Deconamine® SR has no known contraindications with any antibiotic...

Surprisingly, this is not true of all antihistamine/decongestants.

Deconamine® SR
(chlorpheniramine maleate, 8 mg / d-pseudoephedrine HCl, 120 mg)
SUSTAINED-RELEASE capsules
Rx Only

Clears Nasal Congestion • Promotes Sinus Drainage

Deconamine® SR offers onset of action within 1 hour. Surprisingly, even some of the newer antihistamine/decongestants do not deliver this rapid onset of action. Balanced antihistamine/decongestant therapy for effective, long-acting relief of sinusitis symptoms.

- Mild CNS effect
- Low sedation
- Lowest reported cardiotoxicity profile

Chlorpheniramine has been rated as having a low drowsiness factor. However, all cold/flu/allergy medications may cause drowsiness in certain individuals. So, it is advisable to avoid driving a motor vehicle, operating machinery, or drinking alcoholic beverages while taking this or any similar product.

Your Prescription Makes A World Of Difference

KENWOOD LABORATORIES
a division of BRADLEY PHARMACEUTICALS, INC.
383 Route 46 West • Fairfield, NJ 07004-2402
(201) 882-1505 • FAX: (201) 575-5366
CONTRAINDICATIONS: Chlorpheniramine maleate should be used with extreme caution in patients with a history of angioneurotic edema and in those with a tendency to allergic reactions, including asthmatic episodes.

WARNINGS: Chlorpheniramine maleate may be used in patients with mild bronchial hyperreactivity and other conditions involving a tendency to excessive tear production, sinus congestion, and cold symptoms. It may also be used in patients with mild rhinitis and hay fever.

PRECAUTIONS: Information for patients: Antihistamines may impair mental and physical abilities required for the performance of potentially hazardous tasks, such as driving a vehicle or operating machinery. Patients should be warned about possible additive effects with alcohol and other central nervous system depressants (hypnotics, sedatives, tranquilizers).

Drug Interactions: Pseudoephedrine containing drugs should not be given to patients using monoamine oxidase (MAO) inhibitors because of the possibility of precipitating a hypertensive crisis. MAO inhibitors also prolong and intensify the anticholinergic effects of antihistamines. Symptomatic fever may result in the antihistaminic effects of methyldopa, reserpine, veratrum alkaloids, and mecamylamine.

Alcohol and other sedative drugs will potentiate the sedative effects of chlorpheniramine.

Adults should be informed that antihistamines may be used in conjunction with other symptomatic medications, and that adverse effects on the cardiovascular system may be harmful to the patient. Patients with a history of allergic reactions, including bronchial hyperreactivity, should be warned about possible additive effects with other central nervous system depressants (hypnotics, sedatives, tranquilizers).

Pediatric Use: Chlorpheniramine maleate should be used with caution. The safety of chlorpheniramine maleate in children under 12 years of age has not been established.

ADVERSE REACTIONS: Chlorpheniramine maleate: Slight to moderate dryness of the mouth may occur, and the most frequent side effect. Other possible side effects of antihistamines are generally included: General: Urticaria, rashes, phototoxicity; eye irritation, excessive peristalsis, chills, dryness of mouth, nose, and throat; Cardiovascular: Hypertension, headache, palpitation, chest pain, tachycardia, extrasystoles; Metabolic: Hemoconcentration, thrombocytopenia, agranulocytosis; CNS: Sedation, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitement, nervousness, tremor, irritability, insomnia, vertigo, dizziness, headache; Gastrointestinal: Diarrhea, anorexia, nausea, vomiting, abdominal pain, distension, constipation, colics, urinary frequency, frequent urination, urinary retention, early menses; Respiratory: thickening of bronchial secretions, tightness of chest, wheezing, nasal congestion, photosensitivity.

Pseudoephedrine hydrochloride: Pseudoephedrine may cause mild central nervous system stimulation, especially in those patients who are hypersensitive to sympathomimetic drugs. Nervousness, excitability, restlessness, dizziness, weakness, and insomnia may occur. Headache and dizziness have also been reported. Large doses may cause tachycardia, tachyarrhythmia, and palpitations. Pseudoephedrine hydrochloride has also been associated with certain untoward reactions including anxiety, tremor, weakness, fatigue, paresthesia, headache, vertigo, dizziness, insomnia, hallucinations, confusion. CNS depression, ataxia, and cardiovascular collapse with hypertension.

OVERDOSAGE: Acute overdose may produce clinical signs of CNS stimulation and variable cardiovascular effects. Pressure administered should be used with great caution in the presence of pseudoephedrine. Patients with symptoms of stimulation should be treated conservatively.

DOSEAGE AND ADMINISTRATION: SR Capsules: Adults and children over 12 years, 1 capsule every 12 hours. Children under 12 years, DECONAMINE® SR capsules are recommended. Tablets: Adults and children over 12 years, 1 tablet three or four times daily. Children under 12 years, DECONAMINE® SR capsules are recommended. Syrup: Children 2 to 6 years, 10 to 20 mg hydrochloride (5 to 10 mg), three or four times daily; children 12 to 24 months, 1 to 2 teaspoons (5 to 10 mg) every 6 hours; children 6 to 12 years, 2 to 4 teaspoons (10 to 20 mg) every 6 hours; children 12 to 16 years, 4 to 8 teaspoons (20 to 40 mg) every 6 hours; children over 16 years, 8 to 16 teaspoons (40 to 80 mg) every 6 hours. Children under 12 years, as directed by physician. Cautions: Federal law prohibits dispensing without prescription. ©1985 Bradley Pharmaceuticals, Inc.

References:

DECONAMINE® (brand of chlorpheniramine maleate and d-pseudoephedrine HCl) SR CAPSULES, TABLETS, SYRUP Consult package insert for full Prescribing Information.

DESCRIPTION: SR CAPSULES Each sustained-release yellow and blue capsule contains: chlorpheniramine maleate 4 mg d-pseudoephedrine hydrochloride 60 mg The capsules are designed to provide prolonged release of medication.

TABLETS Each scored, white tablet contains:

chlorpheniramine maleate 2 mg d-pseudoephedrine hydrochloride 30 mg in a grape-flavored, aromatic vehicle.

INDICATIONS: DECONAMINE® is indicated for the temporary relief of symptoms such as rhinorrhea, sneezing, and nasal congestion due to upper respiratory infections (the common cold), sinusitis or allergic rhinitis, also to help clear nasal passages and shrink swollen membranes, decongest sinus, open nasal passages, promote sinus drainage and relieve sinus pressure.

CONTRAINDICATIONS: Patients with severe hypertension, severe coronary artery disease and patients on MAO inhibitor therapy. DECONAMINE® medications are also contraindicated in patients sensitive to antihistamines or sympathomimetic agents.

WARNINGS: Chlorpheniramine maleate should be used with extreme caution in patients with a history of angioneurotic edema and in those with a tendency to allergic reactions, including asthmatic episodes.

PRECAUTIONS: Information for patients: Antihistamines may impair mental and physical abilities required for the performance of potentially hazardous tasks, such as driving a vehicle or operating machinery. Patients should be warned about possible additive effects with alcohol and other central nervous system depressants (hypnotics, sedatives, tranquilizers).

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Alcohol and other sedative drugs will potentiate the sedative effects of chlorpheniramine.

Care should be taken in administering DECONAMINE® medications concomitantly with other sympathomimetic medications, since their combined effects on the cardiovascular system may be harmful to the patient.

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

Children: Cautions: Children should be treated conservatively with extreme caution. The safety of chlorpheniramine maleate in children under 12 years of age has not been established.

ADVERSE REACTIONS: Chlorpheniramine maleate: Slight to moderate dryness of the mouth may occur, and the most frequent side effect. Other possible side effects of antihistamines are generally included: General: Urticaria, rashes, phototoxicity; eye irritation, excessive peristalsis, chills, dryness of mouth, nose, and throat; Cardiovascular: Hypertension, headache, palpitation, chest pain, tachycardia, extrasystoles; Metabolic: Hemoconcentration, thrombocytopenia, agranulocytosis; CNS: Sedation, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitement, nervousness, tremor, irritability, insomnia, vertigo, dizziness, headache; Gastrointestinal: Diarrhea, anorexia, nausea, vomiting, abdominal pain, distension, constipation, colics, urinary frequency, frequent urination, urinary retention, early menses; Respiratory: thickening of bronchial secretions, tightness of chest, wheezing, nasal congestion, photosensitivity.

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BRIEF SUMMARY

INDICATIONS AND USAGE

Ambien zolpidem tartrate is indicated for the short-term treatment of insomnia (defined as the need for sleep to help with daytime functioning) of acute onset and of short duration, in cases in which use and resumption of usual daily activities is desired. It is not indicated for use in children younger than 12 years of age.

CONTRAINDICATIONS

None known.

WARNINGS

Sleep-related disuse syndrome is the presenting manifestation of a physical or psychiatric disease associated with a sleep-related disorder. The presenting manifestation may disappear so that the clinician becomes unaware that the patient is suffering from the underlying disease. Some of these patients may be misdiagnosed as suffering from a sleep-related disorder, with resultant improper treatment. In some instances, the presenting manifestation is more lethal than the underlying disease, and the patient may die while under medical care. The clinician should be aware of these so-called sleep-related disuse syndromes and should consider the possibility that the presenting manifestation is more lethal than the underlying disease.

The duration of therapy should not exceed 1 month, except in carefully controlled clinical trials. If patients require more than 1 month of therapy, the patient and the physician should reassess the continued need for treatment and the desirability of other treatments in the management of the patient's disease.

Drug interactions: zolpidem was evaluated in healthy volunteers in single-dose interaction studies for several CNS drugs. A study involving haloperidol and zolpidem revealed no effect of haloperidol on the pharmacokinetics or pharmacodynamics of zolpidem. Imipramine in combination with zolpidem produced no pharmacodynamic interaction other than a 20% decrease in peak levels of imipramine, but there was a 40% decrease in the area under the plasma concentration-time curve. Similar pharmacologic interaction in combination with zolpidem produced no pharmacokinetic interaction, but there was an additivity of side effects. These patients should be closely monitored.

Drug interactions: zolpidem was studied in patients with alcoholic liver disease. In patients treated with zolpidem did not demonstrate drug accumulation or alterations in pharmacokinetics. No dose adjustment in newly impaired patients is required. However, these patients should be closely monitored. Pharmacy Drug Interactions: In subjects with hepatic impairment it did reveal prolonged elimination in this group. Therefore, treatment should be administered with caution in patients with hepatic compromise, and they should be closely monitored.

Injection of various hypnotic drugs into the spinal cord, resulting in deep coma, should be administered with caution to patients exhibiting signs or symptoms of CNS depression, such as those suffering from severe alcoholism, in patients with concurrent respiratory depression, and in patients and protective measures may be required. Intentional or accidental overdose of zolpidem to as much as 300 mg/day in humans has produced serious adverse effects, including respiratory depression, coma, and drug-induced deaths. Patients should be observed for 3 days after the last dose.

Incidence of Treatment-Emitted Adverse Experiences in Long-term Placebo-controlled Clinical Trials (Cont’d)

<table>
<thead>
<tr>
<th>Body System/Adverse Event</th>
<th>Zolpidem (N=152)</th>
<th>Placebo (N=151)</th>
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</thead>
<tbody>
<tr>
<td>Peripheral and Central Nervous System</td>
<td>10</td>
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<td>Headache</td>
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<td>Dizziness</td>
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<tr>
<td>Myalgia</td>
<td>1</td>
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</tbody>
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Events reported by at least 1% of patients are included.

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<tr>
<td>Autonomic Nervous System</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Dizziness</td>
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<td>2</td>
</tr>
<tr>
<td>Headache</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Incontinence</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Rash</td>
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Signs and symptoms: In European postmarketing reports of over dosage with zolpidem, signs and symptoms of respiratory depression ranged from somnolence to light coma, with one case each of cardiovascular and respiratory compromise. Individuals have fully recovered from zolpidem tartrate overdoses up to 400 mg (40 times the maximum recommended dose) without reported sequelae. Overdose with zolpidem should not be used in patients with CNS depression. In the event of overdosage, zolpidem has resulted in more severe symp toms in patients with respiratory depression. Recommended treatment: General symptomatic and supportive measures should be used. The administration of hemodialysis is not recommended. In patients where appropriate. Intravenous fluids should be administered as needed. For patients who are intubated, the use of a pressure transducer, and continuous cardiac monitoring is recommended. The monitoring of vital signs and other measures should be continued. Sedating drugs should be withdrawn following overdosage of zolpidem.

The possibility of multiple drug ingestion should be considered.

Carcinogenesis, mutagenesis, impairment of fertility

Carcinogenesis: There are no reports of carcinogenicity in rodents. Carcinogenicity studies performed in mice for 2 years at dosages of 5, 10, and 20 mg/kg/day in mice, these doses corresponding to 0.5, 1, and 2 times the maximum human dose on a mg/m2 or mg/kg basis, respectively. In rats these doses are 3 to 787 times 1 to 5 times the maximum human dose on a mg/kg or mg/m2 basis, respectively. No evidence of carcinogenicity in rats and mice. Results from in vitro studies in rat hepatocytes and the microsomal test in mice.

Mutagenesis: Zolpidem did not have mutagenic activity in several short-term tests. In a battery of in vitro and in vivo tests, the mutagenic activity was not detected. In a rat reproduction study, the high dose (100 mg/kg) of zolpidem was the no-observed-effect level of all maternal and fetal parameters, but the low dose (10 mg/kg) of zolpidem had no effect on the incidence of fetal malformations. In a similar study, the maximum recommended human dose of 10 mg in rats does not result in an observable increase in the incidence of malformations.

Impairment of fertility: In a rat reproduction study, the high dose (100 mg/kg) of zolpidem was the no-observed-effect level of all maternal and fetal parameters, but the low dose (10 mg/kg) of zolpidem had no effect on the incidence of fetal malformations. In a similar study, the maximum recommended human dose of 10 mg/kg in rats does not result in an observable increase in the incidence of malformations.

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From a unique chemical class of non-benzodiazepine sleep agents

More sleep
Total sleep time is significantly increased compared with placebo. Patients fall asleep quickly; generally within 20 to 30 minutes.\textsuperscript{1,3}

Better sleep
Awakenings were reduced, compared to placebo.

Through the night
No evidence of increased wakefulness during the last third of the night. Normal sleep stages are generally preserved\textsuperscript{1} (clinical significance unknown).

With no objective evidence of tolerance or rebound insomnia
In studies of up to 35 consecutive nights at recommended doses.\textsuperscript{1,2}

Favorable safety and tolerability profile
Adverse events with dosages of ≤ 10 mg that were statistically significant vs placebo

<table>
<thead>
<tr>
<th></th>
<th>Short-term: ≤10 nights</th>
<th>Long-term: 28 to 35 nights</th>
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<tbody>
<tr>
<td>drowsiness</td>
<td>2%</td>
<td>dizziness 5%</td>
</tr>
<tr>
<td>dizziness</td>
<td>1%</td>
<td>drugged</td>
</tr>
<tr>
<td>diarrhea</td>
<td>1%</td>
<td>feelings 3%</td>
</tr>
</tbody>
</table>

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Jeffrey S. Heier, MD; Matthew Uyemura, MD; Robert W. Enzenauer, MD, MPH; Raymond J. Enzenauer, MD; William J. Waterhouse, MD

A Solitary, Erythematous, Hyperkeratotic Papule
LCDR David J. Barnette, Jr, MC, USN, CDR Mark Cobb, MC, USN

All the Colors of the Mango
Ronda L. Wells, MD

Safe Discontinuation of Antihypertensive Therapy
Saeed Ahmad, MD, FRCP, FCCP

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AR<sub>CHIVES</sub> OF
FAMILY MEDICINE

VOL 4 NO. 9, SEPTEMBER 1995

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When seasonal allergies strike, it's not just the nose they ambush. The eyes are fair game, too. In fact, 8 out of 10 patients with allergic noses also suffer from itchy eyes due to seasonal allergic conjunctivitis. Stop the itch with ACULAR® Solution.

In a recent survey (n=272), the vast majority of responding patients confirmed that ACULAR® stopped their ocular itching quickly and effectively. Plus, ACULAR® has a favorable safety profile. There are no steroid-like side effects that can alter intraocular pressure, and no decongestant-like side effects, i.e., no risk to patients with narrow chamber angles.

So help rescue eyes from itching with ACULAR®, the #1 prescribed ophthalmic preparation for the #1 patient complaint of seasonal allergic conjunctivitis — ocular itch. Because annoying antigens prey on more than just the nose.

The most frequently reported adverse events have been transient stinging and burning on instillation (approximately 40%). Not for use while wearing soft contact lenses.

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Please see adjacent page for prescribing information.
ACULAR®
(ketorolac tromethamine) 0.5%
Sterile Ophthalmic Solution

INDICATIONS AND USAGE
ACULAR® ophthalmic solution is indicated for the relief of ocular itching due to seasonal allergic conjunctivitis.

CONTRAINDICATIONS
ACULAR® ophthalmic solution is contraindicated in patients while wearing soft contact lenses and in patients with previously demonstrated hypersensitivity to any of the ingredients in the formulation.

WARNINGs
There is the potential for cross-sensitivity to acetylsalicylic acid, phenylacetic acid derivatives, and other nonsteroidal anti-inflammatory agents. Therefore, caution should be used when treating individuals who have previously exhibited sensitivities to these drugs.

With some nonsteroidal anti-inflammatory drugs, there exists the potential for increased bleeding time due to interference with thrombocyte aggregation. There have been reports that ocularly applied nonsteroidal anti-inflammatory drugs may cause increased bleeding of ocular tissues (including hyphemas) in conjunction with ocular surgery.

PRECAUTIONS
General: It is recommended that ACULAR® ophthalmic solution be used with caution in patients with known bleeding tendencies or who are receiving other medications which may prolong bleeding time.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: An 18-month study in mice at oral doses of ketorolac tromethamine equal to the parenteral MRHD (Maximum Recommended Human Dose) and a 24-month study in rats at oral doses 2.5 times the parenteral MRHD, showed no evidence of tumorigenicity. Ketorolac tromethamine was not mutagenic in Ames test, unscheduled DNA synthesis and repair, and in forward mutation assays. Ketorolac did not cause chromosome breakage in the in vivo mouse micronucleus assay. At 1590 µg/ml (approximately 1000 times the average human plasma levels) and at higher concentrations ketorolac tromethamine increased the incidence of chromosomal aberrations in Chinese hamster ovarian cells. Impairment of fertility did not occur in male or female rats at oral doses of 9 mg/kg (53.1 mg/m²) and 16 mg/kg (94.4 mg/m²) respectively.

Pregnancy: Pregnancy Category C. Reproduction studies have been performed in rabbits, using daily oral doses at 3.6 mg/kg (42.35 mg/m²) and in rats at 10 mg/kg (59 mg/m²) during organogenesis. Results of these studies did not reveal evidence of teratogenicity to the fetus. Oral doses of ketorolac tromethamine at 1.5 mg/kg (8.8 mg/m²), which was half of the human oral exposure, administered after gestation day 17 caused dystocia and higher pup mortality in rats. There are no adequate and well-controlled studies in pregnant women. Ketorolac tromethamine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Caution should be exercised when ACULAR® is administered to a nursing woman.

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This year, over 46,000 women will die from breast cancer.

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October is National Breast Cancer Awareness Month (NBCAM). Don’t let her forget. Make sure she schedules a mammogram, because early detection can find what she may not be able to feel. So you can help save her life.

NBCAM supports the Clinton Administration’s Medicare Mammography Awareness Campaign which encourages Medicare-eligible women to take advantage of Medicare coverage for screening and diagnostic mammograms.

October 19 is National Mammography Day — A good day for a mammogram.

To locate a mammography facility in your area, call any of the following numbers:

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1-800-I’M AWARE

National Alliance of Breast Cancer Organizations (NABCO) 1-800-719-9154

Y-ME National Breast Cancer Organization
1-800-221-2141

A message from the Board of Sponsors of National Breast Cancer Awareness Month, made possible by an educational grant from the Zeneca HealthCare Foundation.
What will you do when sued for breach of contract?

What you should know before you sign a physician employment contract.

Most suits brought by medical entities for breach of contract allege violation of covenants not to compete, also known as restrictive covenants. Physicians entering their first employment following residency training too often anticipate a permanent career relationship and sign contracts containing restrictive covenants. These may result in a severe economic hardship for the physician if the physician is forced to relocate after a brief period of employment.

*How to Negotiate a Physician’s Employment Contract*, just published by the American Medical Association (AMA), provides an extensive review of cases involving judicial treatment of restrictive covenants and numerous other issues physicians and employers need to know before signing an employment contract. These include compensation, essential information about the Americans with Disabilities Act, impact of income taxes on various forms of compensation and an overview of the Stark II self-referral legislation.

A basic specimen form of a physician’s employment agreement, a checklist for preparing an employment contract and an array of optional and alternative clauses are also included.

Written for both employers and physicians, this new publication offers a road map for exploring every critical aspect of a contract and for paving the way to a satisfactory relationship between employer and employee. Published June, 1995. 43 pages.

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The Charter Issue in January told subscribers what they needed to know about health information systems and described how physician members of one community have decided to take a firm hand in shaping their own destinies through incorporation of a community physician organization. Issue Two discussed 11 potential danger areas in a capitation contract such as why you should request a list of included services by CPT code and why the contract should specify exact day of payment. Readers also learned the rules of appropriate business behavior such as why it is important to wear proper business attire to business meetings. Issue Three discussed the importance of low utilization patients to a practice operating in a capitated environment and strategies that may be helpful in capturing the loyalty of the low-use patient.

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As a family physician you are responsible for providing full-service, primary care to your female patients more than ever before. And with so many advances in clinical medicine, you're constantly seeking the information you need to provide quality care for your female patients — and establish a sound patient base.

Look to Archives of Family Medicine for the information you need.

Archives Journal Club/Women's Health will be a special part of Archives of Family Medicine for the second half of 1995. Designed to keep primary care physicians up-to-date with the important issues and advances in women's health, this section provides the information you need to make the right decisions for your female patients in this new practice environment.

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I personally found Dr. Grant's program to be very open-minded and supportive in a time when no one else was. I believe it is of value to all physicians to be evaluated objectively periodically. This is especially true if a physician is having problems. It is sometimes easier for an objective observer to think of solutions for problems when a person cannot do this himself or herself. I would urge anyone having problems to visit a program like Dr. Grant's before a problem becomes a medicolegal issue.

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As Drs. Crump and Pfeil have noted, more than 60% of specialty evaluations can be done over distance, and multiple studies have shown that 90% of patients are satisfied when seeing a specialist using interactive video technology. To date I know of no published studies reporting health outcome results over time or cost-effectiveness. Thus, we have a mature piece of communications technology looking for its place in our health care system. In my opinion, consultations over distance will be used selectively until the incentives for the patient, the primary care physician, the specialty physician, and the health plan are all aligned. Currently, this would occur only when both physicians are compensated by capitation payments and the health plan is responsible for patient transportation. Today these criteria are fulfilled only in some military situations and prison health care systems using managed care concepts. I anticipate that these incentives will be aligned in some of the larger integrated health plans that are currently evolving, and the plans will find telemedicine to be an effective tool.

Thomas C. Tinstman, MD
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The address for the American Medical Association’s web site is http://www.ama-assn.org Click on the Archives Journal Club/Women’s Health icon to scan the full text of the latest issue. You are also welcome to browse the site for other medical information from the AMA including the latest abstracts from the AMA scientific journals, Medical News Briefs from American Medical News, information about AMA membership, the Federation directory, and more.

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phenomenon, and there could have been more of an emphasis, whether via the type size and color or via bold typeface, on the acute therapies for arrhythmias. The chapter on tracheostomy (percutaneous and surgical) was an excellent one, written by Franklin and Friedman from Cook County Hospital, Chicago, Ill. The chapter on severity of illness scoring systems was rather short, only 15 pages, but I like the way it delineated the scoring systems into disease-specific and general severity scoring systems. Unfortunately, there are sections on APACHE (Acute Physiology and Chronic Health Evaluation) I and II, but APACHE III is only mentioned. There is a similar problem with the discussion of the simplified acute physiology score (SAPS), in that SAPS is mentioned but not SAPS II. This is in contradistinction to the 33-page chapter in The High Risk Patient: Management of the Critically Ill, by Ed Sivak, MD (Baltimore, Md, Williams & Wilkins, 1995), also just published, in which SAPS II is covered in its own separate section. Sivak's book is slightly longer at 1753 pages, and the text is set in smaller print. The chapters are similar, but there is a larger section on managerial and quality assurance issues. There are no separate sections on procedures; however, there is a chapter on procedure standards, indications, and quality.

Comparing this book with the second edition of Intensive Care Medicine by James M. Rippe, MD (Boston, Mass, Little Brown & Co, 1991), which is its nearest competition, there are 214 pages of procedures in Rippe's book (section I) and 287 in that of Parillo and Bone. The outlines of both books are almost exactly the same, except that there is a section on overdoses and poisonings and surgical problems in the intensive care unit, as well as a section on transplantation, in Rippe's book. Rippe's text is slightly harder to read because of the smaller print, but at 2071 pages there is more to it.

For the family physician, there is no mention of family physicians and their interaction with the intensivist or the stabilization of critically ill patients and their transfer out of the smaller hospitals that are incapable of caring for the critically ill patient. Very little biopsychosocial model information is provided.

Is this a good text for family physicians? It is hard to say. It depends on whether they are aggressive family physicians working in a situation in which they provide critical care or critical care stabilization. Fully 10% of Health Care Financing Administration's current procedural terminology intensive care unit code 99291 (intensive care unit care) is provided by family physicians and general practitioners—for those physicians, this would be a nice resource, except for the deficiencies listed above.

Len Scarpinato, DO, FCCP
Medical College of Wisconsin
Milwaukee
3. CARDIZEM.

CONTRAINdications
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, (3) patients with hypertension (less than 90 mm Hg systolic), and (4) patients who have demonstrated hypersensitivity to the drug, and (5) patients with acute myocardial infarction and pulmonary congestion documented by x-ray on admission.

WARNINGS
1. Cardiac Conduction. CARDIZEM prolongs AV node refractory period and decreases the atrial fibrillation recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormal slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (13% of 3596 patients or 4.4%).

2. Renal Function. Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index or consistent negative effects on contractility at physiological plasma concentrations. An acute study of oral diltiazem in patients with impaired ventricular function (ejection fraction 24% ± 6%) showed improvement in indices of ventricular function without significant decreases in contractile function (dp/dt). Worthington of congestive heart failure has been reported in patients with preexisting impairment of ventricular function. Experience with the use of CARDIZEM (diltiazem hydrochloride) in combination with beta-blockers in patients with impaired ventricular function is limited. Caution should be exercised when using this combination.

3. Hypotension. Blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic bradycardia.

4. Acute Hepatic Injury. Mild elevations of transaminases with and without concomitant elevation in alkaline phosphatase and bilirubin have been observed in clinical studies. Such elevations were usually transient and frequently resolved even with continued diltiazem treatment. In rare instances, significant elevations in enzymes such as alkaline phosphatase, LDH, SGOT, and other enzymes consistent with acute hepatic injury have been noted. These reactions tended to occur early after therapy initiation (1 to 8 weeks) and have been reversible upon discontinuation of diltiazem therapy. The relationship to CARDIZEM is uncertain in some of these cases. (See PRECAUTIONS.)

PRECAUTIONS

General
CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys in bile and in bile. As with any drug given over prolonged periods, laboratory parameters of renal and hepatic function should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In Sweden, chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; these changes were reversible with continued dosing.

Dermatological Reactions (see ADVERSE REACTIONS section) may be more frequent and may disappear despite continued use of CARDIZEM. However, skin eruptions progressing to erythema multiforme and urticaria have been reported. Erythema multiforme and urticaria have been reported in patients receiving diltiazem. Diltiazem has been associated with neutropenia, agranulocytosis, aplastic anemia, and aplastic crisis.

Drug Interactions
Due to the potential for additive effects, caution and careful titration are warranted in patients receiving CARDIZEM concomitantly with other agents known to affect cardiac conductility and/or conduction. (See WARNINGS.) Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.) As with all drugs, care should be exercised when treating patients with multiple medications. CARDIZEM undergoes biotransformation by cytochrome P-450 mixed function oxidase. Co-administration of CARDIZEM with other agents which follow the same route of biotransformation may result in the competitive inhibition of metabolism. Especially in patients with renal and/or hepatic impairment, dosages of similarly metabolized drugs, particularly those of low therapeutic ratio, may require adjustment when starting or stopping concomitantly administered diltiazem to maintain optimal therapeutic blood levels.

Beta-blockers. Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers is well tolerated. However, studies are insufficient to predict the effects of concomitant treatment in patients with left ventricular dysfunction, particularly patients with congestive heart failure. Administration of CARDIZEM (diltiazem hydrochloride) concomitantly with propranolol in five normal volunteers resulted in increased propranolol clearance, but the bioavailability of propaanolol was increased approximately 50%. In vitro, propranolol appears to block the action of diltiazem by diltiazem. If combination therapy is initiated or withdrawn in conjunction with propranolol, an adjustment in the propranolol dose may be warranted. (See WARNINGS.)

Cimetidine. A study in six healthy volunteers has shown a significant increase in peak diltiazem plasma levels (39%) and area-under-the-curve (53%) after a 1-week course of cimetidine. Despite these increases, the clinical significance of this interaction is uncertain because there was no apparent increase in adverse reactions in patients receiving diltiazem therapy for 1 week who also received cimetidine therapy. (See WARNINGS.)

Antihypertensive Drugs. When diltiazem was administered to hypertensive patients with concomitant therapy with other antihypertensive agents, the antihypertensive effects of both agents were enhanced. The clinical significance of this interaction is uncertain because there were no apparent increases in adverse reactions in patients receiving diltiazem concomitantly with other antihypertensive agents. (See WARNINGS.)

Digitalis. Administration of CARDIZEM with digoxin in 24 healthy male subjects increased plasma digoxin concentrations approximately 20%. Another investigator found no increase in digoxin levels in patients with coronary artery disease. Since there have been conflicting results regarding the effect of diltiazem on the pharmacokinetics of digoxin, patients should be monitored when starting or stopping concomitantly administered diltiazem to maintain optimal therapeutic blood levels. (See WARNINGS.)

Edema. Initiation of therapy with diltiazem has been associated with the development of edema, particularly in patients with left ventricular dysfunction. Although this is frequently reversible, the drug should be discontinued if edema becomes severe.

Myocardial Infarction. Extensive clinical experience has shown that the use of diltiazem after myocardial infarction is associated with a significant incidence of transient hypotension and/or bradycardia. In most instances, these effects are self-limited but may be severe enough to require discontinuation of the drug. If hypotension or bradycardia, especially in patients with hemodynamic instability, occurs during therapy with diltiazem, the drug should be discontinued.

SAFETY AND EFFICACY
Safety and efficacy of diltiazem have not been established in the pediatric population. (See PRECAUTIONS.)

ADVERSE REACTIONS
Serious adverse reactions have been rare in studies conducted to date. In a 12-week, placebo-controlled, double-blind study in patients with left ventricular dysfunction, there were 15% of patients (7 patients) who had at least one adverse experience. The adverse experiences reported were nausea, vomiting, edema, gastrointestinal upset (including anorexia, constipation, and diarrhea), headache, chest pain, dizziness, edema, rash, conjunctivitis, conjunctival hyperemia, pruritus, purpura, urticaria, angioedema, cough, rhinitis, emotional lability, headache, and oral candidiasis. These adverse effects were not accompanied by changes in routine laboratory parameters, including hematologic and coagulation parameters. In the controlled trials of CARDIZEM in patients with left ventricular dysfunction, the following adverse experiences have been reported: anemia, constipation, diarrhea, dyspepsia, flatulence, flushing, and pruritus.

In the controlled trials of CARDIZEM in patients with left ventricular dysfunction, the following adverse experiences have been reported: anemia, constipation, diarrhea, dyspepsia, flatulence, flushing, and pruritus.

In a separate study of 15 patients with myocardial infarction, diltiazem therapy was associated with a significant incidence of edema, particularly in patients with left ventricular dysfunction. Although this is frequently reversible, the drug should be discontinued if edema becomes severe. If hypotension or bradycardia, especially in patients with hemodynamic instability, occurs during therapy with diltiazem, the drug should be discontinued.

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A unique hemodynamic and safety profile for hypertension or angina²,³

- A side-effect discontinuation rate comparable to placebo in both hypertension and angina trials²
- Most commonly reported side effects are headache (5.4%), bradycardia (3.3%), first-degree AV block (3.3%), dizziness (3.0%), edema (2.6%), ECG abnormality (1.6%), and asthenia (1.8%)²

Please see brief summary of prescribing information on adjacent page.

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