



Put the sting on the bugs, not the baby blues.

POLYTRIM® eradicates the most common causative pathogens of bacterial conjunctivitis, including the primary ones, *Haemophilus influenzae* and *Streptococcus pneumoniae*.^{1,2}

Eliminating *H influenzae* is critical, because it causes 3 to 4 times more cases of bacterial conjunctivitis in children than any other ocular pathogen.²

Yet for all its bactericidal activity, POLYTRIM® is *safe and effective for children 2 months of age and over*. Comfortable on instillation, it contains no neomycin or sulfa.

All good reasons why POLYTRIM® is an excellent solution for pinkeye. Especially for those baby blues.

Polytrim®

Ophthalmic Solution Sterile
(trimethoprim sulfate 0.1%, polymyxin B sulfate 10,000 units/mL)

POLYTRIM® is for bacterial conjunctivitis due to susceptible strains of *Haemophilus influenzae*, *Staphylococcus aureus*, *Staphylococcus epidermidis*, *Streptococcus pneumoniae*, *Streptococcus viridans*, and *Pseudomonas aeruginosa* (Efficacy for this organism was studied in fewer than 10 infections.).

The most frequent adverse reaction is local irritation consisting of increased redness, burning, stinging, or itching. Not indicated for the treatment of ophthalmia neonatorum.

Please see adjacent page for references and brief prescribing information.

I t K i l l s P i n k e y e W i t h K i n d n e s s

POLYTRIM® Ophthalmic Solution Sterile (trimethoprim sulfate 0.1% and polymyxin B sulfate 10,000 units/mL)

INDICATIONS AND USAGE: POLYTRIM® Ophthalmic Solution is indicated in the treatment of surface ocular bacterial infections, including acute bacterial conjunctivitis, and blepharoconjunctivitis, caused by susceptible strains of the following microorganisms: *Staphylococcus aureus*, *Staphylococcus epidermidis*, *Streptococcus pneumoniae*, *Streptococcus viridans*, *Haemophilus influenzae* and *Pseudomonas aeruginosa*. * Efficacy for this organism in this organ system was studied in fewer than 10 infections.

CONTRAINDICATIONS: POLYTRIM® Ophthalmic Solution is contraindicated in patients with known hypersensitivity to any of its components.

WARNINGS: NOT FOR INJECTION INTO THE EYE. If a sensitivity reaction to POLYTRIM® occurs, discontinue use. POLYTRIM® Ophthalmic Solution is not indicated for the prophylaxis or treatment of ophthalmia neonatorum.

PRECAUTIONS:

General: As with other antimicrobial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, appropriate therapy should be initiated.

Information for Patients: Avoid contaminating the applicator tip with material from the eye, fingers, or other source. This precaution is necessary if the sterility of the drops is to be maintained. If redness, irritation, swelling or pain persists or increases, discontinue use immediately and contact your physician. **Carcinogenesis, Mutagenesis, Impairment of Fertility:**

Carcinogenesis: Long-term studies in animals to evaluate carcinogenic potential have not been conducted with polymyxin B sulfate or trimethoprim. **Mutagenesis:** Trimethoprim was demonstrated to be non-mutagenic in the Ames assay. In studies at two laboratories, no chromosomal damage was detected in cultured Chinese hamster ovary cells at concentrations approximately 500 times human plasma levels after oral administration; at concentrations approximately 1000 times human plasma levels after oral administration in these same cells a low level of chromosomal damage was induced at one of the laboratories. Studies to evaluate mutagenic potential have not been conducted with polymyxin B sulfate. **Impairment of Fertility:** Polymyxin B sulfate has been reported to impair the motility of equine sperm, but its effects on male or female fertility are unknown. No adverse effects on fertility or general reproductive performance were observed in rats given trimethoprim in oral dosages as high as 70 mg/kg/day for males and 14 mg/kg/day for females.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Animal reproduction studies have not been conducted with polymyxin B sulfate. It is not known whether polymyxin B sulfate can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Trimethoprim has been shown to be teratogenic in the rat when given in oral doses 40 times the human dose. In some rabbit studies, the overall increase in fetal loss (dead and resorbed and malformed conceptuses) was associated with oral doses 6 times the human therapeutic dose. While there are no large well-controlled studies on the use of trimethoprim in pregnant women, Brumfitt and Pursell, in a retrospective study, reported the outcome of 186 pregnancies during which the mother received either placebo or oral trimethoprim in combination with sulfamethoxazole. The incidence of congenital abnormalities was 4.5% (3 of 66) in those who received placebo and 3.3% (4 of 120) in those receiving trimethoprim and sulfamethoxazole. There were no abnormalities in the 10 children whose mothers received the drug during the first trimester. In a separate survey, Brumfitt and Pursell also found no congenital abnormalities in 35 children whose mothers had received oral trimethoprim and sulfamethoxazole at the time of conception or shortly thereafter. Because trimethoprim may interfere with folic acid metabolism, trimethoprim should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: The oral administration of trimethoprim to rats at a dose of 70 mg/kg/day commencing with the last third of gestation and continuing through parturition and lactation caused no deleterious effects on gestation or pup growth and survival. **Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when POLYTRIM® Ophthalmic Solution is administered to a nursing woman. **Pediatric Use:** Safety and effectiveness in children below the age of 2 months have not been established (see WARNINGS).

ADVERSE REACTIONS: The most frequent adverse reaction to POLYTRIM® Ophthalmic Solution is local irritation consisting of increased redness, burning, stinging, and/or itching. This may occur on instillation, within 48 hours, or at any time with extended use. There are also multiple reports of hypersensitivity reactions consisting of lid edema, itching, increased redness, tearing, and/or circumocular rash. Photosensitivity has been reported in patients taking oral trimethoprim.

1. Lohr J, et al. Comparison of three topical antimicrobials for acute bacterial conjunctivitis. *Pediatr Infect Dis J*. 1988;7:626-629.
2. Gigliotti F, et al. Etiology of acute conjunctivitis in children. *J Pediatr*. 1981;98:531-536.

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freedom of
m o v e m e n t .

Two caplets, once a day*

DAYPRO[®]
(oxaprozin) 600-mg caplets

Daylong Confidence. Proactive Control.



DAYPRO is indicated for the treatment of the signs and symptoms of OA and RA.

*Usual adult dosage is 1200 mg (two 600-mg caplets) once a day. For osteoarthritis patients of low body weight or with milder disease, an initial dosage of one 600-mg caplet once a day, or an optional one-time loading dose of 1200 mg, may be appropriate. Dosage should be individualized to the lowest effective dose; the maximum recommended total daily dosage is 1800 mg or 26 mg/kg, whichever is lower, in divided doses.

Contraindicated in patients with hypersensitivity to DAYPRO or in individuals with nasal polyps, angioedema, or bronchospastic reactivity to aspirin or other NSAIDs. Severe and occasionally fatal asthmatic and anaphylactic reactions to NSAIDs have been reported; there have been rare reports of anaphylaxis with DAYPRO. As with other NSAIDs, the most frequently reported adverse reactions were related to the GI tract. In patients treated chronically with NSAID therapy, serious GI toxicity, such as bleeding, ulceration, and perforation, can occur. Severe renal and hepatic reactions have been reported. There may be a risk of fatal hepatitis with oxaprozin, such as has been seen with other NSAIDs.

Please see brief summary of prescribing information on adjacent page.

BRIEF SUMMARY—**DAYPRO[®]** (oxaprozin) 600-mg caplets

Before prescribing please see full prescribing information.

INDICATIONS AND USAGE: Daypro is indicated for the treatment of the signs and symptoms of OA and RA.

CONTRAINDICATIONS: Hypersensitivity to oxaprozin or any of its components or in individuals with the complete or partial syndrome of nasal polyps, angioedema, and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (NSAIDs). Severe and occasionally fatal asthmatic and anaphylactic reactions have been reported in patients receiving NSAIDs, and there have been rare reports of anaphylaxis in patients taking oxaprozin.

WARNINGS: RISK OF GASTROINTESTINAL (GI) ULCERATION, BLEEDING, AND PERFORATION WITH NONSTEROIDAL ANTI-INFLAMMATORY DRUG THERAPY: Serious gastrointestinal toxicity, such as bleeding, ulceration, and perforation, can occur at any time, with or without warning symptoms, in patients treated with NSAIDs. Although minor upper gastrointestinal problems, such as dyspepsia, are common, and usually develop early in therapy, physicians should remain alert for ulceration and bleeding in patients treated chronically with NSAIDs, even in the absence of previous GI tract symptoms. In patients observed in clinical trials for several months to 2 years, symptomatic upper GI ulcers, gross bleeding, or perforation appear to occur in approximately 1% of patients treated for 3 to 6 months, and in about 2% to 4% of patients treated for 1 year. Physicians should inform patients about the signs and/or symptoms of serious GI toxicity and what steps to take if they occur. Patients at risk for developing peptic ulceration and bleeding are those with a prior history of serious GI events, alcoholism, smoking, or other factors known to be associated with peptic ulcer disease. Elderly or debilitated patients seem to tolerate ulceration or bleeding less well than other individuals, and most spontaneous reports of fatal GI events are in these populations. Studies to date are inconclusive concerning the relative risk of various NSAIDs in causing such reactions. High doses of any NSAID probably carry a greater risk of these reactions, and substantial benefit should be anticipated to patients prior to prescribing maximal doses of Daypro.

PRECAUTIONS: General. Hepatic effects: As with other NSAIDs, borderline elevations of one or more liver tests may occur in up to 15% of patients. These abnormalities may progress, remain essentially unchanged, or resolve with continued therapy. The SGPT (ALT) test is probably the most sensitive indicator of liver dysfunction. Meaningful (3 times the upper limit of normal) elevations of SGOT (AST) occurred in controlled clinical trials of Daypro in just under 1% of patients. A patient with symptoms and/or signs suggesting liver dysfunction or in whom an abnormal liver test has occurred should be evaluated for evidence of the development of more severe hepatic reaction while on therapy with this drug. Severe hepatic reactions including jaundice have been reported with Daypro, and there may be a risk of fatal hepatitis with oxaprozin, such as has been seen with other NSAIDs. Although such reactions are rare, if abnormal liver tests persist or worsen, clinical signs and symptoms consistent with liver disease develop, or systemic manifestations occur (eosinophilia, rash, fever), Daypro should be discontinued. Well-compensated hepatic cirrhosis does not appear to alter the disposition of unbound oxaprozin, so dosage adjustment is not necessary. However, the primary route of elimination of oxaprozin is hepatic metabolism, so caution should be observed in patients with severe hepatic dysfunction. **Renal effects:** Acute interstitial nephritis, hematuria, and proteinuria have been reported with Daypro as with other NSAIDs. Long-term administration of some NSAIDs to animals has resulted in renal papillary necrosis and other abnormal renal pathology. This was not observed with oxaprozin, but the clinical significance of this difference is unknown. A second form of renal toxicity has been seen in patients with preexisting conditions leading to a reduction in renal blood flow, where the renal prostaglandins have a supportive role in the maintenance of renal perfusion. In these patients administration of an NSAID may cause a dose-dependent reduction in prostaglandin formation and may precipitate overt renal decompensation. Patients at greatest risk of this reaction are those with previously impaired renal function, heart failure, or liver dysfunction, those taking diuretics, and the elderly. Discontinuation of NSAID therapy is often followed by recovery to the pretreatment state. Those patients at high risk who chronically take oxaprozin should have renal function monitored if they have signs or symptoms that may be consistent with mild azotemia, such as malaise, fatigue, or loss of appetite. As with all NSAID therapy, patients may occasionally develop some elevation of serum creatinine and BUN levels without any signs or symptoms. The pharmacokinetics of oxaprozin may be significantly altered in patients with renal insufficiency or in patients who are undergoing hemodialysis. Such patients should be started on doses of 600 mg/day, with cautious dosage increases if the desired effect is not obtained. Oxaprozin is not dialyzed because of its high degree of protein binding. Like other NSAIDs, Daypro may worsen fluid retention by the kidneys in patients with uncompensated cardiac failure due to its effect on prostaglandins. It should be used with caution in patients with a history of hypertension, cardiac decompensation, in patients on chronic diuretic therapy, or in those with other conditions predisposing to fluid retention. **Photosensitivity:** Oxaprozin has been associated with rash and/or mild photosensitivity in dermatologic testing. An increased incidence of rash on sun-exposed skin was seen in some patients in the clinical trials. **Recommended laboratory testing:** Because serious GI tract ulceration and bleeding can occur without warning symptoms, physicians should follow chronically treated patients for the signs and symptoms of ulceration and bleeding and should inform them of the importance of this follow-up (see **Warnings**). Anemia may occur in patients receiving oxaprozin or other NSAIDs. This may be due to fluid retention, gastrointestinal blood loss, or an incompletely described effect upon erythropoiesis. Patients on long-term treatment with Daypro should have their hemoglobin or hematocrit values determined at appropriate intervals as determined by the clinical situation. Oxaprozin, like other NSAIDs, can affect platelet aggregation and prolong bleeding time. Daypro should be used with caution in patients with underlying hemostatic defects or in those who are undergoing surgical procedures where a high degree of hemostasis is needed. **Information for patients:** Daypro, like other drugs of its class, nonsteroidal anti-inflammatory drugs (NSAIDs), is not free of side effects. The side effects of these drugs can cause discomfort and, rarely, serious side effects, such as gastrointestinal bleeding, which may result in hospitalization and even fatal outcomes. NSAIDs are often essential agents in the management of arthritis, but they may also be commonly employed for conditions that are less serious. Physicians may wish to discuss with their patients the potential risks (see **Warnings, Precautions, and Adverse Reactions**) and likely benefits of Daypro treatment, particularly in less-serious conditions where treatment without Daypro may represent an acceptable alternative to both the patient and the physician. Patients receiving Daypro may benefit from physician instruction in the symptoms of the more common or serious gastrointestinal, renal, hepatic, hematologic, and dermatologic adverse effects. **Laboratory test interactions:** False-positive urine immunoassay screening tests for benzodiazepines have been reported in patients taking Daypro. This is due to lack of specificity of the screening tests. False-positive test results may be expected for several days following discontinuation of Daypro therapy. Confirmatory tests, such as gas chromatography/mass spectrometry, will distinguish Daypro from benzodiazepines. **Drug interactions:** Aspirin: Concomitant administration of Daypro and aspirin is not recommended because oxaprozin displaces salicylates from plasma protein binding sites. Coadministration would be expected to increase the risk of salicylate toxicity. **Oral anticoagulants:** The anticoagulant effects of warfarin were not affected by the coadministration of 1200 mg/day of Daypro. Nevertheless, caution should be exercised when adding any drug that affects platelet function to the regimen of patients receiving oral anticoagulants. **H₂-receptor antagonists:** The total body clearance of oxaprozin was reduced by 20% in subjects who concurrently received therapeutic doses of cimetidine or ranitidine; no other pharmacokinetic parameter was affected. A change of clearance of this magnitude lies within the range of normal variation and is unlikely to produce a clinically detectable difference in the outcome of therapy. **Beta-blockers:** Subjects receiving 1200 mg Daypro qd with 100 mg

metoprolol bid exhibited statistically significant but transient increases in sitting and standing blood pressures after 14 days. Therefore, as with all NSAIDs, routine blood pressure monitoring should be considered in these patients when starting Daypro therapy. **Other drugs:** The coadministration of oxaprozin and antacids, acetaminophen, or conjugated estrogens resulted in no statistically significant changes in pharmacokinetic parameters in single- and/or multiple-dose studies. The interaction of oxaprozin with lithium and cardiac glycosides has not been studied. **Carcinogenesis, mutagenesis, impairment of fertility:** In oncogenicity studies, oxaprozin administration for 2 years was associated with the exacerbation of liver neoplasms (hepatic adenomas and carcinomas) in male CD mice, but not in female CD mice or rats. The significance of this species-specific finding to man is unknown. Oxaprozin did not display mutagenic potential. Results from the Ames test, forward mutation in yeast and Chinese hamster ovary (CHO) cells, DNA repair testing in CHO cells, micronucleus testing in mouse bone marrow, chromosomal aberration testing in human lymphocytes, and cell transformation testing in mouse fibroblast all showed no evidence of genetic toxicity or cell-transforming ability. Oxaprozin administration was not associated with impairment of fertility in male and female rats at oral doses up to 200 mg/kg/day (1180 mg/m²); the usual human dose is 17 mg/kg/day (629 mg/m²). However, testicular degeneration was observed in beagle dogs treated with 37.5 to 150 mg/kg/day (750 to 3000 mg/m²) of oxaprozin for 6 months, or 37.5 mg/kg/day for 42 days, a finding not confirmed in other species. The clinical relevance of this finding is not known. **Pregnancy: Teratogenic Effects—Pregnancy Category C.** There are no adequate or well-controlled studies in pregnant women. Teratology studies with oxaprozin were performed in mice, rats, and rabbits. In mice and rats, no drug-related developmental abnormalities were observed at 50 to 200 mg/kg/day of oxaprozin (225 to 900 mg/m²). However, in rabbits, infrequent malformed fetuses were observed in dams treated with 7.5 to 30 mg/kg/day of oxaprozin (the usual human dosage range). Oxaprozin should be used during pregnancy only if the potential benefits justify the potential risks to the fetus. **Labor and delivery:** The effect of oxaprozin in pregnant women is unknown. NSAIDs are known to delay parturition, to accelerate closure of the fetal ductus arteriosus, and to be associated with dystocia. Oxaprozin is known to have caused decreases in pup survival in rat studies. Accordingly, the use of oxaprozin during late pregnancy should be avoided. **Nursing mothers:** Studies of oxaprozin excretion in human milk have not been conducted; however, oxaprozin was found in the milk of lactating rats. Since the effects of oxaprozin on infants are not known, caution should be exercised if oxaprozin is administered to nursing women. **Pediatric use:** Safety and effectiveness of Daypro in children have not been established. **Geriatric use:** No adjustment of the dose of Daypro is necessary in the elderly for pharmacokinetic reasons, although many elderly may need to receive a reduced dose because of low body weight or disorders associated with aging. No significant differences in the pharmacokinetic profile for oxaprozin were seen in studies in the healthy elderly. Although selected elderly patients in controlled clinical trials tolerated Daypro as well as younger patients, caution should be exercised in treating the elderly, and extra care should be taken when choosing a dose. As with any NSAID, the elderly are likely to tolerate adverse reactions less well than younger patients.

ADVERSE REACTIONS: The most frequently reported adverse reactions were related to the gastrointestinal tract. They were nausea (8%) and dyspepsia (8%). **Incidence greater than 1%:** In clinical trials the following adverse reactions occurred at an incidence greater than 1% and are probably related to treatment. Reactions occurring in 3% to 9% of patients treated with Daypro are indicated by an asterisk(*); those reactions occurring in less than 3% of patients are unmarked. Abdominal pain/distress, anorexia, constipation, * diarrhea, * dyspepsia, * flatulence, nausea, * vomiting, CNS inhibition (depression, sedation, somnolence, or confusion), disturbance of sleep, rash, * tinnitus, dysuria or frequency. **Incidence less than 1%: Probable causal relationship:** The following adverse reactions were reported in clinical trials or from worldwide marketing experience at an incidence of less than 1%. Those reactions reported only from worldwide marketing experience are in *italics*. The probability of a causal relationship exists between the drug and these adverse reactions: Drug hypersensitivity reactions including anaphylaxis and serum sickness, edema, blood pressure changes, peptic ulceration and/or GI bleeding (see **Warnings**), liver function abnormalities including hepatitis (see **Precautions**), stomatitis, hemorrhoidal or rectal bleeding, *pancreatitis*, anemia, thrombocytopenia, leukopenia, *echymoses*, *agranulocytosis*, *pancytopenia*, weight gain, weight loss, weakness, malaise, symptoms of upper respiratory tract infection, pruritus, urticaria, photosensitivity, *pseudoporphyria*, *exfoliative dermatitis*, *erythema multiforme*, *Stevens-Johnson syndrome*, *toxic epidermal necrolysis (Lyell's syndrome)*, blurred vision, conjunctivitis, *acute interstitial nephritis*, *hematuria*, *renal insufficiency*, *acute renal failure*, decreased menstrual flow. **Causal relationship unknown:** The following adverse reactions occurred at an incidence of less than 1% in clinical trials, or were suggested from marketing experience, under circumstances where a causal relationship could not be definitively established. They are listed as alerting information for the physician: Palpitations, alteration in taste, sinusitis, pulmonary infections, alopecia, hearing decrease, increase in menstrual flow.

DRUG ABUSE AND DEPENDENCE: Daypro is a non-narcotic drug. Usually reliable animal studies have indicated that Daypro has no known addiction potential in humans.

OVERDOSAGE: No patient experienced either an accidental or intentional overdose of Daypro in the clinical trials of the drug. Symptoms following acute overdose with other NSAIDs are usually limited to lethargy, drowsiness, nausea, vomiting, and epigastric pain and are generally reversible with supportive care. Gastrointestinal bleeding and coma have occurred following NSAID overdose. Hypertension, acute renal failure, and respiratory depression are rare. Patients should be managed by symptomatic and supportive care following an NSAID overdose. There are no specific antidotes. Gut decontamination may be indicated in patients seen within 4 hours of ingestion with symptoms or following a large overdose (5 to 10 times the usual dose). This should be accomplished via emesis and/or activated charcoal (60 to 100 g in adults, 1 to 2 g/kg in children) with an osmotic cathartic. Forced diuresis, alkalization of the urine, or hemoperfusion would probably not be useful due to the high degree of protein binding of oxaprozin.

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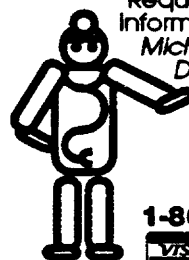
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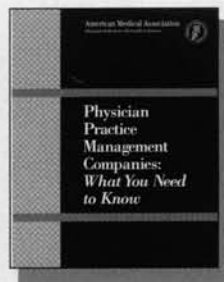
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bidity or mortality, but a strong cultural preference for a sonographic "view of the baby," shared by clinicians and laypeople, perpetuates this practice. It is the pain, effort, and uncertainty of going through labor and still needing an emergency CS that may deter many patients and clinicians from choosing TOL.

Given the strong negative value placed by child-bearing women on a "failed" TOL (ie, one that ends with an emergency CS) and the higher risks associated with emergency rather than elective CS, clinical decision making requires better information about the predictors of a successful TOL. The policy team identified previous vaginal delivery and CS for breech presentation as favorable predictors and previous CS for cephalopelvic disproportion and no previous vaginal delivery as unfavorable predictors, but the variability in success rate for TOL was wide. What aspects of care during labor contribute to successful VBAC? Additional data to quantify the differ-

ences in morbidity associated with emergency CS vs ERCS would also greatly facilitate the woman's choice.

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REFERENCES

1. Roberts RG, Bell HS, Wall EM, Moy JG, Hess GH, Bower HPH. Trial of labor or repeated cesarean section: the woman's choice. *Arch Fam Med*. 1997;6:120-125.
2. Slovic P, Fischhoff B, Lichtenstein S. Informing the public about the risks from ionizing radiation. In: Arkes HR, Hammond KR, eds. *Judgement and Decision Making: An Interdisciplinary Reader*. New York, NY: Cambridge University Press; 1986:114-126.

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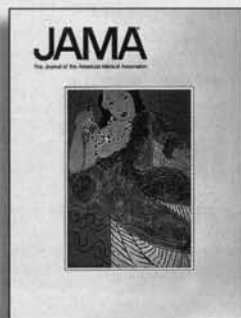
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of the seizures, and the preceding aura on subsequent events in our patients are supportive of the diagnosis of partial epilepsy with secondary generalization.

The neurologic examination is most often normal in patients with epilepsy and no obvious brain disease. Occasionally, a mild facial weakness, reflex asymmetry, or a subtle difference in the size of the nail beds or the extremities can be seen. This was the case in our second patient who had asymmetric tendon reflexes. The normal results of the electroencephalograms do not exclude the diagnosis of epilepsy since the yield of a single electroencephalogram for epileptiform abnormalities in patients with focal epilepsy is only about 50%. The yield reaches a maximum of 80 to 90% with the fourth to fifth study with no further increase in yield on subsequent recording.¹⁶

In conclusion, nocturnal convulsions in epileptic patients may produce vertebral fractures that may be the presenting feature. Epileptic seizures should be considered in the differential diagnosis of what may appear to be an idiopathic vertebral compression fracture.

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REFERENCES

1. Brown RL. Bilateral dislocation of the shoulder. *Injury*. 1984;15:267-273.
2. Goldman A, Sherman O, Price A, Minkoff J. Posterior fracture-dislocation of the shoulder with biceps tendon interposition. *J Trauma*. 1987;27:1083-1086.
3. Kelly JP. Fractures complicating electroconvulsive therapy and chronic epilepsy. *J Bone Joint Surg Br*. 1954;36:70-79.
4. Kristiansen BN, Cristensen S. Fractures of the proximal end of the humerus caused by convulsive seizures. *Injury*. 1984;16:108-109.
5. Lingley RJ, Robbins LL. Fractures following electroshock therapy. *Neurology*. 1947;48:124-128.
6. Shaw JL. Bilateral posterior fracture-dislocation of the shoulder and other trauma caused by convulsive seizures. *J Bone Joint Surg Am*. 1971;53:1437-1440.
7. Finelli PF, Cardi JK. Seizures as a cause of fracture. *Neurology*. 1989;39:858-860.
8. Lehndorff H. Deformitäten der Wirbelsäule und der Rippen im Verlaufe eines schweren Tetanus. *Wien Med Wochenschr*. 1907;6:186.
9. Pedersen KK, Christiansen C, Ahlgren P, Lund M. Incidence of fractures of the vertebral spine in epileptic patients. *Acta Neurol Scand*. 1976;54:200-203.
10. Vasconcelos D. Compression fractures of the vertebrae during major epileptic seizures. *Epilepsia*. 1973;14:323-328.
11. Dubost JJ, Venay D, Soubrier M, Cauhape P, Bussièrè JL, Sauvezie B. Vertebral compression in epilepsy: analyses of 8 cases. *Rev Med Interne*. 1993;14:294-296.
12. Heller E, Binder RL. Clozapine and seizures. *Am J Psychiatry*. 1990;147:1069-1071.
13. Hepburn DA, Steel JN, Frier BN. Hypoglycemic convulsions cause serious musculoskeletal injuries in patients with IDDM. *Diabetes Care*. 1989;12:32-34.
14. McCullen GM, Brown CC. Seizure-induced thoracic burst fractures: a case report. *Spine*. 1994;19:77-79.
15. Youssef JA, McCullen G, Brown CC. Seizure-induced lumbar burst fractures. *Spine*. 1995;20:1301-1303.
16. Salinsky M, Kanter R, Dashieff RM. Effectiveness of multiple EEGs in supporting the diagnosis of epilepsy: an operational curve. *Epilepsia*. 1987;28:331-334.



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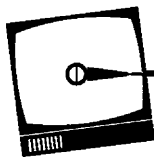
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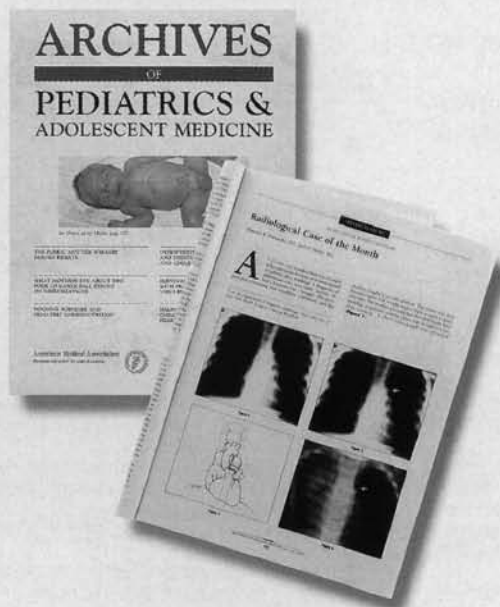
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PRECAUTIONS

General

CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any drug given over prolonged periods, laboratory parameters of renal and hepatic function should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing. Dermatologic events (see ADVERSE REACTIONS section) may be transient and may disappear despite continued use of CARDIZEM. However, skin eruptions progressing to erythema multiforme and/or exfoliative dermatitis have also been infrequently reported. Should a dermatologic reaction persist, the drug should be discontinued.

Drug Interactions

Due to the potential for additive effects, caution and careful titration are warranted in patients receiving CARDIZEM concomitantly with other agents known to affect cardiac contractility and/or conduction. (See WARNINGS.) Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

As with all drugs, care should be exercised when treating patients with multiple medications. CARDIZEM undergoes biotransformation by cytochrome P-450 mixed function oxidase. Coadministration of CARDIZEM with other agents which follow the same route of biotransformation may result in the competitive inhibition of metabolism. Especially in patients with renal and/or hepatic impairment, dosages of similarly metabolized drugs, particularly those of low therapeutic ratio, may require adjustment when starting or stopping concomitantly administered diltiazem to maintain optimum therapeutic blood levels. **Beta-blockers.** Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers is usually well tolerated, but available data are not sufficient to predict the effects of concomitant treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities.

Administration of CARDIZEM (diltiazem hydrochloride) concomitantly with propranolol in five normal volunteers resulted in increased propranolol levels in all subjects and bioavailability of propranolol was increased approximately 50%. In vitro, propranolol appears to be displaced from its binding sites by diltiazem. If combination therapy is initiated or withdrawn in conjunction with propranolol, an adjustment in the propranolol dose may be warranted. (See WARNINGS.)

Cimetidine. A study in six healthy volunteers has shown a significant increase in peak diltiazem plasma levels (58%) and area-under-the-curve (53%) after a 1-week course of cimetidine at 1200 mg per day and a single dose of diltiazem 60 mg. Ranitidine produced smaller, nonsignificant increases. The effect may be mediated by cimetidine's known inhibition of hepatic cytochrome P-450, the enzyme system responsible for the first-pass metabolism of diltiazem. Patients currently receiving diltiazem therapy should be carefully monitored for a change in pharmacological effect when initiating and discontinuing therapy with cimetidine. An adjustment in the diltiazem dose may be warranted.

Digitalis. Administration of CARDIZEM with digoxin in 24 healthy male subjects increased plasma digoxin concentrations approximately 20%. Another investigator found no increase in digoxin levels in 12 patients with coronary artery disease. Since there have been conflicting results regarding the effect of digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing CARDIZEM therapy to avoid possible over- or under-digitalization. (See WARNINGS.)

Anesthetics. The depression of cardiac contractility, conductivity, and automaticity as well as the vascular dilation associated with anesthetics may be potentiated by calcium channel blockers. When used concomitantly, anesthetics and calcium blockers should be titrated carefully.

Cyclosporine. A pharmacokinetic interaction between diltiazem and cyclosporine has been observed during studies involving renal and cardiac transplant patients. In renal and cardiac transplant recipients, a reduction of cyclosporine dose ranging from 15% to 48% was necessary to maintain cyclosporine trough concentrations similar to those seen prior to the addition of diltiazem. If these agents are to be administered concurrently, cyclosporine concentrations should be monitored, especially when diltiazem therapy is initiated, adjusted, or discontinued.

The effect of cyclosporine on diltiazem plasma concentrations has not been evaluated.

Carbamazepine. Concomitant administration of diltiazem with carbamazepine has been reported to result in elevated serum levels of carbamazepine (40% to 72% increase), resulting in toxicity in some cases. Patients receiving these drugs concurrently should be monitored for a potential drug interaction.

Carcinogenesis, Mutagenesis, Impairment of Fertility

A 24-month study in rats at oral dosage levels of up to 100 mg/kg/day and a 21-month study in mice at oral dosage levels of up to 30 mg/kg/day showed no evidence of carcinogenicity. There was also no mutagenic response in vitro or in vivo in mammalian cell assays or in vitro in bacteria. No evidence of impaired fertility was observed in a study performed in male and female rats at oral dosages of up to 100 mg/kg/day.

Pregnancy

Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers

Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded from these studies.

The following table presents the most common adverse reactions reported in placebo-controlled angina and hypertension trials in patients receiving CARDIZEM CD up to 360 mg with rates in placebo patients shown for comparison.

CARDIZEM CD Capsule Placebo-Controlled Angina and Hypertension Trials Combined		
Adverse Reactions	Cardizem CD (n=607)	Placebo (n=301)
Headache	5.4%	5.0%
Dizziness	3.0%	3.0%
Bradycardia	3.3%	1.3%
AV Block First Degree	3.3%	0.0%
Edema	2.6%	1.3%
ECG Abnormality	1.6%	2.3%
Asthenia	1.8%	1.7%

In clinical trials of CARDIZEM CD capsules, CARDIZEM tablets, and CARDIZEM SR capsules involving over 3200 patients, the most common events (ie, greater than 1%) were edema (4.6%), headache (4.6%), dizziness (3.5%), asthenia (2.6%), first-degree AV block (2.4%), bradycardia (1.7%), flushing (1.4%), nausea (1.4%), and rash (1.2%).

In addition, the following events were reported infrequently (less than 1%) in angina or hypertension trials:

Cardiovascular: Angina, arrhythmia, AV block (second- or third-degree), bundle branch block, congestive heart failure, ECG abnormalities, hypotension, palpitations, syncope, tachycardia, ventricular extrasystoles

Nervous System: Abnormal dreams, amnesia, depression, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor

Gastrointestinal: Anorexia, constipation, diarrhea, dry mouth, dysgeusia, dyspepsia, mild elevations of SGOT, SGPT, LDH, and alkaline phosphatase (see hepatic warnings), thirst, vomiting, weight increase

Dermatologic: Petchiae, photosensitivity, pruritus, urticaria

Other: Amblyopia, CPK increase, dyspnea, epistaxis, eye irritation, hyperglycemia, hyperuricemia, impotence, muscle cramps, nasal congestion, nocturia, osteoarthicular pain, polyuria, sexual difficulties

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: allergic reactions, alopecia, angioedema (including facial or periorbital edema), asystole, erythema multiforme (including Stevens-Johnson syndrome, toxic epidermal necrolysis), exfoliative dermatitis, extrapyramidal symptoms, gingival hyperplasia, hemolytic anemia, increased bleeding time, leukopenia, purpura, retinopathy, and thrombocytopenia. In addition, events such as myocardial infarction have been observed which are not readily distinguishable from the natural history of the disease in these patients.

A number of well-documented cases of generalized rash, some characterized as leukocytoclastic vasculitis, have been reported. However, a definitive cause and effect relationship between these events and CARDIZEM therapy is yet to be established.

Prescribing Information as of December 1995A

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ccdb1295Ac

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- References:** 1. Cardizem CD prescribing information. 2. Felicetta JV, Serfer HM, Cutler NR, et al. *Am Heart J.* 1992;123:1022-1026. 3. Thadani U, Glasser S, Bittar N, Beach CL, Diltiazem CD Study Group. *Am J Cardiol.* 1994;74:9-17. 4. Food and Drug Administration. *Approved Drug Products With Therapeutic Equivalence Evaluations* (Orange Book), US Dept of Health and Human Services. 15th ed. Washington, DC;1995.

A UNIQUE HEMODYNAMIC AND SAFETY PROFILE DIFFERENT FROM DIHYDROPYRIDINES

Benefits of a
nondihydropyridine CCB*

Effective 24-hour control of hypertension or angina

- Reduces blood pressure with no reflex tachycardia¹
- Increases exercise tolerance, reduces vasospasm, and decreases heart rate in angina¹

Well-tolerated control regardless of age or gender[†]

- A side-effect discontinuation rate comparable to placebo^{2,3}
- Most commonly reported side effects are headache (5.4%), bradycardia (3.3%), first-degree AV block (3.3%), dizziness (3.0%), edema (2.6%), ECG abnormality (1.6%), and asthenia (1.8%)¹

True 24-hour control from a unique patented delivery system

- No other diltiazem is therapeutically equivalent to Cardizem CD^{4†}

*Cardizem CD is a benzothiazepine calcium channel blocker.

† In clinical trials with Cardizem CD.

‡ FDA does not, at this time, consider other diltiazems to be therapeutically equivalent because bioequivalence has not been demonstrated through appropriate studies.

Please see brief summary of prescribing information on adjacent page.

FOR HYPERTENSION OR ANGINA



ONCE - A - DAY

CARDIZEM[®] CD

(diltiazem HCl) 120-, 180-, 240-, 300-mg Capsules

No other diltiazem is therapeutically equivalent^{4†}