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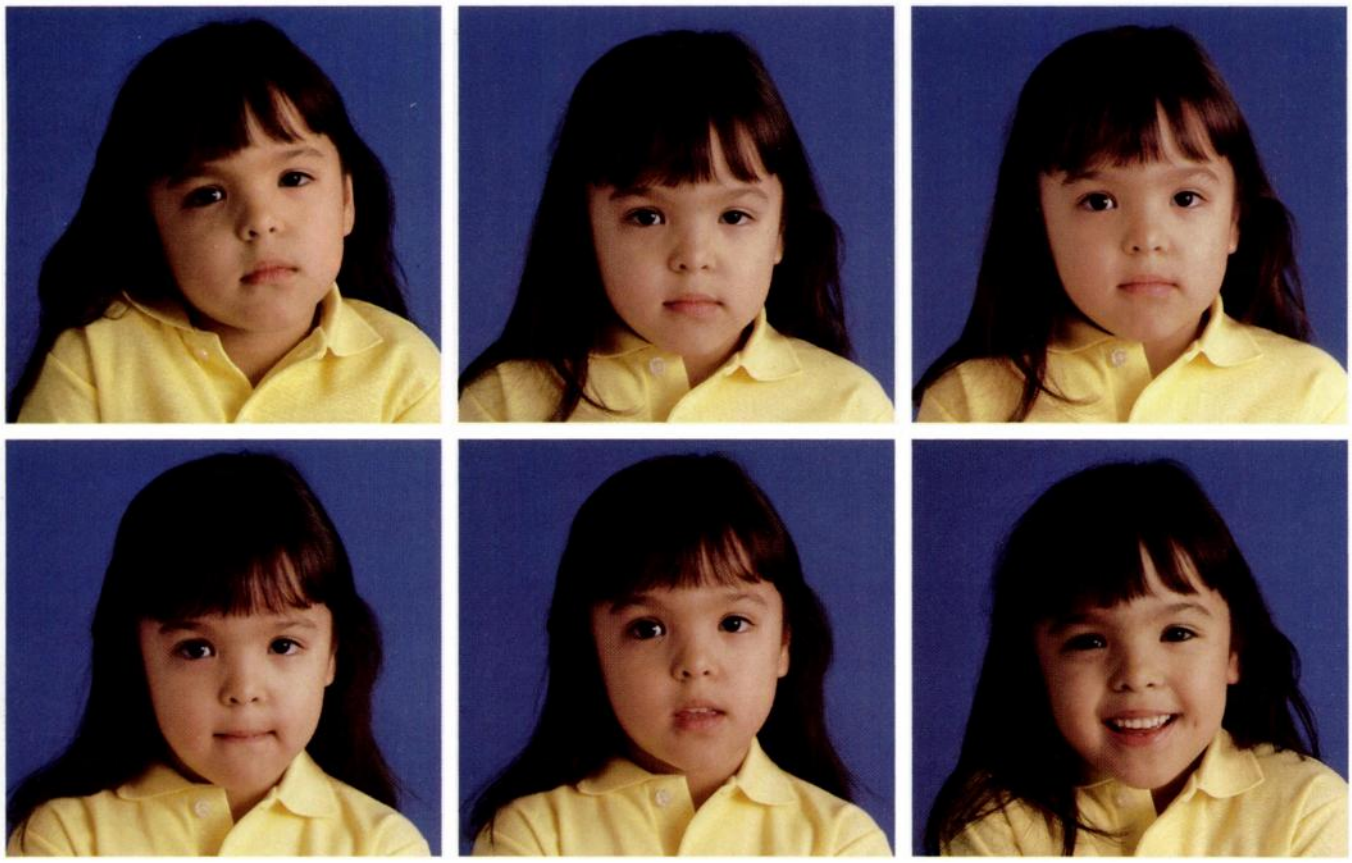

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REFERENCES: 1. Wilder BJ, Bruni J: *Seizure Disorders: A Pharmacological Approach to Treatment.* New York, Raven Press, 1981, p 98. 2. Green JB: Epilepsy in adolescents and adults, in Conn HF (ed): *Current Therapy 1982.* Philadelphia, WB Saunders 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.

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

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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.

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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):

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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

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Revised, January 1984

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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).

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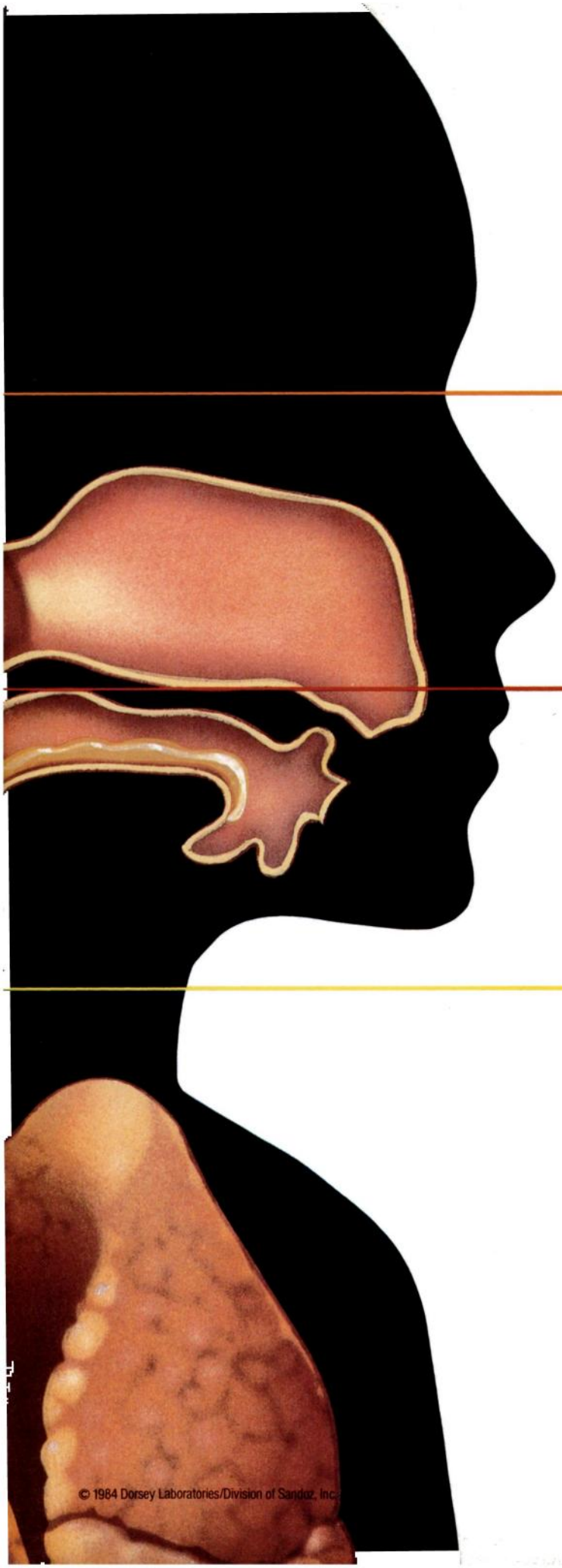

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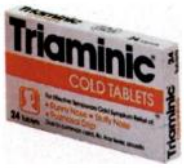

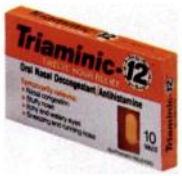

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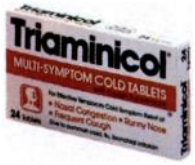

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0.5 F TABLETS	0.5 mg per tablet (half-strength)	120 1200*	grape grape
1.0 F TABLETS	1.0 mg per tablet (full-strength)	120 1000* 5000*	cherry & assorted (cherry, orange, lemon, lime) cherry & assorted cherry
SF 1.0 F TABLETS	1.0 mg per tablet (full-strength)	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.

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SPRING SESSIONS

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Atlanta
April 13–18

1986
Orlando, Florida
April 12–17

1987
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May 8–14

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Phenergan® VC for prompt relief of cold symptoms

Each teaspoonful (5 ml) contains promethazine HCl 6.25 mg and phenylephrine HCl 5 mg in a flavored syrup base. Alcohol 7%.

Phenergan® with Codeine Ⓥ for unsurpassed cough relief

Each teaspoonful (5 ml) contains codeine phosphate 10 mg (⅙ gr) (Warning—may be habit-forming) and promethazine HCl 6.25 mg in a flavored syrup base. Alcohol 7%.

Phenergan® VC with Codeine Ⓥ for unsurpassed cough relief **plus** control of cold symptoms

Each teaspoonful (5 ml) contains codeine phosphate 10 mg (⅙ gr) (Warning—may be habit-forming), promethazine HCl 6.25 mg and phenylephrine HCl 5 mg in a flavored syrup base. Alcohol 7%.

Phenergan® with Dextromethorphan for non-narcotic cough suppression; now with 15 mg dextromethorphan, twice as much as the previous formulation

Each teaspoonful (5 ml) contains promethazine HCl 6.25 mg and dextromethorphan hydrobromide 15 mg in a flavored syrup base. Alcohol 7%.

Phenergan® Syrup Plain for the relief of allergy-related upper respiratory symptoms

Each teaspoonful (5 ml) contains promethazine HCl 6.25 mg in a flavored syrup base. Alcohol 7%.

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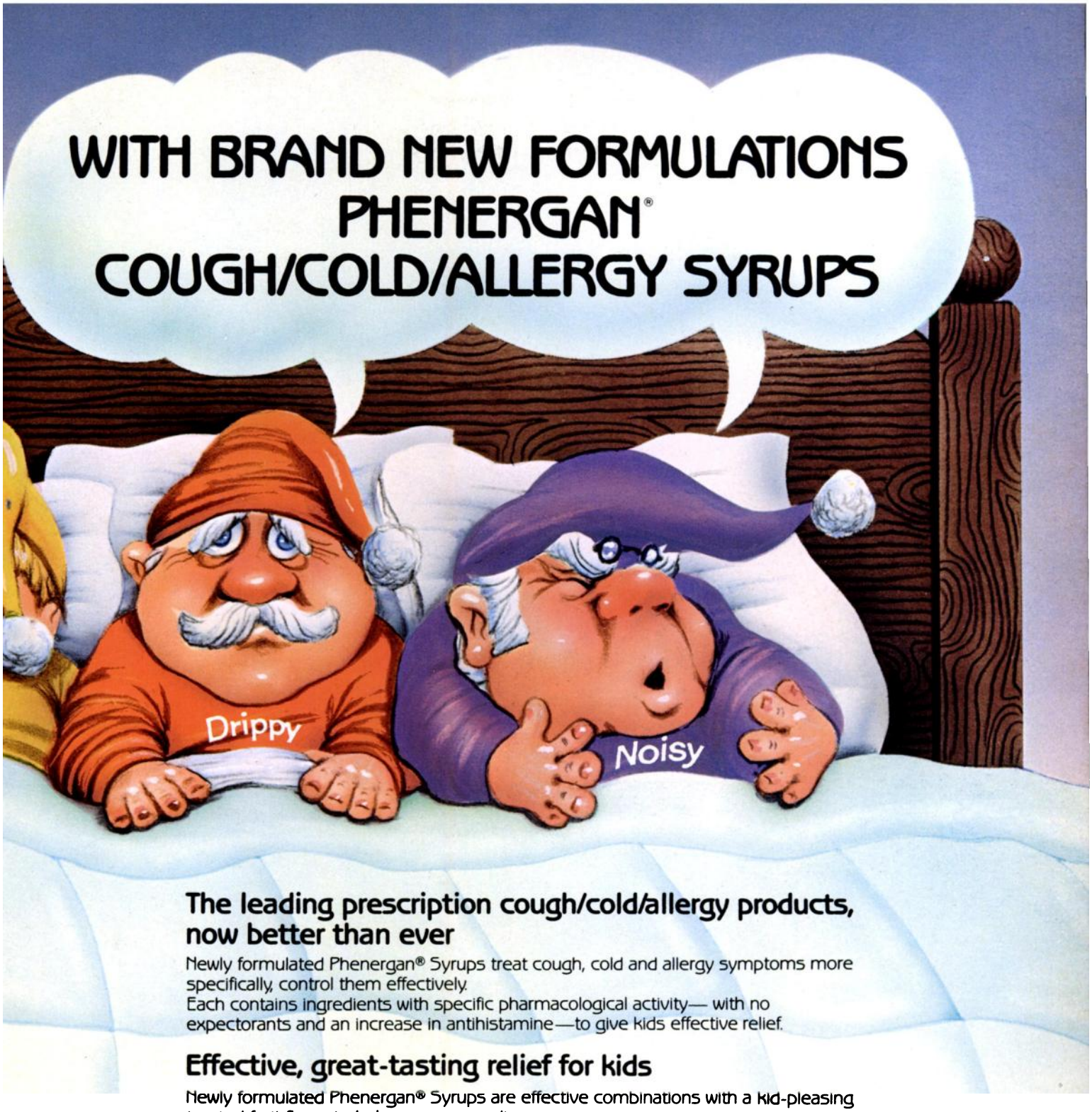

The leading prescription cough/cold/allergy products, now better than ever

Newly formulated Phenergan® Syrups treat cough, cold and allergy symptoms more specifically, control them effectively.
Each contains ingredients with specific pharmacological activity— with no expectorants and an increase in antihistamine—to give kids effective relief.

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Available by prescription only, with a 4-6h dosage schedule for most indications, the new Phenergan® Syrups help keep you in control of your patients' medication.

Brand new formulations Cough/Cold/Allergy Syrups

PHENERGAN®
(promethazine HCl)

A better way for kids to feel better.

See important information on following page.

PHENERGAN® (Promethazine HCl) SYRUPS IN BRIEF:

Indications and Usage:

Temporary relief of coughs and/or upper respiratory symptoms associated with allergy or the common cold

Contraindications:

Contraindicated in patients with hypersensitivity to any component. Promethazine is contraindicated in individuals hypersensitive or who have had an idiosyncratic reaction to it or to other phenothiazines. Phenylephrine is contraindicated in patients with hypertension or with peripheral vascular insufficiency (ischemia may result with risk of gangrene or thrombosis of compromised vascular beds). Avoid phenylephrine in patients hypersensitive to it or on a monoamine oxidase inhibitor (MAOI). Antihistamines and codeine are both contraindicated in those with lower respiratory tract symptoms, including asthma.

Withhold dextromethorphan from patients on a MAOI.

Warnings

CODEINE: Dosage SHOULD NOT BE INCREASED if cough fails to respond; reevaluate unresponsive cough in 5 days or sooner for possible underlying pathology, e.g., foreign body or lower respiratory tract disease.

Codeine may cause or aggravate constipation.

Respiratory depression, leading to arrest, coma, and death, occurred with codeine antitussives in young children, particularly in the under-one-year infants whose ability to deactivate the drug is not fully developed.

Codeine may be accompanied by histamine release; use with caution in atopic children.

Head Injury and Increased Intracranial Pressure: The respiratory-depressant effects of narcotic analgesics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, intracranial lesions, or preexisting increase in intracranial pressure. Narcotics may produce adverse reactions which may obscure the clinical course of patients with head injuries.

Asthma and Other Respiratory Conditions: Narcotic analgesics or cough suppressants, including codeine, should not be used in asthmatic patients (see "Contraindications"), nor in acute febrile illness with productive cough or in chronic respiratory disease where interference with ability to clear the tracheobronchial tree of secretions would have a deleterious effect on respiratory function.

Hypotensive Effect: Codeine may produce orthostatic hypotension in ambulatory patients.

PROMETHAZINE: May cause marked drowsiness. Caution ambulatory patients against driving or operating machinery until it is known that they do not become drowsy or dizzy from promethazine therapy.

The sedative action of promethazine is additive to the sedative effects of CNS depressants; therefore, agents such as alcohol, narcotic analgesics, sedatives, hypnotics, and tranquilizers should either be eliminated or given in reduced dosage in presence of promethazine. When given concomitantly with promethazine, reduce dose of barbiturates by at least ½ and the dose of analgesic depressants, e.g., morphine or meperidine, by ¼ to ½.

Promethazine may lower seizure threshold. Consider this when giving to persons with known seizure disorders or in combination with narcotics or local anesthetics which may also affect seizure threshold.

Avoid sedative drugs or CNS depressants in patients with history of sleep apnea. Use antihistamines with caution in patients with narrow-angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction, and urinary bladder obstruction due to symptomatic prostatic hypertrophy and narrowing of bladder neck.

Promethazine has been associated with cholestatic jaundice.

PHENYLEPHRINE: Because phenylephrine is adrenergic, give with caution to patients with thyroid diseases, diabetes mellitus, and heart diseases or those on tricyclic antidepressants.

Men with symptomatic, benign prostatic hypertrophy can experience urinary retention when given oral nasal decongestants.

Phenylephrine can decrease cardiac output. Use extreme caution when giving the drug, parenterally or orally, to patients with arteriosclerosis, to elderly individuals, and/or to patients with initially poor cerebral or coronary circulation.

Use with caution in patients on diet preparations, such as amphetamines or phenylpropanolamine, because synergistic adrenergic effects could result in serious hypertensive response and possible stroke.

DEXTROMETHORPHAN: May be accompanied by histamine release; use with caution in atopic children.

Precautions

Animal reproduction studies have not been conducted with these drug combinations. It is not known if they can cause fetal harm when given to pregnant women, or affect reproduction capacity. Give to pregnant women only if clearly needed.

GENERAL

Give narcotic analgesics, e.g., codeine, with caution and reduce initial dose in patients with acute abdominal conditions, convulsive disorders, significant hepatic or renal impairment, fever, hypothyroidism, Addison's disease, ulcerative colitis, prostatic hypertrophy, in patients with recent gastrointestinal or urinary tract surgery, and in the very young or elderly or debilitated.

Use promethazine cautiously in persons with cardiovascular disease or with impairment of liver function.

Use phenylephrine with caution in patients with cardiovascular disease, particularly hypertension.

Use dextromethorphan with caution in sedated patients, in the debilitated, and in patients confined to supine position.

INFORMATION FOR PATIENTS

All Phenergan Syrups may cause marked drowsiness or impair mental and/or physical abilities required for hazardous tasks, e.g., driving or operating machinery. Tell ambulatory patients to avoid such activities until it is known that they do not become drowsy or dizzy from Phenergan. Supervise children to avoid harm in bike riding or other hazardous activities. Concomitant use of alcohol or other CNS depressants, including narcotic analgesics, sedatives, hypnotics, and tranquilizers, may have an additive effect and should be avoided or their dosage reduced.

Advise patients to report any involuntary muscle movements or unusual sensitivity to sunlight.

Codeine may produce orthostatic hypotension in ambulatory patients; caution patients.

DRUG INTERACTIONS

CODEINE: In patients receiving MAOIs, an initial small test dose is advisable to allow observation of any excessive narcotic effects or MAOI interaction.

PROMETHAZINE: The sedative action is additive to sedative effects of other CNS depressants, e.g., alcohol, narcotic analgesics, sedatives, hypnotics, tricyclic antidepressants, and tranquilizers; therefore, these agents should be avoided or given in reduced dosage.

PHENYLEPHRINE

Drug	Effect
Phenylephrine with prior administration of MAOIs	Cardiac pressor response potentiated. May cause acute hypertensive crisis
Phenylephrine with tricyclic antidepressants	Pressor response increased
Phenylephrine with ergot alkaloids	Excessive rise in blood pressure
Phenylephrine with bronchodilator sympathomimetic agents and with epinephrine or other sympathomimetics	Tachycardia or other arrhythmias may occur
Phenylephrine with prior administration of propranolol or other β-adrenergic blockers	Cardiostimulating effects blocked
Phenylephrine with atropine sulfate	Reflex bradycardia blocked; pressor response enhanced
Phenylephrine with prior administration of phentolamine or other α-adrenergic blockers	Pressor response decreased
Phenylephrine with diet preparations, e.g., amphetamines or phenylpropanolamine	Synergistic adrenergic response

DRUG/LABORATORY TEST INTERACTIONS

Because narcotic analgesics may increase biliary tract pressure, with resultant increases in plasma amylase or lipase levels, determination of these enzyme levels may be unreliable for 24 hours after a narcotic analgesic has been given. These tests may be affected in patients on promethazine.

Pregnancy Tests

Diagnostic pregnancy tests based on immunological reactions between HCG and anti-HCG may result in false-negative or false-positive interpretations.

Glucose Tolerance Test

Increase in blood glucose has been reported in patients on promethazine.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY

CODEINE, PROMETHAZINE, AND DEXTROMETHORPHAN

Long-term animal studies have not been performed to assess the carcinogenic potential of codeine or of promethazine or of dextromethorphan, nor are there other animal or human data concerning carcinogenicity, mutagenicity, or impairment of fertility with these agents. Codeine has been reported to show no evidence of carcinogenicity or mutagenicity in a variety of test systems, including the micronucleus and sperm abnormality assays and the *Salmonella* assay. Promethazine was nonmutagenic in the *Salmonella* test system of Ames.

PHENYLEPHRINE

A study which followed the development of cancer in 143,574 patients over a 4-year period indicated that in 11,981 patients who received phenylephrine (systemic or topical), there was no statistically significant association between the drug and cancer at any or all sites.

Long-term animal studies have not been performed to assess carcinogenic potential of phenylephrine, nor are there other animal or human data on mutagenicity.

A study of the effects of adrenergic drugs on ovum transport in rabbits indicated that treatment with phenylephrine did not alter incidence of pregnancy; the number of implantations was significantly reduced when high doses were used.

PREGNANCY

Teratogenic Effects—Pregnancy Category C

CODEINE: A study in rats and rabbits reported no teratogenic effect of codeine given in the period of organogenesis in doses ranging from 5 to 120 mg/kg. In the rat, doses at the 120-mg/kg level, in the toxic range for the adult animal, were associated with increase in embryo resorption at implantation. In another study a single 100-mg/kg dose in pregnant mice resulted in delayed ossification in offspring. There are no studies in humans; significance of these findings to humans, if any, is not known.

PROMETHAZINE: Teratogenic effects have not been demonstrated in rat-feeding studies at doses of 6.25 and 12.5 mg/kg of promethazine. These doses are 6 and 16.7 times the maximum recommended total daily dose of promethazine for a 50-kg subject depending on the indication for which the drug is prescribed. Specific studies to test the action of the drug on parturition, lactation, and development of the animal neonate were not done, but a general preliminary study in rats indicated no effect on these parameters. Although antihistamines, including promethazine, have been found to produce fetal mortality in rodents, the pharmacological effects of histamine in the rodent do not parallel those in man. There are no adequate and well-controlled studies of promethazine in pregnant women.

PHENYLEPHRINE: A study in rabbits indicated continued moderate overexposure to phenylephrine (3 mg/day) during the second half of pregnancy (22nd day of gestation to delivery) may contribute to perinatal wastage, prematurity, premature labor, and possibly fetal anomalies; when phenylephrine (3 mg/day) was given to rabbits during first half of pregnancy (3rd day after mating for 7 days), a significant number gave birth to litters of low birth weight. Another study showed that phenylephrine was associated with anomalies of aortic arch and with ventricular septal defect in the chick embryo. Phenergan® (promethazine HCl) Syrups should be used during pregnancy only if potential benefit justifies potential risk to the fetus.

Nonteratogenic Effects

Dependence has been reported in newborns whose mothers took opiates regularly during pregnancy. Withdrawal signs include irritability, excessive crying, tremors, hyperreflexia, fever, vomiting, and diarrhea. Signs usually appear during the first few days of life.

Promethazine taken within two weeks of delivery may inhibit platelet aggregation in newborn.

LABOR AND DELIVERY

Narcotic analgesics cross the placental barrier. The closer to delivery and the larger the dose used, the greater the possibility of respiratory depression in the newborn. Narcotic analgesics should be avoided during labor if delivery of a premature infant is anticipated. If the mother has received narcotic analgesics during labor, newborn infants should be observed closely for signs of respiratory depression. Resuscitation may be required (see "Overdosage"). The effect of codeine, if any, on the later growth, development, and functional maturation of the child is unknown. Administration of phenylephrine to patients in late pregnancy or labor may cause fetal anoxia or bradycardia by increasing contractility of the uterus and decreasing uterine blood flow.

NURSING MOTHERS

Some studies, but not others, have reported detectable amounts of codeine in breast milk. The levels are probably not clinically significant after usual therapeutic dosage. The possibility of clinically important amounts being excreted in breast milk in individuals abusing codeine should be considered. It is not known whether phenylephrine, promethazine or dextromethorphan is excreted in human milk. Caution should be exercised when any Phenergan Syrup is administered to a nursing woman.

PEDIATRIC USE

These products should not be used in children under 2 years of age because safety for such use has not been established.

Adverse Reactions

CODEINE

CNS: CNS depression, particularly respiratory depression, and to a lesser extent circulatory depression, light-headedness, dizziness, sedation, euphoria, dysphoria, headache, transient hallucination, disorientation, visual disturbances, and convulsions.

CV: Tachycardia, bradycardia, palpitation, faintness, syncope, orthostatic hypotension (common to narcotic analgesics).

GI: Nausea, vomiting, constipation, and biliary tract spasm. Patients with chronic ulcerative colitis may experience increased colonic motility; in patients with acute ulcerative colitis, toxic dilation has been reported.

GU: Oliguria, urinary retention, antidiuretic effect has been reported (common to narcotic analgesics).

Allergic: Infrequent pruritus, giant urticaria, angioneurotic edema, and laryngeal edema.

Other: Flushing of the face, sweating and pruritus (due to opiate-induced histamine release), weakness.

PROMETHAZINE

CNS: Sedation, sleepiness, occasional blurred vision, dryness of mouth, dizziness, rarely confusion, disorientation, and extrapyramidal symptoms such as oculogyric crisis, torticollis, and tongue protrusion (usually in association with parenteral injection or excessive dosage).

CV: Increased or decreased blood pressure.

Dermatologic: Rash, rarely photosensitivity.

Hematologic: Rarely leukopenia, thrombocytopenia, agranulocytosis (1 case).

GI: Nausea and vomiting.

PHENYLEPHRINE

CNS: Restlessness, anxiety, nervousness, and dizziness.

CV: Hypertension (see "Warnings").

Other: Precordial pain, respiratory distress, tremor, and weakness.

DEXTROMETHORPHAN

Occasionally causes slight drowsiness, dizziness, and GI disturbances.

Drug Abuse and Dependence

CONTROLLED SUBSTANCE

Phenergan with codeine and Phenergan VC with codeine are Schedule V Controlled Substances.

ABUSE

Codeine is known to be subject to abuse; however, abuse potential of oral codeine appears to be quite low. Even parenteral codeine does not appear to offer psychic effects sought by addicts to the same degree as heroin or morphine. However, codeine must be administered only under close supervision to patients with history of drug abuse or dependence.

DEPENDENCE

Psychological dependence, physical dependence, and tolerance are known to occur.

According to WHO Expert Committee on Drug Dependence, dextromethorphan could produce very slight psychic but no physical dependence.

Overdosage

CODEINE: Serious overdose with codeine is characterized by respiratory depression (decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. The triad of coma, pinpoint pupils, and respiratory depression is strongly suggestive of opiate poisoning. In severe overdosage, particularly by the IV route, apnea, circulatory collapse, cardiac arrest, and death may occur. Promethazine is additive to depressant effects of codeine.

It is difficult to determine what constitutes a standard toxic or lethal dose. However, lethal oral dose of codeine in adults is reported to be in range of 0.5 to 1.0 gram. Infants and children are believed to be relatively more sensitive to opiates on body-weight basis. Elderly patients are also comparatively intolerant to opiates.

PROMETHAZINE: Signs and symptoms of overdosage range from mild CNS and cardiovascular depression to profound hypotension, respiratory depression, and unconsciousness.

Stimulation may be evident, especially in children and geriatric patients. Convulsions may rarely occur. A paradoxical reaction has been reported in children receiving single doses of 75 mg. to 125 mg. orally, characterized by hyperexcitability and nightmares.

Atropine-like signs and symptoms: dry mouth, fixed, dilated pupils, flushing, as well as GI symptoms, may occur.

PHENYLEPHRINE: Signs and symptoms of overdosage include hypertension, headache, convulsions, cerebral hemorrhage, and vomiting. Ventricular premature beats and short paroxysms of ventricular tachycardia may also occur. Headache may be a symptom of hypertension. Bradycardia may also be seen early in phenylephrine overdosage through stimulation of baroreceptors.

DEXTROMETHORPHAN

May produce central excitement and mental confusion. Very high doses may produce respiratory depression. One case of toxic psychosis (hyperactivity, marked visual and auditory hallucinations) after single dose of 20 tablets (300 mg) of dextromethorphan was reported.

TREATMENT

Treatment of overdosage with Phenergan Syrups is essentially symptomatic and supportive. Only in cases of extreme overdosage or individual sensitivity do vital signs including respiration, pulse, blood pressure, temperature, and EKG need to be monitored. Activated charcoal orally or by lavage may be given; or sodium or magnesium sulfate orally as a cathartic. Attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation.

The narcotic antagonist, naloxone HCl, may be given when significant respiratory depression occurs with the codeine syrups; any depressant effects of promethazine are not reversed by naloxone. Diazepam may be used to control convulsions.

The antidotal efficacy of narcotic antagonists to dextromethorphan has not been established.

Avoid analeptics, which may cause convulsions. Acidosis and electrolyte losses should be corrected. A rise in temperature or pulmonary complications may signal the need for institution of antibiotic therapy.

Severe hypotension usually responds to norepinephrine or phenylephrine. EPINEPHRINE SHOULD NOT BE USED since in a patient with partial adrenergic blockade it may further lower blood pressure. Limited experience with dialysis indicates that it is not helpful.

Wyeth Laboratories
Philadelphia, PA 19101

3/14/84

Results of Double-Blind Clinical Study

92%

of babies tested improved in 24 hours

16%

of babies tested improved in 24 hours

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The same standards can apply to your diaper rash recommendation as it would for any prescription.
In a double-blind comparison study between Desitin and A&D, 50 infants with moderate or severe diaper rash were selected. There were 25 infants randomly assigned to be treated with Desitin and the remaining 25 with A&D Ointment. Both products were applied at each diaper change, and results were evaluated at 4, 10 and 24 hours after start of therapy.

Desitin proven superior in double-blind study.
The results: 23 of 25 infants (92%) improved with Desitin within 24 hours. 4 of 25 infants (16%) improved with A&D Ointment within 24 hours. Whether it's a recommendation concerning diaper rash or a prescription for a more serious condition, mothers depend on you to choose the most efficacious treatment for their child. In this comparison study on the treatment of diaper rash, Desitin was proven superior.*

Desitin. Formulated for effectiveness.
Desitin Ointment is effective because it was formulated to be effective—with natural vitamins A and D (from Norwegian cod liver oil) to help promote granulation and the formation of epithelium, high-quality talc...and zinc oxide to dry and soothe. Plus lanolin and petrolatum—two emollients that combine with the zinc oxide in Desitin to form a long-lasting protective barrier against wetness and ammonia compounds that can cause diaper rash.

DESITIN® The recommendation that stands for efficacy.

*Comparative Efficacy of Diaper Rash Ointment, independent laboratory study #80-0913-70, April 15, 1981. Data on file, Leeming/Pacquin Division, Pfizer Inc.

Half a Life...?

Why Should Seizure Therapy Impair the Quality of Life...?

Now It Needn't

From Johns Hopkins Hospital Epilepsy Center

New Findings on Cognitive and Behavioral Impact of Valproate versus Phenobarbital

Significant Advantage

The Study[1] A recent double-blind crossover study demonstrated significant advantage of valproate over phenobarbital. Twenty-one children with epilepsy were maintained at therapeutic levels of each drug for six months. The children were evaluated for adverse effects on intellectual function and behavior.

Cognitive Superiority

Professional Observations The children performed significantly better on valproate in measures of both intelligence and attention:

- Better in Wechsler intelligence scales (vocabulary, picture completion, block design, performance, full-scale IQ)
- Better in auditory attention span for related syllables
- Better in visual attention span

Behavioral Superiority

Parental Observation In 47 of 48 behavioral items, parents reported better results with valproate:

- Less behavioral dysfunction
- Eight areas of statistically significant superiority

[1]Vining, E.P.G., et al., Effects of Phenobarbital and Sodium Valproate on Neuropsychological Function and Behavior, *Annals of Neurology* 14: 360, Sept. 1983.

See adjacent page for brief prescribing information.

Improved Valproate Source

Depakote tablets bring the full benefits of valproate, with features of improved acceptance by patients:

- **Enteric Coated** to minimize chances of G.I. irritation
- **Smaller** and easier to swallow
- **Three Sizes** include 125 mg, 250 mg, and 500 mg strengths for better dosing flexibility and convenience.
- **B.I.D. Option** avoids problems of midday dosing for school children

Start Depakote as a mainstay for controlling absence, or, as a major adjunct in absence that include multiple seizure types.

Before Starting and frequently thereafter, test CBC, bleeding time, and liver profile in view of hepatic reactions, including fatalities, and hematologic abnormalities.

NEW

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- Enteric-coating for improved patient comfort
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DEPAKOTE — a mainstay for absence . . . and a major adjunct in multiple seizure types that include absence

DEPAKOTE — a fundamentally different therapeutic alternative from phenobarbital . . . one that both restores seizure control and sustains a quality of life

DEPAKOTE™
DIVALPROEX SODIUM
ENTERIC-COATED TABLETS

WARNING:
HEPATIC FAILURE RESULTING IN FATALITIES HAS OCCURRED IN PATIENTS RECEIVING VALPROIC ACID AND ITS DERIVATIVES. THESE INCIDENTS USUALLY HAVE OCCURRED DURING THE FIRST SIX MONTHS OF TREATMENT. SERIOUS OR FATAL HEPATOTOXICITY MAY BE PRECEDED BY NON-SPECIFIC SYMPTOMS SUCH AS LOSS OF SEIZURE CONTROL, MALAISE, WEAKNESS, LETHARGY, ANOREXIA AND VOMITING. LIVER FUNCTION TESTS SHOULD BE PERFORMED PRIOR TO THERAPY AND AT FREQUENT INTERVALS THEREAFTER, ESPECIALLY DURING THE FIRST SIX MONTHS.

INDICATIONS AND USAGE: DEPAKOTE (divalproex sodium) is indicated for use as sole and adjunctive therapy in the treatment of simple (petit mal) and complex absence seizures. DEPAKOTE may also be used adjunctively in patients with multiple seizure types which include absence seizures.

In accordance with the International Classification of Seizures, simple absence is defined as very brief clouding of the sensorium or loss of consciousness (lasting usually 2-15 seconds), accompanied by certain generalized epileptic discharges without other detectable clinical signs. Complex absence is the term used when other signs are also present.

SEE "WARNINGS" SECTION FOR STATEMENT REGARDING FATAL HEPATIC DYSFUNCTION.

CONTRAINDICATIONS: DEPAKOTE (DIVALPROEX SODIUM) SHOULD NOT BE ADMINISTERED TO PATIENTS WITH HEPATIC DISEASE OR SIGNIFICANT DYSFUNCTION.

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

WARNINGS: Hepatic failure resulting in fatalities has occurred in patients receiving valproic acid. These incidents usually have occurred during the first six months of treatment. Serious or fatal hepatotoxicity may be preceded by non-specific symptoms such as loss of seizure control, malaise, weakness, lethargy, anorexia and vomiting. Liver function tests should be performed prior to therapy and at frequent intervals thereafter, especially during the first six months. However, physicians should not rely totally on serum biochemistry since these tests may not be abnormal in all instances, but should also consider the results of careful interim medical history and physical examination. Caution should be observed when administering DEPAKOTE to patients with a prior history of hepatic disease. Patients with various unusual congenital disorders, those with severe seizure disorders accompanied by mental retardation, and those with organic brain disease may be at particular risk.

The drug should be discontinued immediately in the presence of significant hepatic dysfunction, suspected or apparent. In some cases, hepatic dysfunction has progressed in spite of discontinuation of drug. The frequency of adverse effects (particularly elevated liver enzymes) may be dose-related. The benefit of improved seizure control which may accompany the higher doses should therefore be weighed against the possibility of a greater incidence of adverse effects.

Usage in Pregnancy: ACCORDING TO RECENT REPORTS IN THE MEDICAL LITERATURE, VALPROIC ACID MAY PRODUCE TERATOGENICITY IN THE OFFSPRING OF HUMAN FEMALES RECEIVING THE DRUG DURING PREGNANCY. THE INCIDENCE OF NEURAL TUBE DEFECTS IN THE FETUS MAY BE INCREASED IN MOTHERS RECEIVING VALPROATE DURING THE FIRST TRIMESTER OF PREGNANCY. BASED UPON A SINGLE FRENCH REPORT,[1] THE CENTERS FOR DISEASE CONTROL (CDC) HAS ESTIMATED THE RISK OF VALPROIC ACID EXPOSED WOMEN HAVING CHILDREN WITH SPINA BIFIDA TO BE APPROXIMATELY 1.2%.[2] THIS RISK IS SIMILAR TO THAT FOR NON-EPILEPTIC WOMEN WHO HAVE HAD CHILDREN WITH NEURAL TUBE DEFECTS (ANENCEPHALY AND SPINA BIFIDA).

THERE ARE MULTIPLE REPORTS IN THE CLINICAL LITERATURE WHICH INDICATE THAT THE USE OF ANTIEPILEPTIC DRUGS DURING PREGNANCY RESULTS IN AN INCREASED INCIDENCE OF BIRTH DEFECTS IN THE OFFSPRING. ALTHOUGH DATA ARE MORE EXTENSIVE WITH RESPECT TO TRIMETHADIONE, PARAMETHADIONE, PHENYTOIN, AND PHENOBARBITAL, REPORTS INDICATE A POSSIBLE SIMILAR ASSOCIATION WITH THE USE OF OTHER ANTIEPILEPTIC DRUGS. THEREFORE, ANTIEPILEPTIC DRUGS SHOULD BE ADMINISTERED TO WOMEN OF CHILDBEARING POTENTIAL ONLY IF THEY ARE CLEARLY SHOWN TO BE ESSENTIAL IN THE MANAGEMENT OF THEIR SEIZURES.

ANIMAL STUDIES HAVE ALSO DEMONSTRATED VALPROIC ACID INDUCED TERATOGENICITY. Studies in rats and human females demonstrated placental transfer of the drug. Doses greater than 65 mg/kg/day given to pregnant rats and mice produced skeletal abnormalities in the offspring, primarily involving ribs and vertebrae; doses greater than 150 mg/kg/day given to pregnant rabbits produced fetal resorptions and (primarily) soft-tissue abnormalities in the offspring. In rats a dose-related delay in the onset of parturition was noted. Postnatal growth and survival of the progeny were adversely affected, particularly when drug administration spanned the entire gestation and early lactation period.

Antiepileptic drugs should not be discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life. In individual cases where the severity and frequency of the seizure disorder are such that the removal of medication does not pose a serious threat to the patient, discontinuation of the drug may be considered prior to and during pregnancy, although it cannot be said with any confidence that even minor seizures do not pose some hazard to the developing embryo or fetus.

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

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

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

Hyperammonemia with or without lethargy or coma has been reported and may be present in the absence of abnormal liver function tests. If elevation occurs, DEPAKOTE should be discontinued.

Since DEPAKOTE (divalproex sodium) may interact with concurrently administered antiepileptic drugs, periodic serum level determinations of concomitant antiepileptic drugs are recommended during the early course of therapy. (See "Drug Interactions" section).

Valproate is partially eliminated in the urine as a keto-metabolite which may lead to a false interpretation of the urine ketone test.

Information for Patients: Since DEPAKOTE may produce CNS depression, especially when combined with another CNS depressant (e.g., alcohol), patients should be advised not to engage in hazardous occupations, such as driving an automobile or operating dangerous machinery, until it is known that they do not become drowsy from the drug.

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

THERE IS EVIDENCE THAT VALPROIC ACID CAN CAUSE AN INCREASE IN SERUM PHENOBARBITAL LEVELS BY IMPAIRMENT OF NON-RENAL CLEARANCE. THIS PHENOMENON CAN RESULT IN SEVERE CNS DEPRESSION. THE COMBINATION OF VALPROIC ACID AND PHENOBARBITAL HAS ALSO BEEN REPORTED TO PRODUCE CNS DEPRESSION WITHOUT SIGNIFICANT ELEVATIONS OF BARBITURATE OR VALPROATE SERUM LEVELS. ALL PATIENTS RECEIVING CONCOMITANT BARBITURATE THERAPY SHOULD BE CLOSELY MONITORED FOR NEUROLOGICAL TOXICITY. SERUM BARBITURATE LEVELS SHOULD BE OBTAINED, IF POSSIBLE, AND THE BARBITURATE DOSAGE DECREASED, IF APPROPRIATE.

Primidone is metabolized into a barbiturate and, therefore, may also be involved in a similar or identical interaction.

THERE HAVE BEEN REPORTS OF BREAKTHROUGH SEIZURES OCCURRING WITH THE COMBINATION OF VALPROIC ACID AND PHENYTOIN. MOST REPORTS HAVE NOTED A DECREASE IN TOTAL PLASMA PHENYTOIN CONCENTRATION. HOWEVER, INCREASES IN TOTAL PHENYTOIN SERUM CONCENTRATION HAVE BEEN REPORTED. AN INITIAL FALL IN TOTAL PHENYTOIN LEVELS WITH SUBSEQUENT INCREASE IN PHENYTOIN LEVELS HAS ALSO BEEN REPORTED. IN ADDITION, A DECREASE IN TOTAL SERUM PHENYTOIN WITH AN INCREASE IN THE FREE VS. PROTEIN BOUND PHENYTOIN LEVELS HAS BEEN REPORTED. THE DOSAGE OF PHENYTOIN SHOULD BE ADJUSTED AS REQUIRED BY THE CLINICAL SITUATION.

THE CONCOMITANT USE OF VALPROIC ACID AND CLONAZEPAM MAY PRODUCE ABSENCE STATUS.

Caution is recommended when DEPAKOTE (divalproex sodium) is administered with drugs affecting coagulation, e.g., aspirin and warfarin. (See "Adverse Reactions" section).

There have been reports of altered thyroid function tests associated with valproate. The clinical significance of these is unknown.

Carcinogenesis: Valproic acid was administered to Sprague Dawley rats and ICR (HA/ICR) mice at doses of 0, 80 and 170 mg/kg/day for two years. Although a variety of neoplasms were observed in both species, the chief findings were a statistically significant increase in the incidence of subcutaneous fibrosarcomas in high dose male rats receiving valproic acid and a statistically significant dose-related trend for benign pulmonary adenomas in male mice receiving valproic acid. The significance of these findings for man is unknown at present.

Mutagenesis: Studies on valproic acid have been performed using bacterial and mammalian systems. These studies have provided no evidence of a mutagenic potential for DEPAKOTE.

Fertility: Chronic toxicity studies in juvenile and adult rats and dogs demonstrated reduced spermatogenesis and testicular atrophy at doses greater than 200 mg/kg/day in rats and greater than 90 mg/kg/day in dogs. Segment I fertility studies in rats have shown doses up to 350 mg/kg/day for 60 days to have no effect on fertility. THE EFFECT OF DEPAKOTE (DIVALPROEX SODIUM) ON THE DEVELOPMENT OF THE TESTES AND ON SPERM PRODUCTION AND FERTILITY IN HUMANS IS UNKNOWN.

Pregnancy: Pregnancy Category D: See "Warnings" section.

Nursing Mothers: Valproate is excreted in breast milk. Concentrations in breast milk have been reported to be 1-10% of serum concentrations. It is not known what effect this would have on a nursing infant. Caution should be exercised when DEPAKOTE is administered to a nursing woman.

ADVERSE REACTIONS: Since valproic acid and its derivatives have usually been used with other antiepileptic drugs, it is not possible, in most cases, to determine whether the following adverse reactions can be ascribed to valproic acid alone, or the combination of drugs.

Gastrointestinal: The most commonly reported side effects at the initiation of therapy are nausea, vomiting and indigestion. These effects are usually transient and rarely require discontinuation of therapy. Diarrhea, abdominal cramps and constipation have been reported. Both anorexia with some weight loss and increased appetite with weight gain have also been reported.

CNS Effects: Sedative effects have been noted in patients receiving valproic acid alone but are found most often in patients receiving combination therapy. Sedation usually disappears upon reduction of other antiepileptic medication. Ataxia, headache, nystagmus, diplopia, asterixis, "spots before eyes," tremor, dysarthria, dizziness, and incoordination have rarely been noted. Rare cases of coma have been noted in patients receiving valproic acid alone or in conjunction with phenobarbital.

Dermatologic: Transient increases in hair loss have been observed. Skin rash and petechiae have rarely been noted.

Psychiatric: Emotional upset, depression, psychosis, aggression, hyperactivity and behavioral deterioration have been reported.

Musculoskeletal: Weakness has been reported.

Hematopoietic: Thrombocytopenia has been reported. Valproic acid inhibits the secondary phase of platelet aggregation. (See "Drug Interactions" section). This may be reflected in altered bleeding time. Bruising, hematoma formation and frank hemorrhage have been reported. Relative lymphocytosis and hypofibrinogenemia have been noted. Leukopenia and eosinophilia have also been reported. Anemia and bone marrow suppression have been reported.

Hepatic: Minor elevations of transaminases (e.g., SGOT and SGPT) and LDH are frequent and appear to be dose related. Occasionally, laboratory test results include, as well, increases in serum bilirubin and abnormal changes in other liver function tests. These results may reflect potentially serious hepatotoxicity. (See "Warnings" section).

Endocrine: There have been reports of irregular menses and secondary amenorrhea occurring in patients receiving valproic acid and its derivatives.

Abnormal thyroid function tests have been reported. (See "Precautions" section).

Pancreatic: There have been reports of acute pancreatitis occurring in patients receiving valproic acid and its derivatives.

Metabolic: Hyperammonemia. (See "Precautions" section).

Hyperglycinemia has been reported and has been associated with a fatal outcome in a patient with preexistent nonketotic hyperglycinemia.

OVERDOSAGE: Overdosage with valproic acid may result in deep coma.

Since DEPAKOTE tablets are enteric-coated, the benefit of gastric lavage or emesis will vary with the time since ingestion. General supportive measures should be applied with particular attention being given to the maintenance of adequate urinary output.

Naloxone has been reported to reverse the CNS depressant effects of valproate overdosage. Because naloxone could theoretically also reverse the antiepileptic effects of DEPAKOTE it should be used with caution.

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2. Centers for Disease Control. Valproic Acid and Spina Bifida: A Preliminary Report — France, *Morbidity and Mortality Weekly Report,* 31(42): 565-566, 1982.

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Similac® with whey 23 mg/100 ml	4140
Similac® 23 mg/100 ml	4140
Cow Milk 52 mg/100 ml	9360

*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.

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BOOKS RECEIVED

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PEDIATRICS IN REVIEW: April 1985 Contents

Ethical Issues in the Care of Handicapped, Chronically Ill, and Dying Children—Fost
Drug Reactions and Interactions in Pediatric Practice—Braden and Walson
Long-Term Outlook for Handicapped Children—Kramer

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1. Frosch PJ, Kligman AM: *J Am Acad Dermatol* 1:35, 1979.
2. Monograph of laboratory and clinical studies available on request.

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Summary of Prescribing Information
Description
Tablets: Contain codeine phosphate*. No. 1—7.5 mg (⅛ gr); No. 2—15 mg (¼ gr), No. 3—30 mg (½ gr), No. 4—60 mg (1 gr)—plus acetaminophen 300 mg.
Capsules: Contain codeine phosphate*. No. 3—30 mg (½ gr), No. 4—60 mg (1 gr)—plus acetaminophen 300 mg.
Elixir: Each 5 ml contains 12 mg codeine phosphate* plus 120 mg acetaminophen (alcohol 7%).
***Warning:** May be habit forming.
Contraindications: Hypersensitivity to acetaminophen or codeine.
Warnings: *Drug dependence*: Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to other oral narcotics. Subject to the Federal Controlled Substances Act.
Precautions: General—*Head injury and increased intracranial pressure*: Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute abdominal conditions: Codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.
Special risk patients: Administer with caution to certain patients such as the elderly or debilitated and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.
Information for Patients: *Usage in ambulatory patients*: Codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.
Drug Interactions: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) with this drug may exhibit additive CNS depression. When such a combination is contemplated, reduce the dose of one or both agents.
The use of MAO inhibitors or tricyclic antidepressants with codeine preparations may increase the effect of either the antidepressant or codeine.
The concurrent use of anticholinergics with codeine may produce paralytic ileus.
Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed with acetaminophen or codeine to determine carcinogenic potential or effects on fertility.
Acetaminophen and codeine have been found to have no mutagenic potential using the Ames Salmonella-Microsomal Activation test, the Basc test on Drosophila germ cells, and the Micronucleus test on mouse bone marrow.
Teratogenic Effects: Pregnancy Category C. Codeine has been shown to be teratogenic in mice when given in doses 17 times the maximum human daily dose. There are no adequate and well controlled studies in pregnant women.
TYLENOL with Codeine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nursing Mothers: It is not known whether the components of this drug are excreted in human milk; caution should be exercised when TYLENOL with Codeine is administered to a nursing woman.
Pediatric Use: Safe dosage of the elixir has not been established in children below the age of three; the tablets and capsules should not be administered to children under 12.
Adverse Reactions: *Most frequent*: Lightheadedness, dizziness, sedation, shortness of breath, nausea and vomiting, and are more prominent in ambulatory than in nonambulatory patients; some of these may be alleviated if the patient lies down. *Others*: euphoria, dysphoria, constipation, and pruritus.
At higher doses codeine has most of the disadvantages of morphine including respiratory depression.
Dosage and Administration: Dosage should be adjusted according to severity of pain and response of the patient.
TYLENOL with Codeine tablets and capsules are given orally.
The usual adult dose is: Tablets No. 1, No. 2, and No. 3 and Capsules No. 3: One or two every four hours as required.
Tablets and Capsules No. 4: One every four hours as required.
The recommended dose of codeine in children is 0.5 mg/kg body weight.
TYLENOL with codeine elixir contains 12 mg of codeine/5 ml teaspoon and is given orally. The usual doses are: *Children (3 to 6 years)*: 1 teaspoonful (5 ml) 3 or 4 times daily. *(7 to 12 years) 2 teaspoonsful (10 ml) 3 or 4 times daily. (under 3 years)*: safe dosage has not been established. *Adults*: 1 tablespoonful (15 ml) every 4 hours as needed.
Full directions for use should be read before administering or prescribing.
For information on symptoms/treatment of overdosage, see full prescribing information.

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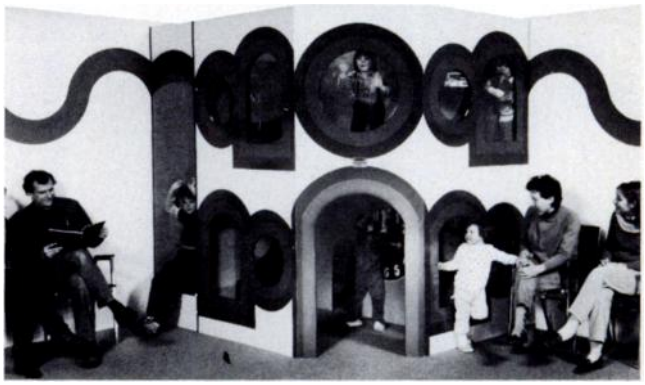

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in children*
*caused by susceptible strains of *Hemophilus influenzae* (including ampicillin-resistant strains)
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(200 mg erythromycin activity and the equivalent of 600 mg sulfisoxazole per 5 ml)
Please see adjacent column for brief summary of prescribing information.

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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 erythomycin 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).

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Robitussin®

the tradition continues

In therapy, tradition is based on effectiveness. And, Robitussin has been an effective part of URI therapy for over 40 years. That's why the tradition continues...in four formulations.

ROBITUSSIN® Expectorant cough formula.
ROBITUSSIN-DM® Expectorant-cough suppressant formula.
ROBITUSSIN-PE® Expectorant-decongestant formula.
ROBITUSSIN-CF® Expectorant-nasal decongestant-cough suppressant formula.

A·H·ROBINS
Consumer Products Division
Richmond, Virginia 23230

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's absorption through the skin is minimal,[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.[2,3]

This study demonstrates that absorption of lindane through the scalp is up to six times greater than in other body areas.[3,4] And children, the usual victims of head lice, may have an even higher rate of absorption than adults.[5]

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).[4,6] But unlike lindane, RID is minimally absorbed[1] and carries little risk of toxicity.

Pfizer

Pfipharmecs Division

New York, NY 10017

Recognized by leading medical authorities as safe and effective

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]

The AMERICAN ACADEMY OF PEDIATRICS calls the active ingredients in RID effective in the treatment of lice and with less potential toxicity than lindane.[9]

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.[7] 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 comb specifically designed to remove all nits from the hair quickly and easily. Scientific tests have proven this comb to be 12 times more effective than the combs included with other pediculicides.[10] The exclusive RID nit comb completes the treatment process and prevents reinfestation of treated persons and the spread of lice to others.

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 the exclusive RID nit comb making it the most effective treatment kit available.

References

1. Pfizer Inc.—Data on file. 2. Gamma benzene hexachloride (Kwell and other products) alert. *FDA Drug Bulletin* 6:28, 1976. 3. Feldmann RJ, Maibach HI: Percutaneous penetration of some pesticides and herbicides in man. *Toxicol Appl Pharmacol* 28:126, 1974. 4. Robinson DH, Shepherd DA: Control of head lice in school children. *Curr Ther Res* 27:1, 1980. 5. Felman YM, Nikitas JA: Adverse drug reactions: Part 2. The less common sexually transmitted diseases. *Sex Med Today* 22:14, 1981. 6. Pfizer Inc.—Data on file. 7. *Federal Register* 47(125):28315, June 29, 1982. 8. American Medical Association, Council on Drugs: AMA Drug Evaluations, 5th ed, 1983, p. 1855. 9. American Academy of Pediatrics: Report of the Committee on Infectious Diseases. 19th ed, AAP, Evanston, IL, 1982, p. 176. 10. Pfizer Inc.—Data on file.

Strong enough for lice, safe enough for children

New

Pedia Care™

Children's Cold Relief

For coughs

PediaCare 1

Contains dextromethorphan HBr (5 mg/5 ml).

For nasal congestion and discharge

PediaCare 2

Contains pseudoephedrine HCl (15 mg/5 ml) and chlorpheniramine maleate (1 mg/5 ml).

For nasal congestion and discharge, cough

PediaCare 3

Contains pseudoephedrine HCl (15 mg/5 ml), chlorpheniramine maleate (1 mg/5 ml) and dextromethorphan HBr (5 mg/5 ml). Also in chewable tablets.

customized cold relief just for children

Treats presenting symptoms only

New *PediaCare*™ Children's Cold Relief is a unique line of nonprescription cold medications that allows you to easily tailor your treatment to a child's presenting symptoms. There's *PediaCare* 1 for coughs, *PediaCare* 2 for nasal congestion and discharge and *PediaCare* 3 for all three symptoms. With a choice of three different formulas, children get only the medication they need. And, of course, *PediaCare* is alcohol-free.

Promotes accurate, easy dosing

PediaCare products are formulated in pediatric concentrations. This provides greater accuracy in measuring the precise amount of medicine for a wide range of children's ages and weights. A calibrated dosage cup clearly marked at half teaspoon intervals is attached to each bottle enabling parents to easily measure the correct dose.

Enhances patient compliance

All *PediaCare* products are very pleasant tasting which helps children take all their medicine, ensuring they get the correct dose. To make it easy for parents, each package is color-coded and clearly labeled with both its ingredients and symptoms treated.

Recommend new *PediaCare*. It's the one line of cold medications customized for accurate, easy treatment of a child's cold.

McNeil Consumer Products Company
Fort Washington, PA 19034
McNEIL


Introducing
Heinz
Instant Baby Food
New!
HEINZ
Instant Baby Food
Peaches
JUST ADD WATER
WT. 1.25 OZ (35g)
HNQ-345/84

Nutritious flakes mixed with water... fresh at every meal

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

With dehydrated, flaked Heinz Instant Baby Foods parents mix only as much as baby needs, fresh at every meal, so there are no jarred leftovers to be refrigerated and sometimes thrown away. And less waste means greater value for parents. In addition, by using 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 at least two to four servings each, so they're easy to carry and convenient for traveling. The foil-lined canisters close tightly with a resealable 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.

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 baby foods. There is a complete line of 23 delicious varieties of Heinz Instant Baby Foods, including fruits, vegetables, dinners, cereals with fruit, and fruit combinations.

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.

Available in limited areas.

New Heinz Instant Baby Food

A fresh approach to infant nutrition

Heinz

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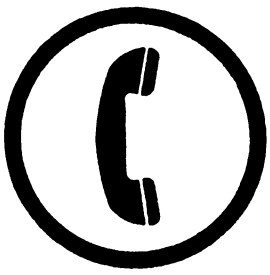

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Your company can help us prevent child abuse.

One of the tragic aspects of child abuse is that it doesn't have to happen.

The National Committee for Prevention of Child Abuse knows how child abuse can be prevented.

But we need your company's help to do it. We need help in two ways.

The first involves educating your employees to the causes and prevention of child abuse—through literature which we can make available.

The second way involves helping us set up additional prevention facilities—through the donation of money in your company's name.

The National Committee for Prevention of Child Abuse is a private, charitable organization. In the last seven years we've made great strides in the prevention of child abuse.

But the problem is still enormous. We need your help. Please mail the attached coupon today.

And help us put an end to child abuse.

Help us get to the heart of the problem.

Write: National Committee for Prevention of Child Abuse
Box 2866, Chicago, Illinois 60690

☐ Please send us information on how we can help.

☐ We want to start helping right now. Enclosed is a check for $_____

NAME _____

TITLE _____ COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

National Committee for Prevention of Child Abuse®

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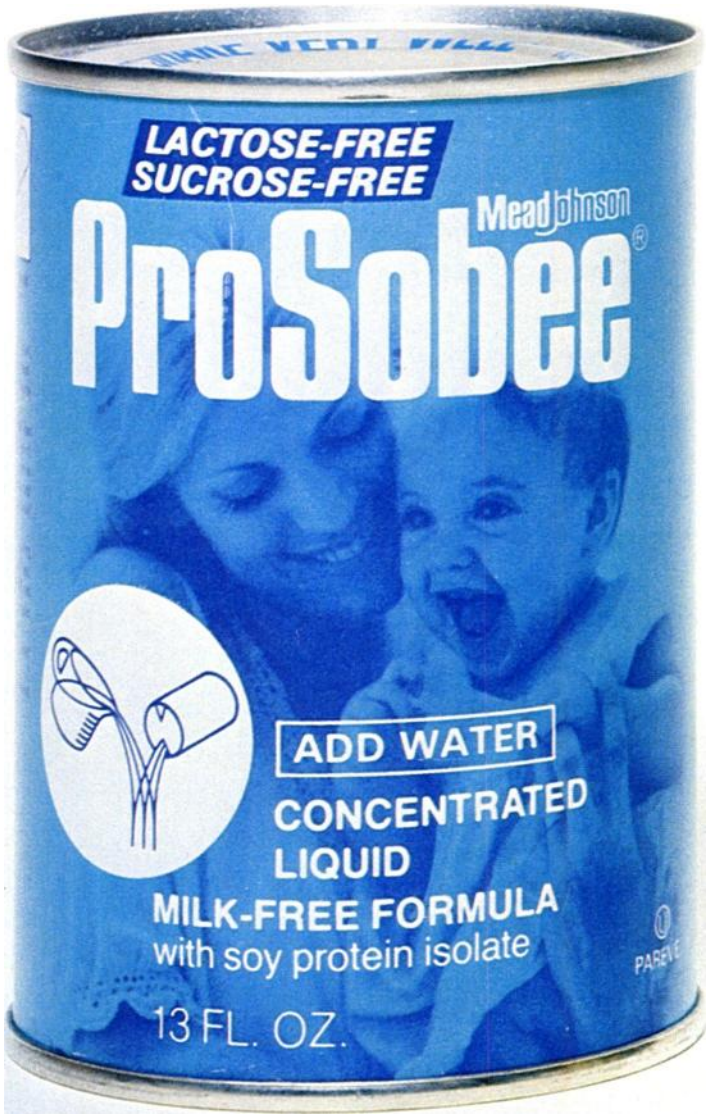
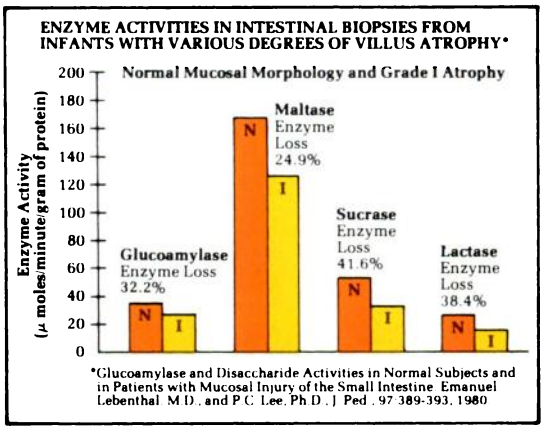
When Making Your Next Soy Formula Specification:



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.

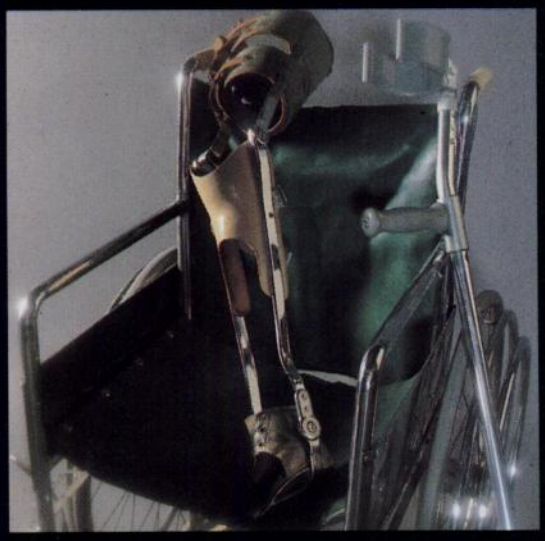
The carbohydrate in ProSobee is 100% glucose polymers*—the most compatible carbohydrate because it avoids reliance on the more fragile brush border enzymes.

LACTOSE-FREE
SUCROSE-FREE
ProSobee®
with 100% glucose polymers

for everyday feeding problems associated with milk sensitivity

Mead Johnson
NUTRITIONAL DIVISION

Remember Polio?



Help keep it a memory.

Orimune®

Poliovirus Vaccine, Live, Oral, Trivalent

Please see following page for brief summary of prescribing information.

Poliovirus Vaccine,
Live, Oral Trivalent ORIMUNE®

INDICATIONS

For prevention of poliomyelitis caused by Poliovirus Types 1, 2, and 3. For complete indications and usage statement, see package insert.

CONTRAINDICATIONS

Under no circumstances should this vaccine be administered parenterally.

Administration of the vaccine should be postponed or avoided in those experiencing any acute illness and in those with any advanced debilitated condition or persistent vomiting or diarrhea.

ORIMUNE *MUST NOT* BE ADMINISTERED TO PATIENTS WITH IMMUNE DEFICIENCY DISEASES SUCH AS COMBINED IMMUNODEFICIENCY, HYPOGAMMAGLOBULINEMIA AND AGAMMAGLOBULINEMIA. IT WOULD ALSO BE PRUDENT TO WITHHOLD ORIMUNE FROM SIBLINGS OF A CHILD KNOWN TO HAVE AN IMMUNODEFICIENCY SYNDROME. FURTHER, ORIMUNE *MUST NOT* BE ADMINISTERED TO PATIENTS WITH ALTERED IMMUNE STATES SUCH AS THOSE OCCURRING IN THYMIC ABNORMALITIES, LEUKEMIA, LYMPHOMA OR GENERALIZED MALIGNANCY OR BY LOWERED RESISTANCE FROM THERAPY WITH CORTICOSTEROIDS, ALKYLATING DRUGS, ANTIMETABOLITES OR RADIATION. ALL PERSONS WITH ALTERED IMMUNE STATUS SHOULD AVOID CLOSE HOUSEHOLD-TYPE CONTACT WITH RECIPIENTS OF THE VACCINE FOR AT LEAST 6-8 WEEKS. IPV IS PREFERRED FOR IMMUNIZING ALL PERSONS IN THIS SETTING.

PRECAUTIONS

Other viruses (including poliovirus and other enterovirus) may interfere with the desired response to this vaccine, since their presence in the intestinal tract may interfere with the replication of the attenuated strains of poliovirus in the vaccine.

It would seem prudent not to administer TOPV shortly after Immune Serum Globulin (ISG) unless such a procedure is unavoidable, for example, with unexpected travel to or contact with epidemic areas or endemic areas. If TOPV is given with or shortly after ISG, the dose probably should be repeated after three months, if immunization is still indicated. However, ISG may not interfere with immunization with TOPV.

The vaccine is not effective in modifying or preventing cases of existing and/or incubating poliomyelitis.

Use in Pregnancy

Although there is no convincing evidence documenting adverse effects of either TOPV or IPV on the developing fetus or pregnant woman, it is prudent on theoretical grounds to avoid vaccinating pregnant women. However, if immediate protection against poliomyelitis is needed, TOPV is recommended. (See CONTRAINDICATIONS and ADVERSE REACTIONS.)

ADVERSE REACTIONS

PARALYTIC DISEASE FOLLOWING THE INGESTION OF LIVE POLIOVIRUS VACCINES HAS BEEN, ON RARE OCCASION, REPORTED IN INDIVIDUALS RECEIVING THE VACCINE, (SEE FOR EXAMPLE CONTRAINDICATIONS) AND IN PERSONS WHO WERE IN CLOSE CONTACT WITH VACCINEES. THE VACCINE VIRUSES ARE SHED IN THE VACCINEE'S STOOLS FOR AT LEAST 6 TO 8 WEEKS AS WELL AS VIA THE PHARYNGEAL ROUTE. MOST REPORTS OF PARALYTIC DISEASE FOLLOWING INGESTION OF THE VACCINE OR CONTACT WITH A RECENT VACCINEE ARE BASED ON EPIDEMIOLOGICAL ANALYSIS AND TEMPORAL ASSOCIATION BETWEEN VACCINATION OR CONTACT AND THE ONSET OF SYMPTOMS. MOST AUTHORITIES BELIEVE THAT A CAUSAL RELATIONSHIP EXISTS. THE RISK OF VACCINE-ASSOCIATED PARALYSIS IS EXTREMELY SMALL FOR VACCINEES, SUSCEPTIBLE FAMILY MEMBERS AND OTHER CLOSE PERSONAL CONTACTS. HOWEVER, PRIOR TO ADMINISTRATION OF THE VACCINE, THE ATTENDING PHYSICIAN SHOULD WARN OR SPECIFICALLY DIRECT PERSONNEL ACTING UNDER HIS AUTHORITY TO CONVEY THE WARNINGS TO THE VACCINEE, PARENT, GUARDIAN OR OTHER RESPONSIBLE PERSON OF THE POSSIBILITY OF VACCINE-ASSOCIATED PARALYSIS. THE CENTERS FOR DISEASE CONTROL REPORT THAT DURING THE YEARS 1969 THROUGH 1980 APPROXIMATELY 290 MILLION DOSES OF TOPV WERE DISTRIBUTED IN THE UNITED STATES. IN THE SAME 12 YEARS, 25 "VACCINE-ASSOCIATED" AND 55 "CONTACT VACCINE-ASSOCIATED" PARALYTIC CASES WERE REPORTED. TWELVE OTHER "VACCINE-ASSOCIATED" CASES HAVE BEEN REPORTED IN PERSONS (RECIPIENTS OR CONTACTS) WITH IMMUNE DEFICIENCY CONDITIONS. THESE STATISTICS DO NOT PROVIDE A SATISFACTORY BASIS FOR ESTIMATING THESE RISKS ON A PER PERSON BASIS.

WHEN THE ATTENUATED VACCINE STRAINS ARE TO BE INTRODUCED INTO A HOUSEHOLD WITH ADULTS WHO HAVE NOT BEEN ADEQUATELY VACCINATED OR WHOSE IMMUNE STATUS CANNOT BE DETERMINED, THE RISK OF VACCINE-ASSOCIATED PARALYSIS CAN BE MINIMIZED BY GIVING THESE ADULTS THREE DOSES OF IPV A MONTH APART BEFORE THE CHILDREN RECEIVE ORIMUNE. THE CDC REPORTS THAT NO PARALYTIC REACTIONS TO IPV ARE KNOWN TO HAVE OCCURRED SINCE THE 1955 CLUSTER OF POLIOMYELITIS CASES CAUSED BY VACCINE THAT CONTAINED LIVE POLIOVIRUSES THAT HAD ESCAPED INACTIVATION.

THE IMMUNIZATION PRACTICES ADVISORY COMMITTEE OF THE U.S. PUBLIC HEALTH SERVICE STATES: "BECAUSE OF THE OVERRIDING IMPORTANCE OF ENSURING PROMPT AND COMPLETE IMMUNIZATION OF THE CHILD AND THE EXTREME RARITY OF OPV-ASSOCIATED DISEASE IN CONTACTS, THE COMMITTEE RECOMMENDS THE ADMINISTRATION OF OPV TO A CHILD REGARDLESS OF THE POLIOVIRUS-VACCINE STATUS OF ADULT HOUSEHOLD CONTACTS. THIS IS THE USUAL PRACTICE IN THE UNITED STATES. THE RESPONSIBLE ADULT SHOULD BE INFORMED OF THE SMALL RISK INVOLVED. AN ACCEPTABLE ALTERNATIVE, IF THERE IS STRONG ASSURANCE THAT ULTIMATE, FULL IMMUNIZATION OF THE CHILD WILL NOT BE JEOPARDIZED OR UNDULY DELAYED, IS TO IMMUNIZE ADULTS ACCORDING TO THE SCHEDULE OUTLINED ABOVE BEFORE GIVING OPV TO THE CHILD."

The Immunization Practices Advisory Committee has concluded that "Oral polio vaccine remains the vaccine of choice for primary immunization of Children."

Lederle Laboratories A Division of American Cyanamid Company Wayne, New Jersey 07470 931-4

Caring for the Young Athlete

As children and adolescents become more active in sports, you need a guide that has answers to common and special sports medicine problems.

The American Academy of Pediatrics' book, *Sports Medicine: Health Care for Young Athletes,* provides you with this needed information—with guidelines on care.

The book discusses prevention and management of sports-related illness and injuries. Other chapters deal with nutrition, stress reduction, and the role of the athletic trainer.

This book is for every physician who has been or will be involved in sports medicine. As an advisor to parents. As a team physician. As the parent of a young athlete from elementary school through high school.

American Academy of Pediatrics

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

Please send me _____ copies of *Sports Medicine: Health Care for Young Athletes* @ $15.00 each.
☐ Payment of $_____ enclosed.
☐ Bill me. Formal purchase order required.
☐ Bill me for UPS delivery within 2 weeks.

Name _____

Address _____

City _____ State _____ Zip _____

☐ AAP Member ☐ Non-member

PED

ENTEX® LIQUID

DESCRIPTION:
Each 5 ml (one teaspoonful) for oral administration contains

phenylephrine hydrochloride	5 mg
phenylpropanolamine hydrochloride	20 mg
guaifenesin	100 mg
alcohol	5%

INDICATIONS AND USAGE: ENTEX LIQUID is indicated for the symptomatic relief of sinusitis, bronchitis, pharyngitis, and coryza when these conditions are associated with nasal congestion and inspissated mucus in the lower respiratory tract.

CONTRAINDICATIONS: ENTEX LIQUID is contraindicated in individuals with hypersensitivity to sympathomimetics, severe hypertension, or in patients receiving monoamine oxidase inhibitors.

WARNINGS: Sympathomimetic amines should be used with caution in patients with hypertension, diabetes mellitus, heart disease, peripheral vascular disease, increased intraocular pressure, hyperthyroidism, or prostatic hypertrophy.

PRECAUTIONS: Drug Interactions: ENTEX LIQUID should not be used in patients taking monoamine oxidase inhibitors or other sympathomimetics.

Drug/Laboratory Test Interactions: Guaifenesin has been reported to interfere with clinical laboratory determinations of urinary 5-hydroxyindoleacetic acid (5-HIAA) and urinary vanilmandelic acid (VMA).

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

Nursing Mothers: It is not known whether the drugs in ENTEX LIQUID are excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants, a decision should be made whether to discontinue nursing or to discontinue the product, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness of ENTEX LIQUID in children below the age of 2 have not been established.

ADVERSE REACTIONS: Possible adverse reactions include nervousness, insomnia, restlessness, headache, nausea, or gastric irritation. These reactions seldom, if ever, require discontinuation of therapy. Urinary retention may occur in patients with prostatic hypertrophy.

OVERDOSAGE: The treatment of overdosage should provide symptomatic and supportive care. If the amount ingested is considered dangerous or excessive, induce vomiting with ipecac syrup unless the patient is convulsing, comatose, or has lost the gag reflex, in which case perform gastric lavage using a large-bore tube. If indicated, follow with activated charcoal and a saline cathartic.

DOSAGE AND ADMINISTRATION:
All dosage should be administered four times daily (every 6 hours).

Children:	
2 to under 4 years	½ teaspoonful (2.5 ml)
4 to under 6 years	1 teaspoonful (5.0 ml)
6 to under 12 years	1½ teaspoonfuls (7.5 ml)
Adults and children 12 years of age and older	2 teaspoonfuls (10.0 ml)

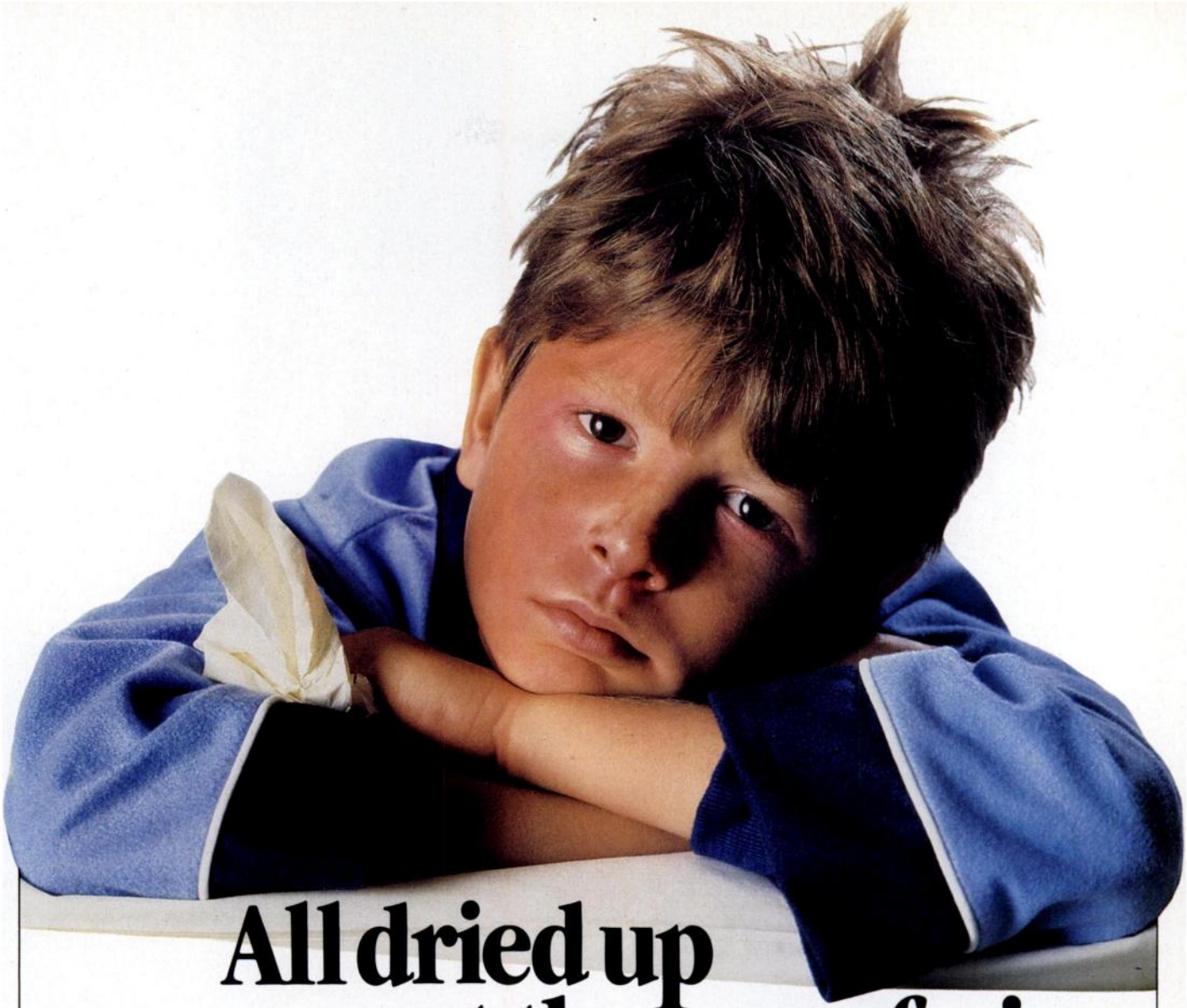
HOW SUPPLIED: ENTEX LIQUID is available as an orange-colored, pleasant-tasting liquid.

NDC 0149-0414-16 16 FL. OZ. (1 Pint) bottle

CAUTION: Federal law prohibits dispensing without prescription.

(ENXLQ-BS3)
REVISED MARCH 1984

Norwich Eaton Pharmaceuticals, Inc.
Norwich, New York 13815
A Procter & Gamble Company



All dried up at the age of nine

(from too many days on antihistamines)

Because antihistamines can make matters worse for children with upper respiratory or bronchial congestion by drying secretions so they become thickened, slow-moving, and difficult to expel.

Which is just what good-tasting Children's Entex® Liquid is designed to avoid.

How you can help.

Entex Liquid decongests swollen nasal passages to promote drainage and freer breathing.

And it thins bronchial secretions to make coughs productive.

With *no* drying antihistamines.

Just decongestion and drainage. Because most kids don't need that other stuff.

ANTIHISTAMINE-FREE

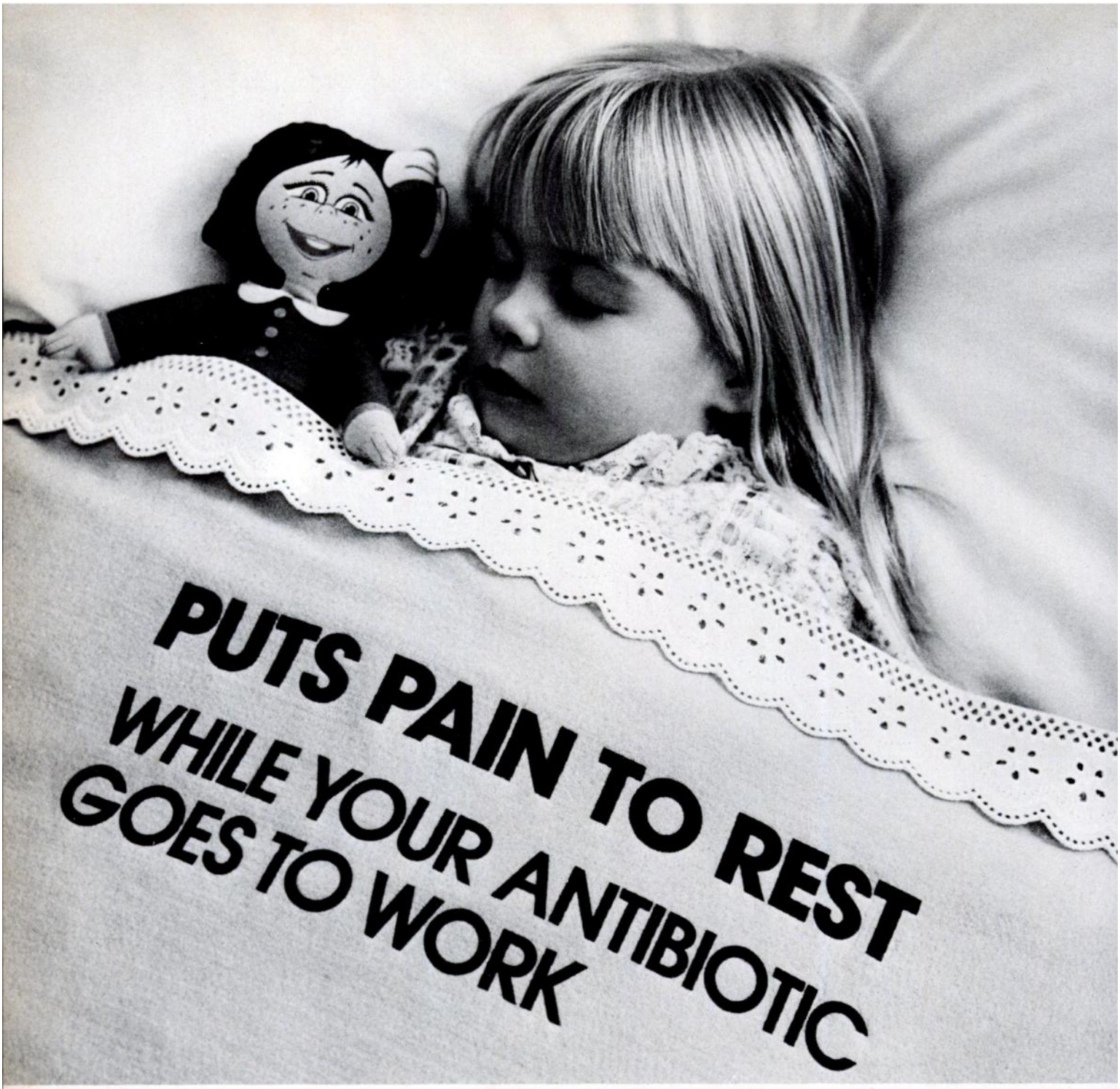
Entex® LIQUID

Each 5 ml (one teaspoonful) contains:

PHENYLEPHRINE HYDROCHLORIDE	5 mg
PHENYLPROPANOLAMINE HYDROCHLORIDE	20 mg
GUAIFENESIN	100 mg
ALCOHOL	5%

Decongestion and drainage, without drying and drowsiness

For samples write:
Entex Liquid Sample Offer
Norwich Eaton Pharmaceuticals, Inc.
P.O. Box 231
Norwich, New York 13815



PUTS PAIN TO REST WHILE YOUR ANTIBIOTIC GOES TO WORK

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

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

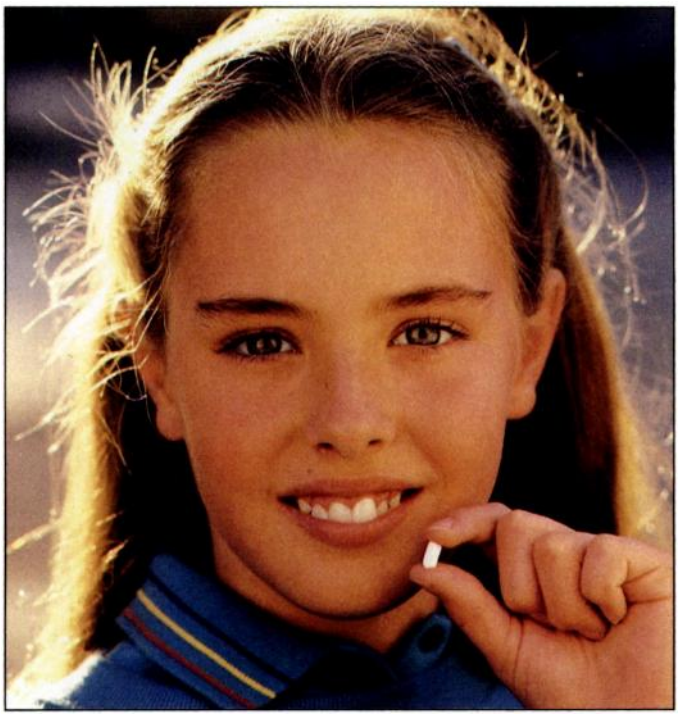
CHILDREN'S TYLENOL® CHEWABLE TABLETS
(80 mg/tablet)
For younger school-age children

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

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Fort Washington, PA 19034

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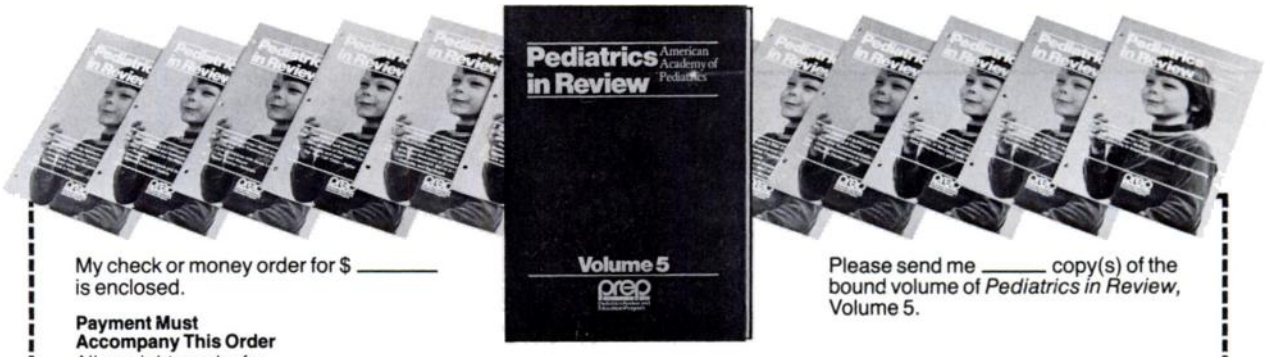

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Ritalin is indicated as adjunctive therapy to other remedial measures (psychological, educational, social) for ADD in children. Drug treatment is not indicated for all children with ADD. Stimulants are not intended for use in the child who exhibits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

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

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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

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Tablets

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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)

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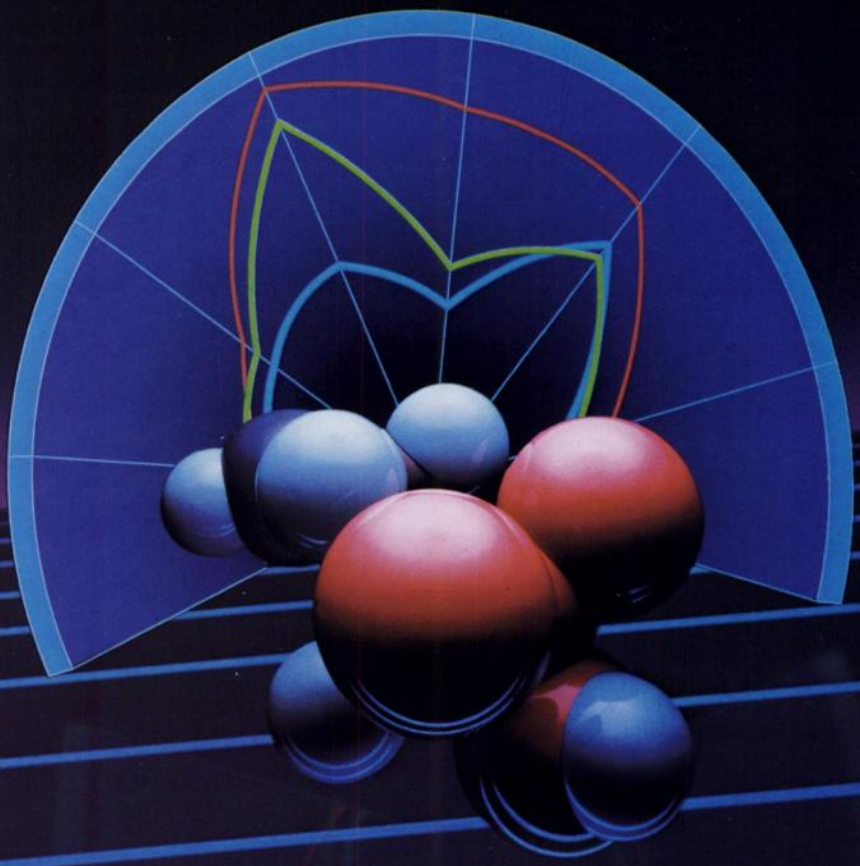
CIBA



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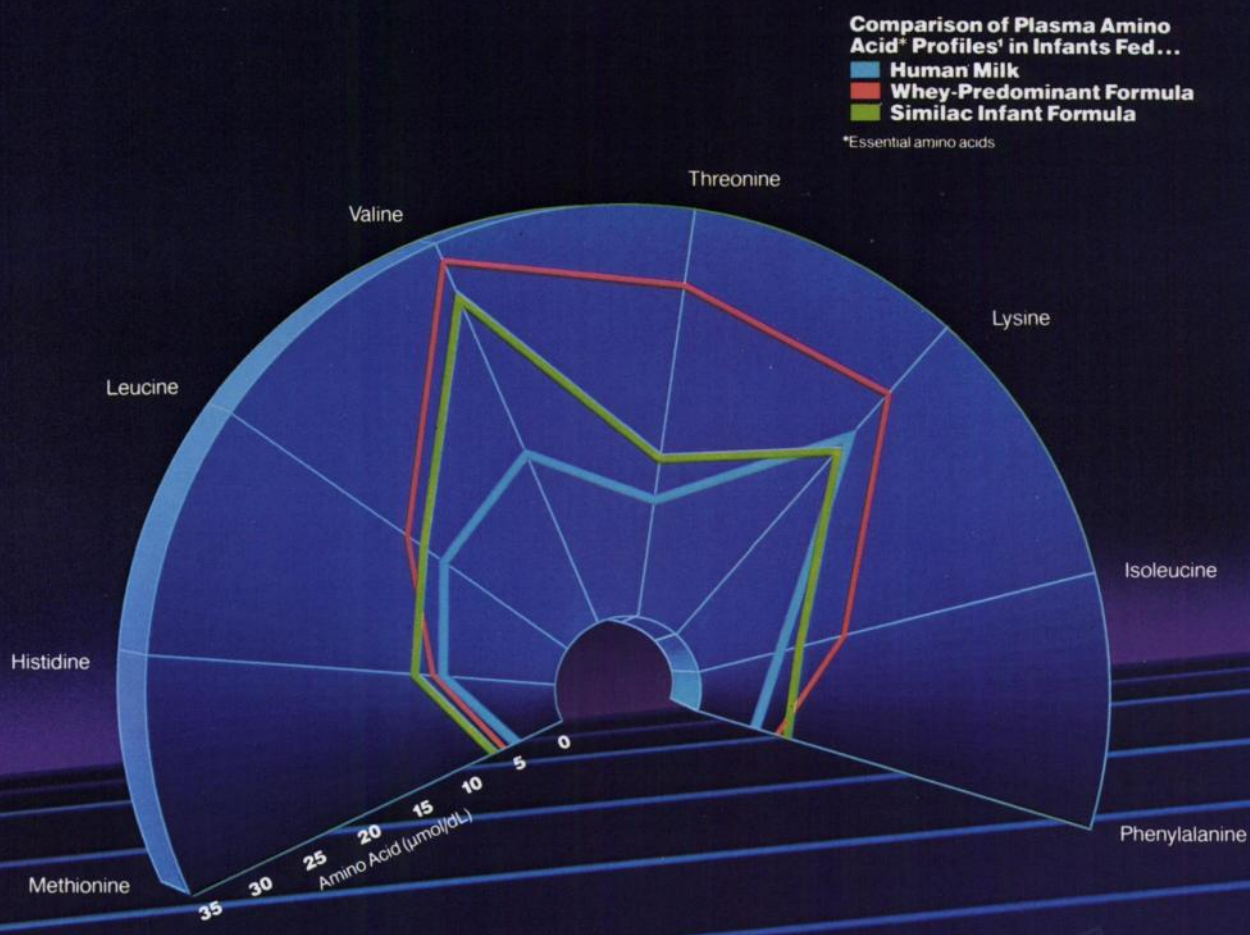
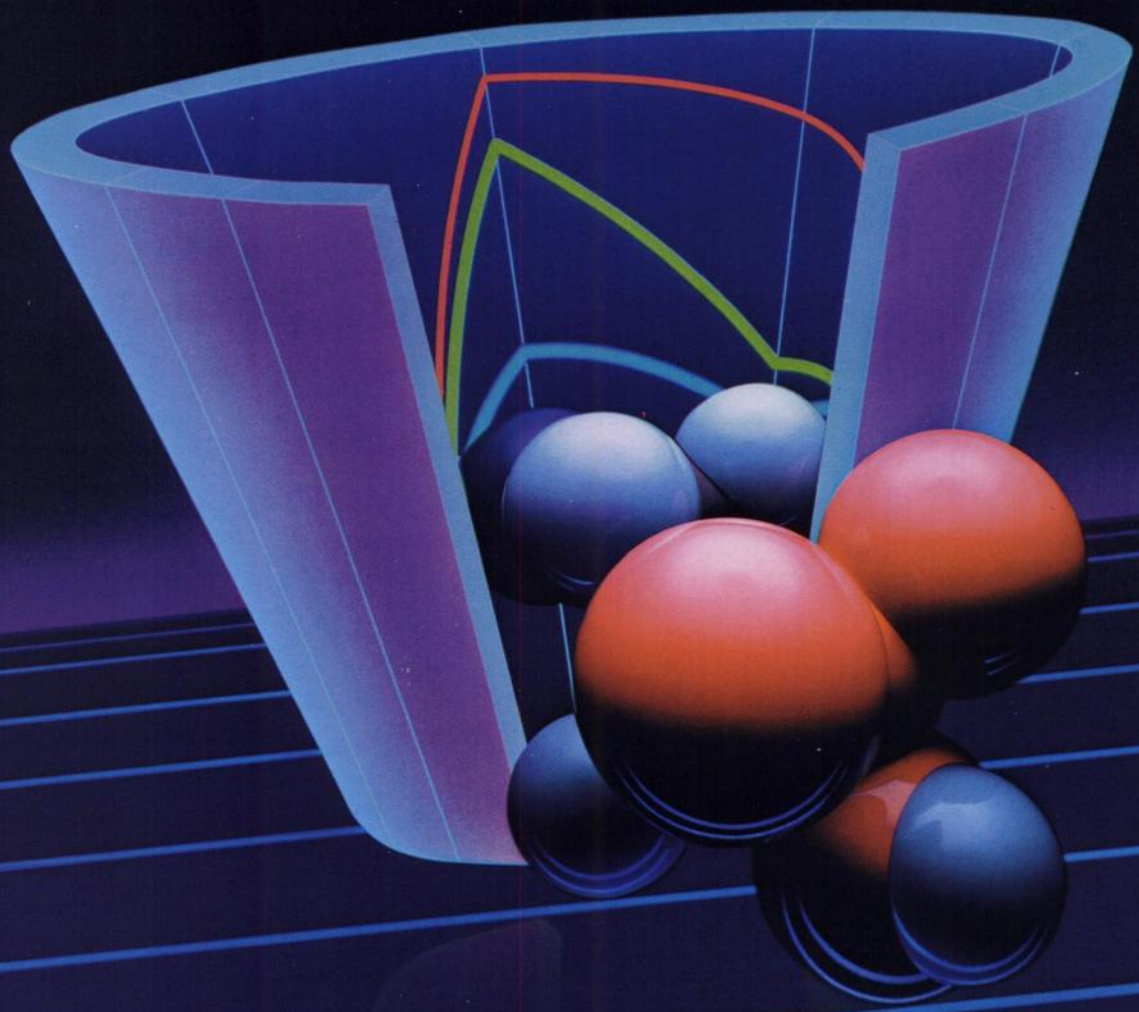


New clinical evidence establishes that the plasma amino acid profile of infants fed Similac is closest to that of breast-fed infants.[1]

Amino acids have many important functions in infancy, especially in the central nervous system. For optimal development, amino acid metabolism of the formula-fed infant should be as close as possible to that of the breast-fed infant, the nutritional norm.[2-5]

Taurine fortification—closest to mother's milk.



Recent research supports the fortification of Similac with taurine.[6-10]

Fortification affords the same benefits of taurine to infants fed Similac that breast-fed infants get from taurine naturally. Similac is the only milk-based formula that contains 6.6 mg of taurine per 100 Cal, an amount closest to the mean in human milk.[11]

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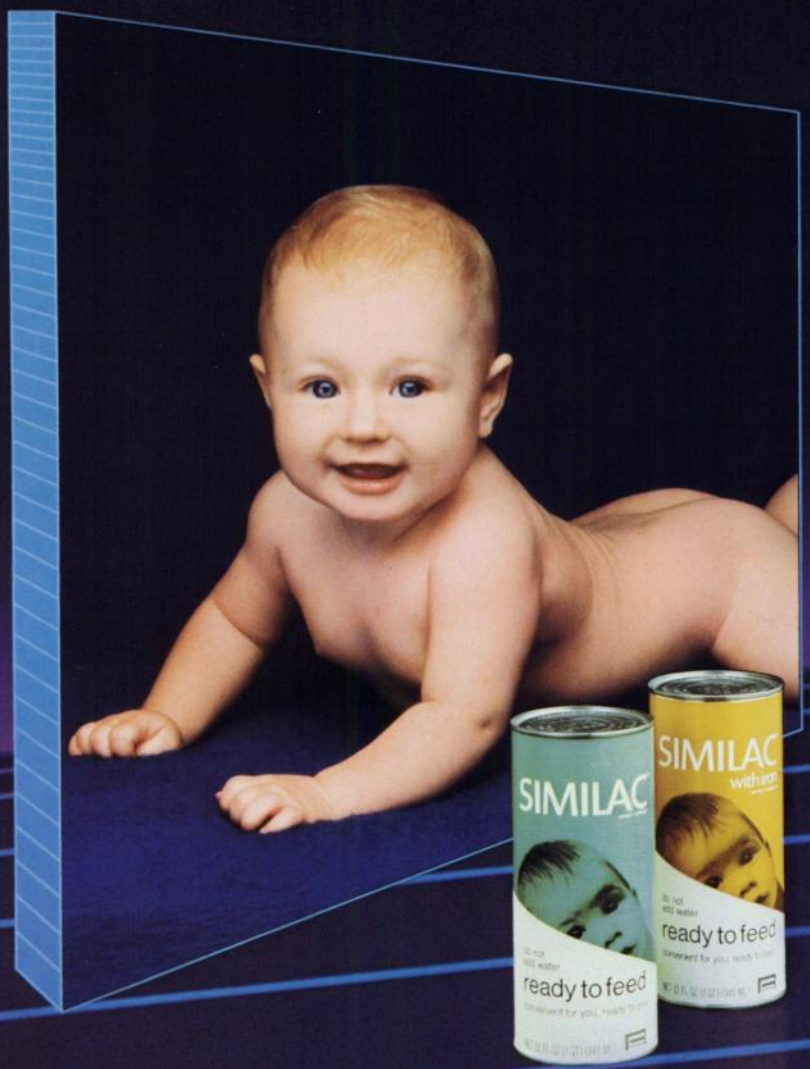

Plasma amino acid profile closest to mother's milk.

Taurine fortification closest to mother's milk.

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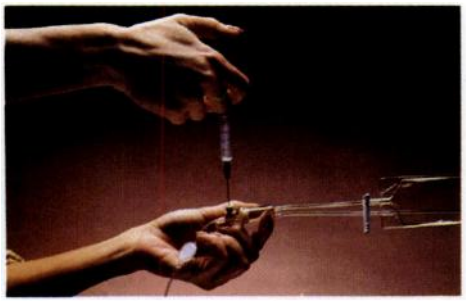

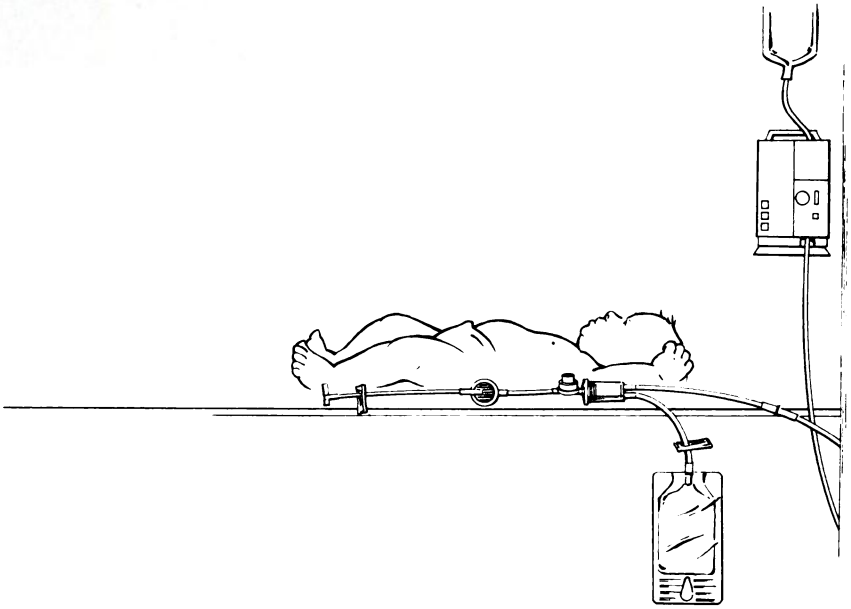

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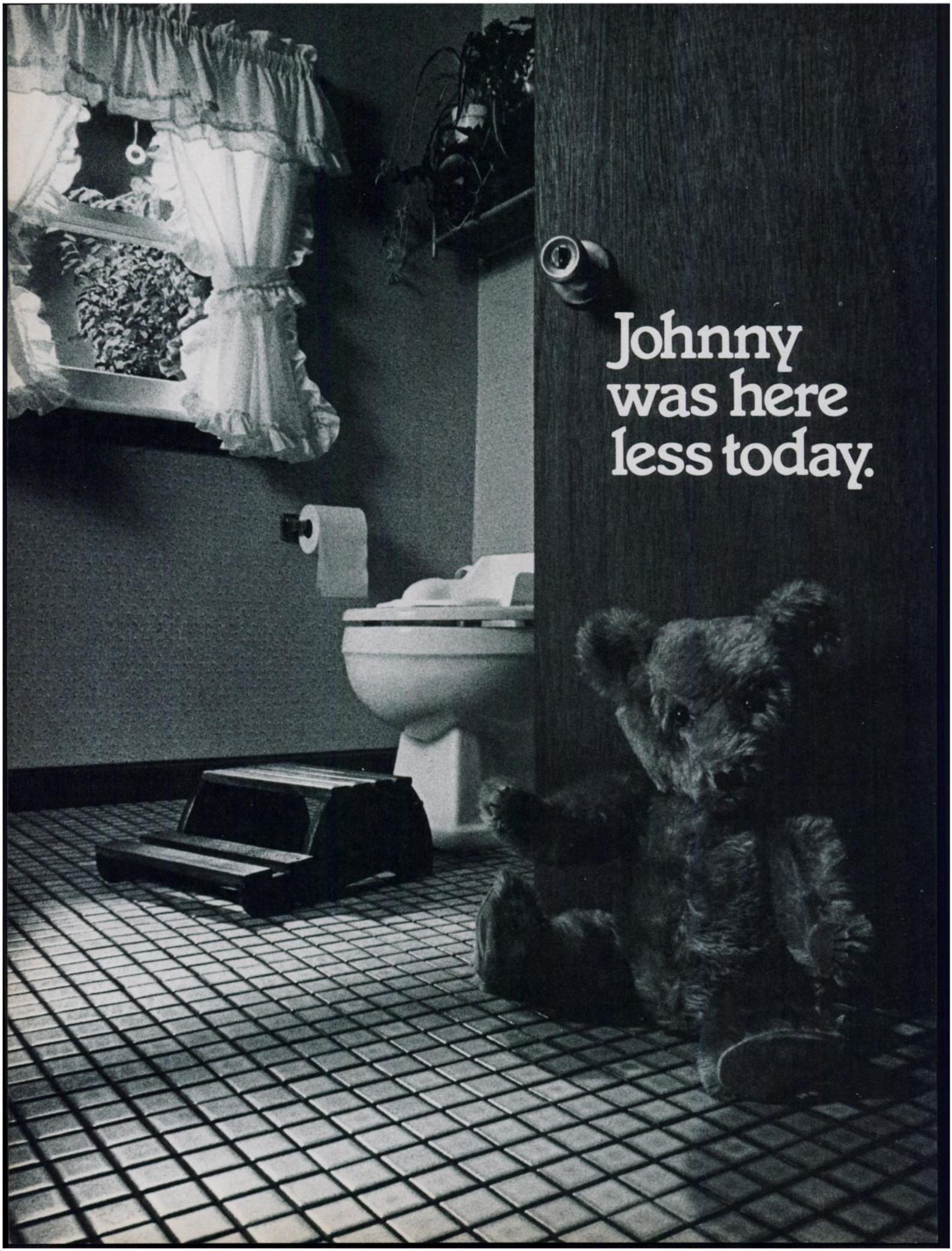
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How to start...first-day dosage guidelines

(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.

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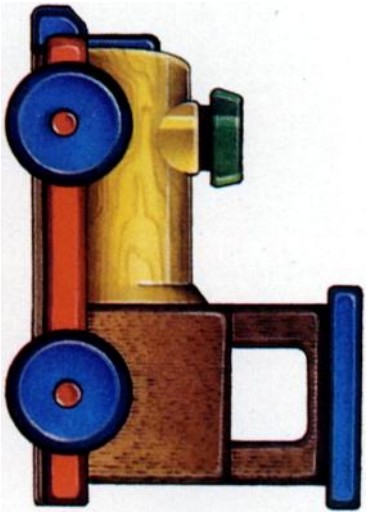

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Plus, little extras that mean extra safety. And convenience. A graduated spoon is included to make measuring more accurate and spills practically impossible. Dosing shown by age—and by weight. Tamper-evident packaging and child-resistant caps.

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Dorcol® Children's Cough Syrup

DESCRIPTION: Each teaspoonful (5 ml) of DORCOL Children's Cough Syrup contains pseudoephedrine hydrochloride 15 mg, guaifenesin 50 mg and dextromethorphan hydrobromide 5 mg. Inactive ingredients: alcohol (5%), benzoic acid, edetate disodium, FD&C Blue No. 1, FD&C Red No. 40, flavors, purified water, saccharin sodium, sodium hydroxide, sucrose, tartaric acid.

INDICATIONS: Provides prompt relief of cough and nasal congestion due to the common cold. The expectorant component helps loosen bronchial secretions. The decongestant, expectorant and antitussive are provided in an antihistamine-free formula.

CONTRAINDICATIONS: Hypersensitivity to any of the ingredients. The use of sympathomimetic agents such as pseudoephedrine hydrochloride is contraindicated in patients with severe hypertension, severe coronary artery disease or in those taking monoamine oxidase inhibitors.

PRECAUTIONS: Exercise prescribing caution in patients with persistent or chronic cough such as occurs with chronic bronchitis or bronchial asthma. Use with caution in patients with hypertension, hyperthyroidism, cardiovascular disease, diabetes mellitus, elevated intraocular pressure or prostatic hypertrophy.

ADVERSE REACTIONS: Occasional blurred vision, cardiac palpitations, flushing, gastrointestinal upsets, nervousness, dizziness, or sleeplessness may occur.

DOSAGE AND ADMINISTRATION: Children 6-12 years—2 teaspoonfuls every 4 hours. Children 2-6 years—1 teaspoonful every 4 hours. The suggested dosage for pediatric patients 3 months to under 12 months of age is 3 drops per kilogram of body weight administered every 4 hours. The suggested dosage for patients 12 months to under 24 months of age is 7 drops (0.2 ml) per kilogram of body weight administered every 4 hours. A maximum of 4 doses per 24 hours is recommended.

HOW SUPPLIED: DORCOL Children's Cough Syrup (grape colored) in 4 fl oz and 8 fl oz plastic bottles with tamper-evident band around child-resistant cap.

Dorcol® Children's Liquid Cold Formula

DESCRIPTION: Each teaspoonful (5 ml) of DORCOL Children's Liquid Cold Formula contains pseudoephedrine hydrochloride 15 mg and chlorpheniramine maleate 1 mg. Inactive ingredients: benzoic acid, D&C Yellow No. 10, FD&C Blue No. 1, FD&C Red No. 40, flavors, purified water, sorbitol solution, sucrose.

INDICATIONS: Provides temporary relief of nasal congestion due to the common cold, hay fever or other upper respiratory allergies, or associated with sinusitis. For relief of sneezing and rhinorrhea as may occur in allergic rhinitis. Promotes nasal and sinus drainage.

CONTRAINDICATIONS: Hypersensitivity to any of the ingredients. The use of sympathomimetic agents such as pseudoephedrine hydrochloride is contraindicated in patients with severe hypertension, severe coronary artery disease or in those taking monoamine oxidase inhibitors.

PRECAUTIONS: Exercise prescribing caution in patients with hypertension, cardiovascular disease, diabetes mellitus, hyperthyroidism, elevated intraocular pressure, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, bladder neck obstruction, angle-closure glaucoma, or bronchial asthma.

ADVERSE REACTIONS: Drowsiness, blurred vision, palpitations, flushing, gastrointestinal upsets, nervousness, dizziness, or sleeplessness may occur. May cause excitability especially in children.

DOSAGE AND ADMINISTRATION:

By age:

Children 6 to 12 years:	2 teaspoonfuls

By weight:

Children 45 to 85 pounds:	2 teaspoonfuls

The suggested dosage for pediatric patients 3 months to under 12 months of age is 2 drops per kilogram of body weight. The suggested dosage for patients 12 months to under 24 months of age is 5 drops (0.2 ml) per kilogram of body weight. The suggested dosage for patients 2 years to under 6 years is 1 teaspoonful.

Give dose every 4 to 6 hours. A maximum of 4 doses per 24 hours is recommended.

HOW SUPPLIED: DORCOL Children's Liquid Cold Formula (light brown) in 4 fl oz bottles with tamper-evident band around child-resistant cap.

Dorcol® Children's Decongestant Liquid

DESCRIPTION: Each teaspoonful (5 ml) of DORCOL Children's Decongestant Liquid contains pseudoephedrine hydrochloride 15 mg. Inactive ingredients: benzoic acid, D&C Yellow No. 10, edetate disodium, FD&C Yellow No. 6, flavors, purified water, sodium hydroxide, sorbitol solution, sucrose.

INDICATIONS: Provides temporary relief of nasal congestion due to the common cold, hay fever or other upper respiratory allergies, or associated with sinusitis. Promotes nasal and sinus drainage.

CONTRAINDICATIONS: Hypersensitivity to any of the components. The use of sympathomimetic agents such as pseudoephedrine hydrochloride is contraindicated in patients with severe hypertension, severe coronary artery disease or in those taking monoamine oxidase inhibitors.

PRECAUTIONS: Exercise prescribing caution in patients with hypertension, cardiovascular disease, diabetes mellitus, hyperthyroidism, elevated intraocular pressure or prostatic hypertrophy.

ADVERSE REACTIONS: Mild CNS stimulation, nervousness, dizziness, excitability, weakness, insomnia or restlessness may occur. Large doses may cause lightheadedness, nausea and/or vomiting.

DOSAGE AND ADMINISTRATION:

By age:

Children 2 to under 6 years:	1 teaspoonful
Children 6 years:	2 teaspoonfuls

By weight:

Children 25 to 45 pounds:	1 teaspoonful
Children 46 to 85 pounds:	2 teaspoonfuls

The suggested dosage for pediatric patients 3 months to under 12 months of age is 3 drops per kilogram of body weight. The suggested dosage for patients 12 months to under 24 months of age is 7 drops (0.2 ml) per kilogram of body weight.

Give dose every 4 hours. A maximum of 4 doses per 24 hours is recommended.

HOW SUPPLIED: DORCOL Children's Decongestant Liquid (pale orange) in 4 fl oz bottles with tamper-evident band around child-resistant cap.

Dorcol® Children's Fever & Pain Reducer

DESCRIPTION: Each teaspoonful (5 ml) of DORCOL Children's Fever & Pain Reducer contains acetaminophen 160 mg. Inactive ingredients: alcohol (10%), benzoic acid, edetate disodium, FD&C Red No. 40, flavors, glycerin, polyethylene glycol, povidone, purified water, saccharin sodium, sodium chloride, sorbitol solution, sucrose.

INDICATIONS: Provides analgesic/antipyretic action for infants and children with conditions requiring relief of pain or reduction of fever.

CONTRAINDICATIONS: Hypersensitivity to any of the ingredients. Repeated administration of acetaminophen is contraindicated in patients with anemia or cardiac, pulmonary, renal or hepatic disease.

PRECAUTIONS: Acetaminophen is relatively nontoxic in therapeutic doses. However, it should be used with caution in patients with preexisting anemia, since cyanosis may not be apparent despite very high levels of methemoglobin.

ADVERSE REACTIONS: Acetaminophen has rarely been found to produce any side effects. Sensitivity reactions have been reported.

DOSAGE AND ADMINISTRATION:

By Age:

Children 2 to under 4 years:	1 teaspoonful
Children 4 to under 6 years:	1½ teaspoonfuls
Children 6 years:	2 teaspoonfuls

By Weight:

Children 25 to 35 pounds:	1 teaspoonful
Children 36 to 45 pounds:	1½ teaspoonfuls
Children 46 to 60 pounds:	2 teaspoonfuls

The suggested dosage for pediatric patients 3 months to under 12 months of age is 3 drops per kilogram of body weight. The suggested dosage for patients 12 months to under 24 months of age is 7 drops (0.2 ml) per kilogram of body weight.

Give dose every 4 hours while symptoms persist. A maximum of 5 doses per 24 hours is recommended.

HOW SUPPLIED: DORCOL Children's Fever & Pain Reducer (red) in 4 fl oz bottles with tamper-evident band around child-resistant cap.

Dorcol® Children's Liquid Calcium Supplement

DESCRIPTION: Each teaspoonful (5 ml) of DORCOL Children's Liquid Calcium Supplement contains glubionate calcium 1.8 gm (calcium content 115 mg). Also contains benzoic acid, citric acid, flavors, purified water, saccharin sodium, sorbitol solution, sucrose.

INDICATIONS: As a dietary supplement for the prevention of calcium deficiency which may be associated with childhood growth periods and inadequate dietary intake.

CONTRAINDICATIONS: Hypersensitivity to any of the ingredients. Calcium salts are contraindicated in patients with hypercalcemia or renal calculi.

ADVERSE REACTIONS: DORCOL Children's Liquid Calcium Supplement is exceptionally well tolerated. Gastrointestinal disturbances are rare. Symptoms of hypercalcemia include anorexia, nausea, vomiting, constipation, abdominal pain, dryness of the mouth, thirst and polyuria.

DOSAGE AND ADMINISTRATION: As a dietary supplement for prevention of calcium deficiency.

Dosage	Amount of Calcium Supplied Daily	Percentage of U.S. Recommended Daily Allowance (U.S. RDA)	
		Children 1 to under 4 (800 mg)	Children 4 to 6 (1000 mg)
1 teaspoonful 3 times daily	345 mg	45%	35%
2 teaspoonfuls 3 times daily	690 mg	90%	70%

(Part of need is supplied by diet.)

HOW SUPPLIED: DORCOL Children's Liquid Calcium Supplement (straw yellow) in 4 fl oz bottles with tamper-evident band around child-resistant cap.

Dorsey®
LABORATORIES
Division of Sandoz, Inc.
LINCOLN, NEBRASKA 68501

METABOLIC SCREENING PROGRAM IN JAPAN

A nationwide neonatal screening program for phenylketonuria (PKU), maple syrup urine disease (MSUD), homocystinuria, histidinemia and galactosemia was started in Japan in 1977. The total number of infants screened had reached 6,311,754 by March, 1982. A follow-up study revealed the incidence of the disease in Japan: 1/108,823 for PKU; 1/450,840 for hyperphenylalaninemia (HPA); 1/1,577,939 for biopterin deficiency; 1/525,980 for MSUD: 1/151,959 for homocystinuria; 1/8,371 for histidinemia, and 1/788,969 for galactosemia type 1. The incidences of PKU, HPA, homocystinuria, and galactosemia (type 1) were found to be markedly low in Japan as compared with those in Caucasian countries. There was no great difference in the incidence of MSUD between both. On the other hand, the incidence of histidinemia was higher in Japan. It was found that most of the patients with PKU, HPA, MSUD, homocystinuria, or galactosemia are developing normally due to the early initiation of dietary treatment. These results clearly indicate that the neonatal mass screening program plays a great role in preventing the occurrence of handicapped children.

From Tada K, et al: Follow-up study of a nation-wide neonatal metabolic screening program in Japan (*Eur J Pediatr* 1984;142:204–207).

COMMON MARKET NATIONS HAVE A GLUT OF DOCTORS AND IT WILL GET WORSE

The Common Market nations are faced with a glut of physicians. The students who crowded European medical schools during the prosperous 1960s and 1970s have spilled out into the marketplace, and the oversupply of doctors is creating serious problems, for the health system as well as the individuals concerned. "It seems paradoxical that an excess of doctors now constitutes a major threat to health care," Roger Brearley, a member of the Common Market advisory committee on specialist training, said in a recent lecture at Green College in Oxford, England. But medical officials say symptoms of the oversupply are turning up: overtreatment, lack of experience, and, occasionally, fraud.

The doctor glut varies in severity around the Continent. In Italy, where admission to medical school is unrestricted, a whopping 50,000 doctors are unemployed. In West Germany, unemployed doctors now number about 5,000, up from almost none three years ago, according to a spokeswoman for the German Medical Association. By 1990, she says, the figure is expected to soar to 31,000. Britain has about 1,600 jobless doctors, according to Common Market calculations. The bulge in the European medical population, then, is likely to last—and grow worse—for years to come. "There's nothing you can do about it now," says a Common Market public-health expert. "Some people are saying it will last well into the next century."

From T. K. Smith in *The Wall Street Journal*, Oct 4, 1984, p 36.

THIS END UP
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 is not recommended for use in children under 6 years of age.

THEO-DUR®

SPRINKLE

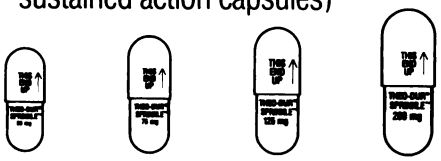
(theophylline anhydrous)

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.

Drug-Food Interactions:
Theo-Dur Sprinkle has not been adequately studied to determine whether its bioavailability is altered when given with food.
Available data suggest that drug administration at the time of food ingestion may influence the absorption characteristics of some or all theophylline controlled-release products resulting in serum values different from those found after administration in the fasting state.
A drug-food effect, if any, would likely have its greatest clinical significance when high theophylline serum levels are being maintained and/or when large single doses (greater than 13 mg/kg or 900 mg) of a controlled-release theophylline product are given. The influence of the type and amount of food on performance of controlled-release theophylline products is under study at this time.

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 09/84

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This course will familiarize pediatricians and family and emergency physicians with the *current management of pediatric crises* and emergencies which may arise in the office, emergency room or on the hospital ward. Workshops include demonstrations of new equipment as well as individual "hands on" supervised practice in intubation, delivery room resuscitation, mechanical ventilation, splinting, bandaging, and initial management of the multiply-injured child.

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When it's a question of growth . . .

Growth disorder testing needn't be stressful to the patient *or* the clinician. Nichols Institute Diagnostics now presents a diagnostic test kit that can virtually rule out growth hormone deficiency and in many cases eliminate the need for time-consuming, and stressful provocative growth hormone testing.

The Nichols Institute Diagnostics Somatomedin-C (SM-C) RIA Kit simplifies screening for growth disorders because a normal SM-C value means that a growth hormone deficiency is highly unlikely. Only those patients with low levels of SM-C need more extensive evaluation.

Nichols Institute Diagnostics has been the leader in the development of Somatomedin-C testing. After eight years of development and five years of clinical use, the SM-C assay has been thoroughly validated. We have established the most extensive normative data for all age groups in both sexes (over 850 children, 220 adults).

Here are some of the advantages of the Nichols Institute Diagnostics SM-C Kit:

- Only one, extremely small sample is required. (Ideal for children)
- Sample can be taken without regard to time of day or interval since last feeding.
- The reagent set permits measurement of SM-C without extraction of the sample.
- A reliable method of diagnosing growth deficiency in children and acromegaly in adults.

Somatomedin-C

Sound too good to be true? Not really, only another example of the Nichols Institute Option from Nichols Institute Diagnostics. For more information, contact your Nichols Institute representative, or for your free questions and answers booklet on the new Somatomedin technology: **Clinical Applications of Somatomedin-C Measurements,** call us toll free at (800) 854-7113 or in California (800) 432-3547.

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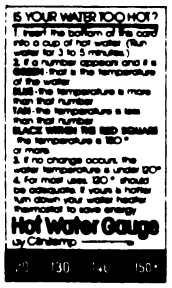
Thousands of Children Are Burned In Preventable Accidents Every Year!

Now YOU can do something that will really help.



Prevent Tap Water Scalding Accidents with the HOT WATER GAUGE

* Hot Water Heaters are preset at 150°.
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Now in stock at leading Drug Stores, nationwide.

Easy-to-Use • Energy Saving • Only $2.50

Make every Bath SAFE and BURN FREE with the FROG PRINCE Bath Safety Thermometer

* Bath water at 120° is too hot for comfort
* Safe and comfortable bath water is 100°
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Non-Toxic • Unbreakable • Only $2.95

Prevent Thermal Contact Burns with "STOP HOT!" Burn Prevention Decals

* Identify every hot surface in the home with a "STOP HOT!" decal
* Looks like a stop sign when cool
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Now in stock at leading Drug Stores, nationwide.

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Order samples to protect your family first, Doctor. We'll also include **200 free copies** of our **Burn Prevention Guide for the Early Years** for each of your young patient's mothers to follow.

Yes, please send me a sample packet of the Burn Prevention Thermometers shown above to protect my family, first. **Enclosed is $2.00 to cover postage and handling.**

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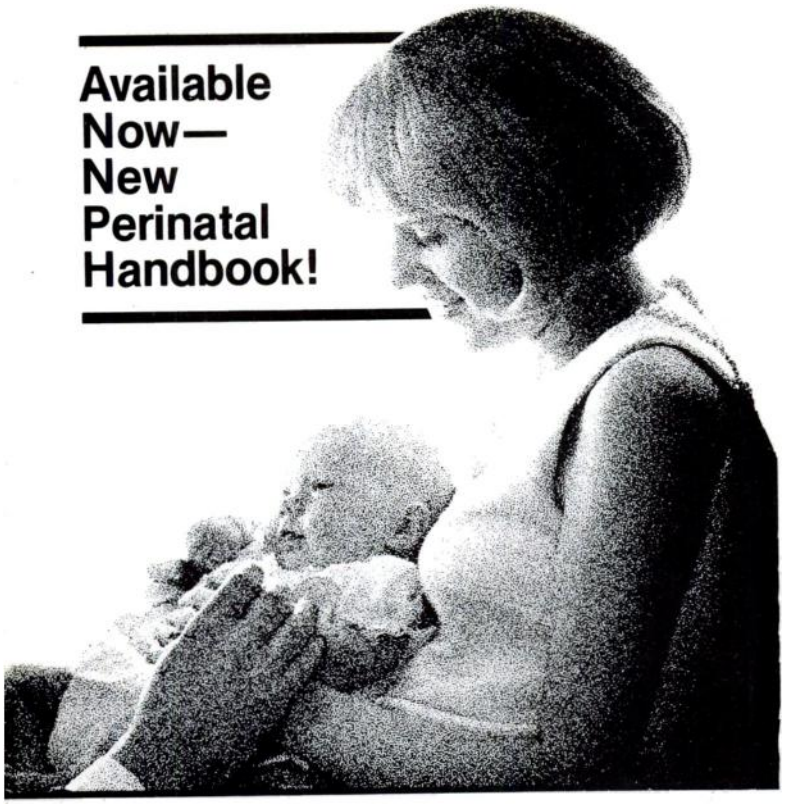

Available Now— New Perinatal Handbook!

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.

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PED

Ilosone® (erythromycin estolate)

Brief Summary. Consult the package literature for prescribing information.

Warning

Hepatic dysfunction with or without jaundice has occurred, chiefly in adults, in association with erythromycin estolate administration. It may be accompanied by malaise, nausea, vomiting, abdominal colic, and fever. In some instances, severe abdominal pain may simulate an abdominal surgical emergency.

If the above findings occur, discontinue Ilosone promptly.

Ilosone is contraindicated for patients with a known history of sensitivity to this drug and for those with preexisting liver disease.

Indications: *Streptococcus pyogenes* (Group A Beta-Hemolytic)—Upper and lower respiratory tract, skin, and soft-tissue infections of mild to moderate severity.

Injectable penicillin G benzathine is considered by the American Heart Association to be the drug of choice in the treatment and prevention of streptococcal pharyngitis and in long-term prophylaxis of rheumatic fever.

When oral medication is preferred for treating the above-mentioned conditions, penicillin G or V or erythromycin is the alternate drug of choice.

The importance of the patient's strict adherence to the prescribed dosage regimen must be stressed when oral medication is given. A therapeutic dose should be administered for at least 10 days.

Alpha-Hemolytic Streptococci (Viridans Group)—Although no controlled clinical efficacy trials have been conducted, oral erythromycin has been suggested by the American Heart Association and American Dental Association for use in a regimen for prophylaxis against bacterial endocarditis in patients hypersensitive to penicillin who have congenital heart disease or rheumatic or other acquired valvular heart disease when they undergo dental procedures and surgical procedures of the upper respiratory tract! Erythromycin is not suitable for such prophylaxis prior to genitourinary or gastrointestinal tract surgery.

Note: When selecting antibiotics for the prevention of bacterial endocarditis, the physician or dentist should read the full joint statement of the American Heart Association and the American Dental Association!

Staphylococcus aureus—Acute infections of skin and soft tissue which are mild to moderately severe. Resistance may develop during treatment.

S. (Diplococcus) pneumoniae—Infections of the upper respiratory tract (e.g., otitis media, pharyngitis) and lower respiratory tract (e.g., pneumonia) of mild to moderate severity.

Mycoplasma pneumoniae (Eaton Agent, PPLO)—In the treatment of respiratory tract infections due to this organism.

Haemophilus influenzae—May be used concomitantly with adequate doses of sulfonamides in treating upper respiratory tract infections of mild to moderate severity. Not all strains of this organism are susceptible at the erythromycin concentrations ordinarily achieved (see appropriate sulfonamide labeling for prescribing information).

Treponema pallidum—Erythromycin is an alternate choice of treatment for primary syphilis in penicillin-allergic patients. In primary syphilis, spinal-fluid examinations should be done before treatment and as part of follow-up after therapy.

Corynebacterium diphtheriae—As an adjunct to antitoxin, to prevent establishment of carriers, and to eradicate the organism in carriers.

C. minutissimum—In the treatment of erythrasma.

Entamoeba histolytica—In the treatment of intestinal amebiasis only. Extraenteric amebiasis requires treatment with other agents.

Listeria monocytogenes—Infections due to this organism.

Bordetella pertussis—Erythromycin is effective in eliminating the organism from the nasopharynx of infected individuals, rendering them noninfectious. Some clinical studies suggest that erythromycin may be helpful in the prophylaxis of pertussis in exposed susceptible individuals.

Legionnaires' Disease—Although no controlled clinical efficacy studies have been conducted, in vitro and limited preliminary clinical data suggest that erythromycin may be effective in treating Legionnaires' disease.

Chlamydia trachomatis—Erythromycins are indicated for treatment of the following infections caused by *C. trachomatis:* conjunctivitis of the newborn, pneumonia of infancy, urogenital infections during pregnancy (*see* Warnings). When tetracyclines are contraindicated or not tolerated, erythromycin is indicated for the treatment of adults with uncomplicated urethral, endocervical, or rectal infections due to *C. trachomatis*[2].

Contraindication: Erythromycin is contraindicated in patients with known hypersensitivity to this antibiotic.

Warnings: (*See* Warning box above.) The administration of erythromycin estolate has been associated with the infrequent occurrence of cholestatic hepatitis. Laboratory findings have been characterized by abnormal hepatic function test values, peripheral eosinophilia, and leukocytosis. Symptoms may include malaise, nausea, vomiting, abdominal cramps, and fever. Jaundice may or may not be present. In some instances, severe abdominal pain may simulate the pain of biliary colic, pancreatitis, perforated ulcer, or an acute abdominal surgical problem. In other instances, clinical symptoms and results of liver function tests have resembled findings in extrahepatic obstructive jaundice.

Initial symptoms have developed in some cases after a few days of treatment but generally have followed 1 or 2 weeks of continuous therapy. Symptoms reappear promptly, usually within 48 hours after the drug is readministered to sensitive patients. The syndrome seems to result from a form of sensitization, occurs chiefly in adults, and has been reversible when medication is discontinued.

Usage in Pregnancy—Safety of this drug for use during pregnancy has not been established.

Therefore, the physician should consider carefully the benefits and risks of use of this drug during pregnancy.

Precautions: Since erythromycin is excreted principally by the liver, caution should be exercised in administering the antibiotic to patients with impaired hepatic function.

The use of erythromycin in patients who are receiving high doses of theophylline may be associated with an increase in 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.

Adverse Reactions: The most frequent side effects of erythromycin preparations are gastrointestinal (e.g., 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 arise, the drug should be discontinued and appropriate therapy instituted.

Mild allergic reactions, such as urticaria and other skin rashes, have occurred. Serious allergic reactions, including anaphylaxis, have been reported.

There have been isolated reports of reversible hearing loss occurring chiefly in patients with renal insufficiency and in patients receiving high doses of erythromycin.

1. American Heart Association: Prevention of Bacterial Endocarditis, Circulation, *56*:139A, 1977.
2. Sexually Transmitted Diseases Treatment Guidelines 1982. Centers for Disease Control, Morbidity and Mortality Weekly Report, U.S. Department of Health and Human Services, Atlanta, *31*(Supplement):355, 1982.

520005 [060684]

DISTA

Address medical inquires to:
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Beg... Implore... Plead...

...or give him good-tasting Ilosone® Liquid

erythromycin estolate

No matter how effective the antibiotic, if the little patient won't take it, it's *not* effective.

Ilosone® Liquid (erythromycin estolate) has a child-pleasing taste and is effective in these infections of mild to moderate severity:

Upper and lower respiratory tract infections due to susceptible strains of—

- *Streptococcus pyogenes* (group A beta-hemolytic)*
- *S. pneumoniae*
- *Mycoplasma pneumoniae*

Skin and soft-tissue infections due to susceptible strains of—

- *S. pyogenes* (group A beta-hemolytic)
- *Staphylococcus aureus*

Good taste...effective...
good reasons for prescribing Ilosone.

Cherry-flavored
Ilosone® Liquid, 250
erythromycin estolate 250 mg† per 5 ml

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Ilosone® Liquid, 125
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*Injectable penicillin G benzathine is considered by the American Heart Association to be the drug of choice. With oral therapy, a therapeutic dose should be given for at least ten days.

†Equivalent to erythromycin.

Hepatic dysfunction with or without jaundice has occurred, chiefly in adults, in association with erythromycin estolate administration.

DISTA

520005

See adjoining column for summary of prescribing information.

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.

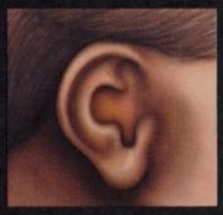
Wyeth Laboratories
Philadelphia PA 19101

Pioneers in Infant Nutrition™

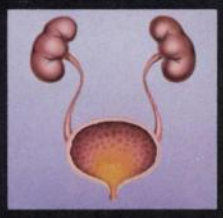
Burning questions in pediatric practice

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).

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The Office of Disease Prevention and Health Promotion, Public Health Service, has developed a publication to assist organizations in fund-raising for health promotion projects. The publication is divided into four sections which discuss:

- The principles and procedures of fundraising;
- Sources of funds and ways to apply for these in the private sector;
- Sources of funds and the ways to apply for these in the public sector, particularly from federal agencies concentrating on health promotions; and
- Useful tools, such as publications, databases, and organizations, for those seeking funds.

An appendix contains a glossary, an acronym dictionary, and a sample Public Health Service grant application form.

This publication will be useful to planning agencies in obtaining funds for health promotion projects and, additionally, in assisting state and local organizations to obtain funds. Due to the limited supply, single copies only may be requested, while supplies last, from the:

National Health Information Clearinghouse
PO Box 1133
Washington, DC 20013

From the *American Journal of Public Health*, October 1984, p 1149.

NATIONAL SOCIAL PROGRAMS

The WIC program—like Head Start, Improved Pregnancy Outcome (IPO), and other large child health and welfare programs—was sold to legislators by advocacy groups on the grounds that the services provided would achieve gains in health that could be measured by specific health indicators. The scientific evidence for such claims in the United States was debatable at best, and particularly uncertain for a large scale national program in which execution of the intermediate steps as planned could never be guaranteed. The strategy by which these programs were promoted and sold to legislators thus left their advocates in a vulnerable position if evaluation failed to show that measurable outcomes had been achieved as promised, or that the program costs exceeded their benefits by a substantial margin.

The existence of programs such as WIC and IPO did indeed provide an opportunity for large scale scientific research that might have helped us identify interventions in the form of health services, educational activities, or nutritional supplementation that led to healthier reproductive outcomes. Many types of research can be planned as part of the introduction of a new program that cannot be planned at a later date. Furthermore, the research can be entirely ethical. The fact that advantage was not taken of these opportunities accounts for the paucity and poor quality of WIC and IPO program-related research. From a purely scientific point of view, the claims which were used to sell these programs to legislators remain as debatable today as they were before the programs were initiated.

From Yankauer A: Science and social policy (*Am J Public Health* 1984;74:1148–1149).

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*Slifkin M, Gil GM: *J Clin Microbiol*, 1984;20(1):12-14.
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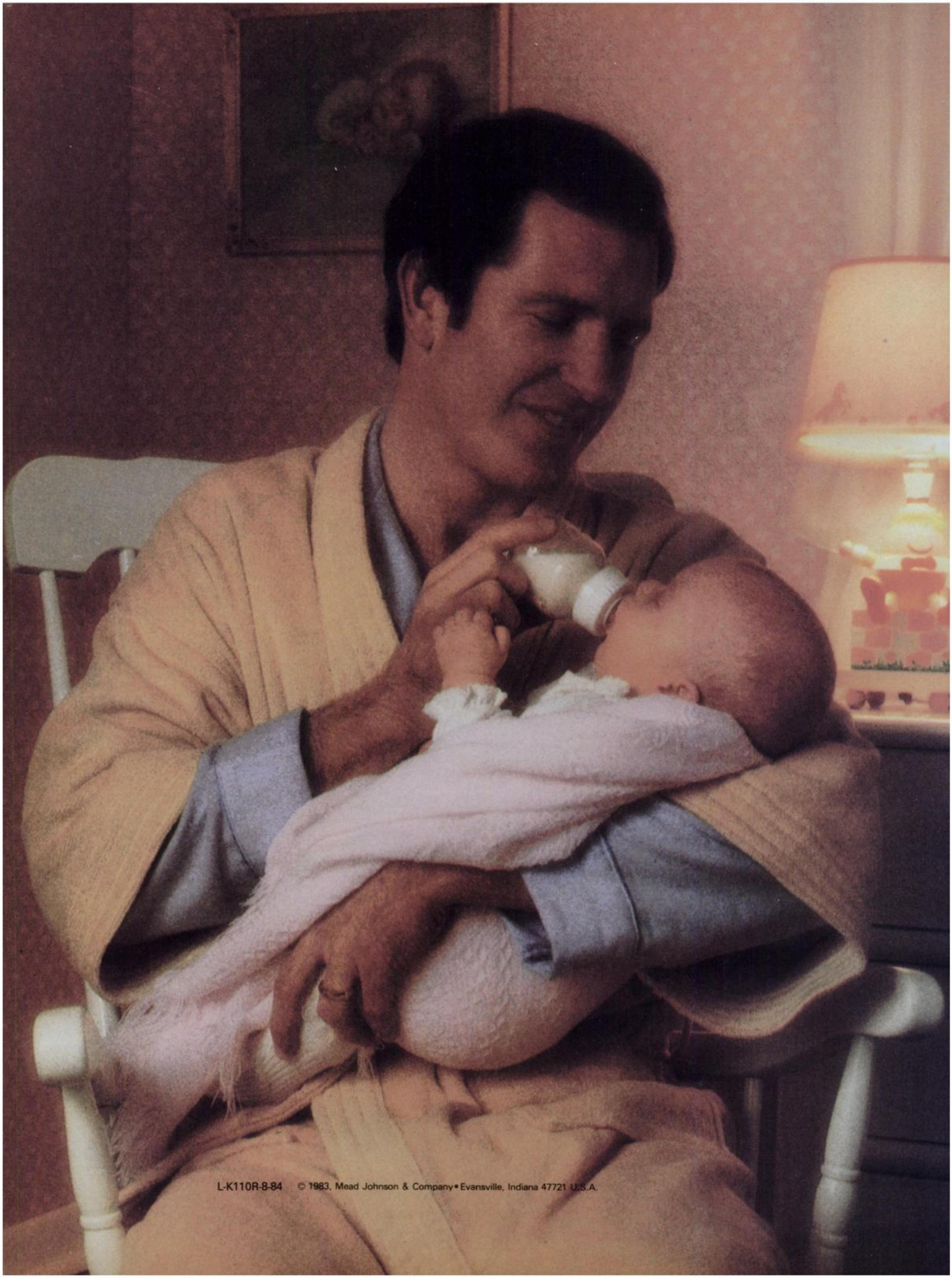
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[1] Armstrong MD *et al:* Free Amino Acids in Milk. *Proceed. of Society of Exper. Biology Medicine* 113:680-683, 1983.

[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.

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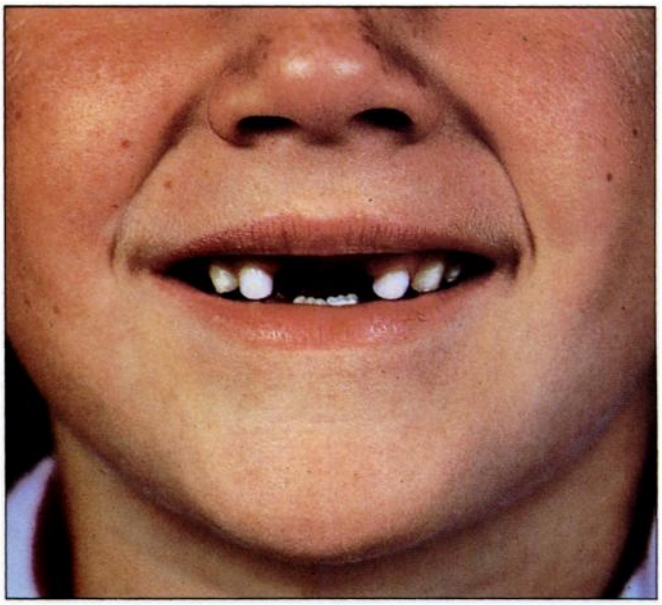

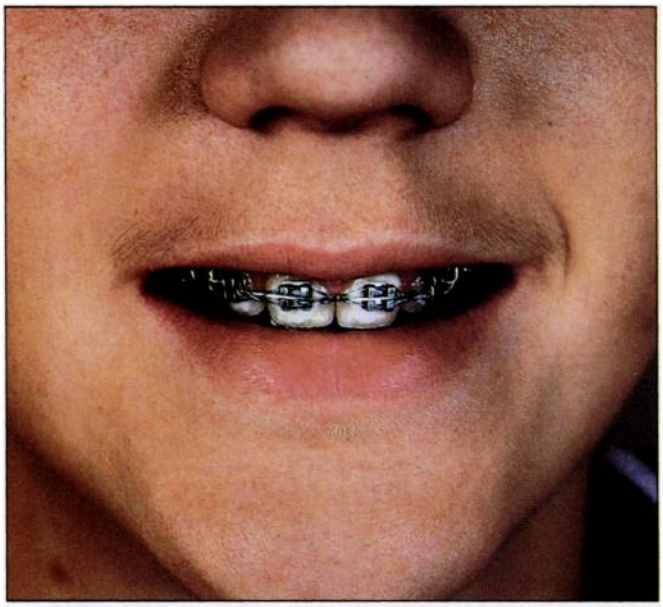

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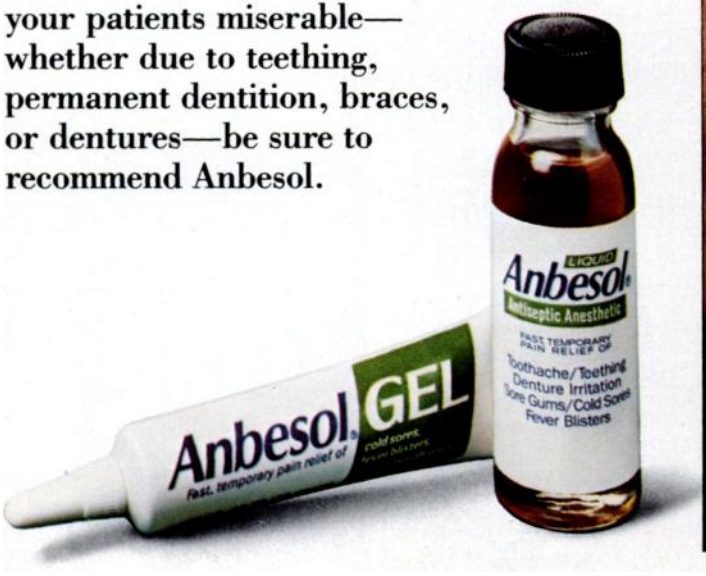

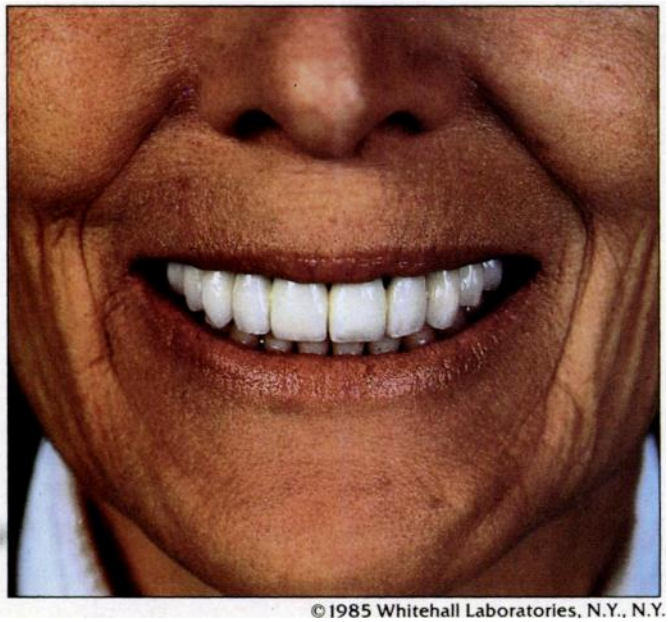

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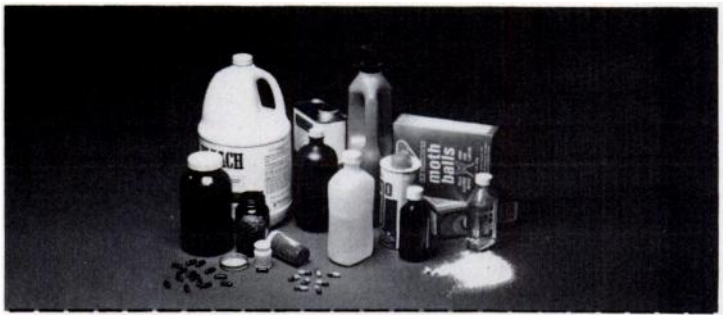

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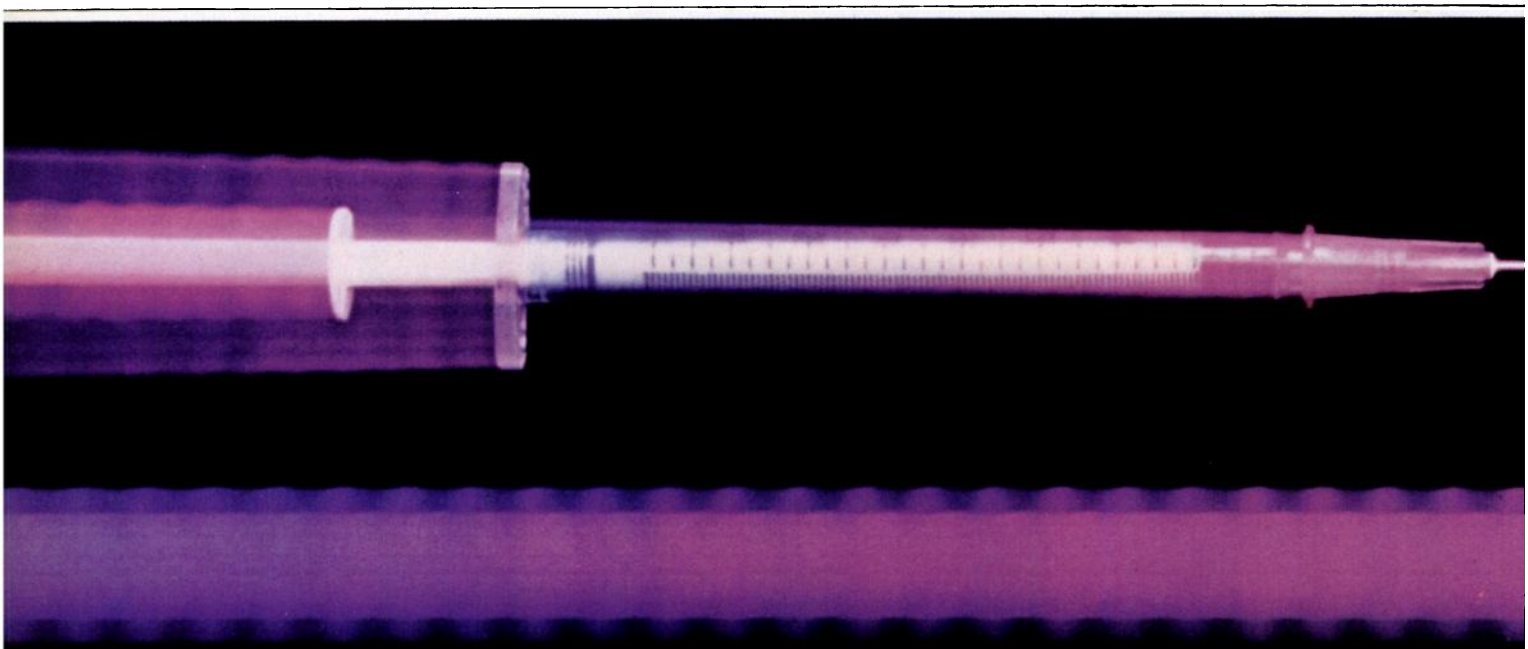

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Indications: For screening for tuberculosis
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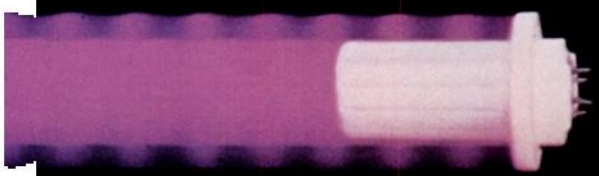

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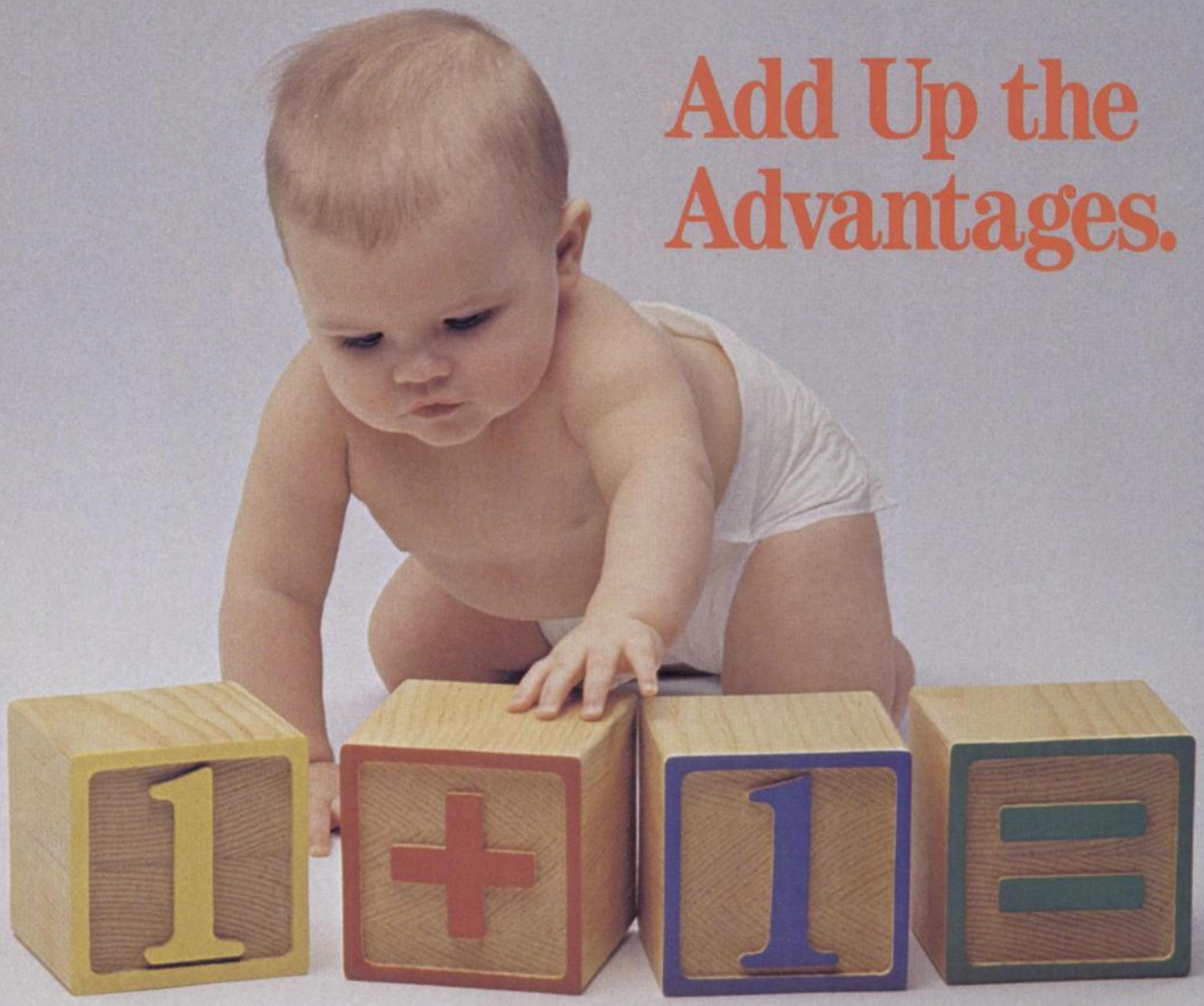

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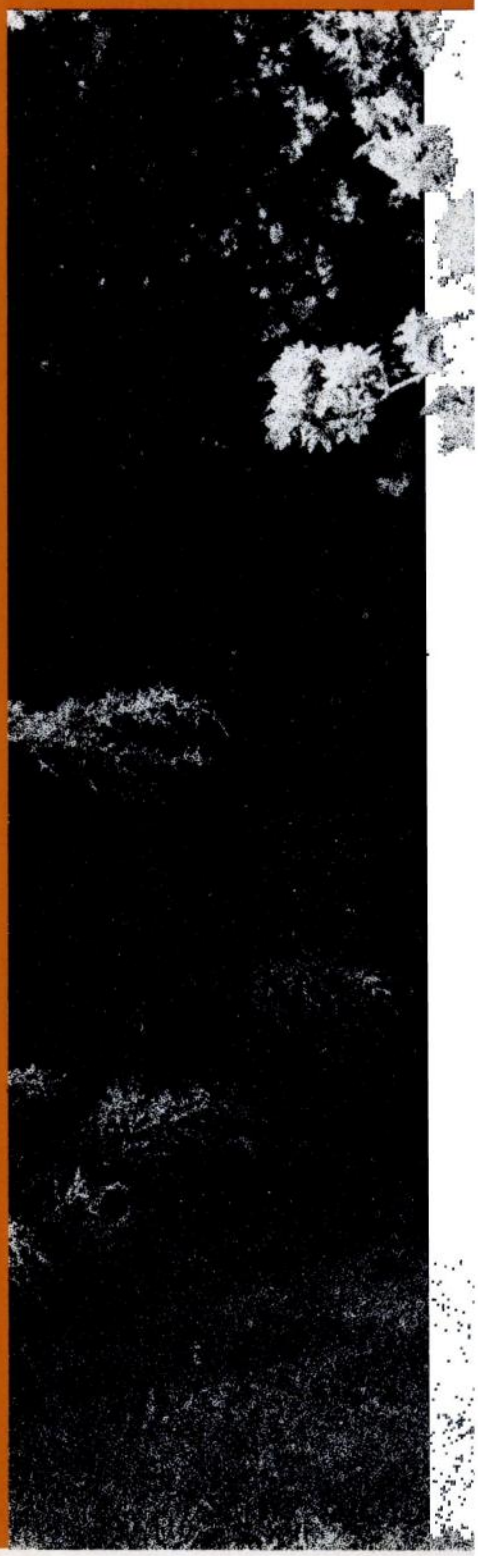

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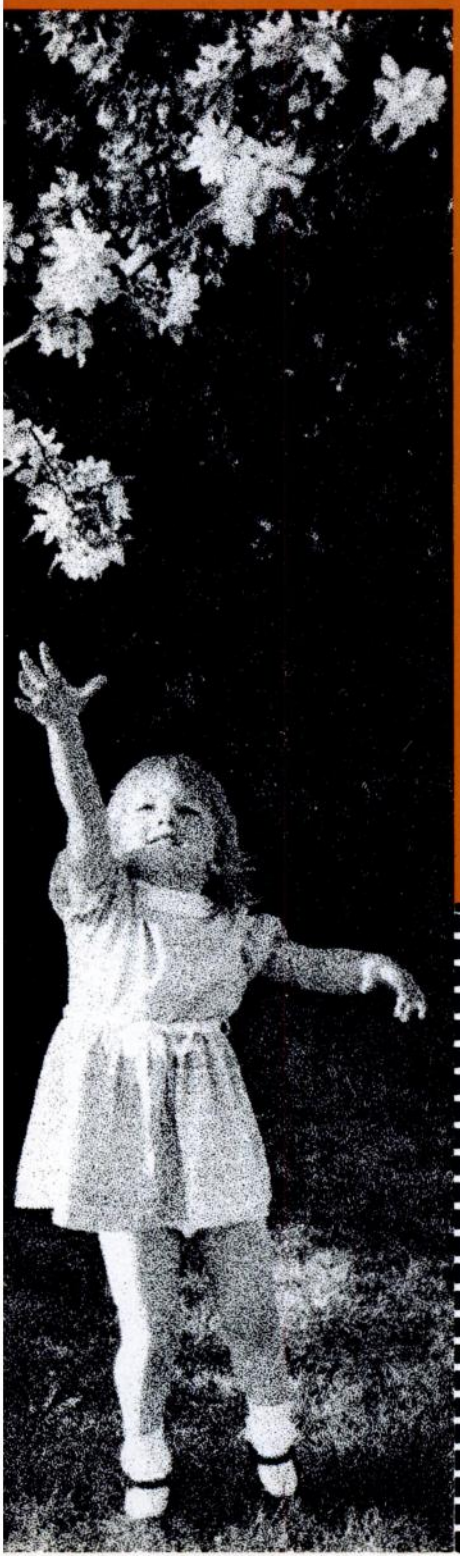

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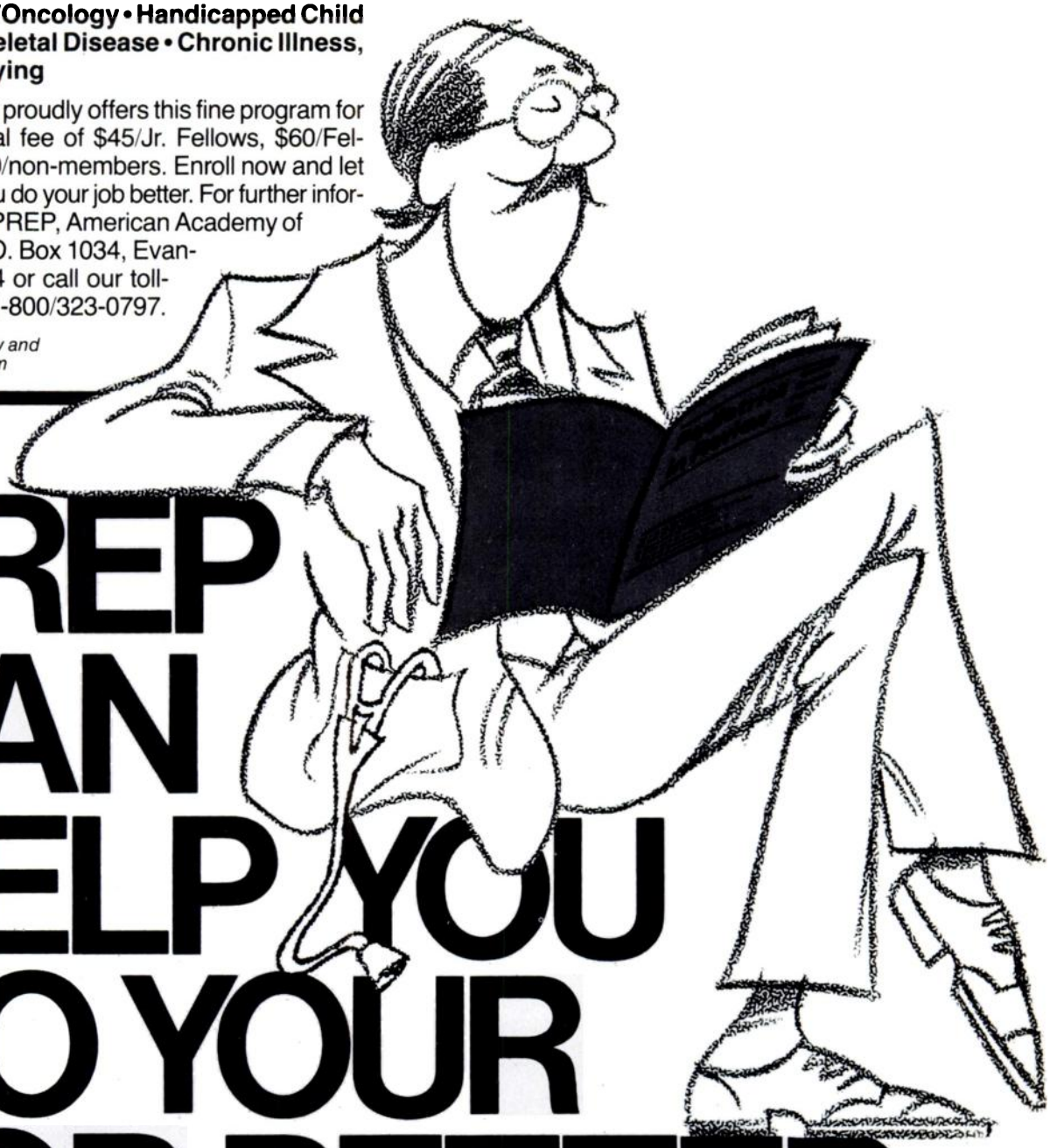

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PEDIATRICIAN—BC/BE: Chronic Illness/Nephrology Assistant Professor. Background and inpatient experience in chronic illness and end-stage renal disease to join medical staff of university affiliated New Jersey Pediatric Rehabilitation Hospital. Duties include team management and development of programs specific to the area of home care. Strong commitment to research in renal immunology. Send CV and cover letter to Henry S. Cecil, MD, Director, Division of Child Development and Rehabilitation, The Children's Hospital of Philadelphia, 34th St and Civic Center Blvd, Philadelphia, PA 19104. The Children's Hospital of Philadelphia, The Children's Seashore House and The University of Pennsylvania are Equal Opportunity/Affirmative Action Employers.

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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.

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PEDIATRICIAN: An outstanding opportunity exists for a BC/BE pediatrician to join a dynamic growing multispecialty internal medicine group in western Connecticut. Send CV to Albert R. Casazza, MD, Associated Internists of Danbury, PC, 67 Sand Pit Rd, Danbury, CT 06810.

INDIANA—General pediatrician BC/BE and pediatrician-subspecialty adolescent medicine or pulmonary medicine, 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 Street, Lafayette, IN 47904, (317) 447-4171.

□

ILLINOIS—BC/BE pediatrician to work with well-established pediatrician in the far west Chicagoland area. Excellent opportunity in a rapidly growing area. Guaranteed salary with incentives and future partnership. Reply to Box #028513.

□

BOULDER, COLORADO—33 physician multi-specialty group seeking Board certified or eligible pediatrician with interest in allergy, by July 1985. Send CV: Stephen Fries, MD, 2750 Broadway, Boulder, CO 80302.

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MULTISPECIALTY GROUP—with FFS and HMO seeks to add Pediatrics for July 1985. Guaranteed salary 2 years. Liberal benefits. Send CV to John Willis, MD, Chairman, Staff Development Committee, Central Ohio Medical Group, 497 E Town Street, Columbus, OH 43215.

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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 15 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 W Harrison Street, Chicago, IL 60612, (312) 666-7611.

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PEDIATRIC INTENSIVIST—Department of Pediatrics, The Fairfax Hospital in northern Virginia, seeks full-time pediatric intensivist to establish private consultative practice and share attending coverage with Director of five-bed pediatric ICU. The department is affiliated with Georgetown University School of Medicine, with pediatric subspecialty support, active house staff and student teaching program, and level III intensive care nursery. Background in pulmonary medicine including sleep apnea preferable. Salary and benefits guaranteed as private practice develops. Reply with CV to Mohsen Ziai, MD, Chairman, Department of Pediatrics, The Fairfax Hospital, 3300 Gallows Rd, Falls Church, VA 22046.

Continued on page A104

Continued from page A103

PEDIATRICIAN—southeast Florida. BC/BE to join growing group practice. Excellent opportunity. Send CV to Box #028504.

□

THE DEPARTMENT OF PEDIATRICS—Northwestern University Medical School is seeking an adolescent medicine specialist for its patient care activities and educational programs at the Evanston Hospital and the Children's Memorial Hospital. This individual will spend the majority of time at the Evanston Hospital where inpatient and outpatients units serving the needs of adolescents exist, including a child and adolescent center with over 2,000 adolescent visits annually. Participation in the ambulatory clinics of Northwestern University Student Health Service will occur. This position will have responsibility for the organization and implementation of a teaching curriculum in adolescent medicine for 50–60 pediatric residents from the residency training program of Children's Memorial Hospital. Ample time will be provided to permit involvement in clinical research of interest to the individual. Interest in sports medicine is desirable. Board eligibility/certification in pediatrics and completing of an adolescent medicine fellowship are required. Faculty rank and salary will be commensurate with a candidate's experience. Interested candidates should send curriculum vitae and supporting documents to David Ingall, MD, Chairman, Department of Pediatrics, The Evanston Hospital, 2650 Ridge Ave, Evanston, IL 60201. The Evanston Hospital and Children's Memorial Hospital are Equal Opportunity Employers.

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PEDIATRICIAN—Maternal and Child Health Program in the Division of Population and Family Health, Columbia University School of Public Health, is seeking a Board eligible or certified pediatrician with an MPH and 2 or more years experience in domestic MCH. The position is offered at the assistant or associate professor level, commensurate with experience. Duties include teaching and applied research in MCH areas, and clinical association with the Department of Pediatrics, College of Physicians and Surgeons. Send curriculum vitae to: Director, Division of Population and Family Health, 60 Haven Ave, New York, NY 10032. An Equal Opportunity Employer.

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PEDIATRIC CARDIOLOGIST—to serve 500-bed hospital in northern Illinois. Candidate must be Board eligible or certified in pediatric cardiology. Opportunity to develop successful practice and help develop a pediatric intensive care unit. Medical school affiliation with teaching opportunities. Reply Box #028505.

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GENERAL ACADEMIC PEDIATRICIAN—Additional, full-time faculty member wanted to join exciting and dynamic pediatric department in a university-affiliated community hospital in Pittsburgh. Requirements: extensive training and experience in pediatrics including a minimum 2-year fellowship in general academic pediatrics, ambulatory care, or pediatric subspecialty. Responsibilities include teaching medical students and residents, direct patient care, and administrative duties. Qualified individuals wishing to join this innovative and rapidly growing pediatric program please contact: Jamies A. Amrhein, MD, Chairman, Department of Pediatrics, Forbes Regional Health Center, 2570 Haymaker Rd, Monroeville, PA 15146.

MASSACHUSSETTS—seeking BC/BE pediatrician to join exciting 75 physician (eight pediatricians), multispecialty group, 35 miles from Boston. Rewarding practice, reasonable call schedule, competitive salary, vacation, and fringes. Opportunity for medical student and resident teaching exists. Send CV to Mr Alan Stoll, Fallon Clinic, Inc, 630 Plantation St, Worcester, MA 01605.

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SOLO INCORPORATED PEDIATRIC/NEONATOLOGY PRACTICE—wishes to broaden its subspecialty abilities by adding one, or more, of the following: Pediatric Allergist, Pediatric Neurologist, or Pediatric Pulmonary Disease Specialist. Modern hospital facilities. Located in mid-west Pennsylvania. Convenient to resort community. Lakes and outdoor activities in abundance. Salary negotiable leading to full association. Reply with CV to Box #028502.

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NEW YORK—Two BC pediatricians one hour from New York City in thriving practice seeking BE/BC pediatrician to join their group. Beautiful area to live. Opportunity to participate in growth of practice. Reply Box #028514.

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PEDIATRICIAN—needed in an expanding multispecialty clinic located in Southern California, near Los Angeles. Must be Board certified or Board eligible. Send CV to Box #028508.

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PEDIATRICIAN—Rapidly growing, well-established health maintenance organization in Syracuse area seeks Board certified/Board eligible pediatrician to join seven-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. Position available July 1985. Please respond to: Ellen G. Wilson, Health Services Association, 8280 Willett Parkway, Baldwinsville, NY 13027. Equal Opportunity Employer.

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GENERAL PEDIATRICIAN—needed at university-affiliated children's hospital in Boston beginning July 1985. Full-time clinical and teaching position involving inpatient, emergency room, and outpatient responsibilities. Patient population includes children with neurologic deficits, multiple handicaps, language and behavior problems, chronic medical and psychosomatic diseases. Board certification and minimum 1-year posttraining relevant clinical experience required. Respond with CV to Box #028501. An Equal Opportunity Employer.

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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 #118401.

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NEVADA: Pediatrician to join four-physician pediatric group. Excellent opportunity from every standpoint. Excellent command of English language required. Reply to Box #118401.

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PART-TIME PEDIATRICIAN—wanted to join one Board certified part-time pediatrician in an established private practice in the Upper Peninsula of **MICHIGAN's** lovely Keweenaw Peninsula. Great recreational area. Excellent community hospital and staff. Write: Janice S. Klemp, MD, 80 First St, Laurium, MI 49913.

□

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 Karen Kato, MD, 784 14th Ave, Longview, WA 98632.

□

PEDIATRICIAN—Board certified or eligible to join progressive Primary Care Group including three pediatricians. Prime Southern California suburb with excellent growth potential, convenient to beach, desert, and mountains. Minimum salary guarantee and benefits with excellent incentives. Immediate position available. Send CV to CAO, Professional Health Centers, Inc, 8990 Garfield, Suite 10, Riverside, CA 92503.

□

TEXAS, LOUISIANA, AND MISSOURI—Private solo associate and group practices. Please send CV to: W. Sanford Smith, Professional Practice Management, Inc, 900 Rockmead Dr, Kingwood, TX 77339.

□

OHIO—Attending physician in pediatric emergency medicine. The Department of Pediatrics at Rainbow Babies and Children's Hospital, a teaching hospital of Case Western Reserve University, is seeking a Board certified/Board eligible academically oriented physician with training or experience in pediatric emergency medicine. The position includes ambulatory and inpatient care, teaching, and research. Please respond with CV to J. L. Blumer, PhD, MD, Division of Pediatric Pharmacology and Critical Care, Rainbow Babies and Children's Hospital, 2101 Adelbert Rd, Cleveland, OH 44106.

□

PEDIATRICIANS, CALIFORNIA—Idyllic mountain community, approximately three hours east of Los Angeles, resort area. Multispecialty group desires pediatrician. **OREGON**—Scenic coastal community in southern Oregon near California border. Join small multispecialty group. **TEXAS**—Pleasant west Texas community north of Amarillo offers exceptional practice opportunity. All of the above opportunities offer generous compensation package designed to fit the practitioner's needs. For information, please call or send CV to: **MEDICUS MEDICAL GROUP**, 1373 Post St, San Francisco, CA 94109, Attn: Private Practice Division. (415) 441-8232.

FLORIDA, EAST COAST—Opportunity for BC/BE pediatrician to assume established practice in coastal community of 40,000 near major metropolitan city. Minimal investment. $60,000/year net, coverage available. Send reply to: Box #028507.

□

TENNESSEE—Pediatric emergency medicine: LeBonheur Children's Medical Center/University of Tennessee Center for Health Sciences seeks academically oriented pediatrician with subspecialty training or experience, as Director of Emergency Room in university tertiary care referral children's medical center. The Children's Medical Center has active residency and fellowship training programs, operates in active land/air transport service, and is a regional trauma center. Salary and academic appointment commensurate with training and experience. Contact John Griffith, MD, Professor and Chairman, Department of Pediatrics, or Greg Stidham, MD, Director of Critical Care, LeBonheur Children's Medical Center, 848 Adams Ave, Memphis, TN 38103.

□

DIRECTOR, PEDIATRIC INTENSIVE CARE—The Department of Pediatrics, Loyola University Medical Center is recruiting an intensivist to direct the Pediatric Intensive Care Unit. The position is of rank and salary appropriate to training and experience. Interested individuals should send their CV with a list of three references to R. Morrison Hurley, MD, Professor and Chairman, Department of Pediatrics, Loyola University Medical Center, 2160 S First Ave, Maywood, IL 60153.

□

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.

□

GROWING PEDIATRIC PRACTICE—in western North Carolina mountains needs second pediatrician. Excellent opportunity to live in beautiful surroundings where recreational facilities abound, and practice at new 50-bed hospital in community of 2,500 with referral area of 45,000. Reply to: Peachtree Pediatric Clinic, Route 1 Box 542, Murphy, NC 28906, or call (704) 837-2128.

□

PEDIATRICIAN—to join two busy pediatricians in a 27-physician midwest multispecialty group practice. Fee for service. Full partnership after 1 year. Excellent benefits and starting income. Teaching opportunity available. University community. Population area 350,000. Modern well-equipped hospitals. Send CV to Box #028510.

□

NEONATOLOGIST—Modern, 380-bed teaching hospital requires a neonatologist for its 30-bed NICU. Reporting to the Chairman of the Pediatrics Department, responsible for medical care of all infant patients as well as enforcing established policies and routines and participating on various committees. Qualified candidates must be Board certified, possess a current Michigan Medical License, and have an appropriate administrative background. If interested, please contact the Personnel Office at: Pontiac General Hospital, Seminole at West Huron, Pontiac, MI 48053. (313) 857-7504. Equal Opportunity Employer.

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PEDIATRICIAN—BC/BE. An exceptional opportunity to join a unique seven-physician pediatric group in southeastern Massachusetts. Subspecialty preferred. One hour from Boston, one-half hour from Providence, Rhode Island, academic affiliation possible, modern building one block from hospital, incorporated, with business manager; excellent fringe benefits; coastal community; swimming, fishing, sailing. Reply to Box #028512.

□

NEONATOLOGIST, CALIFORNIA—Board certified/eligible. Well-qualified individual wanted for hospital-based practice in tertiary level regional center with 20% high-risk obstetrical service. 22-bed ICN, 2,400 deliveries/year with three full-time neonatologists. Hospital affiliated with major university medical center in Bay area. Excellent salary and benefits. Equal opportunity employer. Interested persons send CV to Walter C. Boutwell, MD, Director of Nurseries, Santa Clara Valley Medical Center, 751 S Bascom Ave, San Jose, CA 95128, or phone (408) 299–5134.

□

DEVELOPMENTAL PEDIATRICIAN—To work in Department of Pediatrics, Blanchfield Army Community Hospital, Ft Campbell, Kentucky to identify, screen, and assess children for the Exceptional Family Member (EFM) Program. Assesses and organizes program needs for the EFM Program. Establishes liaison with early intervention programs. Monitors the progress of developmentally disabled children in OT, PT, speech, and other intervention programs. Manages most medical and developmental/behavioral aspects of handicapping conditions. Requires a Board eligible or Board certified pediatrician with a strong interest and background in developmental pediatrics. Salary: $42,928 per annum. Contact: Pat Podurgal, Ft Campbell Civilian Personnel Office, (502) 798-7168, for further information and application forms. Early consideration given to applicants who respond quickly. Equal opportunity employer. Cut-off date for applications is April 1, 1985.

□

ASSISTANT PROFESSOR OF PEDIATRICS NEEDED—The University of Alabama in Huntsville, School of Primary Medical Care. Pediatrician with competence in teaching of medical students and residents. Training for interest in pediatric pulmonary medicine or pediatric intensive care desirable. Must be Board certified or eligible. Please submit CV, including bibliography and names of three references by February 28, 1985 to: Dr John R. Montgomery, Chief of Pediatric Programs, The University of Alabama School of Medicine, 109 Governors Dr, Room 205, Huntsville, AL 35801. (205) 536-5511, ext 425. The University of Alabama in Huntsville is An Affirmative Action/Equal Opportunity Institution.

□

UNIVERSITY OF CALIFORNIA, IRVINE-NEONATOLOGIST—Faculty position in the Department of Pediatrics at the assistant professor level for participation in a multidisciplinary program. Requirements include eligibility or certified for neonatal/perinatal subboards as well as pediatric cardiology subboards and documented research ability. Duties include clinical care, teaching, and research. Send CV and names/addresses of three references to: Louis Gluck, MD, Department of Pediatrics, University of California, Irvine Medical Center, 101 The City Drive South, Bldg 27, Orange, CA 92668. An Affirmative Action/Equal Opportunity Employer. (Closing date April 30, 1985.)

MIDWEST—Neonatologist wanted to assume newborn responsibility for large subspecialty oriented pediatric group: active Level II nursery with some Level III and outpatient exposure. Send CV to Box #028509.

□

THE DEPARTMENT OF PEDIATRICS—University of California, San Francisco, is seeking a full-time academic physician at the assistant professor level with a commitment to teaching, patient care, and research. Applicants should be Board certified or eligible in pediatrics and must qualify for licensure in California. Major responsibilities will be assisting Director of Residency Program with recruiting, matching, and supervision of house staff. Academic effort could be in primary care, general pediatrics, or infectious diseases. Interested candidates should send their curriculum vitae to: Moses Grossman, MD, Department of Pediatrics, Room 6-E-9, San Francisco General Hospital, San Francisco, CA 94110. UCSF is an equal opportunity employer. Women and minorities are encouraged to attend.

□

FACULTY-PEDIATRIC GASTROENTEROLOGIST—The University of Illinois College of Medicine at Peoria has a full-time faculty position available immediately for a pediatrician with expertise in pediatric gastroenterology. Teaching, service, and research responsibilities. 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, Associate Professor and Acting Chairman, Department of Pediatrics, University of Illinois College of Medicine at Peoria, c/o Saint Francis Medical Center, North Building, 530 NE Glen Oak Ave, Peoria, IL 61637.

□

FACULTY POSITION AVAILABLE—The Division of Developmental Disabilities of the Department of Pediatrics, University of Iowa, has a faculty position at either the assistant professor level requiring completion of fellowship, successful completion of Pediatric Boards and experience would be anticipated; or at the associate professor level requiring completion of fellowship and Pediatric Boards, 3–5 years experience with demonstrated investigative, teaching, and clinical ability in an academic setting (MD required at both levels). The position relates to the evaluation and care of infants, children, and young adults with a variety of disabilities including cerebral palsy, mental retardation, learning disabilities, myelodysplasia, and chronic illness. The University of Iowa is An Equal Opportunity/Affirmative Action Employer. Respond to: Alfred Healy, MD, Chairman, Department of Pediatrics, Division of Developmental Disabilities, University Hospital School, University of Iowa, Iowa City, IA 52242.

□

NEONATOLOGIST OR PEDIATRICIAN—with training and special interest in practice of neonatology and part time pediatrics; in a Level II+ special care nursery with 12 beds in a 290-bed private hospital. Population 30,000 with serving area of 150,000; 2,000 deliveries with possibility of covering nearby hospital with 2,000 more deliveries. First year guaranteed salary, leading to early partnership. Reply to Box #028503.

□

TEXAS—BC/BE pediatrician to join private practice. Large drawing area but small-town atmosphere. Good schools. Send resume to Debbie Reese, MD, 307 North M, Midland, TX 79701 (915) 684-5541.

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THE DEPARTMENT OF PEDIATRICS—Oral Roberts University School of Medicine is seeking a pediatric neurologist or developmental pediatrician. Successful candidate should have completed fellowship training in neurology or child development in addition to a residency in pediatrics and have demonstrated clinical and teaching skills. Rank and salary will be commensurate with experience and qualifications. Send CV to David Schrum, MD, Chairman, Department of Pediatrics, Oral Roberts University School of Medicine, PO Box 707070, Tulsa, OK 74170, or telephone (918) 493-8038. The Oral Roberts University School of Medicine is an Affirmative Action and Equal Opportunity Employer.

□

PEDIATRICIAN—We offer a complete and modern multifacility hospital with multispecialty support. Progressive university community within 20 miles of the Maine north woods, one hour from Boston via scheduled airlines. A developing Level II nursery with a highly qualified support staff. A growing hospital-sponsored pediatric group practice. Excellent compensation package, including liberal benefits. We want someone who is Board eligible or certified. Recently trained. Has neonatal intensive care background. Appreciates the Maine good life. For more information, call or write The Aroostook Medical Center, PO Box 151, Preseque Isle, ME 04769, Attn: John J. Ginty, Jr, Associate Director. Telephone (207) 768-4018.

CAMP PHYSICIAN WANTED—Camp Somerset for Girls, Oakland, Maine. Full eight-week camp season, June 19 to August 22. Salary $4,000 for season; excellent family accommodations; board; laundry. Write full details to: Camp Somerset, 180 East End Ave, New York, NY 10128. (212) 744-3420.

□

ASSISTANT PROFESSOR—General/ambulatory pediatrics research teaching position. Previous fellowship training desired in infectious disease or general pediatrics. Send CV: Alvin H. Novack, MD, University of Washington, Department of Pediatrics RD-20, Seattle, WA 98195.

□

CALIFORNIA—Summer/Fall 1985. BC/BE pediatrician to join two pediatricians in established Sierra foothills practice. Only pediatricians in town. Four OB/GYNs. Medical student teaching in office. Excellent local hospital. Growing area. Good place to raise a family. Send reply and references to Box #018515.

□

BC/BE—trained pediatrician to join young solo practitioner in growing practice. 45 minutes from Memphis. New 120-bed hospital, Level II nursery, good OB relations, Pleasant community in ideal location. Salary leading to partnership. Send C.V. to Box #018518.

□

PEDIATRICIAN/MEDICAL DIRECTOR—Board certified/Board eligible pediatricians interested in community pediatrics, to participate in patient care, teaching, and administration at the Odessa Brown Children's Clinic, the Children's Orthopedic Hospital's satellite which serves a multiethnic community in central Seattle. Requires demonstrated ability to work with multiculture, low-income patients. Clinical faculty appointment in Department of Pediatrics, University of Washington. Interested applicants should send their curricula vitae to Edgar Marcuse, MD, COH&MC, PO Box C-5371, Seattle, WA 98105. Affirmative Action/Equal Opportunity Employer. Closing date for receipt of applications March 1, 1985.

□

PENNSYLVANIA—Pediatric practice with three satellite offices expanding service area. BC/BE pediatrician needed to complement current medical staff. Excellent salary and fringe benefit program plus proximity to major metropolitan areas and prime recreational setting make this an excellent career opportunity. Write Box #018506.

□

MASSACHUSETTS—Board eligible pediatrician as part-time associate for suburban Boston private practice. Skills in neonatology required, academic affiliation encouraged. Send CV to Box #018501.

□

PENNSYLVANIA—BC/BE pediatrician to join rapidly growing two-person pediatric practice. Location within suburbs of Pittsburgh. The University of Pittsburgh affiliation. Please send CV and references to Box #018505.

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FACULTY VACANCIES—*PEDIATRICS*

College of Medicine and Medical Sciences
KING FAISAL UNIVERSITY
Dammam, Saudi Arabia

Applications are invited from qualified and experienced candidates for faculty positions in the *DEPARTMENT OF PEDIATRICS AND GASTROENTEROLOGY (NEONATOLOGY).*

Applicants must be American Board Certified in General Pediatrics as well as certified or eligible in Perinatal Medicine.

Successful candidates will be expected to initiate a research program and to participate in teaching and clinical responsibilities. Applicants currently holding similar academic posts are particularly encouraged to apply.

Please obtain the application form and additional information concerning the position from:

The Dean
College of Medicine and Medical Sciences
PEDIATRICS
KING FAISAL UNIVERSITY
US RECRUITING OFFICE
2425 West Loop South, Suite 540
Houston, Texas 70027

(800) 231-0792
(713) 629-5170

The deadline for receipt of applications is March 1, 1985.

□

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 FOR VACANCY IN MULTISPECIALTY GROUP—Pediatrics has been a specialty within the group since 1946. New pediatric suite in large group-owned office building. Lab facilities are in-house. All equipment furnished. Excellent local hospital level II nursery. Minimum salary guaranteed first year. Stockholder status available after 1 year. Rural location in a pleasant area. Contact Dr David L McFadden, Chairman Search Committee, or Robert Fischer, Business Manager, Greenville Medical Center, 90 Shanango St, Greenville, PA 16125. (412) 588-4240.

□

PENNSYLVANIA—Second BC/BE pediatrician needed to join growing general pediatric practice in south central Pennsylvania, located 13 miles from Hershey Medical Center. Practice includes ambulatory plus newborn nursing care. Immediate opening. Salary leading to partnership. Call or write: Elizabeth T. Habecker, MD, 503 Oak St, Lebanon, PA 17042. (717) 272-7695.

PEDIATRICIAN—to join a five-person academically oriented group practice in the mid-Hudson Valley, 75 miles from New York City. Send CV to Blum, Schaffer, Aronzon MD's PC, 104 Fulton Ave, Poughkeepsie, NY 12603.

□

WYOMING—Pediatrician needed to serve thriving town in Rocky Mountain country. New 70-bed hospital, unbeatable outdoor recreation. Contact Hal Lassiter, MD, 511 North 12th E, Riverton, WY 82501.

□

WE ARE AN ACTIVELY GROWING TWO-PHYSICIAN PRACTICE—in Scottsdale, Arizona looking for an additional pediatrician to start as soon as possible. Please send CV to Allen Stone, MD, Pediatricians of Scottsdale, PC, 1402 N Miller Rd, Scottsdale, AZ 85257.

□

PEDIATRICIAN—Excellent opportunity for a Board certified/eligible pediatrician to become the third pediatrician in a 26-physician multispecialty group. 180-bed, modern hospital with Level II nursery. Plentiful recreational, cultural, and educational opportunities in community surrounded by beautiful northwoods. Unique, attractive financial arrangements. Contact: Administrator, Rice Clinic, 2501 Main St, Stevens Point, WI 54481 or call (715) 344-4120.

□

GASTROENTEROLOGIST—the Department of Pediatrics of the Milton S. Hershey Medical Center of The Pennsylvania State University is seeking a gastroenterologist. The successful applicant will be Board certified or eligible in pediatrics and fully trained in gastroenterology. In addition to providing clincial care the applicant should have a sincere commitment to research and academic pediatrics. Applicants should contact Steven J. Wassner, MD, The Milton S. Hershey Medical Center, PO Box 850, Hershey, PA 17033. The Pennsylvania State University is an Affirmative Action/Equal Opportunity Employer.

□

MASSACHUSETTS—BC/BE pediatrician to join practice 15 minutes west of Boston, Level II nursery. Teaching/research. Flexible schedule. Excellent salary and vaction. Send CV to Box #018520.

□

NORTHWESTERN ILLINOIS—22-physician multispecialty group practice seeking a Board eligible or certified pediatrician to join three-physician Board certified pediatric department. Would welcome subspecialty interest with primary emphasis on general pediatrics. Located in the beautiful rolling hills of northwestern Illinois in a community of 30,000+ and a service area of 100,000. Excellent schools, parks, and recreational facilities within the community. Modern, well equipped clinic building with laboratory and x-ray capabilities. Immediately adjacent to a 235-bed acute care JCAH accredited hospital. Excellent salary guarantee and fringe benefits. Reply to Box #018503.

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PEDIATRICIAN—Immediate opening for Board certified pediatrician in a southwest Michigan pediatric group. Recreational, cultural, and educational opportunities abound. Full hospital privileges. Teaching appointments available. Growing practice is a mixture of fee-for-service and prepaid patients. Contact: E. Joseph Alberding, MD, Medical Director, 3624 S Westnedge, Kalamazoo, MI 49008.

□

PEDIATRICIAN—Excellent opportunity for Board certified practitioner to start or relocate solo practice with initial hospital sponsorship. Located in Texas Panhandle. No pediatricians in service area of 30,000. Ninety-nine-bed hospital in city of 18,000. Metropolitan city within hour's drive. Contact Rodger Morrison, Golden Plains Community Hospital, Borger, TX (806) 273-2851.

□

WASHINGTON—Pediatrician BC/BE - general, neurology, pulmonary, allergy. Join six pediatrician subspecialists. Metropolitan setting, Puget Sound. Children's hospital/ NICU. Academic appointment available. CV to Pediatrics Northwest, 1811 South K St, Tacoma, WA 98405.

□

COLORADO BC/BE PEDIATRICIAN NEEDED to join three BC pediatricians, summer 1985, established multispecialty group 35 miles north of Denver. Send curriculum vitae: Roger Garceau, MD, 1925 Mountain View Ave, Longmont, CO 80501.

□

NEONATOLOGIST—Board certified/eligible, interested in practicing neonatology and pediatrics to join an eight-member Pediatric Department servicing a private NICU. We are part of a 32-physician multispecialty group practice located in southern California. Send CV to Gilbert I. Martin, MD, Magan Medical Clinic, Inc, 420 W Rowland St, Covina, CA 91723.

□

ARIZONA, NEONATOLGIST—Board certified/eligible. Well established nursery with 3,000 deliveries per year. The Newborn ICU is well equipped and well staffed with pediatrics house staff, nurse practitioners, and trained nurses. For further information, please contact Mahesh Kotwal, MD, Department of Pediatrics, Maricopa Medical Center, PO Box 5099, Phoenix, AZ 85010. (602) 267-5404.

□

NEW JERSERY-ATLANTIC CITY AREA—BC/BE pediatrician sought to join young solo practitioner in rapidly growing practice providing personalized high quality care. Good salary leading to partnership. Please call (609) 645-8500.

□

WASHINGTON—Multispecialty group practice in Puget Sound region seeks two BC/BE pediatricians interested in primary care for development of a suburban satellite. Academic experience or subspecialty training preferred. CV to Box #018512.

ALABAMA—Children are a heritage from the Lord. Solo pediatrician seeks BC/BE pediatrician of like mind. First year salary and benefits leading to early partnership. Contact: Lloyd Hofer, MD, 2900 McGehee Rd, Montgomery, AL 36111. (205) 284-3200.

□

POSITIONS AVAILABLE FOR PEDIATRICIANS—to join our Department of Pediatrics at CIGNA Healthplan, an established, growing, progressive prepaid group practice in Phoenix, Arizona. An opportunity to practice in a desirable environment coupled with a leisurely southwestern lifestyle. Competitive salary. Excellent benefit package. Please submit CV to: CIGNA Healthplan, PO Box 44678, Dept P, Phoenix, AZ 85064. (602) 954-3506. EOE.

□

CALIFORNIA—Extraordinary practice opportunity for Board certified/eligible pediatrician to join very busy practice in northern California coastal city. Salary first year, then partnership if mutually agreeable. Contact C. Cody, MD, 2800 Harris St, Eureka, CA 95501. (707) 445-8416.

□

UTAH—The Department of Pediatrics, General Pediatric Division, University of Utah School of Medicine and Primary Children's Medical Center seeks applicant for a position at the Assistant Professor level on the tenured or clinical track. Applicants must be Board eligible/certified, with either fellowship or practice experience. The position is hospital based at the Primary Children's Medical Center and includes responsibilities in medical student and housestaff teaching, child abuse and neglect, and in/outpatient secondary and tertiary general pediatric patient management at Primary Children's and University Medical Center. Please address inquiries to Michael A. Simmons, MD, Chairman, Department of Pediatrics, University of Utah School of Medicine, Salt Lake City, Utah 84132. Deadline is March 28, 1985. Applications submitted after the deadline will be accepted if no qualified candidate has been found. The University of Utah is an Affirmative Action/ Equal Opportunity Employer.

□

MASSACHUSETTS BC/BE—University trained pediatrician needed to join five pediatricians in progressive 35-physician multispecialty group 25 miles from Boston. Subspecialty interest desirable. Fee-for-service and HMO patients. First year guaranteed salary and excellent benefits, leading to early partnership. Opening July of 1985. Reply Box #018508.

□

MARYLAND—BC/BE pediatrician to join solo pediatrician with rapidly growing suburban practice near Washington, DC. Send resume to Box #018513.

□

WISCONSIN-PEDIATRICIAN—to join a 25-physician multispecialty primary care clinic with 7-physician Pediatric Department in Appleton, Wisconsin. Excellent hospitals. Guarantee and incentive compensation. Complete benefit package. Medium size community with excellent education, cultural, recreation, and shopping opportunities. Contact Art Schuetze, Administrator, Medical Arts Clinic, SC, 401 N Oneida St, Appleton, WI 54911. Phone (414) 739-0171.

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BC/BE PEDIATRICIAN FOR THIRD—associated 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 #018511.

□

EXPANDING MULTISPECIALTY GROUP NEEDS BE/BC pediatrician to join existing department of four young university trained pediatricians. Residency teaching opportunity, dynamic community of 400,000, excellent salary leading to early partnership. Send CV to Edwin G. Farrell, MD, Springer Clinic, 6160 S Yale Ave, Tulsa, OK 74136.

□

PEDIATRICIAN—full-time BC/BE needed to join busy, two-physician general pediatric practice 60 miles north of New York City. Excellent opportunity. Call (914) 496-3656. Mail resume to: 19 South St, Washingtonville, NY 10992.

□

PEDIATRICIAN—BE/BC to join modern multispecialty urban health center in Syracuse, New York. Guaranteed salary, comprehensive benefit package that includes incentive program and malpractice. Close proximity to hospitals, medical college, and universities. Excellent recreational, educational, and attractive housing opportunities. Send letter of interest with CV to Medical Director, Syracuse Community Health Center, Inc, 819 S Salina St, Syracuse, NY 13202.

□

WISCONSIN—Full-time faculty position in adolescent medicine. Pediatric Department of the Medical College of Wisconsin seeks physician to organize and direct adolescent services at Milwaukee Children's Hospital. University appointment at the assistant or associate professor level. Liberal fringe benefits and salary based on training and experience. Please submit inquiries and curriculum vitae to: Frederic Blodgett, MD or Margaret Layde, MD, Milwaukee Children's Hospital, 1700 W Wisconsin Ave, Milwaukee, WI 53233. The Medical College of Wisconsin and Milwaukee Children's Hospital are Equal Opportunity/Affirmative Action Employers. M/F/H.

□

NEW MEXICO—Two positions: director of ambulatory pediatrics and an ambulatory pediatrician. Both full-time academic positions, in a university teaching hospital. Clinical experience and/or fellowship training preferred. Contact: Edward Schor, MD, Department of Pediatrics, University of New Mexico School of Medicine, Albuquerque, NM 87131.

□

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.

EMERGENCY SERVICES-PEDIATRICS—the Department of Pediatrics, Medical College of Wisconsin, is seeking BC/BE physician with training and/or experience in emergency medicine. Patient care, teaching, and research. Position open now. Write to: Joseph D. Losek, MD, Medical Director, Emergency Department, Milwaukee Children's Hospital, PO Box 1997, Milwaukee, WI 53201. (414) 933-7331. Equal Opportunity/Affirmative Action Employer M/F/H.

□

TEXAS, GALVESTON—faculty in primary pediatrics, University of Texas, BE/BC pediatrician for primary care and teaching. Contact: C. W. Daeschner Jr, MD, Chairman, Pediatric Department, UTMB, Galveston, TX 77550-2776. We are an Affirmative Action/Equal Opportunity M/F/H employer.

□

WISCONSIN BE/BC PEDIATRICIAN NEEDED—for HMO in beautiful college town of 60,000 located 90 miles east of Twin Cities. Excellent hospitals, strong medical community, hard work while working, liberal time off benefits. Reply to Allen F. Meyer, MD, Medical Director, Group Health Cooperative of Eau Claire, 2119 Heights Dr, Eau Claire, WI 54701. Telephone (715) 835-2883.

□

OHIO—BC/BE immediate opportunity to join incorporated practice of seven pediatricians in Cincinnati suburb. Excellent compensation and benefits leading to partnership. University affiliation. Reply Box #128404.

□

PEDIATRICIAN needed to replace retiring partner in active general pediatric practice. Salary first year. Contact: Edward F. Arnett, MD, FAAP, 215 S Louisiana Ave, Martinsburg, WV 25401.

□

BE/BC PEDIATRICIAN—to join an active three-physician group in southern Westchester New York City suburb. Academic orientation preferred. Send resume to Box #118415.

□

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.

□

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.

□

PEDIATRICIAN—Expanding, 30-physician, south Florida multispecialty group seeks dynamic, Board-certified, Florida-licensed physician for private practice in 1985. Candidates must be well qualified, emphasis on high-quality patient care. Send CV with references and letter outlining goals to Box #098404.

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MARYLAND—BC/BE pediatrician needed to join a busy, well-established solo pediatric practice in the Baltimore/Washington area. New building; congenial staff. Send CV to: Marc Rawitt, MD, 555 Baltimore-Annapolis Blvd, Severna Park, MD 21146.

□

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 Philadelphia and New York. Reply to Box #128401.

□

VERMONT—University of Vermont faculty position in general pediatrics. Postresidency training in primary care, general academic pediatrics, behavioral/developmental pediatrics or other area consistent with general pediatric practice preferred. Applications encouraged from women and minorities. Contact Paul C. Young, MD, 1 S Prospect, Burlington, VT 05401.

□

MASSACHUSETTS—BC/BE full-time pediatrician needed to set up private practice in growing central Massachusetts community. Financial incentives available. Reply with CV to Box #128408.

□

CHILD DEVELOPMENT—Division Chief, Pediatrics, University of Texas, Galveston is seeking physician to lead division teaching and research programs. Experience essential in child development, pediatric neurology, or a related area. CV to: C. W. Daeschner Jr, MD, Chairman, Pediatric Department, UTMB, Galveston, TX 77550-2776. We are an Affirmative Action/Equal Opportunity M/F/H employer.

□

UTAH—Pediatric Pulmonary Division, University of Utah School of Medicine seeks a fellowship trained pulmonologist, Board certified or eligible in pediatrics. Strong academic interest necessary. Rank: Research Assistant Professor. Deadline, February 28, 1985. Contact Dennis Nielson, MD, PhD, Department of Pediatrics, 50 N Medical Dr, Salt Lake City, UT 84132. An Equal Opportunity/Affirmative Action Employer.

□

THE DEPARTMENT OF PEDIATRICS—at a major teaching hospital in Cleveland is seeking an academically oriented pediatrician to join two other physicians responsible for the Pediatric Intensive Care Unit. This position includes responsibility for patient care, resident teaching, and at least 6 months per year of protected research time. .The person selected will practice critical care medicine in a 12-bed medical and surgical PICU with emphasis on cooperation of the various pediatric subspecialties. The ideal applicant will combine an interest and experience in critical care medicine with a subspecialty in one of the following: anesthesiology, cardiology, nephrology, neurology, or pulmonary medicine. We offer a competitive salary and benefits. Please respond with a CV to J. L. Blumer, PhD, MD, Chief, Division of Pediatric Pharmacology and Critical Care, Rainbow Babies and Childrens Hospital, 2101 Adelbert Rd, Cleveland, OH, 44106.

FIFTH BC/BE PEDIATRICIAN, central New Jersey, private office-based practice with medical school affiliation, one hour New York City, Philadelphia, suburban living, good schools, salary to partnership. Reply to Box #128403.

□

NEW HAMPSHIRE—Two young pediatricians with growing practice in southern New Hampshire seeking BC/BE associate. Reply to Larry Learner, MD, 505 W Hollis St, Nashua, NH 03062.

□

SOUTHERN CALIFORNIA—University trained, academically oriented pediatrician BC/BE to join four BC pediatricians with subspecialty training and two pediatric nurse practitioners. He/she will assume the practice of a fifth pediatrician who will be retiring. We have a busy University Medical Center affiliated practice in metropolitan area of 250,000. Beautiful southern California college town with a one-hour trip to beach, mountains, and desert. Subspecialty training preferred. Terms negotiable, depending on experience. Contact Trudy Newman, Business Manager, Pediatric Medical Group, 236 Cajon St, Redlands, CA 92373. Telepone (714) 793-2896.

□

NEONATOLOGIST—BC/BE neonatologist to join two other BC neonatologists in 24-bed intensive/special care nursery in large teaching hospital with 4,000 deliveries. Applicants should have a good background in research training and be committed to patient care and teaching. Salary negotiable depending on background and experience. Submit CV to: Evan Charney, MD, Pediatrician-In-Chief, Dept of Pediatrics, Sinai Hospital of Baltimore, Inc, 2401 W Belvedere Ave, Baltimore, MD 21215.

□

PRACTICE FOR SALE

PACIFIC NORTHWEST—Well established solo pediatric practice. Excellent hospitals. Near major recreational and cultural activities. Terms negotiable. Reply to Box #028511.

□

CHESAPEAKE BAY, VIRGINIA—Established pediatric solo practice. Fully equipped, modern building, next to 70-bed rural hospital. Excellent country clubs, boating, fishing; crime-free area. David Summers, MD, PO Box 1299, Kilmarnock, VA 22482. (804) 435-1260.

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CALIFORNIA—Solo San Diego Pediatric Practice. Well established, modern and very organized office in excellent location, ten minutes from beach. Patients well trained. Reason for leaving—spouse must relocate. $100,000.00 For details call (619) 429-5446.

□

COLORADO, PEDIATRIC PRACTICE FOR SALE—Rapidly growing south suburban Denver near I-25, good parking, well-designed and fully-equipped office in medical building. Retiring owner will introduce. Call evenings (303) 674-2867.

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POSITION/PRACTICE WANTED

PEDIATRICIAN—BE, two years busy outpatient military experience, seeks association with established practice in immediate San Francisco Bay area. Flexible regarding part-*v* full-time. Colleen Hogan-Dann, MD, (707) 446-2336, 118 Hillview Dr, Vacaville, CA 95688.

□

BOARD CERTIFIED—pediatrician, experienced, with subspecialty nephrology boards and strong academic background seeks relocation in or around Chicago/Washington, DC areas. Wants hospital, HMO, or group practice. Reply to Box #018517.

□

EXPERIENCED BC PEDIATRICIAN—34, Currently on staff at leading children's hospital, wishes to relocate in practice. Will purchase, establish, or associate. North East preferred. Reply Box #018521.

□

NATIONWIDE—Four fellows completing their two-year Pediatric ICU Fellowship Training Program at Childrens Hospital of Los Angeles are seeking positions on July 1, 1985. They have extensive and well-balanced experience in clinical, education, research, transport, outreach, and administrative activities. Prefer childrens hospital or university based pediatric ICUs. Write or phone Dr Edgardo L. Arcinue, Director, PICU, 4650 Sunset Blvd, Los Angeles, CA 90027. (213) 669-2557.

□

PEDIATRICIAN 45, Board certified and re-certified. Ten years solo practice in Los Angeles. Desire practice opportunity or association in the southern California area. Available summer 1985. Reply Box 128405.

□

FELLOWSHIPS, RESIDENCIES

FELLOWSHIP IN CHILD/NEURODEVELOPMENTAL PSYCHIATRY—Eclectic program combining the best of modern training in child psychiatry and developmental disabilities of children and adolescents, starting July 1, 1985. This program provides a full, approved training in child psychiatry. Applicants interested in 1 year of training or future career in behavioral pediatrics will be also considered. Fellow has an appointment at Harvard Medical School. Contact Ludwik Szymanski, MD, (617) 735-6741, Children's Hospital, 300 Longwood Ave, Boston, MA 02115.

□

NORTH CAROLINA—Neonatology fellowship at East Carolina University Medical School. Program has active NICU with residents and nurse clinicians, outreach and follow-up programs and opportunities to participate in clinical or laboratory research. Contact: Arthur E. Kopelman, MD, Department of Pediatrics, East Carolina University School of Medicine, Greenville, NC 27834. An Affirmative Action/ Equal Opportunity Employer.

MARYLAND-PL-3, July 1985. Opportunity in a large community hospital program. Must be interested in teaching as well as patient care. Reply: Box #018509.

□

NEW MEXICO—Pediatric PL-2 or PL-3 residency position, July 1985. Address inquiries to Robert Greenberg, MD, Department of Pediatrics, University of New Mexico School f Medicine, Albuquerque, NM 87131.

□

PG4 PEDIATRICS—PG4 vacancy in pediatrics available July 1985 at Baystate Medical Center, a 935-bed hospital, Springfield, Massachusetts. The Department of Pediatrics includes 16 full-time specialists and multiple community-based pediatric specialists. The department has strong academic affiliations with the University of Massachusetts Medical School and Tufts University School of Medicine. The Department of Pediatrics includes 55 inpatient beds, a Level IiI Regional Neonatal Center, and a comprehensive ambulatory pediatric care center. The PG4 year will include 4 to 6 months of chief residency status, as well as an opportunity to develop a program in one of many education situations. Address inquiries to: Edward O. Reiter, MD, Department of Pediatrics, BAYSTATE MEDICAL CENTER, 759 Chestnut St, Springfield, MA 01199. An Equal Opportunity Employer M/F/H.

□

NEW ORLEANS—1 PL-2 and 1 PL-3 position available January 1, 1985 and July 1, 1985 at Louisiana State University, Pediatric Department. Call (504) 568-6221 for information. LSU is An Equal Opportunity/Affirmative Action Employer.

□

MATERNAL AND CHILD HEALTH FELLOWSHIPS—for pediatricians available fall 1985 for academic program (MPH) at the School of Public Health, University of California, Berkeley, CA 94720. Write to Prof Frank Falkner, Chairman, MCH Program.

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GENERAL NOTICES

WILLIAM T. GRANT FOUNDATION FACULTY SCHOLARS' AWARD—Each year the William T. Grant Foundation makes awards to five promising young research scholars in the field of children's mental health. Awards are for five (5) years totaling $150,000, plus an indirect cost allowance for the institutions where the Scholars work. The goal of the Faculty Scholars' Program is to promote children's mental health by supporting investigators in the field of stress and coping in school-age children. To achieve this goal, the William T. Grant Foundation will support the research time of up to five talented investigators in the area of children's mental health, per year, for a five-year period beginning in 1986 for each scholar. Award recipients will be called William T. Grant Faculty Scholars. All nominations and supporting documents should be sent to: Robert J. Haggerty, MD, President, William T. Grant Foundation, 919 Third Ave, New York, NY 10022, (212) 752-0071. Deadline for the awards for 1986 is July 1, 1985. Information on application procedures is available from the Foundation.

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Tenth Biennial Growth Seminar

New-Conn Orthodontic Study Group

MARCH 21-22, 1985, The New York Hilton—1355 Avenue of the Americas, N.Y.C.

NASOPHARYNGEAL OBSTRUCTION: Influence on Craniofacial Growth

What constitutes impaired nasal respiratory function? What techniques are used to assess upper airway impairment? Is the orthodontist capable of making valid determinations of respiratory function? What do otolaryngologists/allergists require for an objective and valid estimate of respiratory function?

What is the evidence linking impaired nasal respiratory function with craniofacial growth? How much "impairment" is likely to have a morphogenetic influence on craniofacial growth? How much growth modification is produced? Is this of clinical significance in relation to the etiology, treatment or prognosis for malocclusion?

How do medical practitioners make a decision on the appropriateness of various treatment modalities for airway obstruction: allergy treatment, surgery (tonsillectomy, adenoidectomy, septoplasty, turbinectomy)? How effective is medical treatment for improving respiration? Is there any evidence that ENT/Allergy treatment improves either growth or the stability of orthodontic treatment?

Panel participants include: **Dr James L. Ackerman,** Introductory Comments; **Dr Peter S. Vig,** Unresolved Issues Concerning the Airway and Orthodontics; **Dr Donald W. Warren,** Upper Airway Breathing: Methods of Measurement and Implications for Craniofacial Growth; **Dr Gail Shapiro,** The Effect of Allergic Reactivity on the Upper Airway and Facial Development; **Dr Jack L. Paradise,** Adenoidal Obstruction of the Nasopharyngeal Airway: Clinical and Radiographic Correlations; **Dr James L. Ackerman,** The Day in Perspective; **Dr James A. McNamara,** Clinical Trials of Nasorespiratory Dysfunction and Craniofacial Growth; **Dr Jerold J. Principato,** Nasal Obstruction and Craniofacial Deformity; and **Dr James L. Ackerman,** Seminar Summation.

Registration received after February 1, 1985, $325(US); Student Fee (does not include luncheons), $70(US).

For more information contact Reservation Chairman: Lawrence L. Albert, DDS, 140 E Hartsdale Ave, Hartsdale, NY 10530

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ADVANCES IN ALLERGY, IMMUNOLOGY AND DERMATOLOGY—June 10–12, 1985. The Broadmoor, Colorado Springs, Colorado. Sponsored by the American Academy of Pediatrics. Guest Faculty will include: Dr Clifton Furukawa, Allergy; Dr Jerome M. Buckley, Allergy; Dr Ronald C. Hansen, Dermatology; Dr E. Richard Stiehm, Immunology; Dr Alvin H. Jacobs, Dermatology. A course program and registration form will be sent upon request. Contact: Neal A. Baker, Department of Education, American Academy of Pediatrics, PO Box 927, Elk Grove Village, IL 60007. Or phone toll-free: (800) 433-9016, in Illinois (800) 421-0589.

□

GENERAL PEDIATRICS—May 23–25, 1985. Mariner's Inn, Hilton Head Island, South Carolina. Sponsored by the American Academy of Pediatrics. Guest faculty will include: Dr William Oh, Neonatology; Dr William Long, Adolescence; Dr Melvin D. Levine, Developmental Dysfunctions; Dr Ralph E. Kauffman, Accidents and Poisons; Dr John M. Freeman, Neurology. A course program and registration form will be sent upon request. Contact: Neal A. Baker, Department of Education, American Academy of Pediatrics, PO Box 927, Elk Grove Village, IL 60007. Or phone toll-free: (800) 433-9016: in Illinois (800) 421-0589.

USC

University of Southern California School of Medicine and Childrens Hospital of Los Angeles offer THE 15th ANNUAL REVIEW OF PEDIATRICS May 13–17, 1985. Tuition: Physicians, $360 ($380 after April 12, 1985). Residents, $250. Credit: 25 hours of Category 1 AMA/CMA credit.

Contact: Associate Dean, USC School of Medicine, Postgraduate Division, 2025 Zonal Ave, KAM 307, Los Angeles, CA 90033. (800) 421-6729 outside California; (800) 321-1929 within California.

□

GENERAL PEDIATRICS—March 21–23, 1985. New York Hilton, New York, New York, Sponsored by the American Academy of Pediatrics. Guest Faculty will include: Dr Howard A. Pearson, Hematology; Dr Charles I. Scott, Jr, Genetics; Dr Ronald Gold, Infectious Diseases; Dr Robert A. Doughty, Collagen Diseases/Rheumatology; Dr Stanley I. Greenspan, Child Development. AMA category 1: 16 hours, PREP credits: 10 hours. A course program and registration form will be sent upon request. Contact: Neal A. Baker, Department of Education, American Academy of Pediatrics, PO Box 927, Elk Grove Village, IL 60007. Or phone toll-free (800) 433-9016; in Illinois: (800) 421-0589.

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RESEARCH CONSULTATION—Pediatric Endocrinology. For literature search/review, protocol, data analysis, and manuscript preparation, please write your research interests to CERC, PO Box 345, Park Ridge, NJ 07656.

□

TOILET LEARNING: THE PICTURE BOOK TECHNIQUE FOR CHILDREN AND PARENTS—by Alison Mack (Little, Brown, 1978). "TOILET LEARNING's strengths are its informal, positive, developmental orientations as opposed to punitive and operant orientations." Dr Ira Gordon, Dean, School of Education, University of North Carolina. At your bookseller.

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1985 CME CRUISE/CONFERENCES ON SELECTED MEDICAL TOPICS—Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. Seven to 14 days year-round. Approved for 20–24 CME category 1 credits (AMA/PRA) and AAFP prescribed credit. Distinguished professors. Fly Roundtrip Free on Caribbean, Mexican, and Alaskan Cruises. Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave, Huntington Station, NY 11746. (516) 549-0869.

□

CONTINUING CARE OF THE HIGH-RISK INFANT, April 4, 1985, Park Ridge, Illinois. Sponsored by Ross Laboratories and the Department of Pediatrics, Section of Neonatology, Lutheran General Hospital. Guest faculty include: Marshall Klaus, MD, Michigan State University, and David Caldarelli, MD, Rush Medical College of Rush University. Additional information contact: Mary Lou Mumford, Newborn ICU Office, Lutheran General Hospital, 1775 W Dempster St, Park Ridge, IL 60068, (312) 696-5313.

□

ADVANCES IN PEDIATRIC GASTROENTEROLOGY—On Oct 17–19, 1985 at the Hospital for Sick Children in Toronto, a postgraduate course will be presented, dealing with recent developments in the field of Pediatric Gastroenterology. The course, for which Category 1 ACCME credits are available, will be of interest to pediatricians and gastroenterologists. For further information, contact Dr J. R. Hamilton, Hospital for Sick Children, 555 University Ave, Toronto, Ontario. M5G 1X8. Telephone (416) 598-6185.

□

PHOENIX CHILDREN'S HOSPITAL, "Pediatric Update 1985," March 19–22, 1985, La Posada Resort Hotel, Scottsdale, Arizona. Contact: Ronald A. Christensen, MD, Phoenix Children's Hospital, 1117 E Willetta, Phoenix, AZ 85006. (602) 239-4350.

CRISIS AND EMERGENCY PEDIATRICS—March 7–10, 1985. Doubletree Hotel, Tucson, Arizona. Cosponsored by the American Academy of Pediatrics and the University of Arizona Health Sciences Center. Guest faculty will include: Dr James Garrick, Director of Sports Medicine, St Francis Memorial Hospital, San Francisco, California; Dr W. Alan Hodson, Professor and Head, Department of Pediatrics, University of Washington, Seattle, Washington; Dr Frank A. Oski, Professor and Head, Department of Pediatrics, SUNY, Syracuse, New York; selected guest faculty from the University of Arizona School of Medicine will also present materials. A course program and registration form will be sent upon request. Contact: Neal A. Baker, Department of Education, American Academy of Pediatrics, PO Box 927, Elk Grove Village, IL 60007. Or phone toll-free:(800) 433-9016; in Illinois (800) 421-0589.

□

THIRD ANNUAL SCIENTIFIC CONFERENCE ON PEDIATRIC NUTRITION—Montreal, Canada, June 21–23, 1985. Nutritional needs and problems of newborns, infants, and adolescents shall be emphasized. Besides update lectures, there will be opportunity for presenting short papers and posters. CME credits available. Apply early to avail preregistration rates: Dr R. K. Chandra, Janeway Hospital, St John's, NF, A1A 1R8, Canada.

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FEBRUARY 1985
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Pediatrics

AMERICAN ACADEMY OF PEDIATRICS ELK GROVE VILLAGE ILLINOIS 60007

National Institute of Child Health and Human Development Randomized, Controlled Trial of Phototherapy for Neonatal Hyperbilirubinemia

Supplement

National Institute of Child Health and Human Development Randomized, Controlled Trial of Phototherapy for Neonatal Hyperbilirubinemia

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