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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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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 Zanortin 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 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 disregarded as adequate to prove a definite cause and effect relationship. There are many 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 during pregnancy 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 may occur 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.

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Manuscripts should be prepared in the manner described in Manual for Authors & Editors © 1981 by the American Medical Association. See also "Uniform Requirements for Manuscripts Submitted to Biomedical Journals." A current issue of Pediatrics should be consulted for general style.

Three complete copies of the manuscript including tables and illustrations must be supplied. All material should be typed on white bond paper, 21.6 x 27.9 cm (8½ x 11 in). Use double spacing throughout, including title page, abstract, text, acknowledgments, references, tables, and legends for illustrations.

The author's style will be respected; however, writing should conform to acceptable English usage and syntax, and American Medical Association style preferences will be observed. 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 unavaiable, 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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<table>
<thead>
<tr>
<th>No. participants</th>
<th>Percent of 1-5 year olds receiving:</th>
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<tr>
<td></td>
<td>less than 100% RDA&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>One or more key vitamins</td>
</tr>
<tr>
<td>2,750</td>
<td>53%</td>
</tr>
<tr>
<td></td>
<td>87%</td>
</tr>
</tbody>
</table>

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Depakote tablets are supplied in convenient 500 mg dosage strength, as well as in 250 mg. Substantially smaller per mg than Depakene® capsules, easier to swallow. Suited to B.I.D. dosage — important to youngsters who find it difficult to take midday medication at school.

**Controls absence with or without mixed seizures**
Depakote offers effective primary therapy for absence (petit mal) seizures. It is also a major adjunct in patients with absence accompanied by other seizure types.

**Before prescribing Depakote**
Before prescribing Depakote (divalproex sodium) enteric-coated tablets, and frequently thereafter, test CBC, bleeding time, and liver profile, in view of occasional reports of hepatic reactions with valproate, including fatalities, and hematologic abnormalities.

For brief summary please see an adjoining page.

Abbott Laboratories, North Chicago, IL 60064

TM—Trademark
WARNING: HEPATIC FAILURE RESULTING IN FATALITIES HAS OCCURRED IN PATIENTS RECEIVING VALPROIC ACID AND ITS DERIVATIVES. THESE INCIDENTS USUALLY HAVE OCCURRED DURING THE FIRST SIX MONTHS OF TREATMENT. IN MOST CASES, THE INCREASE IN SERUM TRANSAMINASE LEVELS FOLLOWS A PEAK IN SERUM ALKALINE PHOSPHATASE ACTIVITY AS LOSS OF SEIZURE CONTROL, MALAISE, WEAKNESS, LETHARGY, ANOREXIA AND VOMITING. LIVER FUNCTION TESTS SHOULD BE PERFORMED PRIOR TO THERAPY AND AT FREQUENT INTERVALS THEREAFTER, ESPECIALLY DURING THE FIRST SIX MONTHS.

INDICATIONS AND USAGE: DEPAKOTE (valproic acid) is indicated for use as sole and adjuvant therapy in the treatment of: spastic quadriplegia and complex absence seizures. DEPAKOTE may also be used adjuvantly in patients with multiple seizure disorders.

In accordance with the International Classification of Seizures, simple absence is defined as very brief clonic of the amount and frequency of clonic convulsions usually 1 second, accompanied by certain general signs of epileptic discharges without other detectable clinical signs. Complex absence is the term used when other signs are also present.

SIXTEEN SIGNIFICANT FIRST REPORTED EFFECTS: DEPAKOTE, a water-soluble acetate of valproic acid, is a colorless, tasteless, odorless powder that has a taste similar to that of acetic acid.

DEPAKOTE is contraindicated in patients with known hypersensitivity to the drug.

Hepatic failure resulting in fatalities has occurred in patients receiving valproic acid. These incidents usually have occurred during the first six months of treatment. Serum or total hepatotoxicity may be manifested by generalized symptoms such as loss of seizure control, malaise, weakness, lethargy, anorexia and vomiting. Once such findings occur, hospitalization and evaluation of the patient should be undertaken without delay. In general, DEPAKOTE should be discontinued in patients with a prior history of hepatic disease. Patients with various unexplained encephalopathies, those with severe renal disease accompanied by azotemia, and those with obvious brain disease may be at particular risk. The drug should be discontinued immediately in the presence of significant hepatotoxicity, suspected or apparent. In some cases, hepatic dysfunction has progressed in spite of discontinuation of the drug. The frequency of adverse effects (particularly elevated liver enzymes) may be dose related. The benefit of improved seizure control may be a compromise. Therefore, the higher doses should be weighed against the possibility of a greater incidence of adverse effects.

Use in Pregnancy: According to recent reports in the medical literature, VALPROIC ACID MAY PRODUCE TERATOGENICITY IN THE OFFSPRING OF HUMAN FEMALES RECEIVING THE DRUG DURING PREGNANCY. The incidence of neural tube defects in the fetuses may be increased in mothers receiving valproic acid during the 2nd or 3rd trimester of pregnancy. Based upon a single French report, the Centers for Disease Control (CDC) has estimated the risk of valproic acid-exposed women having children with spina bifida to be approximately 1.2% for the first trimester of pregnancy. This is similar to that for nonvalproic acid-exposed women who had children with neural tube defects (anecephaly and spina bifida). There are multiple reports in the clinical literature indicating that the use of antiepileptic drugs in pregnancy has been associated with increased incidence of birth defects in the offspring. Although data are more extensive with respect to trimethadione, phenobarbital, and phenytin, antiepileptic reports indicate a possible similar association with the use of any antiepileptic drugs. Therefore, antiepileptic drugs should be administered to women of childbearing potential only if they are clearly shown to be essential in the management of their seizures.

Animal studies have also demonstrated valproic acid induced teratogenicity. Studies in rats and human females demonstrated placental transfer of the drug. Doses greater than 65 mg/kg/day given to pregnant rats and mice produced skeletal abnormalities in the offspring, primarily involving ribs and vertebral, doses greater than 150 mg/kg/day given to pregnant rabbits produced fetal resorptions and (primarily) soft tissue abnormalities in the offspring. In rats and rabbits, the expected relationship between the plasma drug levels and the degree of the skeletal and soft tissue abnormalities were adversely affected, particularly when drug administration was commenced the gestation period and early lactation period.

Antiepileptic 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 controlling epileptic women of childbearing potential.

PRECAUTIONS: Hepatic Dysfunction: See "Contraindications" and "Warnings" sections.

General: Because of reports of thrombocytopenia and inhibition of the secondary phase of platelet aggregation, plateau counts and bleeding time determinations are recommended before initiating therapy and at periodic intervals. It is recommended that patients receiving DEPAKOTE be monitored for platelet count prior to planned surgery. Clinical evidence of hemorrhage, bruising or a disorder of hemorrhage/leucopenia is an indication for reduction of DEPAKOTE dosage or discontinuation of therapy pending investigation.

Hypersensitivity: As with other therapeutics and coma have been reported and may be present in the absence of abnormal liver function tests. If elevation occurs, DEPAKOTE should be discontinued.

Since DEPAKOTE (valproic acid) may interact with concurrently administered antiepileptic drugs, periodic serum level determinations of concomitant antiepileptic drugs are recommended during the early course of therapy.

Drug Interactions: Valproic acid may potentiate the CNS depressant activity of alcohol.

THERAPEUTIC EFFECTS: DEPAKOTE has been demonstrated by various animal models and clinical studies to be effective in the control of seizures in patients with various seizure disorders including partial seizures, the absence status, the primary generalized tonic-clonic status, and a variety of other types of seizures.

The clinical significance of these findings is not known. It is recommended that when DEPAKOTE (valproic acid) is administered to a nursing woman, DEPAKOTE (valproic acid) is deleterious. It is possible that other antiepileptic drugs may be deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious. It is possible that the drug is deleterious.
4 reasons to recommend Infalyte:

1. Ideal Formulation¹
   - Optimal glucose concentration (111 MMOL/Liter)
   - Optimal sodium concentration (50 meq/L)

2. Efficacy detailed in The New England Journal of Medicine²

3. Conveniently packaged in portable 24 Gm packets

4. Priced significantly lower than Pedialyte®³

¹ Based on oral electrolyte replenisher guidelines set forth at a March 15, 1982 meeting held under the auspices of the Division of Geographic Medicine and the Departments of Maternal and Child Health and Population Dynamics of the Johns Hopkins University.


³ Based on Redbook average wholesale prices.

*Pedialyte* is a registered trademark of Ross Laboratories.
Not until now...

Armour introduces the first multiple-vitamin infusion to meet the AMA/NAG guidelines for parenteral use in pediatric patients.

The only formulation of its kind—and the most convenient—M.V.I. Pediatric is ready for administration within 3 minutes of reconstitution.

M.V.I. Pediatric is prepared by lyophilization—rapid freezing and dehydration—to give you a highly stable product with a long shelf life. And speaking of shelves, that's just where you can store M.V.I. Pediatric, because it requires no refrigeration until reconstitution.

Also, you won't find propylene glycol in M.V.I. Pediatric, so there's little chance of inducing lactic acidosis in infants.

Please see accompanying page for brief summary of prescribing information.

ARMOUR PHARMACEUTICAL COMPANY
Kankakee, Illinois 60901

M.V.I.
PEDIATRIC
Multi-Vitamins for Infusion
M.V.I.® PEDIATRIC
Multi-Vitamins for Infusion

DESCRIPTION: M.V.I.® Pediatric is a lyophilized, sterilized powder intended for reconstitution and dilution in intravenous infusions. Each vial provides:
- vitamin A (retinol) 80 mcg
- ergocalciferol (D) 0.7 mcg
- thiamine (B1) 1.0 mcg
- niacinamide 3.0 mg
- vitamin E (d-alpha tocopheryl acetate) 1.0 mg
- biotin 0.7 mcg
- pyridoxine (B6) 2.0 mcg
- riboflavin 0.5 mcg
- niacinamide 1.0 mg
- thiamine 1.0 mg
- pyridoxine 2.0 mcg
- vitamin E 400 USP units
- vitamin A 200 USP units
- water solubilized with polysorbate 80.

INDICATIONS AND USAGE: This formulation is indicated as daily multi-vitamin maintenance dosage for infants and children up to 11 years of age receiving parenteral nutrition.

It is also indicated in other situations where administration by the intravenous route is required. Such situations include surgery, extensive burns, fractures and other trauma, severe infectious diseases, and catabolic states, which may provoke a stress situation with profound alterations in the body's metabolic demands and consequent tissue depletion of nutrients.

The physician should not await the development of clinical signs of vitamin deficiency before initiating vitamin therapy. The use of a multi-vitamin product obviates the need to speculate on the status of individual vitamin nutriture. M.V.I.® Pediatric (reconstituted and administered in intravenous fluids under proper dilution) contributes intake of these necessary vitamins toward maintaining the body's normal resistance and repair processes.

Patients with multiple vitamin deficiencies or with markedly increased requirements may be given multiples of the daily dosage for two or more days as indicated by the clinical status.

CONTRAINDICATIONS: Known hypersensitivity to any of the vitamins in this product or to a pre-existing hypervitaminosis.

PRECAUTIONS: General: Unlike the adult formulation, M.V.I.®-12, this product contains phytantriol (vitamin K1).

Drug Interactions: M.V.I.® Pediatric is not physically compatible with DIAMOX® (acetazolamide) 500 mg, DIURIL® (chlorothiazide sodium) 500 mg, aminophylline 125 mg, ampicillin 500 mg, or moderately alkaline solutions. ACHROMYCIN® (tetracycline HCl) 500 mg may not be physically compatible with M.V.I.® Pediatric. It has been reported that tetracycline is unstable in the presence of calcium salts such as calcium gluconate.

Carcinogenicity: Carcinogenicity studies have not been performed.

ADVERSE REACTIONS: Allergic reaction has been known to occur following intravenous administration of thiamine. This risk, however, is negligible if the thiamine is administered with other vitamins of the B group.

HOW SUPPLIED: Boxes of 25 vials (NDC 0053-0815-36) and cartons of 100 vials (NDC 0053-0815-37).

See product circular for full prescribing information.

ARMOUR PHARMACEUTICAL COMPANY
Kankakee, Illinois 60901 U.S.A.

Issued: February 1983

GENETIC SERVICES
Is the demand being met?

Chromosome abnormalities as a percent of all births compared to maternal age.


PERCENT OF ALL BIRTHS

F4CTS:

- The most common indication for genetic services is amniocentesis for women 35 years and over, but women of all ages are requesting this procedure.
- Demographic trends predict an increasing number of women in the 35 and over age group with an increased number of births over the next ten years.
- New technology promises screening for even more genetic disorders e.g. Fragile X for mental retardation.
- University medical centers are having difficulty accommodating requests in all areas of genetic testing.

THE SOLUTION:

Diagenetic Laboratories, Inc.
Specialists in diagnostic genetic testing beginning with chromosome studies on:

- AMNIOTIC FLUID CELLS
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PEDIATRICS IN REVIEW: September 1983 Contents

Neonatal Seizures—Myers and Cassady
Diagnosis and Treatment of Gastroesophageal Reflux—Herbst
Care of Children with Acute Leukemia—Dunn and Maurer
Renal Trauma—Reisman
Start a lifetime habit that could save his skin.

Many of your patients' best health habits start right in your office, after discussion with the parents. Implementing a complete immunization program, for example. Laying the foundation of sound nutrition. Establishing proper sleep and exercise habits.

Now, a mounting body of evidence supports the need to encourage yet another habit in pediatric patients: proper sun protection.

Parents in general don't appreciate this need because they don't realize that the sun's damage—in addition to causing painful sunburn—is cumulative, irreversible, and begins with the very first exposure.

The goal, then, in starting a lifetime habit of sunscreening, is to help prevent premature skin aging and even skin cancer.

A range of sunscreen protection

The selection of a sunscreen should be based on consideration of those variables that determine how much radiation the skin can absorb before damage occurs: skin type, geography, time of day and duration of exposure. The degree of sun protection offered by a sunscreen is indicated by its Sun Protection Factor (SPF).
SUNDOWN® is available in three sunscreen formulations—

- moderate protection (SPF 4),
- extra protection (SPF 6),
- maximal protection (SPF 8)—and an ultra protection sunblock formulation (SPF 15).

Durability: Key factor in sunscreen selection

Swimming and perspiration erode the protective shield provided by a sunscreen. SUNDOWN Sunscreen has achieved the highest durability classification of all: waterproof. This means that SUNDOWN Sunscreen protection remains at its rated SPF even after four 20-minute swims. And SUNDOWN Sunblock, classified water-resistant, maintains its SPF rating of 15 after two 20-minute swims. For young children who often spend long periods bobbing in and out of the water, such durability is particularly important. (Since no chemical sunscreen provides absolute protection, all patients should be warned against overexposure to the sun.)

Good sun protection habits should start early. Because a healthy skin is well worth saving.

SUNDOWN® SUNSCREEN/SUNBLOCK

The most preferred protection under the sun.
In rabies prophylaxis:

Almost 2,000,000 doses administered worldwide.

Rabies vaccine, of human diploid cell origin, is the product of choice in rabies prophylaxis.1

Proven effective
Imovax™ Rabies Vaccine (Human Diploid Cell) is both highly effective and convenient to administer—only three doses pre-exposure and five doses post-exposure. In a study of 45 people severely bitten by dogs or wolves with confirmed rabies, Imovax™ Rabies Vaccine proved 100% effective even when the vaccine administration or treatment was initiated 14 days after exposure.2

No instances of failure to develop antibody protection have occurred with Imovax™ Rabies Vaccine when the recommended schedule for pre- or post-exposure prophylaxis was followed.

A vaccine with exceptional safety
Imovax™ Rabies Vaccine has been used worldwide since 1974, with over 1.8 million doses administered. In the United States, a quarter of a million doses have been administered since 1980.3 Despite this wide usage, no neurological reactions have been caused by Imovax™ Rabies Vaccine and virtually no serious side effects or reactions have occurred.

Merieux has prepared a poster: “Rabies: What to do in an emergency.” To receive a free poster, write: Merieux Institute, Inc., 1200 N.W. 78th Avenue, Suite 109, Miami, Florida 33126.

References
3. Data on file, Merieux Institute, Inc.

IMOVAX™
RABIES VACCINE
(HUMAN DIPLOID CELL)

Merieux Institute USA
We are available 24 hours a day, 7 days a week; call: (800) 327-2842.

Please see next page for a summary of prescribing information.
RABIES VACCINE
IMOVAX™ RABIES
(HUMAN DIPLOID CELL)
Wistar Rabies Virus Strain PM-1503-3M
Grown in Human Diploid Cell Cultures

DESCRIPTION: The imovax™ Rabies Vaccine produced by Institut Merieux is a sterile, freeze-dried suspension of rabies virus prepared from strain PM-1503-3M obtained from the Wistar Institute, Philadelphia, Pennsylvania. The virus is harvested from infected human diploid cells, MRC-5 strain, concentrated by ultrafiltration and is deactivated by beta propiolactone. One dose of reconstituted vaccine contains less than 100 mg human albumin, less than 150 µg neomycin sulfate and 20 µg of phenol red indicator.

The vaccine contains no preservative or stabilizer. It should be used immediately after reconstitution.

CONTRAINDICATIONS: For post-exposure treatment there are no known specific contraindications to the use of Merieux imovax™ Rabies Vaccine. In cases of pre-exposure immunization, there are no known specific contraindications other than situations such as developing febrile illness, etc.

WARNING: Local or mild systemic adverse reactions to the vaccine are infrequent; they do not contraindicate continuing immunization and may be treated symptomatically. Neuroparalytic reactions such as encephalomyelitis, transverse myelitis and other central neuropathies have not been reported in recipients of vaccine produced in human diploid cell cultures. One case of Guillain-Barré syndrome temporally associated with rabies immunization has been reported (1). It was followed by complete recovery. No cause-effect relationship was established. Should a neurological complication develop, vaccine treatment should be discontinued. Any serious reactions should be immediately reported to the State Health Department or the Viral Disease Division, Bureau of Epidemiology, Centers for Disease Control, Atlanta, Georgia (telephone 404-329-3696).

PRECAUTIONS: Epinephrine should be available for immediate use should an anaphylactoid reaction occur.

Drug Interactions—Corticosteroids and immunosuppressive agents may interfere with the development of active immunity and predispose the patient to developing rabies. They should not be administered during post-exposure therapy unless essential for the treatment of other serious conditions. If rabies post-exposure therapy is administered to persons receiving steroids or immunosuppressive therapy, it is especially important that serum be tested for rabies antibody to ensure that an adequate response has developed.

Usage in Pregnancy—Pregnancy is not a contraindication to rabies post-exposure therapy. Based on limited data, there have been no fetal abnormalities associated with rabies vaccination. If there is substantial risk of rabies exposure, pre-exposure treatment may also be indicated during pregnancy.

ADVERSE REACTIONS: Clinical experience with Merieux imovax™ Rabies Vaccine has resulted in a low incidence of adverse reactions when administered by the recommended route of injection. Local reactions consist of swelling, erythema, induration and slight ache. Their incidence has ranged from approximately 3% to 15% (2,3,4,5). Allergic reactions to Merieux rabies diploid cell vaccines are rare. In the few cases reported (1), which ranged in severity from hives to anaphylactic shock, it was not necessary to discontinue the post-exposure prophylaxis regimen. Mild local or systemic reactions can be treated with anti-inflammatory, antipyrine agents, e.g., aspirin and antihistamines. If an anaphylactic reaction should occur epinephrine is indicated.

REFERENCES

Revised November, 1981

Manufactured by INSTITUT MERIEUX
17, RUE BOURGELAT
LYON-FRANCE

Distributed by MERIEUX INSTITUTE, INC.
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Merieux Institute USA

Every third of a second someone in the world uses one of our vaccines.

The new "Red Book" is here...

The 19th edition of the Academy’s quick reference guide to more than 100 communicable diseases is now available for purchase.

New sections of this authoritative handbook, officially known as the “Report of the Committee on Infectious Diseases,” include recently described diseases caused by coronaviruses, Legionella pneumophila, hepatitis B and non A and non B hepatitis, Kawasaki disease and yersinia species, and use of new vaccines and specific immune globulin preparations for hepatitis, rabies, varicella-zoster, and pneumococcal infection. 1982; 32 tables; indexed; 379 pages.

Note: All Fellows and Junior Fellows will be mailed one complimentary copy in June.

Please send me: ______________________ copies: ______________.
Infectious Diseases @ $15.00
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Publications Department
P.O. Box 1034
Evanston, Illinois 60204

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□ Personal order must be prepaid. Make check payable to: American Academy of Pediatrics.

□ Bill the institution. Formal purchase order required.
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Introducing the State-of-the-Art Infant Formula...
Improved Formulation Enfamil®

Nutritionally closer to breast milk for good growth and development

Today's Enfamil—A significant advance in product formulation

Improved Formulation Enfamil has been designed to give your babies an infant formula that is nutritionally unsurpassed. When breast-feeding is not chosen, unsuccessful, inappropriate, or stopped early, Today’s Enfamil is the newest, most-advanced alternative.

60 Whey Protein: 40 Casein Ratio

Today's Enfamil is formulated with a 60:40 whey protein/casein ratio that brings it closer than ever to breast milk. The whey protein-predominant formulation provides abundant levels of essential amino acids and brings the cystine amino acid level closer to that found in breast milk.

All Vegetable Oil Fat Blend

Today’s Enfamil uses a fat blend of 55% coconut:45% soy oil. The polyunsaturated fatty acid (PUFA) level is within the range of breast-milk values. Studies show that fat absorption is greater than 90% with the new blend—about the same as breast milk.

Appropriate Sodium Content

The reduced-minerals whey used in Enfamil permits the sodium content to be close to the midpoint of the recommended* range.

Calcium:Phosphorus Ratio—1.5:1

This calcium:phosphorus ratio is closer to breast milk than other routine infant formulas. The levels have been clinically validated to provide excellent growth and development in infants, and to promote excellent calcium absorption.

100% Lactose

Improved Formulation Enfamil uses 100% lactose—the carbohydrate found in breast milk to assure good calcium absorption.

Thoroughly Tested

Today’s Enfamil is the result of more than seven years of product development, laboratory, preclinical, and clinical testing. Clinical testing included Metabolic Balance studies, 112-Day Growth studies, and Acceptance and Tolerance studies. You and your parents can be assured of product quality and performance.

*Committee on Nutrition of the American Academy of Pediatrics

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See for yourself how Enfamil® measures up

Below are comparisons of some of the nutritional elements that are important to the growth and development of infants.

<table>
<thead>
<tr>
<th>Ratios</th>
<th>Breast Milk</th>
<th>Improved Formulation Enfamil</th>
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<tr>
<td>Whey Protein:</td>
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<tr>
<td>Casein</td>
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<tr>
<td>Whey: Casein</td>
<td>60% 40%</td>
<td>60% 40%</td>
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Essential Amino Acids:
- Nonessential: 1.0 1.0
- Essential: 0.5 0.5

Cystine: Methionine
- Cystine: 0.9 0.6

Sodium: mEq/liter
- 8.5* 9.0

Potassium: mEq/liter
- 15.0* 17.6

Chloride: mEq/liter
- 13.1* 11.9

Please ask your Mead Johnson Nutritional Division representative about other important aspects of the new formulation.

Improved Formulation Enfamil

A total commitment to the future of infant nutrition from Mead Johnson NUTRITIONAL DIVISION

Dealing with the problems of school children

A new (1981) edition of School Health: A Guide for Health Professionals is now available. Revised by the AAP Committee on School Health, this manual gives practical information on how school health programs function and how these programs fit into the school structure. It discusses the problems of pre-school age children, elementary school children and adolescents, and has a section on children with special educational needs. In addition, it reports on screening tests needed as well as the essentials of history and physical examination, follow-up procedures and record keeping. Other points of interest are: health education, physical education, physical activities for children with handicaps, dental care, school sports programs, communicable disease, emergency care in schools, school personnel problems and school safety.

The book also includes 16 appendices and 3 tables. Indexed: 297 pages.

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Coly-Mycin S Otic
with Neomycin and Hydrocortisone
(colistin sulfate-neomycin sulfate-thomsonium bromide-hydrocortisone acetate otic suspension)

Before prescribing, please see full prescribing information. A Brief Summary follows.

INDICATIONS AND USAGE
For the treatment of superficial bacterial infections of the external auditory canal, caused by organisms susceptible to the action of the antibiotics; and for the treatment of infections of mastoidectomy and fenestration cavities, caused by organisms susceptible to the antibiotics.

CONTRAINDICATIONS
This product is contraindicated in those individuals who have shown hypersensitivity to any of its components, and in herpes simplex, vaccinia and variella.

WARNINGS
As with other antibiotic preparations, prolonged treatment may result in overgrowth of non-susceptible organisms and fungi. If the infection is not improved after one week, cultures and susceptibility tests should be repeated to verify the identity of the organism and to determine whether therapy should be changed. Patients who prefer to warn the medication before using should be cautioned against handling the solution above body temperature, in order to avoid loss of potency.

PRECAUTIONS
General
If sensitization or irritation occurs, medication should be discontinued promptly.
This drug should be used with care in cases of perforated ear drum and in longstanding cases of chronic otitis media because of the possibility of ototoxicity caused by neomycin. Treatment should not be continued for longer than ten days.
Allergic cross-reactions may occur which could prevent the use of any or all of the following antibiotics for the treatment of future infections: kanamycin, paromomycin, streptomycin, and possibly gentamicin.

ADVERSE REACTIONS
Neomycin is a not uncommon cutaneous sensitizer. There are articles in the current literature that indicate an increase in the prevalence of persons sensitive to neomycin.

DOSEAGE AND ADMINISTRATION
The external auditory canal should be thoroughly cleansed and dried with a sterile cotton applicator.
For adults, 4 drops of the suspension should be instilled into the affected ear 3 or 4 times daily. For infants and children, 3 drops are suggested because of the smaller capacity of the ear canal.
The patient should be with the affected ear upward and then the drops should be instilled. This position should be maintained for 5 minutes to facilitate penetration of the drops into the ear canal. Repeat, if necessary, for the opposite ear.
If preferred, a cotton wick may be inserted into the canal and then the cotton may be saturated with the solution. This wick should be kept moist by adding further solution every 4 hours. The wick should be replaced at least once every 24 hours.

HOW SUPPLIED
Coly-Mycin S Otic is supplied as:
N 0071-3141-08—5 ml bottle
N 0071-3141-10—10 ml bottle
Each ml contains: Colistin sulfate equivalent to 3 mg of colistin base, Neomycin sulfate equivalent to 3.3 mg neomycin base, Hydrocortisone acetate 10 mg (1%), Thiomorium bromide 0.5 mg (0.05%), and Polysorbate 80 in an aqueous vehicle buffered with acetic acid and sodium acetate. Thimerosal (mercury derivative) 0.002% added as a preservative.

Shake well before using.
Store at controlled room temperature 59°-86°F (15°-30°C). Stable for 18 months at room temperature; prolonged exposure to higher temperatures should be avoided.

3141G031
PARKE-DAVIS
Div of Warner-Lambert Co. Morris Plains, NJ 07950
In Otitis Externa
The only otic drop that works in three dimensions

Coly-Mycin® S OTIC
with neomycin and hydrocortisone
(colistin sulfate—neomycin sulfate—thonzonium bromide—hydrocortisone acetate otic suspension)

The Antiinfective Dimension.
Colistin sulfate and neomycin sulfate, together, offer broad-spectrum antibacterial effectiveness against most pathogens associated with otitis externa...especially against Pseudomonas aeruginosa...the organism implicated in 7 out of 10 such cases.

The Antiinflammatory Dimension.
Hydrocortisone acetate provides relief of pain, reduction of swelling and inflammation.

Recommended Dosage:
Adults
4 drops in each affected ear, 3-4 times a day.
Infants and Children
3 drops in each affected ear, 3-4 times a day.

Available in two sizes—5 ml and 10 ml—each in a convenient shatterproof bottle with built-in dropper.

PARKE-DAVIS
Div of Warner-Lambert Co / Morris Plains, NJ 07950
A-200 Pyrinate® The pediculicidal effect of lindane—without its potential for CNS toxicity.
Unlike the prescription pediculicide, which contains lindane (gamma benzene hexachloride), no neurotoxic potential is known for A-200 Pyrinate Pediculicide Shampoo—even after 40 years and millions of treatments.

Low surface tension 10-minute shampoo—key to A-200 Pyrinate effectiveness.
The A-200 Pyrinate formula includes a carrier vehicle of solvents, emulsifiers, and surfactants that produce a low surface tension. This permits a complete uniform spreading and coating action for total contact with hair, lice, and eggs—thus effecting maximum penetration of the active ingredients.

Natural, safe pyrethrins.
A-200 Pyrinate contains natural, safe pyrethrins, derived from the chrysanthemum flower. Pyrethrins are among the most effective and safe pediculicides available. Safe enough for use on young children. In addition, A-200 Pyrinate is not a primary irritant or sensitizer.

A-200 Pyrinate. The most widely used treatment for the control of head lice.
A-200 Pyrinate is the well-accepted formula in use by School and Community Health Professionals. And Pharmacists have made A-200 Pyrinate their most frequently recommended pediculicide. Available at pharmacies in 2 and 4 fl. oz. liquid and 1 oz. gel.
Each 5 ml contains 12 mg codeine phosphate† plus 120 mg acetaminophen (Alcohol 7%)

*Warning: May be habit forming

The narcotic-containing analgesic especially formulated for children.†

*Please see "Warnings" section in the Summary of Prescribing Information on the following page for information on usage in children.
TYLENOL with Codeine (acetaminophen with codeine)

TABLETS AND CAPSULES  
acetaminophen 300 mg plus codeine phosphate  
No. 3 30 mg (1/2 gr), No. 4 60 mg (1 gr)

Summary of Prescribing Information

Description
Tablets: Contain codeine phosphate* No. 1 7.5 mg (1/2 gr)  
No. 2 15 mg (1 gr)  
No. 3 30 mg (1/2 gr)  
No. 4 60 mg (1 gr) plus acetaminophen 300 mg
Capsules: Contain codeine phosphate* No. 3 30 mg (1/2 gr)  
No. 4 60 mg (1 gr) plus acetaminophen 300 mg
Elixir: Each 5 ml contains 12 mg codeine phosphate* plus 120 
mg acetaminophen (alcohol 7%)  
*Warning: May be habit forming

Contraindications: Hypersensitivity to acetaminophen or 
codeine

Warnings: Drug dependence: Codeine can produce drug 
dependence of the morphine type and may be abused.  
Dependence and tolerance may develop, upon repeated ad-
mnistration, prolong and administer with same caution ap-
propriate to other narcotic analgesics. Subject to the Federal 
Controlled Substances Act

Precautions: General: Head injury and increased intra-
cranial pressure. Respiratory depressant effects of narcotics 
and their capacity to elevate intracranial pressure may be 
markedly exaggerated in the presence of head injury, other 
intracranial lesions, or a pre-existing increase in intracranial 
pressure. Narcotics produce adverse reactions which may 
disturb the clinical course of patients with head injuries.
Acute abdominal conditions: Codeine or other narcotics may 
doctrine the diagnosis or clinical course of acute abdominal 
conditions.
Special risk patients: Administer with caution to certain pa-
tients such as the elderly or debilitated and those with 
severe impairment of hepatic or renal function, hypothyroidism, 
Addison's disease, and chronic obstructive pulmonary or renal 
structure.

Information for Patients: Usage in ambulatory patients 
Codeine may impair mental and/or physical abilities, required 
for performance of potentially hazardous tasks such as driving 
a car or operating machinery.

Drug Interactions: Patients receiving other narcotic 
analgesics, general anesthetics, phenothiazines, other tranquilizers, 
selective serotonin inhibitors or other CNS depressants including 
drug with this may exacerbate the adverse effects of this 
combination on the CNS: Use with caution and, if necessary, 
reduce the dose of one or both agents.
The use of MAO inhibitors or tri cyclic antidepressants 
with codeine preparations may increase the effect of either 
the antidepressant or codeine.
The concurrent use of anticholinergics with codeine may 
produce paralytic ileus.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No 
long-term studies in animals have been performed with 
acetaminophen plus codeine to determine carcinogenic potential 
or effects on fertility.

Acetaminophen and codeine have been found to have 
no mutagenic potential using the Ames Salmonella Microsome 
Mutagenicity Assay (the Basic test on Dro sophila germ cells, and the 
Micronucleus test on mouse bone marrow).

Teratogenic Effects: Pregnancy Category C: Codeine has 
been shown to be teratogenic in mice when given in doses 10 
times the maximum human daily dose. There are no adequate 
and well-controlled studies in pregnant women. 

TYLENOL with Codeine should not be used during pregnancy only 
the potential benefits justify the potential risk to the fetus.

Nursing Mothers: It is not known whether the components 
of this drug are excreted in human milk. Caution should be 
exercised if TYLENOL with Codeine is administered to a 
nursing woman.

Pediatric Use: Safety of the ex-iii has not been 
established in children below the age of three. The tablets, and 
capsules should not be administered to children under 12.

Adverse Reactions: Most frequent: Lightheadedness, sleep-
lessness, sedation, dryness of mouth, constipation, nausea.

At higher doses, codeine has most of these disadvantages of 
morphine including respiratory depression.

Dosage and Administration: Dosage should be adjusted 
according to severity of pain and response of the patient. 
TYLENOL with Codeine tablets, and capsules are given orally. 
The usual adult dose is 5 tabs No. 1 No. 2, and No. 3 and 
Capsules No. 3. One or two every four hours as required 
for tablets and capsules. No. 3. One every four hours as required. 
The recommended dose of codeine in children is 0.5 mg/kg 
body weight.

TYLENOL with codeine ex-iii contains 12 mg of codeine 5 
mg/teaspoon and a given daily. The usual doses are: Children  
10 to 36 years: 1 teaspoonful (5 ml) every 4 hours, (170 lbs 2 years)  
2 teaspoonful (10 ml) 3 or 4 times daily (under 3 years: safe 
use has not been established.Adults: 1 tablespoonful (15 
ml) every 4 hours as needed. 

Full directions for use should be read before administering 
or prescribing.

For information on symptoms/treatment of over dosage see 
full prescribing information.

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26619-9/15/82

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Spring House, PA 19477
SPY SYSTEM IN THE NURSERY

Recently issued regulations, in effect, set up a spy system in the nursery:
Health care providers receiving Federal assistance—most hospitals—are now required to post a sign in every ward listing the telephone number of a “Handicapped Infant Hotline.” Anyone “having knowledge” that a handicapped baby is being denied food or customary medical care is invited to dial the toll-free number. The tipster may remain anonymous; an investigator will be dispatched.

But what kind of medical attention, and how much, should be given a badly damaged infant are questions that won’t thus go away. Given the advances in neonatal care, they will be heard more and more. Federal and state civil rights workers investigating anonymous, conceivably even malicious complaints are hardly trained to understand the problem or provide an answer.


JUDGE STRIKES RULE REQUIRING CARE FOR INFANTS WITH DEFECTS

A Federal district judge today struck down a new rule that required 6,400 hospitals around the country to provide food and medical care to infants born with severe mental or physical defects.

Judge Gerhard A. Gesell said that the rule, issued by the Reagan Administration March 7, was “arbitrary and capricious.” Further, he said, it was adopted in violation of the Administrative Procedure Act, which requires Government agencies to give the public an opportunity to comment on most rules. Therefore, he said the rule was invalid and “has no further force or effect. The regulation,” he said, “provides for an intrusive on-premises enforcement mechanism that can be triggered by a simple anonymous call.”

Judge Gesell bluntly criticized the quality of the decision-making process at the Department of Health and Human Services, saying, “This court is forced to conclude that haste and inexperience have resulted in agency action based on inadequate consideration. As even the most cursory investigation by the Secretary would have revealed,” the Judge wrote, “there is no customary standard of care for the treatment of severely defective infants. The regulation thus purports to set up an enforcement mechanism without defining the violation, and is virtually without meaning beyond its intrinsic ‘in terrorem’ effect” (‘in terrorem’ is a Latin phrase that means “in terror or warning; by way of threat”).

At a court hearing last week, a Government lawyer said the Reagan Administration wanted to make sure that “extraneous nonmedical factors,” like the cost of rearing a handicapped infant, did not interfere with medical decisions!

The Administration announced it would appeal Judge Gessell’s ruling.

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OTIC SOLUTION (hydrocortisone 1%, acetic acid—nonaqueous 2%)

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In vivo and in vitro studies demonstrate that VŏSol™ HC has antimicrobial activity equal to that of Coly-Mycin™ S and Cortisporin®¹¹,¹³ With VŏSol HC, there have been no resistant strains reported.

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VŏSol™ HC does not contain an antibiotic, which means with VŏSol™ HC there is no potential for antibiotic side effects such as allergic reactions or cross-reactions.⁶

For a brief summary of prescribing information, please see following page.
VoSol® HC OTC SOLUTION
(hydrocortisone 1%, acetic acid—nonaqueous 2%)

VoSol® OTC SOLUTION
(acetic acid—nonaqueous 2%)

Before prescribing, please consult complete product information. A brief summary of important information follows:

**Indications:** VoSol: For the treatment of superficial infections of the external auditory canal caused by organisms susceptible to the action of the antimicrobial. VoSol HC: For the treatment of superficial infections of the external auditory canal caused by organisms susceptible to the action of the antimicrobial, complicated by inflammation.

**Contraindications:** Hypersensitivity to any of the components, perforated tympanic membranes are frequently considered a contraindication. VoSol HC is also contraindicated in vaccinia and varicella.

**Precautions:** If sensitization or irritation occurs, discontinue promptly.

VoSol HC: As safety of topical steroids during pregnancy has not been confirmed, they should not be used for an extended period during pregnancy. Systemic side effects may occur with extensive use of steroids.

**How Supplied:** VoSol Otic Solution in 15 ml and 30 ml measured-dose, safety-tip plastic bottles.

VoSol HC Otic Solution in 10 ml measured-dose, safety-tip plastic bottle. Rev. 1/83

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Manufactured by Denver Chemical (Puerto Rico), Inc. Humacao, Puerto Rico 00661

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Division of Carter-Wallace, Inc. Cranbury, New Jersey 08512

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The manual, written by the Academy’s Committee on Sports Medicine, focuses on the special needs of children in all phases of sports activities. It demonstrates that sports medicine isn’t just injuries … only five of the 22 chapters deal with trauma. Other chapter titles include counseling families, preparticipation health evaluation, nutrition, physical training, drugs, thermoregulation, and the athletic trainer. The book also includes 42 illustrations and 24 tables. Indexed; 325 pages; $15.

Note: AAP Fellows (not Junior Fellows) may receive one free copy by mailing the completed coupon with their membership I.D. number.

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See prescribing information on next page.

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Now children can have all the benefits of Theo-Dur tablets in a dosage form that’s easy to swallow. New Theo-Dur Sprinkle Sustained Action Capsules provide q12h dosing, even in children who metabolize theophylline very rapidly.

Theo-Dur Sprinkle is designed to minimize fluctuation of blood levels in children. Dosing q12h with Theo-Dur Sprinkle produces smooth steady-state serum theophylline concentrations with no unprotected hours and minimized peak-trough fluctuation.

Dosage titration and administration is easy with Theo-Dur Sprinkle oversized capsules. Simply twist off the cap to open and pour the contents onto a small amount of soft food. Every minipellet contains active drug, with no starch, no dyes, no preservatives.

Theo-Dur Sprinkle can be titrated in 25 mg increments and is available in 50, 75, 125, and 200 mg strengths.

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Easy-to-swallow q12h theophylline for the rapid metabolizer.

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Please see next page for a summary of prescribing information.
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The 19th edition of the Academy's quick reference guide to more than 100 communicable diseases is now available for purchase.

New sections of this authoritative handbook, officially known as the "Report of the Committee on Infectious Diseases," include recently described diseases caused by coronaviruses, Legionella pneumophila, hepatitis B and non A and non B hepatitis, Kawasaki disease and varicella-zoster, and pneumococcal infection. 1982; 32 tables; indexed; 379 pages.

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The manual places great emphasis on the integration of family-centered care into every phase of perinatal services. It defines the interaction of two specialties in a regionalized approach to perinatal care and discusses facilities, staff and services needed to provide optimum maternal and newborn care.

Some further highlights . . .

Before Birth: antenatal risk assessment and genetic counseling if necessary, prenatal care, childbirth education classes, management of labor and delivery.

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The “Perinatal” manual is a “must” for every physician and nurse who cares for pregnant women and newborns.

Indexed; 336 pages.

Note: All members of the Academy and the College will be mailed one complimentary copy in May.
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The standard ADD medication in once-a-day dosage

One 20-mg sustained-release Ritalin-SR tablet given at breakfast provides a therapeutic effect equivalent to that of the standard 10-mg tablet given twice daily.1


Eliminates the need to take medication in school

"The availability of a sustained-release (SR) formulation of methylphenidate would greatly improve patient compliance and lessen school-related dosing problems..."1

Improves compliance... affords greater convenience and greater privacy

Ritalin is indicated as adjunctive therapy to other remedial measures (psychological, educational, social) for ADD in children. Drug treatment is not indicated for all children with ADD. Stimulants are not intended for use in the child who exhibits symptoms secondary to environmental factors and/or primary psychiatric disorders, including psychosis.

Also available: Regular tablets of 5, 10 and 20 mg.

Please see next page for brief Prescribing Information

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Special Diagnostic Considerations
Specific etiology of this syndrome is unknown, and there is no single diagnostic test. An apparently safe dosage is the only method 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. Leaky brain. 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 or primary psychiatric disorders, including psychosis. Appropriate educational placement is essential and psychosocial intervention is generally necessary. Often 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, in patients with glaucoma, and in patients with motor tics or with a family history or diagnosis of Tourette's syndrome.

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 rate, 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 poor history of seizures, with poor 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 hypertensive 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, phenytoin, phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when concomitantly with Ritalin.

Use 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.

ADVERSE REACTIONS
Nervousness and insomnia are the most common adverse reactions observed. Adverse reactions are usually controlled and are not prevented by a reduced dosage of the drug in the afternoon or evening. Other reactions include hypertension (including skin rash, urticana, fever, arthralgia, transient dermatitis, erythema 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. There have been rare reports of Tourette's syndrome. 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. There have been rare reports of Tourette's syndrome. 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.

DOSE AND ADMINISTRATION
Dosage should be individualized according to the needs and responses of the patient.

Children (6 years and over)
Ritalin should be initiated in small doses, with gradual weekly increments of 10 mg not to exceed 60 mg per day. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.

Tablets: Start with 5 mg twice daily (before breakfast and lunch) with gradual increments of 5 to 10 mg weekly.

SR Tablets: Ritalin-SR tablets have a duration of action of approximately 8 hours. Therefore, Ritalin-SR tablets may be used in place of Ritalin tablets when the 8-hour dosage of Ritalin corresponds to the 8-hour dosage of Ritalin-SR. In the presence of severe symptoms, the drug may be continued.

Ritalin should be periodically discontinued to assess the child's condition. 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.

Geriatric: Signs and symptoms of acute overdosage, resulting principally from overstimulation of the central nervous system and from anticholinergic effects, may include: vomiting, agitation, tremors, hyperventilation, regression, convulsions (may be followed by coma), mydridia, confusion, hallucinations, delirium, sweating, flushing, headache, hyperpyrexia, tachycardia, palpitations, cardiac arrhythmias, mydriasis, and dryness of mucous membranes. Treatment consists of appropriate supportive measures. The patient must be protected against self-injury and against external stimuli that would aggravate overstimulation already present. If symptoms and signs are not too severe and the patient is conscious, gastric contents may be evacuated by induction of emesis or gastric lavage. In the presence of severe intoxication, use a carefully titrated dosage of a short-acting barbiturate before performing gastric lavage.

There is no specific antidote to maintain adequate circulatory and respiratory exchange. External cooling procedures may be required for hyperpyrexia.

Efficiency of peritoneal dialysis or extracorporeal hemodialysis for Ritalin overdosage has not been established.

HOW SUPPLIED
Tablets: 10 mg—round, pale yellow scored (imprinted CIBA 34) Bottles of 100 NDC 0083-0003-30
100 NDC 0083-0003-40
Tablets 10 mg—round, pale green scored (imprinted CIBA 34) Bottles of 100 NDC 0083-0003-35
500 NDC 0083-0003-45
Accu-Pak®Unit Dose ( blister pack) Box of 100 strips (10) NDC 0083-0003-32
Tablets 5 mg—round, yellow (imprinted CIBA 77) Bottles of 100 NDC 0083-0007-35
100 NDC 0083-0007-40
SR Tablets 20 mg—round, white, coated (imprinted CIBA 16) Bottles of 100 NDC 0083-0016-30
Note: SR Tablets are color-additive free
Do not store above 86°F (30°C). Protect from moisture.
Dispense in tight, light-resistant container (L/R)

CIBA-263 (Rev 1 83)

Consult complete product literature before prescribing

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

Reference

Part of the ADD management team—only when medication is indicated

Ritalin* hydrochloride C methylphenidate hydrochloride USP tablets

Ritalin-SR® C methylphenidate hydrochloride sustained-release tablets

Brief Summary of Prescribing Information

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, Minor 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.

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. Chronic abuse of the drug can lead to a state of tolerance, and patients may develop a physical dependence on the drug. In rare instances, withdrawal symptoms may occur, especially with parental 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 physicians' assessment of the chronicity and severity of the child's symptoms and their appropriateness for the child's needs. Treatment may be necessary for a prolonged period.

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

CIBA-263 (Rev 1 83)

Consult complete product literature before prescribing

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901
Less trauma for your patients, more convenient for you.

Less fear. As this cutaway drawing shows, SclavoTest-PPD hides the points from view. That means less "hassle" for you.

More control. You project the points with gentle pressure only after the device is placed flat on the skin. This is designed to deliver tuberculin accurately to the preset depth of penetration and to minimize the possibility of accidental scratches or bleeding.

with other innovative features...

Delivers purified — not "old" — tuberculin
Like the International Standard,* SclavoTest-PPD employs Tuberculin Purified Protein Derivative (PPD)… not Old Tuberculin (OT) as used in some traditional tine-type tests. The purification process removes most of the impurities and nonreactive components.

Hermetically sealed blister is identified and covers entire device
Designed to impede the passage of moisture while maintaining sterility. The lot number and expiration date are stamped on each blister pack.

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Easy to use
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No needles, syringes, or vials needed.

No refrigeration needed
Stable for two years at room temperature.

Patient Record Cards
Available at no charge. English and Spanish.

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*0.1 ml of 5 TU PPD-S administered by the Mantoux Method. PPD-S is purified Protein Derivative (Seibert), adopted as the standard by the World Health Organization and used to prepare the official U.S. Public Health Service 5 TU solution of tuberculin for skin testing.
DESCRIPTION: Tuberculin PPD (ScavoTest-PPD)
ScavoTest-PPD is a sterile multiple puncture intradermal device containing a tuberculin PPD used for the identification of individuals who have a delayed hypersensitivity to tuberculin. ScavoTest-PPD is an easy to use, self-contained, unit dose disposable system which minimizes waste and can be stored at room temperature. No needles, syringes, or vials are needed.

The ScavoTest-PPD device is composed of a single-use handle with four stainless steel points to which has been affixed and dried a tuberculin PPD solution. The retracted points are projected, after the device is placed upon the skin by gentle pressure applied through a spring inside the handle. This design overcomes emotional reactions which sometimes occur with a needle and syringe and reduces the possibility of accidental twisting of the device which might cause pain, bleeding, or false positive reactions due to trauma. ScavoTest-PPD is stored at room temperature until the moment of use in a hermetically sealed unit dose blister pack, which is designed to improve the passage of moisture and to maintain sterility.

The antigen used in ScavoTest-PPD is from a master batch of Tuberculin PPD (Lot MT 1) prepared essentially as described by Magnusson et al using approximately equal parts of HU and Johnstown strain of Mycobacterium tuberculosis, and filtered through a sharp stainless steel needle to which contains 0.01 Quinios as a preservative to a final concentration of 0.025 μg per device.

CLINICAL PHARMACOLOGY:
Intradermal injection into the skin of a tuberculin positive person reacts with sensitized lymphocytes which can cause the release of mediators of cellular hypersensitivity. Among the mediators is skin reactive factor which induces the inflammatory response resulting in a positive reaction.

Clinical studies: Clinical studies with ScavoTest-PPD were performed in several sections of the USA including areas with a high prevalence of non-M tuberculosis mycobacterial infections. The concentration of tuberculin was selected to identify at least as many bacteriologically confirmed cases of tuberculosis as 5 TU of PPD S* administered by the Mantoux method, with both tests read at 48 hours.

Reactions to ScavoTest-PPD were discrete and easily palpable. Because the size of reactions to ScavoTest-PPD was smaller than with the PPD S Mantoux test, the ScavoTest-PPD is less likely to elicit discomfort among the clients. Bleeding at the administration site was less than 1% with ScavoTest-PPD compared with 7% for PPD S Mantoux.

INDICATIONS AND USAGE:
ScavoTest-PPD tuberculin purified protein derivative is indicated as an aid for the identification of old or recent tuberculosis infection or with without disease. ScavoTest-PPD is most suitable for use in the private practice and is particularly useful for mass screening programs, epidemiologic surveys, and situations which can benefit from greater patient acceptance, unit dose dispensing or ease of use. ScavoTest-PPD is advantageous for use in children who might object to needle and syringe. Also, due to its low rate of vasculitis and its smaller size of tuberculin reactions when compared against the intradermal method, ScavoTest-PPD may be a method of choice for persons suspected to be strong reactors to tuberculin.

Frequency of repeated tuberculin test depends upon the suspicion of recent exposure, the prevalence of tuberculosis in the population group, and the risk of exposure to active disease, including such high risk groups as hospital personnel and institutionalized individuals. Infants should always be tested known or suspected cases of active disease regardless of age, and tested at approximately one year of age at the time of or preceding the measles immunization and in certain areas prior to entrance into the first grade.

CONTRAINDICATIONS:
Tuberculin testing should be avoided in persons with history of high sensitivity to bacilli because of the severity of reactions (vascular, ulceration or necrosis).

WARNINGS:
The intensity of the reaction may be diminished by many factors which affect delayed hypersensitivity reactions in a nonspecific manner by mechanisms not fully understood. These factors or conditions include acute viral infection or recent vaccination with viral vaccines, immunosuppression by disease, pregnancy, immunosuppressive agents, or steroid hormones, a state of general energy such as that associated with sarcoidosis or malignancy, especially lymphoma, maintenance in children, overwhelming infection, and the warning of delayed hypersensitivity associated with advancing age. In addition, there is a small proportion of sensibles with tuberculin who have none of the above conditions but who still do not react to ordinary doses of tuberculin. Although a recent publication suggests that this proportion may be as high as 20%, observations over many years have documented that it is usually no more than 5% (occasionally up to 10%) with the use of intermediate strength tuberculin (5TU) and 1% or less with high doses (100 to 250 TU) of tuberculin in most patients who are seen with tuberculin skin test who have negative result becomes positive after a few weeks of treatment.

Since a positive tuberculin test two to three times in the presence of active tuberculosis, antituberculin chemotherapy should not be instituted solely on the basis of a single positive result to a tuberculin test. Further diagnostic procedures to be considered include chest x-ray and bacteriology examination of sputum or other appropriate specimens. However, the preventive treatment should be seriously considered for recent converters and other high risk groups even without evidence of active disease.

PRECAUTIONS:
General: The ScavoTest-PPD device should never be reused and should be disposed of carefully immediately after use.

Information for patients: To avoid unnecessary apprehension, the patient or the parent should be informed that a positive tuberculin reaction may be caused by infection with tubercle bacilli, but does not indicate active disease or pathological damage. The patient or parent should be informed that a positive tuberculin test may not accurately reflect the presence or absence of infection with tubercle bacilli due to high sensitivity to tuberculin. Patients should be told that false positive reactions can occur due to recent immunization, drug reactions, or exposure to non-tuberculotic antigens and that cold packs or topical steroid preparations may be employed for symptomatic relief.

Disregard for negative results: Suppression of tuberculin reactivity may occur as a result of administration of steroid hormones, immunosuppressive agents, and viral vaccines. This may be a reason for deeming tuberculin testing, or for repeating the test sooner than usual. Vaccination with BCG may result in tuberculin sensitivity and the degree of sensitivity may vary from individual to individual.

Pregnancy category C: Animal reproduction studies have not been conducted with ScavoTest-PPD. It is also not known whether PPD can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. ScavoTest-PPD should be given to a pregnant woman only if clearly needed. During pregnancy, reactivity to tuberculin may be suppressed.

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 ScavoTest-PPD is administered to a nursing woman.

ADVERSE REACTIONS:
Some vasculitis was noted in clinical trials with ScavoTest-PPD (tuberculin purified protein derivative). Occasional cases of necrosis and ulceration have been reported for multiple-puncture devices.

DOSEAGE AND ADMINISTRATION:
One device is used for each person tested. The preferred site is the volar (flexor) surface of the forearm. 2 to 4 inches below the bend of the elbow. The site should be free of scars, moles, and other conditions which might interfere with the reading of the test.

1. Be sure that the site is intact
2. Cleanse the test site with alcohol or other suitable material and ALLOW TO DRY
3. Remove the ScavoTest-PPD from its blister pack by exerting pressure on the bubble of the handle and releasing the thumb.
4. Grasp the patient's forearm firmly and stretch the skin with the thumb.
5. Using the tip of the dispensing lancet puncture the skin at the center of the administration site. Exert pressure on the handle until it is completely depressed and HOLD FOR AT LEAST 1 SEC. DO NOT TWIST
6. Remove the device and dispose of it safely to avoid the possibility of hazard. DO NOT REUSE.
7. Puncture the skin at least once, and only once, at the selected site.

Reaction of results: Readings should be made approximately 48 hours (2 days) from administration of ScavoTest-PPD, under a good light. The diameter of induration in millimeters of the reaction at the largest of the four puncture points should be determined visually and by palpation. The EPIEMA shall be DISREGARDED if the reactions at two or more of the puncture points coalesce, the average diameter of coalesced induration should be recorded.

Following are the recommendations of the American Thoracic Society (ATS) for multiple-puncture tests which were developed prior to the availability of ScavoTest-PPD. Accordingly, for the guidance of the medical practitioner, results of clinical studies obtained with ScavoTest-PPD are also shown.

Vesication = Positive

ATS: The test is interpreted as POSITIVE and the management of the patient is the same as that for one classified as positive to the Mantoux test.

2 mm or More of Induration without Vesication = POSITIVE

ATS: Categorized as DOUBTFUL. Even though reactions in this size range may be due to M tuberculosis, a significant proportion of them may be confirmed by a positive reaction to the standard Mantoux test. This is particularly true of reactions on the low side of this range. Therefore, a standard Mantoux test should be done on all persons in this group, and management should be based on the reaction to the Mantoux test.

Studies with ScavoTest-PPD
Coalesced reaction from two or more points.

In every instance (105 subjects) a coalescence to ScavoTest-PPD was associated with POSITIVE reactions (>10 mm to PPD-S) or with bacteriologically confirmed cases. Analysis of the data showed a Chi Squared test of 9.83 and a P value of 0.001. This probability is high enough to coalescence to ScavoTest-PPD is equivalent to a positive Mantoux reaction.

2 mm or more of induration without coalescence = The ATS recommendations were confirmed for ScavoTest-PPD.

Less than 2 mm of Induration = Negative Reaction

There is no need for retesting unless the person is a contact of a patient with spuhot positive for M tuberculosis or there is clinical evidence suggestive of the disease.

HOW SUPPLIED:
Strip of 1 unit individually blister sealed. Cat. No. 414-04
20 units individually blister sealed strips. Cat. No. 414-16
250 units individually blister sealed strips. Cat. No. 414-17

STORAGE:
ScavoTest-PPD (tuberculin purified protein derivative) may be stored with out refrigeration at a temperature between 2° and 30°C (36° and 86°F).

References:

SCLAVO 1004-1 PRINTED IN USA APRIL '983
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See next page for a brief summary of prescribing information.
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 may contribute to 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 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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A new edition of School Health: A Guide for Health Professionals is now available. "This is a manual that all pediatricians should have in their office if they are engaged in the care of pre-school, elementary and high school children," according to the chairman of the Committee on School Health which revised the book.

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The appendices have a wealth of information on immunization schedules, vision and hearing screening, maturity classification, screening for scoliosis, dental conditions, terminology for heart murmurs, school health appraisal forms, sports field examinations, first aid equipment and supplies, health supervision of food handlers, school policies on first aid and hemoglobin and hematocrit values. 1981 Indexed: 297 pages.

Note AAP Fellows (not Junior Fellows) may receive one free copy by calling 800-323-0797.

Please send me: 

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As is the case with all anticholinergic agents, dosage must be adjusted to the needs and condition of the patients. In dehydrated patients, such as those with diarrhea and vomiting, dosage should be initiated at lower drug levels.

Before prescribing, please consult complete product information, a summary of which follows:

CONTRAINDICATIONS: Glaucoma, obstructive uropathy, obstructive disease of the gastrointestinal tract, paralytic ileus, intestinal atony of the elderly or debilitated patients, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon, complicating ulcerative colitis, myasthenia gravis.

WARNINGS: In the presence of high environmental temperature, heat prostration can occur with drug use. Diarrhea may be an early symptom of incomplete intestinal obstruction. In this instance, treatment with this drug would be inappropriate and possibly harmful. It may produce dryness of the mouth, urinary hesitancy and retention, blurred vision and tachycardia, palpitations, mydriasis, cycloplegia, increased ocular tension, drowsiness, suppression of lactation.

ADVERSE REACTIONS: Dryness of the mouth, urinary hesitancy and retention, blurred vision and tachycardia, palpitations, mydriasis, cycloplegia, increased ocular tension, drowsiness, suppression of lactation.
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- Rheumatic Diseases
- Endocrinology
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- Otolaryngology

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- The Role of Artificial Surfactant Today and in the Future
- Retrolental Fibroplasia
- Hospitals. Newborns and Viruses
- Complications of Breast Feeding
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- Update Meningitis
- The Acquired Immunodeficiency Syndrome: A New Epidemic
- Infections, Diseases in Day Care Centers
- Sexually Transmitted Diseases
- The E. H. Christopherson Lecture on International Child Health
- Environmental Hazards to Children and Adolescents
- Training for Gymnasts
- Extraordinary Joint Plenary Session with American Academy of Child Psychiatry

3 Hour Seminars
- Diabetes Mellitus
- Ophthalmology
- Management of the Complicated Newborn
- Speech and Language Disorders from Birth to Three
- Nephrology Update
- The Family in Pediatric Practice
- Dermatology
- Neurologic Problems of Newborn Infants
- Seizures
- Food Faddism in Pediatric Nutrition
- Failure to Thrive
- Endocrinology
- Learning Disabilities
- Advanced Pulmonary Physiology for Neonatologists
- Adolescent Sexuality
- Infectious Diseases
- Basic Clinical Immunology
- Advanced Immunology
- Acute Diarrheal Diseases
- Cardiac Problems in the Newborn
- Fluid and Electrolytes
- Overview of Pediatric Urology
- Sports Medicine
- Invasive and Non-invasive Monitoring
- Adolescent Alcohol and Drug Abuse
- Problems of Divorce
- Hematology

Workshops
- Computers in Medicine
- Management of the Pediatric Airway
- Taping and Splinting
- Adolescent Gynecology
- Basic Office Surgery
- Advanced Office Surgery
- Stabilization of the Newborn
- Office Pulmonary Function Testing

Sections
- Workshop: Examining Adolescent Male Genitalia
- The Adolescent, Sports and Practice Growth
- An Update on Asthma
- Management of Cardiac Arrhythmias
- At Risk Infants: Psychological and Developmental Factors
- The Community Pediatrician and Cancer
- New Drugs for Children: 1983
- Pulmonary Update for the Practitioner 1983
- Pediatric Emergencies from Pre-hospital Care to Emergency Room to Intensive Care Unit
- Use and Abuse of Neurodiagnostic Tests
- The Pediatric Airway
- The Problems of Diagnosing and Treating Vacultis

For more information and registration forms, contact: Meeting Registration, American Academy of Pediatrics, PO. Box 1034, Evanston, Illinois 60204. Or call toll-free 800/323-0797
You be the judge. MBF™ has a record of relieving symptoms in cases of:

- Milk intolerance — the most commonly implicated food allergy during infancy.
- Family history of allergies — appropriate for prophylactic feedings or differential diagnosis of milk allergy or intolerance.
- Concurrent soy and milk allergy — as reported in clinical trials.¹,²
- Lactase deficiency — provides symptomatic relief while assuring adequate nutrition.
- Galactosemia — prepared with cane sugar rather than beet sugar to avoid possible traces of galactose.
- Milk-induced steatorrhea — with celiac-like symptoms but traceable to a beta-lacto-globulin intolerance.
- Glycogen storage disease — of the type requiring a galactose-free diet that allows small amounts of levulose.

Price is comparable to that of ready-to-feed soy formulas, and much less than the price of milk hydrolysate products. Distribution is nationwide.

References:
THE SPY IN THE NURSERY FIASCO

A federal judge has just told the federal government to keep its investigators out of the nation’s baby hospitals and pediatric wards. Margaret Heckler, the new HHS secretary, said the government will file an immediate appeal. Please don’t. The Reagan administration has sufficiently embarrassed itself and conservatives generally on this issue without making a further spectacle of itself in the courts.

Early last month the Department of Health and Human Services, acting on orders from President Reagan, notified the nation’s hospitals that on March 22 they would be required to hang in all wards dealing with infants a sign which said in part: “Any person having knowledge that a handicapped infant is being discriminatorily denied food or customary medical care should immediately contact the Handicapped Infant Hotline.” The hotline was a round-the-clock 800 number which rang at HHS in Washington. HHS would then call someone in its regional Office for Civil Rights and send him down to the hospital to check out accusations that a newborn was being maltreated. During the hotline’s short life, HHS fielded some 572 calls, found seven cases worth pursuing and none justifying federal intervention.

To get some understanding of why a genuinely conservative man like Ronald Reagan would order HHS, of all departments, to whip up a big new federal rule to cover something as private as infant care—and with a speed that would have made Harry Hopkins’s head spin—one has to know just how stunted Washington’s view of the world has become.

The rule was enacted after Mr. Reagan learned of an incident in which a handicapped newborn was apparently allowed to die by its parents and an attending physician. Mr. Reagan has a constituency that thinks many of the nation’s most influential thinkers and institutions have lost their bearings on a wide range of social issues—schools, the family, crime, sex and so forth. Right-to-life groups had charged that the problem of denying medical care to handicapped infants is serious and rising. So if the president gets it into his head that the right-to-life people have identified a serious threat to handicapped newborns, why not throw them the bone of a full-blown HHS rule?


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IF HITLER APPLIED FOR A PL-1

We have reduced the letter of recommendation to an academic charade of “Guess what I really mean.”

The dean’s letter, which is supposed to be objective, is just as bad. Only favorable extracts are included; all negative statements are carefully edited out as unobjective. The dean’s letter on Adolph Hitler might have read: “A natural leader ... good communication skills ... assisted in the development of a number of new technical advancements ... did independent work with minority groups ... liked to find solutions to problems ... special interest in mental health ...”

Richard B. Friedman, MD

Educational and scientific programs in pediatric ultrasound will be featured at the 28th Annual Convention of the American Institute of Ultrasound in Medicine to be held at the New York Hilton, October 18-21, 1983. A comprehensive review of current developments in clinical pediatric ultrasound, instrumentation, and bioeffects will be presented. The scientific program will encompass all aspects of diagnostic ultrasound including sessions totally dedicated to pediatric and neonatal ultrasound as well as to related areas including obstetrical and cardiac ultrasound. All scientific and educational sessions are approved for Category I credit from the AMA.

Special features of the 1983 meeting include a SYMPOSIUM ON CONTROVERSIES IN ULTRASOUND which will include discussion of the questions "Is the Routine Obstetrical Sonogram Justified" by Drs. Campbell and Hobbins and "Is the Static Scanner Obsolete" by Drs. Lyons and Winsberg. A Plenary Session dealing with multidisciplinary application of DOPPLER ULTRASOUND will also be held.

To complement this comprehensive educational and scientific program will be the world's largest display of Commercial Ultrasound Equipment, Supplies, and Services, enabling you to view and compare the latest advances in ultrasound equipment and instrumentation.

Plan now to participate in this meeting by requesting registration materials and further program information. Contact:

American Institute of Ultrasound in Medicine
4405 East-West Highway
Suite 504
Bethesda, MD 20814
301-656-6117

Please send registration materials and program information on the 1983 AIUM/SDMS Annual Convention.

Name ____________________________  PED ____________________________
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Viokase® costs your patients less than most other pancreatic preparations
(Based on Drug Topics 1982 Redbook published prices.)

Each 325 mg.
Tablet contains:
Lipase, U.S.P. Units 6,500;
Protease, U.S.P. Units 32,000;
Amylase, U.S.P. Units 48,000

Twenty-Five Year Veteran
in digestive management of cystic fibrosis

"We have used pancreatin (Viokase) in powder or tablet form as an effective product since 1951... The initiation of dietary and pancreatic replacement therapy prior to or with the appearance of early signs of gastrointestinal involvement in the absence of pulmonary symptoms permits nearly normal growth and development. It will diminish the usual complaints of frequent, loose, foul movements, protuberant abdomen and excessive appetite, it will markedly reduce the incidence of rectal prolapse and possibly secondary fecal impaction which may result in intestinal obstruction."**


VIOKASE® (pancreatin)

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

The enzyme potency of the tablets and powder are:

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<th>Each 325 mg.</th>
<th>Each 0.75 gram</th>
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<td>Tablet</td>
<td>Powder</td>
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<tr>
<td>Lipase, U.S.P. Units</td>
<td>6,500</td>
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<td>Protease, U.S.P. Units</td>
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<td>Amylase, U.S.P. Units</td>
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Under conditions of the U.S.P. test method (in vitro) VIOKASE has the following total digestive capacity:

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<th>Each 325 mg.</th>
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<tr>
<td>Dietary Fat</td>
<td>23</td>
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<td>Dietary Starch</td>
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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: ½ 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.