OCTOBER 1984

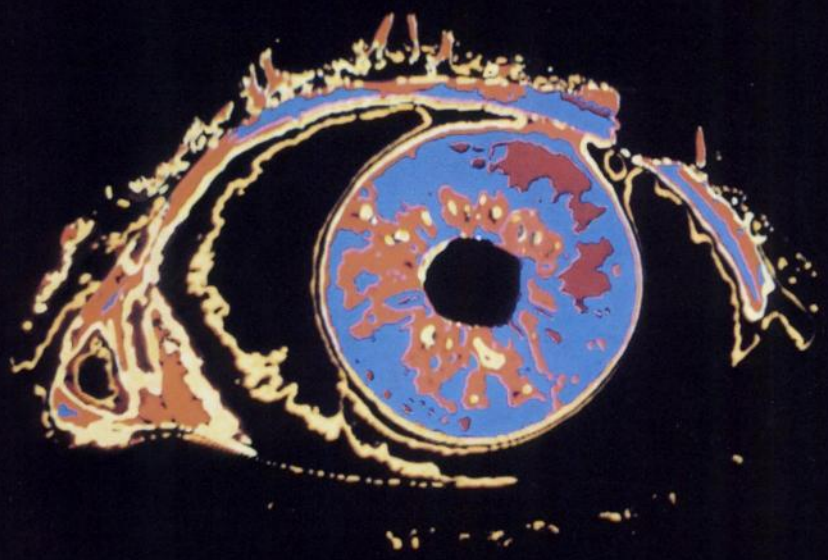
VOLUME 74
NUMBER 4

Pediatrics

AMERICAN ACADEMY OF PEDIATRICS ELK GROVE VILLAGE ILLINOIS 60007

PEDIAU 74(4) pp. 453–572 (1984)

Clears up bacterial hot spots in a hurry.



NEOSPORIN®
OPHTHALMIC

SOLUTION Sterile
(polymyxin B-neomycin-gramicidin) / OINTMENT Sterile
(polymyxin B-bacitracin-neomycin)

The following is a Combined Brief Summary. For complete prescribing information, please consult the full prescribing information in B.W. Co.* literature or the PDR.

NEOSPORIN* OPHTHALMIC OINTMENT Sterile (Polymyxin B Sulfate-Bacitracin Zinc-Neomycin Sulfate)

DESCRIPTION: Each gram contains: Aerosporin* (polymyxin B sulfate) 10,000 units, bacitracin zinc 400 units, neomycin sulfate equivalent to 3.5 mg neomycin base and special white petrolatum, qs.

HOW SUPPLIED: Tube of 1/8 oz with ophthalmic tip. (NDC-0081-0732-86) Store at 15°-30°C (59°-86°F).

NEOSPORIN* OPHTHALMIC SOLUTION Sterile (Polymyxin B Sulfate-Neomycin Sulfate-Gramicidin)

DESCRIPTION: Each ml contains: Aerosporin* (polymyxin B sulfate) 10,000 units, neomycin sulfate equivalent to 1.75 mg neomycin base and gramicidin 0.025 mg. The vehicle contains alcohol 0.5%, thimerosal 0.001% (added as a preservative) and the inactive ingredients propylene glycol, polyoxyethylene polyoxypropylene compound, sodium chloride and water for injection.

HOW SUPPLIED: Drop Dose* of 10 ml (plastic dispenser bottle). (NDC-0081-0728-69) Store at 15°-30°C (59°-86°F) and protect from light.

The information below applies to both the ointment and the solution.

INDICATIONS AND USAGE: For the short term treatment of superficial external ocular infections caused by organisms susceptible to one or more of the antibiotics contained therein.

CONTRAINDICATIONS: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNINGS: The manifestation of sensitization to neomycin are usually itching, reddening and edema of the conjunctiva and eyelid. It may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable, and the patient should be told to discontinue the product if they are observed. These symptoms subside quickly on withdrawing the medication. Neomycin-containing applications should be avoided for the patient thereafter.

PRECAUTIONS:

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

Information for Patients: If redness, irritation, swelling or pain persists or increases, discontinue use and contact your physician. Avoid contaminating the ointment applicator tip or the solution dropper with material from the eye, fingers, or other source. This caution is necessary if the sterility of the product is to be preserved.

ADVERSE REACTIONS: Neomycin Sulfate may cause cutaneous and conjunctival sensitization. A precise incidence of hypersenitivity reactions (primarily skin rash) due to topical neomycin is not known.

Wellcome

BURROUGHS WELLCOME CO.,
Research Triangle Park, NC 27709

84-NEO-4

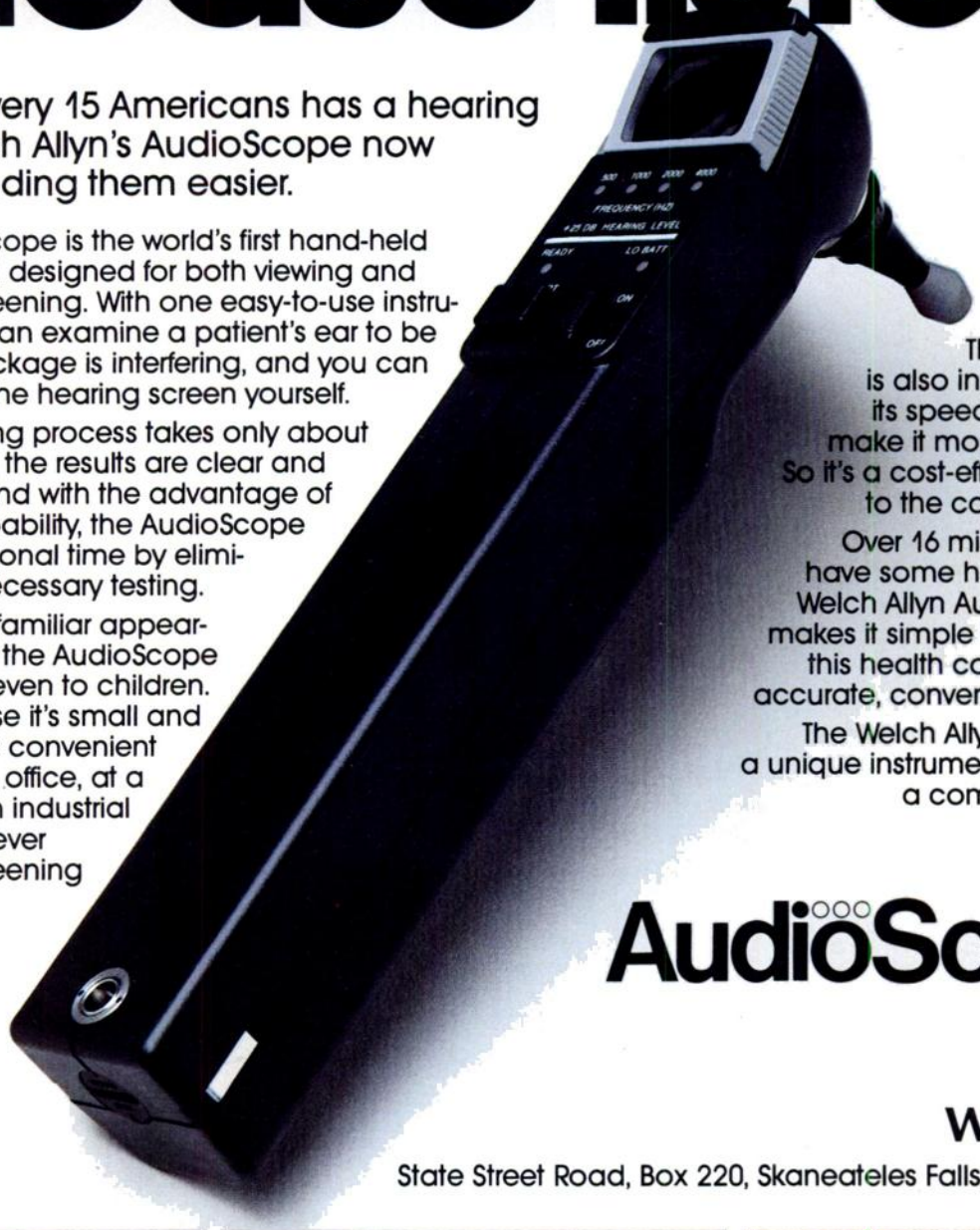
Please listen.

One in every 15 Americans has a hearing loss. Welch Allyn's AudioScope now makes finding them easier.

The AudioScope is the world's first hand-held audiometer, designed for both viewing and hearing screening. With one easy-to-use instrument, you can examine a patient's ear to be sure no blockage is interfering, and you can administer the hearing screen yourself.

The screening process takes only about 15 seconds, the results are clear and accurate, and with the advantage of viewing capability, the AudioScope saves additional time by eliminating unnecessary testing.

Its size and familiar appearance make the AudioScope agreeable even to children. And because it's small and portable, it's convenient to use in an office, at a clinic, on an industrial site — wherever hearing screening is needed.



The AudioScope is also inexpensive, and its speed and precision make it more economical. So it's a cost-effective addition to the care you provide.

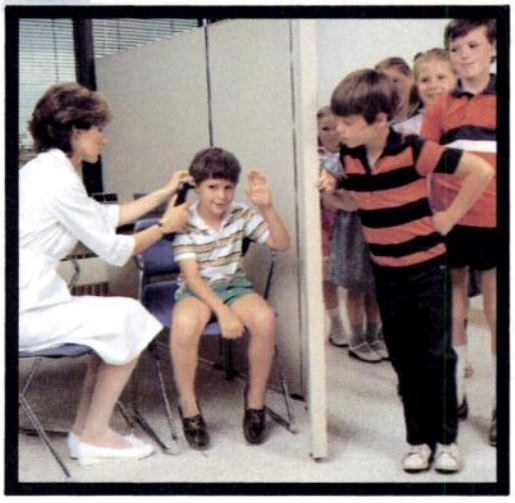
Over 16 million Americans have some hearing loss. The Welch Allyn AudioScope now makes it simple for you to meet this health concern with fast, accurate, convenient screening.

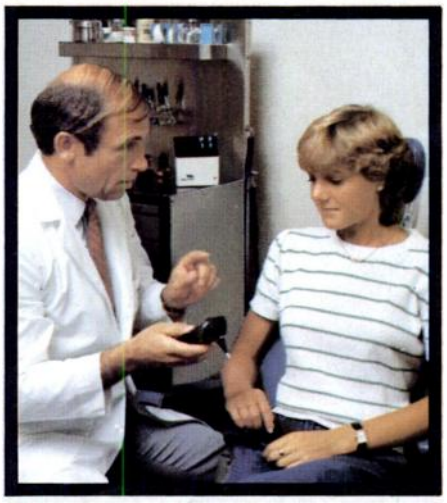
The Welch Allyn AudioScope: a unique instrument for detecting a common problem.

AudioScope™

Welch Allyn

State Street Road, Box 220, Skaneateles Falls, NY 13153-0220
(315) 685-8351





"One two. Buckle my shoe. Three four...."

Suddenly, no more.

Absence seizures don't last very long. But they disrupt the child's school performance so that teachers may think of these children as "inattentive."

Once simple absence seizures are diagnosed, ZARONTIN® (ethosuximide) is the drug of choice for treatment. ZARONTIN has a well-known safety record and has been generally well tolerated. Hepatic toxicity has not been reported.*

Since ZARONTIN has a specific anti-absence seizure effect, it will not mask generalized tonic-clonic activity. More than two decades of clinical experience have helped ZARONTIN earn its reputation.

ZARONTIN®

(ethosuximide, USP)

Capsules 250mg—Syrup 250mg/5mL

The drug of choice[1-3] for absence (petit mal) seizures

*Minor alterations have been observed in some hepatic and renal function tests. Ethosuximide should therefore be administered with extreme caution to patients with known hepatic or renal disease.

REFERENCES: 1. Wilder BJ, Bruni J: *Seizure Disorders: A Pharmacological Approach to Treatment.* New York, Raven Press, 1981, p 98. 2. Green JB: Epilepsy in adolescents and adults, in Conn HF (ed): *Current Therapy 1982.* Philadelphia, WB Saunders Co, 1982, pp 720-726. 3. Fernandez RJ, Samuels MA: Epilepsy, in Samuels MA (ed): *Manual of Neurologic Therapeutics with Essentials of Diagnosis.* Boston, Little Brown & Co, 1981, pp 75-117.

PARKE-DAVIS

Please see next page for brief summary of prescribing information.

ZARONTIN® (ethosuximide capsules, USP)

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

INDICATION: Zarontin is indicated for the control of absence (petit mal) epilepsy.
CONTRAINDICATION: Ethosuximide should not be used in patients with a history of hypersensitivity to succinimides.
WARNINGS: Blood dyscrasias, including some with fatal outcome, have been reported to be associated with the use of ethosuximide; therefore, periodic blood counts should be performed.

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

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

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

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

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

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

Hazardous Activities: Ethosuximide may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as driving a motor vehicle or other such activity requiring alertness; therefore, the patient should be cautioned accordingly.
PRECAUTIONS: Ethosuximide, when used alone in mixed types of epilepsy, may increase the frequency of grand mal seizures in some patients.

As with other anticonvulsants, it is important to proceed slowly when increasing or decreasing dosage, as well as when adding or eliminating other medication. Abrupt withdrawal of anticonvulsant medication may precipitate absence (petit mal) status.
ADVERSE REACTIONS: Gastrointestinal System: Gastrointestinal symptoms occur frequently and include anorexia, vague gastric upset, nausea and vomiting, cramps, epigastric and abdominal pain, weight loss, and diarrhea.

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

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

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

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

0237GO20

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

PD-12-JA-1790-P-1(9-83)

MANUSCRIPT PREPARATION

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

Manuscripts for *Pediatrics* will be accepted for review with the stipulation that they are being submitted only to the American Academy of Pediatrics and that the material has not been previously published. This should be confirmed by an accompanying written statement. Once a manuscript has been reviewed and accepted for publication, the author(s) will receive a standard Copyright Assignment which should be read, signed, and returned to the Editor as soon as possible to avoid delay in the publication process.

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 × 27.9 cm (8½ × 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 unavoidable, will be indicated by capitalization of the first letter. Conversions to accepted standards and terms should be made before the manuscript is submitted.

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

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

References must be numbered consecutively according to their citation in the text. Abbreviations for journals should be those listed in *Index Medicus*. The following reference style (a modified form of that shown in "Uniform Requirements for Manuscripts Submitted to Biomedical Journals") will appear in the journal effective with volume 71 (January 1983 issue):

Journal (list first three authors then et al):

1. Starzl TE, Klintmalm GBG, Porter KA, et al: Liver transplantation with use of cyclosporin A and prednisone. *N Engl J Med* 1981; 305:266–269

Book

1. Kavet J: Trends in the utilization of influenza vaccine: An examination of the implementation of public policy in the United States, in Selby P (ed): *Influenza: Virus, Vaccines, and Strategy*. New York, Academic Press Inc, 1976, pp 297–308

Tables must be comprehensible to the reader without reference to the text and typed (double-spaced) rather than photographed. Each table should be typed on a separate sheet, be numbered consecutively, and have a brief title. Care should be taken to make tables as concise and brief as possible.

Illustrations—Photographs of line drawings and any other figures that are not composed simply of letters, numerals, and routine symbols must be furnished. Do not send original artwork or printed forms. A reasonable number of black-and-white illustrations will be printed from black-and-white glossies or film without charge.

Each illustration should be identified on its back, indicating the number, author's name, and "top." They should be keyed in the text. If unessential, their omission may be requested. The prints should not be stapled, clipped together, mounted, or trimmed. Details to be emphasized or crop marks should be indicated on a tissue overlay, not on the illustration itself. Illustrations of poor quality may be returned for improvement. Photographs of patients should be submitted *only* when written parental permission has been obtained. It is the responsibility of the authors to obtain this permission and to keep it in their files. If a figure has been published, acknowledge the original source and obtain written permission for its use from the copyright holder. Use cardboard inserts to protect illustrations in the mail. Legends for figures are to be on a separate sheet.

Color illustrations and other special processing involve extra costs that are usually borne by the author. Manuscripts containing such materials will not be processed until arrangements for payment, on the basis of estimated prices, are made. Color work requires one month longer for production.

Statistical Guidelines—Authors should consult Altman DG, et al: Statistical guidelines for contributors to medical journals. *Br Med J* 1983;286:1485–1488 for advice concerning the presentation of the statistical aspects of studies.

Revised, January 1984

PEDIATRICS (ISSN 0031 4005) is owned and controlled by the American Academy of Pediatrics. It is published monthly by the American Academy of Pediatrics, Pediatrics, P.O. Box 927, Elk Grove Village, IL 60007.

Subscription price per year: U.S., $42.00; other countries, $52.00. Special rate for medical students, hospital residents and Fellows in full-time training in U.S., $28.00 per year. Renewal at special rate beyond two years will require a letter from an appropriate authority stating the individual's eligibility. Air mail delivery available outside U.S. and Canada for an additional $55 per year. Please allow 6–8 weeks for delivery of first issue. Single issues $5.50. Payment must accompany order.

Second-class postage paid at ELK GROVE VILLAGE, ILLINOIS 60007 and at additional mailing offices.

MANUSCRIPT PREPARATION

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

Manuscripts for *Pediatrics* will be accepted for review with the stipulation that they are being submitted only to the American Academy of Pediatrics and that the material has not been previously published. This should be confirmed by an accompanying written statement. Once a manuscript has been reviewed and accepted for publication, the author(s) will receive a standard Copyright Assignment which should be read, signed, and returned to the Editor as soon as possible to avoid delay in the publication process.

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 × 27.9 cm (8½ × 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 unavoidable, will be indicated by capitalization of the first letter. Conversions to accepted standards and terms should be made before the manuscript is submitted.

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

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

References must be numbered consecutively according to their citation in the text. Abbreviations for journals should be those listed in *Index Medicus*. The following reference style (a modified form of that shown in "Uniform Requirements for Manuscripts Submitted to Biomedical Journals") will appear in the journal effective with volume 71 (January 1983 issue):

Journal (list first three authors then et al):

1. Starzl TE, Klintmalm GBG, Porter KA, et al: Liver transplantation with use of cyclosporin A and prednisone. *N Engl J Med* 1981; 305:266–269

Book

1. Kavet J: Trends in the utilization of influenza vaccine: An examination of the implementation of public policy in the United States, in Selby P (ed): *Influenza: Virus, Vaccines, and Strategy*. New York, Academic Press Inc, 1976, pp 297–308

Tables must be comprehensible to the reader without reference to the text and typed (double-spaced) rather than photographed. Each table should be typed on a separate sheet, be numbered consecutively, and have a brief title. Care should be taken to make tables as concise and brief as possible.

Illustrations—Photographs of line drawings and any other figures that are not composed simply of letters, numerals, and routine symbols must be furnished. Do not send original artwork or printed forms. A reasonable number of black-and-white illustrations will be printed from black-and-white glossies or film without charge.

Each illustration should be identified on its back, indicating the number, author's name, and "top." They should be keyed in the text. If unessential, their omission may be requested. The prints should not be stapled, clipped together, mounted, or trimmed. Details to be emphasized or crop marks should be indicated on a tissue overlay, not on the illustration itself. Illustrations of poor quality may be returned for improvement. Photographs of patients should be submitted *only* when written parental permission has been obtained. It is the responsibility of the authors to obtain this permission and to keep it in their files. If a figure has been published, acknowledge the original source and obtain written permission for its use from the copyright holder. Use cardboard inserts to protect illustrations in the mail. Legends for figures are to be on a separate sheet.

Color illustrations and other special processing involve extra costs that are usually borne by the author. Manuscripts containing such materials will not be processed until arrangements for payment, on the basis of estimated prices, are made. Color work requires one month longer for production.

Statistical Guidelines—Authors should consult Altman DG, et al: Statistical guidelines for contributors to medical journals. *Br Med J* 1983;286:1485–1488 for advice concerning the presentation of the statistical aspects of studies.

Revised, January 1984

PEDIATRICS (ISSN 0031 4005) is owned and controlled by the American Academy of Pediatrics. It is published monthly by the American Academy of Pediatrics, Pediatrics, P.O. Box 927, Elk Grove Village, IL 60007.

Subscription price per year: U.S., $42.00; other countries, $52.00. Special rate for medical students, hospital residents and Fellows in full-time training in U.S., $28.00 per year. Renewal at special rate beyond two years will require a letter from an appropriate authority stating the individual's eligibility. Air mail delivery available outside U.S. and Canada for an additional $55 per year. Please allow 6–8 weeks for delivery of first issue. Single issues $5.50. Payment must accompany order.

Second-class postage paid at ELK GROVE VILLAGE, ILLINOIS 60007 and at additional mailing offices.

First Class First Aid

• Broad-spectrum antibacterial • Handy applicator tip

DESCRIPTION: Each gram contains: Aerosporin* (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and ½ oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

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

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

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

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

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

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

OCTOBER 1984 VOL. 74 NO. 4

Pediatrics

OFFICIAL PUBLICATION OF THE AMERICAN ACADEMY OF PEDIATRICS

PUBLISHER
American Academy of Pediatrics
Linda Napora, Copy Editor

PEDIATRICS (ISSN 0031 4005) is owned and controlled by the American Academy of Pediatrics. It is published monthly by the American Academy of Pediatrics, P.O. Box 927, Elk Grove Village, IL 60007.

Subscription price per year: U.S., $42.00; other countries, $52.00. Special rate for medical students, hospital residents and Fellows in full-time training in U.S., $28.00 per year. Renewal at special rate beyond two years will require a letter from an appropriate authority stating the individual's eligibility. Air mail delivery available outside U.S. and Canada for an additional $55 per year. Please allow 6–8 weeks for delivery of first issue. Single issues $5.50. Payment must accompany order.

Second-class postage paid at ELK GROVE VILLAGE, ILLINOIS 60007 and at additional mailing offices.

ARTICLES

DEBATE SECTION

ARTICLES continued

WHEN LIFESTYLES RESULT IN MEALS THAT ARE MORE CONVENIENT THAN NUTRITIOUS...

Help provide important vitamins and minerals that today's children may need.

Nearly half of today's mothers with preschool children work,[1] and more than 70% of the mothers in a recent consumer study cited convenience and taste preference as more important than nutrition in choosing foods.[2]

In addition, finicky eating habits may limit the variety of foods—and many nutrients—preschoolers may eat.[3] Recent government data show that *55% of children ages 1 through 5 receive less than 70% of the RDA* for one or more key vitamins or iron.[4]

Now more than ever, your patients may need the nutritional support of Poly-Vi-Sol* Vitamins or Poly-Vi-Flor* Fluoride Vitamin Supplements.*

Recommend daily supplementation with

Poly-Vi-Sol® or Poly-Vi-Flor®

Mead Johnson

NUTRITIONAL DIVISION

Mead Johnson & Company
Evansville, Indiana 47721-0001 U.S.A.

*Available by prescription only

Please see adjacent copy for brief summary of prescribing information

AMERICAN ACADEMY OF PEDIATRICS

141 Northwest Point Road
Elk Grove Village, IL 60007

SCHEDULE OF MEETINGS

ANNUAL MEETINGS

1985
San Antonio, Texas
October 19–24

1986
Washington, DC
November 1–6

1987
New Orleans
October 17–22

1988
San Francisco
October 22–27

Note: All Annual Meetings start on Saturday

PRESCRIBE LURIDE®
...when children need supplemental fluoride.

Adjustable dosage lets you accurately prescribe for each patient's age and water fluoridation level.

Luride drops and tablets meet all your criteria for precise titration. And Luride gives you the flexibility to prescribe the most desirable systemic fluoride dosage depending on your patients' needs. Available in increments of 0.125 (⅛) mg. F.

Plus, with Luride, you don't have the problem that may occur with fluoride-vitamin combinations. That is, recommending optimum fluoride levels may alter desired vitamin intake, while maintaining optimum vitamin levels may result in too little or too much fluoride.

For your patients' welfare, prescribe Luride drops for infants, Luride Lozi-Tabs® tablets for older children.

Accepted COUNCIL on DENTAL THERAPEUTICS AMERICAN DENTAL ASSOCIATION

This advertisement has been reviewed for compliance with the advertising standards of the American Dental Association.

For complete product information call Hoyt, toll free: 1-800-225-3756

Mass. residents call collect: 617-769-6850.

COLGATE hoyt

COLGATE-HOYT LABORATORIES/575 UNIVERSITY AVE./NORWOOD, MA 02062 U.S.A.
Division of Colgate-Palmolive Company

LURIDE® DROPS let you titrate dosage to 0.125 (⅛) mg. F.

One study showed that fluoride supplements such as Luride drops and tablets, used daily, prevented caries as effectively as fluoridated water.[1] Luride Drops and Lozi-Tabs have been shown to reduce caries up to 80% when used on a daily basis in non-fluoridated areas.[2] (Luride DMFS = 1.57, Control = 7.93)

Luride Drops are sugar-free and saccharin-free, unlike many fluoride-vitamin combinations. And you can titrate dosage to the nearest 0.125 mg. F—to a single ⅛ mg. drop.

LURIDE® LOZI-TABS® TABLETS: 3 fluoride strengths, 7 child-pleasing flavors.

For children old enough to chew a tablet or let it dissolve in the mouth, Luride tablets are the logical choice. A variety of delicious fruit flavors (including our unique 4-flavor assorted package) encourages the habit of consistent, continuous use. Three strengths available—1.0 mg. F, 0.5 mg. F, and 0.25 mg. F.

LURIDE® BRAND OF SODIUM FLUORIDE DENTAL CARIES PREVENTIVE.
DESCRIPTION and HOW SUPPLIED:
All LURIDE systemic fluoride products are free of sugar and saccharin.

Product	Strength (F ION)	Package Size	Flavor
DROPS	0.125 mg. per drop	30 ml	peach
0.25 F TABLETS	0.25 mg. per tablet (quarter-strength)	120	vanilla
0.5 F TABLETS	0.5 mg. per tablet (half-strength)	120 1200*	grape grape
1.0 F TABLETS	1.0 mg. per tablet (full-strength)	120 1000* 5000*	cherry & assorted (cherry, orange, lemon, lime) cherry & assorted cherry
SF 1.0 F TABLETS	1.0 mg. per tablet (full-strength)	120	Special Formula, no artificial flavor or color.

*For dispensing only in quantities containing 120 mg. F. or less.
CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

ADMINISTRATION AND DOSAGE FLEXIBILITY:
Adjustable dose LURIDE gives you the flexibility to prescribe optimal DAILY dosage (based on age and fluoride content of water).

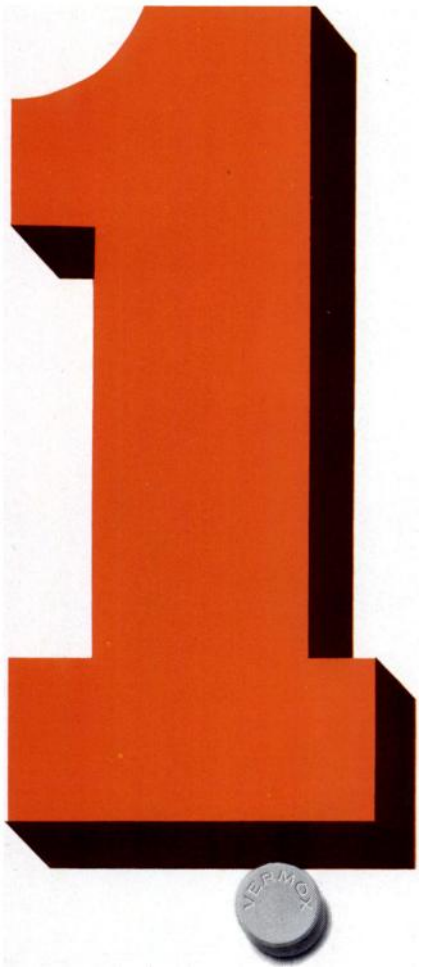
F-Content of Drinking Water	Daily Dosage (Fluoride Ion)* Birth to Age 2	Age 2-3	Age 3-13
less than 0.3 ppm	0.25 mg. tab or 2 drops	0.5 mg. tab or 4 drops	1.0 mg. tab or 8 drops
0.3 to 0.7 ppm	one-half above dosage		
over 0.7 ppm	Fluoride dietary supplements contraindicated		

*American Dental Association, Accepted Dental Therapeutics, Edition 39 1982, page 349. American Academy of Pediatrics, Committee on Nutrition, Fluoride supplementation: revised dosage schedule. Pediatrics 63:150-152, 1979.

PRECAUTIONS: Recommended dosage should not be exceeded since prolonged overdosage may result in dental fluorosis.

REFERENCES:
(1) Arnold F.A. Jr., McClure, F.J., and White, C.L. Sodium fluoride tablets for children. D. Progress 1:8-12, 1960.

(2) Aasenden, R., and Peebles, T.C. Effects of fluoride supplementation from birth on human deciduous and permanent teeth. Arch. Oral Biol. 19:321-326, 1974; 23:111-115, 1978.



No need to count higher

No dosage calculations

The same dose for children and adults

VERMOX®
(mebendazole)
CHEWABLE TABLETS

JANSSEN PHARMACEUTICA
Piscataway, NJ 08854

 JPI-451

AMERICAN ACADEMY OF PEDIATRICS

141 Northwest Point Road
Elk Grove Village, IL 60007

SCHEDULE OF MEETINGS

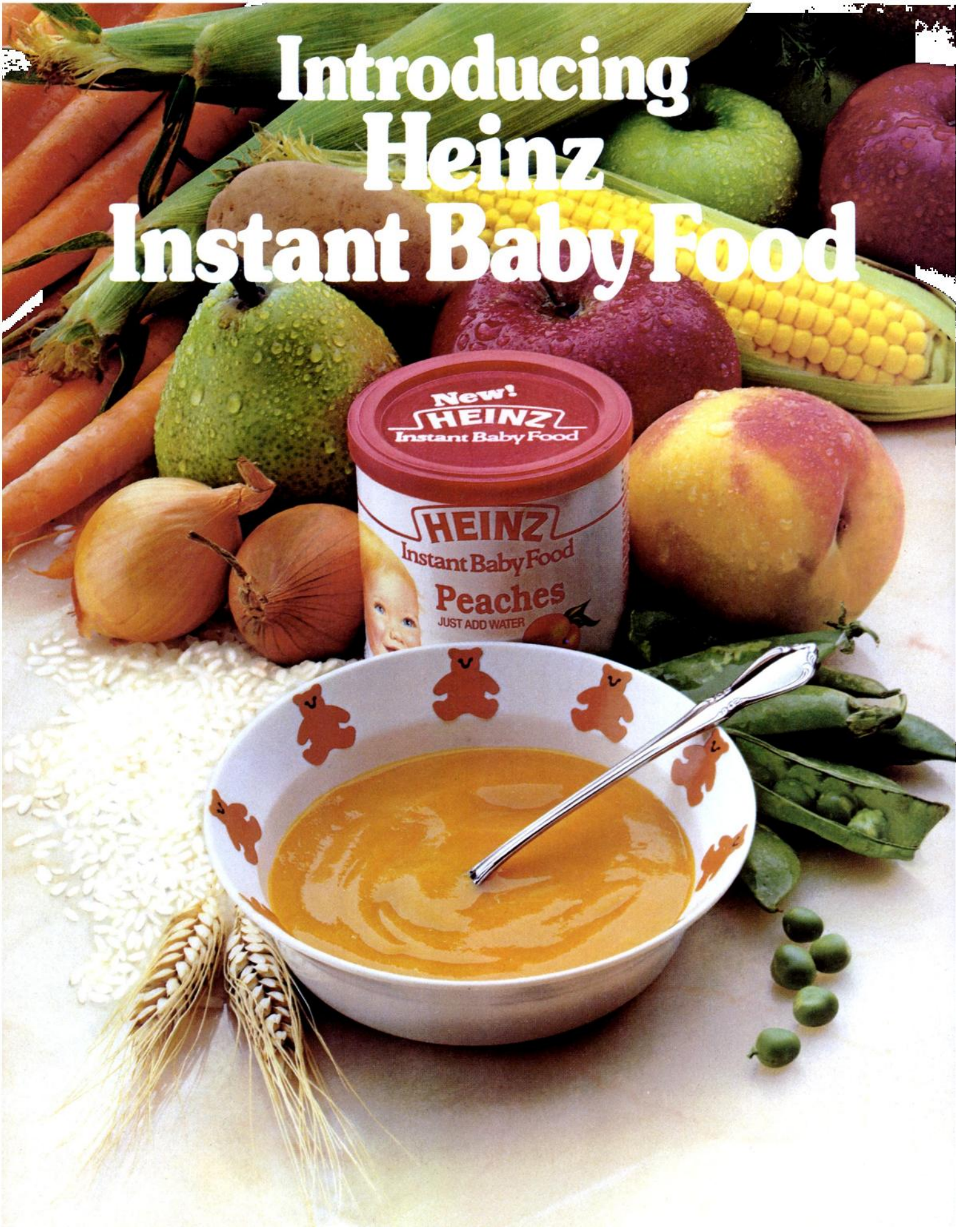
SPRING SESSIONS

1985
Atlanta
April 13–18

1986
Orlando, Florida
April 12–17

1987
San Francisco
May 8–14

Note: All Spring Sessions start on Saturday


Introducing
Heinz
Instant Baby Food
New!
HEINZ
Instant Baby Food
HEINZ
Instant Baby Food
Peaches
JUST ADD WATER

HNQ-033/84

Solid advantages for baby and parents

All the nutrition of jarred baby foods... without all the waste

The nutrition babies need

Solid nutrition—that's what growing babies need. And that's what Heinz gives them, because Heinz Instant Baby Foods are just as nutritious as jarred foods. And our 23 delicious varieties of fruits, vegetables, dinners, cereals with fruit, and fruit combinations make Heinz Instant Baby Foods a complete replacement for strained foods.

No added sugar, salt, or modified starch

Heinz adds:

- NO sugar
- NO salt
- NO modified starch or tapioca
- NO preservatives
- NO artificial flavors
- NO artificial colors
- NO MSG

to any variety.

Less waste than jarred foods... mixed fresh every time

Because parents mix only as much as baby needs, Heinz Instant Baby Foods are fresh every time. There are no jarred leftovers to be refrigerated and sometimes thrown away. And less waste means greater value for parents. Also, by adding more or less water, parents can make the food thinner for baby's initial feedings, and thicker as baby learns the technique of eating solid foods.

The convenience parents want

Heinz Instant Baby Foods come in lightweight, unbreakable canisters containing two or more servings each, so they're easy to carry and convenient for travelling. The stackable canisters reseal tightly with a convenient plastic lid to keep Heinz Instant Baby Foods fresh up to 2 weeks after opening when stored in a cool, dry place. And, unlike jarred leftovers, Heinz Instant Baby Foods never require refrigeration.

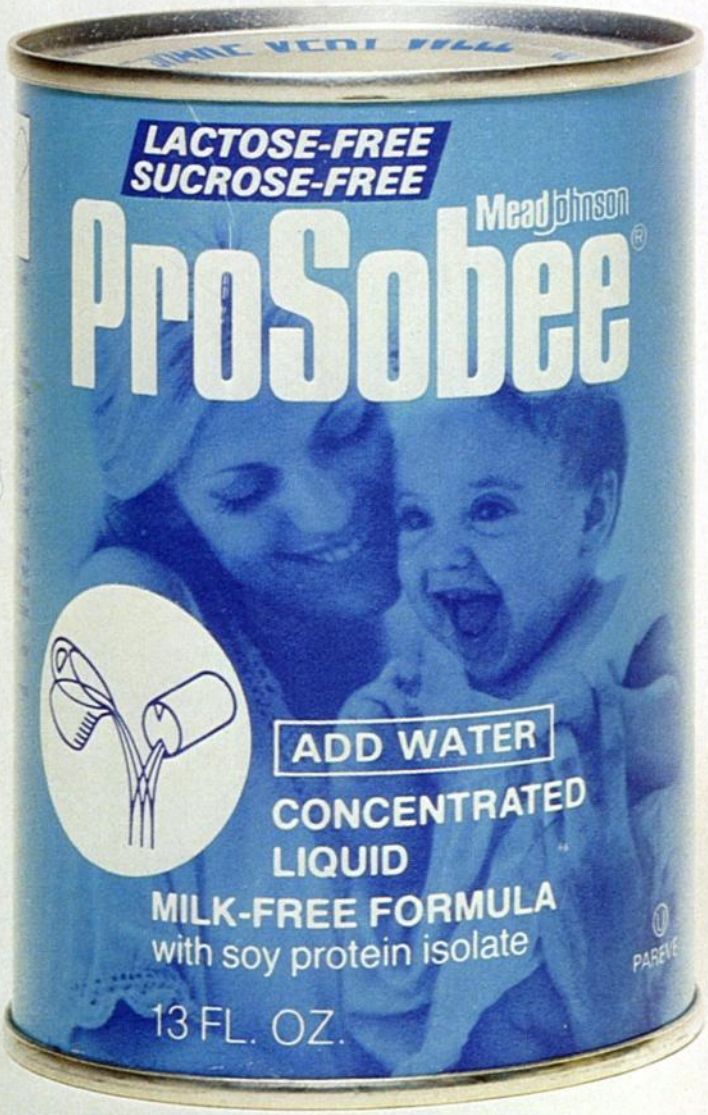
Available in limited areas.

New Heinz Instant Baby Food

A fresh approach to infant nutrition

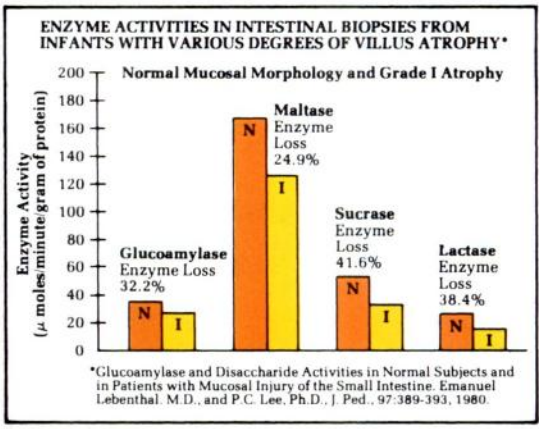
Heinz

When Making Your Next Soy Formula Specification:



1. Consider enzyme activity.

Glucoamylase and maltase are more active than the more fragile brush border enzymes sucrase and lactase in infants with gastrointestinal illness (Grade I villus atrophy).



2. Choose the most compatible carbohydrate source.

Glucose polymers is the most compatible carbohydrate for infants with everyday feeding problems associated with gastrointestinal illness because it is digested by glucoamylase and maltase—the enzymes most resistant to mucosal injury.

3. Specify ProSobee.

The carbohydrate in ProSobee is 100% glucose polymers*—the most compatible carbohydrate because it avoids reliance on the more fragile brush border enzymes.

LACTOSE-FREE
SUCROSE-FREE

ProSobee®

with 100% glucose polymers

for everyday feeding problems associated with milk sensitivity

Mead Johnson
NUTRITIONAL DIVISION

Now alcohol free

CHILDREN'S TYLENOL®

acetaminophen

for fever and pain relief you've come to depend on

ALCOHOL FREE

INFANTS' TYLENOL® DROPS
(80 mg/dropperful)
For newborns and infants

ALCOHOL FREE

CHILDREN'S TYLENOL® ELIXIR
(160 mg/5 ml)
For preschoolers

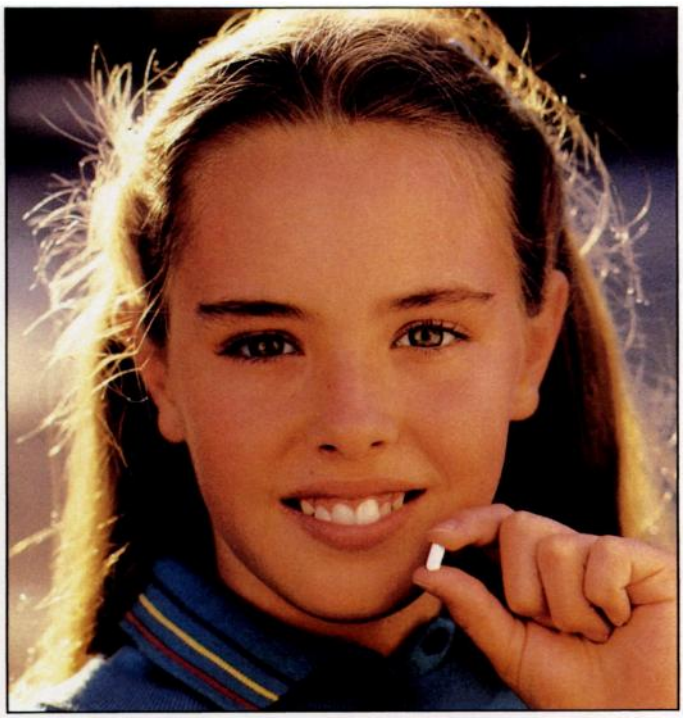
CHILDREN'S TYLENOL® CHEWABLE TABLETS
(80 mg/tablet)
For younger school-age children

JUNIOR STRENGTH TYLENOL®

160 mg acetaminophen

SWALLOWABLE TABLETS

the first fever and pain reliever specifically designed for the 6-14 year-old



Easy to dose...easy to swallow

McNeil Consumer Products Company
Fort Washington, PA 19034

McNEIL

The hand-held Acoustic Otoscope is lightweight, portable, battery-operated–activated by a single push button.

Testing for middle ear fluid– it's a whole lot faster, and a lot more fun, than it used to be.

With the Acoustic Otoscope,™ you can test for middle ear effusions and get reproduceable results in seconds. The Acoustic Otoscope auditory impedance tester, from Endeco Medical, represents a major breakthrough in fluid-diagnosis technology for diagnosing, screening and monitoring children of all ages.

Unlike conventional fluid testing devices, the Acoustic Otoscope measures *reflected sound waves* from the middle ear, using quarter wavelength cancellation.[1] It gives instant, accurate results, even through partial cerumen blockage. There is no seal, no pressure, no pain. The tip never enters the ear canal.

And if the child is crying? It really doesn't matter. The Acoustic Otoscope has a built-in noise detector. Readings caused by external sounds are automatically discarded while new readings are taken until one is found with no outside interference. The child may even *stop* crying when he hears our "chirping bird."

We want you to be right–as right as you can be. Normal-looking asymptomatic ears aren't always what they appear to be. That's why we developed the Acoustic Otoscope, and tested it three years under realistic conditions.[1][2] Now you can test *all* of your patients for middle ear fluid–routinely, accurately and efficiently. And you can track them visit to visit. (For permanent record-keeping, the Acoustic Otoscope is available with print-out capability.)

Detailed information or personal demonstration available on request. Call toll-free 1-800-325-3015. (In Massachusetts, call 1-617-748-2117.) Or write: Endeco Medical, 13 Atlantis Drive, Marion, MA 02738. Telex: 929451.

ENDECO MEDICAL

(1) Teele DW, Teele J: Detection of Middle Ear Effusion by Acoustic Reflectometry. (J. Pediatr. **104**:832, 1984) (2) Additional data on file, ENDECO MEDICAL.

Can you identify the salt-sensitive baby?

Because no one can, it makes sense to provide a natural sodium level for all healthy, bottle-fed babies

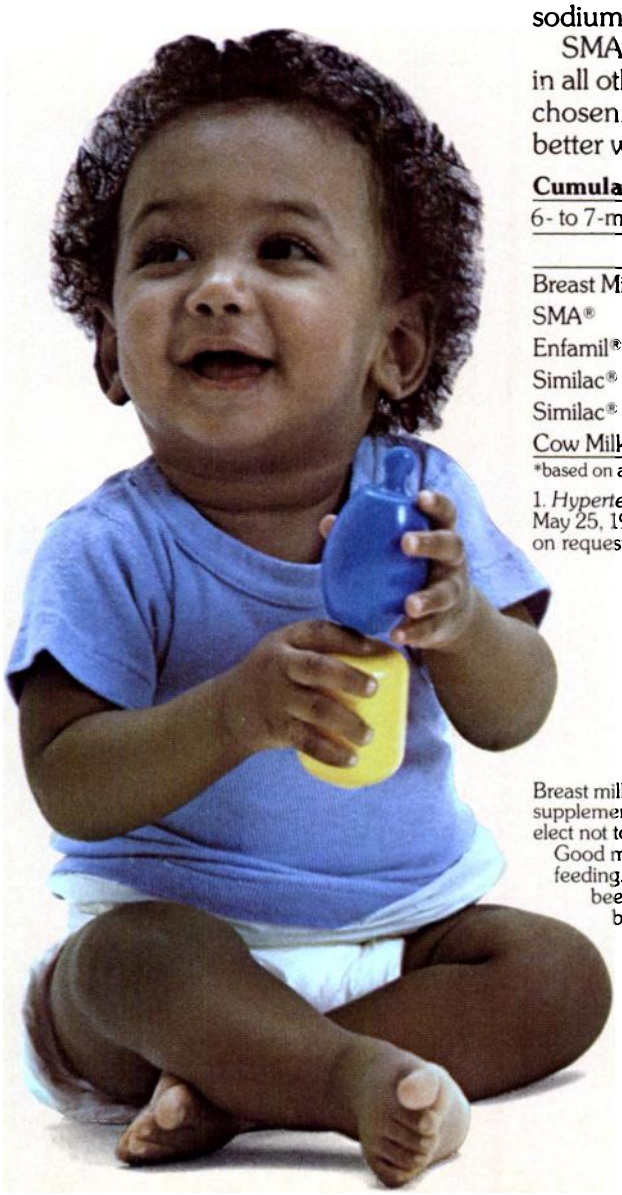
Most pediatricians would agree that breast milk provides the ideal amount of sodium—and, therefore, may help protect against the development of adult hypertension, a disease that afflicts 20 percent of the adult population.

It would be reasonable, then, to reduce the sodium intake to the level found in breast milk for bottle-fed babies who are salt-sensitive and/or genetically predisposed to hypertension. But since no one can now identify such infants, the most prudent course is to modify sodium intake for *all* healthy, bottle-fed babies—beginning at birth.[1] For this reason, Wyeth has created the Salt Modification Action Plan (SMAP™), a "family" program to help modify your patients' salt intake.

Only SMA® has a natural sodium level

SMA contains 15 mg of sodium per 100 ml, the closest to breast milk. The other infant formulas have approximately 1½ times the sodium of breast milk or SMA, while cow milk has approximately 3½ times the sodium of breast milk or SMA (see table).

SMA is closest to breast milk not only in sodium content, but also in all other nutritional components. When breast-feeding is not chosen, you can recommend SMA with confidence that there is no better way to meet your total nutritional goals for your patients.



Cumulative difference of sodium intake

6- to 7-month-old infant

	mg/100 ml	mg/month*
Breast Milk	15	**3780**
SMA®	15	**3780**
Enfamil®	21	**5292**
Similac® with whey	23	**5796**
Similac®	23	**5796**
Cow Milk	52	**13104**

*based on approximately 210 ml/feeding, 4 feedings/day, times 30 days.

1. *Hypertension: Prevention, Diet and Treatment in Infancy and Childhood.* Symposium, May 25, 1983, Bethesda, MD. (Monograph available through your Wyeth Representative or on request.)

SMA® INFANT FORMULA

a natural sodium level

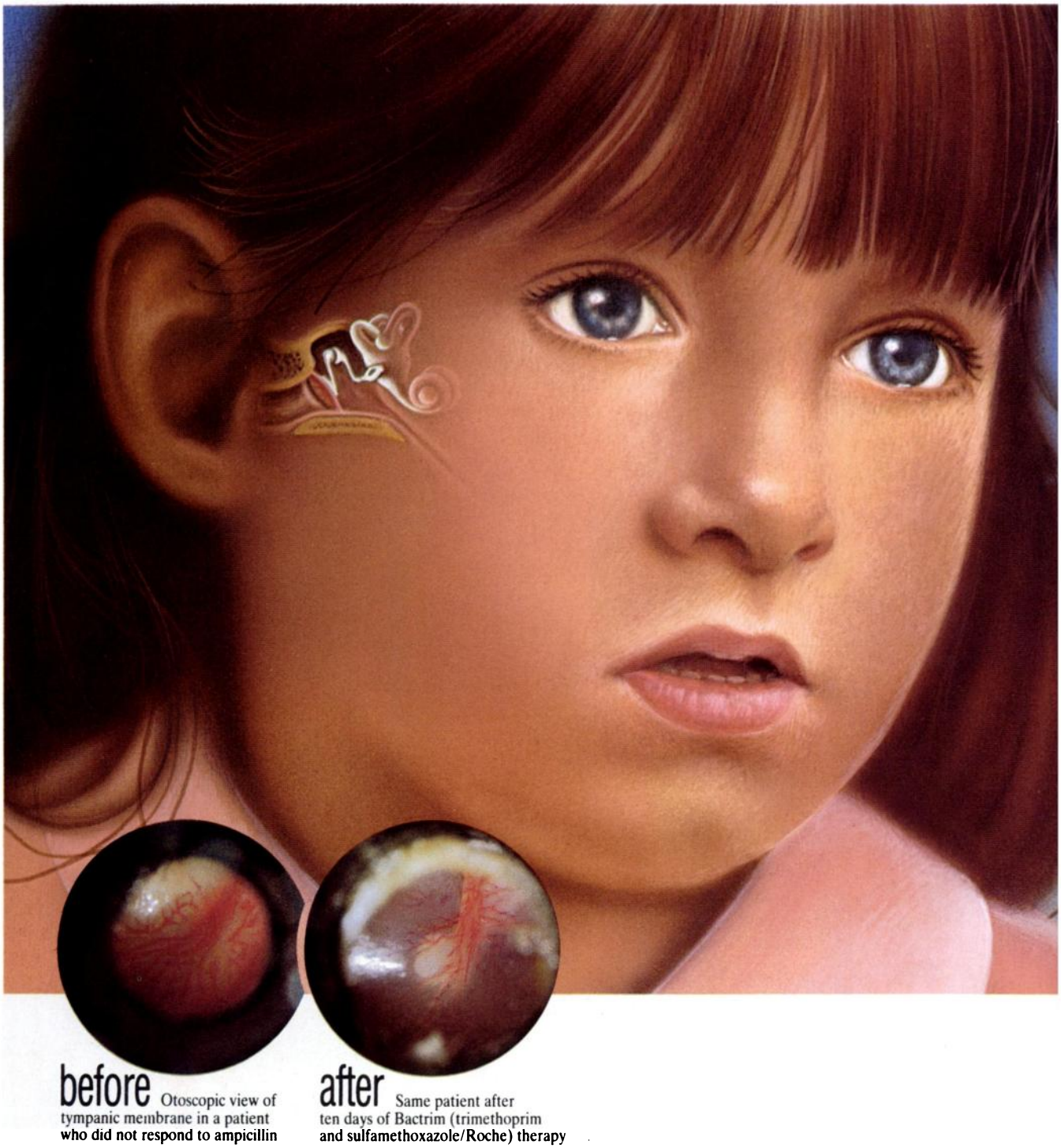
Breast milk is the preferred feeding for newborns. Infant formula is intended to replace or supplement breast milk when breast-feeding is not possible or is insufficient, or when mothers elect not to breast-feed.

Good maternal nutrition is important for the preparation and maintenance of breast-feeding. Extensive or prolonged use of partial bottle-feeding, before breast-feeding has been well established, could make breast-feeding difficult to maintain. A decision not to breast-feed could be difficult to reverse.

Professional advice should be followed on all matters of infant feeding. Infant formula should always be prepared and used as directed. Unnecessary or improper use of infant formula could present a health hazard. Social and financial implications should be considered when selecting the method of infant feeding.

Wyeth Laboratories
Philadelphia, PA 19101
Pioneers in Infant Nutrition™

Strong on results.



before Otoscopic view of tympanic membrane in a patient who did not respond to ampicillin

after Same patient after ten days of Bactrim (trimethoprim and sulfamethoxazole/Roche) therapy

Simple to take.

ROCHE

in acute otitis media

- **Penetrates and clears middle-ear fluid of susceptible strains of *H. influenzae* and *S. pneumoniae*[1]**
- **Reduces evidence of inflammation and bulging eardrum[2]**
- **Results in a reduction of fever, pain and other symptoms[2,3]**

Active against 86% of *H. influenzae in vitro*—even amoxicillin- and ampicillin-resistant strains

Overall, 86% of *Haemophilus influenzae* strains taken from sputum cultures prove susceptible *in vitro* to Bactrim.[4] In one study, 100% of 191 ampicillin-resistant *H. influenzae* isolates were susceptible to Bactrim.[5] However, *in vitro* data do not necessarily correlate with clinical results.

Active against 91% of *S. pneumoniae in vitro*

In sputum cultures of *Streptococcus pneumoniae*, the most frequent pathogen in acute otitis media, 91% of isolates show susceptibility *in vitro* to Bactrim.[4]

Excellent clinical activity—and economical

In comparative clinical trials in children with acute otitis media, Bactrim *b.i.d.* was unsurpassed by ampicillin, amoxicillin or cefaclor.[6]
And the average cost of Bactrim is lower than that of cefaclor and comparable to that of ampicillin and amoxicillin.[7]
Bactrim is indicated in acute otitis media due to susceptible organisms when it offers an advantage over other antimicrobials. Bactrim is contraindicated in pregnancy, lactation, infants under two months of age and documented megaloblastic anemia due to folate deficiency.

Cherry-flavored suspension

Bactrim™ Pediatric

(trimethoprim and sulfamethoxazole/Roche)

B.I.D. for enhanced compliance.

Please see references and summary of product information on following page.

References: 1. Klimek JJ *et al: J Pediatr* 96:1087-1089, Jun 1980. 2. Schwartz RH *et al: Rev Infect Dis* 4:514-516, Mar-Apr 1982. 3. Cooper J, Inman JS, Dawson AF: *Practitioner* 217:804-809, Nov 1976. 4. Antibiotic Sensitivity Report, Winter 1983. BAC-DATA Medical Information Systems, Inc. 5. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 6. Wormser GP, Keusch GT, Heel RC: *Drugs* 24:459-518, Dec 1982. 7. *Med Lett Drugs Ther* 23:93-95, Oct 30, 1981.

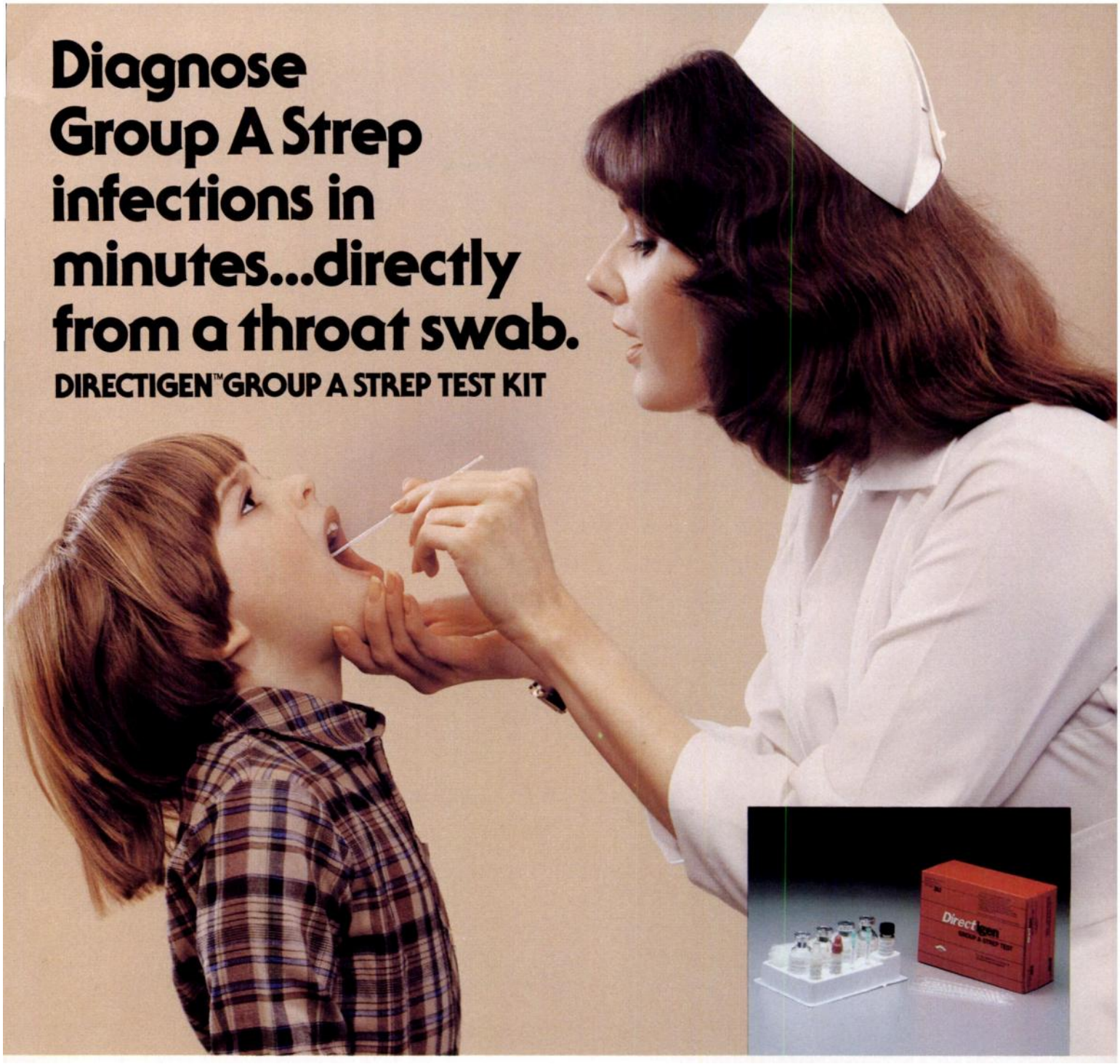
BACTRIM™ (trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Diagnose Group A Strep infections in minutes...directly from a throat swab.

DIRECTIGEN™ GROUP A STREP TEST KIT



Highly sensitive, highly specific, very accurate
- Greater than 94% overall clinical accuracy

Non-growth dependent
- Tests directly from throat swabs
- Detects Group A Strep where cultures may be negative[1]
- Rapid, dependable results in minutes

Rapid identification
- Superior antibody/antigen technology to specifically detect Group A *Streptococcus* in minutes
- Physicians get fast, accurate information for timely therapeutic decisions

Specific, effective early treatment
- DIRECTIGEN reactions are fast, specific, easy-to-interpret
- Specific therapy can precede the 24 to 48 hours now required by conventional methods
- Helps prevent the prescription of unnecessary antibiotics

ALSO AVAILABLE:
The DIRECTIGEN Meningitis System includes the Directigen Meningitis Test Kit, the Directigen *Neisseria Meningitidis* Group B Test Kit and the Directigen Group B Strep Test Kit, which simultaneously detect and identify the most clinically significant meningitis pathogens in minutes.

THE DIRECTIGEN DIFFERENCE:
An ongoing commitment to provide answers in minutes... not hours
Directigen utilizes sophisticated biotechnology in a simple, rapid test format yielding more timely, accurate results.

1. In a laboratory study, the Directigen test detected Group A Strep which could not be recovered by culture after exposure to over-the-counter throat remedies.

Directigen™

Sensitivity with Simplicity

Hynson, Westcott & Dunning
Chase and Charles Streets
Baltimore, Maryland 21201
Toll Free (800) 638-1532

BECTON DICKINSON

BOOKS RECEIVED

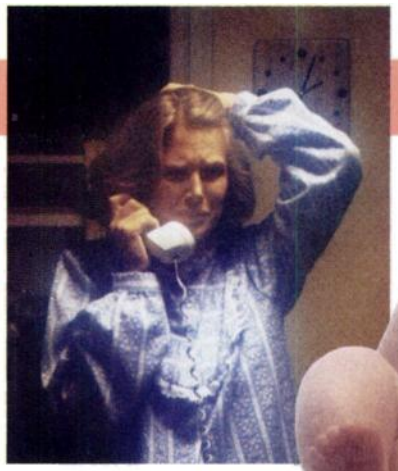
Handbook of Pediatric Primary Care, ed 2. M. P. Chow, et al. New York, John Wiley & Sons, Inc, 1984, $36.95, 1300 pp.
Vitamine De et Maladies des os et du Metabolisme Mineral. A. Fournier, et al. Paris, Masson, 1984, 316 pp.
Clinical Atlas of Human Chromosomes, ed 2. J. de Grouchy and C. Turleau. New York, John Wiley & Sons, Inc, 1984, $59.50, 487 pp.
Crybabies, Coping with Colic: What to Do When Baby Won't Stop Crying. M. Weissbluth. New York, Arbor House Publishing Co, 1984, $5.95, 176 pp.
Case Studies in Paediatrics. D. J. Field and J. Stroobant. Baltimore, Urban & Schwarzenberg, 1984, $11.50, 82 pp.
Stimulating the Exceptional Child. C. Kiernan, R. Jordan, and C. Saunders. Englewood Cliffs, NJ, Prentice-Hall, Inc, Publishers, 1984, $17.95 ($8.95 paper), 311 pp.
Gait Disorders in Childhood and Adolescence. D. H. Sutherland. Baltimore, Williams & Wilkins, 1984, $35, 201 pp.
Hearing in Children, ed 3. J. L. Northern and M. P. Downs. Baltimore, Williams & Wilkins, 1984, $27, 391 pp.
Suicide in Children and Adolescents. S. A. Husain and T. Vandiver. Jamaica, NY, SP Medical & Scientific Books, 1984, $24.95, 284 pp.
The Misunderstood Child. L. B. Silver. New York, McGraw-Hill Book Co, 1984, $14.95, 212 pp.
Child Neurology: A Clinical Manual. B. O. Berg. Greenbrae, CA, Jones Medical Publications, 1984, $16.95, 316 pp.

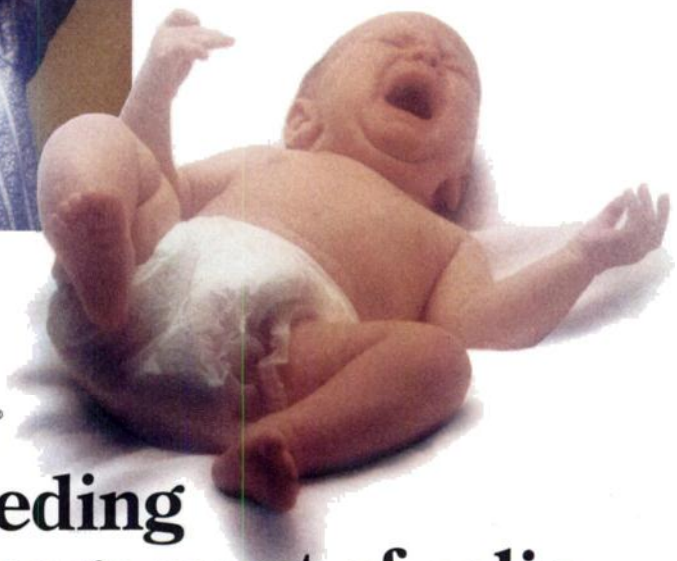
PEDIATRICS IN REVIEW: December 1984 Contents

COLIC

Distressing for infants and parents.

Frustrating for you.





Consider Nutramigen® for the feeding management of colic.

In a double-blind study[1] of 60 colicky infants fed cow milk-based formula*:

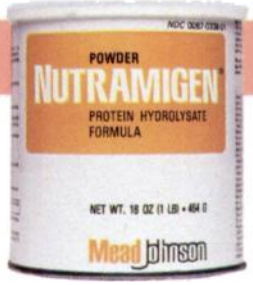
- In 11 infants (18%), symptoms disappeared within 48 hours after receiving soy formula, but not after receiving cow's milk formula.
- Over half (32 infants) were unchanged or worse when fed cow's milk formula or soy formula.
- All 32 of these infants became symptom-free within 48 hours when switched to NUTRAMIGEN.

The AAP/CON has stated that this study "raises the possibility that cow's milk is a precipitating factor in some infants with colic and suggests that it may be most effectively managed by the use of a casein hydrolysate."[2] The committee has recommended further studies on this common problem.

When the symptoms of colic point to a formula change, consider

NUTRAMIGEN®

Protein Hydrolysate Infant Formula



Available in local pharmacies.

Mead Johnson NUTRITIONAL DIVISION

References:
1. Lothe L, Lindberg T, Jakobsson I: Cow's milk formula as a cause of infantile colic: A double-blind study. *Pediatrics* 1982;70:7-10.
2. American Academy of Pediatrics/Committee on Nutrition: Soy-protein formulas: Recommendations for use in infant feeding. *Pediatrics* 1983; 72:359-363.

*Seventeen infants had spontaneous recovery on cow milk-based formula.

VICE-PRESIDENT
MEDICAL AFFAIRS/MEDICAL DIRECTOR

Mt. Washington Pediatric Hospital is a 62-bed facility serving the medical, emotional, social and educational needs of children from birth to adolescence who require post acute, habilitative and rehabilitative care. Founded in 1922, the hospital, both JCAH and CARF accredited, is totally redeveloping its patient care programs and embarking on a major building and expansion program.

Clinical excellence and a firm commitment to the rehabilitation process are among the qualities being sought. Candidates must possess strong organization and leadership skills, be able to motivate, communicate, and play an intrinsic role in charting the institution's future.

The candidate selected will be responsible for

- Clinical Program Development
- Educational/Training Programs
- Participating in Research
- Establishing a Program in Postgraduate Medical Education
- Serving as Liaison to Referral Sources & Private Practitioners

Mt. Washington Pediatric Hospital, Inc.

Please reply in writing, or call:
Frank A. Pommett, President
MT. WASHINGTON PEDIATRIC HOSPITAL
1708 W. Rogers Avenue Baltimore, Maryland 21209
(301) 578-8600

Clinical Center Study of Pubertal Patients with Extreme Short Stature

The cooperation of physicians is requested in the referral of pubertal patients with extreme short stature (greater than four standard deviations below the mean for age) who are between the ages of 10 through 13. The Developmental Endocrinology Branch, National Institute of Child Health and Human Development at the Clinical Center, National Institutes of Health, Bethesda, Maryland, is conducting a double-blind, placebo-controlled study of a long-acting LHRH analog to delay puberty and attempt to enhance ultimate stature. Patients will receive a complete endocrine evaluation. Upon completion of the study, patients will be returned to the care of the referring physician who will receive a summary of the findings.

Physicians interested in having their patients considered for admission may write or telephone:

Dr. Ora H. Pescovitz
Dr. Fernando Cassorla
Dr. Gordon B. Cutler, Jr.
Building 10, Room 10B09
National Institutes of Health
Bethesda, MD 20205
301-496-2646

Stopped by SYMMETREL®

100 MG CAPSULES
50 MG/5 ML SYRUP
[AMANTADINE HCl]

Reduces severity of symptoms and shortens duration of flu

Rx for treating adults: 14 capsules—1 b.i.d. for 7 days

Please see following page for brief summary of prescribing information.

DUPONT

SYMMETREL®

100 MG CAPSULES [AMANTADINE HCl]

BRIEF SUMMARY OF PRESCRIBING INFORMATION

INDICATION: *Influenza A Virus Respiratory Tract Illness* SYMMETREL® (amantadine hydrochloride) is indicated in the prevention and treatment of respiratory tract illness caused by influenza A virus strains SYMMETREL should be considered especially for high risk patients, close household or hospital ward contacts of index cases and patients with severe influenza A virus illness In the prophylaxis of influenza due to A virus strains, early immunization as periodically recommended by the Public Health Service Advisory Committee on Immunization Practices is the method of choice When early immunization is not feasible, or when the vaccine is contraindicated or not available, SYMMETREL can be used for chemoprophylaxis against influenza A virus illness Because SYMMETREL does not appear to suppress antibody response, it can be used chemoprophylactically in conjunction with inactivated influenza A virus vaccine until protective antibody responses develop There is no clinical evidence that this drug has efficacy in the prophylaxis or treatment of viral respiratory tract illnesses other than those caused by influenza A virus strains

CONTRAINDICATIONS: SYMMETREL is contraindicated in patients with known hypersensitivity to the drug

WARNINGS: Patients with a history of epilepsy or other "seizures" should be observed closely for possible increased seizure activity

Patients with a history of congestive heart failure or peripheral edema should be followed closely as there are patients who developed congestive heart failure while receiving SYMMETREL

Patients receiving SYMMETREL who note central nervous system effects or blurring of vision should be cautioned against driving or working in situations where alertness is important

PRECAUTIONS: The dose of SYMMETREL may need careful adjustment in patients with renal impairment, congestive heart failure, peripheral edema, or orthostatic hypotension Since SYMMETREL is not metabolized and is mainly excreted in the urine, it may accumulate when renal function is inadequate

Care should be exercised when administering SYMMETREL to patients with liver disease, a history of recurrent eczematoid rash, or to patients with psychosis or severe psychoneurosis not controlled by chemotherapeutic agents Careful observation is required when SYMMETREL is administered concurrently with central nervous system stimulants

No long-term studies in animals have been performed to evaluate the carcinogenic potential of SYMMETREL The mutagenic potential of the drug has not yet been determined in experimental systems

Pregnancy Category C: SYMMETREL (amantadine hydrochloride) has been shown to be embryotoxic and teratogenic in rats at 50 mg/kg/day, about 12 times the recommended human dose, but not at 37 mg/kg/day Embryotoxic and teratogenic drug effects were not seen in rabbits which received up to 25 times the recommended human dose There are no adequate and well-controlled studies in pregnant women

SYMMETREL should be used during pregnancy only if the potential benefit justifies the potential risk to the embryo or the fetus

Nursing Mothers: SYMMETREL is excreted in human milk Caution should be exercised when SYMMETREL is administered to a nursing woman

Pediatric Use: The safety and efficacy of SYMMETREL in newborn infants, and infants below the age of 1 year have not been established

ADVERSE REACTIONS: The most frequently occurring serious adverse reactions are depression, congestive heart failure, orthostatic hypotensive episodes, psychosis, and urinary retention Rarely convulsions, leukopenia, and neutropenia have been reported

Other adverse reactions of a less serious nature which have been observed are the following: hallucinations, confusion, anxiety, and irritability, anorexia, nausea, and constipation, ataxia and dizziness (lightheadedness), livedo reticularis and peripheral edema Adverse reactions observed less frequently are the following: vomiting, dry mouth, headache, dyspnea, fatigue, insomnia, and a sense of weakness Infrequently, skin rash, slurred speech, and visual disturbances have been observed Rarely eczematoid dermatitis and oculogyric episodes have been reported

OVERDOSAGE: There is no specific antidote However, slowly administered intravenous physostigmine in 1 and 2 mg doses in an adult[1] at 1 to 2 hour intervals and 0 5 mg doses in a child[2] at 5 to 10 minute intervals up to a maximum of 2 mg/hour have been reported to be effective in the control of central nervous system toxicity caused by amantadine hydrochloride For acute overdosing, general supportive measures should be employed along with immediate gastric lavage or induction of emesis Fluids should be forced and, if necessary, given intravenously The pH of the urine has been reported to influence the excretion rate of SYMMETREL Since the excretion rate of SYMMETREL increases rapidly when the urine is acidic, the administration of urine acidifying drugs may increase the elimination of the drug from the body The blood pressure, pulse, respiration and temperature should be monitored The patient should be observed for hyperactivity and convulsions, if required, sedation, and anticonvulsant therapy should be administered The patient should be observed for the possible development of arrhythmias and hypotension, if required, appropriate antiarrhythmic and antihypotensive therapy should be given The blood electrolytes, urine pH and urinary output should be monitored If there is no record of recent voiding, catheterization should be done The possibility of multiple drug ingestion by the patient should be considered

1 D F Casey, N Engl J Med 298 516, 1978 2 C D Berkowitz, J Pediatr 95 144, 1979

DOSAGE AND ADMINISTRATION: Dosage for Prophylaxis and Treatment of Influenza A Virus Respiratory Tract Illness:

Adult: The adult daily dosage of SYMMETREL (amantadine hydrochloride) is 200 mg two 100 mg capsules (or four teaspoonfuls of syrup) as a single daily dose, or the daily dosage may be split into one capsule of 100 mg (or two teaspoonfuls of syrup) twice a day If central nervous system effects develop on once-a-day dosage, a split dosage schedule may reduce such complaints

Children: 1 yr -9 yrs of age The total daily dose should be calculated on the basis of 2 to 4 mg/lb/day (4 4 to 8 8 mg/kg/day), but not to exceed 150 mg per day

9 yrs -12 yrs of age The total daily dose is 200 mg given as one capsule of 100 mg (or two teaspoonfuls of syrup) twice a day

Prophylactic dosing should be started in anticipation of contact or as soon as possible after contact with individuals with influenza A virus respiratory illness SYMMETREL should be continued daily for at least 10 days following a known exposure If SYMMETREL is used chemoprophylactically in conjunction with inactivated influenza A virus vaccine until protective antibody responses develop, then it should be administered for 2 to 3 weeks after the vaccine has been given When inactivated influenza A virus vaccine is unavailable or contraindicated, SYMMETREL should be administered for up to 90 days in case of possible repeated and unknown exposures Treatment of influenza A virus illness should be started as soon as possible after onset of symptoms and should be continued for 24 to 48 hours after the disappearance of symptoms

6043-13BSF

Capsules manufactured by R P Scherer-North America, St Petersburg, Florida 33702 for

Rev June, 1983 10/84SH5334

Du Pont Pharmaceuticals
E.I. du Pont de Nemours & Co. (Inc.)
Wilmington, Delaware 19898

DUPONT

When the Focus Is Diarrhea Management...

the Solution Is Clearer Than Ever

- **Improved formulation** based on latest research in oral maintenance and rehydration therapy
- Ready-to-use liquid for rapid and safe management
- Unmatched choice of forms and strengths to meet your individual patient needs
- Widely available in drugstores and groceries for patient convenience

Pedialyte®
Oral Electrolyte Maintenance Solution
—flavored or unflavored
45 mEq of sodium/L
25 g of dextrose/L

Pedialyte® RS
Oral Electrolyte Rehydration Solution
— Unflavored
75 mEq of sodium/L
25 g of dextrose/L

Specify the clear solutions to manage and prevent dehydration in acute diarrhea of infants and children.

B708/4890 LITHO IN USA

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

Try looking at potato chips from a slightly different point of view.

The back.

That's where you'll find this nutrition label. It's for a one ounce serving, which adds up to between 15 and 20 good-sized chips. The same amount you get in a lunch size bag.

The first thing on the label that'll probably catch your eye is the number next to Calories. 150. That's a lot fewer than most people might expect. Especially for potato chip lovers like kids and teenagers, who burn up a lot of the calories they take in.

You'll also notice something else on the label. That typical one ounce bag contains approximately 175 milligrams of sodium.* That's about 1/10 of a teaspoon of salt. No more than you'll find in a couple slices of bread.

A one ounce serving of potato chips contains about 1/10 of a teaspoon of salt.

Potato Chips
NUTRITION INFORMATION
(Per Serving) Serving Size 1 ounce.

Calories	150
Protein	2 grams
Carbohydrate	14 grams
Fat	10 grams
Cholesterol* (0 mg/100 g)	0 milligrams
Sodium	175 milligrams
Potassium	205 milligrams
Percentage of U.S. Recommended Daily Allowance (U.S. RDA)	
Protein	2
Vitamin A	**
Vitamin C	10
Thiamine	2
Riboflavin	**
Niacin	4
Calcium	**
Iron	2
Vitamin B_6	8
Phosphorus	4
Magnesium	4
Copper	6

*Information on cholesterol content is provided for individuals who, on the advice of a physician are modifying their total dietary intake of cholesterol.
**Contains less than 2% U.S. RDA for this nutrient.

Nutrition label developed according to the FDA guidelines found in Title 21 of the Federal Code of Regulations.

The 10 grams of fat you see on the label translate into about 2¼ teaspoons of oil. That's less than a lot of people use to pop a batch of popcorn. And according to the Health and Nutrition Examination Survey (HANES II)**, the fat in potato chips accounts for less than 1% of the daily calories in the average American diet.

Most potato chips are cooked in vegetable oils.

As for cholesterol, most potato chips don't contain any. That's because most potato chips are cooked only in vegetable oils.

So you see, when it comes to potato chips, there is another side to the story. Of course, the information on the nutrition label doesn't mean they're for everyone. But it is good to know about one of America's favorite foods.

The Potato Chip Information Bureau

*National industry assays indicate that the typical one ounce bag of potato chips contains 175 milligrams of sodium. The range for the samples tested was from 100 to 260 milligrams per ounce.

**HANES II was conducted by the United States Department of Health and Human Services from 1976 to 1980.

For more information, write the Potato Chip Information Bureau, 1711 King Street, Alexandria, Virginia 22314.

These shelves are filled with antitussives chemically unrelated to narcotics proved to selectively inhibit cough at the cough control center...

BENYLIN®
COUGH SYRUP

Each teaspoonful (5 ml) contains diphenhydramine hydrochloride, 12.5 mg. Alcohol, 5%.

Cough control equivalent to codeine... without narcotic abuse potential, available OTC

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

PD-83-JA-1802-P-1 (8-83)

THE VACCINE SPECIALISTS

SQUIBB CONNAUGHT

BRINGS TOGETHER THE UNIQUE RESOURCES OF ITS PARENT COMPANIES

a broad range of human vaccines and biologicals

convenient availability and responsive service

comprehensive medical and professional education support

For product/technical information call (609) 683-0400 or (800) V·A·C·C·I·N·E
To order, contact your Squibb representative or local Squibb distribution center.

Diphtheria Antitoxin, USP
(Purified, Concentrated Globulin-EQUINE)
Diphtheria and Tetanus Toxoids and Pertussis Vaccine Adsorbed, USP
(For Pediatric Use) (DTP)
Fluzone® (Influenza Virus Vaccine, USP)
(Zonal Purified, Whole Virion)
Fluzone® (Influenza Virus Vaccine, USP)
(Zonal Purified, Subvirion)
Menomune®-A/C (Meningococcal Polysaccharide Vaccine, Groups A and C Combined)
Menomune®-A/C/Y/W-135 (Meningococcal Polysaccharide Vaccine, Groups A, C, Y and W-135 Combined)
Poliomyelitis Vaccine, Purified
(IPV, Salk-Type)
Tetanus and Diphtheria Toxoids, Adsorbed, USP
(For Adult Use) (Td)
Tetanus Toxoid, USP ("Fluid" or "Plain")
Tetanus Toxoid, Adsorbed, USP
Tubersol® (Tuberculin Purified Protein Derivative, Mantoux)
(5TU; 1TU; 250TU)
YF-VAX™ (Yellow Fever Vaccine)
(Live 17D Strain, Avian Leukosis-Free, Stabilized)

Mfd. by:
Connaught Laboratories

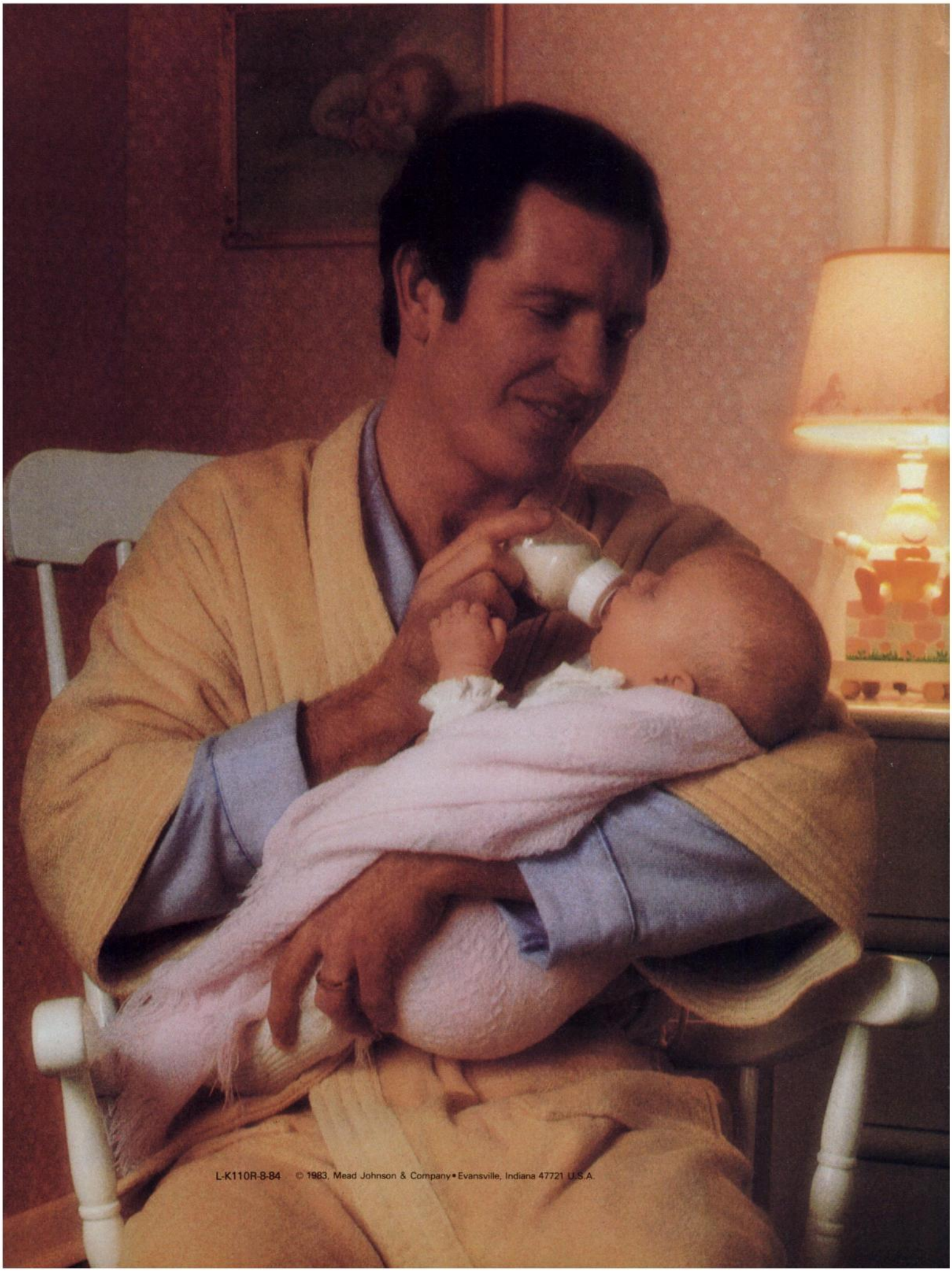
Dist. by:
E.R. Squibb & Sons

SQUIBB® CONNAUGHT®
THE VACCINE SPECIALISTS

Squibb/Connaught, Inc.
330 Alexander Street
Princeton, New Jersey 08540

414-503

August 1984



Improved Formulation Enfamil®*

Now with 50 mg/qt ADDED TAURINE
An Amount Similar to the Average Content of Breast Milk[1,2,3]

Now, Even Closer to Breast Milk

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 Today's Enfamil permits the sodium content to be close to the midpoint of the CON/AAP 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

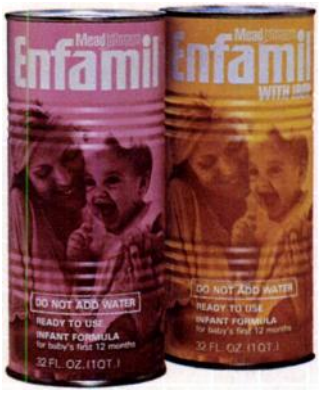
Improved Formulation Enfamil uses 100% lactose—the carbohydrate found in breast milk to assure good calcium absorption.

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.

A Total Commitment to the Future of Infant Nutrition



Mead Johnson
NUTRITIONAL DIVISION

* Mead Johnson recognizes breast milk as the preferred nutrition for babies. Improved Formulation Enfamil with its 60:40 whey protein to casein ratio continues to be the best nutritional alternative for those infants who are not breast-fed, who need a supplemental formula or who are weaned early.

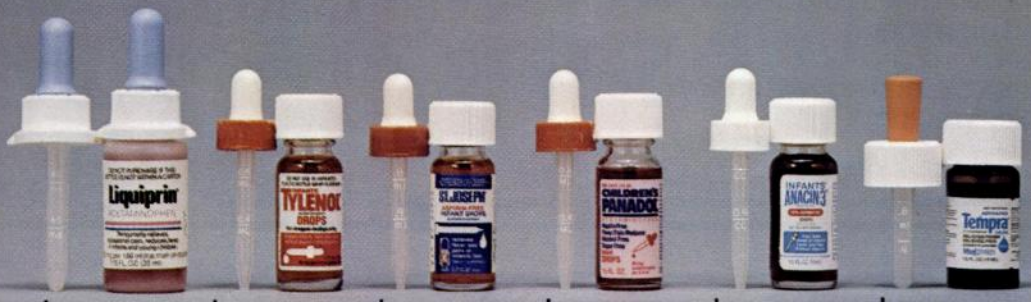
[1] Armstrong MD *et al.*: Free Amino Acids in Milk. *Proceed. of Society of Exper. Biology Medicine* 113:680-683, 1983.

[2] Rassin D and Gaull G: Taurine and Other Free Amino Acids of Milk of Man and Other Mammals. *Ear. Hum. Dev.* 2:1-13, 1978.

[3] Svandberg U, Gebre-Medhin M, Ljungquist B, and Olsen M: Breast Milk Composition in Ethiopian and Swedish Mothers III. Amino Acids and Other Nitrogenous Substances. *AJCN* 30:499-507, 1977.

No Other Acetaminophen Checks Out Like Liquiprin®

Comparisons of the leading acetaminophen drop formulas for children.



	Liquiprin®	Tylenol®	St. Joseph®	Panadol®	Anacin-3®	Tempra®
No Aspirin Contains 100% acetaminophen.	✓	✓	✓	✓	✓	✓
No Alcohol As recommended by the American Academy of Pediatrics;* not therapeutically necessary.	✓			✓		
Advanced Dropper System Calibrated in milligrams, not in volume. Helps insure accurate dosage.	✓					
Easier-To-Use Oversize Tube and Bulb For better patient compliance.	✓					
Safety-Sealed Package and Child-Resistant Cap	✓	✓	✓	✓	✓	✓
Unbreakable Plastic Bottle	✓					
Priced Below Other Leading Products Per bottle, per dose.	✓					

*March 1984 Pediatrics

Please write for **money-saving certificates** for your patients, good towards purchase of **Liquiprin** Drops.
Write to: Norcliff Thayer Inc.
Professional Relations Dept.
P. O. Box 3807
Stamford, CT 06905

Liquiprin. The logical choice for fever and pain relief.
ACETAMINOPHEN

Improved Formulation Enfamil®*

Now with 50 mg/qt ADDED TAURINE
An Amount Similar to the Average Content of Breast Milk[1,2,3]

Now, Even Closer to Breast Milk

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 Today's Enfamil permits the sodium content to be close to the midpoint of the CON/AAP 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.

A Total Commitment to the Future of Infant Nutrition

Mead Johnson
NUTRITIONAL DIVISION

* Mead Johnson recognizes breast milk as the preferred nutrition for babies. Improved Formulation Enfamil with its 60:40 whey protein to casein ratio continues to be the best nutritional alternative for those infants who are not breast-fed, who need a supplemental formula or who are weaned early.

[1] Armstrong MD *et al:* Free Amino Acids in Milk. *Proceed. of Society of Exper. Biology Medicine* 113:680-683, 1983.
[2] Rassin D and Gaull G: Taurine and Other Free Amino Acids of Milk of Man and Other Mammals. *Ear. Hum. Dev.* 2:1-13, 1978.
[3] Svandberg U, Gebre-Medhin M, Ljungquist B, and Olsen M: Breast Milk Composition in Ethiopian and Swedish Mothers III. Amino Acids and Other Nitrogenous Substances. *AJCN* 30:499-507, 1977.

THERE'S A TRIAMINIC® TREATMENT FOR EVERY KIND OF COLD

For the cold with a dry, hacking cough

For the cold with a stuffy, runny nose

TRIAMINIC®
COLD SYRUP

Contains phenylpropanolamine and chlorpheniramine.
The "Orange Medicine" you've been recommending for years.

For the cold with a frequent, annoying cough

TRIAMINIC-DM®
COUGH FORMULA

Contains phenylpropanolamine and dextromethorphan.
Decongests and gently quiets annoying coughs.

TRIAMINICOL®
MULTI-SYMPTOM COLD SYRUP

Contains phenylpropanolamine, dextromethorphan, and chlorpheniramine.
Relieves stuffy, runny noses and suppresses frequent coughs.

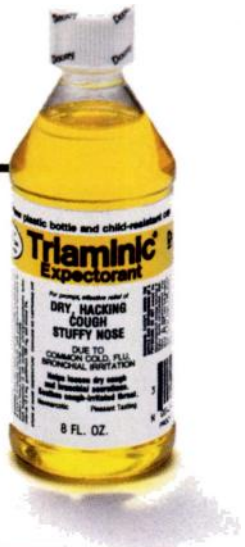
The Recommendables® Line—
Specific ingredients for specific symptoms

Dorsey® LABORATORIES
Division of Sandoz, Inc
LINCOLN NEBRASKA 68501

 08831A

TRIAMINIC®
EXPECTORANT

Contains phenylpropanolamine and guaifenesin.
Loosens bronchial secretions, decongests, and relieves annoying cold symptoms.

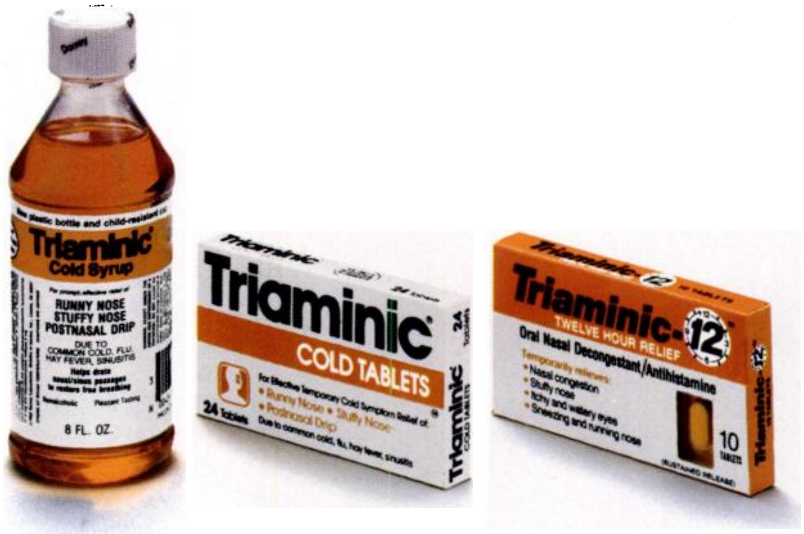


TRIAMINIC®
COLD TABLETS

The adult-preferred tablet form of the liquid. Contains the same, well-tried combination of ingredients.

TRIAMINIC-12®
SUSTAINED RELEASE TABLETS

Long-acting formulation for long-lasting relief of stuffy, runny nose.

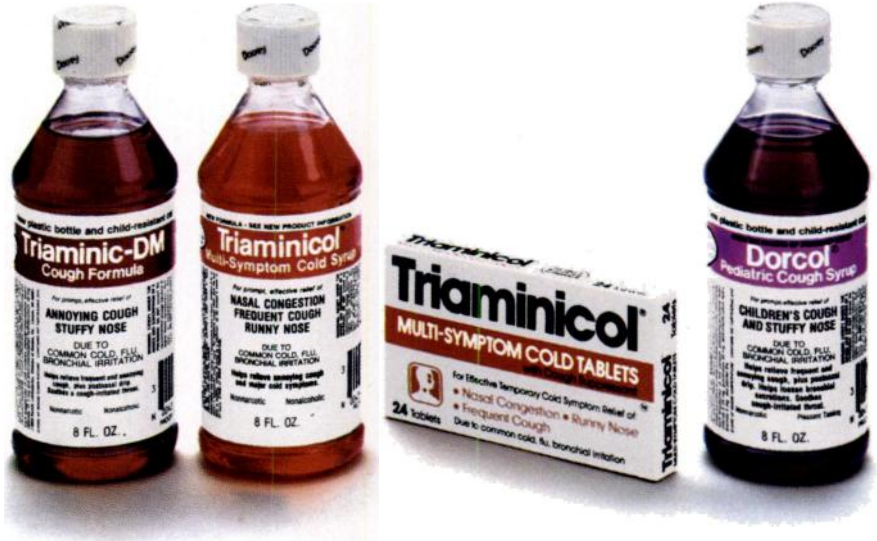


TRIAMINICOL®
MULTI-SYMPTOM COLD TABLETS

The convenient tablet version contains phenylpropanolamine, dextromethorphan, and chlorpheniramine.
Decongests and dries up nasal symptoms while suppressing annoying coughs.

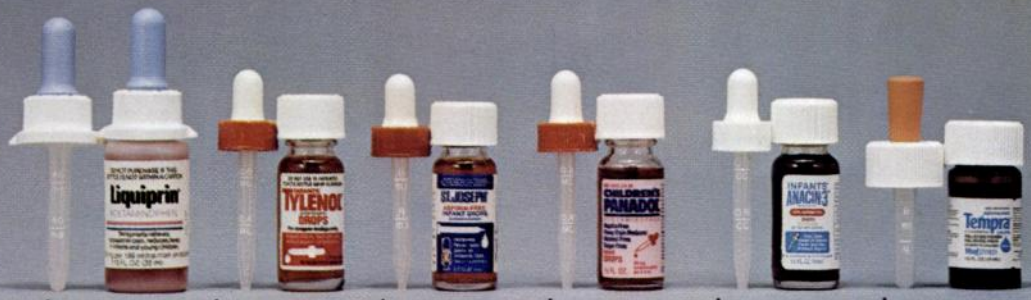
DORCOL®
PEDIATRIC COUGH SYRUP

Contains phenylpropanolamine, dextromethorphan, and guaifenesin.
Children's strength decongestant, antitussive, and expectorant for effective relief of cold symptoms.



No Other Acetaminophen Checks Out Like Liquiprin.®

Comparisons of the leading acetaminophen drop formulas for children.



	Liquiprin*	Tylenol*	St. Joseph*	Panadol*	Anacin-3*	Tempra*
No Aspirin Contains 100% acetaminophen.	✓	✓	✓	✓	✓	✓
No Alcohol As recommended by the American Academy of Pediatrics;* not therapeutically necessary.	✓			✓		
Advanced Dropper System Calibrated in milligrams, not in volume. Helps insure accurate dosage.	✓					
Easier-To-Use Oversize Tube and Bulb For better patient compliance.	✓					
Safety-Sealed Package and Child-Resistant Cap	✓	✓	✓	✓	✓	✓
Unbreakable Plastic Bottle	✓					
Priced Below Other Leading Products Per bottle, per dose.	✓					

*March 1984 Pediatrics

Please write for **money-saving certificates** for your patients, good towards purchase of **Liquiprin** Drops.
Write to: Norcliff Thayer Inc.
Professional Relations Dept.
P.O. Box 3807
Stamford, CT 06905

Liquiprin. The logical choice for fever and pain relief.
ACETAMINOPHEN

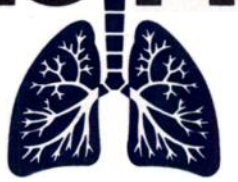
IN SOME PATIENTS THEOPHYLLINE DOESN'T LAST VERY

For these patients, Slo-Phyllin® Gyrocaps® t.i.d. is an excellent choice.

You know which of your patients metabolize or clear theophylline very quickly: mostly children and heavy smokers. For many of them, Slo-Phyllin® Gyrocaps® t.i.d. is an excellent choice.

Once dosage has been titrated, the nearly 100% bioavailability and predictable absorption of Slo-Phyllin® Gyrocaps® help you maintain therapeutic serum theophylline levels—even during long-term therapy. Three strengths—60 mg, 125 mg, and 250 mg—provide dosage flexibility and may be administered as intact capsules or as sprinkled pellets on soft food.

SLO-PHYLLIN® GYROCAPS®



(theophylline, anhydrous)

Timed Release Capsules
60 mg, 125 mg, 250 mg

WILLIAM H. RORER, INC.
Fort Washington, Pennsylvania, U.S.A. 19034

Please see following page for prescribing information.

Brief Summary
SLO-PHYLLIN®
(theophylline, anhydrous)
GYROCAPS®
TIMED RELEASE CAPSULES—60 mg, 125 mg, 250 mg
SLO-PHYLLIN® Tablets—100 mg, 200 mg
(theophylline, anhydrous)
SLO-PHYLLIN® 80 Syrup—80 mg/15 ml
(theophylline, anhydrous)

Indications: For relief and/or prevention of symptoms from asthma and reversible bronchospasm associated with chronic bronchitis, and emphysema.
Contraindications: In individuals who have shown hypersensitivity to any of its components.
Warnings: Status asthmaticus is a medical emergency. Optimal therapy frequently requires additional medication including corticosteroids when the patient is not rapidly responsive to bronchodilators.

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

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

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

Many patients who have higher theophylline serum levels exhibit tachycardia.

Theophylline products may worsen pre-existing arrhythmias.
Usage in Pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development, but neither have adverse effects on fetal development been established. This is, unfortunately, true for most anti-asthmatic medications. Therefore, use of theophylline in pregnant women should be balanced against the risk of uncontrolled asthma.
Precautions: Mean half-life in smokers is shorter than non-smokers, therefore, smokers may require larger doses of theophylline. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, and in the elderly (especially males) and in neonates. Great caution should especially be used in giving theophylline to patients in congestive heart failure. Such patients have shown markedly prolonged theophylline blood level curves with theophylline persisting in serum for long periods following discontinuation of the drug.

Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to G.I. tract although gastrointestinal symptoms are more commonly central and associated with serum concentrations over 20 μg/ml.
Adverse Reactions: The most consistent adverse reactions are usually due to overdose and are:

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

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

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

How Supplied:
Slo-Phyllin® 80 Syrup (80 mg/15 ml), 4 oz., pint, and gallon bottles, 5 ml and 15 ml unit dose bottles.
Slo-Phyllin® 100 mg and 200 mg Tablets, bottles of 100 and 1000, unit dose strip packages.
Slo-Phyllin® Gyrocaps® 60 mg bottles of 100 and 1000.
Slo-Phyllin® Gyrocaps® 125 mg and 250 mg bottles of 100 and 1000, unit dose strip packages.
See package insert for full prescribing information.

SLO-PHYLLIN®
(theophylline, anhydrous)

R O RORER E R
WILLIAM H. RORER, INC.
Fort Washington Pennsylvania, U.S.A. 19034

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

Aplisol®
(Tuberculin Purified Protein Derivative, Diluted [Stabilized Solution])

Aplitest®
Tuberculin Purified Protein Derivative Multiple-Puncture Device

INDICATIONS AND USAGE, Aplisol: Tuberculin PPD is recommended by the American Lung Association as an aid in the detection of infection with *Mycobacterium tuberculosis*. The standard tuberculin test recommended employs the intradermal (Mantoux) test using a 5 TU dose of tuberculin PPD. The 0.1 ml test dose of Aplisol (tuberculin PPD, diluted) is equivalent to the 5 TU dose recommended as clinically established and standardized with PPD-S.

Aplitest: Aplitest is indicated to detect tuberculin-sensitive individuals. Aplitest units are also useful in programs to establish priorities for additional testing (i.e. chest x-rays) and in epidemiological surveys to identify areas with high levels of infection.

All multiple-puncture type devices should be regarded as screening tools and appropriate diagnostic procedures (eg, Mantoux test with tuberculin PPD diluted, Aplisol®) should be employed for retesting "doubtful" reactors.

Regular periodic (annual or biennial) testing of tuberculin-negative persons is recommended and is especially valuable because the conversion of an individual from negative to positive is highly indicative of recent tuberculosis infection. Repeated testing of the uninfected individual does not sensitize to tuberculin. In persons with waning sensitivity to homologous or heterologous mycobacterial antigens, however, the stimulus of a tuberculin test may "boost" or increase the size of reaction to a second test, even causing an apparent development of sensitivity in some instances.

WARNINGS Tuberculin should not be administered to known tuberculin-positive reactors because of the severity of reactions (eg, vesiculation, ulceration or necrosis) that may occur at the test site in very highly sensitive individuals.

Aplisol: Avoid injecting tuberculin subcutaneously. If this occurs, no local reaction develops, but a general febrile reaction and/or acute inflammation around old tuberculous lesions may occur in highly sensitive individuals.

PRECAUTIONS As with any biological product, epinephrine should be immediately available in case an anaphylactoid or acute hypersensitivity reaction occurs.

Aplisol: A separate heat sterilized syringe and needle, or a sterile disposable unit, should be used for each individual patient to prevent possible transmission of homologous serum hepatitis virus and other infectious agents from one person to another.

Syringes that have previously been used with histoplasmin, blastomycin and other antigens should not be used for tuberculin.

Aplitest: A separate, sterile unit must be used for each individual patient and disposed of after use.

Sensitivity may decrease or disappear temporarily during or immediately following severe febrile illness, measles, and other exanthemas, live virus vaccination, sarcoidosis, overwhelming miliary or pulmonary tuberculosis and the administration of corticosteroids or immunosuppressive drugs. Severe malnutrition may also have a similar effect.

A positive tuberculin reaction does not necessarily signify the presence of active disease. Further diagnostic procedures should be carried out before a diagnosis of tuberculosis is made.

Simultaneous application of two or more multiple puncture devices is not recommended. The response of an individual to a single multiple puncture device may be altered by the simultaneous administration of additional tuberculin tests (multiple puncture or Mantoux).

Pregnancy: Teratogenic effects: Pregnancy Category C. Animal reproduction studies have not been conducted with Aplisol/Aplitest. It is also not known whether Aplisol/Aplitest can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Aplisol/Aplitest should be given to a pregnant woman only if clearly needed.

However, the risk of unrecognized tuberculosis and the close postpartum contact between a mother with active disease and an infant leaves the infant in grave danger of tuberculosis and complications such as tuberculous meningitis. Although there have not been reported any adverse effects upon the fetus recognized as being due to tuberculosis skin testing, the prescribing physician will want to consider if the potential benefits outweigh the possible risks for performing the tuberculin test on a pregnant woman or a woman of childbearing age, particularly in certain high risk populations.

ADVERSE REACTIONS In highly sensitive individuals, strongly positive reactions including vesiculation, ulceration or necrosis may occur at the test site. Cold packs or topical steroid preparations may be employed for symptomatic relief of the associated pain, pruritus and discomfort.

Strongly positive test reactions may result in scarring at the test site.

Aplitest: Minimal bleeding may be experienced at a puncture site. This occurs infrequently and does not affect interpretation of the test.

Aplisol 32 Aplitest 21

NEW BEECH-NUT® STAGE 1

SINGLE-INGREDIENT BABY FOODS WITH NO HIDDEN ALLERGENS

Beech-Nut Stage 1 single-ingredient foods contain none of the hidden allergens often found in other ready-made baby foods. Our bananas have no hidden orange juice, no modified starch fillers. The pears are pure Bartlett pears, with no added corn syrup. Our peaches are naturally sweet and delicious, too—no corn syrup added.

Stage 1 products have no milk, eggs, wheat or corn. So you can introduce one *pure* food at a time into baby's diet. And you know exactly which food is responsible, should an allergic reaction ever occur.

Once you've tested for allergies and mother knows what baby likes, Stage 2 foods may be introduced.

Stage 2 products are mixtures of foods, for a baby's developing taste.

Stage 3 products have special Mini-Bites™ for greater texture as the infant starts to chew.

And Table Time® foods are convenient meals with no unwanted food additives for the one-year-old or older, when the family's food is too spicy or too hard to chew.

Beech-Nut® STAGES®—a developmental feeding program from the introduction of solid food to age 1 and beyond.

BEECH-NUT® STAGES®
THE NEW GENERATION OF BABY FOOD.

For further professional information on Beech-Nut® STAGES®, call the special toll-free Beech-Nut Hotline: 1-800-523-6633. (In PA only 1-800-492-2384).

GENERAL INFORMATION

PEDIATRICS publishes papers on original research or observations and special feature or review articles in the field of pediatrics as broadly defined. Papers on material pertinent to pediatrics will also be included from related fields such as nutrition, surgery, dentistry, public health, child health services, human genetics, animal studies, psychology, psychiatry, education, sociology and nursing.

PEDIATRICS is the official publication of the American Academy of Pediatrics and serves as a medium for expression to the general medical profession as well as pediatricians. The Executive Board and Officers of the American Academy of Pediatrics have delegated to the Editor and the Editorial Board the selection of the articles appearing in PEDIATRICS. Statements and opinions expressed in such articles are those of the authors and not necessarily those of the American Academy of Pediatrics, its Committees, PEDIATRICS, or the Editor or Editorial Board of PEDIATRICS.

Communications

Concerning editorial matters and manuscripts should be sent to PEDIATRICS, Dr. Jerold F. Lucey, Editor, Mary Fletcher Hospital, Colchester Avenue, Burlington, Vermont 05401.

Concerning business matters, reprints, and advertising should be sent to PEDIATRICS, Business Office, American Academy of Pediatrics, P.O. Box 927, Elk Grove Village, IL 60007.

Concerning the American Academy of Pediatrics should be sent to Dr. M. Harry Jennison, Executive Director, P.O. Box 927, Elk Grove Village, IL 60007.

Concerning subscriptions, renewals, and address changes should be sent to PEDIATRICS, P.O. Box 927, Elk Grove Village, IL 60007.

Please include the 8 digit number on your journal label for address changes.

Reprint Orders

Reprint order forms will be sent to the senior author with galley proofs. *Upon receiving reprint order forms, please read them carefully.* All instructions thereon are final.

Please submit orders through the senior author. Reprints are available at any time after publication. However, it is suggested that reprint orders be placed promptly so that they are not subject to any price increases necessitated by paper and labor cost increases. *Delivery of reprints is usually 4 to 6 weeks after receipt of order.*

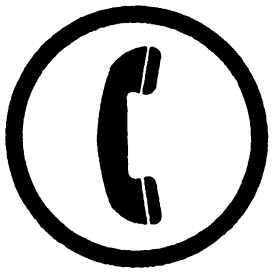
All reprints are saddle-stitched and self-covered, unless covers are ordered. Any additional changes from the standard pages are subject to additional charges. Orders for over 1,000 are, please note, subject to special quotations.

Finally, prepayment must accompany reprint orders.

Information for Contributors

Papers are accepted on the condition that they have not been published elsewhere in whole or in part and that they are contributed exclusively to this Journal, except by special consideration. Manuscripts should be prepared according to the instructions for "Manuscript Preparation."

Permission to reproduce material from PEDIATRICS must be requested and obtained in writing from the author and the American Academy of Pediatrics.



SUBSCRIPTION PROBLEMS?

To solve any subscription problems, readers may call (312) 869-4255.
Sorry, but no collect calls, please.
For speedy service, refer to the 8-digit number on your address label.

Neo-Synephrine®

The Short and Long of Nasal Decongestants

The Short

Neo-Synephrine®

brand of phenylephrine hydrochloride

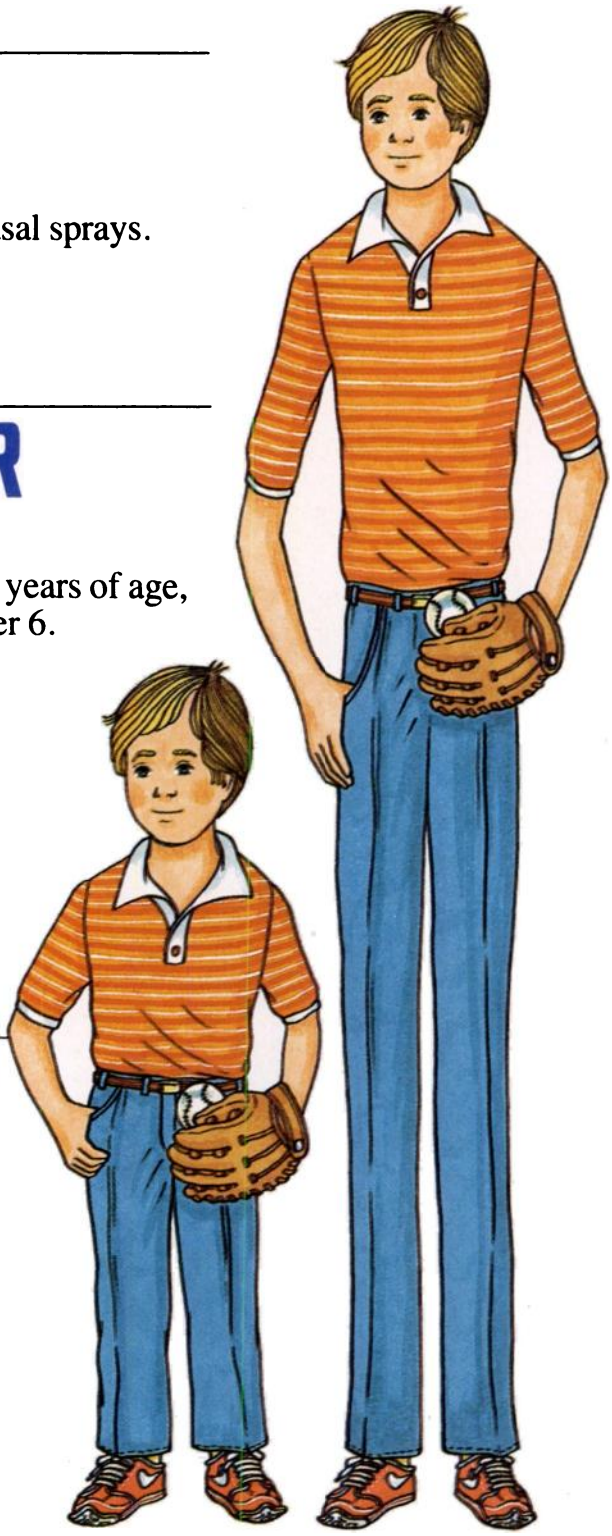
Available in various strengths of nose drops and nasal sprays.

The Long

Neo-Synephrine® 12 HOUR

brand of oxymetazoline hydrochloride

Available in nose drops of .025% for children 2–5 years of age, and nasal spray and drops of .05% for children over 6.



Winthrop Consumer Products

Division of Sterling Drug Inc.
90 Park Avenue, New York, NY 10016

NEW

TAURINE FORTIFICATION OF ALL ROSS LABORATORIES INFANT FORMULAS...

A significant advance in our quest to produce infant formulas that perform closest to human milk.

- Taurine is one of the most abundant free amino acids in human milk.
- Until now, cow's-milk-based infant formulas contained very little taurine. Soy protein formulas contained none.

SIMILAC® Infant Formulas **ISOMIL®** Soy Protein Formulas and **ADVANCE®** Nutritional Beverage

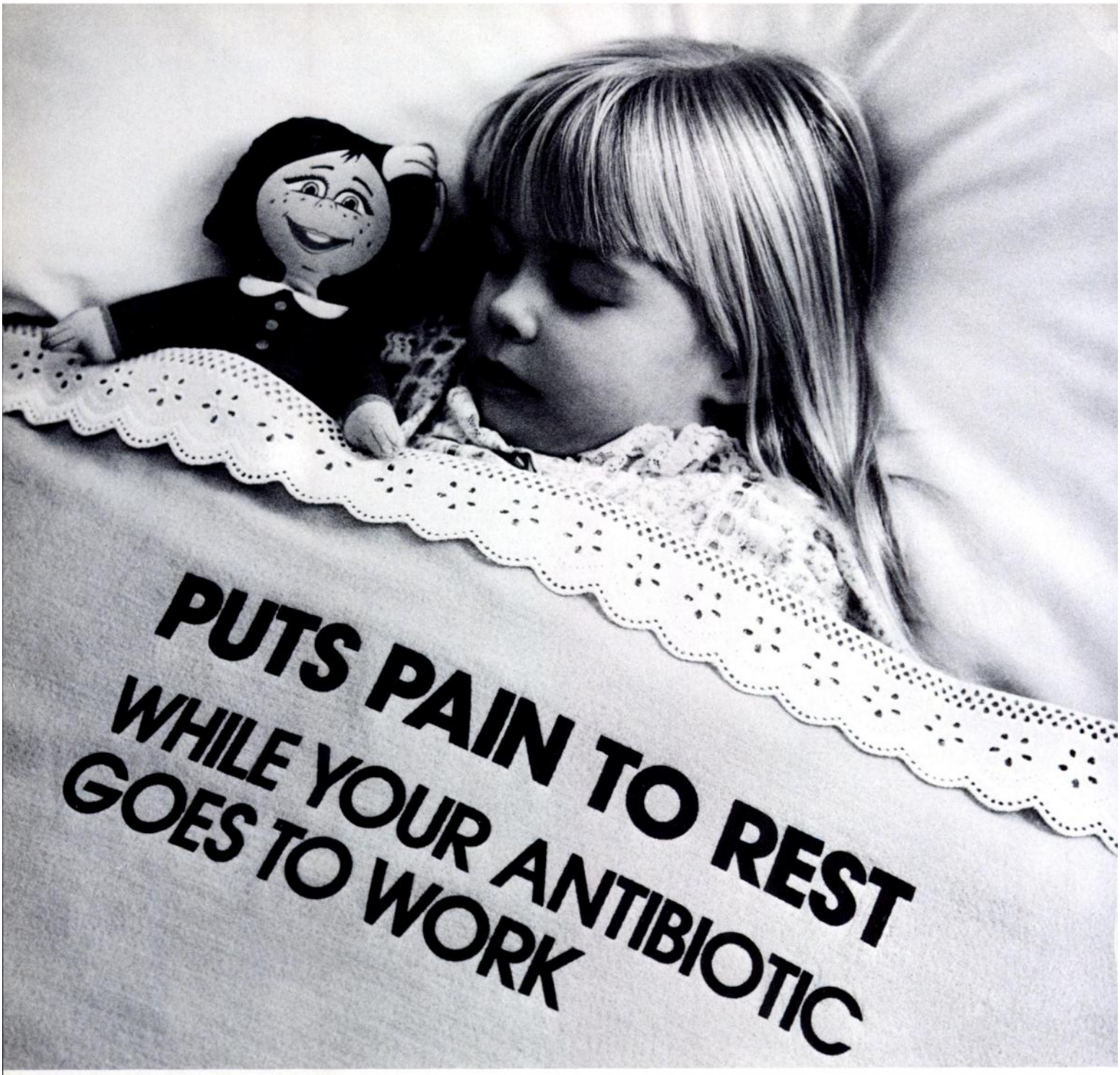
Now contain the level of taurine found in human milk (6.6 mg/100 kcal).

From Ross Laboratories–

the pioneer in the research and development of taurine-fortified infant formulas.

B149/4870

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



When acute *otitis media* threatens your young patients with a sleepless night... prescribe AURALGAN. It promptly relieves the pain and reduces the inflammation, while your systemic antibiotic takes care of the infection.

AURALGAN combines the topical analgesic action of benzocaine with the decongestant action of dehydrated glycerin—for relief of pressure and pain. No more ear tears, thanks to AURALGAN.

Available on your prescription only.

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

9021/284

BRIEF SUMMARY (For full prescribing information, see package circular.)
AURALGAN® Otic Solution
Each ml contains:

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

(contains not more than 0.6% moisture) (also contains oxyquinoline sulfate)

INDICATIONS: *Acute otitis media of various etiologies*
—prompt relief of pain and reduction of inflammation in the congestive and serous stages
—adjuvant therapy during systemic antibiotic administration for resolution of the infection.

CONTRAINDICATIONS: Hypersensitivity to any of the components or substances related to them. In the presence of spontaneous perforation or discharge.

DOSAGE AND ADMINISTRATION: *Acute otitis media:* Instill AURALGAN, permitting the solution to run along the wall of the canal until it is filled. Avoid touching the ear with dropper. Then moisten a cotton pledget with AURALGAN and insert into meatus. Repeat every one to two hours until pain and congestion are relieved.

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

IN ACUTE *OTITIS MEDIA* Auralgan® OTIC SOLUTION

FOR SYMPTOMATIC RELIEF OF RHINORRHEA AND CONGESTION

RYNATAN®

PEDIATRIC SUSPENSION B.I.D.

Each 5 ml (teaspoonful) contains: phenylephrine tannate, 5 mg; chlorpheniramine tannate, 2 mg; pyrilamine tannate, 12.5 mg.

- Twice-a-day formulation lessens "dosing chore" in pediatric patients
- Strawberry-currant flavor enhances patient compliance
- Alcohol-free formulation
- Available by prescription only

Also available: scored, titratable

RYNATAN® TABLETS B.I.D.

Each capsule-shaped tablet contains: phenylephrine tannate, 25 mg; chlorpheniramine tannate, 8 mg; pyrilamine tannate, 25 mg.

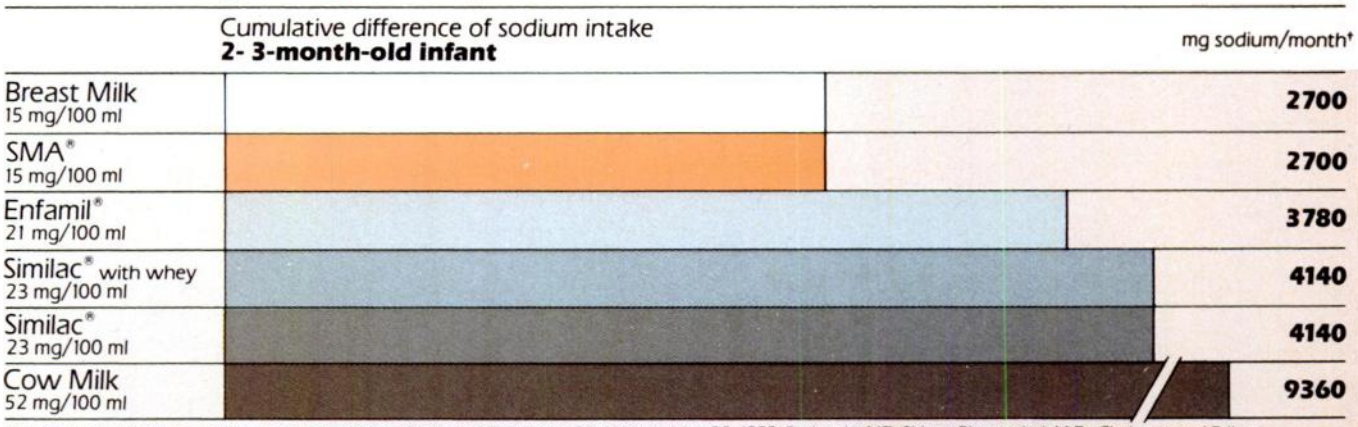
Please see following page for brief summary of prescribing information.

Only SMA® has a natural sodium level

The sodium level closest to breast milk
SMA® contains 15 mg sodium per 100 ml, which is closest to that found in breast milk. The other leading formulas have approximately one and a half times the sodium of either breast milk or SMA®. Keeping babies on breast milk, or on a formula that contains an amount of sodium closest to breast milk, may be an important measure in preventing essential hypertension.* And this is beneficial to all healthy, full-term infants – beginning at birth.

SMA® is closest to breast milk in all nutritional components...
and has been for over 20 years. SMA® gives parents a sound nutritional alternative when breast-feeding has not been chosen.

Compare the sodium content of the formula you may be using with breast milk.



*Hypertension: Prevention, Diet and Treatment in Infancy and Childhood, Symposium, May 25, 1983, Bethesda, MD, Sidney Blumenthal, M.D., Chairman and Editor.
†based on approximately 120 ml/feeding, 5 feedings/day, times 30 days.

Breast milk is the preferred feeding for newborns. Infant formula is intended to replace or supplement breast milk when breast-feeding is not possible or is insufficient, or when mothers elect not to breast-feed.

Good maternal nutrition is important for the preparation and maintenance of breast-feeding. Extensive or prolonged use of partial bottle-feeding, before breast-feeding has been well established, could make breast-feeding difficult to maintain. A decision not to breast-feed could be difficult to reverse.

Professional advice should be followed on all matters of infant feeding. Infant formula should always be prepared and used as directed. Unnecessary or improper use of infant formula could present a health hazard. Social and financial implications should be considered when selecting the method of infant feeding.

Only Wyeth has

SMAP™

the Salt Modification Action Plan to help you modify your patients' salt intake

Wyeth Laboratories
Philadelphia, PA 19101
Pioneers in Infant Nutrition


THEO-DUR®
SPRINKLE™
125 mg

Some patients need to be spoon-fed.

Theo-Dur Sprinkle is the theophylline for patients who find tablets or capsules hard to swallow. Theo-Dur Sprinkle contains microencapsulated anhydrous theophylline—no alcohol, placebo beads, starch, dyes or preservatives. A patient (or parent) just twists the top off the oversized capsule and carefully pours the contents onto a spoonful of soft food, such as applesauce. Each dose is easy and pleasant to swallow.

Theo-Dur Sprinkle, when properly titrated, is designed to keep blood levels in the therapeutic range with convenient q12h dosing. Once steady state is achieved, each dose produces smooth serum concentrations with minimal peak-trough fluctuations—even in rapid metabolizers. And there are only two doses to remember every day.

Theo-Dur Sprinkle and other sustained-release, bead-filled capsules may exhibit decreased absorption when administered with meals. Current findings suggest that Theo-Dur Sprinkle should be administered to adults and children several hours before or after meals to minimize any potential effect of food on drug absorption. Theo-Dur Sprinkle is not recommended for use in children under 6 years of age.

THEO-DUR®

SPRINKLE

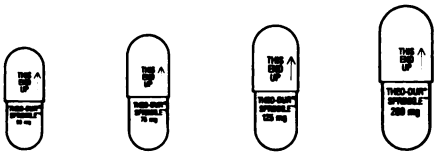
(theophylline anhydrous)

Sustained Action Capsules

Please see next page for brief summary of prescribing information.

THEO-DUR® SPRINKLE™

(theophylline anhydrous sustained action capsules)



DESCRIPTION:
THEO-DUR SPRINKLE sustained action capsules contain anhydrous theophylline, a bronchodilator, in a sustained release formulation with no color additives.

CLINICAL PHARMACOLOGY:
Theophylline directly relaxes the smooth muscle of the bronchial airways and pulmonary blood vessels, thus acting mainly as a bronchodilator and smooth muscle relaxant. The drug also produces other actions typical of the xanthine derivatives: coronary vasodilator, cardiac stimulant, diuretic, cerebral stimulant, and skeletal muscle stimulant. The actions of theophylline may be mediated through inhibition of phosphodiesterase and a resultant increase in intracellular cyclic AMP. Apparently, no development of tolerance occurs with chronic use of theophylline.

INDICATIONS:
THEO-DUR SPRINKLE is indicated for relief and/or prevention of symptoms of bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

CONTRAINDICATIONS:
THEO-DUR SPRINKLE is contraindicated in individuals who have shown hypersensitivity to theophylline or any of the capsule components.

WARNINGS:
Excessive theophylline doses may be associated with toxicity; serum theophylline levels should be monitored to insure maximum benefit with minimum risk. Incidence of toxicity increases at serum levels greater than 20 mcg/ml. High blood levels of theophylline resulting from conventional doses are correlated with clinical manifestation of toxicity in: patients with lowered body plasma clearances, patients with liver dysfunction or chronic obstructive lung disease, and patients who are older than 55 years of age, particularly males. There are often no early signs of less serious theophylline toxicity such as nausea and restlessness, which may occur in up to 50% of patients prior to onset of convulsions. Ventricular arrhythmias or seizures may be the first signs of toxicity. Many patients who have higher theophylline levels exhibit tachycardia. Theophylline products may worsen pre-existing arrhythmias.

PRECAUTIONS:
THEO-DUR SPRINKLE CAPSULES SHOULD NOT BE CHEWED OR CRUSHED. Theophylline should not be administered concurrently with other xanthine medications. Use with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease, in the elderly (especially males) and in neonates. In particular, great caution should be used in giving theophylline to patients with congestive heart failure. Frequently, such patients have markedly prolonged theophylline serum levels with theophylline persisting in serum for long periods following discontinuation of the drug. Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to the G.I. tract although gastrointestinal symptoms are more commonly centrally mediated and associated with serum drug concentrations over 20 mcg/ml.

USAGE IN PREGNANCY:
Animal reproduction studies have not been conducted with theophylline. It is not known whether theophylline can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Xanthines should be given to a pregnant woman only if clearly needed.

Nursing Mothers:
It has been reported that theophylline distributes readily into breast milk and may cause adverse effects in the infant. Caution must be used if prescribing xanthines to a mother who is nursing, taking into account the risk-benefit of this therapy.

Pediatric Use
Safety and effectiveness of THEO-DUR SPRINKLE in children under 6 years of age have not been established.

ADVERSE REACTIONS:
The most consistent adverse reactions are usually due to overdose and are:
Gastrointestinal: nausea, vomiting, epigastric pain, hematemesis, diarrhea.
Central nervous system: headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.
Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, ventricular arrhythmias.
Respiratory: tachypnea.
Renal: albuminuria, increased excretion of renal tubular and red blood cells, potentiation of diuresis.
Others: rash, hyperglycemia and inappropriate ADH syndrome.

HOW SUPPLIED:
THEO-DUR SPRINKLE 50, 75, 125 and 200 mg sustained action capsules are available in bottles of 100.

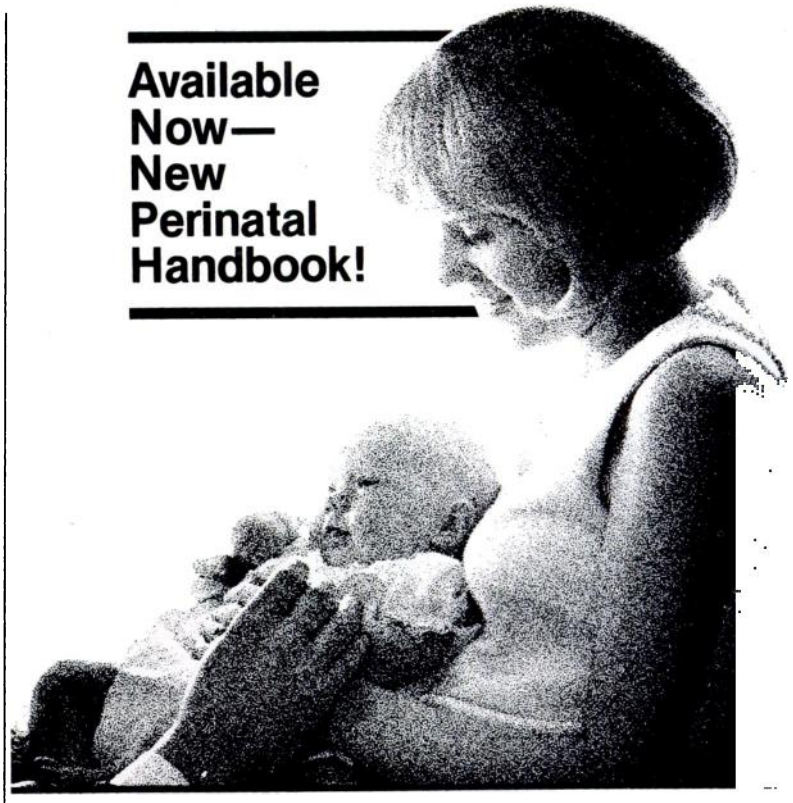
CAUTION:
Federal law prohibits dispensing without prescription.
For full prescribing information, see package insert.

Revised 01/84

KEY PHARMACEUTICALS, INC.
Miami, Florida 33269-0670
World leader in drug delivery systems.

TDS-1170

Available Now— New Perinatal Handbook!



Guidelines for Perinatal Care is required reading for all physicians and nurses who care for pregnant women and newborns. It details the joint recommendations of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Special Emphasis On: family-centered care, regional health care delivery, high-risk considerations. With guidelines for facilities, personnel, and services. *Also included:* useful listings for resources and recommended readings.

Order Now. Complete the coupon. Or charge it by calling 312/228-5005. MasterCard/Visa accepted.

American Academy of Pediatrics

American College of Obstetricians and Gynecologists

Please send me:
____copies,
"Perinatal Manual"
@ $25.00

Mail to:
American Academy of Pediatrics
Publications Department
P.O. Box 927
Elk Grove Village, IL 60007

☐ Check enclosed, payable to AAP.
☐ Bill me. (Formal purchase order required.)
☐ Bill me for UPS delivery within 2 weeks.

Name _____

Address _____

City _____ State_____ Zip_____

☐ AAP Member. ID# _____
(required for processing)
☐ Non-member

PED

Only Loma Linda makes two soy formulas to cover infants' sensitivities.

Rx prescribe for babies with sensitivities to lactose and cow milk protein.

Over half-a-century of clinical use.

Rx prescribe for infants with additional sensitivities including corn products.

It works where other formulas fail.

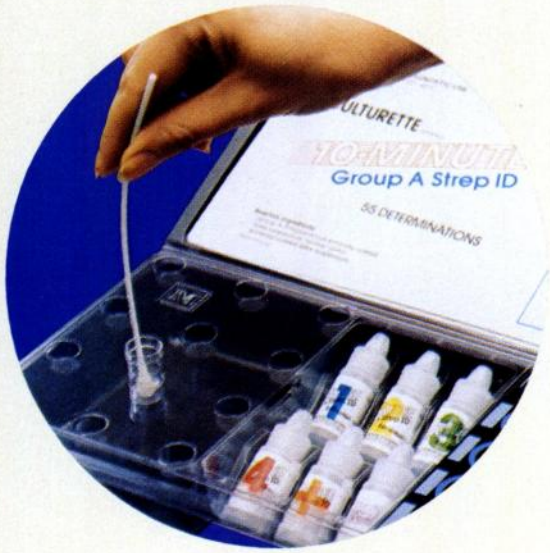
LOMA LINDA

Pioneer in Infant Soy Formulas.

11503 Pierce Street, Riverside, CA 92515 1-(800) 442-4917 (Calif. only) 1-(800) 932-5525 (714) 687-7800

MARION SCIENTIFIC ANNOUNCES

The Rapid Office Test



For Group A Strep

Fast, Accurate Confirmation for the Patients Who Need It Most

95% sensitivity, 92% specificity in multicenter pediatric studies.*

Confirm your diagnosis of group A strep STAT...in your own office. CULTURETTE Brand 10-MINUTE GROUP A STREP ID is the first test fast *and* practical enough to make a difference.

Dependable Accuracy—CULTURETTE STREP ID uses the latest latex agglutination technology to ensure easy, accurate readings test after test.

10-Minute TOTAL Turnaround—Go from swab to results in six easy steps. That's all it takes to run and read the complete test.

Simple User Protocol—Only 3½ minutes "hands-on" time required to perform the test, which can be run individually or batched for your convenience.

A Complete Test Kit—Everything you need for 50 tests is contained in each kit. No need for cumbersome culture plates or costly equipment. And all items are easily disposable after use.

Now you have the option to send out for a culture or run CULTURETTE STREP ID in your own office—anytime.

Find out for yourself the difference it can make. Have CULTURETTE STREP ID performed in your own office. Simply call 1-800-421-0098 for a free demonstration.

CULTURETTE Brand
10-MINUTE GROUP A STREP ID

*Data on file, Marion Laboratories, Inc.

...In time to make a difference

MARION SCIENTIFIC
A Division of Marion Laboratories, Inc.
Kansas City, Missouri 64114

All-night, all-day relief of cold and allergy symptoms

New CORSYM™ offers the unique benefits of b.i.d. convenience and precise, predictable blood levels in a pleasant-tasting, nonalcoholic liquid. Recommend nonprescription CORSYM in convenient 3 oz bottles.

CORSYM™ dosage* schedule

Adults: 2 teaspoonsful b.i.d.

Children 6-12: 1 teaspoonful b.i.d.

Children 2-5†: ½ teaspoonful b.i.d.

*Do not exceed recommended dosage.
†Use under the supervision of a physician.

Each teaspoonful (5 ml) contains phenylpropanolamine polistirex equivalent to 37.5 mg phenylpropanolamine HCl, plus chlorpheniramine polistirex equivalent to 4 mg chlorpheniramine maleate.

New

CORSYM™

A PENNKINETIC™ PRODUCT

phenylpropanolamine polistirex and chlorpheniramine polistirex

The only liquid nasal decongestant/ antihistamine with 12-hour efficacy

PENNWALT CORP.
PRESCRIPTION DIVISION
Rochester, N.Y. 14623

A-424

Printed in U.S.A.

Available Now!

Pediatrics in Review

BOUND EDITION

1983-1984 • VOLUME 5

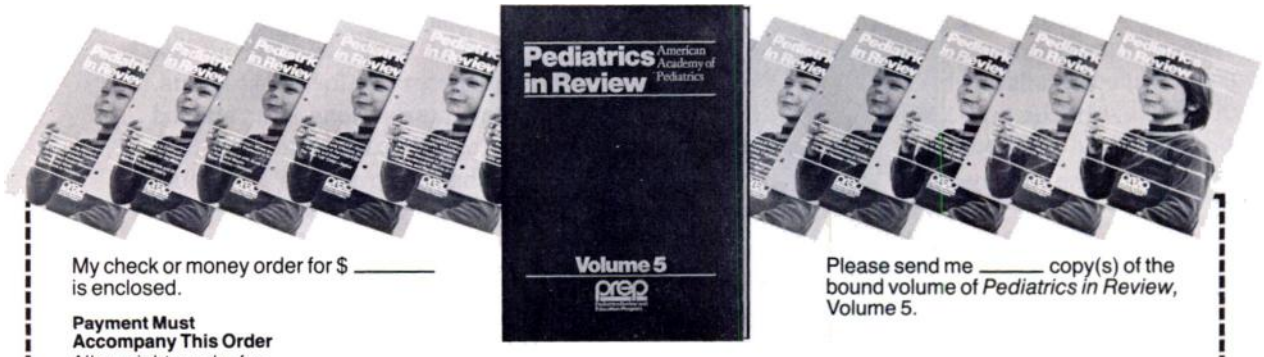
Get the most comprehensive selection of review articles on advances in pediatrics in *Pediatrics in Review,* Bound Edition, Volume 5.

This year, the bound edition contains a wide selection of articles on the following subjects:

Endocrinology • Metabolic Disease • Genitourinary System Disease • Nutrition • Fluid and Electrolyte Metabolism • Gastrointestinal Disease

You'll find no better source for up-to-date information in such a handy reference.

Supplies are limited, so mail your order today. Payment of (U.S.) $40 must accompany your order.



My check or money order for $ _____ is enclosed.

Payment Must Accompany This Order

Allow eight weeks for delivery

Return to:
PIR Bound Volume
American Academy of Pediatrics
P.O. Box 927
Elk Grove Village, IL 60007

Please send me _____ copy(s) of the bound volume of *Pediatrics in Review,* Volume 5.

Name _____

Address _____

City _____ State _____ Zip _____

P PED

Now— a standard therapy for ADD becomes more convenient... more simple... more private...

RITALIN-SR® ©

methylphenidate

20-mg sustained-release tablets

Reference

1. Whitehouse D, Shah U, Palmer FB: *J Clin Psychiatry* 1980 (Aug); 41(8):282-285.

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

Ritalin® hydrochloride ©
methylphenidate hydrochloride USP
Tablets

Ritalin-SR® ©
methylphenidate hydrochloride
sustained-release tablets

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)*

INDICATIONS

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

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

Special Diagnostic Considerations

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

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

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

CONTRAINDICATIONS

Marked anxiety, tension, and agitation are contraindications to Ritalin, since the drug may aggravate these symptoms. Ritalin is contraindicated also in patients known to be hypersensitive to the drug, 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 (*ie*, weight gain, and/or height) has been reported with the long-term use of stimulants in children. Therefore, patients requiring long-term therapy should be carefully monitored.

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

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

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

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

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

Drug Interactions

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

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

Usage in Pregnancy

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

Drug Dependence

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

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

PRECAUTIONS

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

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

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

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

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

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. 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, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

DOSAGE 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. Daily dosage above 60 mg is not recommended.

If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.

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-SR corresponds to the titrated 8-hour dosage of Ritalin.

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

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.

OVERDOSAGE

Signs and symptoms of acute overdosage, resulting principally from overstimulation of the central nervous system and from excessive sympathomimetic effects, may include the following: vomiting, agitation, tremors, hyperreflexia, muscle twitching, convulsions (may be followed by coma), euphoria, confusion, hallucinations, delirium, sweating, flushing, headache, hyperpyrexia, tachycardia, palpitations, cardiac arrhythmias, hypertension, 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 signs and symptoms 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.

Intensive care must be provided to maintain adequate circulation and respiratory exchange; external cooling procedures may be required for hyperpyrexia.

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

HOW SUPPLIED

Tablets 20 mg—round, pale yellow, scored (imprinted CIBA 34)
Bottles of 100 ..... NDC 0083-0034-30
Bottles of 1000 ..... NDC 0083-0034-40

Tablets 10 mg—round, pale green, scored (imprinted CIBA 3)
Bottles of 100 ..... NDC 0083-0003-30
Bottles of 500 ..... NDC 0083-0003-35
Bottles of 1000 ..... NDC 0083-0003-40
Accu-Pak® Unit Dose (blister pack)
Box of 100 (strips of 10) ..... NDC 0083-0003-32

Tablets 5 mg—round, yellow (imprinted CIBA 7)
Bottles of 100 ..... NDC 0083-0007-30
Bottles of 500 ..... NDC 0083-0007-35
Bottles of 1000 ..... 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 (USP).

C84-29 (Rev. 6/84)

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

174-7904-A

CIBA

Available Now!

Pediatrics in Review

BOUND EDITION

1983-1984 • VOLUME 5

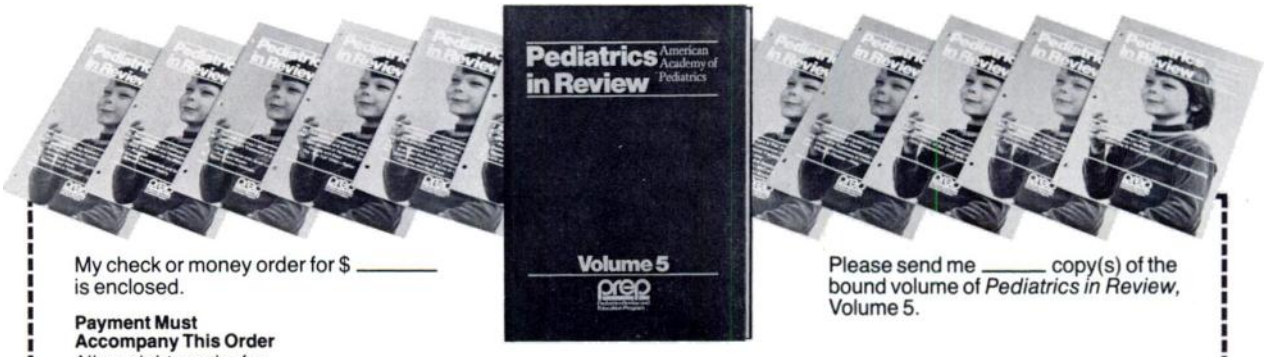
Get the most comprehensive selection of review articles on advances in pediatrics in *Pediatrics in Review,* Bound Edition, Volume 5.

This year, the bound edition contains a wide selection of articles on the following subjects:

Endocrinology • Metabolic Disease • Genitourinary System Disease • Nutrition • Fluid and Electrolyte Metabolism • Gastrointestinal Disease

You'll find no better source for up-to-date information in such a handy reference.

Supplies are limited, so mail your order today. Payment of (U.S.) $40 must accompany your order.



My check or money order for $ _____ is enclosed.

Payment Must Accompany This Order
Allow eight weeks for delivery

Return to:
PIR Bound Volume
American Academy of Pediatrics
P.O. Box 927
Elk Grove Village, IL 60007

Please send me _____ copy(s) of the bound volume of *Pediatrics in Review,* Volume 5.

Name _____

Address _____

City _____ State _____ Zip _____

P PED

$10 MILLION IS AWARDED OVER A POLIO VACCINE

Drug company lawyers say they will appeal a record $10 million judgment awarded to a farmer who said he contracted poliomyelitis from a vaccine given his infant daughter. A Sedgwick County District Court jury ordered Lederle Laboratories of Pearl River, N.Y., a subsidiary of the American Cyanamid Company of Wayne, N.J., to pay $2 million in actual damages and $8 million in punitive damages to Emil Johnson, 62 years old, of Ottawa, Kan. Mr. Johnson said the drug companies were "life in its lowest form" and hailed the decision as a warning to consumers. Lawyers for Lederle said the company would appeal the decision. The jury began deliberations May 24.

Mr. Johnson's infant daughter was given the oral polio vaccine "Orimune" in November 1975. Orimune is based on live, weakened polio viruses. Mr. Johnson said he caught poliomyelitis after the girl spat up some of the vaccine on his hands. Mr. Johnson's lawyers say he now suffers breathing problems, his right arm is paralyzed and he has been unable to work on his farm.

The trial lasted almost two months. Dr. Darrell Salk, the son of Dr. Jonas Salk, the polio vaccine pioneer, testified against the companies.

From *The New York Times*, June 2, 1984.

TOO MANY LAWYERS

A year ago, President Derek Bok of Harvard captured headlines by asserting that "the legal system looks grossly inequitable and inefficient, [and that] there is far too much law for those who can afford it and far too little for those who cannot."

The number of lawyers in the U.S. has risen to about 650,000 today from 350,000 in 1970—and it threatens to reach one million sometime during the 1990s. Two-thirds of the world's lawyers now practice in this country, and one-third of these were graduated during the past five years. The number of law students doubled between 1960 and 1970 and increased an additional 50% (to 125,000) by 1980. More lawyers joined the legal profession in the 1970s than in the previous 100 years. A major factor in the flood of students entering law schools has been the growth in federal and state loan programs for law students. In the mid-1960s, a modest federal program of below-market loans was started to aid lower-income college students. The initial program was limited and cost the taxpayer less than $200 million a year. Today that program has an annual budget of more than $8 billion (and is in default by more than $750 million). More than half of today's law students get interest-free loans of as much as $5,000 annually, even though such students often come from wealthy families or could easily borrow funds privately.

Federal financial aid to law students now exceeds $300 million annually; nearly 30% of the $1 billion legal education industry budget is now supported by the federal government. State aid programs add further to that figure. Surely it is time to recognize that these programs need to be scaled back and reformed.

From *The Wall Street Journal*, June 7, 1984.

Watch "The Brain" Wednesdays on PBS starting October 10

NOW... 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.

Before prescribing, please consult Brief Summary of Prescribing Information on next page.

RITALIN-SR®

methylphenidate

20-mg sustained-release tablets

CIBA

Now— a standard therapy for ADD becomes more convenient... more simple... more private...

RITALIN-SR®Ⓒ

methylphenidate

20-mg sustained-release tablets

Reference

1. Whitehouse D, Shah U, Palmer FB: *J Clin Psychiatry* 1980 (Aug); 41(8):282-285.

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

Ritalin® hydrochloride Ⓒ

methylphenidate hydrochloride USP

Tablets

Ritalin-SR® Ⓒ

methylphenidate hydrochloride

sustained-release tablets

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)*

INDICATIONS

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

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

Special Diagnostic Considerations

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

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

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

CONTRAINDICATIONS

Marked anxiety, tension, and agitation are contraindications to Ritalin, since the drug may aggravate these symptoms. Ritalin is contraindicated also in patients known to be hypersensitive to the drug, 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 (*ie*, weight gain, and/or height) has been reported with the long-term use of stimulants in children. Therefore, patients requiring long-term therapy should be carefully monitored.

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

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

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

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

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

Drug Interactions

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

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

Usage in Pregnancy

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

Drug Dependence

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

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

PRECAUTIONS

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

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

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

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

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

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. 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, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

DOSAGE 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. Daily dosage above 60 mg is not recommended.

If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.

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-SR corresponds to the titrated 8-hour dosage of Ritalin.

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

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.

OVERDOSAGE

Signs and symptoms of acute overdosage, resulting principally from overstimulation of the central nervous system and from excessive sympathomimetic effects, may include the following: vomiting, agitation, tremors, hyperreflexia, muscle twitching, convulsions (may be followed by coma), euphoria, confusion, hallucinations, delirium, sweating, flushing, headache, hyperpyrexia, tachycardia, palpitations, cardiac arrhythmias, hypertension, 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 signs and symptoms 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.

Intensive care must be provided to maintain adequate circulation and respiratory exchange; external cooling procedures may be required for hyperpyrexia.

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

HOW SUPPLIED

Tablets 20 mg—round, pale yellow, scored (imprinted CIBA 34)
Bottles of 100 . . . . . NDC 0083-0034-30
Bottles of 1000 . . . . . NDC 0083-0034-40

Tablets 10 mg—round, pale green, scored (imprinted CIBA 3)
Bottles of 100 . . . . . NDC 0083-0003-30
Bottles of 500 . . . . . NDC 0083-0003-35
Bottles of 1000 . . . . . NDC 0083-0003-40
Accu-Pak® Unit Dose (blister pack)
Box of 100 (strips of 10) . . . . . NDC 0083-0003-32

Tablets 5 mg—round, yellow (imprinted CIBA 7)
Bottles of 100 . . . . . NDC 0083-0007-30
Bottles of 500 . . . . . NDC 0083-0007-35
Bottles of 1000 . . . . . 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 (USP).

C84-29 (Rev. 6/84)

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

174-7904-A

CIBA

ACTIONS: Dimetapp effectively reduces excessive nasopharyngeal secretions and diminishes inflammatory mucosal edema and congestion in the upper respiratory tract.

The antihistaminic action of brompheniramine maleate reduces or abolishes the allergic response of nasal tissue. It is complemented by the mild vasoconstrictor action of phenylephrine hydrochloride and phenylpropanolamine hydrochloride which provide a nasal decongestant effect.

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably effective" for Dimetapp Elixir: The symptomatic treatment of seasonal and perennial allergic rhinitis and vasomotor rhinitis; and "lacking substantial evidence of effectiveness as a fixed combination" for the following indications: Symptomatic relief of allergic manifestations of upper respiratory illnesses, acute sinusitis, nasal congestion, and otitis.

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

CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp is contraindicated during pregnancy and in concurrent MAO inhibitor therapy. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma.

WARNINGS: *Use in Children.* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases, hypertension, diabetes or thyroid disease. Use cautiously in patients with a history of bronchial asthma, narrow angle glaucoma, gastrointestinal obstruction or urinary bladder neck obstruction. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

ADVERSE REACTIONS: Adverse reactions to Dimetapp may include hypersensitivity reactions such as rash, urticaria; leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis. CNS depressant and (less often) stimulant effect, increased irritability or excitement, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

DOSAGE AND ADMINISTRATION: *Adults*—1 to 2 teaspoonfuls 3 or 4 times daily.

Children (4 to 12 years)—1 teaspoonful 3 or 4 times daily; *(2 to 4 years)*—¾ teaspoonful 3 or 4 times daily; *(7 months to 2 years)*—½ teaspoonful 3 or 4 times daily; *(1 to 6 months)*—¼ teaspoonful 3 or 4 times daily.

HOW SUPPLIED: Grape-flavored Elixir in 4 fl. oz. (NDC 0031-2224-32), pints (NDC 0031-2224-25), gallons (NDC 0031-2224-29), and 5 ml Dis-Co® Unit Dose Packs (10 x 10s) (NDC 0031-2224-23).

Rev. Aug. 1982

Dimetapp® Elixir

ANTIHISTAMINE/ NASAL DECONGESTANT

Each 5 ml (1 teaspoonful) contains:

Brompheniramine Maleate, USP	4 mg
Phenylephrine Hydrochloride, USP	5 mg
Phenylpropanolamine Hydrochloride, USP	5 mg
Alcohol, 2.3%	

A·H·ROBINS

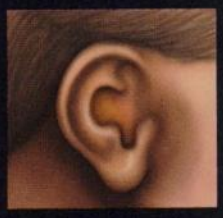
Pharmaceutical Division
Richmond, Virginia 23261-6609

Burning questions

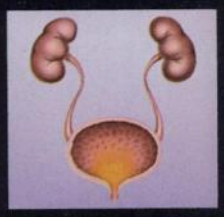
in pediatric practice

How do you treat:

Eye infections?



Ear infections?



Urinary infections?

Gantrisin®
(sulfisoxazole diolamine/Roche) Ophthalmic Solution

For conjunctivitis, bacterial corneal ulcers and other superficial eye infections

The Ophthalmic Solution—a sterile, isotonic preparation containing 4% (40 mg/ml) sulfisoxazole diolamine—is a highly effective answer to superficial pediatric eye infections caused by susceptible microorganisms, such as *Staphylococcus aureus*. It's easy to administer (two or three drops, three or more times daily), usually without significant stinging or burning.

Gantrisin®
(acetyl sulfisoxazole/Roche) 0.5 Gm/5 ml Pediatric Suspension and Syrup

For acute otitis media and for acute cystitis

For children with acute nonobstructed cystitis, the Pediatric Suspension offers prompt, effective control of most common pathogens, such as susceptible strains of *E. coli* and *Klebsiella-Aerobacter*. Used concomitantly, the Suspension is also an excellent "working partner" for penicillin when *H. influenzae* is implicated in acute otitis media. As with all sulfonamides, adequate fluid intake should be maintained. Gantrisin should not be given to infants under two months of age.

Gantrisin®
sulfisoxazole/Roche
has an answer!

Please see summary of product information on the following page.

ROCHE®

GANTRISIN® (sulfisoxazole diolamine/Roche)
Ophthalmic Solution, Ophthalmic Ointment

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

Indications: Conjunctivitis, corneal ulcer, other superficial ocular infections due to susceptible microorganisms, as adjunct in systemic sulfonamide therapy of trachoma.

Contraindications: Hypersensitivity.

Precautions: Incompatible with silver preparations; inactivated by para-aminobenzoic acid in purulent exudates; may increase growth of nonsusceptible organisms, including fungi. Ointment may retard corneal healing. Discontinue use if undesirable reactions occur.

Dosage and Administration: Solution: 2-3 drops in eye 3 or more times daily. Take care not to contaminate dropper. Ointment: small amount in lower conjunctival sac 1-3 times daily and at bedtime.

How Supplied: Solution, ½-oz bottles with dropper. Ointment, ⅛-oz tubes.

GANTRISIN® (sulfisoxazole/Roche) Tablets
GANTRISIN® (acetyl sulfisoxazole/Roche) Pediatric Suspension

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

Indications: Nonobstructed urinary tract infections (mainly cystitis, pyelitis, pyelonephritis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter*, staphylococcus, *P. mirabilis, P. vulgaris*). Acute otitis media due to *H. influenzae* (concomitantly with adequate doses of penicillin or erythromycin; see appropriate erythromycin labeling for prescribing information) IMPORTANT NOTE: *In vitro* sensitivity tests not always reliable; must be coordinated with bacteriological and clinical response. Add aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms limits usefulness of antibacterial agents, especially in chronic and recurrent urinary infections. Maximum safe total sulfonamide blood level, 20 mg/100 ml; measure levels as variations may occur.

Contraindications: Hypersensitivity to sulfonamides; infants less than 2 months of age; pregnancy at term and during the nursing period.

Warnings: Safety in pregnancy not established. Do not use for group A beta-hemolytic streptococcal infections, as sequelae (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias. Sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. CBC and urinalysis with careful microscopic examination should be performed frequently.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma. Hemolysis, frequently dose-related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia; *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis; *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, anorexia, pancreatitis and stomatitis; *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; *Miscellaneous reactions:* Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Contraindicated in infants under 2 months except in the treatment of congenital toxoplasmosis as adjunctive therapy with pyrimethamine.

Usual adult dosage—2 to 4 Gm initially, then 4 to 8 Gm/24 hrs. in 4 to 6 doses. *Usual dosage for infants over 2 months and children*—½ 24-hr dose initially, then 150 mg/kg/24 hrs. in 4 to 6 doses; not over 6 Gm/24 hrs.

How Supplied: Tablets containing 0.5 Gm sulfisoxazole, white, scored—bottles of 100, 500 and 1000, Tel-E-Dose® packages of 100, Prescription Paks of 100.

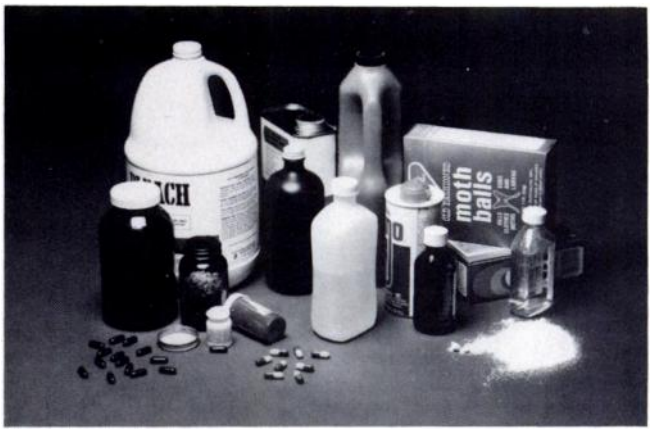
Pediatric Suspension, containing, in each teaspoonful (5 ml), the equivalent of approximately 0.5 Gm sulfisoxazole in the form of acetyl sulfisoxazole, raspberry flavored—bottles of 4 oz and 16 oz (1 pint).

Syrup, containing, in each teaspoonful (5 ml), the equivalent of approximately 0.5 Gm sulfisoxazole in the form of acetyl sulfisoxazole, chocolate flavored—bottles of 16 oz (1 pint).

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

ROCHE®

Some practical reasons for a guide on common childhood poisonings.



Poisonings are one of the leading causes of morbidity and death in young children. And, many poisonings are caused by common products in the home.

The American Academy of Pediatrics' *Handbook of Common Poisonings in Children*, second edition, offers current information on care and treatment of common poisoning experiences. There are descriptions of more than 50 common poisons, with details on ingredients, toxicity, symptoms, and treatment.

This book is designed as a quick reference for pediatricians, other primary care physicians, nurses, emergency room personnel, and pharmacists.

Academy Fellows—not Jr. Fellows—get one free copy on request.
For your copy, return the coupon to:

American Academy of Pediatrics, Publications Department, P.O. Box 927, Elk Grove Village, IL 60007

American Academy of Pediatrics
Publications Department
P.O. Box 927
Elk Grove Village, IL 60007

Please send me _____ copies of *Handbook of Common Poisonings in Children* at $15 each. (UPS Shipping charges: Add $1.60 each.)
Total: $_____

Please print:

Name _____

Address _____

City **State** **Zip**

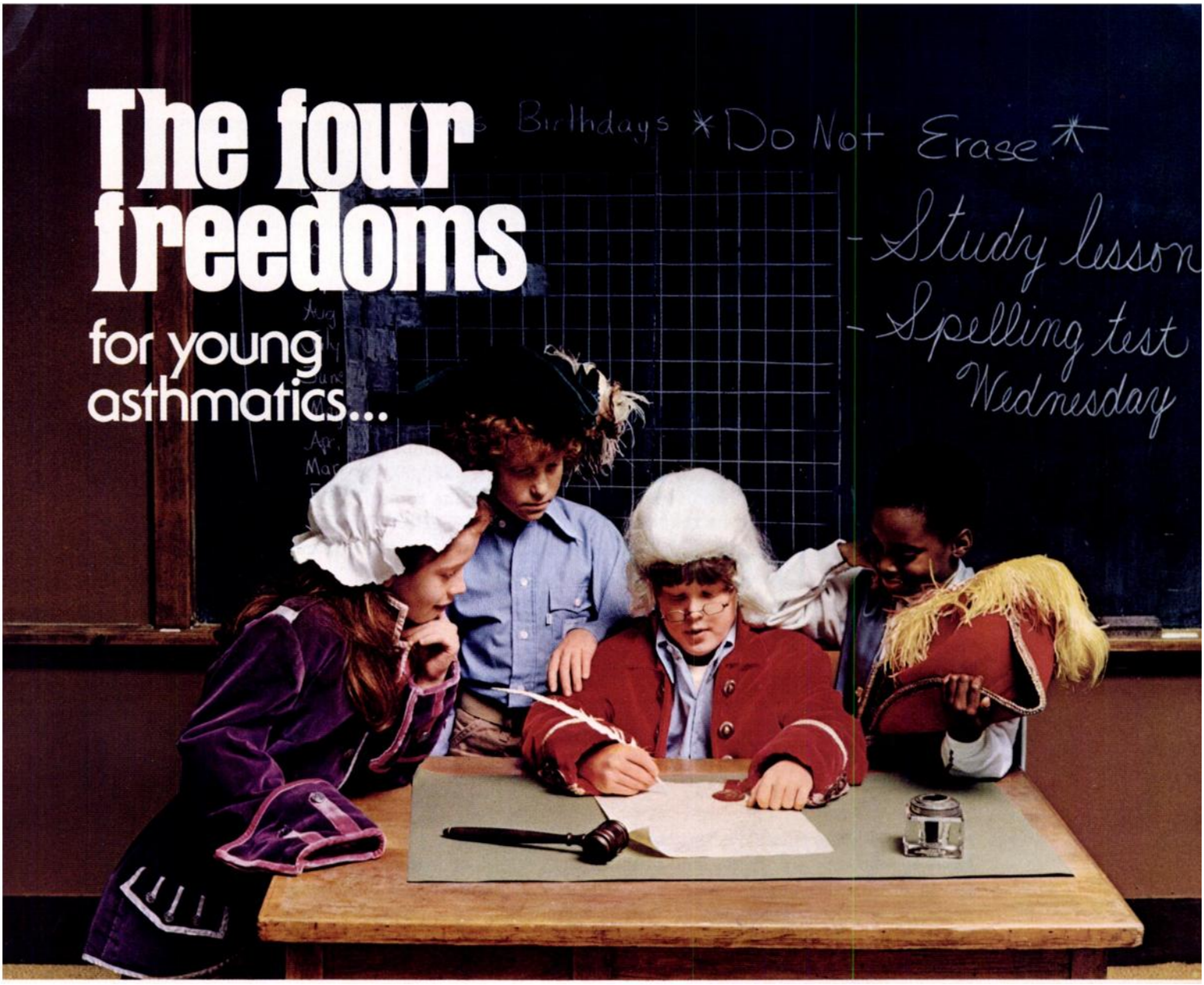
☐ **AAP Member** **ID Number _____ required for processing** ☐ **Non-member**

☐ **Check/money order payable to American Academy of Pediatrics enclosed.** ☐ **Visa** ☐ **MasterCard**

Credit Card Number **Expiration Date** **MasterCard only: 4 digit bank # over your name.**

Signature **Phone Number**

PED



- free of alcohol
- free of dye
- free of artificial preservatives
- free of additive-induced side effects

LIQUID
QUIBRON®

Each tablespoonful (15 ml) contains theophylline (anhydrous) 150 mg and guaifenesin 90 mg

Indications: For the symptomatic treatment of bronchospasm associated with such conditions as bronchial asthma, chronic bronchitis, and pulmonary emphysema.
Dosage: Treatment should be initiated at 150 mg theophylline every 6 hours for adults and 4 mg/kg every 6 hours for children. The usual recommended dosages are *Adults:* 1-2 capsules or 1-2 tablespoons (15 ml) liquid every 6-8 hours. *Children 9 to 12:* 4-5 mg theophylline/kg bodyweight every 6-8 hours. *Children under 9:* 4-6 mg theophylline/kg bodyweight every 6-8 hours. When necessary to achieve greater efficacy theophylline dosage may be cautiously adjusted upward. Serum theophylline determinations are helpful in monitoring therapeutic progress. When dosages exceed the usual recommended ranges serum determinations are essential. In the absence of side effects, the dosage may be titrated upward cautiously by increments of no more than 25% of previous dose, increasing the dose no more than every third day until the desired clinical response is obtained. If nausea, vomiting or other evidence of toxicity occurs, omit one dose and resume treatment at a lower dose.
Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.
Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e., clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 mcg/ml.
How Supplied: Capsules, containing theophylline (anhydrous) 150 mg and guaifenesin 90 mg, in bottles of 100 and 1000 and unit-dose packs of 100; Liquid in bottles of 1 pint and 1 gallon.
See package insert for complete prescribing information.

Mead Johnson PHARMACEUTICAL DIVISION


Now you can extend steroid benefits to more asthmatic patients who need them

Gantrisin®
(sulfisoxazole diolamine/Roche) Ophthalmic Solution

For conjunctivitis, bacterial corneal ulcers and other superficial eye infections

The Ophthalmic Solution—a sterile, isotonic preparation containing 4% (40 mg/ml) sulfisoxazole diolamine—is a highly effective answer to superficial pediatric eye infections caused by susceptible microorganisms, such as *Staphylococcus aureus*. It's easy to administer (two or three drops, three or more times daily), usually without significant stinging or burning.

Gantrisin®
(acetyl sulfisoxazole/Roche) 0.5 Gm/5 ml Pediatric Suspension and Syrup

For acute otitis media and for acute cystitis

For children with acute nonobstructed cystitis, the Pediatric Suspension offers prompt, effective control of most common pathogens, such as susceptible strains of *E. coli* and *Klebsiella-Aerobacter*. Used concomitantly, the Suspension is also an excellent "working partner" for penicillin when *H. influenzae* is implicated in acute otitis media. As with all sulfonamides, adequate fluid intake should be maintained. Gantrisin should not be given to infants under two months of age.

Gantrisin®
sulfisoxazole/Roche
has an answer!

Please see summary of product information on the following page.

ROCHE®

GANTRISIN® (sulfisoxazole diolamine/Roche)
Ophthalmic Solution, Ophthalmic Ointment

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

Indications: Conjunctivitis, corneal ulcer, other superficial ocular infections due to susceptible microorganisms, as adjunct in systemic sulfonamide therapy of trachoma.

Contraindications: Hypersensitivity.

Precautions: Incompatible with silver preparations; inactivated by para-aminobenzoic acid in purulent exudates; may increase growth of nonsusceptible organisms, including fungi. Ointment may retard corneal healing. Discontinue use if undesirable reactions occur.

Dosage and Administration: Solution: 2-3 drops in eye 3 or more times daily. Take care not to contaminate dropper. Ointment: small amount in lower conjunctival sac 1-3 times daily and at bedtime.

How Supplied: Solution, ½-oz bottles with dropper. Ointment, ⅛-oz tubes.

GANTRISIN® (sulfisoxazole/Roche) Tablets
GANTRISIN® (acetyl sulfisoxazole/Roche) Pediatric Suspension

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

Indications: Nonobstructed urinary tract infections (mainly cystitis, pyelitis, pyelonephritis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, staphylococcus, *P. mirabilis*, *P. vulgaris*). Acute otitis media due to *H. influenzae* (concomitantly with adequate doses of penicillin or erythromycin; see appropriate erythromycin labeling for prescribing information). IMPORTANT NOTE: *In vitro* sensitivity tests not always reliable; must be coordinated with bacteriological and clinical response. Add aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms limits usefulness of antibacterial agents, especially in chronic and recurrent urinary infections. Maximum safe total sulfonamide blood level, 20 mg/100 ml; measure levels as variations may occur.

Contraindications: Hypersensitivity to sulfonamides; infants less than 2 months of age; pregnancy at term and during the nursing period.

Warnings: Safety in pregnancy not established. Do not use for group A beta-hemolytic streptococcal infections, as sequelae (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias. Sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. CBC and urinalysis with careful microscopic examination should be performed frequently.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma. Hemolysis, frequently dose-related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, anorexia, pancreatitis and stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia. *Miscellaneous reactions:* Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Contraindicated in infants under 2 months except in the treatment of congenital toxoplasmosis as adjunctive therapy with pyrimethamine.

Usual adult dosage—2 to 4 Gm initially, then 4 to 8 Gm/24 hrs. in 4 to 6 doses. *Usual dosage for infants over 2 months and children*—½ 24-hr dose initially, then 150 mg/kg/24 hrs. in 4 to 6 doses; not over 6 Gm/24 hrs.

How Supplied: Tablets containing 0.5 Gm sulfisoxazole, white, scored—bottles of 100, 500 and 1000, Tel-E-Dose® packages of 100, Prescription Paks of 100.

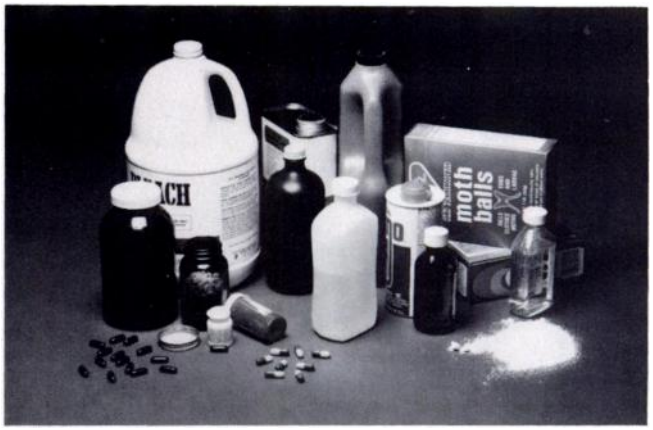
Pediatric Suspension, containing, in each teaspoonful (5 ml), the equivalent of approximately 0.5 Gm sulfisoxazole in the form of acetyl sulfisoxazole, raspberry flavored—bottles of 4 oz and 16 oz (1 pint).

Syrup, containing, in each teaspoonful (5 ml), the equivalent of approximately 0.5 Gm sulfisoxazole in the form of acetyl sulfisoxazole, chocolate flavored—bottles of 16 oz (1 pint).

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

ROCHE®

Some practical reasons for a guide on common childhood poisonings.



Poisonings are one of the leading causes of morbidity and death in young children. And, many poisonings are caused by common products in the home.

The American Academy of Pediatrics' *Handbook of Common Poisonings in Children*, second edition, offers current information on care and treatment of common poisoning experiences. There are descriptions of more than 50 common poisons, with details on ingredients, toxicity, symptoms, and treatment.

This book is designed as a quick reference for pediatricians, other primary care physicians, nurses, emergency room personnel, and pharmacists.

Academy Fellows—not Jr. Fellows—get one free copy on request.
For your copy, return the coupon to:

American Academy of Pediatrics, Publications Department, P.O. Box 927, Elk Grove Village, IL 60007

American Academy of Pediatrics
Publications Department
P.O. Box 927
Elk Grove Village, IL 60007

Please send me _____ copies of *Handbook of Common Poisonings in Children* at $15 each. (UPS Shipping charges: Add $1.60 each.)
Total: $_____

Please print:

Name _____

Address _____

City _____ **State** _____ **Zip** _____

☐ **AAP Member** **ID Number _____ required for processing** ☐ **Non-member**

☐ **Check/money order payable to American Academy of Pediatrics enclosed.** ☐ **Visa** ☐ **MasterCard**

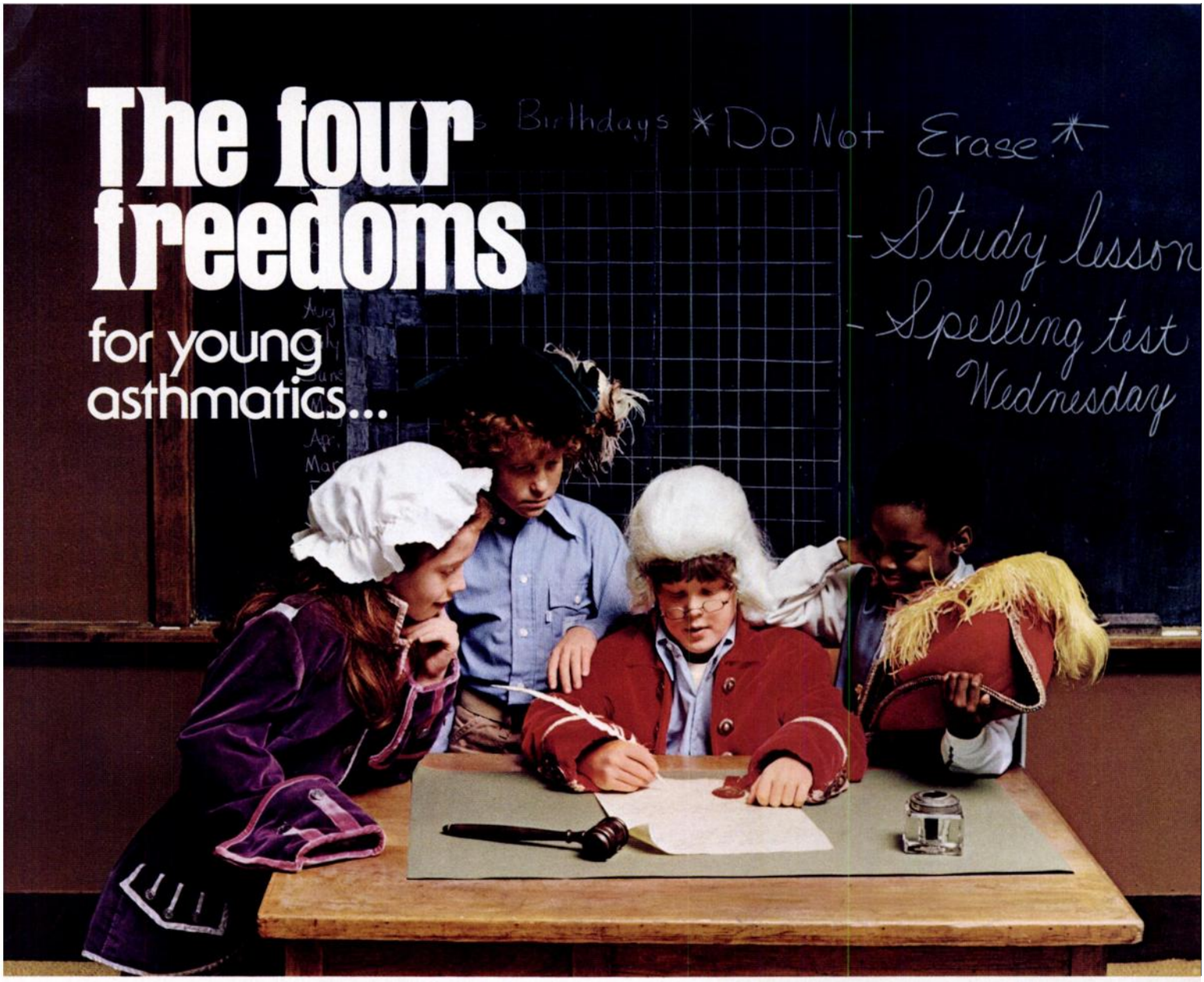
Credit Card Number _____ **Expiration Date** _____ **MasterCard only: 4 digit bank # over your name.** _____

Signature _____ **Phone Number** _____

PED

The four freedoms

for young asthmatics...



- free of alcohol
- free of dye
- free of artificial preservatives
- free of additive-induced side effects

LIQUID

QUIBRON®

Each tablespoonful (15 ml) contains theophylline (anhydrous) 150 mg and guaifenesin 90 mg

Indications: For the symptomatic treatment of bronchospasm associated with such conditions as bronchial asthma, chronic bronchitis, and pulmonary emphysema.
Dosage: Treatment should be initiated at 150 mg theophylline every 6 hours for adults and 4 mg/kg every 6 hours for children. The usual recommended dosages are *Adults:* 1-2 capsules or 1-2 tablespoons (15 ml) liquid every 6-8 hours. *Children 9 to 12:* 4-5 mg theophylline/kg bodyweight every 6-8 hours. *Children under 9:* 4-6 mg theophylline/kg bodyweight every 6-8 hours. When necessary, to achieve greater efficacy theophylline dosage may be cautiously adjusted upward. Serum theophylline determinations are helpful in monitoring therapeutic progress. When dosages exceed the usual recommended ranges serum determinations are essential. In the absence of side effects, the dosage may be titrated upward cautiously by increments of no more than 25% of previous dose, increasing the dose no more than every third day until the desired clinical response is obtained. If nausea, vomiting or other evidence of toxicity occurs, omit one dose and resume treatment at a lower dose.
Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.
Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e., clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 mcg/ml.
How Supplied: Capsules, containing theophylline (anhydrous) 150 mg and guaifenesin 90 mg, in bottles of 100 and 1000 and unit-dose packs of 100; Liquid in bottles of 1 pint and 1 gallon.
See package insert for complete prescribing information.

Mead Johnson PHARMACEUTICAL DIVISION

BONUS FOR ATTENDANCE LEAVES SCHOOL BIG BILL

Hoping to improve attendance, Richmond High School last year offered $100 to any student who was in school every day. But school officials hardly expected 200 students to qualify, and now they are trying to find $20,000 for the payoff.

Marshall Moore, originator of the program, said that the administrators "had no idea at all there would be that many students" with perfect attendance out of a total of more than 1,400. Thirty-seven students had perfect attendance last year.

From *The New York Times*, May 6, 1984.

BABY DOE LAWS RULED ILLEGAL

A federal judge ruled Wednesday, May 16, 1984 that the government's "Baby Doe" regulations are illegal, and granted the request of medical groups to bar the government from investigating treatment of handicapped newborns. The decision, which strikes down use of the regulations nationwide, was based on the case of the handicapped infant known in court records as Baby Jane Doe. The American Medical Association and five other health groups filed suit March 12, 1984 arguing that the decision in the Baby Jane Doe case—in which the federal government was barred from reviewing the child's records—meant regulations allowing the investigation were illegal. Judge Charles L. Brieant Jr agreed, issuing a two-page order at US District Court in Manhattan declaring the regulations are "invalid, unlawful and must be set aside."

From *The Burlington Free Press*, May 23, 1984.

T.L.C.

The "C" stands for "Chloraseptic®"

Waiting for throat culture results takes time.

Waiting for an antibiotic to work takes time.

But relieving the *pain* of a sore throat doesn't.

It's as fast and easy as recommending Children's Chloraseptic® Lozenges.

Because, whatever the cause—viral or bacterial—Chloraseptic has its effect.

And that's the kind of T.L.C. children and their parents will really appreciate.

For temporary relief of minor sore throat pain

CHILDREN'S

Chloraseptic® Lozenges

No sore throat treatment is complete without it.

For complimentary patient samples write "Children's Chloraseptic" on your prescription blank and mail to CHILDREN'S CHLORASEPTIC® Box 171 CINCINNATI, OHIO 45202


Now you can extend steroid benefits to more asthmatic patients who need them

Beclovent® Oral Inhaler (beclomethasone dipropionate, USP/Glaxo)

- *Topical* steroid therapy with no systemic steroid effects reported in recommended doses*
- Minimal local adverse effects
- Indicated for patients inadequately controlled on bronchodilators in whom steroids were withheld because of concern about adverse effects

*Although systemic absorption is possible, in clinical trials there were no reports of HPA suppression (See PRECAUTIONS).

Brief summary of prescribing information for oral inhalation only.

For full prescribing information, please consult package insert.

CONTRAINDICATIONS BECLOVENT® (beclomethasone dipropionate, USP) Oral Inhaler is contraindicated in the primary treatment of status asthmaticus or other acute episodes of asthma where intensive measures are required.

Hypersensitivity to any of the ingredients of this preparation contraindicates its use.

WARNINGS

Particular care is needed in patients who are transferred from systemically active corticosteroids to BECLOVENT® Oral Inhaler because deaths due to adrenal insufficiency have occurred in asthmatic patients during and after transfer from systemic corticosteroids to aerosol beclomethasone dipropionate. After withdrawal from systemic corticosteroids, a number of months are required for recovery of hypothalamic-pituitary-adrenal (HPA) function. During this period of HPA suppression, patients may exhibit signs and symptoms of adrenal insufficiency when exposed to trauma, surgery or infections, particularly gastroenteritis. Although BECLOVENT Oral Inhaler may provide control of asthmatic symptoms during these episodes, it does NOT provide the systemic steroid which is necessary for coping with these emergencies.

During periods of stress or a severe asthmatic attack, patients who have been withdrawn from systemic corticosteroids should be instructed to resume systemic steroids (in large doses) immediately and to contact their physician for further instruction. These patients should also be instructed to carry a warning card indicating that they may need supplementary systemic steroids during periods of stress or a severe asthma attack. To assess the risk of adrenal insufficiency in emergency situations, routine tests of adrenal cortical function, including measurement of early morning resting cortisol levels, should be performed periodically in all patients. An early morning resting cortisol level may be accepted as normal only if it falls at or near the normal mean level.

Localized infections with *Candida albicans* or *Aspergillus niger* have occurred frequently in the mouth and pharynx and occasionally in the larynx. Positive cultures for oral *Candida* may be present in up to 75% of patients. Although the frequency of clinically apparent infection is considerably lower, these infections may require treatment with appropriate antifungal therapy or discontinuance of treatment with BECLOVENT Oral Inhaler.

BECLOVENT Oral Inhaler is not to be regarded as a bronchodilator and is not indicated for rapid relief of bronchospasm.

Patients should be instructed to contact their physician immediately when episodes of asthma which are not responsive to bronchodilators occur during the course of treatment with BECLOVENT Oral Inhaler. During such episodes, patients may require therapy with systemic corticosteroids.

There is no evidence that control of asthma can be achieved by the administration of BECLOVENT® (beclomethasone dipropionate, USP) Oral Inhaler in amounts greater than the recommended doses.

Transfer of patients from systemic steroid therapy to BECLOVENT Oral Inhaler may unmask allergic conditions previously suppressed by the systemic steroid therapy, e.g., rhinitis, conjunctivitis, and eczema.

PRECAUTIONS During withdrawal from oral steroids, some patients may experience symptoms of systemically active steroid withdrawal, e.g., joint and/or muscular pain, lassitude and depression, despite maintenance or even improvement of respiratory function (See DOSAGE AND ADMINISTRATION for details).

In responsive patients, beclomethasone dipropionate may permit control of asthmatic symptoms without suppression of HPA function. Since beclomethasone dipropionate is absorbed into the circulation and can be systemically active, the beneficial effects of BECLOVENT® Oral Inhaler in minimizing or preventing HPA dysfunction may be expected only when recommended dosages are not exceeded.

The long-term effects of beclomethasone dipropionate in human subjects are still unknown. In particular, the local effects of the agent on developmental or immunologic processes in the mouth, pharynx, trachea, and lung are unknown. There is also no information about the possible long-term systemic effects of the agent.

The potential effects of BECLOVENT Oral Inhaler on acute, recurrent, or chronic pulmonary infections, including active or quiescent tuberculosis, are not known. Similarly, the potential effects of long-term administration of the drug on lung or other tissues are unknown.

Pulmonary infiltrates with eosinophilia may occur in patients on BECLOVENT Oral Inhaler therapy. Although it is possible that in some patients this state may become manifest because of systemic steroid withdrawal when inhalational steroids are administered, a causative role for beclomethasone dipropionate and/or its vehicle cannot be ruled out.

Use in Pregnancy: Glucocorticoids are known teratogens in rodent species and beclomethasone dipropionate is no exception.

Teratology studies were done in rats, mice, and rabbits treated with subcutaneous beclomethasone dipropionate. Beclomethasone dipropionate was found to produce fetal resorption, cleft palate, agnathia, microstomia, absence of tongue, delayed ossification and partial agenesis of the thymus. Well-controlled trials relating to fetal risk in humans are not available. Glucocorticoids are secreted in human milk. It is not known whether beclomethasone dipropionate would be secreted in human milk but it is safe to assume that it is likely. The use of beclomethasone dipropionate in pregnancy, nursing mothers, or women of childbearing potential requires that the possible benefits of the drug be weighed against the potential hazards to the mother, embryo, or fetus. Infants born of mothers who have received substantial doses of corticosteroids during pregnancy should be carefully observed for hypoadrenalism.

ADVERSE REACTIONS Deaths due to adrenal insufficiency have occurred in asthmatic patients during and after transfer from systemic corticosteroids to aerosol beclomethasone dipropionate (See WARNINGS).

Suppression of HPA function (reduction of early morning plasma cortisol levels) has been reported in adult patients who received 1600 mcg daily doses of BECLOVENT® Oral Inhaler for one month. A few patients on BECLOVENT Oral Inhaler have complained of hoarseness or dry mouth. Bronchospasm and rash have been reported rarely.

DOSAGE AND ADMINISTRATION FOR PATIENTS DEPENDENT ON OR RECEIVING SYSTEMIC STEROIDS: Transfer to BECLOVENT® Oral Inhaler and subsequent management may be more difficult as recovery from impaired adrenal function is usually slow. These effects may last up to 12 months. Studies have shown that BECLOVENT Oral Inhaler may be effective in management of these asthmatic patients and may permit replacement or significant systemic steroid dosage reduction.

Stabilize asthmatic patients before BECLOVENT Oral Inhaler therapy. Initially use inhaler concurrently with usual steroid maintenance dose. After approximately one week gradually reduce either the daily or alternate-day steroid dose. The next reduction is made after 1-2 weeks depending on response. Do not reduce systemic steroid dose greater than 2.5 mg of prednisone or its equivalent. Slow withdrawal is important. Steroid withdrawal symptoms may be experienced during this transition period such as: joint and/or muscular pain, lassitude and depression, despite maintenance or improvement of respiratory function. Encourage patient to continue therapy, watch carefully for objective signs of adrenal insufficiency, eg. hypotension, weight loss. If evidence of adrenal insufficiency occurs, increase systemic steroids temporarily and stabilize. Then continue withdrawal more slowly.

Transfer patient will require supplemental systemic steroids during periods of stress or severe attacks. Exacerbation of asthma during therapy should be treated with a short course of systemic steroids and gradually tapered as symptoms subside. There is no evidence that exceeding the recommended dosage will achieve asthma control.

Glaxo Inc., Research Triangle Park, NC 27709

June 1980

BEL-0106R-0684

Glaxo Glaxo Inc., Research Triangle Park, NC 27709

Originators of inhaled beclomethasone dipropionate

Announcing the first CME TV program for pediatricians...

by pediatricians

PedSat™ is the first regularly scheduled Continuing Medical Education television program produced exclusively for pediatricians.

Under the guidance of a national editorial board headed by Dr. Alexander S. Nadas, Chief of Cardiology Emeritus at the Children's Hospital of Boston and Professor of Pediatrics at the Harvard Medical School, PedSat programs offer you clinically useful information presented by international authorities in the field of pediatrics. Included will be lectures and demonstrations exploring both currently accepted and new techniques for examination and diagnosis.

PedSat has been designated for Category I credit toward the Physician's Recognition Award of the American Medical Association. Details on how you can view PedSat over your home television are contained in the Medical Television Program Guide which you will receive free on a regular basis. For further information, please feel free to write or call:

PedSat, 221 Longwood Avenue
Boston, Massachusetts 02115 (617) 739-2746

We've changed the face of cough control

DELSYM™

DEXTROMETHORPHAN POLISTIREX

THE FIRST LIQUID NONNARCOTIC ANTITUSSIVE WITH PROVEN 12-HOUR DURATION

Convenient b.i.d. dosage*—Adults: 2 teaspoonsful b.i.d.; Children 6-12: 1 teaspoonful b.i.d.; Children 2-5: ½ teaspoonful b.i.d.

Each teaspoonful (5 ml) contains dextromethorphan polistirex equivalent to 30 mg dextromethorphan hydrobromide.

Precise, predictable blood levels—Unique controlled release formulation provides 12 hours of consistent cough control.

No bitter taste—Pleasant orange flavoring has been added to improve patient compliance.

Nonprescription, available in 3 oz. bottles

*Do not exceed recommended dosage

A PENNKINETIC™ PRODUCT

PENNWALT CORP.
PRESCRIPTION DIVISION
Rochester, N.Y. 14623

Is there a pediculicide that kills lice in the hair where they live...

without significant absorption through the scalp?

Yes, there's RID.®

Because RID is poorly absorbed through the skin,[1] it's an ideal pediculicide for the tender scalps of children. A study has shown that lindane, the active ingredient in an alternative product (Kwell®), may cause potentially serious side effects due to skin penetration.[2]

This study demonstrates that absorption of lindane through the scalp is up to six times greater than in other body areas.[3] And children, the usual victims of head lice, may have an even higher rate of absorption than adults.[4]

Proven clinical efficacy without Kwell's risk of serious side effects due to percutaneous absorption

In vivo studies by leading clinicians show RID to be as effective as Kwell (lindane).[3,5] But unlike lindane, RID is poorly absorbed and carries little risk of toxicity due to percutaneous absorption.[1]

Recognized by leading medical authorities as safe and effective

THE CENTERS FOR DISEASE CONTROL calls the active ingredients in RID an effective treatment against lice.[6]

THE FDA ADVISORY REVIEW PANEL for over-the-counter drugs has concluded that the active ingredients in RID are safe and effective.[7]

AMA DRUG EVALUATIONS states that the active ingredients in RID are effective and among the safest available.[8]

No other pediculicide —prescription or OTC— completes the treatment process more effectively than RID®

Even after application of a pediculicide, the hair must be combed to remove all nits. The problem is most combs don't do the job completely—and this is a major cause of reinfestation. But RID—and only RID—has a special nit removing comb. It's uniquely designed so the spacing between the teeth is up to 10 times closer than that of competitive combs. The result is fast, 100% effective nit removal that saves hours of tedious combing.

Recommend the safest, most effective treatment kit

RID not only offers your patients the safest medication, it provides a step-by-step instruction booklet and a 100% effective nit comb making it the most effective treatment kit available.

References

1. Newsom JH *et al*: Treatment of infestation with phthirus pubis: Comparative efficacies of synergized pyrethrins and gamma-benzene hexachloride. *Sex Trans Dis* 6:203, 1979. 2. Gamma benzene hexachloride (Kwell and other products) alert. *FDA Drug Bulletin* 6:28, 1976. 3. Robinson DH, Shepherd DA: Control of head lice in school children. *Curr Ther Res* 27:1, 1980. 4. Felman YM, Nikitas JA: Adverse drug reactions: Part 2. The less common sexually transmitted diseases. *Sex Med Today* 22:14, 1981. 5. Pfizer Inc.—Data on file. 6. Juranek DD: Pediculicides and scabicides. *Handbook of Drug Therapy*, USDHEW, 1979. 7. *Federal Register* 47 (125): 28315, June 29, 1982. 8. American Medical Association, Council on Drugs, *AMA Drug Evaluations*, 5 ed, 1983.

Strong enough for lice, safe enough for children

Pfizer

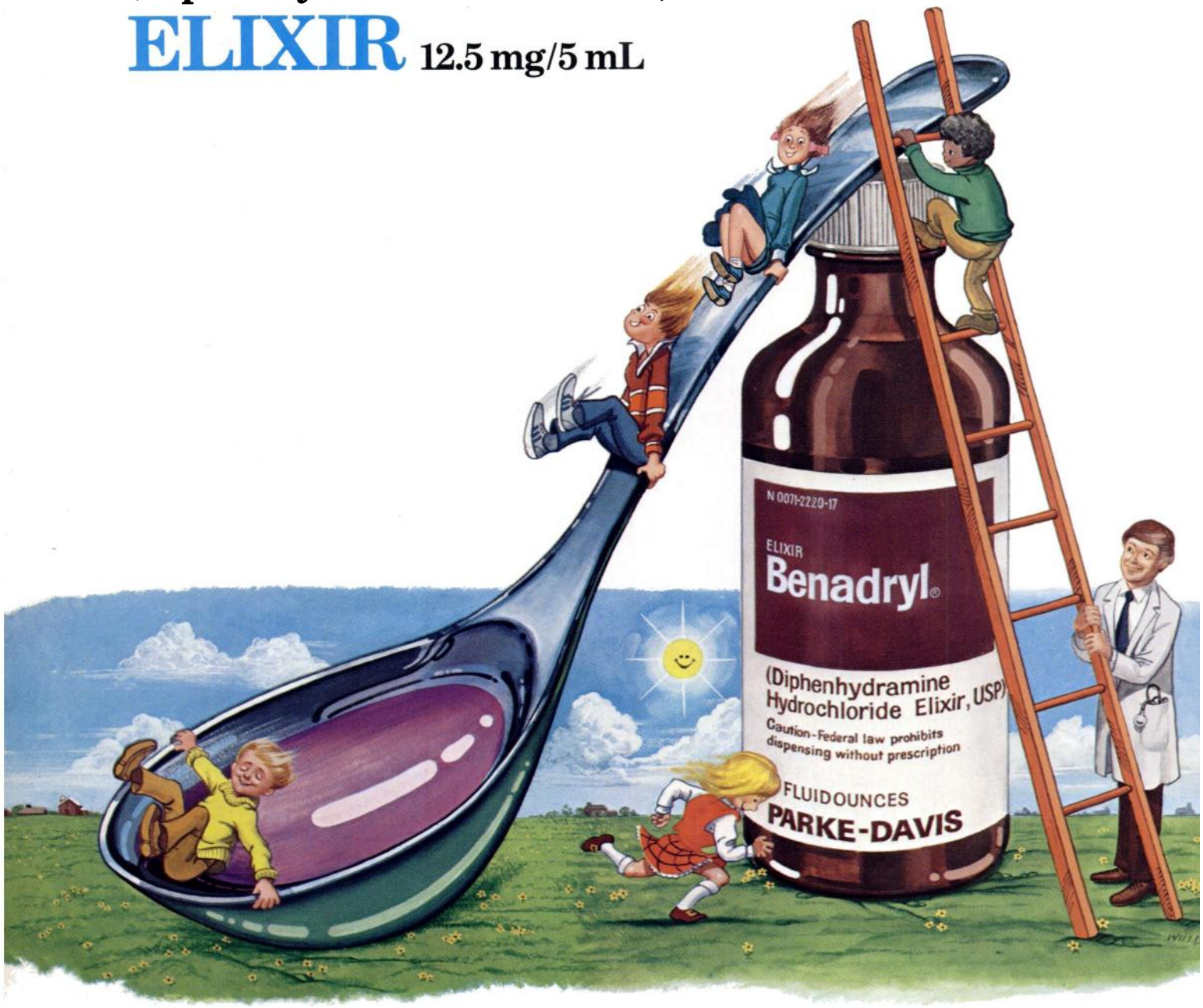
Pfipharmecs Division

New York, NY 10017

SJW6074

The one physicians look to...

BENADRYL®
(Diphenhydramine HCl Elixir, USP)
ELIXIR 12.5 mg/5 mL



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

PD-61-JA-2162-P-1(5-84)

Strep A? Know in just minutes.

New Q Test Strep.
No more waiting for overnight and weekend cultures or lab results. With the new Q Test™ Strep card method, you can have Strep A results in your office, in minutes.

More accurate than culture: As you save time, you also gain accuracy. Q Test Strep is 99.8% accurate.[1] This is in contrast to the 70% accuracy found with cultures tested by bacitracin on a primary plate.[2] Q Test also detects streptococci after exposure to oral antiseptics—where culture may yield false negative results.[3]

Prescribe sooner with confidence: Now you'll know if it's strep *before* your patient fills the prescription. With results in just 70 minutes, you can start treatment right away, and be certain that your therapy is correct.

Fits easily into office workflow: With less than 2 minutes of hands-on time and one complete kit, anyone on your staff can perform this test. No special training is needed.

Call for your card: Ask your local distributor for the Clay Adams easy strep test.

[1] Data on file at Clay Adams
[2] Facklam RR. Isolation and identification of streptococci. Centers for Disease Control 1979
[3] Data on file at Clay Adams

NEW
Q Test Strep
from Clay Adams
division of
Becton Dickinson and Company

BECTON DICKINSON


Johnny
was here
less today.

Now for the child 2 years or older,
all the advantages of IMODIUM in a sugarless,
cherry-anise flavored liquid form...

NEW!

Imodium® LIQUID
(loperamide HCl)

The safe and effective antidiarrheal

- ▲ Non-narcotic, nonhabituating
- ▲ Acts rapidly
- ▲ Relieves cramping
- ▲ Reduces water and electrolyte loss
- ▲ Available by prescription only

How to start...first-day dosage guidelines

(One 5-ml teaspoonful = 1mg; 2 teaspoonfuls = 1 capsule, 2mg)

2 to 5 years (13 to 20 kg)	1 teaspoonful t.i.d.* (3-mg total daily dose)
5 to 8 years (20 to 30 kg)	2 teaspoonfuls b.i.d.* (4-mg total daily dose)
8 to 12 years (greater than 30 kg)	2 teaspoonfuls t.i.d.* (6-mg total daily dose)

*Following the first treatment day, it is recommended that subsequent IMODIUM doses (1mg/10kg body weight) be administered only after a loose stool, and total daily dosage should not exceed recommended dosages for the first day.

Antiperistaltic agents should not be used in acute diarrhea associated with organisms that penetrate the intestinal mucosa.

JANSSEN PHARMACEUTICA

 JPI-520

Please see brief summary of Prescribing Information on next page.

Imodium® LIQUID/CAPSULES
(loperamide HCl)

BRIEF SUMMARY
Before prescribing, please consult complete prescribing information, a summary of which follows.

CONTRAINDICATIONS
IMODIUM is contraindicated in patients with known hypersensitivity to the drug and in those in whom constipation must be avoided.

WARNINGS
Antiperistalic agents should not be used in acute diarrhea associated with organisms that penetrate the intestinal mucosa, e.g., enteroinvasive E. coli, salmonella, shigella, and in pseudomembranous colitis associated with broad-spectrum antibiotics.

Fluid and electrolyte depletion may occur in patients who have diarrhea. The use of IMODIUM does not preclude the administration of appropriate fluid and electrolyte therapy. In some patients with acute ulcerative colitis, agents which inhibit intestinal motility or delay intestinal transit time have been reported to induce toxic megacolon. IMODIUM therapy should be discontinued promptly if abdominal distention occurs or if other untoward symptoms develop in patients with acute ulcerative colitis.

IMODIUM should be used with special caution in young children because of the greater variability of response in this age group. Dehydration, particularly in younger children, may further influence the variability of response to IMODIUM.

PRECAUTIONS
General: In acute diarrhea, if clinical improvement is not observed in 48 hours, the administration of IMODIUM should be discontinued.

Patients with hepatic dysfunction should be monitored closely for signs of CNS toxicity because of the apparent large first pass biotransformation.

Information for Patients: Patients should be advised to check with their physician if their diarrhea doesn't stop after a few days or if they develop a fever.

Drug Interactions: There was no evidence in clinical trials of drug interactions with concurrent medications.

Carcinogenesis, mutagenesis, impairment of fertility: In an 18 month rat study with doses up to 133 times the maximum human dose (on a mg/kg basis), there was no evidence of carcinogenesis. Mutagenicity studies were not conducted. Reproduction studies in rats indicated that high doses (150-200 times the human dose) could cause marked female infertility and reduced male fertility.

Pregnancy
Teratogenic Effects
Pregnancy Category B
Reproduction studies in rats and rabbits have revealed no evidence of impaired fertility or harm to the fetus at doses up to 30 times the human dose. High doses impaired the survival of mothers and nursing young. The studies offered no evidence of [illegible] activity. There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

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

Pediatric Use: See the "Warnings" Section for information on the greater variability of response in this age group.

In case of accidental overdosage of IMODIUM by children, see "Overdosage" section for suggested treatment.

ADVERSE REACTIONS
The adverse effects [illegible] clinical experience of IMODIUM are difficult to distinguish from symptoms associated with the [illegible] syndrome. Adverse experiences recorded during clinical studies with IMODIUM were [illegible] of a minor and self-limiting nature. They were more commonly observed during the treatment of chronic diarrhea.

The following patient complaints have been reported and are listed in decreasing order of frequency with the exception of hypersensitivity reactions which is listed first since it may be the most serious.

- Hypersensitivity reactions (including skin rash) have been reported with IMODIUM use.
- Abdominal pain, distension or discomfort
- Nausea and vomiting
- Constipation
- Tiredness
- Drowsiness or dizziness
- Dry mouth

DRUG ABUSE AND DEPENDENCE
Abuse: A specific clinical study designed to assess the abuse potential of loperamide at high doses resulted in a finding of extremely low abuse potential. Additionally, after years of extensive use there has been no evidence of abuse or dependence.

Dependence: Physical dependence to IMODIUM in humans has not been observed. However, studies in morphine dependent monkeys demonstrated that loperamide hydrochloride at doses above those recommended for humans prevented signs of morphine withdrawal. However, in humans, the naloxone challenge pupil test, which when positive indicates opiate-like effects, performed after a single high dose, or after more than two years of therapeutic use of IMODIUM, was negative. Orally administered IMODIUM (loperamide formulated with magnesium stearate) is both highly insoluble and penetrates the CNS poorly.

OVERDOSAGE
Animal pharmacological and toxicological data indicate that overdosage in man may result in constipation, CNS depression and gastrointestinal irritation. Clinical trials have demonstrated that a slurry of activated charcoal administered promptly after ingestion of loperamide hydrochloride can reduce the amount of drug which is absorbed into the systemic circulation by as much as ninefold. If vomiting occurs spontaneously upon ingestion, a slurry of 100 gms of activated charcoal should be administered orally as soon as fluids can be retained.

If vomiting has not occurred, gastric lavage should be performed followed by administration of 100 gms of the activated charcoal slurry through the gastric tube. In the event of overdosage, patients should be monitored for signs of CNS depression for at least 24 hours. Children may be more sensitive to central nervous system effects than adults. If CNS depression is observed, naloxone may be administered. If responsive to naloxone, vital signs must be monitored carefully for recurrence of symptoms of drug overdose for at least 24 hours after the last dose of naloxone.

In view of the prolonged action of loperamide and the short duration (one to three hours) of naloxone, the patient must be monitored closely and treated repeatedly with naloxone as indicated. Since relatively little drug is excreted in the urine, forced diuresis is not expected to be effective for IMODIUM overdosage.

In clinical trials an adult who took three 20 mg doses within a 24 hour period was nauseated after the second dose and vomited after the third dose. In studies designed to examine the potential for side effects, intentional ingestion of up to 60 mg of loperamide hydrochloride in a single dose to healthy subjects resulted in no significant adverse effects.

Date: June 1984 631-60-540-5
CAUTION: FEDERAL LAW PROHIBITS DISPENSING WITHOUT A PRESCRIPTION

An original product of JANSSEN PHARMACEUTICA, n.v., B-2340 Beerse, Belgium
JANSSEN PHARMACEUTICA INC., Piscataway, New Jersey 08854
U.S. Patent 3,714,159

world leader in antidiarrheal research

JANSSEN PHARMACEUTICA

Pediazole®
erythromycin ethylsuccinate and sulfisoxazole acetyl for oral suspension

BRIEF SUMMARY:
Please see package enclosure for full prescribing information.

Indication
For treatment of ACUTE OTITIS MEDIA in children caused by susceptible strains of *Hemophilus influenzae*.

Contraindications
Known hypersensitivity to either erythromycin or sulfonamides.
Infants less than 2 months of age.
Pregnancy at term and during the nursing period, because sulfonamides pass into the placental circulation and are excreted in human breast milk and may cause kernicterus in the infant.

Warnings
Usage in Pregnancy (SEE ALSO: CONTRAINDICATIONS): The safe use of erythromycin or sulfonamides in pregnancy has not been established. The teratogenic potential of most sulfonamides has not been thoroughly investigated in either animals or humans. However, a significant increase in the incidence of cleft palate and other bony abnormalities of offspring has been observed when certain sulfonamides of the short, intermediate and long-acting types were given to pregnant rats and mice at high oral doses (7 to 25 times the human therapeutic dose).
Reports of deaths have been associated with sulfonamide administration from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving sulfonamides.
The frequency of renal complications is considerably lower in patients receiving the most soluble sulfonamides such as sulfisoxazole. Urinalysis with careful microscopic examination should be obtained frequently in patients receiving sulfonamides.

Precautions
Erythromycin is principally excreted by the liver. Caution should be exercised in administering the antibiotic to patients with impaired hepatic function. There have been reports of hepatic dysfunction, with or without jaundice occurring in patients receiving oral erythromycin products.
Recent data from studies of erythromycin reveal that its use in patients who are receiving high doses of theophylline may be associated with an increase of serum theophylline levels and potential theophylline toxicity. In case of theophylline toxicity and/or elevated serum theophylline levels, the dose of theophylline should be reduced while the patient is receiving concomitant erythromycin therapy.
Surgical procedures should be performed when indicated.
Sulfonamide therapy should be given with caution to patients with impaired renal or hepatic function and in those patients with a history of severe allergy or bronchial asthma. In the presence of a deficiency in the enzyme glucose-6-phosphate dehydrogenase, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and renal stone formation.

Adverse Reactions
The most frequent side effects of oral erythromycin preparations are gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting and diarrhea occur infrequently with usual oral doses. During prolonged or repeated therapy, there is a possibility of overgrowth of nonsusceptible bacteria or fungi. If such infections occur, the drug should be discontinued and appropriate therapy instituted. The overall incidence of these latter side effects reported for the combined administration of erythromycin and a sulfonamide is comparable to those observed in patients given erythromycin alone. Mild allergic reactions such as urticaria and other skin rashes have occurred. Serious allergic reactions, including anaphylaxis, have been reported with erythromycin.
The following untoward effects have been associated with the use of sulfonamides:
Blood dyscrasias: Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.
Allergic reactions: Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.
Gastrointestinal reactions: Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis.
C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia.
Miscellaneous reactions: Drug fever, chills and toxic nephrosis with oliguria or anuria. Periarteritis nodosa and L.E. phenomenon have occurred.
The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents.
Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration
PEDIAZOLE SHOULD NOT BE ADMINISTERED TO INFANTS UNDER 2 MONTHS OF AGE BECAUSE OF CONTRAINDICATIONS OF SYSTEMIC SULFONAMIDES IN THIS AGE GROUP.
For Acute Otitis Media in Children: The dose of Pediazole can be calculated based on the erythromycin component (50 mg/kg/day) or the sulfisoxazole component (150 mg/kg/day to a maximum of 6 g/day). Pediazole should be administered in equally divided doses four times a day for 10 days. It may be administered without regard to meals.
The following approximate dosage schedule is recommended for using Pediazole:
Children: Two months of age or older.

Weight	Dose—every 6 hours
Less than 8 kg (less than 18 lb)	Adjust dosage by body weight
8 kg (18 lb)	½ teaspoonful (2.5 ml)
16 kg (35 lb)	1 teaspoonful (5 ml)
24 kg (53 lb)	1½ teaspoonfuls (7.5 ml)
Over 45 kg (over 100 lb)	2 teaspoonfuls (10 ml)

How Supplied
Pediazole Suspension is available for teaspoon dosage in 100 ml (**NDC** 0074-8030-13) and 200-ml (**NDC** 0074-8030-53) bottles, in the form of granules to be reconstituted with water. The suspension provides erythromycin ethylsuccinate equivalent to 200 mg erythromycin activity and sulfisoxazole acetyl equivalent to 600 mg sulfisoxazole per teaspoonful (5 ml).

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

B131/2810


Familiar therapy
in a
convenient form
For acute otitis media
in children*
*caused by susceptible strains of *Hemophilus influenzae* (including ampicillin-resistant strains)
ROSS LABORATORIES
COLUMBUS, OHIO 43216
Division of Abbott Laboratories, USA
B131/2810
Pediazole®
erythromycin ethylsuccinate
and sulfisoxazole acetyl
for oral suspension
(200 mg erythromycin activity and the equivalent of
600 mg sulfisoxazole per 5 ml)
Please see adjacent column for brief summary of
prescribing information.

PEDIATRICS INSURANCE CONSULTANTS

PEDIATRICS INSURANCE CONSULTANTS provides nine benefit programs for the members of the American Academy of Pediatrics. These programs are underwritten by companies of the Kemper Group.

You can write for full details about any one or all nine of the benefit programs available to members (use the coupon in this ad). We'll rush all of the information you need, including rates and application forms, direct-by-mail.

If you need this information immediately, please call us TOLL FREE . . . **1-800-257-3220**

In Illinois, call collect 1-312-439-3220

Pediatrics Insurance Consultants, Inc.
141 Northwest Point Road
Elk Grove Village, Illinois 60007

Strep A? Know in just minutes.

New Q Test Strep.
No more waiting for overnight and weekend cultures or lab results. With the new Q Test™ Strep card method, you can have Strep A results in your office, in minutes.

More accurate than culture: As you save time, you also gain accuracy. Q Test Strep is 99.8% accurate.[1] This is in contrast to the 70% accuracy found with cultures tested by bacitracin on a primary plate.[2] Q Test also detects streptococci after exposure to oral antiseptics—where culture may yield false negative results.[3]

Prescribe sooner with confidence: Now you'll know if it's strep *before* your patient fills the prescription. With results in just 70 minutes, you can start treatment right away, and be certain that your therapy is correct.

Fits easily into office workflow: With less than 2 minutes of hands-on time and one complete kit, anyone on your staff can perform this test. No special training is needed.

Call for your card: Ask your local distributor for the Clay Adams easy strep test.

[1] Data on file at Clay Adams
[2] Facklam RR. Isolation and identification of streptococci. Centers for Disease Control 1979
[3] Data on file at Clay Adams

NEW

Q Test Strep

from Clay Adams
division of
Becton Dickinson and Company

BECTON DICKINSON


Johnny
was here
less today.

Now for the child 2 years or older,
all the advantages of IMODIUM in a sugarless,
cherry-anise flavored liquid form...

NEW!

Imodium® LIQUID
(loperamide HCl)

The safe and effective antidiarrheal

- ▲ Non-narcotic, nonhabituating
- ▲ Acts rapidly
- ▲ Relieves cramping
- ▲ Reduces water and electrolyte loss
- ▲ Available by prescription only

How to start...first-day dosage guidelines

(One 5-ml teaspoonful = 1mg; 2 teaspoonfuls = 1 capsule, 2mg)

2 to 5 years (13 to 20 kg)	1 teaspoonful t.i.d.* (3-mg total daily dose)
5 to 8 years (20 to 30 kg)	2 teaspoonfuls b.i.d.* (4-mg total daily dose)
8 to 12 years (greater than 30 kg)	2 teaspoonfuls t.i.d.* (6-mg total daily dose)

*Following the first treatment day, it is recommended that subsequent IMODIUM doses (1mg/10kg body weight) be administered only after a loose stool, and total daily dosage should not exceed recommended dosages for the first day.

Antiperistaltic agents should not be used in acute diarrhea associated with organisms that penetrate the intestinal mucosa.

JANSSEN PHARMACEUTICA

 JPI-520

Please see brief summary of Prescribing Information on next page.

Imodium® LIQUID/CAPSULES
(loperamide HCl)

BRIEF SUMMARY
Before prescribing, please consult complete prescribing information, a summary of which follows.

CONTRAINDICATIONS
IMODIUM is contraindicated in patients with known hypersensitivity to the drug and in those in whom constipation must be avoided.

WARNINGS
Antiperistalic agents should not be used in acute diarrhea associated with organisms that penetrate the intestinal mucosa, e.g., enteroinvasive E. coli, salmonella, shigella, and in pseudomembranous colitis associated with broad-spectrum antibiotics.

Fluid and electrolyte depletion may occur in patients who have diarrhea. The use of IMODIUM does not preclude the administration of appropriate fluid and electrolyte therapy. In some patients with acute ulcerative colitis, agents which inhibit intestinal motility or delay intestinal transit time have been reported to induce toxic megacolon. IMODIUM therapy should be discontinued promptly if abdominal distention occurs or if other untoward symptoms develop in patients with acute ulcerative colitis.

IMODIUM should be used with special caution in young children because of the greater variability of response in this age group. Dehydration, particularly in younger children, may further influence the variability of response to IMODIUM.

PRECAUTIONS
General: In acute diarrhea, if clinical improvement is not observed in 48 hours, the administration of IMODIUM should be discontinued.

Patients with hepatic dysfunction should be monitored closely for signs of CNS toxicity because of the apparent large first pass biotransformation.

Information for Patients: Patients should be advised to check with their physician if their diarrhea doesn't stop after a few days or if they develop a fever.

Drug Interactions: There was no evidence in clinical trials of drug interactions with concurrent medications.

Carcinogenesis, mutagenesis, impairment of fertility: In an 18 month rat study with doses up to 133 times the maximum human dose (on a mg/kg basis), there was no evidence of carcinogenesis. Mutagenicity studies were not conducted. Reproduction studies in rats indicated that high doses (150-200 times the human dose) could cause marked female infertility and reduced male fertility.

Pregnancy
Teratogenic Effects
Pregnancy Category B
Reproduction studies in rats and rabbits have revealed no evidence of impaired fertility or harm to the fetus at doses up to 30 times the human dose. High doses impaired the survival of mothers and nursing young. The studies offered no evidence of teratogenic activity. There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

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

Pediatric Use: See the "Warnings" Section for information on the greater variability of response in this age group.

In case of accidental overdosage of IMODIUM by children, see "Overdosage" section for suggested treatment.

ADVERSE REACTIONS
The adverse effects commonly occurring in clinical investigations of IMODIUM are difficult to distinguish from symptoms associated with the diarrheal syndrome. Adverse experiences recorded during clinical studies with IMODIUM were rare, usually of a minor and self-limiting nature. They were more commonly observed during the treatment of chronic diarrhea.

The following patient complaints have been reported and are listed in decreasing order of frequency with the exception of hypersensitivity reactions which is listed first since it may be the most serious.

- Hypersensitivity reactions (including skin rash) have been reported with IMODIUM use.
- Abdominal pain, distension or discomfort
- Nausea and vomiting
- Constipation
- Tiredness
- Drowsiness or dizziness
- Dry mouth

DRUG ABUSE AND DEPENDENCE
Abuse: A specific clinical study designed to assess the abuse potential of loperamide at high doses resulted in a finding of extremely low abuse potential. Additionally, after years of extensive use there has been no evidence of abuse or dependence.

Dependence: Physical dependence to IMODIUM in humans has not been observed. However, studies in morphine dependent monkeys demonstrated that loperamide hydrochloride at doses above those recommended for humans prevented signs of morphine withdrawal. However, in humans, the naloxone challenge pupil test, which when positive indicates opiate-like effects, performed after a single high dose, or after more than two years of therapeutic use of IMODIUM, was negative. Orally administered IMODIUM (loperamide formulated with magnesium stearate) is both highly insoluble and penetrates the CNS poorly.

OVERDOSAGE
Animal pharmacological and toxicological data indicate that overdosage in man may result in constipation, CNS depression and gastrointestinal irritation. Clinical trials have demonstrated that a slurry of activated charcoal administered promptly after ingestion of loperamide hydrochloride can reduce the amount of drug which is absorbed into the systemic circulation by as much as ninefold. If vomiting occurs spontaneously upon ingestion, a slurry of 100 gms of activated charcoal should be administered orally as soon as fluids can be retained.

If vomiting has not occurred, gastric lavage should be performed followed by administration of 100 gms of the activated charcoal slurry through the gastric tube. In the event of overdosage, patients should be monitored for signs of CNS depression for at least 24 hours. Children may be more sensitive to central nervous system effects than adults. If CNS depression is observed, naloxone may be administered. If responsive to naloxone, vital signs must be monitored carefully for recurrence of symptoms of drug overdose for at least 24 hours after the last dose of naloxone.

In view of the prolonged action of loperamide and the short duration (one to three hours) of naloxone, the patient must be monitored closely and treated repeatedly with naloxone as indicated. Since relatively little drug is excreted in the urine, forced diuresis is not expected to be effective for IMODIUM overdosage.

In clinical trials an adult who took three 20 mg doses within a 24 hour period was nauseated after the second dose and vomited after the third dose. In studies designed to examine the potential for side effects, intentional ingestion of up to 60 mg of loperamide hydrochloride in a single dose to healthy subjects resulted in no significant adverse effects.

Date: June 1984 631-60-540-5
CAUTION: FEDERAL LAW PROHIBITS DISPENSING WITHOUT A PRESCRIPTION

An original product of JANSSEN PHARMACEUTICA, n.v., B-2340 Beerse, Belgium
JANSSEN PHARMACEUTICA INC., Piscataway, New Jersey 08854
U.S. Patent 3,714,159

world leader in antidiarrheal research

JANSSEN PHARMACEUTICA

The safe and effective antidiarrheal

Pediazole®
erythromycin ethylsuccinate and sulfisoxazole acetyl for oral suspension

BRIEF SUMMARY:
Please see package enclosure for full prescribing information.

Indication
For treatment of ACUTE OTITIS MEDIA in children caused by susceptible strains of *Hemophilus influenzae*.

Contraindications
Known hypersensitivity to either erythromycin or sulfonamides.
Infants less than 2 months of age.
Pregnancy at term and during the nursing period, because sulfonamides pass into the placental circulation and are excreted in human breast milk and may cause kernicterus in the infant.

Warnings
Usage in Pregnancy (SEE ALSO: CONTRAINDICATIONS): The safe use of erythromycin or sulfonamides in pregnancy has not been established. The teratogenic potential of most sulfonamides has not been thoroughly investigated in either animals or humans. However, a significant increase in the incidence of cleft palate and other bony abnormalities of offspring has been observed when certain sulfonamides of the short, intermediate and long-acting types were given to pregnant rats and mice at high oral doses (7 to 25 times the human therapeutic dose).
Reports of deaths have been associated with sulfonamide administration from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving sulfonamides.
The frequency of renal complications is considerably lower in patients receiving the most soluble sulfonamides such as sulfisoxazole. Urinalysis with careful microscopic examination should be obtained frequently in patients receiving sulfonamides.

Precautions
Erythromycin is principally excreted by the liver. Caution should be exercised in administering the antibiotic to patients with impaired hepatic function. There have been reports of hepatic dysfunction, with or without jaundice occurring in patients receiving oral erythromycin products.
Recent data from studies of erythromycin reveal that its use in patients who are receiving high doses of theophylline may be associated with an increase of serum theophylline levels and potential theophylline toxicity. In case of theophylline toxicity and/or elevated serum theophylline levels, the dose of theophylline should be reduced while the patient is receiving concomitant erythromycin therapy.
Surgical procedures should be performed when indicated.
Sulfonamide therapy should be given with caution to patients with impaired renal or hepatic function and in those patients with a history of severe allergy or bronchial asthma. In the presence of a deficiency in the enzyme glucose-6-phosphate dehydrogenase, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and renal stone formation.

Adverse Reactions
The most frequent side effects of oral erythromycin preparations are gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting and diarrhea occur infrequently with usual oral doses. During prolonged or repeated therapy, there is a possibility of overgrowth of nonsusceptible bacteria or fungi. If such infections occur, the drug should be discontinued and appropriate therapy instituted. The overall incidence of these latter side effects reported for the combined administration of erythromycin and a sulfonamide is comparable to those observed in patients given erythromycin alone. Mild allergic reactions such as urticaria and other skin rashes have occurred. Serious allergic reactions, including anaphylaxis, have been reported with erythromycin.
The following untoward effects have been associated with the use of sulfonamides:
Blood dyscrasias: Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.
Allergic reactions: Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.
Gastrointestinal reactions: Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis.
C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia.
Miscellaneous reactions: Drug fever, chills and toxic nephrosis with oliguria or anuria. Periarteritis nodosa and L.E. phenomenon have occurred.
The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents.
Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration
PEDIAZOLE SHOULD NOT BE ADMINISTERED TO INFANTS UNDER 2 MONTHS OF AGE BECAUSE OF CONTRAINDICATIONS OF SYSTEMIC SULFONAMIDES IN THIS AGE GROUP.
For Acute Otitis Media in Children: The dose of Pediazole can be calculated based on the erythromycin component (50 mg/kg/day) or the sulfisoxazole component (150 mg/kg/day to a maximum of 6 g/day). Pediazole should be administered in equally divided doses four times a day for 10 days. It may be administered without regard to meals.
The following approximate dosage schedule is recommended for using Pediazole:
Children: Two months of age or older.

Weight	Dose—every 6 hours
Less than 8 kg (less than 18 lb)	Adjust dosage by body weight
8 kg (18 lb)	½ teaspoonful (2.5 ml)
16 kg (35 lb)	1 teaspoonful (5 ml)
24 kg (53 lb)	1½ teaspoonfuls (7.5 ml)
Over 45 kg (over 100 lb)	2 teaspoonfuls (10 ml)

How Supplied
Pediazole Suspension is available for teaspoon dosage in 100 ml (**NDC** 0074-8030-13) and 200-ml (**NDC** 0074-8030-53) bottles, in the form of granules to be reconstituted with water. The suspension provides erythromycin ethylsuccinate equivalent to 200 mg erythromycin activity and sulfisoxazole acetyl equivalent to 600 mg sulfisoxazole per teaspoonful (5 ml).

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

B131/2810


Familiar therapy
in a
convenient form
For acute otitis media
in children*
*caused by susceptible strains of *Hemophilus influenzae* (including ampicillin-resistant strains)
ROSS LABORATORIES
COLUMBUS, OHIO 43216
Division of Abbott Laboratories, USA
B131/2810
Pediazole®
erythromycin ethylsuccinate
and sulfisoxazole acetyl
for oral suspension
(200 mg erythromycin activity and the equivalent of
600 mg sulfisoxazole per 5 ml)
Please see adjacent column for brief summary of
prescribing information.

PEDIATRICS INSURANCE CONSULTANTS

PEDIATRICS INSURANCE CONSULTANTS provides nine benefit programs for the members of the American Academy of Pediatrics. These programs are underwritten by companies of the Kemper Group.

You can write for full details about any one or all nine of the benefit programs available to members (use the coupon in this ad). We'll rush all of the information you need, including rates and application forms, direct-by-mail.

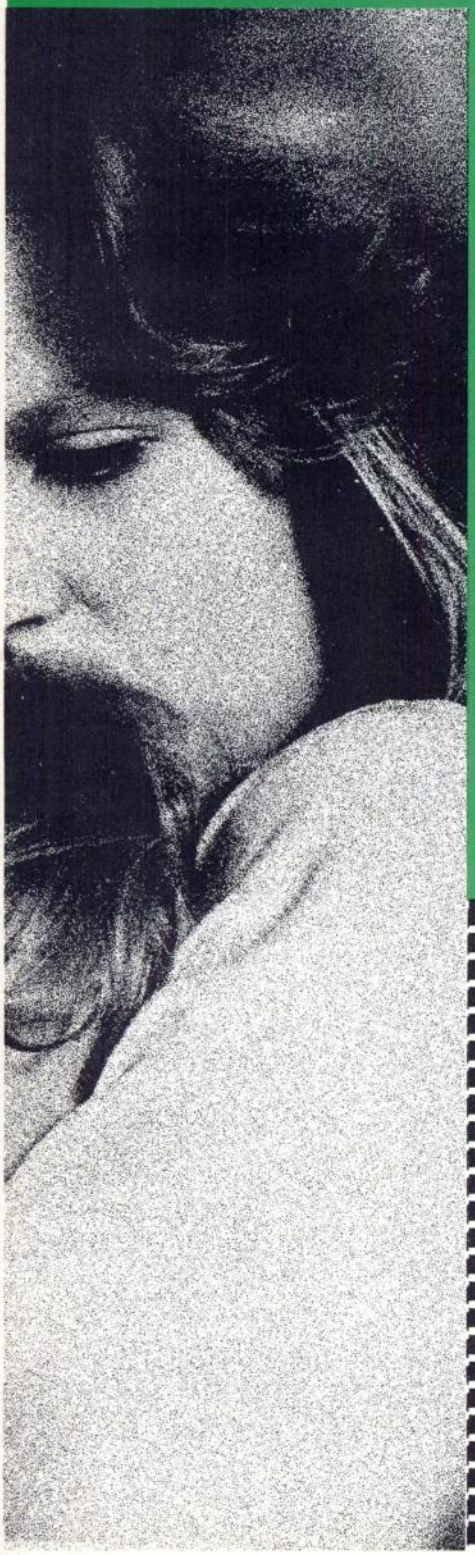
If you need this information immediately, please call us TOLL FREE . . . **1-800-257-3220**

In Illinois, call collect 1-312-439-3220

Pediatrics Insurance Consultants, Inc.
141 Northwest Point Road
Elk Grove Village, Illinois 60007

PEDIATRICS INSURANCE CONSULTANTS

20% RATE REDUCTION effective Sept. 1, 1984



Add up to $200,000 to your life insurance ESTATE at low group rates*

Most insurance experts agree that you should automatically review your life insurance needs every year... or whenever your financial responsibilities increase.

When you think about it, this makes especially good sense right now during these days of run-away inflation. *The life insurance program you set up years ago may not be enough* TODAY, to meet the needs of your family.

So take a look at your financial picture. Compare it to what it was when you bought your present insurance. Chances are it's changed, and chances are you need more protection. If so, your next concern should be getting the best value for your money. That's where your American Academy of Pediatrics GROUP LIFE INSURANCE plan comes in...

*If you're under age 55 you can be eligible to apply for up to $200,000. (Under 60—up to $100,000.) Spouse benefits are also available (up to $100,000 if under age 60). Dependent children are also eligible for life insurance benefits. (See brochure for limits and eligibility factors.)

SEND FOR FREE DETAILS, INCLUDING RATES FOR YOUR AGE AND A DIRECT-BY-MAIL ENROLLMENT KIT.

DIRECT-BY-MAIL

☐ FREE INFORMATION REQUEST

Please send me benefit information, rates and applications on the following Academy Insurance Benefit Plans:

*Read the prospectus before investing or forwarding funds.

- ☐ GROUP I.R.A.*
- ☐ DAILY HOSPITAL BENEFIT/up to $100-a-day
- ☐ GROUP TERM LIFE/up to $200,000
- ☐ $1,000,000 COMPREHENSIVE MAJOR MEDICAL
- ☐ DISABILITY INCOME PROTECTION
- ☐ OFFICE OVERHEAD EXPENSE/up to $7,500
- ☐ EXCESS PERSONAL LIABILITY
- ☐ HOME INSURANCE
- ☐ AUTO INSURANCE

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

☐ Please call me/Phone No.:

( ) _____
area code

Mail to:
Pediatrics Insurance Consultants, Inc.
141 Northwest Point Road
Elk Grove Village, Illinois 60007

P/1084

WHERE POPULATION CONTROL CUTS A DIFFERENT WAY

At a January 1983 news conference, President Francois Mitterrand declared that France's low birth rate was one of its major problems. From about 2.5 children a couple in 1972, it had fallen to less than two in 1982. But a birth rate of 2.1 is needed to maintain the current French population of 55 million.

France isn't the only West European nation with a declining birth rate. In 1982, the average for the nine Common Market countries was 1.67 children a couple, with West Germany last at 1.4. Yet only France appears to be worried about it.

The problem of *denatalite*—as the low birth rate is called—is a regular item for both the French press and television. A recent opinion poll in the magazine Paris Match revealed that out of 1,000 people questioned, 59% thought the French birth rate was insufficient, while only 32% believed it was adequate.

Curiously enough, the French apparently all agree that the birth rate ought to be increased, and so the traditional left-right distinctions do not seem to apply. While deploring the "statism" of the Mitterrand government, for example, the French right advocates direct state intervention to raise the birth rate. The champion of this policy is Michel Debre, De Gaulle's prime minister from 1958 to 1962 and a presidential candidate in the last election.

The left, though concerned about the birth rate, is dubious about the notion of an official policy on birth rates. Georgina Dufoix, minister of family affairs, argues that most attempts to increase the population by direct means, in Romania and East Germany as well as in France, have failed.

From *The Wall Street Journal*, June 20, 1984, p 31.

YOUNG VICTIMS OF AIDS SUFFER ITS HARSH STIGMA

Last June 1983, the foster parents of a 3-year-old girl suffering from respiratory distress took her to Lincoln Hospital in the Bronx. Her condition deteriorated and she lost weight. After extensive tests, doctors found that the girl, whose name is Tracy, had AIDS, the disorder that attacks the body's immune system. Soon after, the foster parents told hospital officials they were giving Tracy up. Children like Tracy, beyond fighting a deadly illness, have become social outcasts because of unwarranted fears about the contagiousness of AIDS, according to doctors, social workers and the families of the children. Young victims of AIDS have been left in hospitals, some by mothers who have died or are dying of AIDS, they said. Others were accepted back in their homes only to be excluded from schools, dentists' offices and contact with neighbors. Tracy is one of seven AIDS children abandoned in New York City hospitals for whom Special Services for Children, the city's child welfare agency, is seeking fostor homes, said Arthur T. Hilson, the director of the agency's Office of Placement and Accountability. He said he knew of no successful effort to find a home for an abandoned AIDS child.

Officials at the Centers for Disease Control have counted 57 children nationwide with AIDS, 39 of whom have died. Dr. Pauline Thomas, an epidemiologist for the New York City Health Department, said 29 children in the city met the Federal criteria for AIDS. These figures are disputed as too low by some pediatric immunologists who contend that the Federal definition of AIDS is unduly strict. The Federal Government counts only children who have a malignancy or "opportunistic" infections—infections caused by agents that pose no danger to healthy people but can be deadly to the immune-deficient.

Dr. Rubinstein said he was treating 44 children with the disease. Dr. James Oleske of St. Michael's Hospital and the Newark College of Medicine said he had 18 patients and six more suspected cases.

From *The New York Times*, June 17, 1984, p 22.

Aspirin

Aspirin-Free

CHILDREN'S ANALGESICS

Only St. Joseph® has them all.

Now, along with Chewable Aspirin for Children, there's Aspirin-Free Chewable Tablets, new Aspirin-Free Infant Drops and new Aspirin-Free Elixir—so you can recommend St. Joseph for children of any age.

St. Joseph has been the innovator in key advances in children's medicines. It was the first to introduce children's aspirin in 1¼ grain tablets in 1947. And first to introduce safety closures in 1958.

St. Joseph has always stood for fast, safe, effective children's medicines. So whether you're treating a child's fever or the symptoms of a cold or flu, remember St. Joseph.

The trusted name for over 35 years.

DOSAGE RECOMMENDATIONS

AGE GROUP	0-3 Months	4-11 Months	12-23 Months	2-3 Years	4-5 Years	6-8 Years	9-10 Years	11 Years
Weight (lbs.)	7-12	13-21	22-26	27-35	36-45	46-65	66-76	77-83
Dose of ST. JOSEPH								
Acetaminophen (mg.)	40	80	120	160	240	320	400	480
Aspirin (mg.)	—	—	122	162	243	324	405	486
Acetaminophen Drops Dropperfuls	½	1	1½	2	3	4	5	—
Acetaminophen Elixir Teaspoonfuls	—	½	¾	1	1½	2	2½	3
Chewable Tablets Acetaminophen (80 mg. each) Aspirin (81 mg. each)	—	—	1½	2	3	4	5	6

Dose should be administered every 4 hours—but not to exceed 5 doses in 24 hours.

The full line of St. Joseph products comes in tamper resistant, child-resistant packages.

NOTE: Since St. Joseph pediatric products are available without prescription, parents are advised on the package label to consult a physician for use by children under two years.

St. Joseph® from Plough, Inc.

A subsidiary of Schering-Plough Corporation.

One thing separates a Kip® from a Nuk®. A Kip can't separate.

A piece of a Nuk.

The Nuk Orthodontic Exerciser is a fine product. But as the Nuk people themselves warn on the back of their package, you should always test it to be sure that the nipple portion doesn't separate.

Another piece.

At The First Years, safety is a virtual obsession. (Our Mothers' Council wouldn't have it any other way.) So when we designed *our* orthodontic pacifier, we did things differently.

Another piece.

The Kip Orthodontic Pacifier.
One-piece for safety, all-soft for comfort.

To make Kip totally safe, we made it in one piece. And safety is just one of its virtues.

Kip's super-soft vinyl stays soft. Without getting sticky the way latex can.

Kip's naturally shaped nipple resembles the soft, soothing nipple of a nursing mother.

Kip's soft shield pulls inward to help keep growing teeth in proper alignment.

Still another.

The fact is, Kip offers everything new mothers should look for in an orthodontic pacifier.

And unlike Nuk, Kip offers it all in one piece.

the first years®

MBF™-Put it on trial for the milk-intolerant child.

Gerber will send you a list of retail outlets in your area, along with MBF™ technical and patient literature.

NAME

Practice: ☐ General/family practitioner ☐ Pediatrician ☐ Allergist ☐ Other

ADDRESS

CITY/STATE/ZIP

Return to: Medical Marketing Services, 445 State Street, Fremont, MI 49412.

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.

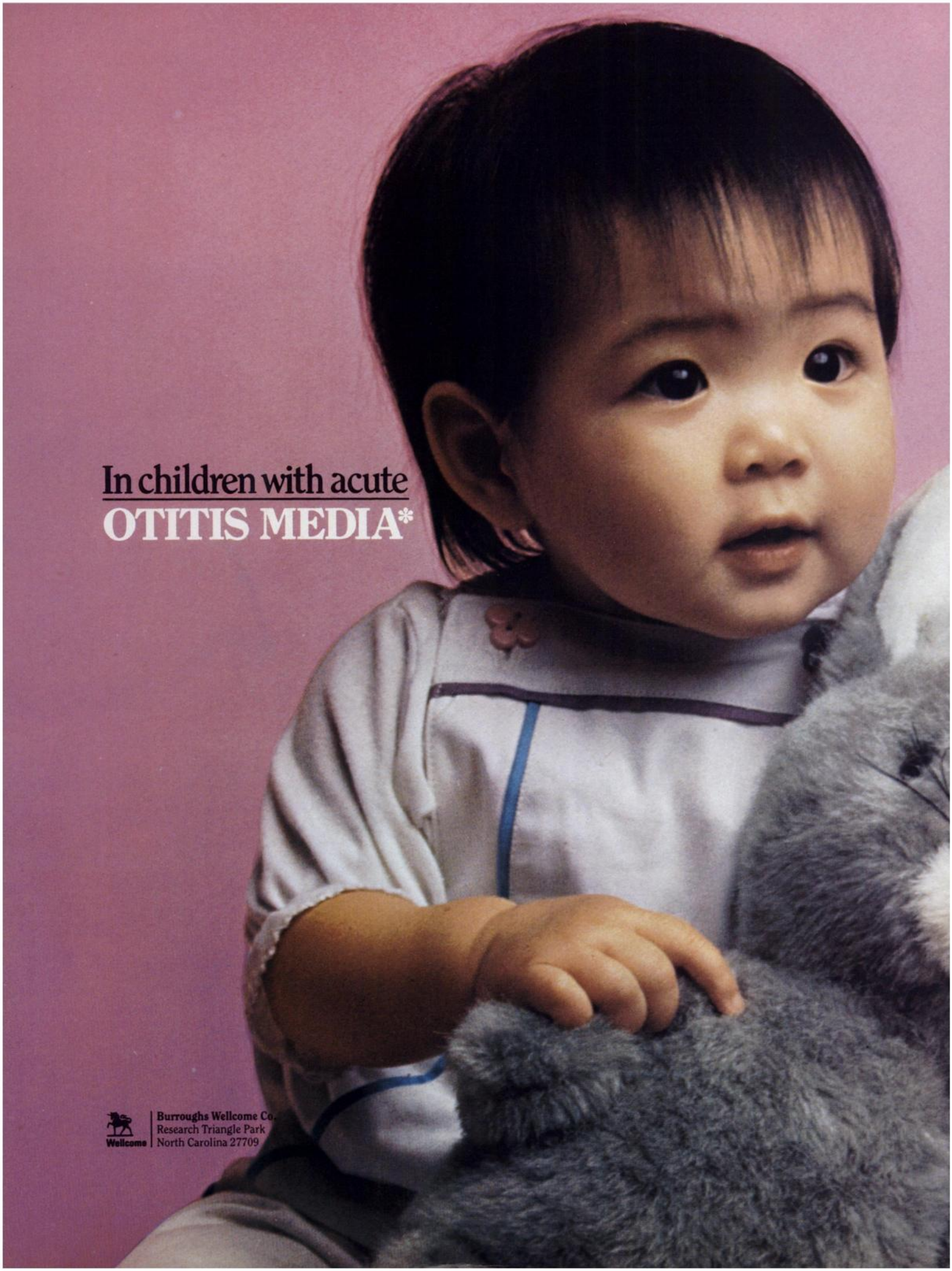
Price is comparable to that of ready-to-feed soy formulas, and much less than the price of milk hydrolysate products. Distribution is nationwide.

1. Gerrard et al.: Cow's milk allergy: Prevalence and manifestations in an unselected series of newborns. *Acta Paediatrica Scand* (supp) 234:3, 1973.

2. Speer F, Dockhorn RJ: Allergy and Immunology in Children. Springfield, IL: Charles C. Thomas, 1973.

Gerber®

Gerber Products Company
Medical Marketing Services
445 State Street, Fremont, MI 49412


In children with acute
OTITIS MEDIA*
Wellcome
Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Initiate therapy with

trimethoprim-sulfamethoxazole

It is effective against the pathogens most frequently isolated in acute otitis media: *Streptococcus pneumoniae* and *Haemophilus influenzae* including strains of *H influenzae* resistant to ampicillin/amoxicillin.

Gentle enough to be well tolerated...

In comparative studies in the treatment of acute otitis media, the incidence and types of side effects associated with SEPTRA therapy in children have been generally the same as those associated with penicillin derivative therapy.[1,2] In a comparative study[3] with ampicillin it was reported that there was an "acceptably low frequency" of side effects in both treatment groups, with no "clinically significant toxicity" or hematological abnormalities observed. Since severe adverse reactions, although rare, have been reported, physicians should review full prescribing information.

yet strong enough for consistent results

Generally, well-tolerated effectiveness is an established and documented fact because SEPTRA penetrates serum and middle ear fluid with antibacterial concentrations well above the MICs required for *S pneumoniae* and *H influenzae*. And SEPTRA is administered b.i.d. for improved potential for patient compliance.

SEPTRA SUSPENSION
trimethoprim-sulfamethoxazole

because well-tolerated results are what count.

*Due to susceptible strains of *S pneumoniae* and *H influenzae*.
Please see brief summary of prescribing information on next page.

When they're caught in the grip of hacking cough

Prescribe...

Novahistine® DH℗

Each 5 ml of liquid contains: codeine phosphate 10 mg (Warning: may be habit forming), pseudoephedrine HCl 30 mg, chlorpheniramine maleate 2 mg, alcohol 5%

antitussive/decongestant/ antihistamine

And for...

Cough with tenacious pulmonary secretions

Novahistine® Expectorant℗

Each 5 ml of liquid contains: codeine phosphate 10 mg (Warning: may be habit forming), pseudoephedrine HCl 30 mg, guaifenesin 100 mg, alcohol 7.5%

antitussive/decongestant/ expectorant

Pleasant tasting and effective cough control for children and adults

Merrell Dow

MERRELL DOW PHARMACEUTICALS INC.
Subsidiary of The Dow Chemical Company
Cincinnati, Ohio 45215, U.S.A.

2-0687 (B-0090)

MNQ-343

MBF™-Put it on trial for the milk-intolerant child.

Gerber will send you a list of retail outlets in your area, along with MBF™ technical and patient literature.

NAME

Practice: ☐ General/family practitioner ☐ Pediatrician ☐ Allergist ☐ Other

ADDRESS

CITY/STATE/ZIP

Return to: Medical Marketing Services, 445 State Street, Fremont, MI 49412.

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.

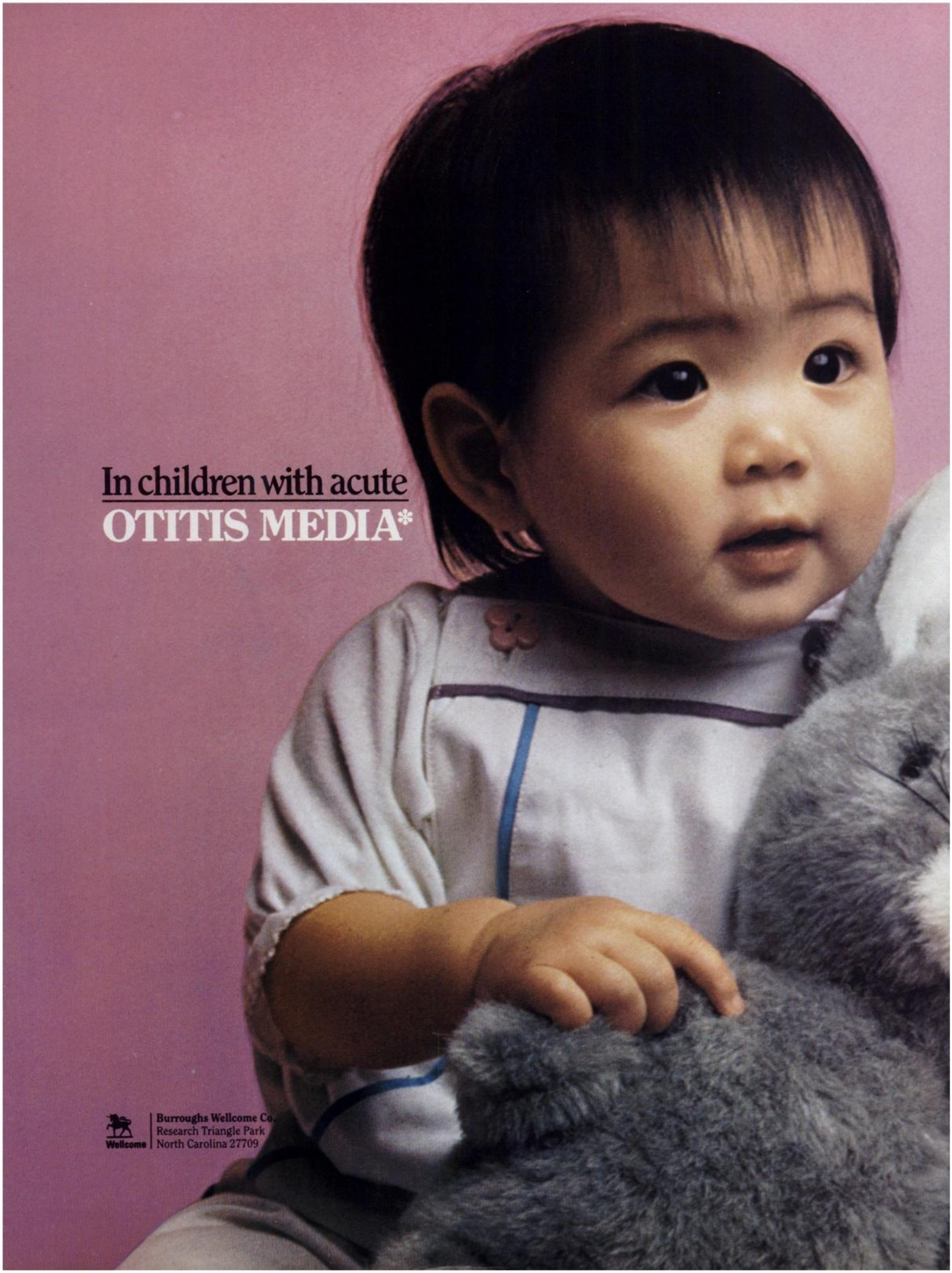
Price is comparable to that of ready-to-feed soy formulas, and much less than the price of milk hydrolysate products. Distribution is nationwide.

1. Gerrard et al.: Cow's milk allergy: Prevalence and manifestations in an unselected series of newborns. *Acta Paediatrica Scand* (supp) 234:3, 1973.

2. Speer F, Dockhorn RJ: Allergy and Immunology in Children. Springfield, IL: Charles C. Thomas, 1973.

Gerber®

Gerber Products Company
Medical Marketing Services
445 State Street, Fremont, MI 49412


In children with acute
OTITIS MEDIA*
Wellcome
Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Initiate therapy with

SEPTRA®
trimethoprim-sulfamethoxazole
SUSPENSION

It is effective against the pathogens most frequently isolated in acute otitis media: *Streptococcus pneumoniae* and *Haemophilus influenzae* including strains of *H influenzae* resistant to ampicillin/amoxicillin.

Gentle enough to be well tolerated...

In comparative studies in the treatment of acute otitis media, the incidence and types of side effects associated with SEPTRA therapy in children have been generally the same as those associated with penicillin derivative therapy.[1,2] In a comparative study[3] with ampicillin it was reported that there was an "acceptably low frequency" of side effects in both treatment groups, with no "clinically significant toxicity" or hematological abnormalities observed. Since severe adverse reactions, although rare, have been reported, physicians should review full prescribing information.

yet strong enough for consistent results

Generally, well-tolerated effectiveness is an established and documented fact because SEPTRA penetrates serum and middle ear fluid with antibacterial concentrations well above the MICs required for *S pneumoniae* and *H influenzae*. And SEPTRA is administered b.i.d. for improved potential for patient compliance.

SEPTRA SUSPENSION
trimethoprim-sulfamethoxazole

because well-tolerated results are what count.

*Due to susceptible strains of *S pneumoniae* and *H influenzae*.
Please see brief summary of prescribing information on next page.

COMING!

Practice of PEDIATRICS 1985

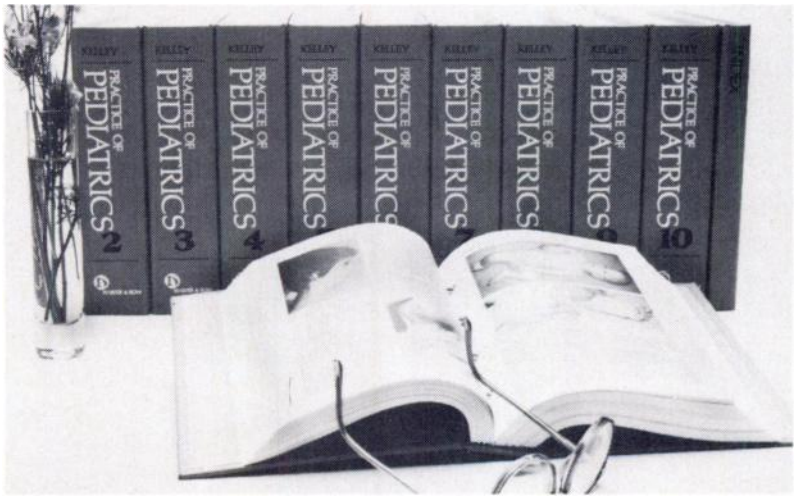
the complete ever-current loose leaf reference

edited by Vincent C. Kelley, M.D., Ph.D.
32 Renowned Section Editors

...heavily revised to keep pace with today's pediatric practice

PRACTICE OF PEDIATRICS 1985 now reflects today's state of the art—for the pediatrician who knows that keeping up to date is a vital part of caring for his patient. Complete, comprehensive, in efficient loose leaf form that insures the continued immediacy of books that serve you through a lifetime of practice.

- 10 volumes—nearly 8,000 pages
- over 400 chapters—61 new or extensively revised
- 411 distinguished contributors
- over 2,000 sharp, clear figures and illustrations
- over 1,000 tables
- newly designed binders
- PLUS the yearly new page service
- **separate index volume completely revised with new Index of Syndromes**



Editorial Board

Allergic Diseases
Sheldon C. Siegel, M.D.
Circulatory System
Warren G. Guntheroth, M.D.
Dermatology
Ronald C. Hansen, M.D.
Developmental Pediatrics
Sherrel L. Hammar, M.D.
Endocrinology and Metabolism
Neil R. M. Buist, M.D., Ch.B.
Neil R. M. Buist, M.B., Ch.B.
George A. Limbeck, M.D.
Dan C. Moore, M.D.
Michael R. Soules, M.D.
Mark A. Sperling, M.D.
Gastroenterology
George A. Limbeck, M.D.
Steven L. Werlin, M.D.
Hematology
Ronald G. Strauss, M.D.
Infections and Immunology
Starkey D. Davis, M.D.
C. George Ray, M.D.
Ralph J. Wedgwood, M.D.
Musculoskeletal System
Ronald J. Lemire, M.D.
Kenneth M. Jaffe, M.D.
Neonatology
Robert D. Guthrie, M.D.
W. Alan Hodson, M.D.
Neurology
Michael J. Painter, M.D.
John M. Pellock, M.D.
Nutrition
C. Larry Kien, M.D., Ph.D.
Oncology
Ronald G. Strauss, M.D.
Ophthalmology
Leonard B. Nelson, M.D.
Oral Cavity and Related Structures
Robert J. Gorlin, D.D.S.
Otolaryngology
Sylvan E. Stool, M.D.
Pharmacology and Trauma
Alan K. Done, M.D.,
Psychiatry
Shirley B. Lansky, M.D.
Rehabilitation Medicine
Yasoma B. Challenor, M.D.
John A. Downey, M.D., Ph.D.
Renal Diseases
Howard G. Worthen, M.D., Ph.D.
Respiratory Diseases
W. Alan Hodson, M.D.
Gregory J. Redding, M.D.
David E. Woodrum, M.D.
Rheumatic Diseases
Ralph J. Wedgwood, M.D.
Sports Medicine
William B. Strong, M.D.

J. B. Lippincott Company
The Health Professions Publisher of Harper and Row, Inc.
Loose Leaf Service, East Washington Square
P.O. Box 1430, Philadelphia, PA 19105

Please send me for 30 days' no-charge examination PRACTICE OF PEDIATRICS 1985. If I keep the books, I shall pay according to the plan checked below. (If I do not wish to keep the books, I shall return them within 30 days, without any further obligation.) I also subscribe, until discontinued by either party, to the New Page Service after the first year to be billed at $55.00. (Price subject to change.) The first year's Pages will be sent at no charge.

Income Tax deductions are permitted by U.S. Regulation 1-162-6 for expenses accrued in the purchase of professional books and journals.

Lippincott

☐ Enclosed is my check for $315.00*. We pay shipping, handling.
☐ Please bill me in full for $350 plus shipping, handling charges.
☐ Please bill me in 10 equal monthly installments. Shipping, handling charges will be included in monthly payment.
☐ Charge It*: ☐VISA ☐MasterCard ☐American Express ☐CHOICE
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiration date_____

***10% discount when payment accompanies order.**

Name _____

Address _____

City/State/Zip _____

Prices may vary and installment terms not applicable outside of the U.S. & Canada. Orders subject to the approval of Lippincott. Sales tax will be added where applicable. Prices quoted in U.S. funds and subject to change. 281-84 LL

Pediatrics

CLASSIFIED ADVERTISEMENTS

Your advertisement in the Classified Section of Pediatrics will reach more than 40,000 child health care professionals each month. This circulation includes more than 85% of all Board-certified pediatricians, over 90% of all certified pediatric allergists, cardiologists, and surgeons, and 2,500 pediatric residents. An average of 24 responses are received for each ad run three times or more, with box service.

RATES: 30 words or less—1 time, $65.00, 3 times or more, $52.00 each time. Each word over 30, $1.00 each time. **Bold face** or *italics*, $5.00 one time charge. Blind box charge, $6.00 each time. Boxed ad, $45.00 one time charge.

Note: Initials or abbreviations equal 1 word. Telephone number with area code equals 1 word.

TERMS: Payment must accompany order. Make checks payable to American Academy of Pediatrics. Advertiser may cancel ad without refund.

DEADLINE: 1st of second month preceding issue (January 1st for March issue). Please submit ad copy typed. No telephone orders will be accepted.

ADDRESS: **PEDIATRICS Classifieds**
(Blind Box #) If Used
American Academy of Pediatrics
P.O. Box 72099
Chicago, IL 60690-2099

OPPORTUNITIES

FIFTH PEDIATRICIAN—To join general pediatric suburban Philadelphia group in comfortable and convenient Montgomery county. Active newborn service. Subspecialty training preferred but not required. Reply to Box #108412.

□

BOSTON AREA—Busy 3½-person practice in suburban community seeks general pediatrician. Good hospitals; good housing; close to city, beaches, and mountains. Practice-type experience preferred. Reply to Box #108401.

□

TEXAS/PEDIATRICIAN—Two BC/BE pediatricians to join in 25-physician multispecialty group in west-central Texas. Neonatal training required. Community of 80,000 with drawing area of 150,000. New clinic and hospital facilities. Excellent first year guarantee, then shareholder status. Contact Jim Fajkus, Administrator, Angelo Clinic Association, PO Box 5961, San Angelo, TX 76902.

□

INDIANA—General pediatrician BC/BE and pediatrician-subspecialty adolescent medicine or pulmonology, to join progressive group of 60 physicians including six pediatricians. Located in midwestern university town of 100,000. Excellent opportunity. Send CV to: Wendell A. Riggs, MD, Arnett Clinic, Inc, 2600 Greenbush St, Lafayette, IN 47904. (317) 447-4171.

NEONATOLOGIST—Board certified preferred, Board eligible considered. Progressive 40-bed maternity hospital located in highly desirable residential community of capital district. Two physicians provide coverage of Level II service and have practice on hospital premises in neonatology and pediatrics. Need interest in education and teaching. Quality housing, schools, and recreation within minutes of hospital. Reply to Dr Mary Eleanor Toms, Chairman, Search Committee, Bellevue Maternity Hospital, PO Box 1030, Schenectady, NY 12301.

□

ASSISTANT DIRECTOR FOR AMBULATORY PEDIATRIC SERVICES—Attractive opportunity at our 470-bed ultramodern university-affiliated teaching hospital noted for high quality of patient care and progressive medical practices. Position entails resident teaching, consultations, acute care, ambulatory research. Academic appointment expected. NYS license and current registration or eligibility required. Rank/salary commensurate with experience. Please send CV to Steven C. Shapiro, MD, Director of Pediatrics, The Staten Island Hospital, 475 Seaview Ave, Staten Island, NY 10305. An Equal Opportunity Employer. M/F/H.

□

ASSISTANT DIRECTOR, PEDIATRIC INTENSIVE CARE SERVICES—We are a progressive, dynamic, 450+-bed university-affiliated hospital located in suburban NYC known for a long tradition of medical excellence. Assistant Director will be responsible for planning and development of the inpatient pediatric program and pediatric ICU; pulmonary or cardiology background desired. Applicant must have proven administrative, clinical, and research skills equal to the task. Academic appointments expected. NYS license or eligibility required. Salary commensurate with experience. Submit CV to Box #108403. An Equal Opportunity Employer. M/F/H.

□

CHAIRMAN, DEPARTMENT OF PEDIATRICS—Excellent opportunity for Board-certified pediatrician to become Chairman, Department of Pediatrics of The Allentown Hospital. Candidates must possess leadership ability, both administratively and clinically; must be progressive and forward thinking; and shall harbor a commitment to remain current in the theory and practice of pediatrics. Candidates must have previous administrative responsibilities/accomplishments and teaching experience in pediatrics. Board certification in a pediatric subspecialty is desirable. The Allentown Hospital is a progressive 300-bed teaching community hospital (a subsidiary of HealthEast, Inc, a 738-bed system). The hospital's Maternal and Children's Service includes a 27-bed pediatric unit and a 20-bed, Level III neonatal intensive care unit. It serves a population of more than 500,000 and is located in a very desirable city that is in the forefront of medical technology and in close proximity to all major East Coast cities. Competitive remuneration and benefits. All interested candidates should write, in complete confidence, to: Search Committee/Chairman, Department of Pediatrics, c/o Darryl R. Lippman, President, The Allentown Hospital, 17th and Chew Sts, Allentown, PA 18102. (215) 778-2204.

Continued on page A98

Continued from page A97

CONNECTICUT—BC pediatrician seeks BC/BE university-trained pediatrician to join very busy practice in southwestern Connecticut. Located 1½ hours from NYC, one hour from Yale. Please call (203) 355-4113.

□

NEW YORK—Pediatrician, Board certified or eligible to join Capital Area Community Health Plan, a federally qualified HMO serving 50,000 members. Practice includes hospital and office-based care. The multispecialty staff includes eight pediatricians plus family practitioners, orthopedists, surgeons, ENT, and others. CHP is located in New York's capital district within easy reach of Boston, New York City, and Montreal. The area offers a wide range of residential styles and has an abundance of cultural and recreational options. Professionals enjoy attractive salary and fringe benefits. Need pediatrician by January 1985. Address inquiries to Stanley W. Kilty, MD, Medical Director, Capital Area Community Health Plan, Inc, 1201 Troy Schenectady Rd, Latham, NY 12110. Telephone (518) 783-3110.

□

QUINCY, MASSACHUSETTS—Starting date at once. Board-certified or Board-eligible pediatrician wanted to assume responsibility for an established private practice. Strong affiliation and support from a large, hospital-based pediatric practice for night-call, inpatient services, CME, etc. Contact: Robert P. Younes, MD, Director, Department of Pediatrics, Carney Hospital, 2100 Dorchester Ave, Dorchester, MA 02124. (617) 296-4000, ext 2192.

□

NORTHWEST PENNSYLVANIA—Woods, hills, rivers. Rural setting. Join two Board-certified pediatricians in a busy practice. Teach residents and students. Practice quality medicine in a friendly town. Pittsburgh and Cleveland within two hours. We have a large referral practice with many allergy patients. Write to Box #108414.

□

PEDIATRIC NEUROLOGIST—Northwestern University Medical School, Children's Memorial Hospital, Chicago. Senior level faculty appointment as Head, Division of Neurology. Excellent opportunity to direct an active research, teaching and clinical program in a university-based children's hospital. Inquiries with CV by Nov 1, 1984 to David G. McLone, MD, PhD, Chairman, Neurology Search Committee, Children's Memorial Hospital, 2300 Children's Plaza, Chicago, IL 60614. An Equal Opportunity Employer.

□

PEDIATRICIAN—Board eligible or certified to join established primary care group in New Jersey for full- or part-time. Attractive suburban setting in south-central NJ. Reply Box #108405.

□

PART-TIME PEDIATRICIAN—BC/BE to job share with two young pediatricians in growing practice. Exciting opportunity in scenic Finger Lakes community 50 minutes south of Rochester, New York. Primary care, referral from Family Practice Associates, teaching, and hospital responsibilities. Flexible schedule. Contact: Joan Flender, Box 177, Dansville, NY 14437. (716) 335-2618.

APPLICATIONS ARE INVITED—for the position of Head, Department of Pediatrics, Dalhousie University, and Chief of Pediatrics, the Izaak Walton Killam Hospital for Children, Halifax, Nova Scotia. Dalhousie University is an equal opportunity employer but in accordance with Canadian immigration requirements, priority will be given to Canadian citizens and permanent residents of Canada. The applicant should have an outstanding academic and clinical record and demonstrated administrative experience. The applicant should be certified or eligible for certification by the Royal College of Physicians and Surgeons of Canada. The successful applicant will direct an academic department consisting of 41 full-time and 15 part-time members. Applicants are requested to submit a curriculum vitae, list of publications, and names of three referees to: Dr Thomas J. Marrie, Chairman, Pediatrics Search Committee, c/o Office of The Dean of Medicine, Dalhousie University, Halifax, Nova Scotia, B3H 4H7, Canada.

□

SOUTHERN CALIFORNIA—Two pediatricians, male and female, need third pediatrician/neonatologist: Level II neonatal nursery/general pediatrics. Excellent economic opportunity. Reply to: James A. Ellis Medical Corporation, 1665 S Imperial Ave, El Centro, CA 92243. (619) 352-7216.

□

WANTED—Board-certified/eligible pediatrician to associate with established BC internist and family practice nurse practitioner, lower Florida Keys. Immediate opening available. Reply Box 2841, Key West, FL 33040.

□

HAMAD GENERAL HOSPITAL—660-bed referral facilities, invites qualified consultant pediatricians to apply for the post of Consultant in Children's Development Disabilities. Candidates should hold appropriate postgraduate qualifications in pediatrics (membership of Colleges of Pediatrics or American Boards) and be experienced in clinical and community pediatrics. Previous work with cerebral palsy and physically and mentally handicapped children an advantage. The selected applicant will enjoy generous fringe benefit package, ie, 60 days paid leave per year, air ticket for employee, wife, and up to three eligible children up to the age of 18 years, transport allowance of QRs $600/month, furnished family accommodation and contracts for period of 3 years. Please send complete CV with contact telephone number to: Medical Director, Hamad General Hospital, PO Box 3050, Doha, State of Qatar, Arabian Gulf.

□

MASSACHUSETTS—Pulmonologist-Intensivist. Department of Pediatrics at Baystate Medical Center, a 950-bed hospital in Springfield, Massachusetts, is seeking a full-time pulmonologist/intensivist to join a 17-member multispecialty faculty. A cardiologist/intensivist currently directs the five-bed Pediatric Intensive Care Unit, so we seek to increase attending coverage of that unit. This department has strong academic affiliations with the University of Massachusetts Medical School and Tufts University School of Medicine with full faculty appointments based on experience and qualifications. A large neonatology service, 52-bed inpatient service, and busy ambulatory program provide abundant opportunities for patient care, resident and student teaching, and clinical research. Apply with curriculum vitae and letters of recommendation to Edward O. Reiter, MD, Chairman, Department of Pediatrics, Baystate Medical Center, 759 Chestnut St, Springfield, MA 01199. An equal opportunity employer. M/F/H.

Continued on page A99

Continued from page A98

PEDIATRICIAN—Rapidly growing, well-established health maintenance organization in Syracuse area seeks Board certified/eligible physician to join six-person department. Metropolitan area of 600,000 with numerous four-season recreational and cultural amenities. Good housing market. Medical school faculty appointment and educational programs less than 15 minutes from office. Opportunity to perform diverse services (eg, suturing, casting) and to participate in management of organization. Competitive salary and fringe benefits. Please respond to: Ellen G. Wilson, Health Services Association, 8280 Willett Pkwy, Baldwinsville, NY 13027. Equal Opportunity Employer.

□

EMERGENCY MEDICINE/PEDIATRIC PHYSICIAN—Rhode Island Hospital is seeking physician for patient care, house staff instruction, pediatric emergency. Emergency medicine graduates with pediatric experience or pediatrics graduates with emergency medicine. Apply Jack Franaszek, MD, Department of Emergency Medicine, Rhode Island Hospital, 593 Eddy St, Providence, RI 02902. (401) 277-5826. Affiliate Brown University. An EO/AAE.

□

ADMINISTRATIVE NURSE III PEDIATRICS (Head Nurse)—With an average daily census of 35 to 45 patients, applicants should be familiar with the operation of a large teaching hospital with multiple medical-surgical admitting services. Although this is an administrative career position in our Critical Care and Pediatric Clinical Division, clinical competency in the nursing care of infants/children/adolescents is required. Preference will be given to applicants with an advanced nursing degree (MSN) and previous head nurse/supervisory experience at a children's hospital. GENERAL DUTIES—24-hour administrative responsibility for the unit. Responsibilities include: evaluation, planning, and implementation of Nursing Service Philosophy and Objectives; supervising a staff of RNs (some units have LVNs) in hiring, orientation, evaluations, and continuing education/development needs; administering the unit budget, including staff schedules, unit supplies, and capital equipment recommendations. Establish and implement interventions in providing quality patient care. Participate in committee work and relevant research studies (nursing and patient care related). GENERAL QUALIFICATIONS—California-licensed RN with 3 years minimum clinical expertise in specialty and excellent interpersonal skills. Preference will be given to those with an advanced master's degree and previous management background. All applicants are welcome to submit professional resumes to: Bud Bednarski, RN, BSN, Coordinator Nursing Resources, UCLA Medical Center, Room 14-177 CHS, 10833 LeConte Ave, Los Angeles, CA 90024. Affirmative Action Employer.

□

NORTH CAROLINA—BC/BE pediatrician to join two others in well-established private pediatric practice. Active neonatal service. Excellent hospital. Level 2.5 nursery. Small city setting, excellent location. Call Dr William Adams, (919) 738-6033.

□

NEW HAMPSHIRE—BC/BE pediatrician to join with five Board-certified pediatricians in Manchester, New Hampshire, a city of 100,000 in thriving southern New Hampshire. Reply with CV to Box #108413.

CONNECTICUT—BC/BE pediatrician to replace third associate departing July 1, 1985 for specialty training. Busy southwest Connecticut. Practice on Long Island Sound, convenient to NYC and New England. Teaching hospital with Level III nursery. Contact: Dr Peter Mcloughlin, 2475 North Ave, Bridgeport, CT 06604.

□

PEDIATRICIAN—BC/BE Special training in adolescents helpful. To join partner in large well-established pediatric practice in multispecialty group located in northern New Jersey, 40 minutes from New York. Excellent recreational area. Rewarding salary and benefits leading to early partnership. Send CV to: Administrator, Medical Associates, PA, 77 Union St, Dover, NJ 07801.

□

NORTHEASTERN AND SOUTHERN NEW HAMPSHIRE—BC/BE, university-trained pediatricians needed for four-physician office of progressive 35-physician multispecialty group serving fee-for-service and HMO patients. First year guaranteed salary and excellent benefits, leading to early partnership. Openings for now and July 1985. Reply to Box #108402.

□

TEXAS—Seeking third BE/BC neonatologist for private neonatal practice, Level III, 4,500 births; 14 ICU beds, expanded facility opened July 1984, located in rapidly growing north Dallas. All pediatric and surgical consultants available. Send CV to Box #108410.

□

BOSTON AREA—Full-time BC/BE pediatrician for growing three-physician practice. Office adjacent to strong 350-bed community hospital with expanding Level II nursery with SCU. Send CV: PM New England, Inc, 615 Jefferson Blvd, Warwick, RI 02886.

□

PEDIATRICIAN—Solo BC pediatrician seeking BC/BE associate. Modern, expanding, 102-bed acute care hospital with pediatric ward and young, progressive medical staff. Academic affiliation available. Rural, attractive Massachusetts community located 35 miles NW of Boston. Hospital-sponsored financial support available. Female candidates encouraged. Please send CV and references to Roland Larson, President, The Nashoba Community Hospital, 200 Groton Road, Ayer, MA 01432.

□

SCOTTSDALE, ARIZONA—Board certified or eligible pediatrician to join two Board-certified pediatricians in an active practice. Our practice couples an excellent practice opportunity with a chance to enjoy the outdoor advantages of the sunny Scottsdale/Phoenix metropolitan area. Send CV to: Papago Buttes Pediatric Center, PC, 6880 E McDowell Rd, Scottsdale AZ 85257. (602) 947-2457.

Continued on page A100

Continued from page A99

DEPARTMENT OF PEDIATRICS—The Milton S. Hershey Medical Center of The Pennsylvania State University is seeking a pediatric hematologist/oncologist to fill the position of Chief of the Division. The division currently has one hematologist/oncologist at the Assistant Professor level. We seek someone with a major commitment to research who is an established independent investigator with well-developed laboratory interests and skills. In addition, the individual should have sufficient experience, as well as the personal qualities necessary, to function as Chief of the Division. Applicants should submit a curriculum vitae to: M. Jeffrey Maisels, MD, Chief, Division of Newborn Medicine, Department of Pediatrics, The Milton S. Hershey Medical Center, The Pennsylvania State University, PO Box 850, Hershey, PA 17033. Affirmative Action/Equal Opportunity Employer.

□

NEONATOLOGIST—Division of Newborn Medicine, Department of Pediatrics, The Milton S. Hershey Medical Center of The Pennsylvania State University College of Medicine, is seeking a neonatologist at the Assistant Professor level. We seek someone with a major commitment to research (70% time) who is an independent investigator with well-developed laboratory interests and skills and who has had 2 years of experience beyond the usual 2-year neonatal fellowship. Applicants should submit a curriculum vitae to: M. Jeffrey Maisels, MD, Chief, Division of Newborn Medicine, Department of Pediatrics, The Milton S. Hershey Medical Center, The Pennsylvania State University, PO Box 850, Hershey, PA 17033. Affirmative Action/Equal Opportunity Employer.

□

PEDIATRICIANS—Join a successful, expanding, multispecialty prepaid group practice in a pleasant coastal New England community. Rhode Island Group Health Association, a four-center HMO, is seeking additional full-time and part-time BE/BC pediatricians to meet the needs of our growing membership: subspecialties considered. RIGHA offers excellent salary, liberal fringe benefits, practice coverage, and opportunity for teaching hospital affiliation. For further information, please contact: MEDICAL DIRECTOR, RHODE ISLAND GROUP HEALTH ASSOCIATION, TWO DAVOL SQUARE, PROVIDENCE, RI 02903.

□

NEW YORK—College town of 30,000 upstate. Replace recently retired partner, July 1985 or sooner. Week-end and night coverage shared with area pediatricians. Level III hospital one hour away. Reply Box #108411.

□

DIVISION OF GENERAL PEDIATRICS, in the Department of Pediatrics of the Case Western Reserve University School of Medicine and Rainbow Babies and Children's Hospital is seeking applicants for positions at the assistant professor level and above. We are an active division involved in research, education, and patient care. Individuals with fellowship training or experience in general pediatrics, adolescent medicine, school health, or behavioral pediatrics are encouraged to apply. RB and C and CWRU are Affirmative Action/Equal Opportunity Employers. Interested individuals should contact: Jerome A. Paulson, MD, Chief, Division of General Pediatrics, Rainbow Babies and Childrens's Hospital, 2101 Adelbert Rd, Clevelend, OH 44106. (216) 844-3657.

PEDIATRICIAN—Needed January 1985. Group Health, a well-established HMO in upstate New York, is opening a third new facility, to be staffed with one internist, family physician, and pediatrician. This position will be part of the Department of Pediatrics at the main facility. Attractive salary and benefits. Reply: Gerald Lurie, MD, Chief of Pediatrics, Wilson Health Center, 800 Carter St, Rochester, NY 14621.

□

NORTHERN VIRGINIA—Wanted, third pediatrician to join two-physician pediatric practice in Alexandria with satellite office 20-minute drive south of town. Fellowship in adolescent medicine desirable. Send resumes to Richard H. Ryan, MD, or Thomas J. Sullivan, MD. Box #16093, Alexandria, VA 22302.

□

ILLINOIS—Neonatologist to join hospital-based, practicing neonatologists, with major responsibilities for resident and student teaching for Southern Illinois University School of Medicine. Apply to: John Holland, MD, Medical Director, St John's Hospital, 800 E Carpenter St, Springfield, IL 62769. (217) 544-6464, ext 4578.

□

MARROW TRANPLANTATION-ST JUDE CHILDREN'S RESEARCH HOSPITAL—Position available in expanding Marrow Transplantation Program for physician interested in clinical research. Opportunity to pursue laboratory research if desired. For details contact Dr F. Leonard Johnson, St Jude Children's Research Hospital, 332 North Lauderdale, PO Box 318, Memphis, TN 38101. (901) 522-0485. Affirmative Action Employer.

□

MISSOURI—Department of Pediatrics, University of Health Sciences-College of Osteopathic Medicine, is seeking two pediatricians for patient care and teaching. Must be Board certified/eligible. Prior teaching experience is preferred but not required. Faculty rank and salary will be commensurate with the individual's experience. Interested applicants should send a curriculum vitae to: Dennis J. Hey, DO, Head, Department of Pediatrics, University Hospital, 2105 Independence Blvd, Kansas City, MO 64124. (816) 283-2245.

□

PEDIATRIC GENETICIST POSITION—At the University of Illinois College of Medicine at Chicago. We are seeking a qualified individual who has Board certification or is Board eligible in pediatrics and clinical genetics for a tenure track faculty appointment. The position involves teaching and research, and includes major clinical responsibility in the center for craniofacial anomalies. Contact: George R. Honig, MD, Professor and Head, Department of Pediatrics, University of Illinois College of Medicine, 840 S Wood St, RM 1245 HA, Chicago, IL 60612.

□

PEDIATRIC IMMUNOLOGIST-RHEUMATOLOGIST—Tenure track academic position at the University of Illinois College of Medicine at Chicago. We are seeking an individual with Board certification in Pediatrics and in Allergy and Immunology, with a strong background in teaching and research. Contact: George R. Honig, MD, PhD, Professor and Head, Department of Pediatrics, University of Illinois, College of Medicine, 840 S Wood St, Room 1245, Chicago, IL 60621. The University of Illinois is an Affirmative Action/Equal Opportunity Employer.

Continued on page A101

Continued from page A100

PEDIATRIC FACULTY—Department of Pediatrics, University of Illinois College of Medicine at Peoria (UICOMP) is offering full-time academic positions for subspecialists in the following disciplines: Genetics and Dysmorphology, Pediatric Gastroenterology, Pediatric Cardiology, Pediatric Hematology/Oncology, Child Development, Pediatric Intensive Care, and Ambulatory Pediatrics. Each position offers significant opportunities for teaching, patient care, and clinical research. Board eligibility in Pediatrics required. Rank and salary commensurate with prior experience and qualifications. The University of Illinois is an Affirmative Action/Equal Opportunity Employer. Applications will be considered until positions are filled. Send CV and three letters of reference to: William H. Albers, MD, Acting Chairman, Department of Pediatrics, University of Illinois College of Medicine at Peoria, Box 1649, Peoria, IL 61656.

□

FACULTY-PEDIATRIC CARDIOLOGIST—Department of Pediatrics, University of Illinois College of Medicine at Peoria, has a full-time faculty position available Aug 1, 1984, or after. Will have teaching, service, and research responsibilities. Must be Board certified or eligible in Pediatrics and Board eligible in Pediatric Cardiology. Rank and salary commensurate with qualifications and responsibility. The University of Illinois is an Affirmative Action-Equal Opportunity Employer. Send curriculum vitae and three letters of reference to: William H. Albers, MD, Acting Chairman, Associate Professor of Pediatrics, Department of Pediatrics, University of Illinois College of Medicine at Peoria, c/o Saint Francis Medical Center, 530 NE Glen Oak Ave, Peoria, IL 61637.

□

ASSISTANT PROFESSOR—Division of Adolescent Medicine in Department of Pediatrics, University of Washington. Position requires Board certification in Pediatrics or Internal Medicine, 3 years teaching experience, and prior fellowship training in Adolescent Medicine. Position requirements also include extensive experience in developing and coordinating institutional health programs for delinquent adolescents, and development of adolescent health care training curricula. Documented experience in grant writing and research in several areas of adolescent health care is required. Reply to: Robert Deisher, MD, Department of Pediatrics, WJ-10, University of Washington, Seattle, WA 98195. The University of Washington is an Equal Opportunity Employer.

□

SEEKING NEONATOLOGIST—To direct newborn program. Senior academic appointment. Research experience essential Write: Joel J. Alpert, MD, Professor and Chairman, Department of Pediatrics, Boston University School of Medicine and Boston City Hospital, 818 Harrison Ave, Boston, MA 02118. An Equal Opportunity Employer. M/F.

□

WEST VIRGINIA—Second pediatric hematologist/oncologist needed for full-time faculty position in an expanding program. Must be Sub-Board certified or eligible. Send curriculum vitae to: Priscilla A. Gilman, MD, Department of Pediatrics, West Virginia University Medical Center, Morgantown, WV 26506. An Equal Opportunity/Affirmative Action Institution.

WASHINGTON—Immediate opening for a full-time Board-certified or eligible pediatrician to join three pediatricians in a 30-physician multispecialty clinic located in southeastern Washington in the foothills of the Blue Mountains. Abundant unparalleled recreation opportunities in the Pacific Northwest. Walla Walla's population is 27,000 with a serving area of approximately 150,000. Salary guarantee with immediate participation in incentive program. Liberal vacation and fringe benefits. Please forward a copy of your CV to the attention of the Pediatric Search Committee, Walla Walla Clinic, 55 West Tietan, Walla Walla, WA 99362. (509) 525-3720.

□

CONNECTICUT—Immediate opening for BC/BE pediatrician to join rapidly growing two-person practice in shoreline New Haven area. Affiliation with Yale teaching hospitals. Send resume to Gary Wanerka, MD, 784 East Main St, Branford, CT 06405, or call (203) 481-7008.

□

ADOLESCENT SPECIALIST—Pediatrician with fellowship training or equivalent experience in adolescent health care to develop a clinical and educational program in adolescent medicine. Duties to include research, patient care, and teaching at the graduate and undergraduate levels. Previous academic experience preferred. Should be eligible for appointment as associate or full-professor. Reply to Dr Barbara Jones, Department of Pediatrics, West Virginia University School of Medicine, Morgantown, WV 26506. An Equal Opportunity/Affirmative Action Institution.

□

DEVELOPMENTAL PEDIATRICIAN—Wanted to participate in general pediatric teaching clinic and to organize a multidisciplinary evaluation program for children with developmental disabilities, learning disorders, etc. Fellowship or equivalent experience desirable. Teaching, patient care, and research required. Contact Barbara Jones, MD, or Kenneth L. Wible, MD, Department of Pediatrics, West Virginia University School of Medicine, Morgantown, WV 26506. (304) 293-4451. An Equal Opportunity/Affirmative Action Institution.

□

PEDIATRICIAN—Wanted for expanding 27-physician multispecialty group on Puget Sound near Seattle. Expanding area of 170,000. Excellent salary, bonus, fringes with partnership second year. Contact: R. B. Pinckney, Adm, Doctors Clinic, 2515 Wheaton Way, Bremerton, WA 98310. (206) 478-6286.

□

INFECTIOUS DISEASE—The Department of Pediatrics, Wright State University School of Medicine and the Children's Medical Center, Dayton, Ohio, are seeking an academic pediatrician to be Head, Division of Infectious Disease. The candidate to be selected must have completed fellowship training in infectious disease and have a strong commitment to teaching, patient care, and research. Applicants must be licensed or licensable to practice in Ohio. Qualified physicians from minority groups and women are encouraged to apply. Interested applicants should send their curricula vitae to: Maurice Kogut, MD, Professor and Chairman, Department of Pediatrics, Wright State University School of Medicine, The Children's Medical Center, One Children's Plaza, Dayton, OH 45404. The closing date for receipt of applications is Oct 31, 1984. If the position is not filled, the second closing date will be Feb 1, 1985. Affirmative Action/Equal Opportunity Employers.

Continued on page A102

Chairperson
Dept of Pediatrics

Danbury Hospital, a modern 450-bed regional university-affiliated medical center seeks a full-time Chairperson for the Department of Pediatrics. This Board-Certified Pediatrician will direct a department that includes Outpatient, Neonatal Level II, and a new Inpatient service.

The successful candidate will develop and supervise a house staff program and represent the department in hospital, community, and national activities. Qualified applicants will have demonstrated accomplishments in an appropriate pediatric subspecialty and be eligible for appointment at the clinical professorial level in a major medical school.

Danbury Hospital is located in a growing Western Connecticut community 60 miles from New York City and 35 miles from New Haven. An excellent salary and benefit program accompany this fine position. Please send inquiries together with curriculum vitae to William A. Bauman, MD, Executive Vice President, Medical Affairs.

Danbury hospital
Hospital Ave., Danbury, CT 06810
an equal opportunity employer m/f

□

CALIFORNIA—Pediatric allergist. Coastal Orange County. Solo practice. Large number of pediatricians, obstetricians at growing hospital center. Contact W. Cohen, MD, 1855 Capri Circle, Costa Mesa, CA 92626. (714) 979-6100.

□

MINNEAPOLIS, MINNESOTA—Second pediatrician needed for private pediatric practice which provides both general and consultative pediatrics. Contact: Fridley Children's and Teenagers' Medical Center, 500 Osborne Rd, Minneapolis, MN 55432.

□

PEDIATRICIAN—Part- to full-time, Board certified/ Board eligible, to start within next year at suburban office of hospital-based multispecialty group. Send resume to Dr Richard Lawrence, 220 Alexander St, Rochester, NY 14607. (716) 263-6340.

□

VIRGINIA-TIDEWATER AREA—Two BC/BE pediatricians to join multispecialty clinic in rapidly expanding traditional fee-for-service and prepaid practice. Desirable environment with excellent recreational opportunities. Teaching opportunities available with nearby medical school. Send CV to Box #098414.

PENNSYLVANIA NEONATOLOGIST—Board certified/ Board eligible to join three neonatologists in a clinical program based in a 20-bed, level III, regional NICU. Interest in developmental follow-up desirable. Progressive hospital located in close proximity to major East Coast urban and resort centers. Competitive salary and benefits. Send inquiries to Thomas G. Seabourne, Vice President, Human Resources, The Allentown Hospital, 17th and Chew Sts, Allentown, PA 18102.

□

MIDDLE TENNESSEE—BE/BC pediatrician, preferably university trained to join busy four-physician group. Prefer generalist who can do high level of newborn care in a nursery that functions as Level II center. Salary and fringes very competitive. Send reply to Box #098410.

□

CONNECTICUT—Coastal town. BC/BE pediatrician to join active growing practice. Send CV to Box #098402.

□

GROUP OF FIVE PEDIATRICIANS—Looking for Board certified/eligible pediatrician to join our practice in northeastern Ohio. Reply with CV to: Children's Medical Group, 4575 Everhard Rd NW, Canton, OH 44718.

□

COLORADO—Pediatrician to join seven BC pediatricians in established multispecialty group with combined FFS and prepaid practice. Send CV: Joseph L. Corrigan, MD, 209 South Nevada, Colorado Springs, CO 80903.

□

OB-GYN—PEDIATRICIAN TEAM

New Hospital Opening in Fall of 1984 in Fulton, Missouri

This represents an outstanding medical practice opportunity. County of 30,000 primary service area with fine small community of 12,000+ hosting two nationally known colleges and a growing industrial base. We are close to the Lake of the Ozarks as well as multiple other recreational opportunities and facilities. The Hospital has a fine tradition of strong family-practice physicians and has recently recruited an orthopedic surgeon to build its surgical team to two. There are over 400 births in this County each year, and the pediatric population is growing steadily. Residents want the best in specialist medical care. For futher information regarding guarantees or other considerations contact Sharon R. Heinlen, Administrator, Callaway Community Hospital, Hospital Drive, Fulton, MO, 65251. (314) 642-3376.

Continued on page A103

PEDIATRICIAN

Opportunities exist for physicians with Board Certified or Eligible status to join the medical staff of our Health Maintenance Organization.

Position available: July, 1985

Practices are located in the suburbs of Boston within a 30-minute drive to the downtown area. Health Centers are located in Braintree, Framingham, and Peabody.

For information relating to our practice, salary and fringe benefits, please send a copy of your curriculum vitae to Frank W. Schultz, M.D., Medical Director, Medical East Community Health Plan, 340 Wood Road, Braintree, MA 02184.

Medical East
a region of community health plan
Medical West
Community Health Plan, Inc

Sponsored by and affiliated with Blue Cross Blue Shield of Massachusetts

We are an equal opportunity affirmative action employer

□

KENTUCKY—BC/BE pediatrician to join rapidly growing, 2-year-old practice in Lexington. Outstanding family/cultural opportunities. University community with medical school. Position available 1985. Send CV to James Mack, MD, 422 Codell Dr, Lexington, KY 40509.

□

CONNECTICUT—Board eligible/Board certified pediatrician to join two busy pediatricians in southeastern Connecticut. Salary first year leading to early partnership. Located equidistant to Boston and New York City. Send CV to Box #098406.

□

NORTHWEST PENNSYLVANIA—Third pediatrician to join two young, Board-certified, university-trained partners in rapidly expanding practice in northwest Pennsylvania. Twenty-bed pediatric unit, excellently equipped. Level II nursery. Must be competent to handle delivery room and other common pediatric emergencies. Currently practicing in new 2,500-sq ft office building. Excellent fishing, hunting, and water sports in area. Chautauqua Institution only 40 minutes away. Salary leading to early partnership. Contact Dr Bob Morelli, 145 Pleasant Dr, Warren PA 16365. (814) 723-8023.

□

IMMEDIATE OPENING—Available for BE/BC pediatrician anxious to enter very busy and rapidly growing practice, one-hour drive from NYC. Early opportunity to share in this growth. Reply to Box #098412.

□

PEDIATRICIAN/PART-TIME CHIEF—100-bed general hospital seeks a Board-certified/eligible pediatrician to strengthen existing pediatric program as part-time chief plus develop own clinical practice in beautiful area of Litchfield County, Connecticut. Private clinical and administrative experience desirable. Send CV to Richard E. Pugh, President and Executive Director, New Milford Hospital, 21 Elm St, New Milford, CT 06776.

WESTERN MONTANA—BC/BE pediatrician to join three pediatricians in multispecialty group. Located in the Rocky Mountain foothills, capital city, service area 40,000. Contact Dan Smelko, Business Manager, 1930 Ninth Ave, Helena, MT 59601. (406) 442-9523.

□

FLORIDA—Two young pediatricians seeking BC/BE pediatrician to join established, growing practice in beautiful Ft Lauderdale area. Excellent opportunity. Position available July 1985. Send CV to Box #098403.

□

PEDIATRICIAN—Expanding, 30-physician, south Florida multispecialty group seeks dynamic, Board-certified, Florida-licensed physician for private practice in 1984. Candidates must be well qualified, emphasis on high-quality patient care. Send CV with references and letter outlining goals to Box #098404.

□

CONNECTICUT—Two-physician practice seeking third member, attractive salary leading to partnership. Desirable location midway between New Haven and New York. Level II hospital, university affiliation available. BE/BC required. Reply with resume. Pediatric Associates of Norwalk, PC, 149 East Ave, Norwalk, CT 06851.

□

MEDICAL SCHOOL children's hospital seeks BC/BE pediatrician for off-site, suburban general pediatric practice. Good salary, benefits, and office. Academic appointment. Send CV and references to Box #098405.

□

PRACTICE OPPORTUNITIES IN PEDIATRICS

DALLAS
Establish solo practice in growing North Dallas suburb. Local community hospitals will provide financial and practice management assistance.

MIAMI
Pediatricians needed in growing communities north of Miami. Areas served by fully-equipped, new hospitals.

All placement services including practice management consultation provided at no cost to physicians. For further information, call or send C.V. to:

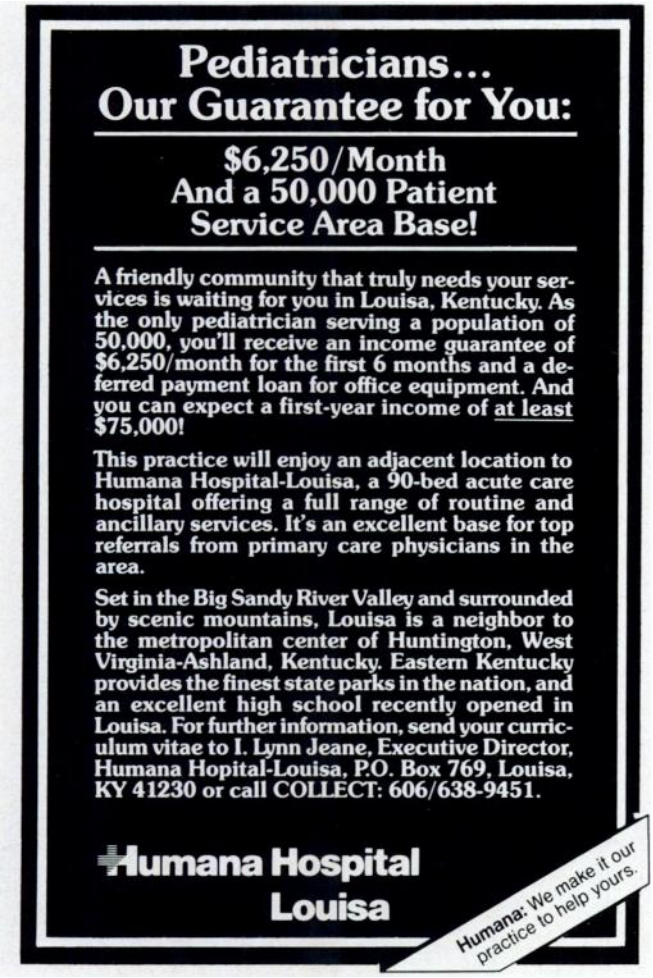
Professional Relations
NATIONAL MEDICAL ENTERPRISES, INC.
P.O. Box 2140,
Santa Monica, CA 90406
(213) 452-4320
(800) 421-7470 (outside Calif.)

nme

An Equal Opportunity Employer M/F

Continued on page A104

Continued from page A103



□

VIRGINIA—BC/BE pediatrician to join solo pediatrician with thriving 3-year old practice emphasizing quality, personalized care. Located in city of 100,000 in beautiful Blue Ridge Mountains. Three local hospitals, several pediatric subspecialists, regional NICU. Teaching opportunities. Send letter and CV to William M. Jacobs, MD, 2105 Crystal Spring, Roanoke, VA 24014. (703) 344-5665.

□

WASHINGTON STATE—Challenging practice needs fifth pediatrician. Level II nursery. Excellent OB relations. Salary. Benefits. Curriculum vitae to Mike McGee, MD, 784-14th Ave, Longview, WA 98632.

□

PEDIATRIC ALLERGIST—Excellent opportunity for a Board certified/eligible pediatric allergist with special interest in general pediatrics to become the third pediatrician in a 26-physician multispecialty group; 180-bed, modern hospital with Level II nursery. Ideal family-oriented community with plentiful recreational, cultural, and educational opportunities. Unique, attractive financial arrangements. Contact: Administrator, Rice Clinic, 2501 Main St, Stevens Point, WI 54481. (715) 344-4120.

□

CALIFORNIA—Solo pediatrician seeks BC/BE associate with strong neonatal experience for growing practice, half an hour north of San Diego. Contact: Don Rostow, MD, 161-111 Thunder Drive, Vista, CA 92083. (619) 941-3630.

CALIFORNIA—Adolescent medicine specialist to join the pediatric department at the Kaiser-Permanente Medical Center in Sacramento. Send curriculum vitae to: Kieran J. Fitzpatrick, MD, The Permanente Medical Group, Inc, PO Box 254999, Sacramento, CA 95825. An Equal Opportunity Employer.

□

NEW JERSEY—Fourth pediatric associate wanted to join a growing practice in northwest New Jersey in July 1985. Must be BE/BC. Two hospital affiliations; one teaching hospital with NICU. One hour from NYC. Respond with CV to Box #098415.

□

BEAUTIFUL AREA IN UPPER MIDWEST—Full-time position for neonatologist at a Level III regional perinatal center. Generous salary and fringe benefits. University appointment a possibility. Reply with CV and two letters of recommendation to Box #098408.

□

NEONATOLOGIST AND/OR PEDIATRICIAN WITH SPECIAL INTEREST IN NEONATOLOGY—Board-eligible or certified neonatologist and/or pediatrician with neonatal expertise. Texas Tech University Health Sciences Center headquartered in Lubbock, Texas, has established regional facilities in Amarillo and El Paso. The developing Odessa campus offers an opportunity to work with practicing pediatricians and faculty in the development of a pediatric program with a wide referral base. Applicants must be committed to patient care and teaching with an interest in research. Rank and salary commensurate with experience and training. Send curriculum vitae to: Edgar O. Ledbetter, MD, Chairman, Department of Pediatrics, TTUHSC, Lubbock, TX 79430. TTUHSC is an Equal Opportunity/Affirmative Action Employer.

□

WASHINGTON-BE/BC NEONATOLOGIST—Clinical salaried private practice position. No housestaff. New 25-bed Level II and III unit. Large delivery service with perinatal group association. Respond with CV to Box #098407.

□

GENERAL ACADEMIC PEDIATRICIAN—Faculty position in Division of General Pediatrics, Department of Pediatrics, assistant professor level. Requirements: MD degree; Board certification or eligibility in pediatrics; completion of ambulatory or general pediatric fellowship training; experience teaching in an academic medical center; and evidence of research potential. Responsibilities include teaching and service in ambulatory clinics, newborn nursery, and pediatric inpatient service; research activities in health care delivery, community pediatrics, and child abuse. Send curriculum vitae and names/addresses of three references to: John Madden, MD, Chair, Search Committee, University of California, Irvine Medical Center, 101 The City Dr S, Bldg 27, Orange, CA 92668. An Affirmative Action/Equal Opportunity Employer. (Closing date Nov 30, 1984.)

□

MINNESOTA—Immediate opening for a fourth BC/BE pediatrician in a high-quality suburban Minneapolis practice. Competitive salary and benefits. Full- or part-time. Send CV to Wayzata Children's Clinic, 250 N Central Ave, Wayzata, MN 55391.

Continued on page A105

Continued from page A104

CENTRAL IDAHO—BC/BE pediatrician to join four pediatricians in multispecialty group. Located in river valley on West edge of Rocky Mountains. Excellent recreational opportunities and life-style. Contact: Bob Baker, Valley Medical Center/Children's Clinic, 2318 Vineyard Ave, Lewiston, ID 83501. (208) 746-1383.

□

MARYLAND—BC/BE pediatrician to join rapidly growing solo pediatric practice. Location within one hour of Baltimore/Washington/Harrisburg. Newly built modern office. Looking for lifelong partner. Third year residents welcomed. Send CV and references to: B. E. Weneck, MD, 303 W Memorial Blvd, Hagerstown, MD 21740.

□

MASSACHUSETTS—Pediatrician BC/BE to join an established, growing, young, progressive four-pediatrician group, 10 miles from Boston. Excellent salary. Modern local hospitals with Level II nursery. Four weeks annual vacation. Opportunity for partnership. Please send CV to Box #098413.

□

NEW JERSEY—BC/BE full-time pediatrician needed to join busy, well-established, 1½-physician general pediatric practice. Easy accessibility to Jersey Shore, NYC, and Philadelphia. Salary first year leading to early partnership. Send resume to Box #088418.

□

DIRECTOR
OF PEDIATRIC ONCOLOGY

The Alberta Cancer Board wishes to attract a Director for its Pediatric Oncology program in the Tom Baker Cancer Centre in Calgary, Alberta, which administers the Southern Alberta Cancer Program. The position includes a joint appointment with the Department of Pediatrics of the University of Calgary and appropriate clinical research and teaching responsibilities, as well as a cross-appointment with the Alberta Children's Hospital. Salary scales are competitive and negotiable on the bases of qualifications and experience. Please provide a curriculum vitae quoting file #PED-USA and names of three references by September 1, 1984 to:—

ALBERTA CANCER BOARD

Director
Tom Baker Cancer Centre
1331 - 29th Street N.W.
Calgary, Alberta T2N 4N2
Canada

The Alberta Cancer Board is an equal opportunity employer but, in accordance with Canadian immigration requirements, priority will be given to Canadian citizens and permanent residents of Canada.

□

PEDIATRIC PSYCHIATRIST—University Hospital, Jacksonville, Florida, is seeking a chief for the Division of Child Psychiatry in the Department of Psychiatry. University Hospital is academically affiliated with the University of Florida College of Medicine. The purpose of this position is the development of a program for the short-term psychiatric inpatient care of children and adolescents. The Acute Crisis Unit will be built on a team concept. There will be a full supporting staff available with teaching and administrative responsibilities. There will also be a close working relationship with the Department of Pediatrics. The academic appointment would be at the assistant/associate professor level or full professor level depending on qualifications of the applicant. Application recruiting deadline is Dec 30, 1984. Interested applicants are invited to forward curricula vitae, names and addresses of three references to: Donna Seger, MD, Department of Emergency Medicine, University Hospital of Jacksonville, 655 W 8th St, Jacksonville, FL 32209.

□

THE UNIVERSITY OF MICHIGAN—Department of Pediatrics seeks a Board-certified/eligible pediatric intensivist/pulmonologist. An immediate faculty position exists in a rapidly expanding, multidisciplinary ICU in our 250-bed children's hospital. Patient care, teaching, research, and some administrative responsibilities. Direct CV to Joseph R. Custer, MD, Director, Mott ICU, Department of Pediatrics, C6111 Outpatient Bldg, Ann Arbor, MI 48109. The University of Michigan is a nondiscriminatory, Affirmative Action Employer.

PEDIATRICIANS...

CHOOSE THE PRACTICE YOU PREFER IN THE SETTING YOU DESIRE!

When seeking a private practice, the word to remember is variety. And no one has a better variety of solo, group and associate practice opportunities than Humana!

With over 90 hospitals in 23 states, Humana knows how to find the best opportunities, in the best areas – from sunny beaches to glistening ski slopes. And, in many cases, financial assistance is available to assist you in establishing your new practice.

Opportunities are currently available in the following communities: Enterprise, AL, Montgomery, AL, Phoenix, AZ, Denver, CO, Cartersville, GA, Dodge City, KS, Louisa, KY, Abilene, TX.

For further information, send your curriculum vitae to Gordon Crawford, Manager Professional Relations, Humana, The Hospital Company, Dept. I-10, 1800 First National Tower, Louisville, KY 40201 or call TOLL-FREE: 800-626-1590. There is no obligation.

Humana
The Hospital Company

Humana: We make it our practice to help yours.

Continued on page A106

FLORIDA

PEDIATRICS

CIGNA Healthplan of Florida, Inc. seeks specialists in Pediatrics to practice in Orlando, Tampa Bay, or South Florida.

CIGNA Healthplan of Florida, Inc. presents an opportunity for you to practice quality medicine without the hassles of billing or business. Opportunities are available in: Orlando, Tampa Bay, or South Florida.

Work reasonable hours with predictable time off and paid vacations.

Enjoy a generous salary with outstanding benefits such as professional liability coverage, health insurance, pension, supplemental retirement plans, profit-sharing, auto allowance and paid study leave.

Join us, and become part of the nation's largest investor-owned HMO organization.

For consideration, send your c.v. to your choice of locations, attention Department of Physician Recruitment-Y7

South Florida: P.O. Box 693800
Miami, FL 33169 305-944-4433
Tampa: P.O. Box 24203
Tampa, FL 33623 813-884-2400
Orlando: 2603 Maitland Center Parkway, Suite 204B
Orlando, FL 32751 305-660-1344

CIGNA Healthplan of Florida, Inc.
a CIGNA company

CIGNA

Equal Opportunity Employer

□

MONTANA, BE/BC pediatrician to join two others in professionally stimulating practice in southwest Montana. Respond with CV to: Dennis McCarthy, MD, 401 S Alabama, Butte, MT 59701. (406) 723-4337.

□

MISSOURI—Emergency Room full-time staff pediatrician. Newly created position in a growing department. Excellent opportunity for a BC/BE pediatrician with an interest in emergency pediatrics to combine teaching and pursue clinical research. University-affiliated program. Flexible scheduling. Excellent fringe benefits. Salary and rank commensurate with experience. Send CV to: Jane Knapp, MD, Director, Emergency Services, Children's Mercy Hospital, 24th at Gillham Rd, Kansas City, MO 64108. (816) 234-3079. An EEO Employer.

□

MICHIGAN, GRAND RAPIDS—375-bed hospital in metropolitan area has position for residency-trained pediatrician with training and experience in emergency medicine. Duties would include leadership position in teaching and program development for inpatient pediatric program and also working with group of Board-certified emergency physicians in the emergency department. Excellent renumeration and opportunity. Located within ½ hour of Lake Michigan in beautiful country. Call or write: William C. Daney, MD, FACEP, 200 Jefferson SE, Grand Rapids, MI 49503. (616) 774-6789.

PULMONARY DISEASE—The Department of Pediatrics, Wright State University School of Medicine and The Children's Medical Center, Dayton, Ohio, are seeking an academic pediatrician with a subspecialty in pulmonary disease with a strong commitment to teaching, patient care, and research to join two full-time pediatricians in the Division of Pulmonary Medicine. Additional experience in intensive care desirable. Applicants must be licensed or licensable to practice in Ohio. Qualified physicians from minority groups and women are encouraged to apply. Interested applicants should send their curricula vitae to: Maurice D. Kogut, MD, Professor and Chairman, Department of Pediatrics, Wright State University School of Medicine, The Children's Medical Center, One Children's Plaza, Dayton, OH 45404. Closing date for receipt of applications will be Dec 1, 1984. Affirmative Action/Equal Opportunity Employer.

□

SUBSPECIALIST, pediatric gastroenterologist or cardiologist, to join unique subspecialty private practice group. Highly desirable mid-Atlantic location. Reply with resume to Box #088407.

□

PEDIATRIC NEUROLOGIST—East Carolina University School of Medicine is seeking a pediatric neurologist to join full-time faculty. Candidate must be Board eligible or certified. Send letter of inquiry and curriculum vitae to: Jon B. Tingelstad, MD, Department of Pediatrics, East Carolina University School of Medicine, Greenville, NC 27834. An Equal Opportunity/Affirmative Action Employer.

□

PEDIATRIC INTENSIVE CARE PHYSICIANS

Discover the Professional Advantages & Personal Adventures of Southern California!

Southern California is a place like no other. It blends cultural adventures with a natural beauty. And for a Pediatric Intensive Care Physician, it's the perfect place to practice.

Humana Hospital-West Hills has an immediate opportunity for a Pediatric Intensive Care Physician in its new Pediatric Intensive Care Unit. This 4-bed unit can easily be expanded and is supported by pediatric specialists in the area, including a Nephrologist, Orthopedic Surgeon, Cardiologist and General Surgeons. This hospital-based position enjoys an excellent referral base from the 35-40 Pediatricians in the area, as well as a full range of amenities including a first year income guarantee, paid on-site visits and moving expenses.

Canoga Park, located northwest of Los Angeles in the western end of the San Fernando Valley, is a self-contained community offering easy access to the many attractions of Southern California. For more specific details, send your curriculum vitae to: Donald Stewart, Executive Director, Humana Hospital-West Hills, 7300 Medical Center Drive, Canoga Park, CA 91307 or call COLLECT 213/884-7060.

Humana Hospital West Hills

Humana: We make it our practice to help yours.

Continued on page A107

Continued from page A106

PEDIATRIC GASTROENTEROLOGIST—Academic position. Associate professor or assistant professor level. Candidate must be Board eligible or certified in pediatrics and fully trained in pediatric gastroenterology. Send letter of inquiry to Jon B. Tingelstad, MD, Department of Pediatrics, East Carolina University School of Medicine, Greenville, NC 27834. East Carolina University is an Equal Opportunity/Affirmative Action Employer.

□

PEDIATRICIAN—Board certified/eligible for satellite which is affiliated with 43-physician multispecialty group. Satellite is located eight miles south of main facility, in a rapidly growing suburban area. Main facility has four-physician pediatric department, with a fifth pediatrician already located in another successful satellite. Opportunity for exceptional personal/professional life-style with competitive salary and excellent benefits. Position available January 1985. Send CV to: Leslie G. Nelson, MD, The Everett Clinic, 3912 Colby Ave, Everett, WA 98201.

□

TWO BC/BE PEDIATRICIANS to join rapidly growing staff model HMO with 40,000+ enrollment. Two fully equipped ambulatory facilities with plans for two more. Pediatrics department has five MDs and three NPs. Medical school in town with excellent pediatric residency. Competitive salary, excellent fringe benefits. Contact: Gertrude Sadoff, Health Central, 2316 South Cedar, Lansing, MI 48910.

□

TEXAS—BC/BE pediatrician seeking private solo practice in urban community. Call arrangements available. Respond with CV to Box #088409.

□

PEDIATRICIAN BC/BE to join growing primary/referral practice. Level II nursery. Suburb of Milwaukee, Wisconsin. First year income guarantee. Contact: Raymond Wolf, 250 Regency Ct, Waukesha, WI 53186. (414) 785-6500.

□

SOLO PEDIATRICIAN seeks BC/BE associate. Teaching opportunity. Immediate opening upstate New York. Apply to Box #088412.

□

MAINE—Thriving, academically oriented pediatric practice at unique referral, university-affiliated hospital seeks third BC/BE. Growing, friendly community close to mountains and sea combines best of rural/city life-styles. Send CV to Box #088414.

□

PENNSYLVANIA—BC pediatrician seeking BE/BC associate in large solo newborn and general practice. Level II nursery. Residents, university teaching positions available. Beautiful community, 2 hours from New York City and Philadelphia. Excellent salary and benefits leading to early partnership. Send CV to Box #088405.

□

NEW JERSEY—BC/BE to join established, four-physician pediatric group in central Jersey university/medical school community; 35 miles from New York City. Reply to Box #088403.

PENNSYLVANIA—Excellent pediatric private practice opportunity in a family-oriented community. Beautiful setting for practice located 1½ hours from Philadelphia, shore points, and Poconos. Established practice with strong association with children's hospitals. Would encourage interested BE/BC pediatrician to visit soon. Position available July 1985. Reply to Box #088410.

□

PEDIATRIC CARDIOLOGIST—The Department of Pediatrics of the University of Utah and the Primary Children's Medical Center, Salt Lake City are seeking a fifth pediatric cardiologist to join the faculty at assistant or associate professor level. A strong commitment to excellent patient care and teaching essential. Clinical and/or laboratory research desirable and facilities available within the division. Area also offers excellent winter skiing and summer outdoor activities and a good cultural environment. Position available July 1984 or later. Plase contact or send curriculum vitae to: Garth S. Orsmond, MD, Associate Professor of Pediatrics, Head, Division of Pediatric Cardiology of University of Utah, Primary Children's Medical Center, 320 12th Ave, Salt Lake City, UT 84103. (801) 363-1221, ext 263.

□

WATERTOWN, NEW YORK—1000 Island Region—Wanted, Board eligible/certified pediatrician to join thriving, two-pediatrician practice. Excellent hospitals. Town 30,000 population. Excellent recreational facilities. Starting salary negotiable. Call (315) 782-4391.

□

PEDIATRICIAN needed to establish new practice in north-central Michigan. Service area includes six counties. No pediatrician within service area, with a population of approximately 40,000. Critical need for this specialty in this rural, tourist area. Excellent family environment and outdoor recreation. Financial assistance available. Send CV or call Barbara Lester, Mercy Hospital, 1100 Michigan Ave, Grayling, MI 49738. (517) 348-5461.

□

PEDIATRIC CARDIOLOGIST—To join active private practice in midwestern children's hospital setting with university affiliation, excellent surgical program, subspecialty support. Electrophysiologic expertise desirable. Send CV with letter to Box #088406.

□

NEW YORK—BE/BC pediatrician to join busy, three-physician group in lower Hudson Valley, July 1985. Allergy-immunology training desired, but not required. First year salary plus generous benefits leading to partnership. Reply to Box #088402.

□

SEEKING BE/BC pediatrician to join group of four for primary and secondary care in community of 30,000 with much larger drawing area. Level II nursery. Hospital well staffed and equipped. Pediatric and Adolescent Clinic, 1190 Briarstone Dr, Mason City, IA 50401.

□

BC/BE PEDIATRICIAN—For third associate in general pediatrics practice in Orlando/Winter Park area. Pediatric residency program locally. New children's hospital within 5 years. Salary plus benefits first year. Send CV to Box #088416.

Continued on page A108

Continued from page A107

ASSOCIATE CHAIRMAN/DEPARTMENT OF PEDIATRICS—Texas Tech Regional Academic Health Center, Odessa. Texas Tech University Health Sciences Center School of Medicine in Lubbock has Regional Academic Health Centers in Amarillo, El Paso, and Odessa, Texas. The associate chairman in Odessa will assist the chairman in the development of a pediatric department in Odessa which will provide pediatric support for the Family Medicine Residency Program and the existing perinatal effort. Other responsibilities include: the associate chairman will work closely with the departmental chairman (who is based in Lubbock), the Odessa medical community, the associate dean for the Odessa campus, and the associate chairmen of the other clinical departments in Odessa. ABP certification required and additional subspecialty training with experience in academic medicine desired. Faculty rank and salary commensurate with experience. TTUHSCSM is an Equal Opportunity Employer. Send application and CV to: Edgar O. Ledbetter, MD, Chairman, Department of Pediatrics, TTUHSC, Lubbock, TX 79430.

□

PEDIATRIC PULMONOLOGIST/INTENSIVIST—Board certified/Board eligible to develop pulmonology service and laboratory in a teaching program with most subspecialties represented. Contact: Dr Hossein Massoud, Medical Director, TC Thompson Children's Hospital Medical Center, 910 Blackford St, Chattanooga, TN 37403. (615) 778-6217.

□

MAINE—Pediatrician—BC/BE to join busy established two-physician practice in central Maine located 40 minutes from Portland. Send CV to: David M. Walter, MD, Lowell Court, Lewiston, ME 04240.

□

PEDIATRICIAN, Board certified/eligible, to join progressive multispecialty group of 50 physicians. Level II nursery at local hospital. Subspecialty training in allergy desirable but not required. Referral area 150,000. Liberal financial benefits. High quality of life. Many outdoor recreational opportunities. Send curriculum vitae and references to: D. C. Schroeckenstein, MD, 101 Willmar Ave, Willmar, MN 56201. (612) 231-5000.

□

PENNSYLVANIA—Opening for second neonatologist in large community teaching hospital with Level II NICU facilities and with evolving increased nurse's role in care of Level II babies. Annual deliveries: 2,600. Opportunities for: patient care, teaching of family practice and obstetrical residents, clinical research. Location: beautiful south-central Pennsylvania. Send resume and three references to: Merle S. Bacastow, MD, Vice President—Medical Affairs, York Hospital, 1001 S George St, York, PA 17405.

□

PEDIATRICIAN—Outstanding opportunity to associate with three pediatricians in an accredited 50-physician multispecialty group. Drawing area nearly 400,000 with two well-staffed modern hospitals within five minutes of clinic. Stimulating Big-10 university community of 100,000 with superb cultural advantages. Ideal for families. Medical school teaching affiliation if desired. Excellent initial guarantee and fringes with early associateship; subsequent income based exclusively on productivity. Send CV to Box #068403.

ILLINOIS—Pediatrician, Board-eligible/certified, for Chicago metropolitan area. ANCHOR Organization for Health Maintenance is a well-established, rapidly expanding, federally qualified HMO affiliated with Rush-Presbyterian-St Luke's Medical Center and presently operating 13 multispecialty group offices. The position offers an excellent fringe benefit program and a faculty appointment at Rush Medical College located in one of the world's finest entertainment and cultural centers. Contact: Michael Stocker, MD, Medical Director, ANCHOR Organization for Health Maintenance, 1725 West Harrison St, Chicago, IL 60612. (312) 666-7611.

□

PEDIATRICIAN-ALLERGIST IMMUNOLOGIST BC/BE—Outstanding opportunity to associate with three pediatricians in an accredited 50-physician multispecialty group. Drawing area nearly 400,000 with two well-staffed modern hospitals within five minutes of clinic. Stimulating Big-10 university community of 100,000 with superb cultural advantages. Ideal for families. Medical school teaching affiliation if desired. Excellent initial guarantee and fringes with early associateship; subsequent income based exclusively on productivity. Send CV to Box #068403.

□

NEW JERSEY SHORE—Two young easygoing pediatricians seek third physician with quality training. Join comfortable practice in thriving community with ideal location 1½ hours from New York and Philadelphia. Reply to Box #068405.

□

SOUTHWEST UNITED STATES—Pediatricians needed for after-hours pediatric clinic. No hospital rounds. Flexible hours. Good financial opportunity. Region noteworthy for both recreational and cultural opportunities. Reply to Box #058407.

□

NEVADA—Pediatrician to join four-physician pediatric group. Excellent opportunity from every standpoint. Excellent command of the English language required. Reply Box #058407.

□

PRACTICE FOR SALE

OHIO—Lake Erie area. Well established. Solo pediatric practice. Leaving for fellowship. Will introduce. Terms negotiable. Reply Box #108404.

□

ESTABLISHED PEDIATRIC AND ADOLESCENT ALLERGY PRACTICE—available Sept 1, 1984. Equipped lab, medical center location, terms negotiable. Will introduce. Contact Doris Phillips, MD. (205) 871-0520.

□

SUBURB ATLANTA—Long established solo practice-retiring. Desire BC/BE pediatrician. Fully equipped. Excellent hospital Level III nursery. Reply Box #098411.

Continued on page A109

POSITION/PRACTICE WANTED

PEDIATRICIAN—Young, US trained, BE, fluent in Spanish, familiar with Mexican culture, seeks position in clinic or group. Relaxed atmosphere, health of staff, flexible schedule encouraging time for family life, quality medical care, and patient education more important than remuneration. Reply to Box #108408.

□

BOARD-ELIGIBLE PEDIATRICIAN—45, with 7 years private practice and considerable administrative experience in Iran. US hospital trained; seeking job opportunity in southern California: HMO, private or group. Available immediately. Reply to Box #108407.

□

CHILD HEALTH ASSOCIATE/PA-C—with 6 years experience in ambulatory pediatrics plus pediatric PA residency, current academic position. Seeks challenging opportunity in caring, quality office/clinic (private/university). Special interest neonatology. Reply to Box #108415.

□

ACADEMIC POSITION WANTED: AMBULATORY PEDIATRICS-ADOLESCENT MEDICINE—American Board certified. English-speaking Canadian fluent in Spanish, Italian, and French. Reply Box #108406.

□

TWO BOARD-CERTIFIED NEONATOLOGISTS—desire relocation to active Level III service. Experienced in clinical care, research, teaching, and administration. Currently have medical school positions, will consider private practice or academic setting. Reply Box #098409.

FELLOWSHIPS, RESIDENCIES

INFECTIOUS DISEASE FELLOWSHIP—University of Oklahoma Health Sciences Center. Clinical and research fellowships, available January or July 1985. Requirements: Graduate of approved Canadian or US medical school and a minimum of 3 years pediatrics. Contact: M. I. Marks, MD, Pediatric Infectious Diseases, PO Box 26901, University of Oklahoma HSC, Oklahoma City, OK 73190.

□

PEDIATRIC CARDIOLOGY FELLOWSHIPS—Available July 1985. A 2-year fellowship combines clinical experience and research responsibilities in a large-volume medical-surgical program. A third year fellowship is available emphasizing echocardiography, stress testing, or cardiac electrophysiology. Address inquiries to: Iain Black, MD, Division of Pediatric Cardiology, St Christopher's Hospital for Children, 5th and Lehigh Ave, Philadelphia, PA 19133.

□

PULMONARY FELLOWSHIP—Clinical orientation with excellent research potential available July 1, 1985. Two- or three-year position with large children's hospital and Cystic Fibrosis Research Center Affiliation. Contact G. M. Harrison, MD, Pediatric Pulmonary Section, PO Box 20269, Texas Children's Hospital, Baylor College of Medicine, Houston, TX 77030.

THE HOSPITAL FOR SICK CHILDREN
TORONTO, ONTARIO

NEONATAL/PERINATAL MEDICINE

Neonatal/Perinatal Medicine 2-year and 1-year Fellowship positions offered by The University of Toronto Perinatal Complex starting July 1985. The Complex consists of the Neonatal Intensive Care Units in two regional high-risk perinatal centres at The Mount Sinai and Women's College Hospitals with a total of 8,000 annual deliveries, a 60-bed Neonatal Referral Centre at The Hospital for Sick Children, an Neonatal Transport Service carrying 700 patients annually, and two Follow-Up Clinics auditing 90% of NICU graduates. The region has 62,000 annual births. A total of 14 Neonatologists supervise Clinical and Research work and provide active teaching. Fellows are involved in clinical care, supervision and teaching of Residents and Medical Students, and research activities. Opportunities exist for tailoring of training program according to individual needs.

Applicants should have at least 3 years general pediatric training including Neonatal Intensive Care Unit experience.

From January 1986 it is anticipated that graduates of all except USA medical schools will be required to pass the Canadian Medical Council evaluating examination for entry into Canadian programs.

Contact: **Pamela Fitzhardinge, MD**
Mount Sinai Hospital
600 University Avenue
Toronto, Ontario M5G 1X5 Canada

or, **Andrew Shennan, MD**
Women's College Hospital
76 Grenville Street
Toronto, Ontario M5S 1B2 Canada

or, **Paul R. Swyer, MD**
The Hospital for Sick Children
555 University Avenue
Toronto, Ontario M5G 1X8 Canada

□

NEONATOLOGY FELLOWSHIPS—Available January 1985/July 1985 at Edward W. Sparrow Hospital/Michigan State University. The regional perinatal center serves approximately 12,000 deliveries per year and is housed in the recently expanded computer-monitored NICU. Program directed by four full-time neonatologists. Fellows take part in patient care, high risk prenatal and developmental follow-up clinics, regionalization program, clinical and/or laboratory research programs, medical student and residency teaching. Contact: Eugene Dolanski, MD, Director of Nurseries, Edward W. Sparrow Hospital, 1215 E Michigan Ave, Lansing, MI 48909. EOE.

□

GENERAL PEDIATRICS ACADEMIC FELLOWSHIPS—are being offered beginning at the PL-4 year to pediatricians interested in pursuing academic careers in this field. The 2-year fellowships, funded under a program of The Robert Wood Johnson Foundation, offer physicians an opportunity to develop research, education, and clinical skills in areas that deal with everyday health problems of children. The fellowships are offered at Duke University; Johns Hopkins University; Children's Hospital of Philadelphia; the University of Rochester; Stanford University; and Yale University. For further information, indicate fellowship site of your choice and contact: **General Pediatrics Academic Development Program, Dr Robert Haggerty, Department of Pediatrics, Cornell Medical College, 525 E 68th St, N-236, New York, NY 10021.**

Continued on page A110

Continued from page A109

NEONATAL FELLOWSHIP—Vermont, July 1986. Twenty-bed, Level III ICN, active regional program, research program. Four neonatologists on staff. Contact: Jerold Lucey, MD, Medical Center Hospital of Vermont, Burlington, VT 05401.

□

NOV 29–30, 1984. ELEVENTH ANNUAL PIEDMONT PERINATAL SYMPOSIUM—"Perinatal Asphyxia," Greenville Hyatt Regency, Greenville, South Carolina. Guest faculty includes: George Cassady, MD, Sr Jeanne Meurer, CNM, MS, John Morrison, MD, Linda Parker, RN, MS, Robert Vannucci, MD. Contact Barbara Sikes, Nursing Education Coordinator, Spartanburg General Hospital, 101 East Wood St, Spartanburg, SC 29303. (Relevant to all perinatal disciplines).

□

CHILDREN'S HOSPITAL OF EASTERN ONTARIO

NEONATAL FELLOWSHIP

The University of Ottawa, Department of Paediatrics and the Neonatal Intensive Care Unit of the Children's Hospital of Eastern Ontario invite applications for the post of Neonatal Fellow, commencing July 1, 1985. The Neonatal Intensive Care Unit is a tertiary care facility receiving over 350 high-risk infants annually from the Eastern Ontario and Western Quebec regions. The Unit is supervised by four geographic full-time paediatric neonatologists and is staffed by paediatric postgraduate residents on a rotating basis. Suitable applicants should have completed 2–3 years of approved paediatric residency with at least 6 months of neonatal intensive care experience.

Applications including curriculum vitae and appropriate references should be forwarded to:

Dr S. B. MacMurray
Director
Neonatal Intensive Care Unit
Children's Hospital of Eastern Ontario
401 Smyth Road
Ottawa, Ontario, K1H 8L1, Canada

GENERAL NOTICES

MANAGEMENT OF THE TINY BABY—Conference, Jan 24–26, 1985, at the Hyatt Regency Grand Cypress, next to Walt Disney World Village, Lake Buena Vista, Florida. 10 hours of Category I AMA/Credit will be awarded. For additional information please contact: Gregor Alexander, MD, Orlando Regional Medical Center, 1414 S Kuhl Ave, Orlando, FL 32806. Telephone (305) 841-5218.

□

THE HIGH RISK ADOLESCENT: PREVENTION AND INTERVENTION—Sponsored by Cumberland, A Hospital for Children and Adolescents and The Southeast Chapter-Society for Adolescent Medicine, Oct 19–21, 1984, Fort Magruder Inn and Conference Center, Williamsburg, VA. For information call (804) 737-7713, or write to: Mindy Spigel, PO Box 150, New Kent, VA 23124.

SECOND ANNUAL PEDIATRIC CONFERENCE AT THE CITY OF FAITH—Oct 12–13, 1984, Tulsa, Oklahoma. Cardiac and Respiratory Illness in Childhood. Guest Faculty: Drs E. J. O'Connell and David J. Driscoll, Mayo Clinic. Fee $150. Information: Department of Pediatrics, 8181 S Lewis, Tulsa, OK 74170.

□

PRACTICAL PEDIATRIC ENT COURSE—Oct 20–21, 1984. Massachusetts eye and ear infirmary, Boston. Dual objectives: (1) lectures designed for pediatricians, (2) "hands-on" experience with intubation, tympanocentesis of human temporal bones, suturing, etc. Guest speaker: Sylvan Stool, MD, University of Pittsburgh. Local faculty of the infirmary and the children's service of the Massachusetts General Hospital. Course Director: Roland Eavey, MD. Enrollment limited. Contact: Harvard Medical School, Department of Continuing Medical Education, Boston, MA 02115. (617) 732-1525.

Continued on page A111

Continued from page A110

HealthEast, Inc

The Allentown Hospital
Lehigh Valley Hospital Center

Present a

NATIONAL CONFERENCE ON PARENTING

November 16–17, 1984
Allentown Hilton Hotel
Allentown, Pennsylvania

Faculty include:

Annie Bergman, PhD	Selma Kramer, MD
Stella Chess, MD	Henri Parens, MD
Richard A. Gardner, MD	Sally Ann Provence, MD
Stanley I. Greenspan, MD	Marshall D. Schecter, MD
Charles F. Johnson, MD	Benjamin Spock, MD

For additional information contact:

Educational Development
PO Box 689
Allentown, PA 18105-0689
(215) 776-8320

This conference is made possible in part by a grant from the Dorothy Rider Pool Health Care Trust.

□

MARK YOUR CALENDAR! December 5–9, 1984, The Breakers, Palm Beach, Florida. The Departments of Otolaryngology and Pediatrics, University of Pittsburgh School of Medicine present The 11th Annual Symposium, EAR, NOSE AND THROAT DISEASES IN CHILDREN: A 1984 UPDATE (with experts in pediatric otolaryngology, otology, radiology, audiology, pediatric allergy, pediatric infectious diseases, and head and neck surgery). Course Co-Directors: Charles D. Bluestone, MD, Jack L. Paradise, MD, Sylvan E. Stool, MD. University of Pittsburgh Faculty: Hugh D. Curtin, MD, Thomas J. Fria, PhD, Eugene N. Myers, MD, Ellen R. Wald, MD. Invited Guest Faculty: Jerome O. Klein, MD, Robert A. Jahrsdoerfer, MD, David S. Pearlman, MD. Simultaneous translation in Spanish available. CME credits: 17 hours. Tuition: $250 physicians, $185 residents. For further information, contact: Department of Otolaryngology, Children's Hospital of Pittsburgh, 125 De Soto St, Pittsburgh, PA 15213. (412) 647-5466.

BOSTON UNIVERSITY SCHOOL OF MEDICINE

THE LEARNING-DISABLED CHILD: ADVANCES IN TREATMENT

Saturday, October 20, 1984
Sonesta Hotel, Cambridge, MA
Course Director: N. Paul Rosman, MD

RECENT ADVANCES IN MANAGEMENT OF INFECTIOUS DISEASES IN CHILDREN

December 27–29, 1984
Walt Disney World, FL
Course Director: Jerome O. Klein, MD

THE FIRST THIRTY MINUTES: THE BOSTON CITY HOSPITAL APPROACH TO MEDICAL & PEDIATRIC EMERGENCIES

December 27–30, 1984
Walt Disney World, FL
Course Directors: Robert M. Levin, MD & Stephen I. Pelton, MD

Contact: Department of CME, Boston University School of Medicine, 80 E Concord St, Boston, MA 02118
Telephone: (617) 247-5602

□

PEDIATRIC ONCOLOGY/HEMATOLOGY: TODAY AND TOMORROW—Eighth Annual Childhood Cancer Treatment Seminar, Nov 15–17, 1984, Hyatt Hotel, Orlando, Florida. Florida Association of Pediatric Tumor Programs. PO Box #13372, University Station, Gainesville, FL 32604. (904) 375-6848.

□

THREE outstanding patient counseling publications available for review: "Sneezing, Wheezing and Scratching," "Food Sensitivity Diets," Doris Rapp, MD; "The Light Touch to Eating, Sleeping and Toilet Training," Glenn Austin, MD. Each book $1. Write to: ECR, PO Box #615, Los Altos, CA 94022. (415) 948-0875.

□

POLICY: Ads must be relevant to the practice of medicine. We reserve the right to revise or reject advertising copy that is deemed objectionable. Although the American Academy of Pediatrics believes the classified advertisements in these columns to be from reputable sources, the AAP does not investigate the offers made and assumes no responsibility concerning them.

INDEX TO ADVERTISERS

We try to present an accurate index. Occasionally this may not be possible because of a last-minute change or an omission.

Introducing Mediquell™

A NEW ERA IN ANTITUSSIVE DELIVERY SYSTEMS

Liquid-strength efficacy in a unique soft, chewy dosage form.

New **mediquell**™
CHEWY COUGH SQUARES

A breakthrough in antitussive delivery systems
Mediquell is a unique soft, chewy square containing dextromethorphan hydrobromide, the same highly effective, safe, non-narcotic antitussive you've been prescribing for years in liquid form. And new technology virtually eliminates the ordinarily bitter taste of dextromethorphan.

Up to eight hours of continuous relief with every dose
A one-square dose of Mediquell, containing 15 mg of dextromethorphan hydrobromide, can provide your patients, ages six to twelve, with extended cough relief—for a better night's sleep or a full day at school. Mediquell can be given safely to younger children, too, in proportionally smaller doses.

Fast onset of action like the leading liquid dextromethorphan-containing cough product
Clinical studies show that Mediquell's antitussive action begins working rapidly like liquid cough preparations, providing fast, effective cough relief.

One of the safest antitussives available
You can rely on the safety of dextromethorphan, and—unlike liquids—you can be assured that your young patients are receiving the exact dose with Mediquell. Mediquell is a single ingredient product, contains no alcohol, and is comparable in sugar content to the leading professionally recommended liquid products.

Pleasant taste and convenience can increase compliance
Tests conducted among parents and children indicate that a regimen of Mediquell is more likely to be followed than one dependent on liquid cough medication. Mediquell is pleasant tasting, portable—and there's no messy spoon or bottle.

Consider Mediquell the next time you want to treat a child's cough specifically, pleasantly *and* safely.

WARNER LAMBERT
CONSUMER HEALTH PRODUCTS GROUP
Morris Plains, N.J. 07950

Medicine-by-mouth for nausea and vomiting of motion sickness?

It's enough to make you sick!

Oral therapy is impossible if your patient can't keep the medication down or won't accept it. When relief is urgent, a logical alternative is Phenergan® (promethazine HCl) Rectal Suppositories: 12.5 mg and 25 mg.

Phenergan®
[Promethazine HCl]
Rectal Suppositories

...the better route.

In Brief

Indications: Prevention and control of nausea and vomiting associated with certain types of anesthesia and surgery. Active and prophylactic treatment of motion sickness. Antiemetic effect in postop patients.

Contraindications: Known hypersensitivity to the drug.

Warnings: Sedative action is additive to sedative effects of CNS depressants; eliminate or reduce dose of concomitant alcohol, barbiturates, narcotic analgesics, etc. When given with promethazine, reduce barbiturate dose by at least ½ and analgesics dose, e.g. morphine or meperidine, by ¼ to ½.

Precautions: Caution ambulatory patients against driving or operating dangerous machinery until it is known they do not become drowsy or dizzy from promethazine. Antiemetics may mask symptoms of unrecognized disease and interfere with diagnosis.

Adverse Reactions: Patients may occasionally complain of autonomic reactions; e.g. dryness of the mouth, blurring of vision and, rarely, dizziness. Very rare cases were reported where patients receiving promethazine developed leukopenia. In one instance agranulocytosis was reported. Other toxic agents known to cause these conditions almost always were associated with use of promethazine. Cardiovascular by-effects were rare. Minor increases in blood pressure, occasional mild hypotension were reported. Photosensitivity (extremely rare) contraindicates further use of promethazine or related drugs. Patients with abraded or denuded rectal lesions may experience initial local discomfort with promethazine suppositories. Attempted suicides resulted in deep sedation, coma, rarely convulsions and cardiorespiratory symptoms compatible with depth of sedation present. Paradoxical reaction was reported in children after single doses of 75-125 mg orally (hyperexcitability and nightmares).

Composition: 12.5 and 25 mg promethazine HCl with ascorbyl palmitate, silicon dioxide, white wax, and cocoa butter.

See full prescribing information.

Wyeth Laboratories
Philadelphia, Pa 19101

OCTOBER 1984
VOLUME 74
NUMBER 4
PART 2

Pediatrics

AMERICAN ACADEMY OF PEDIATRICS ELK GROVE VILLAGE ILLINOIS 60007

Report of the Task Force on the Assessment of the Scientific Evidence Relating to Infant-Feeding Practices and Infant Health

Supplement

Report of the Task Force on the Assessment of the Scientific Evidence Relating to Infant-Feeding Practices and Infant Health

PEDIATRICS • VOLUME 74 • NUMBER 4 • OCTOBER 1984 • SUPPLEMENT

Members of the Task Force on the Assessment of the Scientific Evidence Relating to Infant-Feeding Practices and Infant Health

William H. Foege, MD, Chairman
Director, Centers for Disease Control
Atlanta
(*Currently:* Special Assistant for Policy Development, Centers for Disease Control)

John E. Anderson, PhD
Division of Reproductive Health
Center for Health Promotion and Education
Centers for Disease Control
Atlanta

Rose Belmont
Director, Office for Multilateral Programs
Office of International Health
Office of the Assistant Secretary for Health
Rockville, Maryland

Christopher Bladen
Director, Division of Science and Public Health Policy
Office of the Assistant Secretary for Planning and Evaluation
Washington, DC

Elizabeth Brannon
Nutrition Specialist
Office of Maternal and Child Health
Health Resources and Services Administration
Rockville, Maryland

John Bryant, MD
Special Assistant to the Assistant Secretary for Health
Fogarty International Center
National Institutes of Health
Bethesda, Maryland

Joginder G. Chopra, MD
Special Assistant for Medical Affairs
Food and Drug Administration
Washington, DC

Ernest Feigenbaum, MD
Medical Officer
National Center for Health Services Research
Office of the Assistant Secretary for Health
Rockville, Maryland

Michael Fishman, MD
Assistant Director for Children and Youth
National Institute of Mental Health
Alcohol, Drug Abuse, and Mental Health Administration
Rockville, Maryland

Michele R. Forman, PhD
Division of Biometry and Epidemiology
National Institute of Child Health and Human Development
National Institutes of Health
Bethesda, Maryland
(*Currently:* Division of Nutrition, Center for Health Promotion and Education, Centers for Disease Control, Atlanta)

David W. Fraser, MD
Office of the Director
Centers for Disease Control
(*Currently:* President, Swarthmore College, Swarthmore, Pennsylvania)

Gilman D. Grave, MD
Chief, Section on Clinical Nutrition and Endocrinology
Center for Research for Mothers and Children
National Institute of Child Health and Human Development
National Institutes of Health
Bethesda, Maryland

Gerry E. Hendershot, PhD
Division of Vital Statistics
National Center for Health Statistics
Office of the Assistant Secretary for Health
Hyattsville, Maryland
(*Currently:* Director, Adolescent Family Life Research, Office of Population Affairs, Office of the Assistant Secretary for Health, Washington, DC)

Janine M. Jason, MD
Office of the Director
Center for Health Promotion and Education
Centers for Disease Control
Atlanta
(*Currently:* Chief, Epidemiology Studies, Division of Host Factors, Center for Infectious Diseases, Centers for Disease Control)

Mary Grace Kovar, DrPH
Special Assistant for Data Policy and Analysis
Office of Interview and Examination Statistics Program
National Center for Health Statistics
Office of the Assistant Secretary for Health
Hyattsville, Maryland

James S. Marks, MD
Chief, Epidemiology Branch
Division of Nutrition
Center for Health Promotion and Education
Centers for Disease Control
Atlanta

J. Michael McGinnis, MD
Deputy Assistant Secretary for Health
(Disease Prevention and Health Promotion)
Office of the Assistant Secretary for Health
Washington, DC

Sanford A. Miller, MD
Director, Bureau of Foods
Food and Drug Administration
Washington, DC

Lenora Moragne, PhD
Senior Advisor, Nutrition Coordinating Office
Office of Disease Prevention and Health Promotion
Office of the Assistant Secretary for Health
Washington, DC

Phillip Nieburg, MD
Division of Nutrition
Center for Health Promotion and Education
Centers for Disease Control
Atlanta

Francis Notzon, MA, MS
National Center for Health Statistics
Office of the Assistant Secretary for Health
Hyattsville, Maryland

Tai-Keun Park, MD
Division of Reproductive Health
Center for Health Promotion and Education
Centers for Disease Control
Atlanta

Robert Rubin, MD
Assistant Secretary for Planning and Evaluation
Washington, DC

Mary K. Serdula, MD
Division of Nutrition
Center for Health Promotion and Education
Centers for Disease Control
Atlanta

Jane F. Seward, MBBS
Division of Nutrition (Consultant)
Center for Health Promotion and Education
Centers for Disease Control
Atlanta

Artemis P. Simopoulos, MD
Chairman, Nutrition Coordinating Committee
National Institutes of Health
Bethesda, Maryland

Amy B. Slonim, PhD
Division of Science and Public Health Policy
Office to the Assistant Secretary for Planning and Evaluation
Washington, DC

STAFF ASSISTANT:
Glenda S. Cowart
Centers for Disease Control
Atlanta

Acknowledgments

The members of the task force would like to acknowledge the assistance of the following persons in the preparation of this report:

June Friedlander
Elfrieda Davis
Ann Dickens
Pamela Hayes
Anna Irby
Laura Leathers
Esther Lockhard
Ann Mather
Deria Moore
Pearl Niemiec
Anabelle O'Brien
Elizabeth Schmid
Sally Schroeder
Barbara Scott
Diane Wetherill