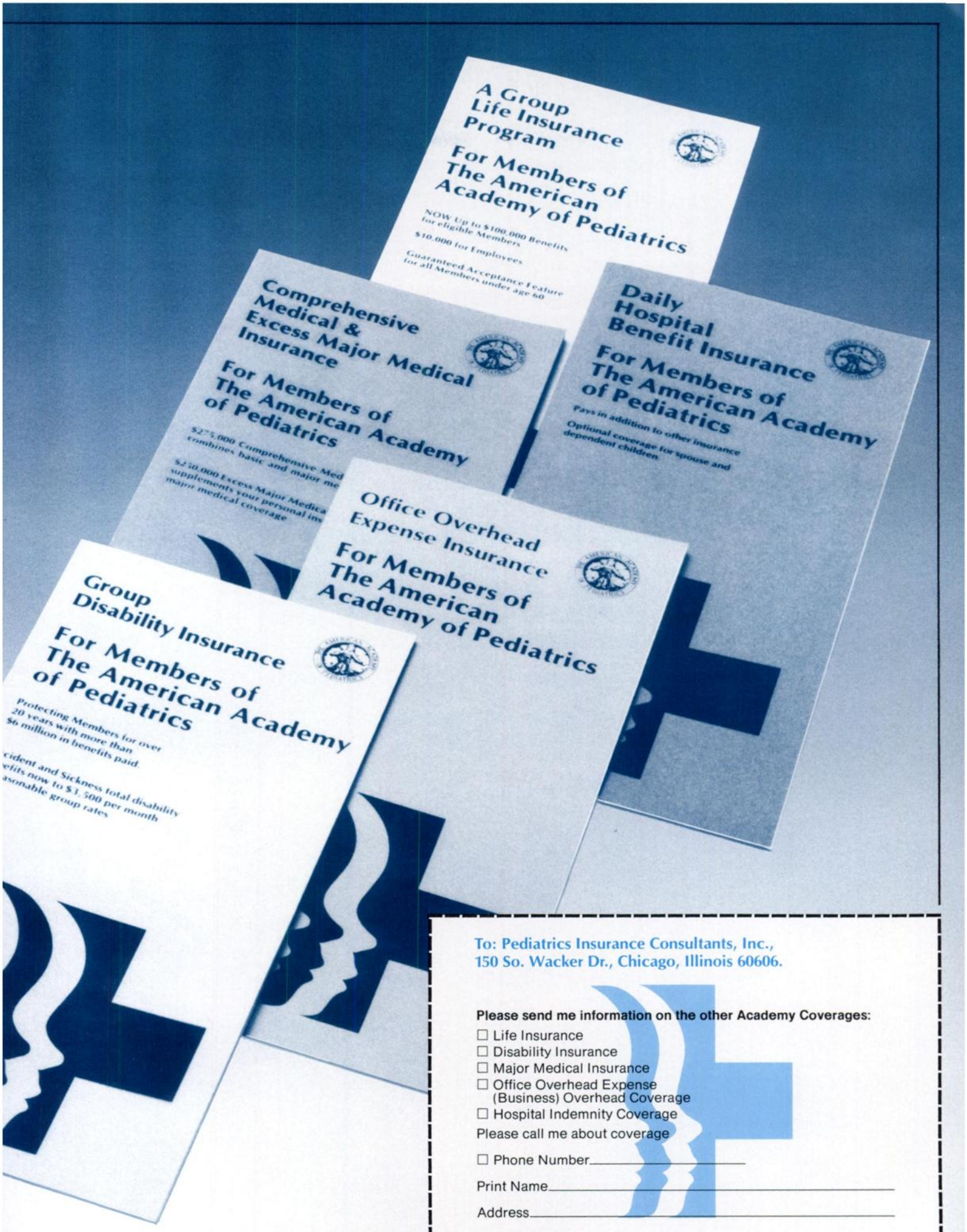

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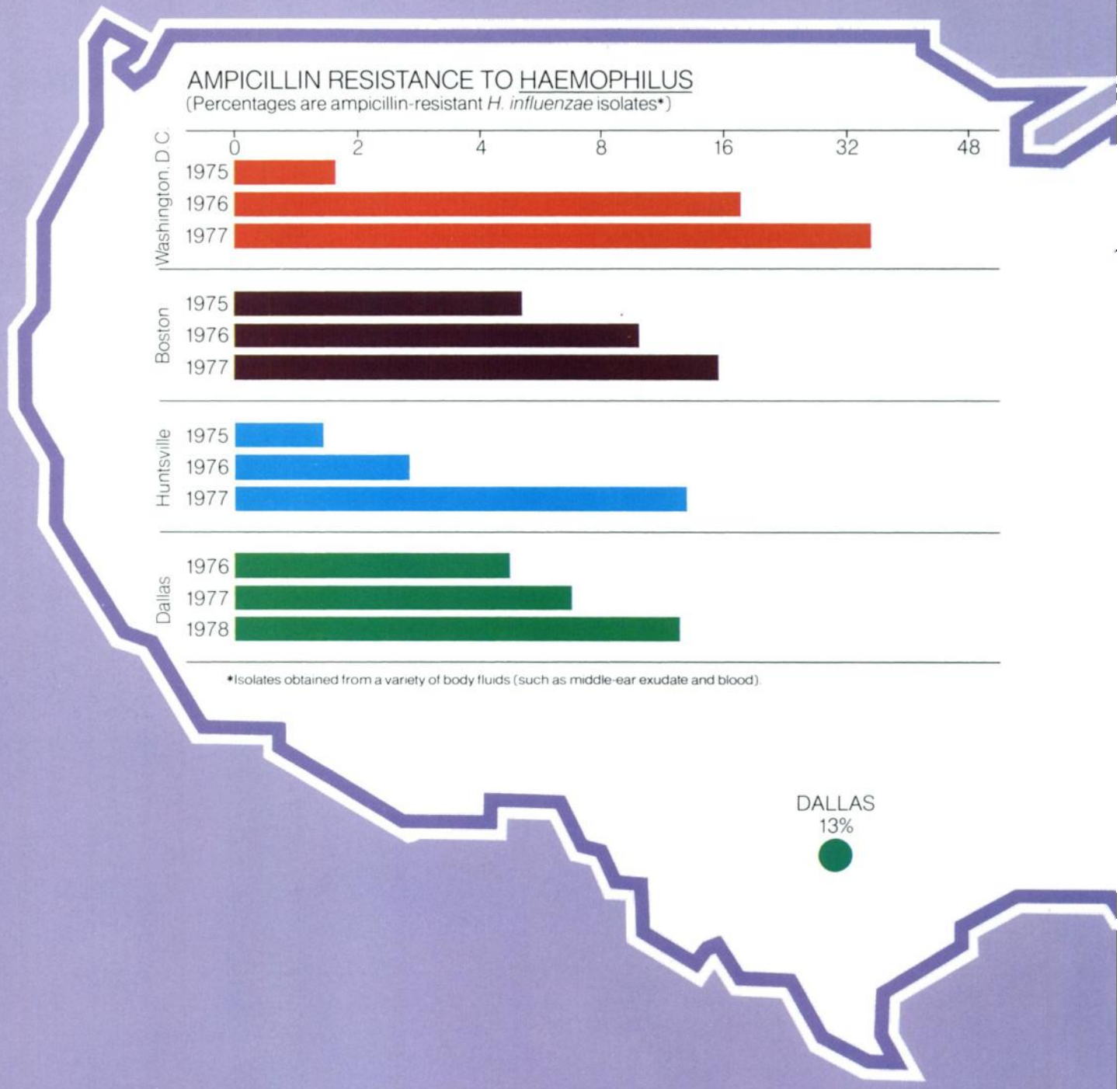
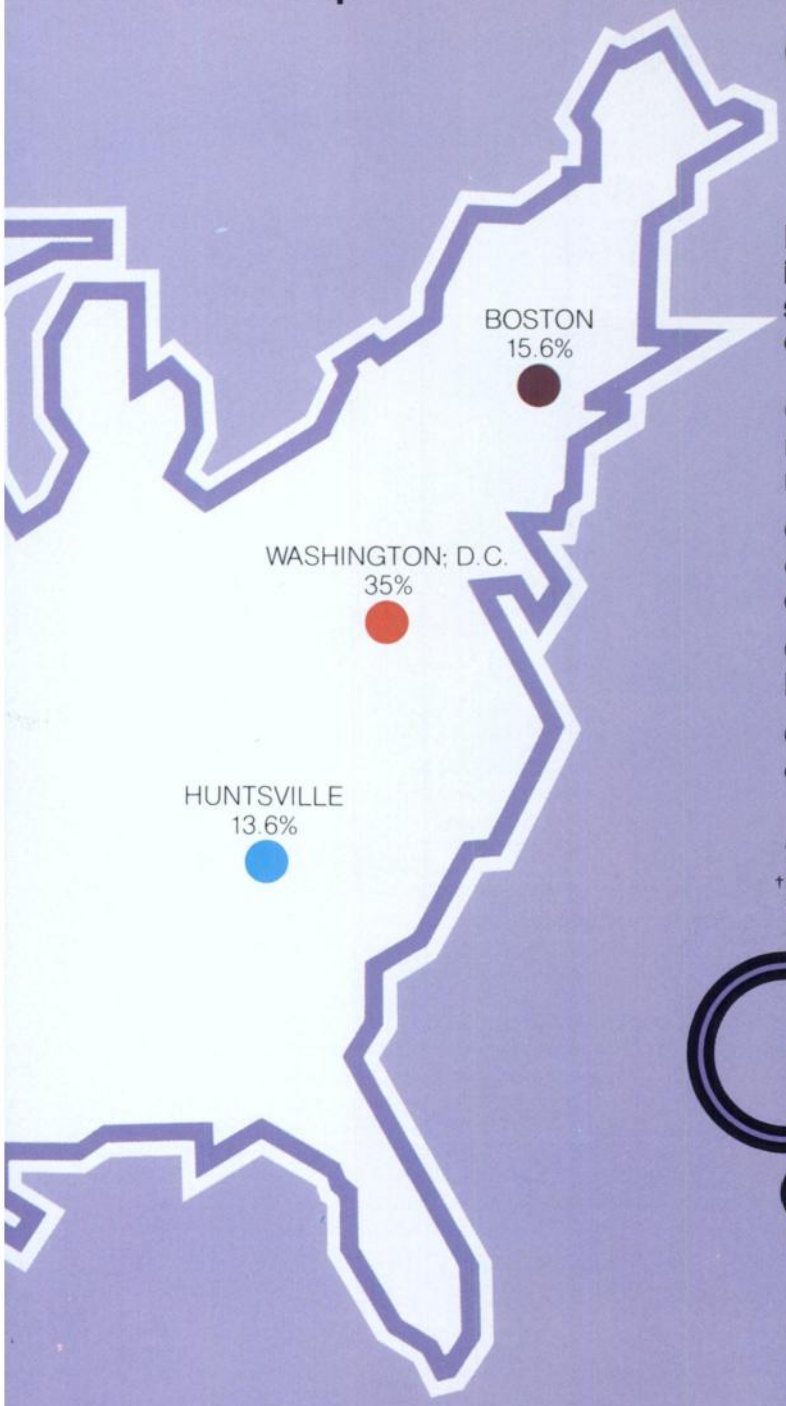


Haemophilus influenzae in otitis media...
a valid concern



In many areas of the country, increasing numbers of *H. influenzae* show resistance to conventional antibiotic therapy.[1-3]

Ceclor is effective in the treatment of otitis media,† including that due to ampicillin-resistant strains of *H. influenzae*.[4-9]

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should be recognized that a positive Coombs test may be due to the drug.

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Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below:

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[0703790]

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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Newborn Care: *Standards and Recommendations for Hospital Care of Newborn Infants* is the authority on perinatal care. It details the facilities and staff needed to provide optimum newborn care and describes intensive care, oxygen therapy, care and feeding of the normal newborn, and regionalization of perinatal care. 1977 Indexed: 178 pages.

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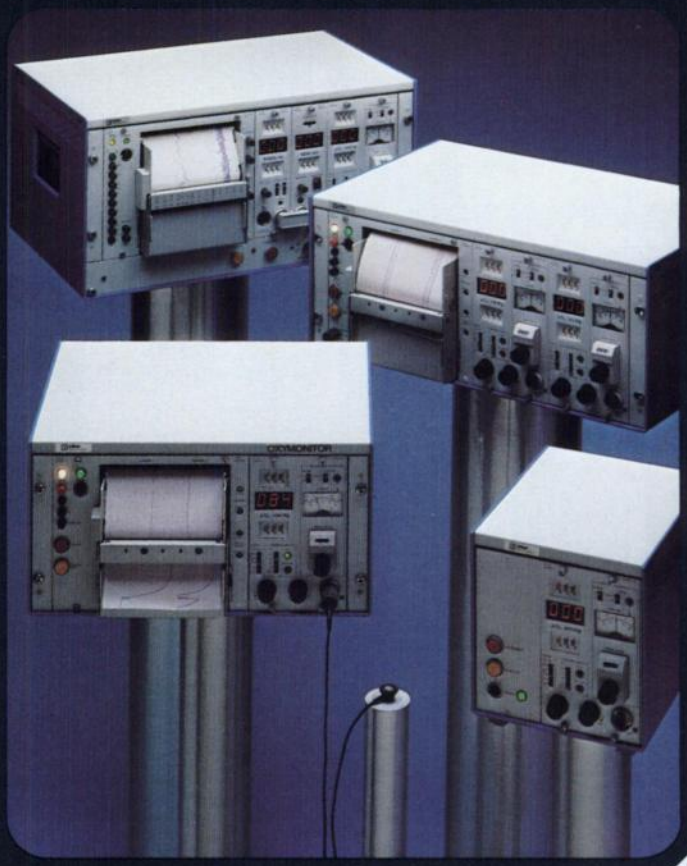

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THE ONLY PRIVILEGED PEOPLE

Most children in the Third world are under-fed and ill-educated. The youngsters of Cuba are an exception. I asked the waiter in the hotel for orange juice at breakfast on my first morning in Cuba, some 10 years ago. 'Only for children,' he said. One of the official slogans then was, 'Children are the only privileged people,' and only families with a child under eight could have any of the rationed supply of orange juice.

This year orange juice, though still rationed, is available to everyone, but there's still a slogan, 'There is nothing more important than a child.'

To arrive in Cuba from another Latin American country is to notice right away the difference in the condition of the children. No ricketty little beggars materialize by your table and stare piteously at your food. Every child in the street looks adequately fed. There is none of that dull-eyed listlessness which signals mental deficiency due to bad diet and lack of stimulation, and which dooms tens of millions of kids to a short life and a wretched one.

In 20 years, since the Castro revolution, Cuba has brought up a generation in health and opportunity. No amount of critique and qualification can detract from this liberation of a previously beset majority of a nation from the withering fears which blight most of humanity. Mothers are free of basic fears for the fate of their children—come what may, they will be fed and, if they fall ill, proper medical care will be available at no charge. There will be free education for them and, if they have the right talents and application, they will be able to attain any position in society. The infant mortality rate is lower than in many parts of the United States. All this has been brought to pass in an agricultural, tropical country of 10 million people, more than half of whom are aged under 16.

From John Erril: The only privileged people. *The Observer*, Sunday September 2, 1979.

the selective approach; at least one view should routinely include the normal hip, with the gonads shielded. Hip injuries in children are most frequently associated with joint effusion, which can only be detected by comparing similar measurements of the opposite joint space.

Other specific areas of appendicular skeleton may require more comparison views. The elbow, with a relatively large number of ossification centers appearing at widely varying times, may prove confusing even to the experienced radiologist; comparison views of this joint may be requested frequently. Detection of joint effusion in the knee and ankle may necessitate a comparison view, in at least one projection. Comparison views may also be useful in evaluating soft tissue planes and subcutaneous fat in suspected inflammatory conditions of the soft tissues or bones.

Thus, although there are well established benefits from comparison radiographs of extremities in childhood, routine radiographs of the uninvolved joint or extremity, with but few exceptions, is not justified. Some practical considerations (eg, availability of a radiologist for interpretation or review or availability of the child for follow-up examination if necessary) may rarely result in continuing a routine comparison policy. The specter of malpractice does not appear to represent a valid reason for continuing routine comparison radiography of extremities, with the rare exceptions noted here. The Committee recognizes the threat of malpractice and its concern to all physicians; however, careful clinical evaluation of the child and close follow-up when necessary will do more toward obviating malpractice cases than all the routine, comparison extremity radiographs. "Routine tests" should not be substituted for good clinical judgment and thorough physical examination.

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INTERNATIONAL GROWTH CHART

A growth chart,[1] suitable for use in all countries, has been developed and tested under the sponsorship of the World Health Organization as part of a scheme to improve the quality of health care. It will provide a standardised system for recording and interpreting growth data and a means of assessing individual and community health. During 1972, 55 examples of existing growth charts from countries in WHO regions were collected and analysed; the results were then reviewed by an international consultative group which included paediatricians, biometricians, nutritionists, and maternal and child-health specialists. In 1974 a model chart was produced and tested in ten centres in different parts of the world; the results are described in the first part of the book which accompanies the chart. Part II contains a guide for instructors of primary health-care workers, with directives on how to record relevant data. The chart has two components: a simple "home chart" to be kept by the mother as a visual record of her child's nutritional and health status and a more complex "service chart" to be retained at the health centre.

Submitted by Student

REFERENCE

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IS ENGLAND THE RIGHT MODEL?

Whereas in England two-thirds of the physicians are general practitioners, in America today two-thirds are specialists. The difference stems from the American pattern of policy accommodation. In England, the government limits the number of training programs in medical specialities in line with the number of specialists the country needs. In America, medical schools and teaching hospitals were allowed to create programs as they saw fit. Since such programs were in their interests (interns and residents represent a cheap source of professional labor), they established more than the society needed. Current manpower policy is trying to correct the imbalance by directing young doctors toward "primary" care. (Some specialists, afraid that their fields may now be getting overcrowded, welcome the shift; from the point of view of "need," there have long been too many surgeons, but thus far the surgeons have kept up their incomes by working less and charging more.) The overspecialization of American medicine is a source of higher costs, since training programs are expensive and the trained specialists are able to charge more than general practitioners (partly because they control Blue Shield, but primarily because price competition is absent and consumers are unable to judge quality).

Submitted by Student

From Starr P, Esping-Andersen G: Passive Intervention. *Working Papers for a New Society* July/August 1979, p 15.

the provision of samples of infant formula at discharge as a tacit discouragement of breast-feeding; therefore it is important that the mothers also receive educational material supportive of breast-feeding, and that the physician convey instructions that the formula be used only as a temporary emergency measure or if the pediatrician recommends supplemental feeding because of insufficient weight gain. Practical demonstration and presentation in the hospital of both verbal and written material on the value of breast-feeding and advice relating to lactation are appropriate for most mothers. After discharge from the hospital, the mother should have easy access to qualified health professionals who will be supportive and provide adequate supervision. Mothers should be reminded that, if they must stop breast-feeding, they should use infant formula rather than plain cow's milk, in accordance with the recommendations of the Committee on Nutrition in 1976.[2]

CONCLUSION

Physicians, nurses, nursing personnel, and hospitals need to examine their practices and procedures that encourage or discourage breast-feeding. The cultural attitudes and life-styles of today's world tend to mitigate against breast-feeding. Yet, the benefits of breast-feeding to the neonate and the mother are so numerous that pediatricians must strongly encourage the practice.

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2. Committee on Nutrition: Commentary on breast-feeding and infant formulas, including proposed standards for formulas. *Pediatrics* 57:278, 1976

You can prove almost anything with the evidence of a small enough segment of time. How often, in the search for truth, the answer of the minute is positive, the answer of the hour qualified, the answers of the year contradictory!—Edwin Way Teal, 1953

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THE CAMPAIGN AGAINST MALNUTRITION

. . .recommendations from last week's WHO/UNICEF meeting on infant and young child feeding. . .are more or less familiar appeals for the achievement of manifestly desirable aims and reforms. That the meeting felt the need to restate them in such numbers is a condemnation of the scant progress made by the nations of the world in combating malnutrition and all the ills it carries. 1979 is the International Year of the Child and this meeting is one of its foremost events. It provides another chance (and success in the past has been limited) to add impetus to the concerted international efforts which are the best paths forward in the battle against hunger and its diseases.

. . .In the weeks preceding the WHO/UNICEF meeting. . .key issues may have been obscured because much attention was centered on the role of the infant-food industry and the argument that the commercial promotion of industrially produced breast-milk substitutes and processed weaning foods should be banned.

. . .The industry's representatives have agreed to stop sales promotion of their infant formulas and weaning foods direct to the public (some companies had already stopped this practice). This wise though long-deferred move is now to be incorporated in a code of marketing practice which will be constructed under the auspices of WHO/UNICEF. It remains for the International Council of Infant Food Industries to ensure that their members adhere to the agreement—under pain of expulsion and (a stronger threat perhaps) public condemnation and boycott. ICIFI has invited manufacturers who are not yet among their members to join them in a demonstration of their resolve to act in the public interest. . .

Noted by A.G.S.P.

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