FOR TYPE II DIABETICS LIFE IS DEMANDING ENOUGH...

TODAY'S LIFE DEMANDS
INSULIN ON DEMAND

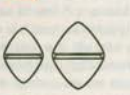
GLUCOTROL® (glipizide) provides patients with insulin when needed, responding on demand to meals and rising blood sugar.[1]

GLUCOTROL, with insulin on demand, controls blood sugar quickly and effectively—all day and all night.[1]

GLUCOTROL works in response to meals; returning insulin to near-normal levels once the meal challenge subsides.[1,2]

When diet alone fails in NIDDM...*

Glucotrol®
(glipizide) 5-mg and 10-mg Scored Tablets

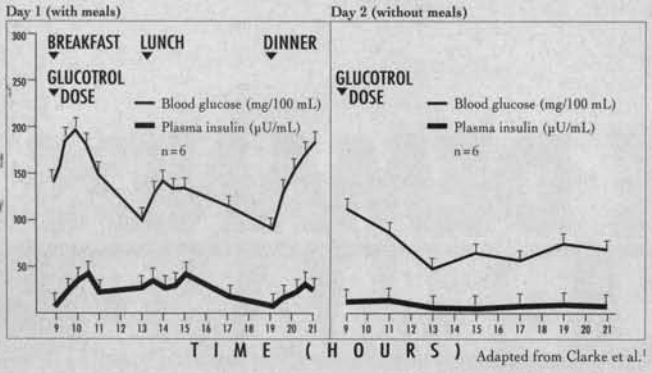


* Non–insulin-dependent diabetes mellitus.
As with all sulfonylureas, hypoglycemia may occur.

Pfizer Pratt Pharmaceuticals

Please see brief summary of prescribing information on last page.

INSULIN ON DEMAND RESPONDS TO MEALS— AND REMAINS AT BASAL LEVELS DURING FASTING



Adapted from Clarke et al.[1]

The effect of fasting on mean blood sugar and plasma insulin levels was measured in a 2-day study of six NIDDM patients whose blood sugar levels had been controlled by a single daily dose of 5 to 10 mg of GLUCOTROL. On the first day, patients were served three meals. On the second, they received no food. Patients received their usual dose of GLUCOTROL at the start of each day.[1]

REFERENCES: 1. Clarke BF, Corrall RJM, Azzopardi J, Bhalla IP, Fraser DM, Duncan LJP. Clinical observations on glipizide: efficacy, duration of activity, and safety. In: *Glipizide: A Worldwide Review*. Princeton, NJ: Excerpta Medica; 1984:234-247. **2.** Goebel R, Leb G. Effects of glyburide and glipizide on levels of immunoreactive insulin and blood sugar. In: *Glipizide: A Worldwide Review*. Princeton, NJ: Excerpta Medica; 1984:9-15.

Brief Summary of Prescribing Information

INDICATIONS AND USAGE: GLUCOTROL is indicated as an adjunct to diet for the control of hyperglycemia in patients with non-insulin-dependent diabetes mellitus (NIDDM, type II) after an adequate trial of dietary therapy has proved unsatisfactory.

CONTRAINDICATIONS: GLUCOTROL is contraindicated in patients with known hypersensitivity to the drug or with diabetic ketoacidosis, with or without coma, which should be treated with insulin.

SPECIAL WARNING ON INCREASED RISK OF CARDIOVASCULAR MORTALITY: The administration of oral hypoglycemic drugs has been reported to be associated with increased cardiovascular mortality as compared to treatment with diet alone or diet plus insulin. This warning is based on the study conducted by the University Group Diabetes Program (UGDP), a long-term prospective clinical trial designed to evaluate the effectiveness of glucose-lowering drugs in preventing or delaying vascular complications in patients with non-insulin-dependent diabetes. The study involved 823 patients who were randomly assigned to one of four treatment groups (*Diabetes*, 19, supp. 2:747-830, 1970).

UGDP reported that patients treated for 5 to 8 years with diet plus a fixed dose of tolbutamide (1.5 grams per day) had a rate of cardiovascular mortality approximately 2½ times that of patients treated with diet alone. A significant increase in total mortality was not observed, but the use of tolbutamide was discontinued based on the increase in cardiovascular mortality, thus limiting the opportunity for the study to show an increase in overall mortality. Despite controversy regarding the interpretation of these results, the findings of the UGDP study provide an adequate basis for this warning. The patient should be informed of the potential risks and advantages of GLUCOTROL and of alternative modes of therapy. Although only one drug in the sulfonylurea class (tolbutamide) was included in this study, it is prudent from a safety standpoint to consider that this warning may also apply to other oral hypoglycemic drugs in this class, in view of their close similarities in mode of action and chemical structure.

PRECAUTIONS: Renal and Hepatic Disease: The metabolism and excretion of GLUCOTROL may be slowed in patients with impaired renal and/or hepatic function. Hypoglycemia may be prolonged in such patients should it occur.

Hypoglycemia: All sulfonylureas are capable of producing severe hypoglycemia. Proper patient selection, dosage, and instructions are important to avoid hypoglycemia. Renal or hepatic insufficiency may increase the risk of hypoglycemic reactions. Elderly, debilitated or malnourished patients and those with adrenal or pituitary insufficiency are particularly susceptible to the hypoglycemic action of glucose-lowering drugs. Hypoglycemia may be difficult to recognize in the elderly or people taking beta-adrenergic blocking drugs. Hypoglycemia is more likely to occur when caloric intake is deficient, after severe or prolonged exercise, when alcohol is ingested, or when more than one glucose-lowering drug is used.

Loss of Control of Blood Glucose: A loss of control may occur in diabetic patients exposed to stress such as fever, trauma, infection or surgery. It may then be necessary to discontinue GLUCOTROL and administer insulin.

Laboratory Tests: Blood and urine glucose should be monitored periodically. Measurement of glycosylated hemoglobin may be useful.

Information for Patients: Patients should be informed of the potential risks and advantages of GLUCOTROL, of alternative modes of therapy, as well as the importance of adhering to dietary instructions, of a regular exercise program, and of regular testing of urine and/or blood glucose. The risks of hypoglycemia, its symptoms and treatment, and conditions that predispose to its development should be explained to patients and responsible family members. Primary and secondary failure should also be explained.

Drug Interactions: The hypoglycemic action of sulfonylureas may be potentiated by certain drugs including nonsteroidal anti-inflammatory agents, some azoles, and other drugs that are highly protein bound, salicylates, sulfonamides, chloramphenicol, probenecid, coumarins, monoamine oxidase inhibitors, and beta-adrenergic blocking agents. *In vitro* studies indicate that GLUCOTROL binds differently than tolbutamide and does not interact with salicylate or dicumarol. However, caution must be exercised in extrapolating these findings to a clinical situation. Certain drugs tend to produce hyperglycemia and may lead to loss of control, including the thiazides and other diuretics, corticosteroids, phenothiazines, thyroid products, estrogens, oral contraceptives, phenytoin, nicotinic acid, sympathomimetics, calcium channel blocking drugs, and isoniazid. A potential interaction between oral miconazole and oral hypoglycemic agents leading to severe hypoglycemia has been reported. Whether this interaction also occurs with the intravenous, topical, or vaginal preparations of miconazole is not known. The effect of concomitant administration of DIFLUCAN (fluconazole) and GLUCOTROL has been demonstrated in a placebo-controlled crossover study in normal volunteers. All subjects received GLUCOTROL alone and following treatment with 100 mg of DIFLUCAN as a single daily oral dose for 7 days. The mean percentage increase in the GLUCOTROL AUC after fluconazole administration was 56.9% (range: 35 to 81).

Carcinogenesis, Mutagenesis, Impairment of Fertility: A 20-month study in rats and an 18-month study in mice at doses up to 75 times the maximum human dose revealed no evidence of drug-related carcinogenicity. Bacterial and *in vivo* mutagenicity tests were uniformly negative. Studies in rats of both sexes at doses up to 75 times the human dose showed no effects on fertility.

Pregnancy: Pregnancy Category C: GLUCOTROL (glipizide) was found to be mildly fetotoxic in rat reproductive studies at all dose levels (5-50 mg/kg). This fetotoxicity has been similarly noted with other sulfonylureas, such as tolbutamide and tolazamide. The effect is perinatal and believed to be directly related to the pharmacologic (hypoglycemic) action of GLUCOTROL. In studies in rats and rabbits no teratogenic effects were found. There are no adequate and well-controlled studies in pregnant women. GLUCOTROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Because recent information suggests that abnormal blood glucose levels during pregnancy are associated with a higher incidence of congenital abnormalities, many experts recommend that insulin be used during pregnancy to maintain blood glucose levels as close to normal as possible.

Nonteratogenic Effects: Prolonged severe hypoglycemia has been reported in neonates born to mothers who were receiving a sulfonylurea drug at the time of delivery. This has been reported more frequently with the use of agents with prolonged half-lives. GLUCOTROL should be discontinued at least one month before the expected delivery date.

Nursing Mothers: Since some sulfonylurea drugs are known to be excreted in human milk, insulin therapy should be considered if nursing is to be continued.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: In controlled studies, the frequency of serious adverse reactions reported was very low. Of 702 patients, 11.8% reported adverse reactions and in only 1.5% was GLUCOTROL discontinued.

Hypoglycemia: See PRECAUTIONS and OVERDOSAGE sections.

Gastrointestinal: Gastrointestinal disturbances, the most common, were reported with the following approximate incidence: nausea and diarrhea, one in 70; constipation and gastralgia, one in 100. They appear to be dose-related and may disappear on division or reduction of dosage. Cholestatic jaundice may occur rarely with sulfonylureas: GLUCOTROL should be discontinued if this occurs.

Dermatologic: Allergic skin reactions including erythema, morbilliform or maculopapular eruptions, urticaria, pruritus, and eczema have been reported in about one in 70 patients. These may be transient and may disappear despite continued use of GLUCOTROL; if skin reactions persist, the drug should be discontinued. Porphyria cutanea tarda and photosensitivity reactions have been reported with sulfonylureas.

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, hemolytic anemia, aplastic anemia, and pancytopenia have been reported with sulfonylureas.

Metabolic: Hepatic porphyria and disulfiram-like alcohol reactions have been reported with sulfonylureas. Clinical experience to date has shown that GLUCOTROL has an extremely low incidence of disulfiram-like reactions.

Endocrine Reactions: Cases of hyponatremia and the syndrome of inappropriate antidiuretic hormone (SIADH) secretion have been reported with this and other sulfonylureas.

Miscellaneous: Dizziness, drowsiness, and headache have each been reported in about one in fifty patients treated with GLUCOTROL. They are usually transient and seldom require discontinuance of therapy.

OVERDOSAGE: Overdosage of sulfonylureas including GLUCOTROL can produce hypoglycemia. If hypoglycemic coma is diagnosed or suspected, the patient should be given a rapid intravenous injection of concentrated (50%) glucose solution. This should be followed by a continuous infusion of a more dilute (10%) glucose solution at a rate that will maintain the blood glucose at a level above 100 mg/dL. Patients should be closely monitored for a minimum of 24 to 48 hours since hypoglycemia may recur after apparent clinical recovery. Clearance of GLUCOTROL from plasma would be prolonged in persons with liver disease. Because of the extensive protein binding of GLUCOTROL, dialysis is unlikely to be of benefit.

DOSAGE AND ADMINISTRATION: There is no fixed dosage regimen for the management of diabetes mellitus with GLUCOTROL; in general, it should be given approximately 30 minutes before a meal to achieve the greatest reduction in postprandial hyperglycemia.

Initial Dose: The recommended starting dose is 5 mg before breakfast. Geriatric patients or those with liver disease may be started on 2.5 mg. Dosage adjustments should ordinarily be in increments of 2.5–5 mg, as determined by blood glucose response. At least several days should elapse between titration steps.

Maximum Dose: The maximum recommended total daily dose is 40 mg.

Maintenance: Some patients may be effectively controlled on a once-a-day regimen, while others show better response with divided dosing. Total daily doses above 15 mg should ordinarily be divided.

HOW SUPPLIED: GLUCOTROL tablets are white, dye-free, scored, diamond-shaped, and imprinted as follows:

5 mg—Pfizer 411; 10 mg—Pfizer 412.

5 mg Bottles: 100's (NDC 0049-4110-66), (NDC 59012-411-66); 500's (NDC 0049-4110-73), (NDC 59012-411-73); Unit Dose 100's (NDC 0049-4110-41), (NDC 59012-411-41).

10 mg Bottles: 100's (NDC 0049-4120-66), (NDC 59012-412-66); 500's (NDC 0049-4120-73), (NDC 59012-412-73); Unit Dose 100's (NDC 0049-4120-41), (NDC 59012-412-41).

CAUTION: Federal law prohibits dispensing without prescription.

More detailed professional information available on request.

Revised Jan. 1993

FOR TYPE II DIABETES,

TODAY'S LIFE DEMANDS INSULIN ON DEMAND

When diet alone fails in NIDDM...

Glucotrol®

(glipizide) 5-mg and 10-mg Scored Tablets

Pfizer Pratt Pharmaceuticals

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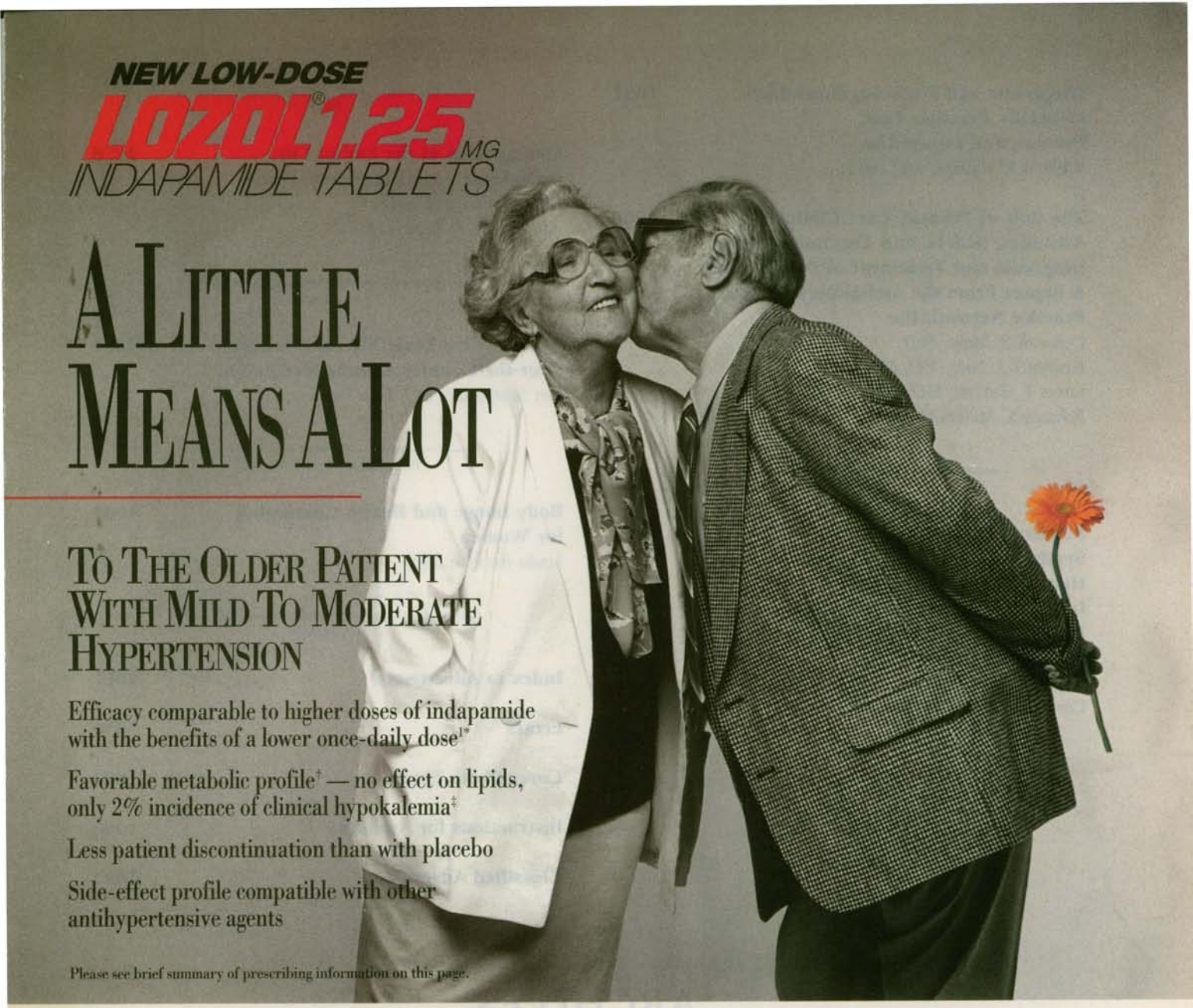
ARCHIVES OF FAMILY MEDICINE

VOL 2 NO. 10, OCT 1993

American Medical Association
Physicians dedicated to the health of America

NEW LOW-DOSE

LOZOL® 1.25 MG
INDAPAMIDE TABLETS



A LITTLE MEANS A LOT

TO THE OLDER PATIENT WITH MILD TO MODERATE HYPERTENSION

Efficacy comparable to higher doses of indapamide with the benefits of a lower once-daily dose[1*]

Favorable metabolic profile† — no effect on lipids, only 2% incidence of clinical hypokalemia‡

Less patient discontinuation than with placebo

Side-effect profile compatible with other antihypertensive agents

Please see brief summary of prescribing information on this page.

LOZOL® (indapamide) 1.25 mg and 2.5 mg tablets
BRIEF SUMMARY

INDICATIONS: LOZOL (indapamide) is indicated for the treatment of hypertension, alone or in combination with other antihypertensive drugs, and for the treatment of salt and fluid retention associated with congestive heart failure.

Usage in Pregnancy: See PRECAUTIONS.

CONTRAINDICATIONS: Anuria, hypersensitivity to indapamide or other sulfonamide-derived drugs.

WARNINGS: Infrequent cases of severe hyponatremia, accompanied by hypokalemia, have been reported with 2.5 mg and 5.0 mg indapamide primarily in elderly females. Symptoms were reversed by electrolyte replenishment. Hyponatremia considered possibly clinically significant (<125 mEq/L) has not been observed in clinical trials with the 1.25 mg dosage (see PRECAUTIONS). Hypokalemia occurs commonly with diuretics (**see ADVERSE REACTIONS, hypokalemia**), and electrolyte monitoring is essential. In general, diuretics should not be given with lithium.

PRECAUTIONS: Perform serum electrolyte determinations at appropriate intervals, especially in patients who are vomiting excessively or receiving parenteral fluids, in patients subject to electrolyte imbalance, or in patients on a salt-restricted diet. In addition, patients should be observed for clinical signs of fluid or electrolyte imbalance, such as hyponatremia, hypochloremic alkalosis, or hypokalemia. The risk of hypokalemia secondary to diuresis and natriuresis is increased with larger doses, with brisk diuresis, with severe cirrhosis, and with concomitant use of corticosteroids or ACTH. Interference with adequate oral intake of electrolytes will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis, such as increased ventricular irritability.

Dilutional hyponatremia may occur in edematous patients; appropriate treatment is usually water restriction. In actual salt depletion, appropriate replacement is the treatment of choice. Chloride deficit is usually mild, not requiring specific treatment except in extraordinary circumstances (liver, renal disease).

Hyperuricemia may occur, and frank gout may be precipitated in certain patients receiving indapamide. Serum concentrations of uric acid should be monitored periodically.

Use with caution in patients with severe renal disease; consider withholding or discontinuing if progressive renal impairment is observed. Renal function tests should be performed periodically.

Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Latent diabetes may become manifest and insulin requirements in diabetic patients may be altered during thiazide administration. A mean increase in glucose of 6.47 mg/dL was observed in patients treated with indapamide 1.25 mg, which was not considered clinically significant in these trials. Serum concentrations of glucose should be monitored routinely during treatment with indapamide.

Calcium excretion is decreased by diuretics pharmacologically related to indapamide. After six to eight weeks of indapamide 1.25 mg treatment and in long-term studies of hypertensive patients with higher doses of indapamide, however, serum concentrations of calcium increased only slightly with indapamide. Indapamide may decrease serum PBI levels without signs of thyroid disturbance. Complications of hyperparathyroidism have not been seen. Discontinue before tests of parathyroid function are performed.

Thiazides have exacerbated or activated systemic lupus erythematosus. Consider this possibility with indapamide.

DRUG INTERACTIONS: LOZOL may add to or potentiate the action of other antihypertensive drugs. The antihypertensive effect of the drug may be enhanced in the postsympathectomized patient. Indapamide may decrease arterial responsiveness to norepinephrine, but this does not preclude the use of norepinephrine.

In mouse and rat lifetime carcinogenicity studies, there were no significant differences in the incidence of tumors between the indapamide-treated animals and the control groups.

Pregnancy Category B: Diuretics cross the placental barrier and appear in cord blood. Indapamide should be used during pregnancy only if clearly needed. Use may be associated with fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse effects that have occurred in adults. It is not known whether this drug is excreted in human milk. If use of this drug is deemed essential, the patient should stop nursing.

ADVERSE REACTIONS: Most adverse effects have been mild and transient. From Phase II/III placebo-controlled studies with indapamide 1.25 mg, adverse reactions with ≥5% cumulative incidence: headache, infection, pain, back pain, dizziness, rhinitis; <5% cumulative incidence: asthenia, flu syndrome, abdominal pain, chest pain, constipation, diarrhea, dyspepsia, nausea, peripheral edema, nervousness, hypertonia, cough, pharyngitis, sinusitis, conjunctivitis. All other clinical adverse reactions occurred at an incidence of <1%. In controlled clinical trials of six to eight weeks in duration, 20% of patients receiving indapamide 1.25 mg, 61% of patients receiving indapamide 5.0 mg, and 80% of patients receiving indapamide 10.0 mg had at least one potassium value below 3.4 mEq/L. In the indapamide 1.25 mg group, about 40% of those patients who reported hypokalemia as a laboratory adverse event returned to normal serum potassium values without intervention. Hypokalemia with concomitant clinical signs or symptoms occurred in 2% of patients receiving indapamide 1.25 mg. From Phase II placebo-controlled studies and long-term controlled clinical trials with LOZOL 2.5 mg or 5.0 mg, adverse reactions with ≥ 5% cumulative incidence: headache, dizziness, fatigue, weakness, loss of energy, lethargy, tiredness or malaise, muscle cramps or spasm or numbness of the extremities, nervousness, tension, anxiety, irritability or agitation; <5% cumulative incidence: lightheadedness, drowsiness, vertigo, insomnia, depression, blurred vision, constipation, nausea, vomiting, diarrhea, gastric irritation, abdominal pain or cramps, anorexia, orthostatic hypotension, premature ventricular contractions, irregular heart beat, palpitations, frequency of urination, nocturia, polyuria, rash, hives, pruritus, vasculitis, impotence or reduced libido, rhinorrhea, flushing, hyperuricemia, hyperglycemia, hyponatremia, hypochloremia, increase in serum BUN or creatinine, glycosuria, weight loss, dry mouth, tingling of extremities. Hypokalemia with concomitant clinical signs or symptoms occurred in 3% of patients receiving indapamide 2.5 mg q.d. and 7% of patients receiving indapamide 5 mg q.d. In long-term controlled clinical trials comparing the hypokalemic effects of daily doses of indapamide and hydrochlorothiazide, however, 47% of patients receiving indapamide 2.5 mg, 72% of patients receiving indapamide 5 mg, and 44% of patients receiving hydrochlorothiazide 50 mg had at least one potassium value (out of a total of 11 taken during the study) below 3.5 mEq/L. In the indapamide 2.5 mg group, over 50% of those patients returned to normal serum potassium values without intervention. Other adverse reactions reported with antihypertensive/diuretics are intrahepatic cholestatic jaundice, sialadenitis, xanthopsia, photosensitivity, purpura, bullous eruptions, Stevens-Johnson syndrome, necrotizing angiitis, fever, respiratory distress (including pneumonitis), anaphylactic reactions, agranulocytosis, leukopenia, thrombocytopenia, aplastic anemia.

CAUTION: Federal (U.S.A.) law prohibits dispensing without prescription.

Keep tightly closed. Store at controlled room temperature, 15°-30°C (59°-86°F). Avoid excessive heat. Dispense in tight containers as defined in USP.

See product circular for full prescribing information.

Revised: April 1993

* In a controlled clinical trial, at 8 weeks the change in supine diastolic BP with 5 mg of indapamide was -10.8 mm Hg vs. -8.8 mm Hg with LOZOL 1.25 mg.

† Because of the diuretic effects of LOZOL 1.25, changes in certain electrolytes and blood chemistries can occur. Serum electrolytes and blood chemistries should therefore be monitored.

‡ 19.6% of patients had values less than 3.4 mEq/L. Only 7.5% had potassium levels below 3.2 mEq/L and less than 1% fell below 3.0 mEq/L. Metabolic changes at higher doses of indapamide may be greater.

Reference: 1. Data on file, Rhône-Poulenc Rorer Pharmaceuticals Inc.

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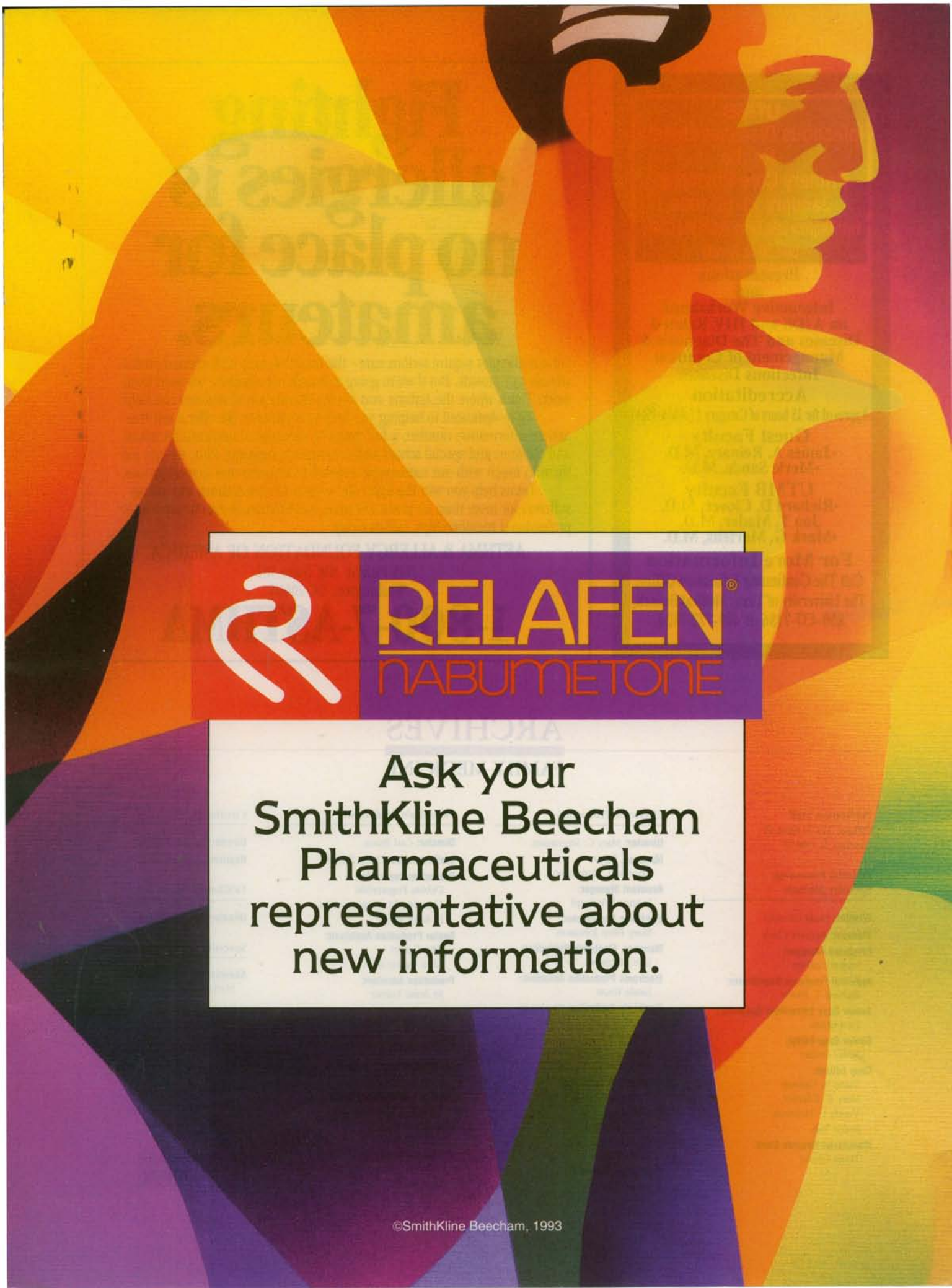
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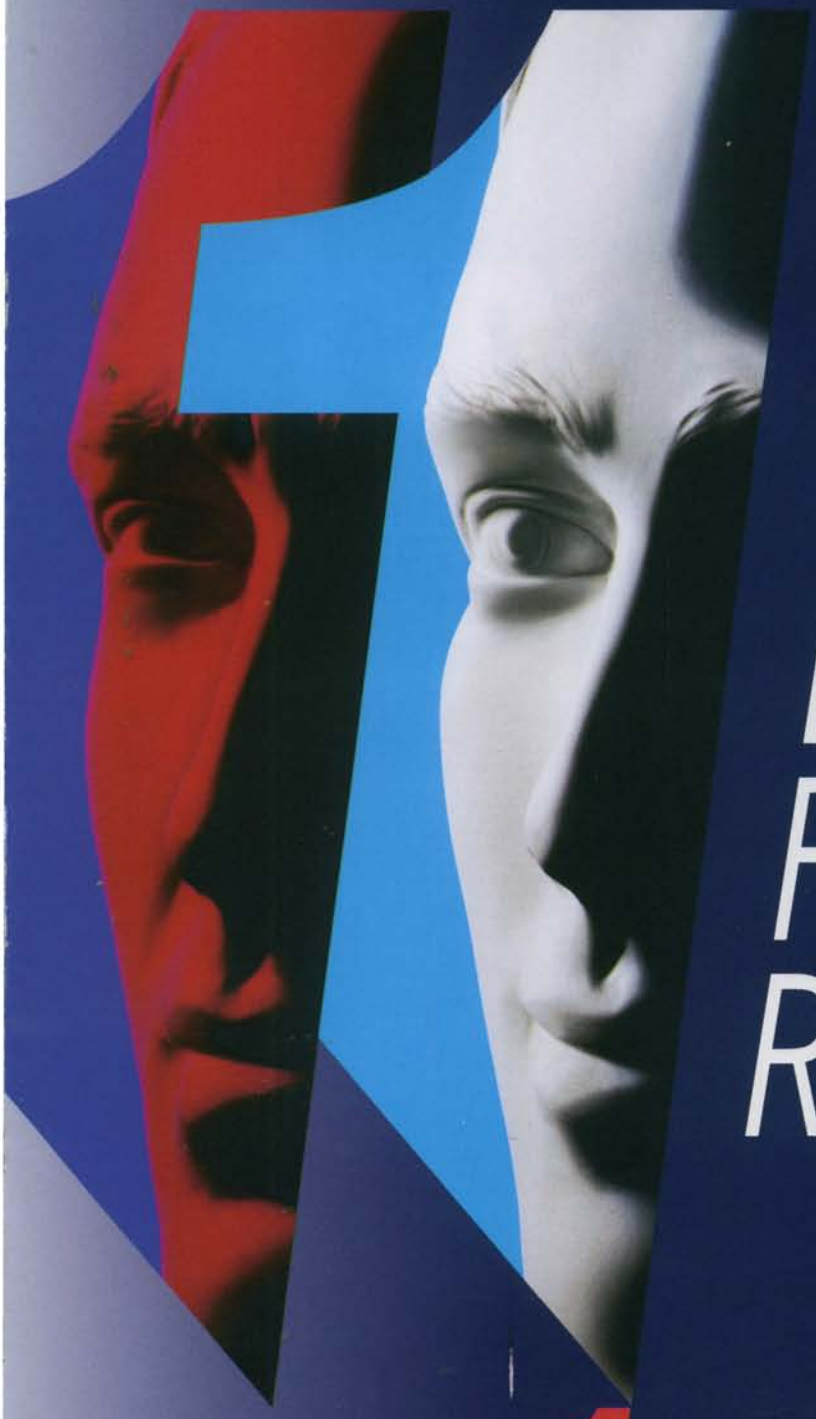


Now, for allergic rhinitis...

ONCE DAILY FOR RELIEF

Once daily for convenience

Once daily for comfort[1,2]

Once daily for unsurpassed safety[3-5]

ONCE DAILY

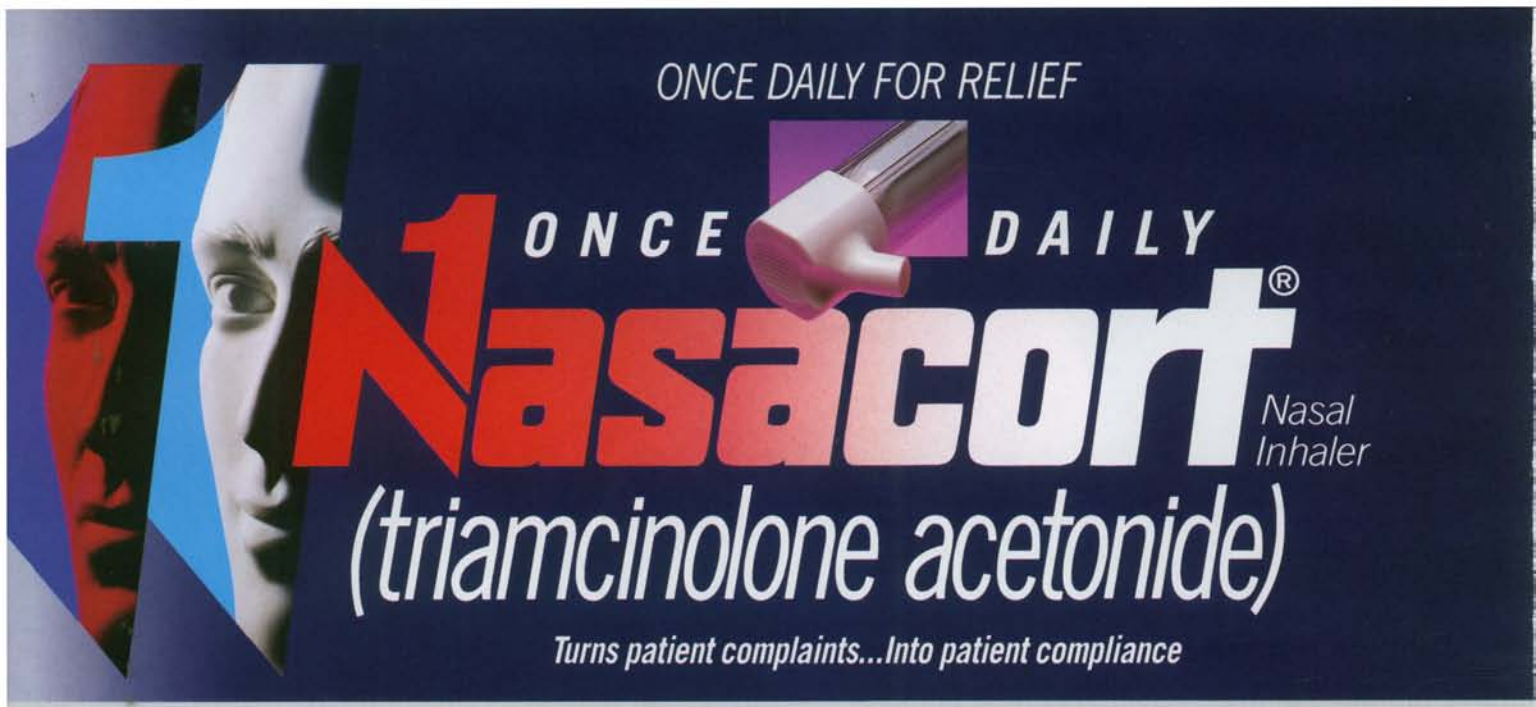
Nasacort®

Nasal Inhaler

(triamcinolone acetonide)

Turns patient complaints...Into patient compliance

Please see brief summary of prescribing information on adjacent page.



ONCE DAILY **Nasacort®** Nasal Inhaler
(triamcinolone acetonide)

For Intranasal Use Only
Shake Well Before Using

BRIEF SUMMARY

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

WARNINGS: The replacement of a systemic corticosteroid with a topical corticoid can be accompanied by signs of adrenal insufficiency and, in addition, some patients may experience symptoms of withdrawal, *e.g.*, joint and/or muscular pain, lassitude and depression. Patients previously treated for prolonged periods with systemic corticosteroids and transferred to topical corticoids should be carefully monitored for acute adrenal insufficiency in response to stress. In those patients who have asthma or other clinical conditions requiring long-term systemic corticosteroid treatment, too rapid a decrease in systemic corticosteroids may cause a severe exacerbation of their symptoms.

Children who are on immunosuppressant drugs are more susceptible to infections than healthy children. Chickenpox and measles, for example, can have a more serious or even fatal course in children on immunosuppressant doses of corticosteroids. In such children, or in adults who have not had these diseases, particular care should be taken to avoid exposure. If exposed, therapy with varicella zoster immune globulin (VZIG) or pooled intravenous immunoglobulin (IVIG), as appropriate, may be indicated. If chickenpox develops, treatment with antiviral agents may be considered.

The use of Nasacort Nasal Inhaler with alternate-day systemic prednisone could increase the likelihood of hypothalamic-pituitary-adrenal (HPA) suppression compared to a therapeutic dose of either one alone. Therefore, Nasacort Nasal Inhaler should be used with caution in patients already receiving alternate-day prednisone treatment for any disease.

PRECAUTIONS

General: In clinical studies with triamcinolone acetonide administered intranasally, the development of localized infections of the nose and pharynx with *Candida albicans* has rarely occurred. When such an infection develops it may require treatment with appropriate local therapy and discontinuance of treatment with Nasacort Nasal Inhaler.

Triamcinolone acetonide administered intranasally has been shown to be absorbed into the systemic circulation in humans. Patients with active rhinitis showed absorption similar to that found in normal volunteers. Nasacort at 440 mcg/day for 42 days did not measurably affect adrenal response to a six hour cosyntropin test. In the same study prednisone 10 mg/day significantly reduced adrenal response to ACTH over the same period (see CLINICAL TRIALS section).

Nasacort Nasal Inhaler should be used with caution, if at all, in patients with active or quiescent tuberculous infections of the respiratory tract or in patients with untreated fungal, bacterial, or systemic viral infections or ocular herpes simplex.

Because of the inhibitory effect of corticosteroids on wound healing in patients who have experienced recent nasal septal ulcers, nasal surgery or trauma, a corticosteroid should be used with caution until healing has occurred.

When used at excessive doses, systemic corticosteroid effects such as hypercorticism and adrenal suppression may appear. If such changes occur, Nasacort Nasal Inhaler should be discontinued slowly, consistent with accepted procedures for discontinuing oral steroid therapy.

Information for Patients: Patients being treated with Nasacort Nasal Inhaler should receive the following information and instructions.

Patients who are on immunosuppressant doses of corticosteroids should be warned to avoid exposure to chickenpox or measles and, if exposed, to obtain medical advice.

Patients should use Nasacort Nasal Inhaler at regular intervals since its effectiveness depends on its regular use. A decrease in symptoms may occur as soon as 12 hours after starting steroid therapy and generally can be expected to occur within a few days of initiating therapy in allergic rhinitis. The patient should take the medication as directed and should not exceed the prescribed dosage. The patient should contact the physician if symptoms do not improve after three weeks, or if the condition worsens. Nasal irritation and/or burning or stinging after use of the spray occur only rarely with this product. The patient should contact the physician if they occur.

For the proper use of this unit and to attain maximum improvement, the patient should read and follow the accompanying patient instructions carefully. Because the amount dispensed per puff may not be consistent, it is important to shake the canister well. Also, the canister should be discarded after 100 actuations.

Carcinogenesis, Mutagenesis: Animal studies of triamcinolone acetonide to test its carcinogenic potential are underway.

Impairment of Fertility: Male and female rats which were administered oral triamcinolone acetonide at doses as high as 15 mcg/kg/day (110 mcg/m^2/day, as calculated on a surface area basis) exhibited no evidence of impaired fertility. The maximum human dose, for comparison, is 6.3 mcg/kg/day (240 mcg/m^2/day). However, a few female rats which received maternally toxic doses of 8 or 15 mcg/kg/day (60 mcg/m^2/day or 110 mcg/m^2/day, respectively, as calculated on a surface area basis) exhibited dystocia and prolonged delivery.

Developmental toxicity, which included increases in fetal resorptions and stillbirths and decreases in pup body weight and survival, also occurred at the maternally toxic doses (2.5 - 15.0 mcg/kg/day or 20 - 110 mcg/m^2/day, as calculated on a surface area basis). Reproductive performance of female rats and effects on fetuses and offspring were comparable between groups that received placebo and non-toxic or marginally toxic doses (0.5 and 1.0 mcg/kg/day or 3.8 mcg/m^2/day and 7.0 mcg/m^2/day).

Pregnancy: Pregnancy Category C. Like other corticoids, triamcinolone acetonide has been shown to be teratogenic in rats and rabbits. Teratogenic effects, which occurred in both species at 0.02, 0.04 and 0.08 mg/kg/day (approximately 135, 270 and 540 mcg/m^2/day in the rat and 320, 640 and 1280 mcg/m^2/day in the rabbit, as calculated on a surface area basis), included a low incidence of cleft palate and/or internal hydrocephaly and axial skeletal defects. Teratogenic effects, including CNS and cranial malformations, have also been observed in non-human primates at 0.5 mg/kg/day (approximately 6.7 mg/m^2/day). The doses of 0.02, 0.04, 0.08, and 0.5 mg/kg/day used in these toxicology studies are approximately 12.8, 25.5, 51, and 318.7 times the minimum recommended dose of 110 mcg of Nasacort per day and 3.2, 6.4, 12.7, and 80 times the maximum recommended dose of 440 mcg of Nasacort per day based on a patient body weight of 70 kg. Administration of aerosol by inhalation to pregnant rats and rabbits produced embryotoxic and fetotoxic effects which were comparable to those produced by administration by other routes. There are no adequate and well-controlled studies in pregnant women. Triamcinolone acetonide should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Experience with oral corticoids since their introduction in pharmacologic as opposed to physiologic doses suggests that rodents are more prone to teratogenic effects from corticoids than humans. In addition, because there is a natural increase in glucocorticoid production during pregnancy, most women will require a lower exogenous steroid dose and many will not need corticoid treatment during pregnancy.

Nonteratogenic Effects: Hypoadrenalism may occur in infants born of mothers receiving corticosteroids during pregnancy. Such infants should be carefully observed.

Nursing Mothers: It is not known whether triamcinolone acetonide is excreted in human milk. Because other corticosteroids are excreted in human milk, caution should be exercised when Nasacort Nasal Inhaler is administered to nursing women.

Pediatric Use: Safety and effectiveness have not been established in children below the age of 12. Oral corticoids have been shown to cause growth suppression in children and teenagers, particularly with higher doses over extended periods. If a child or teenager on any corticoid appears to have growth suppression, the possibility that they are particularly sensitive to this effect of steroids should be considered.

ADVERSE REACTIONS: In controlled and uncontrolled studies, 1257 patients received treatment with intranasal triamcinolone acetonide. Adverse reactions are based on the 567 patients who received a product similar to the marketed Nasacort canister. These patients were treated for an average of 48 days (range 1 to 117 days). The 145 patients enrolled in uncontrolled studies received treatment from 1 to 820 days (average 332 days).

The most prevalent adverse experience was headache, being reported by approximately 18% of the patients who received Nasacort. Nasal irritation was reported by 2.8% of the patients receiving Nasacort. Other nasopharyngeal side effects were reported by fewer than 5% of the patients who received Nasacort and included: dry mucous membranes, naso-sinus congestion, throat discomfort, sneezing, and epistaxis. The complaints do not usually interfere with treatment and in the controlled and uncontrolled studies approximately 1% of patients have discontinued because of these nasal adverse effects.

In the event of accidental overdose, an increased potential for these adverse experiences may be expected, but systemic adverse experiences are unlikely (see OVERDOSAGE section).

OVERDOSAGE: Acute overdosage with this dosage form is unlikely. The acute topical application of the entire 15 mg of the canister would most likely cause nasal irritation and headache. It would be unlikely to see acute systemic adverse effects if the nasal application of the 15 mg of triamcinolone acetonide was administered all at once.

Caution: Federal (U.S.A.) law prohibits dispensing without prescription.

Please see product circular for full prescribing information.

REFERENCES: 1. Winder J, Barker J, Bell T, et al: Intranasal triamcinolone acetonide aerosol versus beclomethasone dipropionate aqueous spray in perennial allergic rhinitis. *Medical Interface* 1992;5(6, suppl):16. 2. Data on file, Rhône-Poulenc Rorer Pharmaceuticals Inc. 3. Findlay S, Huber F, Garcia J, et al: Efficacy of once-a-day intranasal administration of triamcinolone acetonide in patients with seasonal allergic rhinitis. *Ann Allergy* 1992;68(3):228-232. 4. Storms W, Bronsky E, Findlay S, et al: Once daily triamcinolone acetonide nasal spray is effective for the treatment of perennial allergic rhinitis. *Ann Allergy* 1991;66(4):329-334. 5. Feiss G, Morris R, Rom D, et al: A comparative study of the effects of intranasal triamcinolone acetonide aerosol (ITAA) and prednisone on adrenocortical function. *J Allergy Clin Immunol* 1992;89(6):1151-1156.

Marketed by:

RHÔNE-POULENC RORER

RHÔNE-POULENC RORER PHARMACEUTICALS INC.
500 ARCOLA ROAD
COLLEGEVILLE, PA 19426

NA06X193(X)A 1/93 FC#93-F18

THE PRAVACHOL® DIRECTION

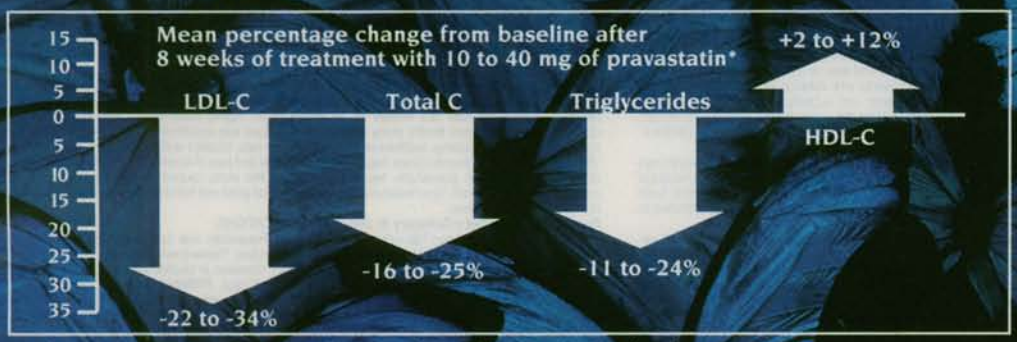
Effective lipid management doesn't have to be tough

PRAVACHOL® (pravastatin sodium) is indicated as an adjunct to diet for the reduction of elevated total and LDL-cholesterol levels in patients with primary hypercholesterolemia (Types IIa and IIb) when the response to diet alone has not been adequate.

IN LIPID MANAGEMENT

Effective lipid management—improves key lipids

Significantly reduces LDL-C. Increases beneficial HDL-C.[1]



*Each arrow represents a range of means derived from a single placebo-controlled study that included 55 patients treated with pravastatin.

Excellent safety/tolerability profile for patients

- Low incidence of side effects
- Discontinuation rate from pravastatin (1.7%) was not statistically different from that of placebo (1.2%)
- Active liver disease *or* unexplained transaminase elevations, pregnancy and lactation are contraindications to the use of pravastatin

Easy dosing regimen and other patient benefits

- Usual dose: 20 mg once daily at bedtime, with or without food
- PRAVACHOL can be used confidently with many other medications

PRAVACHOL®

pravastatin sodium 20 mg tablets

Bristol-Myers Squibb Company

Please see CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the final page of this advertisement.

Reference: 1. Jones PH, et al. Once-daily pravastatin in patients with primary hypercholesterolemia: a dose-response study. *Clin Cardiol.* 1991;14:146-151.

PRAVACHOL® (Pravastatin Sodium Tablets)

CONTRAINDICATIONS

Hypersensitivity to any component of this medication.

Active liver disease or unexplained, persistent elevations in liver function tests (see WARNINGS).

Pregnancy and lactation. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS

Liver Enzymes: HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the U.S. over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients.

As with other lipid-lowering agents, liver function tests should be performed during therapy with pravastatin. Serum aminotransferases, including ALT (SGPT), should be monitored before treatment begins, every six weeks for the first three months, every eight weeks during the remainder of the first year, and periodically thereafter (e.g., at about six-month intervals). Special attention should be given to patients who develop increased transaminase levels. Liver function tests should be repeated to confirm an elevation and subsequently monitored at more frequent intervals. If increases in AST and ALT equal or exceed three times the upper limit of normal and persist, then therapy should be discontinued. Persistence of significant aminotransferase elevations following discontinuation of therapy may warrant consideration of liver biopsy.

Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see CONTRAINDICATIONS). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect.

Skeletal Muscle: Rhabdomyolysis with renal dysfunction secondary to myoglobinuria has been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see ADVERSE REACTIONS). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper limit of normal was reported to be possibly due to pravastatin in only one patient in clinical trials (<0.1%). Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy.**

The risk of myopathy during treatment with lovastatin is increased if therapy with either cyclosporine, gemfibrozil, erythromycin, or niacin is administered concurrently. There is no experience with the use of pravastatin together with cyclosporine. Myopathy has not been observed in clinical trials involving small numbers of patients who were treated with pravastatin together with niacin. One trial of limited size involving combined therapy with pravastatin and gemfibrozil showed a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy. Myopathy was not reported in this trial (see PRECAUTIONS: Drug Interactions). One patient developed myopathy when clofibrate was added to a previously well tolerated regimen of pravastatin; the myopathy resolved when clofibrate therapy was stopped and pravastatin treatment continued. **The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should generally be avoided.**

PRECAUTIONS

General: Pravastatin may elevate creatine phosphokinase and transaminase levels (see ADVERSE REACTIONS). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin.

Homozygous Familial Hypercholesterolemia. Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors.

Renal Insufficiency. A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3α-hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored.

Information for Patients: Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever.

Drug Interactions: *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See WARNINGS: Skeletal Muscle.

Antipyrine: Clearance by the cytochrome P450 system was unaltered by concomitant administration of pravastatin. Since pravastatin does not appear to induce hepatic drug-metabolizing enzymes, it is not expected that any significant interaction of pravastatin with other drugs (e.g., phenytoin, quinidine) metabolized by the cytochrome P450 system will occur.

Cholestyramine/Colestipol: Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See DOSAGE AND ADMINISTRATION: Concomitant Therapy.)

Warfarin: In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed.

Cimetidine: The $AUC_{0\text{-}12hr}$ for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid.

Digoxin: In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered.

Gemfibrozil: In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended.

In interaction studies with *aspirin, antacids* [1 hour prior to PRAVACHOL (pravastatin sodium)], *cimetidine, nicotinic acid,* or *probucol,* no statistically significant differences in bioavailability were seen when PRAVACHOL was administered.

Other Drugs: During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, converting-enzyme inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin.

Endocrine Function: HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p<0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a ≥50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones.

CNS Toxicity: CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class.

A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallerian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg dose.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p<0.01$). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, their serum drug levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by AUC.

The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p<0.05$). The incidence was not dose-related and male mice were not affected.

A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls.

No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*; a forward mutation assay in L5178Y TK +/− mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice.

In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear.

Pregnancy: Pregnancy Category X: See CONTRAINDICATIONS.

Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter^2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL, it should be discontinued and the patient advised again as to the potential hazards to the fetus.

Nursing Mothers: A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see CONTRAINDICATIONS).

Pediatric Use: Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. (See also PRECAUTIONS: **General**.)

ADVERSE REACTIONS

Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients.

Adverse Clinical Events: All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

	All Events %		Events Attributed to Study Drug %	
Body System/Event	Pravastatin (N = 900)	Placebo (N = 411)	Pravastatin (N = 900)	Placebo (N = 411)
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic				
Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

The following effects have been reported with drugs in this class:

Skeletal: myopathy, rhabdomyolysis.

Neurological: dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy.

Hypersensitivity Reactions: An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematous-like syndrome, polymyalgia rheumatica, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome.

Gastrointestinal: pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting.

Reproductive: gynecomastia, loss of libido, erectile dysfunction.

Eye: progression of cataracts (lens opacities), ophthalmoplegia.

Laboratory Test Abnormalities: Increases in serum transaminase (ALT, AST) values and CPK have been observed (see WARNINGS).

Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with other HMG-CoA reductase inhibitors.

Concomitant Therapy: Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is **not** associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See WARNINGS: **Skeletal Muscle** and PRECAUTIONS: **Drug Interactions.**)

OVERDOSAGE

There have been no reports of overdoses with pravastatin.

Should an accidental overdose occur, treat symptomatically and institute supportive measures as required.

DK-003

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Bristol-Myers Squibb Company

Would woman abuse remain harmless if not acknowledged and discussed? Given that people usually do not volunteer the history of abuse unless asked, is there any benefit to screening—that is, asking patients if they have been threatened, assaulted, or injured? In the strict sense, it is true that such "screening" is not "evidence-based." But neither are most other questions that we ask as part of a medical history. Sometimes the answer can make sense of a confusing array of symptoms and signs of distress, and can suggest what to do. It is true that interventions have not yet been proven to stop woman abuse or to help women to heal. Funding and scientific examination of treatment and prevention for family violence should be a priority. Do we really believe that we can and should ignore this problem until the evidence for a benefit from diagnosing woman abuse is in?

Finally, although most people are in relatively powerless situations sometime during their lives, and indeed, violence is ubiquitous in our culture, women rarely assault, molest, or rape men. Thus, secondary prevention of further harm to those at risk can be targeted at women (and other less powerful groups, such as children and dependent elders). On the other hand, primary *prevention of interpersonal violence* would *involve almost everyone in learning different ways of conflict resolution, eschewing violent models, redressing power imbalances in what we believe should be symmetrical relationships, and teaching everyone self-love and self-protection. Such a social transformation will never be based on evidence, but on values.*

Louise Acheson, MD
Case Western Reserve University
Cleveland, Ohio

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2. Saunders DG, Hamberger LK, Hovey M. Indicators of woman abuse based on a chart review at a family practice center. *Arch Fam Med.* 1993;2:537-543.
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NEW LODINE® 400mg
ETODOLAC TABLETS

Extra Strength, 400 mg, That Works In Osteoarthritis

Simple B.I.D. Choice*

Same Favorable LODINE Tolerability†

NEW LODINE® 400mg
ETODOLAC TABLETS

More Strength To Live With Osteoarthritis

* Recommended starting dosage in OA is 800 mg to 1,200 mg/day in divided doses.

† As with other NSAIDs, the most frequent complaints relate to the GI tract. In patients treated chronically with NSAID therapy, serious GI toxicity such as perforation, ulceration, and bleeding can occur.

63848N

Please see adjacent page for brief summary of prescribing information.

FREEDOM FROM COUGH!

Alcohol Free

New Expectorant vicodin TUSS™

(hydrocodone bitartrate 5mg (May be habit forming) and guaifenesin 100mg per (5mL) teaspoon)

Sugar Free

Expectorant vicodin TUSS™ Dual Action Cough Therapy

New Expectorant

vicodin TUSS™ III

(hydrocodone bitartrate 5mg (Warning: May be habit forming) and guaifenesin 100mg per (5mL) teaspoon)

Combines the antitussive action of hydrocodone with the expectorant action of guaifenesin.

- Hydrocodone helps suppress dry, hacking coughs for up to 6 hours.
- Guaifenesin enables those coughs that do occur to be more productive.
- Long lasting relief in a sugar-free, alcohol-free, dye-free, cherry flavored formula.
- Adult Dose: 1 teaspoon (5mL) every 4-6 hours not to exceed 6 teaspoons in a 24 hour period.

Alcohol Free

New Expectorant

vicodin TUSS™ III

(hydrocodone bitartrate 5mg (Warning: May be habit forming) and guaifenesin 100mg per (5mL) teaspoon)

Sugar Free

Effective cough relief you can phone in.

INDICATIONS AND USAGE: VICODIN TUSS™ Expectorant is indicated for the symptomatic relief of irritating non-productive cough associated with upper and lower respiratory tract congestion. **CONTRAINDICATIONS:** VICODIN TUSS™ Expectorant is contraindicated in patients hypersensitive to hydrocodone or guaifenesin. Patients known to be hypersensitive to other opioids may exhibit cross sensitivity to VICODIN TUSS™ Expectorant. Hydrocodone is contraindicated in the presence of an intracranial lesion associated with increased intracranial pressure; and whenever ventilatory function is depressed. **WARNINGS:** May be habit forming. Hydrocodone can produce drug dependence of the morphine type and therefore has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of VICODIN TUSS™ Expectorant and it should be prescribed and administered with the same degree of caution appropriate to the use of other narcotic drugs (see DRUG ABUSE AND DEPENDENCE). **Respiratory Depression:** VICODIN TUSS™ Expectorant produces dose-related respiratory depression by directly acting on the brain stem respiratory centers. If respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride and other supportive measures when indicated. **Head Injury and Increased Intracranial Pressure:** The respiratory depressant properties 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. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. **Acute Abdominal Conditions:** The administration of VICODIN TUSS™ Expectorant or other opioids may obscure the diagnosis or clinical course of patients with acute abdominal conditions. **PRECAUTIONS:** Before prescribing medication to suppress or modify cough, it is important to ascertain that the underlying cause of cough is identified, that modification of cough does not increase the risk of clinical or physiologic complications, and that appropriate therapy for the primary disease is provided. **Usage in Ambulatory Patients:** Hydrocodone, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, and patients should be warned accordingly. **Drug Interactions:** Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative hypnotics or other CNS depressants (including alcohol) concomitantly with hydrocodone may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced (see WARNINGS). **Laboratory Interactions:** The metabolite of guaifenesin has been found to produce an apparent increase in urinary 5-hydroxyindoleacetic acid, and guaifenesin therefore may interfere with the interpretation of this test for the diagnosis of carcinoid syndrome. Guaifenesin administration should be discontinued 24 hours prior to the collection of urine specimens for the determination of 5-hydroxyindoleacetic acid. **Carcinogenesis, mutagenesis, impairment of fertility:** Carcinogenicity, mutagenicity and reproduction studies have not been conducted with VICODIN TUSS™ Expectorant. **Usage in Pregnancy:** Pregnancy Category C. Animal reproduction studies have not been conducted with VICODIN TUSS™ Expectorant. It is also not known whether VICODIN TUSS™ Expectorant can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. VICODIN TUSS™ Expectorant should be given to a pregnant woman only if clearly needed. **Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting and fever. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose. There is no consensus on the best method of managing withdrawal. Chlorpromazine 0.7-1.0 mg/kg q 6 h, phenobarbital 2 mg/kg q 6 h, and paregoric 2-4 drops/kg q 4 h, have been used to treat withdrawal symptoms in infants. The duration of therapy is 4 to 28 days, with the dosages decreased as tolerated. **Nursing mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN TUSS™ Expectorant, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother. **ADVERSE REACTIONS Respiratory System:** Hydrocodone produces dose-related respiratory depression by acting directly on brain stem respiratory centers. **Cardiovascular System:** Hypertension, postural hypotension and palpitations. **Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported with opiates. **Central Nervous System:** Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes and blurred vision. **Gastrointestinal System:** Nausea and vomiting occur more frequently in ambulatory than in recumbent patients. **DRUG ABUSE AND DEPENDENCE:** Special care should be exercised in prescribing hydrocodone for emotionally unstable patients and for those with a history of drug misuse. Such patients should be closely supervised when long-term therapy is contemplated. VICODIN TUSS™ Expectorant is a Schedule III narcotic. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN TUSS™ Expectorant should always be prescribed and administered with caution. Physical dependence is the condition in which continued administration of the drug is required to prevent the appearance of a withdrawal syndrome. Patients physically dependent on opioids will develop an abstinence syndrome upon abrupt discontinuation of the opioid or following the administration of a narcotic antagonist. The character and severity of the withdrawal symptoms are related to the degree of physical dependence. Manifestations of opioid withdrawal are similar to but milder than that of morphine and include lacrimation, rhinorrhea, yawning, sweating, restlessness, dilated pupils, anorexia, goose-flesh, irritability, and tremor. In more severe forms, nausea, vomiting, intestinal spasm and diarrhea, increased heart rate and blood pressure, chills, and pains in bones and muscles of the back and extremities may occur. Peak effects will usually be apparent at 48 to 72 hours. Treatment of withdrawal is usually managed by providing sufficient quantities of an opioid to suppress **severe** withdrawal symptoms and then gradually reducing the dose of opioid over a period of several days. **OVERDOSAGE: Signs and Symptoms:** Serious overdosage with VICODIN TUSS™ Expectorant is characterized by respiratory depression (a 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. In severe overdosage apnea, circulatory collapse, cardiac arrest, and death may occur. **Treatment:** Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonist naloxone hydrochloride is a specific antidote for respiratory depression which may result from overdosage or unusual sensitivity to narcotics including hydrocodone. Therefore, an appropriate dose of naloxone hydrochloride should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation. For further information, see full prescribing information for naloxone hydrochloride. An antagonist should not be administered in the absence of clinically significant respiratory depression. Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated. Gastric emptying may be useful in removing unabsorbed drug. Activated charcoal may be of benefit.

QUALITY TOWARD EXCELLENCE
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V3110/7-93

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IN MANY CHRONIC ARTHRITIS PATIENTS

Expect Success from the #1 Prescribed NSAID*

Color-enhanced 3-D MRI of OA knee with medial compartment narrowing and anterior osteophytes in red. Supplied by David W. Stoller, MD, of California Advanced Imaging.

Color-enhanced barium contrast study of stomach.

A proven efficacy and safety profile backed by 16 years of clinical success.

As with other NSAIDs, the most frequent complaints are gastrointestinal, and rare hepatic and renal reactions have been reported.

Please see brief summary of prescribing information on adjacent page.

EXPECT SUCCESS FROM NAPROSYN®

(NAPROXEN) 500 mg tablets

Also available in 375 and 250 mg tablets and in suspension 125 mg/5 mL

*Leading industry audits for 12 months ending April 1992. Pharmacy sales of Naprosyn (naproxen) in the U.S. Data on file, Syntex Laboratories, Inc, Document NP92181-A.

SYNTEX

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The times and places for open discussions of physicians' concerns

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Speak face to face with Congressional leaders, Presidential advisors and top Administration officials on the political pressures that will ultimately form health care policy. Help ensure that patients' needs remain the focus of reform. Hear governors and heads of state health departments describe how their states are preparing for a new national policy.

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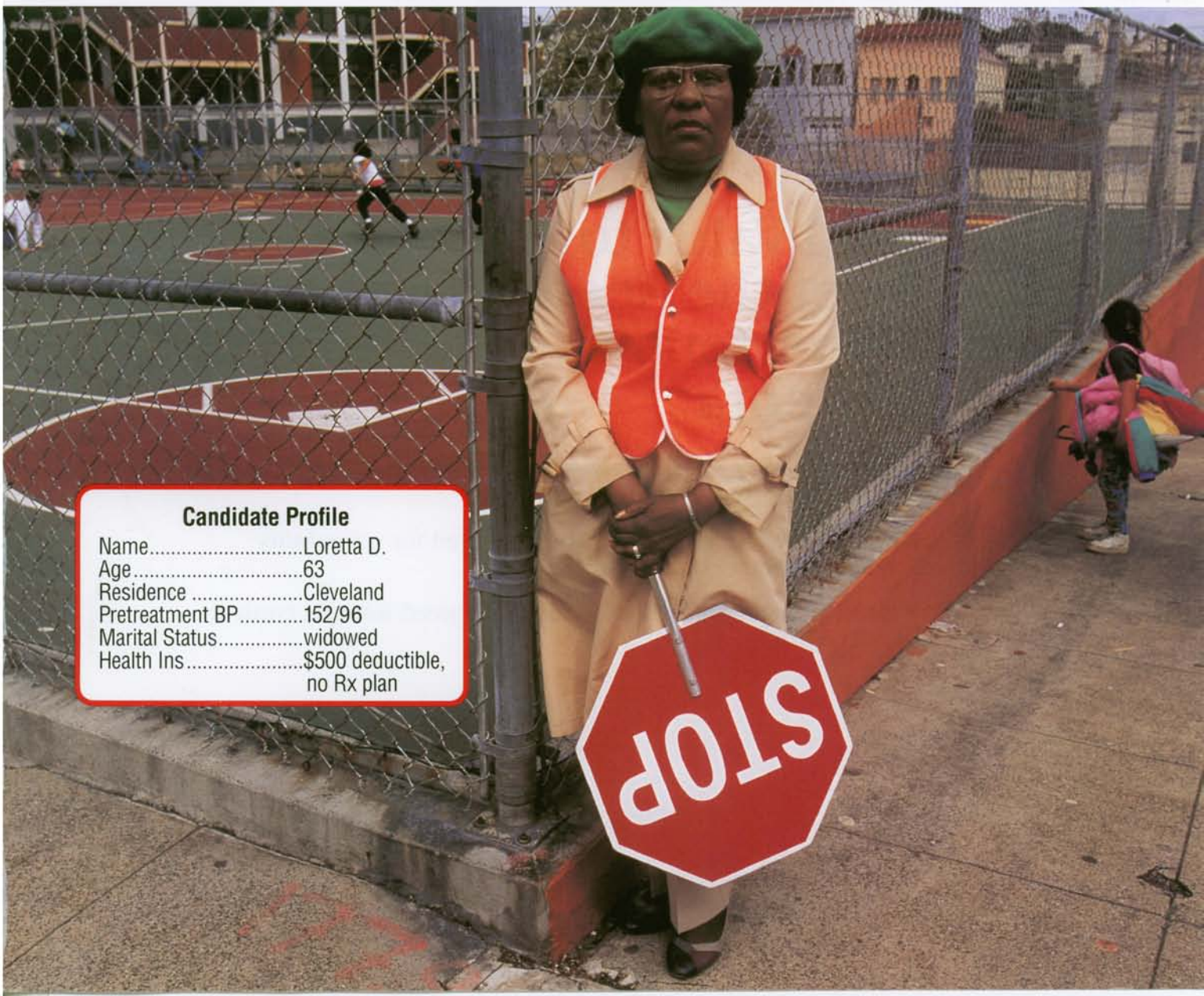
NEW

Adalat® CC

nifedipine EXTENDED RELEASE TABLETS

30mg, 60mg & 90mg

Real Value for Real People with Hypertension



Candidate Profile

Name	Loretta D.
Age	63
Residence	Cleveland
Pretreatment BP	152/96
Marital Status	widowed
Health Ins	$500 deductible, no Rx plan

Once-A-Day

NEW

Adalat® CC

nifedipine EXTENDED RELEASE TABLETS

30mg, 60mg & 90mg

"Save as much as $111 a year?

Real Value to Meet the Needs of Hypertensive Patients

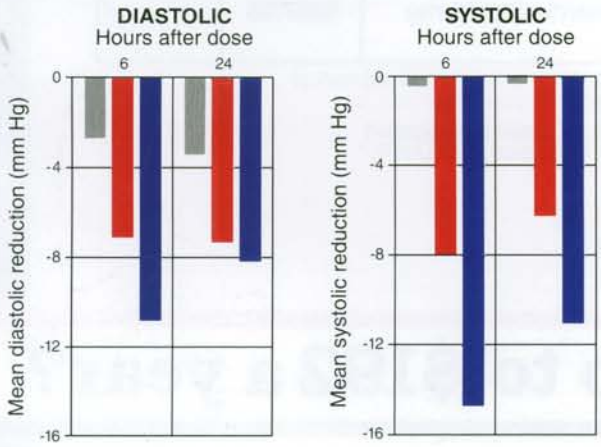
- **Real therapeutic value** to meet the need for efficacy and reliability
- **Real human value** to meet the need for tolerability and convenience
- **Real economic value** to meet the need for cost control and savings

That's two weeks' worth of groceries."

Real Therapeutic Value

- The benefits of long-acting nifedipine
- Sustained blood pressure reduction over 24 hours[1]
- Significant reduction in both diastolic and systolic blood pressure[1]

Mean changes from baseline in supine diastolic and systolic BP: average of 24-hour, in-clinic data from weeks 5 and 6 of therapy[1]



Real People, Real Needs, Real Value

Please see brief summary of Prescribing Information on the last page of this advertisement.

Real Human Value in Antihypertensive Therapy

- Once-daily regimen could enhance compliance
- Long-acting nifedipine therapy that is well-tolerated
- Frequency and type of side effects are typical of dihydropyridine calcium channel blockers. Peripheral edema and headache were the most common dose-related adverse events reported; flushing / heat sensation, dizziness, and fatigue/asthenia were all reported at an incidence of 4%
- Contraindications: known hypersensitivity to nifedipine

Real Economic Value

- "The cost of therapy may be a barrier to controlling hypertension"[2]
- Adalat® CC is priced (AWP) 25% below the Average Wholesale Price of Procardia XL®*†[3]
- Adalat® CC brings Cost Control to once-daily nifedipine therapy for hypertension; it is not indicated for angina
- Adalat® CC should be administered on an empty stomach
- Careful titration may be necessary when switching between Procardia XL® and Adalat® CC

Projected annual savings† per hypertensive patient

	Annualized Average Wholesale Price†	Potential Annual Patient Savings†
Adalat® CC 30 mg Procardia XL® 30 mg	**$306.97** $417.71	**$111**
Adalat® CC 60 mg Procardia XL® 60 mg	**$531.08** $722.74	**$192**
Adalat® CC 90 mg Procardia XL® 90 mg	**$650.54** $867.35	**$217**

*Procardia XL is a registered trademark of Pfizer Labs Division, Pfizer Inc.

†Calculations based on suggested Average Wholesale Price (AWP).[3]

"Save up to $192 a year?

Once-A-Day

NEW

Adalat® CC

nifedipine EXTENDED RELEASE TABLETS

30mg, 60mg & 90mg

Real People, Real Needs, Real Value

Please see brief summary of Prescribing Information on the last page of this advertisement.

That's a few months' gas and electric."

Once-A-Day

NEW **Adalat® CC**

nifedipine EXTENDED RELEASE TABLETS

30mg, 60mg & 90mg

Start with*

℞

Adalat CC
30mg
once daily

Titrate, if necessary*

℞

Adalat CC
60mg
once daily

- The benefits of long-acting nifedipine therapy for hypertension
- Convenient, well-tolerated therapy
- Lower price (AWP) than Procardia XL® 30 mg, 60 mg and 90 mg—**potential 25% savings**[+3]

*Please see DOSAGE AND ADMINISTRATION section in brief summary of Prescribing Information below.

BRIEF SUMMARY
CONSULT PACKAGE INSERT FOR FULL PRESCRIBING INFORMATION
For Oral Use

PZ100744BS 5/93

INDICATION AND USAGE: ADALAT CC is indicated for the treatment of hypertension. It may be used alone or in combination with other antihypertensive agents.

CONTRAINDICATIONS: Known hypersensitivity to nifedipine.

WARNINGS: Excessive Hypotension: Although in most patients the hypotensive effect of nifedipine is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients using concomitant beta-blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients who received immediate release capsules together with a beta-blocking agent and who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of nifedipine and a beta-blocker, but the possibility that it may occur with nifedipine alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In nifedipine-treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for nifedipine to be washed out of the body prior to surgery.

Increased Angina and/or Myocardial Infarction: Rarely, patients, particularly those who have severe obstructive coronary artery disease, have developed well documented increased frequency, duration and/or severity of angina or acute myocardial infarction upon starting nifedipine or at the time of dosage increase. The mechanism of this effect is not established.

Beta-Blocker Withdrawal: When discontinuing a beta-blocker it is important to taper its dose, if possible, rather than stopping abruptly before beginning nifedipine. Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of nifedipine treatment will not prevent this occurrence and on occasion has been reported to increase it.

Congestive Heart Failure: Rarely, patients (usually while receiving a beta-blocker) have developed heart failure after beginning nifedipine. Patients with tight aortic stenosis may be at greater risk for such an event, as the unloading effect of nifedipine would be expected to be of less benefit to these patients, owing to their fixed impedance to flow across the aortic valve.

PRECAUTIONS: General - Hypotension: Because nifedipine decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of ADALAT CC is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure (See WARNINGS).

Peripheral Edema: Mild to moderate peripheral edema occurs in a dose-dependent manner with ADALAT CC. The placebo subtracted rate is approximately 8% at 30 mg, 12% at 60 mg and 19% at 90 mg daily. This edema is a localized phenomenon, thought to be associated with vasodilation of dependent arterioles and small blood vessels and not due to left ventricular dysfunction or generalized fluid retention. With patients whose hypertension is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Information for Patients: ADALAT CC is an extended release tablet and should be swallowed whole and taken on an empty stomach. It should not be administered with food. Do not chew, divide or crush tablets.

Laboratory Tests: Rare, usually transient, but occasionally significant elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted. The relationship to nifedipine therapy is uncertain in most cases, but probable in some. These laboratory abnormalities have rarely been associated with clinical symptoms; however, cholestasis with or without jaundice has been reported. A small increase (<5%) in mean alkaline phosphatase was noted in patients treated with ADALAT CC. This was an isolated finding and it rarely resulted in values which fell outside the normal range. Rare instances of allergic hepatitis have been reported with nifedipine treatment. In controlled studies, ADALAT CC did not adversely affect serum uric acid, glucose, cholesterol or potassium.

Nifedipine, like other calcium channel blockers, decreases platelet aggregation *in vitro*. Limited clinical studies have demonstrated a moderate but statistically significant decrease in platelet aggregation and increase in bleeding time in some nifedipine patients. This is thought to be a function of inhibition of calcium transport across the platelet membrane. No clinical significance for these findings has been demonstrated.

Positive direct Coombs' test with or without hemolytic anemia has been reported but a causal relationship between nifedipine administration and positivity of this laboratory test, including hemolysis, could not be determined.

Although nifedipine has been used safely in patients with renal dysfunction and has been reported to exert a beneficial effect in certain cases, rare reversible elevations in BUN and serum creatinine have been reported in patients with pre-existing chronic renal insufficiency. The relationship to nifedipine therapy is uncertain in most cases but probable in some.

Drug Interactions: Beta-adrenergic blocking agents: (See WARNINGS).

ADALAT CC was well tolerated when administered in combination with a beta blocker in 187 hypertensive patients in a placebo-controlled clinical trial. However, there have been occasional literature reports suggesting that the combination of nifedipine and beta-adrenergic blocking drugs may increase the likelihood of congestive heart failure, severe hypotension, or exacerbation of angina in patients with cardiovascular disease.

Digitalis: Since there have been isolated reports of patients with elevated digoxin levels, and there is a possible interaction between digoxin and ADALAT CC, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing ADALAT CC to avoid possible over- or under-digitalization.

Coumarin Anticoagulants: There have been rare reports of increased prothrombin time in patients taking coumarin anticoagulants to whom nifedipine was administered. However, the relationship to nifedipine therapy is uncertain.

Quinidine: There have been rare reports of an interaction between quinidine and nifedipine (with a decreased plasma level of quinidine).

Cimetidine: Both the peak plasma level of nifedipine and the AUC may increase in the presence of cimetidine. Ranitidine produces smaller non-significant increases. This effect of cimetidine may be mediated by its known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of nifedipine. If nifedipine therapy is initiated in a patient currently receiving cimetidine, cautious titration is advised.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Nifedipine was administered orally to rats for two years and was not shown to be carcinogenic. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose. *In vivo* mutagenicity studies were negative.

Pregnancy: Pregnancy Category C. In rodents, rabbits and monkeys, nifedipine has been shown to have a variety of embryotoxic, placentotoxic and fetotoxic effects, including stunted fetuses (rats, mice and rabbits), digital anomalies (rats and rabbits), rib deformities (mice), cleft palate (mice), small placentas and underdeveloped chorionic villi (monkeys), embryonic and fetal deaths (rats, mice and rabbits), prolonged pregnancy (rats; not evaluated in other species), and decreased neonatal survival (rats; not evaluated in other species). On a mg/kg or mg/m^2 basis, some of the doses associated with these various effects are higher than the maximum recommended human dose and some are lower, but all are within an order of magnitude of it.

The digital anomalies seen in nifedipine-exposed rabbit pups are strikingly similar to those seen in pups exposed to phenytoin, and these are in turn similar to the phalangeal deformities that are the most common malformation seen in human children with *in utero* exposure to phenytoin.

There are no adequate and well-controlled studies in pregnant women. ADALAT CC should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Nifedipine is excreted in human milk. Therefore, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

ADVERSE EXPERIENCES: The incidence of adverse events during treatment with ADALAT CC in doses up to 90 mg daily were derived from multi-center placebo-controlled clinical trials in 370 hypertensive patients. Atenolol 50 mg once daily was used concomitantly in 187 of the 370 patients on ADALAT CC and in 64 of the 126 patients on placebo. All adverse events reported during ADALAT CC therapy were tabulated independently of their causal relationship to medication.

The most common adverse event reported with ADALAT® CC was peripheral edema. This was dose related and the frequency was 18% on ADALAT CC 30 mg daily, 22% on ADALAT CC 60 mg daily and 29% on ADALAT CC 90 mg daily versus 10% on placebo.

Other common adverse events reported in the above placebo-controlled trials include: Headache (19%, versus 13% placebo incidence); Flushing/heat sensation (4%, versus 0% placebo incidence); Dizziness (4%, versus 2% placebo incidence); Fatigue/asthenia (4%, versus 4% placebo incidence); Nausea (2%, versus 1% placebo incidence); Constipation (1%, versus 0% placebo incidence).

Where the frequency of adverse events with ADALAT CC and placebo is similar, causal relationship cannot be established.

The following adverse events were reported with an incidence of 3% or less in daily doses up to 90 mg:

Body as a Whole/Systemic: chest pain, leg pain **Central Nervous System:** paresthesia, vertigo **Dermatologic:** rash **Gastrointestinal:** constipation **Musculoskeletal:** leg cramps **Respiratory:** epistaxis, rhinitis **Urogenital:** impotence, urinary frequency

Other adverse events reported with an incidence of less than 1.0% were:

Body as a Whole/Systemic: cellulitis, chills, facial edema, neck pain, pelvic pain, pain **Cardiovascular:** atrial fibrillation, bradycardia, cardiac arrest, extrasystole, hypotension, palpitations, phlebitis, postural hypotension, tachycardia, cutaneous angiectases **Central Nervous System:** anxiety, confusion, decreased libido, depression, hypertonia, insomnia, somnolence **Dermatologic:** pruritus, sweating **Gastrointestinal:** abdominal pain, diarrhea, dry mouth, dyspepsia, esophagitis, flatulence, gastrointestinal hemorrhage, vomiting **Hematologic:** lymphadenopathy **Metabolic:** gout, weight loss **Musculoskeletal:** arthralgia, arthritis, myalgia **Respiratory:** dyspnea, increased cough, rales, pharyngitis **Special Senses:** abnormal vision, amblyopia, conjunctivitis, diplopia, tinnitus **Urogenital/Reproductive:** kidney calculus, nocturia, breast engorgement

The following adverse events have been reported rarely in patients given nifedipine in other formulations: allergenic hepatitis, alopecia, anemia, arthritis with ANA (+), depression, erythromelalgia, exfoliative dermatitis, fever, gingival hyperplasia, gynecomastia, leukopenia, mood changes, muscle cramps, nervousness, paranoid syndrome, purpura, shakiness, sleep disturbances, syncope, taste perversion, thrombocytopenia, transient blindness at the peak plasma level, tremor and urticaria.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to each patient's needs. It is recommended that ADALAT CC be administered orally once daily on an empty stomach. ADALAT CC is an extended release dosage form and tablets should be swallowed whole, not bitten or divided. In general, titration should proceed over a 7-14 day period starting with 30 mg once daily. Upward titration should be based on therapeutic efficacy and safety. The usual maintenance dose is 30 mg to 60 mg once daily. Titration to doses above 90 mg daily is not recommended.

If discontinuation of ADALAT CC is necessary, sound clinical practice suggests that the dosage should be decreased gradually with close physician supervision.

Care should be taken when dispensing ADALAT CC to assure that the extended release dosage form has been prescribed.

PZ100744BS 5/93 3060
Printed in USA

Real People, Real Needs, Real Value

References:

1. Data on file, Miles Inc.
2. The Fifth Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure (JNC V). *Arch Intern Med.* 1/25/1993;153:154-183.
3. *Redbook Update.* Oradell, NJ, Medical Economics Co., March 1993;p. 32.

+Calculations based on suggested Average Wholesale Price (AWP).
Procardia XL is a registered trademark of Pfizer Labs Division, Pfizer Inc.

MILES

Pharmaceutical Division

Distributed by:
Miles Inc.
Pharmaceutical Division
400 Morgan Lane
West Haven, CT 06516 USA
Made in Germany

XO9032

M-11767

I.V. INJECTION/TABLETS

TENORMIN (atenolol) 25, 50, 100 mg tablets

(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT.)

INDICATIONS AND USAGE: Hypertension: TENORMIN is indicated in the management of hypertension. It may be used alone or concomitantly with other antihypertensive agents, particularly with a thiazide-type diuretic.

Angina Pectoris Due to Coronary Atherosclerosis: TENORMIN is indicated for the long-term management of patients with angina pectoris.

Acute Myocardial Infarction: TENORMIN is indicated in the management of hemodynamically stable patients with definite or suspected acute myocardial infarction to reduce cardiovascular mortality. Treatment can be initiated as soon as the patient's clinical condition allows. (See DOSAGE AND ADMINISTRATION, CONTRAINDICATIONS, and WARNINGS.) In general, there is no basis for treating patients like those who were excluded from the ISIS-1 trial (blood pressure less than 100 mm Hg systolic, heart rate less than 50 bpm) or have other reasons to avoid beta blockade. As noted above, some subgroups (eg, elderly patients with systolic blood pressure below 120 mm Hg) seemed less likely to benefit.

CONTRAINDICATIONS: TENORMIN is contraindicated in sinus bradycardia, heart block greater than first degree, cardiogenic shock, and overt cardiac failure. (See WARNINGS.)

WARNINGS: Cardiac Failure: Sympathetic stimulation is necessary in supporting circulatory function in congestive heart failure, and beta blockade carries the potential hazard of further depressing myocardial contractility and precipitating more severe failure. In patients who have congestive heart failure controlled by digitalis and/or diuretics, TENORMIN should be administered cautiously. Both digitalis and atenolol slow AV conduction.

In patients with acute myocardial infarction, cardiac failure which is not promptly and effectively controlled by 80 mg of intravenous furosemide or equivalent therapy is a contraindication to beta-blocker treatment.

In Patients Without a History of Cardiac Failure: Continued depression of the myocardium with beta-blocking agents over a period of time can, in some cases, lead to cardiac failure. At the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or be given a diuretic and the response observed closely. If cardiac failure continues despite adequate digitalization and diuresis, TENORMIN should be withdrawn. (See DOSAGE AND ADMINISTRATION.)

Cessation of Therapy with TENORMIN: Patients with coronary artery disease, who are being treated with TENORMIN, should be advised against abrupt discontinuation of therapy. Severe exacerbation of angina and the occurrence of myocardial infarction and ventricular arrhythmias have been reported in angina patients following the abrupt discontinuation of therapy with beta blockers. The last two complications may occur with or without preceding exacerbation of the angina pectoris. As with other beta blockers, when discontinuation of TENORMIN is planned, the patients should be carefully observed and advised to limit physical activity to a minimum. If the angina worsens or acute coronary insufficiency develops, it is recommended that TENORMIN be promptly reinstituted, at least temporarily. Because coronary artery disease is common and may be unrecognized, it may be prudent not to discontinue TENORMIN therapy abruptly even in patients treated only for hypertension. (See DOSAGE AND ADMINISTRATION.)

Bronchospastic Diseases: PATIENTS WITH BRONCHOSPASTIC DISEASE SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. Because of its relative beta, selectivity, however, TENORMIN may be used with caution in patients with bronchospastic disease who do not respond to, or cannot tolerate, other antihypertensive treatment. Since beta, selectivity is not absolute, the lowest possible dose of TENORMIN should be used with therapy initiated at 50 mg and a beta,-stimulating agent (bronchodilator) should be made available. If dosage must be increased, dividing the dose should be considered in order to achieve lower peak blood levels.

Anesthesia and Major Surgery: It is not advisable to withdraw beta-adrenoreceptor blocking drugs prior to surgery in the majority of patients. However, care should be taken when using anesthetic agents such as those which may depress the myocardium. Vagal dominance, if it occurs, may be corrected with atropine (1-2 mg IV).

Additionally, caution should be used when TENORMIN I.V. Injection is administered concomitantly with such agents.

TENORMIN, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects on the heart can be reversed by administration of such agents: eg, dobutamine or isoproterenol with caution (see section on OVERDOSAGE).

Diabetes and Hypoglycemia: TENORMIN should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. At recommended doses TENORMIN does not potentiate insulin-induced hypoglycemia and, unlike nonselective beta blockers, does not delay recovery of blood glucose to normal levels.

Thyrotoxicosis: Beta-adrenergic blockade may mask certain clinical signs (eg, tachycardia) of hyperthyroidism. Patients suspected of having thyroid disease should be monitored closely when administering TENORMIN I.V. Injection. Abrupt withdrawal of beta blockade might precipitate a thyroid storm; therefore, patients suspected of developing thyrotoxicosis from whom TENORMIN therapy is to be withdrawn should be monitored closely. (See DOSAGE AND ADMINISTRATION.)

Pregnancy and Fetal Injury: TENORMIN can cause fetal harm when administered to a pregnant woman. TENORMIN crosses the placental barrier and appears in cord blood. No studies have been performed on the use of TENORMIN in the first trimester and the possibility of fetal injury cannot be excluded. TENORMIN has been used under close supervision for the treatment of hypertension in the third trimester. Administration of TENORMIN for longer periods to pregnant women in the management of mild to moderate hypertension has been associated with intrauterine growth retardation. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus.

Atenolol has been shown to produce a dose-related increase in embryo/fetal resorptions in rats at doses equal to or greater than 50 mg/kg/day or 25 or more times the maximum recommended human antihypertensive dose.* Although similar effects were not seen in rabbits, the compound was not evaluated in rabbits at doses above 25 mg/kg/day or 12.5 times the maximum recommended human antihypertensive dose.*

*Based on the maximum dose of 100 mg/day in a 50 kg patient.

PRECAUTIONS: General: Patients already on a beta blocker must be evaluated carefully before TENORMIN is administered. Initial and subsequent TENORMIN dosages can be adjusted downward depending on clinical observations including pulse and blood pressure. TENORMIN may aggravate peripheral arterial circulatory disorders.

Impaired Renal Function: The drug should be used with caution in patients with impaired renal function. (SEE DOSAGE AND ADMINISTRATION.)

Drug Interactions: Catecholamine-depleting drugs (eg, reserpine) may have an additive effect when given with beta-blocking agents. Patients treated with TENORMIN plus a catecholamine depletor should therefore be closely observed for evidence of hypotension and/or marked bradycardia which may produce vertigo, syncope, or postural hypotension.

Beta blockers may exacerbate the rebound hypertension which can follow the withdrawal of clonidine. If the two drugs are coadministered, the beta blocker should be withdrawn several days before the gradual withdrawal of clonidine. If replacing clonidine by beta-blocker therapy, the introduction of beta blockers should be delayed for several days after clonidine administration has stopped.

Caution should be exercised with TENORMIN I.V. Injection when given in close proximity with drugs that may also have a depressant effect on myocardial contractility. On rare occasions, concomitant use of intravenous beta blockers and intravenous verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Information on concurrent usage of atenolol and aspirin is limited. Data from several studies, ie, TIMI-II, ISIS-2, currently do not suggest any clinical interaction between aspirin and beta blockers in the acute myocardial infarction setting.

While taking beta blockers, patients with a history of anaphylactic reaction to a variety of allergens may have a more severe reaction on repeated challenge, either accidental, diagnostic, or therapeutic. Such patients may be unresponsive to the usual doses of epinephrine used to treat the allergic reaction.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Two long-term (maximum dosing duration of 18 or 24 months) rat studies and one long-term (maximum dosing duration of 18 months) mouse study, each employing dose levels as high as 300 mg/kg/day or 150 times the maximum recommended human antihypertensive dose,* did not indicate a carcinogenic potential of atenolol. A third (24 month) rat study, employing doses of 500 and 1,500 mg/kg/day (250 and 750 times the maximum recommended human antihypertensive dose*) resulted in increased incidences of benign adrenal medullary tumors in males and females, mammary fibroadenomas in females, and anterior pituitary adenomas and thyroid parafollicular cell carcinomas in males. No evidence of a mutagenic potential of atenolol was uncovered in the dominant lethal test (mouse), in vivo cytogenetics test (Chinese hamster), or Ames test (*S typhimurium*).

Fertility of male or female rats (evaluated at dose levels as high as 200 mg/kg/day or 100 times the maximum recommended human dose*) was unaffected by atenolol administration.

Animal Toxicology: Chronic studies employing oral atenolol performed in animals have revealed the occurrence of vacuolation of epithelial cells of Brunner's glands in the duodenum of both male and female dogs at all tested dose levels of atenolol (starting at 15 mg/kg/day or 7.5 times the maximum recommended human antihypertensive dose*) and increased incidence of atrial degeneration of hearts of male rats at 300 but not 150 mg atenolol/kg/day (150 and 75 times the maximum recommended human antihypertensive dose,* respectively).

Usage in Pregnancy: Pregnancy Category D: See WARNINGS - Pregnancy and Fetal Injury.

Nursing Mothers: Atenolol is excreted in human breast milk at a ratio of 1.5 to 6.8 when compared to the concentration in plasma. Caution should be exercised when TENORMIN is administered to a nursing woman. Clinically significant bradycardia has been reported in breast fed infants. Premature infants, or infants with impaired renal function, may be more likely to develop adverse effects.

Pediatric Use: Safety and effectiveness in children have not been established.

*Based on the maximum dose of 100 mg/day in 50 kg patient.

ADVERSE REACTIONS: Most adverse effects have been mild and transient.

The frequency estimates in the following table were derived from controlled studies in hypertensive patients in which adverse reactions were either volunteered by the patient (US studies) or elicited, eg, by checklist (foreign studies). The reported frequency of elicited adverse effects was higher for both TENORMIN and placebo-treated patients than when these reactions were volunteered. Where frequency of adverse effects of TENORMIN and placebo is similar, causal relationship to TENORMIN is uncertain.

	Volunteered (US Studies)		Total - Volunteered and Elicited (Foreign + US Studies)	
	Atenolol (n = 164) %	Placebo (n = 206) %	Atenolol (n = 399) %	Placebo (n = 407) %
CARDIOVASCULAR				
Bradycardia	3	0	3	0
Cold Extremities	0	0.5	12	5
Postural Hypotension	2	1	4	5
Leg Pain	0	0.5	3	1
CENTRAL NERVOUS SYSTEM/ NEUROMUSCULAR				
Dizziness	4	1	13	6
Vertigo	2	0.5	2	0.2
Light-headedness	1	0	3	0.7
Tiredness	0.6	0.5	26	13
Fatigue	3	1	6	5
Lethargy	1	0	3	0.7
Drowsiness	0.6	0	2	0.5
Depression	0.6	0.5	12	9
Dreaming	0	0	3	1
GASTROINTESTINAL				
Diarrhea	2	0	3	2
Nausea	4	1	3	1
RESPIRATORY (see WARNINGS)				
Wheeziness	0	0	3	3
Dyspnea	0.6	1	6	4

Acute Myocardial Infarction: In a series of investigations in the treatment of acute myocardial infarction, bradycardia and hypotension occurred more commonly, as expected for any beta blocker, in atenolol-treated patients than in control patients. However, these usually responded to atropine and/or to withholding further dosage of atenolol. The incidence of heart failure was not increased by atenolol. Inotropic agents were infrequently used. The reported frequency of these and other events occurring during these investigations is given in the following table.

In a study of 477 patients, the following adverse events were reported during either intravenous and/or oral atenolol administration:

	Conventional Therapy Plus Atenolol (n=244)		Conventional Therapy Alone (n=233)	
Bradycardia	43	(18%)	24	(10%)
Hypotension	60	(25%)	34	(15%)
Bronchospasm	3	(1.2%)	2	(0.9%)
Heart Failure	46	(19%)	56	(24%)
Heart Block 6BB + Major	11	(4.5%)	10	(4.3%)
Axis Deviation	16	(6.6%)	28	(12%)
Supraventricular Tachycardia	28	(11.5%)	45	(19%)
Atrial Fibrillation	12	(5%)	29	(11%)
Atrial Flutter	4	(1.6%)	7	(3%)
Ventricular Tachycardia	39	(16%)	52	(22%)
Cardiac Reinfarction	0	(0%)	6	(2.6%)
Total Cardiac Arrests	4	(1.6%)	16	(6.9%)
Nonfatal Cardiac Arrests	4	(1.6%)	12	(5.1%)
Deaths	7	(2.9%)	16	(6.9%)
Cardiogenic Shock	1	(0.4%)	4	(1.7%)
Development of Ventricular Septal Defect	0	(0%)	2	(0.9%)
Development of Mitral Regurgitation	0	(0%)	2	(0.9%)
Renal Failure	1	(0.4%)	0	(0%)
Pulmonary Emboli	3	(1.2%)	0	(0%)

In the subsequent International Study of Infarct Survival (ISIS-1) including over 16,000 patients of whom 8,037 were randomized to receive TENORMIN treatment, the dosage of intravenous and subsequent oral TENORMIN was either discontinued or reduced for the following reasons:

	Reasons for Reduced Dosage IV Atenolol Reduced Dose (< 5mg)*		Oral Partial Dose	
Hypotension/Bradycardia	105	(1.3%)	1168	(14.5%)
Cardiogenic Shock	4	(.04%)	35	(.44%)
Reinfarction	0	(0%)	5	(.06%)
Cardiac Arrest	5	(.06%)	28	(.34%)
Heart Block (> first degree)	5	(.06%)	143	(1.7%)
Cardiac Failure	1	(.01%)	233	(2.9%)
Arrhythmias	3	(.04%)	22	(.27%)
Bronchospasm	1	(.01%)	50	(.62%)

*Full dosage was 10 mg and some patients received less than 10 mg but more than 5 mg.

During postmarketing experience with TENORMIN, the following have been reported in temporal relationship to the use of the drug: elevated liver enzymes and/or bilirubin, headache, impotence, Peyronie's disease, psoriasiform rash or exacerbation of psoriasis, purpura, reversible alopecia, and thrombocytopenia. TENORMIN, like other beta blockers, has been associated with the development of antinuclear antibodies (ANA) and lupus syndrome.

POTENTIAL ADVERSE EFFECTS: In addition, a variety of adverse effects have been reported with other beta-adrenergic blocking agents, and may be considered potential adverse effects of TENORMIN.

Hematologic: Agranulocytosis.

Allergic: Fever, combined with aching and sore throat, laryngospasm, and respiratory distress.

Central Nervous System: Reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation of time and place; short-term memory loss; emotional lability with slightly clouded sensorium; and, decreased performance on neuropsychometrics.

Gastrointestinal: Mesenteric arterial thrombosis, ischemic colitis.

Other: Erythematous rash, Raynaud's phenomenon.

Miscellaneous: There have been reports of skin rashes and/or dry eyes associated with the use of beta-adrenergic blocking drugs. The reported incidence is small, and in most cases, the symptoms have cleared when treatment was withdrawn. Discontinuance of the drug should be considered if any such reaction is not otherwise explicable. Patients should be closely monitored following cessation of therapy. (SEE DOSAGE AND ADMINISTRATION.)

The oculomucocutaneous syndrome associated with the beta blocker practolol has not been reported with TENORMIN. Furthermore, a number of patients who had previously demonstrated established practolol reactions were transferred to TENORMIN therapy with subsequent resolution or quiescence of the reaction.

OVERDOSAGE: Overdosage with TENORMIN has been reported with patients surviving acute doses as high as 5 g. One death was reported in a man who may have taken as much as 10 g acutely.

The predominant symptoms reported following TENORMIN overdose are lethargy, disorder of respiratory drive, wheezing, sinus pause, and bradycardia. Additionally, common effects associated with overdosage of any beta-adrenergic blocking agent and which might also be expected in TENORMIN overdose are congestive heart failure, hypotension, bronchospasm, and/or hypoglycemia.

Treatment of overdose should be directed to the removal of any unabsorbed drug by induced emesis, gastric lavage, or administration of activated charcoal. TENORMIN can be removed from the general circulation by hemodialysis. Other treatment modalities should be employed at the physician's discretion and may include:

BRADYCARDIA: Atropine intravenously. If there is no response to vagal blockade, give isoproterenol cautiously. In refractory cases, a transvenous cardiac pacemaker may be indicated.

HEART BLOCK (SECOND OR THIRD DEGREE): Isoproterenol or transvenous cardiac pacemaker.

CARDIAC FAILURE: Digitalize the patient and administer a diuretic. Glucagon has been reported to be useful.

HYPOTENSION: Vasopressors such as dopamine or norepinephrine (levarterenol). Monitor blood pressure continuously.

BRONCHOSPASM: A beta, stimulant such as isoproterenol or terbutaline and/or aminophylline.

HYPOGLYCEMIA: Intravenous glucose.

Based on the severity of symptoms, management may require intensive support care and facilities for applying cardiac and respiratory support.

DOSAGE AND ADMINISTRATION: Hypertension: The initial dose of TENORMIN is 50 mg given as one tablet a day either alone or added to diuretic therapy. The full effect of this dose will usually be seen within one to two weeks. If an optimal response is not achieved, the dosage should be increased to TENORMIN 100 mg given as one tablet a day. Increasing the dosage beyond 100 mg a day is unlikely to produce any further benefit.

TENORMIN may be used alone or concomitantly with other antihypertensive agents including thiazide-type diuretics, hydralazine, prazosin, and alpha-methyldopa.

Angina Pectoris: The initial dose of TENORMIN is 50 mg given as one tablet a day. If an optimal response is not achieved within one week, the dosage should be increased to TENORMIN 100 mg given as one tablet a day. Some patients may require a dosage of 200 mg once a day for optimal effect.

Twenty-four hour control with once daily dosing is achieved by giving doses larger than necessary to achieve an immediate maximum effect. The maximum early effect on exercise tolerance occurs with doses of 50 to 100 mg, but at these doses the effect at 24 hours is attenuated, averaging about 50% to 75% of that observed with once a day oral doses of 200 mg.

Acute Myocardial Infarction: In patients with definite or suspected acute myocardial infarction, treatment with TENORMIN I.V. Injection should be initiated as soon as possible after the patient's arrival in the hospital and after eligibility is established. Such treatment should be initiated in a coronary care or similar unit immediately after the patient's hemodynamic condition has stabilized. Treatment should begin with the intravenous administration of 5 mg TENORMIN over 5 minutes followed by another 5 mg intravenous injection 10 minutes later. TENORMIN I.V. Injection should be administered under carefully controlled conditions including monitoring of blood pressure, heart rate, and electrocardiogram. Dilutions of TENORMIN I.V. Injection in Dextrose Injection USP, Sodium Chloride Injection USP, or Sodium Chloride and Dextrose Injection may be used. These admixtures are stable for 48 hours if they are not used immediately.

In patients who tolerate the full intravenous dose (10 mg), TENORMIN Tablets 50 mg should be initiated 10 minutes after the last intravenous dose followed by another 50 mg oral dose 12 hours later. Thereafter, TENORMIN can be given orally either 100 mg once daily or 50 mg twice a day for a further 6-9 days or until discharge from the hospital. If bradycardia or hypotension requiring treatment or any other untoward effects occur, TENORMIN should be discontinued.

Data from other beta blocker trials suggest that if there is any question concerning the use of IV beta blocker or clinical estimate that there is a contraindication, the IV beta blocker may be eliminated and patients fulfilling the safety criteria may be given TENORMIN Tablets 50 mg twice daily or 100 mg once a day for at least seven days (if the IV dosing is excluded).

Although the demonstration of efficacy of TENORMIN is based entirely on data from the first seven postinfarction days, data from other beta blocker trials suggest that treatment with beta blockers that are effective in the postinfarction setting may be continued for one to three years if there are no contraindications.

TENORMIN is an additional treatment to standard coronary care unit therapy.

Elderly Patients or Patients with Renal Impairment: TENORMIN is excreted by the kidneys; consequently dosage should be adjusted in cases of severe impairment of renal function. Some reduction in dosage may also be appropriate for the elderly, since decreased kidney function is a physiologic consequence of aging. Atenolol excretion would be expected to decrease with advancing age.

No significant accumulation of TENORMIN occurs until creatinine clearance falls below 35 mL/min/1.73m². Accumulation of atenolol and prolongation of its half-life were studied in subjects with creatinine clearance between 5 and 105 mL/min. Peak plasma levels were significantly increased in subjects with creatinine clearances below 30 mL/min.

The following maximum oral dosages are recommended for elderly, renally-impaired patients and for patients with renal impairment due to other causes:

Creatinine Clearance (mL/min/1.73m²)	Atenolol Elimination Half-Life (h)	Maximum Dosage
15-35	16-27	50 mg daily
<15	>27	25 mg daily

Some renally-impaired or elderly patients being treated for hypertension may require a lower starting dose of TENORMIN: 25 mg given as one tablet a day. If this 25 mg dose is used, assessment of efficacy must be made carefully. This should include measurement of blood pressure just prior to the next dose ("trough" blood pressure) to ensure that the treatment effect is present for a full 24 hours.

Although a similar dosage reduction may be considered for elderly and/or renally-impaired patients being treated for indications other than hypertension, data are not available for these patient populations.

Patients on hemodialysis should be given 25 mg or 50 mg after each dialysis; this should be done under hospital supervision as marked falls in blood pressure can occur.

Cessation of Therapy in Patients with Angina Pectoris: If withdrawal of TENORMIN therapy is planned, it should be achieved gradually and patients should be carefully observed and advised to limit physical activity to a minimum.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit.

HOW SUPPLIED

TENORMIN Tablets: Tablets of 25 mg atenolol, NDC 0310-0107 (round, flat, uncoated white tablets with "T" debossed on one side and 107 debossed on the other side) are supplied in bottles of 100 tablets.

Tablets of 50 mg atenolol, NDC 0310-0105 (round, flat, uncoated white tablets identified with ICI debossed on one side and 105 debossed on the other side, bisected) are supplied in bottles of 100 tablets and 1000 tablets, and unit dose packages of 100 tablets. These tablets are distributed by ICI Pharma.

Tablets of 100 mg atenolol, NDC 0310-0101 (round, flat, uncoated white tablets with ICI debossed on one side and 101 debossed on the other side) are supplied in bottles of 100 tablets and unit dose packages of 100 tablets. These tablets are distributed by ICI Pharma.

Store at controlled room temperature, 15°-30 °C (59°-86 °F). Dispense in well-closed, light resistant containers.

TENORMIN I.V. Injection

TENORMIN I.V. Injection, NDC 0310-0108, is supplied as 5 mg atenolol in 10 mL ampules of isotonic citrate-buffered aqueous solution.

Protect from light. Keep ampules in outer packaging until time of use. Store at room temperature.

REV Y 03/92

ZENECA Pharmaceuticals
A Business Unit of ZENECA Inc
Wilmington, Delaware 19897 USA

FSA-1511 ICI-2870R

WHY CONSIDER TENORMIN BEFORE ALL OTHER BETA BLOCKERS?

- Convenient, once-daily dosing for all indications
- Effective control of blood pressure and angina
- Cardioprotection—improving survival during and after MI[1,2*]
- Well-tolerated

I.V. INJECTION/TABLETS

TENORMIN®
(atenolol)

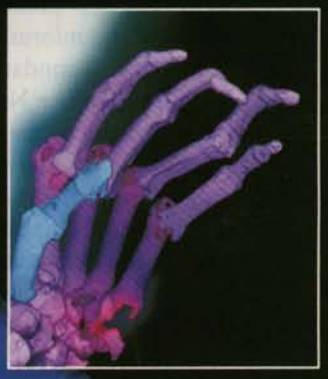
* Good clinical judgment suggests that patients who are dependent on sympathetic stimulation for adequate cardiac output and BP are not good candidates for beta blockade. In addition to patients excluded from the ISIS-1 study, those with borderline BP (ie, systolic < 120, especially if over age 60) are less likely to benefit.

References: 1. ISIS-1 (First International Study of Infarct Survival) Collaborative Group. Randomised trial of intravenous atenolol among 16 027 cases of suspected acute myocardial infarction: ISIS-1. *Lancet*. 1986;2:57-66. **2.** Glamann DB, Lange RA, Hillis LD. Beneficial effect of long-term beta blockade after acute myocardial infarction in patients without anterograde flow in the infarct artery. *Am J Cardiol*. 1991;68:150-154.

See adjacent page for brief summary of prescribing information.

FOR CHR

EXPECT



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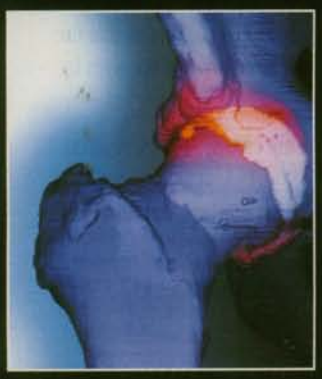
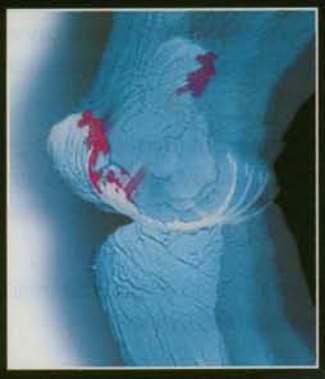


REDUCTION IN JOINT PAIN AND TENDERNESS



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As with other NSAIDs, the most frequent complaints are gastrointestinal, and rare hepatic and renal reactions have been reported.

Please see brief summary of prescribing information on adjacent page.

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NAPROSYN®

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Also available in 375 and 250 mg tablets and in suspension 125 mg/5 mL

SYNTEX

1993
Depression in the Elderly

Sponsored by:
American Medical Association
supported by a grant from the
National Institute of Mental Health
D/ART Program

Recognizing and Treating Depression in the Elderly

The recognition of depression may be more difficult in late compared with early life. In the elderly age group, both clinicians and patients may incorrectly attribute depressive symptoms to the aging process. Estimates of depression in elderly people vary widely; however, there is a consensus that the size of the problem is underestimated. Furthermore, victims of depression, generally are not seen by mental health professionals.

Major depressive episodes require treatment in all age groups, including the elderly. All depressions negatively affect quality of life and are associated with increased risk of comorbid medical illnesses and suicide. They are not "normal and acceptable" features of aging and warrant early attention by physicians.

Families and primary care physicians remain at the front line in recognizing depression and facilitating patient access to professional help.

Three Regional Workshops are being offered to you at *no cost.*

The American Medical Association, through a grant from the National Institute of Mental Health, will present 3 regional workshops on the *"Recognition and Treatment of Depression in the Elderly"*. They have been scheduled in regions having a high density of elderly in their populations. The workshops will discuss:

- depression in late life vs. earlier life
- diagnosis of depression
- risk factors for depression
- epidemiology of depression
- differentiation of depression from other psychiatric illnesses including dementia
- what to look for and how to evaluate suicide potential
- treatment, including psychotherapies (individual, family and group), pharmacotherapies, electroconvulsive therapy
- prognosis
- preventing relapses

Clinical vignettes will be presented and will be the focus for discussion.

Who Should Attend

Primary care physicians, including family and general practitioners, internists, geriatricians, Ob/Gyn as well as other allied health professionals caring for the elderly.

CME Credit!

The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The AMA designates this continuing medical education activity for 5 hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association.

Workshop Dates and Locations:

- October 16, 1993
  Cedars Medical Center
  Miami, Florida
- November 6, 1993
  Iowa Lutheran Hospital
  Des Moines, Iowa
- November 13, 1993
  Tucson Medical Center
  Tucson, Arizona

For additional information or to register, please call or write:
Department of Mental Health
American Medical Association
515 N. State Street
Chicago, IL 60610
(312) 464-5066

HOW MUCH HAVE YOUR MIGRAINE PATIENTS TOLD YOU LATELY ABOUT THEIR CURRENT TREATMENT?

"My medicine knocks the pain out,
but it knocks me out too...

I guess it's probably the best
I can hope for."

MORE OF YOUR PATIENTS MAY

Because it works fast.[1]

The most frequently reported adverse events associated with IMITREX are injection-site reactions (59%), atypical sensations (e.g., tingling, warm/hot sensation) (42%), and dizziness/vertigo (12%). IMITREX is contraindicated in patients with ischemic heart disease, symptoms or signs consistent with ischemic heart disease, or Prinzmetal's angina because of the potential to cause coronary vasospasm. IMITREX is contraindicated in patients with uncontrolled hypertension because it can give rise to increases in blood pressure (usually small). IMITREX should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. (Please see Precautions.) IMITREX should not be administered to patients with basilar or hemiplegic migraine.

Reference: 1. Cady RK, Wendt JK, Kirchner JR, Sargent JD, Rothrock JF, Skaggs H Jr. Treatment of acute migraine with subcutaneous sumatriptan. *JAMA*. June 1991;265:2831-2835.

BENEFIT FROM IMITREX

Because it works well.[1]

Because it is nonsedating.

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IMITREX™

SUMATRIPTAN SUCCINATE

MIGRAINE RELIEF THAT CAN CHANGE PATIENTS' LIVES

Please consult Brief Summary of Prescribing Information on last page of this advertisement.

BRIEF SUMMARY

Imitrex™ (sumatriptan succinate) Injection

For Subcutaneous Use Only.

The following is a brief summary only. Before prescribing, see complete prescribing information in Imitrex™ Injection product labeling.

INDICATIONS AND USAGE: Imitrex™ Injection is indicated for the acute treatment of migraine attacks with or without aura.

Imitrex Injection is not for use in the management of hemiplegic or basilar migraine (see WARNINGS).

Safety and effectiveness have also not been established for cluster headache, which is present in an older, predominantly male population.

CONTRAINDICATIONS: Imitrex™ Injection should not be given intravenously because of its potential to cause coronary vasospasm.

For similar reasons, Imitrex Injection should not be given subcutaneously to patients with ischemic heart disease (angina pectoris, history of myocardial infarction, or documented silent ischemia) or to patients with Prinzmetal's angina. Also, patients with symptoms or signs consistent with ischemic heart disease should not receive Imitrex Injection. Because Imitrex Injection can give rise to increases in blood pressure (usually small), it should not be given to patients with uncontrolled hypertension.

Imitrex Injection should not be used concomitantly with ergotamine-containing preparations.

Imitrex Injection is contraindicated in patients with hypersensitivity to sumatriptan.

WARNINGS: Imitrex™ Injection should not be administered to patients with basilar or hemiplegic migraine.

Cardiac Events/Coronary Constriction: Serious coronary events following Imitrex Injection can occur but are extremely rare; nonetheless, **consideration should be given to administering the first dose of Imitrex Injection in the physician's office to patients in whom unrecognized coronary disease is comparatively likely** (postmenopausal women; males over 40; patients with risk factors for CAD, such as hypertension, hypercholesterolemia, obesity, diabetes, smokers, and strong family history). **If symptoms consistent with angina occur, electrocardiographic (ECG) evaluation should be carried out to look for ischemic changes.**

Sumatriptan may cause coronary vasospasm in patients with a history of coronary artery disease, who are known to be more susceptible than others to coronary artery vasospasm, and, rarely, in patients without prior history suggestive of coronary artery disease. There were eight patients among the more than 1,900 who participated in controlled trials who sustained clinical events during or shortly after receiving subcutaneous sumatriptan that may have reflected coronary vasospasm. Six of these eight patients had ECG changes consistent with transient ischemia, but without symptoms or signs. Of the eight patients, four had some findings suggestive of coronary artery disease prior to treatment. None of these adverse events was associated with a serious clinical outcome.

There have been rare reports from countries in which Imitrex Injection has been marketed of serious and/or life-threatening arrhythmias, including atrial fibrillation, ventricular fibrillation, ventricular tachycardia; myocardial infarction; and marked ischemic ST elevations associated with Imitrex Injection. In addition, there have been rare, but more frequent, reports of chest and arm discomfort thought to represent angina pectoris.

Use in Women of Childbearing Potential: (see PRECAUTIONS)

PRECAUTIONS:

General: Chest, jaw, or neck tightness is relatively common after Imitrex™ Injection, but has only rarely been associated with ischemic ECG changes.

Imitrex Injection may cause mild, transient elevation of blood pressure and peripheral vascular resistance.

Imitrex Injection should also be administered with caution to patients with diseases that may alter the absorption, metabolism, or excretion of drugs, such as impaired hepatic or renal function.

Although written instructions are supplied with the autoinjector, patients who are advised to self-administer Imitrex Injection in medically unsupervised situations should receive instruction on the proper use of the product from the physician or other suitably qualified health care professional prior to doing so for the first time.

Information for Patients: See PATIENT INFORMATION at the end of the product package insert for the text of the separate leaflet provided for patients.

Laboratory Tests: No specific laboratory tests are recommended for monitoring patients prior to and/or after treatment with Imitrex Injection.

Drug Interactions: There is no evidence that concomitant use of migraine prophylactic medications has any effect on the efficacy or unwanted effects of sumatriptan. In two Phase III trials in the US, a retrospective analysis of 282 patients who had been using prophylactic drugs (verapamil n=63, amitriptyline n=57, propranolol n=94, for 45 other drugs n=123) were compared to those who had not used prophylaxis (n=452). There were no differences in relief rates at 60 minutes postdose for Imitrex Injection, whether or not prophylactic medications were used. There were also no differences in overall adverse event rates between the two groups.

Ergot-containing drugs have been reported to cause prolonged vasospastic reactions. Because there is a theoretical basis that these effects may be additive, use of ergotamine and sumatriptan within 24 hours of each other should be avoided (see CONTRAINDICATIONS).

Drug/Laboratory Test Interactions: Imitrex Injection is not known to interfere with commonly employed clinical laboratory tests.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a 104-week lifetime study in rats given sumatriptan by oral gavage, serum concentrations achieved were dose related, ranging at the low dose from approximately twice the peak concentration of the drug after the recommended human subcutaneous dose of 6 mg to more than 100 times this concentration at the high dose. There was no evidence of an increase in tumors considered to be related to sumatriptan administration.

In a 78-week study in which mice received sumatriptan continuously in drinking water, there was no evidence for an increase in tumors considered to be related to sumatriptan administration. That study, however, did not use the maximum tolerated dose and therefore did not fully explore the carcinogenic potential of Imitrex™ (sumatriptan succinate) Injection in the mouse.

A Segment I rat fertility study by the subcutaneous route has shown no evidence of impaired fertility.

Pregnancy: *Pregnancy Category C:* Sumatriptan has been shown to be embryolethal in rabbits when given in daily doses producing plasma levels 3-fold higher than those attained following a 6-mg subcutaneous injection (i.e., recommended dose) to humans. There is no evidence that establishes that sumatriptan is a human teratogen; however, there are no adequate and well-controlled studies in pregnant women. Imitrex Injection should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

In assessing this information, the following additional findings should be considered.

Embryolethality: When given intravenously to pregnant rabbits daily throughout the period of organogenesis, sumatriptan caused embryolethality at doses at or close to those producing maternal toxicity. The mechanism of the embryolethality is not known. At these doses, peak concentrations of drug in plasma were more than 3-fold higher than the range observed in humans after the recommended subcutaneous dose of 6 mg.

The intravenous administration of sumatriptan to pregnant rats throughout organogenesis at doses producing plasma concentrations more than 50 times those seen after the recommended subcutaneous human dose did not cause embryolethality. In a study of pregnant rats given subcutaneous sumatriptan daily prior to and throughout pregnancy, there was no evidence of increased embryo/fetal lethality.

Teratogenicity: Term fetuses from Dutch Stride rabbits treated during organogenesis with oral sumatriptan exhibited an increased incidence of cervicothoracic vascular defects and minor skeletal abnormalities. The functional significance of these abnormalities is not known.

In a study in rats dosed daily with subcutaneous sumatriptan prior to and throughout pregnancy, there was no evidence of teratogenicity.

Studies in rats and rabbits evaluating the teratogenic potential of sumatriptan administered subcutaneously only during organogenesis (standard Segment II studies) have not been performed.

Nursing Mothers: Sumatriptan is excreted in breast milk in animals. No data exist in humans. Therefore, caution should be exercised when considering the administration of Imitrex Injection to a nursing woman.

Pediatric Use: Safety and effectiveness of Imitrex Injection in children have not been established.

Use in the Elderly: The safety and effectiveness of Imitrex Injection in individuals over age 65 have not been systematically evaluated. However, the pharmacokinetic disposition of Imitrex Injection in the elderly is similar to that seen in younger adults. No unusual adverse, age-related phenomena have been identified in patients over the age of 60 who participated in clinical trials with Imitrex Injection.

ADVERSE REACTIONS: (see also PRECAUTIONS) Sumatriptan may cause coronary vasospasm in patients with a history of coronary artery disease, known to be susceptible to coronary artery vasospasm, and, very rarely, without prior history suggestive of coronary artery disease.

There have been rare reports from countries in which Imitrex™ Injection has been marketed of serious and/or life-threatening arrhythmias, including atrial fibrillation, ventricular fibrillation, ventricular tachycardia; myocardial infarction; and marked ischemic ST elevations associated with Imitrex Injection (see WARNINGS). More often, there has been chest discomfort that appeared to represent angina pectoris.

Other untoward clinical events associated with the use of subcutaneous Imitrex Injection are: pain or redness at the injection site, atypical sensations (such as sensations of warmth, cold, tingling or paresthesia, pressure, burning, numbness, tightness, all of which may be localized or generalized), flushing, chest symptoms (pressure, pain, or tightness), fatigue, dizziness, and drowsiness. All these untoward effects are usually transient, although they may be severe in some patients. Transient rises in blood pressure soon after treatment have been recorded.

Among patients in clinical trials of subcutaneous Imitrex Injection (n=6,218), up to 3.5% of patients withdrew for reasons related to adverse events.

Incidence in Controlled Clinical Trials: The following Table lists adverse events that occurred in two large US, Phase III, placebo-controlled clinical trials following either a single dose of Imitrex Injection or placebo. Only events that occurred at a frequency of 1% or more in Imitrex Injection treatment groups and were at least as frequent as in the placebo group are included in Table.

Treatment-Emergent Adverse Experience Incidence in Two Large Placebo-Controlled Clinical Trials: Events Reported by at Least 1% of Imitrex Injection Patients

	Percent of Patients Reporting	
Adverse Event Type	Imitrex Injection 6 mg SC n=547	Placebo n=370
Atypical sensations	42.0	9.2
Tingling	13.5	3.0
Warm/hot sensation	10.8	3.5
Burning sensation	7.5	0.3
Feeling of heaviness	7.3	1.1
Pressure sensation	7.1	1.6
Feeling of tightness	5.1	0.3
Numbness	4.6	2.2
Feeling strange	2.2	0.3
Tight feeling in head	2.2	0.3
Cold sensation	1.1	0.5
Cardiovascular		
Flushing	6.6	2.4
Chest discomfort	4.5	1.4
Tightness in chest	2.7	0.5
Pressure in chest	1.8	0.3
Ear, nose, and throat		
Throat discomfort	3.3	0.5
Discomfort: nasal cavity/sinuses	2.2	0.3
Eye		
Vision alterations	1.1	0.0
Gastrointestinal		
Abdominal discomfort	1.3	0.8
Dysphagia	1.1	0.0
Injection site reaction	58.7	23.8
Miscellaneous		
Jaw discomfort	1.8	0.0
Mouth and teeth		
Discomfort of mouth/tongue	4.9	4.6
Musculoskeletal		
Weakness	4.9	0.3
Neck pain/stiffness	4.8	0.5
Myalgia	1.8	0.5
Muscle cramp(s)	1.1	0.0
Neurological		
Dizziness/vertigo	11.9	4.3
Drowsiness/sedation	2.7	2.2
Headache	2.2	0.3
Anxiety	1.1	0.5
Malaise/fatigue	1.1	0.8
Skin		
Sweating	1.6	1.1

The sum of the percentages cited are greater than 100% because patients may experience more than one type of adverse event. Only events that occurred at a frequency of 1% or more in Imitrex™ (sumatriptan succinate) Injection treatment groups and were at least as frequent as in the placebo groups are included.

Other Events Observed in Association With the Administration of Imitrex Injection: In the paragraphs that follow, the frequency of less commonly reported adverse clinical events are presented. Because the reports cite events observed in open and uncontrolled studies, the role of Imitrex Injection in their causation cannot be reliably determined. Furthermore, variability associated with reporting requirements, the terminology used to describe adverse events, etc., limit the value of the quantitative frequency estimates provided.

Event frequencies are calculated as the number of patients reporting an event divided by the total number of patients (n=6,218) exposed to subcutaneous Imitrex Injection. Given their imprecision, frequencies for specific adverse event occurrences are defined as follows: "infrequent" indicates a frequency estimated as falling between 1/1,000 and 1/100; "rare," a frequency less than 1/1,000.

Cardiovascular: Infrequent were hypertension, hypotension, bradycardia, tachycardia, palpitations, pulsating sensations, various transient ECG changes (nonspecific ST or T wave changes, prolongation of PR or QTc intervals, sinus arrhythmia, nonsustained ventricular premature beats, isolated junctional ectopic beats, atrial ectopic beats, delayed activation of the right ventricle), and syncope. Rare were pallor, arrhythmia, abnormal pulse, vasodilatation, and Raynaud's syndrome.

Endocrine and Metabolic: Infrequent was thirst. Rare were polydipsia and dehydration.

Eye: Infrequent was irritation of the eye.

Gastrointestinal: Infrequent were gastroesophageal reflux, diarrhea, and disturbances of liver function tests. Rare were peptic ulcer, retching, flatulence/eructation, and gallstones.

Musculoskeletal: Infrequent were various joint disturbances (pain, stiffness, swelling, ache). Rare were muscle stiffness, need to flex calf muscles, backache, muscle tiredness, and swelling of the extremities.

Neurological: Infrequent were mental confusion, euphoria, agitation, relaxation, chills, sensation of lightness, tremor, shivering, disturbances of taste, prickling sensations, paresthesia, stinging sensations, headaches, facial pain, photophobia, and lachrymation. Rare were transient hemiplegia, hysteria, globus hystericus, intoxication, depression, myoclonia, monoplegia/diplegia, sleep disturbance, difficulties in concentration, disturbances of smell, hyperesthesia, dysesthesia, simultaneous hot and cold sensations, tickling sensations, dysarthria, yawning, reduced appetite, hunger, and dystonia.

Respiratory: Infrequent was dyspnea. Rare were influenza, diseases of the lower respiratory tract, and hiccoughs.

Dermatological: Infrequent were erythema, pruritus, and skin rashes and eruptions. Rare was skin tenderness.

Urogenital: Rare were dysuria, frequency, dysmenorrhea, and renal calculus.

Miscellaneous: Infrequent were miscellaneous laboratory abnormalities, including minor disturbances in liver function tests, "serotonin agonist effect," and hypersensitivity to various agents. Rare was fever.

Postmarketing Experience: Frequency and causality for sumatriptan are not established for many of the following reports, which come from worldwide postmarketing experience: Episodes of Prinzmetal's angina, myocardial infarction, acute renal failure, seizure, cerebrovascular accident, dysphasia, subarachnoid hemorrhage, and arrhythmias (atrial fibrillation, ventricular fibrillation, and ventricular tachycardia). Hypersensitivity to Imitrex Injection has been reported, including anaphylactoid reactions, rash, urticaria, pruritus, erythema, and shortness of breath.

DRUG ABUSE AND DEPENDENCE: The abuse potential of Imitrex™ Injection cannot be fully delineated in advance of extensive marketing experience. One clinical study enrolling 12 patients with a history of substance abuse failed to induce subjective behavior and/or physiologic response ordinarily associated with drugs that have an established potential for abuse.

CERENEX™ PHARMACEUTICALS
DIVISION OF GLAXO INC
Research Triangle Park, NC 27709

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Brief Summary:

Contraindications: Patients who have had allergic reactions to NAPROSYN, ANAPROX or ANAPROX DS or in whom aspirin or other NSAIDs induce the syndrome of asthma, rhinitis, and nasal polyps. Because anaphylactic reactions usually occur in patients with a history of such reactions, question patients for asthma, nasal polyps, urticaria, and hypotension associated with NSAIDs before starting therapy. If such symptoms occur, discontinue the drug. **Warnings:** Serious GI toxicity such as bleeding, ulceration, and perforation can occur at any time, with or without warning symptoms, in patients treated chronically with NSAIDs. Remain alert for ulceration and bleeding in such patients even in the absence of previous GI tract symptoms. In clinical trials, symptomatic upper GI ulcers, gross bleeding or perforation appear to occur in approximately 1% of patients treated for 3-6 months, and in about 2-4% of patients treated for one year. Inform patients about the signs and/or symptoms of serious GI toxicity and what steps to take if they occur. Studies have not identified any subset of patients not at risk of developing peptic ulceration and bleeding. Except for a prior history of serious GI events and other risk factors known to be associated with peptic ulcer disease, such as alcoholism, smoking, etc., no risk factors (e.g., age, sex) have been associated with increased risk. Elderly or debilitated patients seem to tolerate ulceration or bleeding less well than others and most spontaneous reports of fatal GI events are in this population. In considering the use of relatively large doses (within the recommended dosage range), sufficient benefit should be anticipated to offset the potential increased risk of GI toxicity. **Precautions:** DO NOT GIVE **NAPROSYN®** (NAPROXEN) CONCOMITANTLY WITH **ANAPROX®** (NAPROXEN SODIUM) OR **ANAPROX® DS** (NAPROXEN SODIUM) SINCE THEY BOTH CIRCULATE IN PLASMA AS THE NAPROXEN ANION. Acute interstitial nephritis with hematuria, proteinuria, and nephrotic syndrome has been reported. Patients with impaired renal function, heart failure, liver dysfunction, patients taking diuretics, and the elderly are at greater risk of overt renal decompensation. If this occurs, discontinue the drug. Use with caution and monitor serum creatinine and/or creatinine clearance in patients with significantly impaired renal function. Use caution in patients with baseline creatinine clearance less than 20 mL/minute. Use the lowest effective dose in the elderly or in patients with chronic alcoholic liver disease or cirrhosis. With NSAIDs, borderline elevations of liver tests may occur in up to 15% of patients. They may progress, remain unchanged, or be transient with continued therapy. Elevations of SGPT or SGOT occurred in controlled clinical trials in less than 1% of patients. Severe hepatic reactions, including jaundice and fatal hepatitis, have been reported rarely. If liver disease develops or if systemic manifestations occur (e.g., eosinophilia or rash), discontinue therapy. If steroid dosage is reduced or eliminated during therapy, do so slowly and observe patients closely for adverse effects, including adrenal insufficiency and exacerbation of arthritis symptoms. Determine hemoglobin values periodically for patients with initial values of 10 grams or less who receive long-term therapy. Peripheral edema has been reported. Therefore, use with caution in patients with fluid retention, hypertension or heart failure. The drug's antipyretic and anti-inflammatory activities may reduce fever and inflammation, diminishing their diagnostic value. Conduct ophthalmic studies if any change or disturbance in vision occurs. For patients with restricted sodium intake, note that the suspension contains 8 mg/mL of sodium. **Information for Patients:** Side effects of NSAIDs can cause discomfort and, rarely, there are more serious side effects, such as GI bleeding, which may result in hospitalization and even fatal outcomes. Physicians may wish to discuss with patients the potential risks and likely benefits of NSAID treatment, particularly when they are used for less serious conditions where treatment without NSAIDs may be an acceptable alternative. Patients should use caution for activities requiring alertness if they experience drowsiness, dizziness, vertigo or depression during therapy. **Laboratory Tests:** Because serious GI tract ulceration and bleeding can occur without warning symptoms, follow chronically treated patients for signs and symptoms of these and inform them of the importance of this follow-up. **Drug Interactions:** Use caution when giving concomitantly with coumarin-type anticoagulants; a hydantoin, sulfonamide or sulfonylurea; furosemide; lithium; beta-blockers; probenecid; or methotrexate. **Drug/Laboratory Test Interactions:** The drug may decrease platelet aggregation and prolong bleeding time or increase urinary values for 17-ketogenic steroids. Temporarily stop therapy for 72 hours before doing adrenal function tests. The drug may interfere with urinary assays of 5HIAA. **Carcinogenesis:** A 2-year rat study showed no evidence of carcinogenicity. **Pregnancy:** Category B. Do not use during pregnancy unless clearly needed. Avoid use during late pregnancy. **Nursing Mothers:** Avoid use in nursing mothers. **Pediatric Use:** Single doses of 2.5-5 mg/kg, with total daily dose not exceeding 15 mg/kg/day, are safe in children over 2 years of age. **Adverse Reactions:** In a study, GI reactions were more frequent and severe in rheumatoid arthritis patients on 1,500 mg/day than in those on 750 mg/day. In studies in children with juvenile arthritis, rash and prolonged bleeding times were more frequent, GI and CNS reactions about the same, and other reactions less frequent than in adults. Incidence Greater Than 1%; Probable Causal Relationship: GI: The most frequent complaints related to the GI tract: constipation,* heartburn,* abdominal pain,* nausea,* dyspepsia, diarrhea, stomatitis. CNS: headache,* dizziness,* drowsiness,* light-headedness, vertigo. Dermatologic: itching (pruritus),* skin eruptions,* ecchymoses,* sweating, purpura. Special Senses: tinnitus,* hearing disturbances, visual disturbances. Cardiovascular: edema,* dyspnea,* palpitations. General: thirst. Incidence Less Than 1%; Probable Causal Relationship: GI: abnormal liver function tests, colitis, GI bleeding and/or perforation, hematemesis, jaundice, melena, peptic ulceration with bleeding and/or perforation, vomiting. Renal: glomerular nephritis, hematuria, hyperkalemia, interstitial nephritis, nephrotic syndrome, renal disease, renal failure, renal papillary necrosis. Hematologic: agranulocytosis, eosinophilia, granulocytopenia, leukopenia, thrombocytopenia. CNS: depression, dream abnormalities, inability to concentrate, insomnia, malaise, myalgia and muscle weakness. Dermatologic: alopecia, photosensitive dermatitis, skin rashes. Special Senses: hearing impairment. Cardiovascular: congestive heart failure. Respiratory: eosinophilic pneumonitis. General: anaphylactoid reactions, menstrual disorders, pyrexia (chills and fever). Causal Relationship Unknown: Hematologic: aplastic anemia, hemolytic anemia. CNS: aseptic meningitis, cognitive dysfunction. Dermatologic: epidermal necrolysis, erythema multiforme, photosensitivity reactions resembling porphyria cutanea tarda and epidermolysis bullosa, Stevens-Johnson syndrome, urticaria. GI: non-peptic GI ulceration, ulcerative stomatitis. Cardiovascular: vasculitis. General: angioneurotic edema, hyperglycemia, hypoglycemia. **Overdosage:** May have drowsiness, heartburn, indigestion, nausea, vomiting. A few patients have had seizures. Empty stomach and use usual supportive measures. In animals 0.5 g/kg of activated charcoal reduced plasma levels of naproxen. **Caution:** Federal law prohibits dispensing without prescription. See package insert for full Prescribing Information.

*Incidence of reported reaction 3%-9%. Where unmarked, incidence less than 3%.

SYNTEX

U.S. patent nos. 3,904,682, 3,998,966 and others.

 Rev. 39 September 1990

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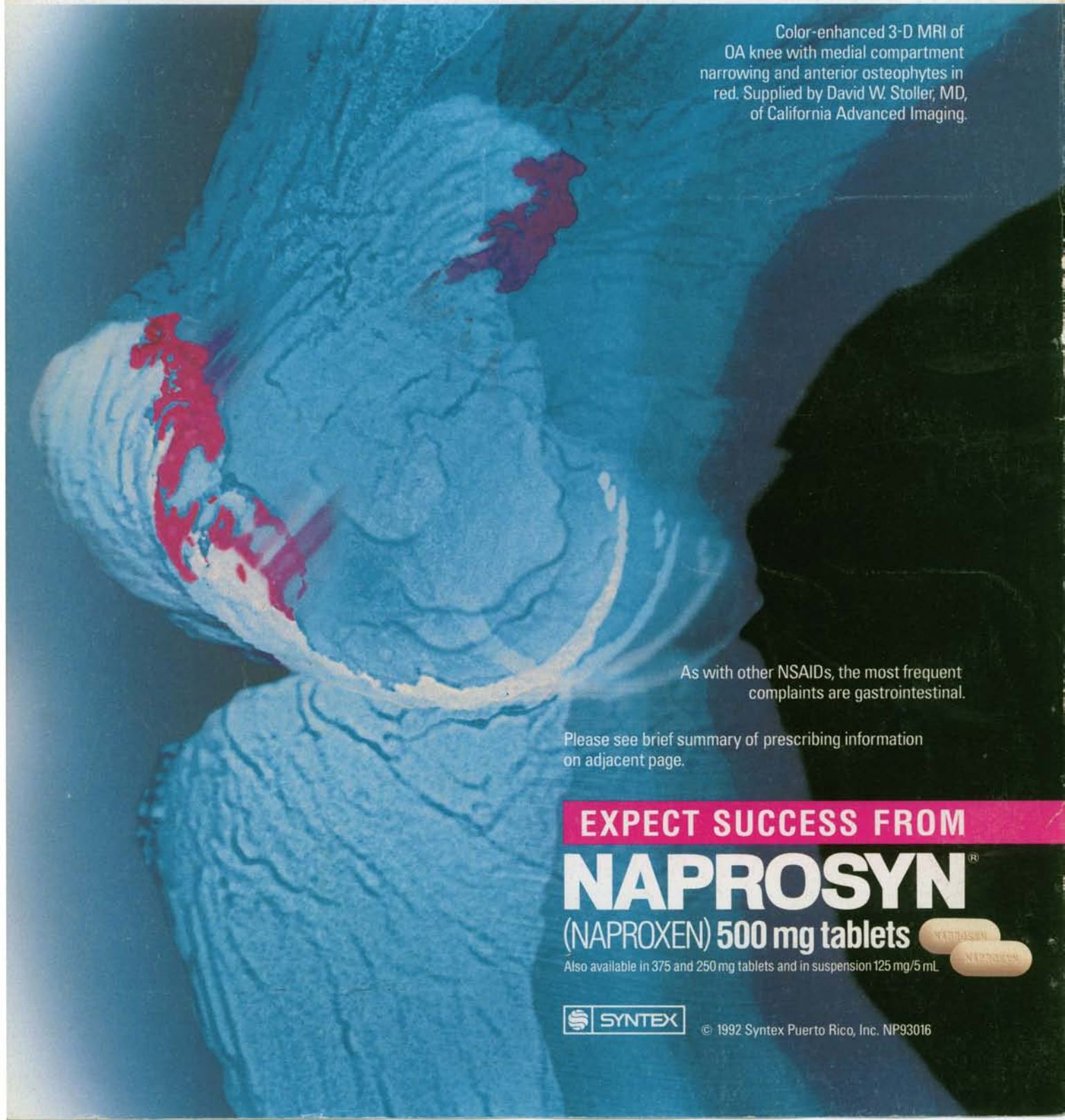

Color-enhanced 3-D MRI of OA knee with medial compartment narrowing and anterior osteophytes in red. Supplied by David W. Stoller, MD, of California Advanced Imaging.

As with other NSAIDs, the most frequent complaints are gastrointestinal.

Please see brief summary of prescribing information on adjacent page.

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SYNTEX