INFORMATION FOR AUTHORS

These guidelines are in accordance with the “Uniform Requirements for Manuscripts Submitted to Biomedical Journals.” (The complete document is available in the June 12, 1982, issue of the British Medical Journal and the June 1982 issue of the Annals of Internal Medicine.)

MANUSCRIPTS

Manuscripts containing original material are accepted for consideration with the understanding that neither the article nor any part of its essential substance, tables, or figures has been or will be published or submitted for publication elsewhere before appearing in the Journal. This restriction does not apply to abstracts or press reports published in connection with scientific meetings. Copies of any possibly duplicative manuscripts should be submitted to the Editor along with the manuscript that is to be considered by the Journal. The Journal strongly discourages the submission of more than one article dealing with related aspects of the same study. In almost all cases, a single study is best reported in a single paper.

Submit an original and one copy of the complete manuscript, including text pages, legends, tables, references, and glossy prints of figures. Only typed copies, on standard-sized typewriter paper and double-spaced throughout, with margins of at least 2.5 cm, are acceptable. Address all submissions to John P. Geyman, M.D., Editor, the Journal of the American Board of Family Practice, Dept. of Family Medicine (RF-30), School of Medicine, University of Washington, Seattle, WA 98195. A covering letter should identify the person (with the address and telephone number) responsible for negotiations concerning the manuscript; the letter should make it clear that the final manuscript has been seen and approved by all authors.

CONFICT OF INTEREST

The Journal expects authors to disclose any commercial associations that might pose a conflict of interest in connection with the submitted article. All funding sources supporting the work should be routinely acknowledged on the title page, as should all institutional or corporate affiliations of the authors. Other kinds of associations, such as consultancies, stock ownership or other equity interests, or patent-licensing arrangements should be disclosed to the Editor in a covering letter at the time of submission. Such information will be held in confidence while the paper is under review and will not influence the editorial decision. If the manuscript is accepted, the Editor will discuss with the authors how best to disclose the relevant information. Questions about this policy should be directed to the Editor.

UNITS OF MEASUREMENT

The Journal will print measurements in Systemic International (SI) and conventional units (this practice applies only to clinical investigation and review articles). Authors may use either as their principal system; however, they must also provide the alternative numbers and units in parentheses.

TITLES AND AUTHORS’ NAMES

With the manuscript, provide a page giving the title of the paper; a running head of fewer than 40 letter spaces; the name(s) of the author(s), including the first name(s) and academic degree(s); the name of the department and institution in which the work was done; and the name and address of the author to whom reprint requests should be addressed. Any grant support that requires acknowledgment should be mentioned on this page.

ABSTRACTS

Use one page to provide an abstract of not more than 175 words. This abstract should be factual, not descriptive, and should present the reason for the study, the main findings (give specific data if possible), and the principal conclusions.

KEY WORDS

The Journal has a policy of requiring authors to submit two to four key words with their manuscripts, to be used for purposes of classification by subject.

REFERENCES

References must be typed in double spacing and numbered consecutively as they are cited. References first cited in tables or figure legends must be numbered so that they will be in sequence with references cited in the text. The style of references is that of the Index Medicus. List all authors when there are six or fewer; when there are seven or more, list the first three, then “et al.” Sample references are as follows:


Numbered references to personal communications, unpublished data, and manuscripts either “in preparation” or “submitted for publication” are unacceptable (see “Permissions”). If essential, such material may be incorporated in the appropriate place in the text.

TABLES

Type tables in double spacing on separate sheets, and provide a legend for each. Excessive tabular data are discouraged. If an article is accepted, the Journal will arrange to deposit extensive tables of important data with the National Auxiliary Publications Service (NAPS); we will pay for the deposit and add an appropriate footnote to the text. This service makes microfiche or photocopies of tables available at moderate charges to those who request them.

ILLUSTRATIONS

Figures should be professionally designed. Glossy, black-and-white photographs are requested. Symbols, lettering, and numbering should be clear, and these elements should be large enough to remain legible after the figure has been reduced to fit the width of a single column.

The lack of each figure should include the sequence number, the name of the author, and the proper orientation (e.g., “top”). Do not mount the figure on cardboard. Photomicrographs should be cropped to a width of 8 cm, and electron photomicrographs should have internal scale markers.

If photographs of patients are used, either the subjects should not be identifiable or their pictures must be accompanied by written permission to use the figure. Permission forms are available from the Editor.

Legends for illustrations should be typewritten (double-spaced) on a separate sheet, and should not appear on the illustrations. Color illustrations are used from time to time. Send both transparencies and prints for this purpose.

ABBREVIATIONS

Except for units of measurement, abbreviations are discouraged. Consult the Council of Biology Editors Style Manual (Fifth edition. Bethesda, Md.: Council of Biology Editors, 1983) for lists of standard abbreviations. The first time an abbreviation appears it should be preceded by the words for which it stands.

DRUG NAMES

Generic names should, in general, be used. If an author so desires, brand names may be inserted in parentheses.

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Materials taken from other sources must be accompanied by a written statement from both author and publisher giving permission to the Journal for reproduction.

Obtain permission in writing from at least one author of papers still in press, of unpublished data, and of personal communications.

INCLUSIVE LANGUAGE

Sex bias should be avoided and gender-inclusive language used whenever possible.

REVIEW AND ACTION

Manuscripts are examined by the editorial staff and are usually sent to outside reviewers. Authors will retain anonymity in outside reviews and vice versa. External statistical review will be accomplished where appropriate.

JABFP October-December 1990 Vol. 3 No. 4
IN HYPERTENSION

When patients are difficult to manage...
It's time for TENORETIC.

Some hypertensive patients find it difficult to make dietary and life-style changes you recommend. Others simply don't respond to monotherapy. So continue to encourage a healthier life-style, and prescribe a simple, effective antihypertensive regimen for these patients. Initiate one-tablet-a-day TENORETIC therapy, the simplest regimen available. It works round the clock to lower blood pressure without added tablets or side effects that can so easily discourage compliance.

TENORETIC is not indicated for the initial therapy of hypertension. See adjacent page for brief summary of prescribing information.
What's a common denominator of most heart attack victims?

*Mixed* hyperlipidemias—elevated cholesterol and triglycerides—are common among heart attack victims,¹ and nearly two-thirds of people who developed myocardial infarction in the PROCAM Trial had a low (<35 mg/dL) baseline level of HDL cholesterol.²

---

**HEART ATTACK PATIENTS (PROCAM TRIAL)²**

- HDL over 35 mg/dL: 36%
- HDL under 35 mg/dL: 64%
A powerful case for **LOPID®**

**BID**

(gemfibrozil) 600-mg Tablets

Raised low HDL 25%  
in patients whose baseline HDL was below 35 mg/dL in the landmark Helsinki Heart Study (HHS).³

Reduced heart attack incidence* up to 62%  
in these HHS patients and 45% in HHS patients whose baseline HDL was below the median (46.4 mg/dL). Incidence of serious coronary events was similar for LOPID and placebo subgroups with baseline HDL above the median (46.4 mg/dL).³

Raised HDL levels 1½ to 3 times more effectively than lovastatin  
in a 12-week, double-blind, randomized trial among patients with moderate to severe hyperlipidemia. Lovastatin achieved greater reductions in total serum cholesterol than gemfibrozil in this study population.⁴

RAISES HDL  
DRAMATICALLY REDUCES HEART ATTACK

LOPID is indicated for reducing the risk of coronary heart disease (CHD) in Type IIb patients with low HDL, in addition to elevated LDL and triglycerides, and who have had an inadequate response to weight loss, diet, exercise, and other pharmacologic agents such as bile acid sequestrants and nicotinic acid.

*Defined as a combination of definite coronary death and/or definite myocardial infarction.


Please see last page of this advertisement for warnings, contraindications, and brief summary of prescribing information. © 1989 Warner-Lambert Company
**Lopid** (Gemfibrozil Capsules and Tablets)

**Before prescribing, please see full prescribing information.**

A Brief Summary follows.

**CONTRAINDICATIONS.** 1. Hepatic or severe renal dysfunction, including primary biliary cirrhosis.

2. Preexisting gallbladder disease (See WARNINGS).

3. Hypersensitivity to gemfibrozil.

**WARNINGS.** 1. Because of chemical, pharmacological, and clinical similarities between gemfibrozil and other drugs of the fibrates group, the adverse findings with clofibrate in two controlled clinical studies may also apply to gemfibrozil. In the first of these studies, the Coronary Drug Project, 1000 subjects with previous myocardial infarction were treated for five years with 300 mg of gemfibrozil daily (2000 mg of clofibrate daily) or placebo. At the end of the study, the mortality rate was reduced by 14% in the gemfibrozil-treated subjects and 35% in the clofibrate-treated subjects. Several of the reductions were statistically significant, but this increase was not statistically significant (p=0.1).

Lopid is comprised of approximately 20% of the human dose for 10 weeks resulted in a dose-related decrease of fertility. Subsequent studies demonstrated that this effect was reversed after a drug-free period of about eight weeks, and it was not transmitted to offspring.

2. Pregnancy Category B—Reproduction studies have been performed in the rat at doses 3 and 9 times the human dose, and in the rabbit at 2 and 6.7 times the human dose. Because of the possibility of tumor induction, study results should be interpreted with caution. Gemfibrozil and the rabbit at 2 and 6.7 times the human dose for up to 5 years. There have been no reported cases of drug-related birth defects in children in whom Lopid use during pregnancy has been established. Adverse Reactions in Children: Safety and Efficacy of Gemfibrozil in Pediatric Patients. Additional adverse reactions that have been reported for gemfibrozil are listed below by system. These categories are according to whether a causal relationship to treatment with Lopid is probable or not established.

**CAUSAL RELATIONSHIP PROBABLE: Gastrointestinal: cholestatic jaundice, Central Nervous System: dizziness, somnolence, paresthesia, peripheral neuritis, decreased sexual desire, depression, headache; Eye: Blurred vision; Genitourinary: Musclekeletal: myopathy, myasthenia, myelgia, myalgia, pain, fatigue, weakness, nausea, vomiting, constipation, diaphoresis, flushing, edema, acute renal failure. In most subjects who had an unsatisfactory lip response to either drug alone, the possible benefit of combined therapy with Lovastatin and gemfibrozil does not outweigh the risks of severe myopathy, rhabdomyolysis, and acute renal failure (See Drug Interactions). The use of fiber supplements,NSAIDS, or glucocorticoids, including Lopid, may occasionally be associated with myositis. Patients receiving Lopid and clofibrate together may experience nausea, abdominal pain, nausea, vomiting, constipation, headache, dizziness, dermatitis, rash, dermatitis, pruritus.

**CAUSAL RELATIONSHIP NOT ESTABLISHED: General: weight loss; Cardiac: extrasystoles, syncope, 10 weeks; weight loss; urine, lipid; dermatitis, rash, dermatitis, pruritus.**

**DOSE AND ADMINISTRATION.** The recommended dose for adults is 1200 mg administered in two divided doses 30 minutes before the morning and evening meal. Male and female rats, there was a significant increase in the combined incidence of benign, and malignant liver neoplasms. In male and female mice, there were no statistically significant differences from the controls in incidence of liver tumors, but the doses tested were lower than those shown to be carcinogenic with other fibers. Male rats had a dose-related and statistically significant increase of benign Leydig cell tumors at 1 and 10 times the human dose. Electron microscopy studies have demonstrated a florid hepatic peroxisome proliferation following Lopid administration to the male rat. An adequate study to test for peroxisome proliferation has not been done in humans but changes in peroxisome morphology have been observed. Peroxisome proliferation occurs in humans with either of two other drugs of the fibrate class when liver biopsies were compared before and after treatment in the same individual.

**Safety and Efficacy of Gemfibrozil in Pediatric Patients.** Additional adverse reactions that have been reported for gemfibrozil are listed below by system. These categories are according to whether a causal relationship to treatment with Lopid is probable or not established.

**REFERENCES:**


**Caution—Federal law prohibits dispensing without prescription.**

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CHAIR, DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE

The Search Committee for the position of Chair of the Department of Family and Community Medicine, College of Medicine, invites applications and nominations for this position. The Chair will report to the Senior Vice President for Health Affairs and Dean and will be responsible for all administrative, academic and clinical activities of the department. The Department is in an expansion mode in response to Pennsylvania State University's commitment to family practice. In addition to the pre-doctoral program at The College of Medicine, the Department has a University Hospital/Community Hospital residency program and is expanding its teaching base into the community.

The following criteria will be used to aid in selecting a Chair of the Department of Family and Community Medicine. The candidate must demonstrate:

- Clinical excellence and accomplishment in the field of Family and Community Medicine.
- Administrative and leadership capabilities.
- Commitment to teaching and academic excellence.

The closing date for applications is November 15, 1990.

Nominations and letters of application should be sent to:

G. Victor Rohrer, M.D. and Thomas Leaman, M.D.
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THAT'S STILL GOING STRONG WHEN THE “BIG CATS”<sup>*</sup> SURGE

![Graph showing half-life range for different beta-blockers]

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- **Kerlone<sup>®</sup>** (betaxalol HCl)<sup>1</sup>
- **Tenormin<sup>®</sup>** (atenolol)<sup>3</sup>
- **Lopressor<sup>®</sup>** (metoprolol)<sup>1</sup>

### Noncardioselective
- **Cogard<sup>®</sup>** (nadolol)<sup>1</sup>
- **Inderal<sup>®</sup> LA** (propranolol HCl)<sup>3</sup>

<table>
<thead>
<tr>
<th>Bioavailability&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Interpatient variations in plasma levels (n-fold)&lt;sup&gt;3&lt;/sup&gt;</th>
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<tr>
<td>89%</td>
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<tr>
<td>50%</td>
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<td>50%</td>
<td>10</td>
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<td>30%</td>
<td>7</td>
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<tr>
<td>9%-18%</td>
<td>NA</td>
</tr>
</tbody>
</table>

NA = not available in references cited.
† Numbers shown are not directly comparable since these data have been compiled from different study populations.
‡ Adapted from product information in Physicians’ Desk Reference<sup>®</sup>, ed 44. Oradell, NJ, Medical Economics Co Inc, 1990.

<sup>*</sup> Refers to catecholamines, norepinephrine and epinephrine, serum concentrations of which may increase two- to threefold in the morning compared with trough levels (Reference: Tofler GH, Brezinski D, Schafer AI, et al: Concurrent morning increase in platelet aggregability and the risk of myocardial infarction and sudden death. *N Engl J Med* 1987;316:1514-1518.)


Please see last page of this advertisement for references and a brief summary of prescribing information. Kerlone is contraindicated in patients with known hypersensitivity to betaxalol hydrochloride. As are other beta-blockers, Kerlone is contraindicated in patients with sinus bradycardia, heart block greater than first degree, cardiogenic shock, and overt cardiac failure. Tenormin<sup>®</sup> is a registered trademark of ICI Pharma. Lopressor<sup>®</sup> is a registered trademark of Gelzy Pharmaceuticals. Cogard<sup>®</sup> is a registered trademark of Princeton Pharmaceutical Company. Inderal<sup>®</sup> is a registered trademark of Wyeth-Ayerst Laboratories.

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**Kerlone**<sup>®</sup> (betaxalol HCl)
If desired response is not achieved, dose may be doubled after 7 to 14 days.

- Available in 10-mg (scored) and 20-mg tablets
- Not significantly less than that of a radioselective beta-blocker

References:
1. Kerlone complete prescribing information

Searle Medical Economics
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FAMILY MEDICINE IN THE 21ST CENTURY
MAY 9 TO 14, 1992
VANCOUVER BRITISH COLUMBIA CANADA

Hosted by THE COLLEGE OF FAMILY PHYSICIANS OF CANADA AND THE BRITISH COLUMBIA CHAPTER

Keynote speakers will focus on the 1992 status of world health, the consequences in ten years if current trends continue, strategies that could change our behaviour in appropriate ways, and how we might contribute to the political will needed to meet the anticipated challenges.

Complementing the daily sessions will be a large commercial and scientific exhibit area open daily for delegates.

Family physicians, academies, colleges, university departments and research units are invited to submit specific proposals for presentations. Free-standing papers, poster sessions, symposia and workshops are all channels through which you or your organization can participate.

Blocks of bedrooms have been reserved for conference delegates in a wide variety of downtown hotels.

CLIMATE
May is early summer with temperatures ranging from 15 degrees C to 20 degrees C (60 degrees F to 70 degrees F). Evening temperatures are rarely below 10 degrees C (50 degrees F).

LANGUAGE
The official languages of the World Conference are English and French.

THE VANCOUVER TRADE AND CONVENTION CENTRE
A spectacular venue for the conference. The Centre is located in the heart of the city, on the ocean, overlooking the coastal mountains. The state-of-the-art facility has spacious well-equipped meeting rooms and is convenient to hotels, shops and restaurants.

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The most prescribed calcium channel blocker for hypertension \(^1\) gets even better

**INTRODUCING**

New **VERELAN**

**ONCE-A-DAY**

**PELLET-FILLED CAPSULES**

Verapamil HCl 120 mg 240 mg

Please see brief summary of Prescribing Information on last page.
**New ONCE-A-DAY VERELAN® PELLET-FILLED CAPSULES**

Verapamil HCl 120 mg 240 mg

Verapamil without the food variable

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<table>
<thead>
<tr>
<th></th>
<th>Full Stomach</th>
<th>Empty Stomach</th>
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<tbody>
<tr>
<td>VERELAN 240 mg</td>
<td>77</td>
<td>77</td>
</tr>
<tr>
<td>Traditional SR verapamil* 240 mg</td>
<td>79</td>
<td>164</td>
</tr>
</tbody>
</table>

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> Traditional SR verapamil* should not be taken on an empty stomach. Failure to take traditional SR verapamil with food may result in a two-fold variation in peak blood levels.

With VERELAN, absorption is consistent— with and without food.

*Calan® SR (GD Searle & Co), Isoptin® SR (Knoll Pharmaceuticals).
ENGINEERED WITH A NEW PATENTED* DELIVERY TECHNOLOGY FOR HYPERTENSION

Eliminates the food requirement of traditional SR verapamil therapy—more assurance of proper dosing

- With VERELAN, food intake is not required for consistent absorption. Traditional SR verapamil must be taken with food to achieve the desired absorption profile.

Engineered to provide reliable 24-hour blood pressure control

- Maintains control throughout the early morning hours, the period usually associated with greatest cardiovascular risk

![Graph showing change in diastolic blood pressure](image)

Results of 24-hour ambulatory BP monitoring. VERELAN dosed 240 mg/day (n = 15); placebo (n = 10).

- Maintains 24-hour effectiveness in reducing elevated blood pressure—with one daily dose.

Enhances convenience

- Patients may not be able to take traditional SR verapamil on a full stomach as recommended
- VERELAN can be taken with or without food—thus eliminating the variation in peak levels observed with traditional SR verapamil therapy if taken on an empty stomach.
- VERELAN can be taken once a day at all doses, even for patients requiring doses over 240 mg per day
- Constipation, which can be easily managed in most patients, is the most frequently reported side effect of verapamil

*US Patent Number: 4,863,742
*Calan® SR (GD Searle & Co), Isoptin® SR (Knoll Pharmaceuticals).

Please see brief summary of Prescribing Information on next page.
New

ONCE-A-DAY

VERELAN®

PELLET-FILLED CAPSULES

Verapamil HCl 120 mg 240 mg

Verapamil without the food variable

- New absorption profile
- Advanced convenience
- Advanced dosing simplicity

The usual dose is 240 mg once daily. If adequate response is not obtained, the dose may be titrated up to 360 mg or 480 mg once daily. VERELAN 120 mg is available for patients requiring lower dose verapamil therapy.

References:
1. Pharmaceutical Data Services, Alpha Data Services, December, 1989.
3. Data on file, Lederle Laboratories, Pearl River, NY.

Brief Summary
VERELAN® Verapamil HCl
Sustained-Release Pellet-Filled Capsules

For complete Prescribing Information, consult package insert

CLINICAL PHARMACOLOGY:
Food does not affect the extent or rate of the controlled absorption of verapamil from the VERELAN capsule.

Atrioventricular block can occur in patients without pre-existing condition defects (see WARNINGS). Acceleration of ventricular rate and/or ventricular fibrillation has been reported in patients with atrial flutter or atrial fibrillation and persisting conduction AV pathway-blocking administration of verapamil (see WARNINGS).

In patients with hepatic insufficiency, metabolism is delayed and elimination half-life prolonged up to 14 to 16 hours (see PRECAUTIONS), the volume of distribution is increased, and plasma clearance reduced to about 30% of normal.

CONTRAINDICATIONS: Severe LV dysfunction (see WARNINGS), hypotension (systolic pressure <90 mmHg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), second- or third-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes) (see WARNINGS), hypersensitivity to verapamil.

WARNINGS: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction <30%) or moderate-to-severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. Concomitant use of digitalis and/or diuretics before VERELAN is used. Verapamil may occasionally produce hyperkalemia. Elevations of liver enzymes have been reported.

Several cases of hepatocellular injury have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed on an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving IV verapamil (or digitalis). Because of this risk, verapamil is contraindicated in such patients. All block may occur (second- and third-degree, 0.9%). Development of marked first-degree block or progression to second- or third-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, second-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypotensive cardiomyopathy who were treated with verapamil.

PRECAUTIONS: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdose. Verapamil may decrease neuromuscular transmission in patients with Duchenne muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility. There have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol clearance may occur with combined use. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitals toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Diurepsyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility. AI conduction, and repolarization. Combined verapamil and quindine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Verapamil has been given concomitantly with short- and long-acting nitrates without any undesirable drug interactions. Interaction between metoprolol and chronically administered verapamil has not been studied. In healthy volunteers, clearance of verapamil was reduced or unchanged. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully.

Verapamil may increase circulating angiotensin concentrations during combined use. Atropine may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of digoxin. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required.

Several patients with porophorysy and/or atrioventricular block, Including severe AV block, have been reported. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk. Therefore, nursing should be discontinued during verapamil use. Safety and efficacy of verapamil in children below the age of 18 years have not been established.

ADVERSE REACTIONS: In clinical trials with 285 hypertensive patients on VERELAN verapamil HCI sustained-release pellet-filled capsules for more than 1 week, the following adverse reactions were reported: constipation (7%), headache (5.3%), dizziness (4.2%), tinnitus (2.5%), diplopia (2.5%), rash (14%), ankle edema (14%), sleep disturbance (14%), myalgia (1%). In clinical trials of other formulations of verapamil HCI (N = 4,934), the following reactions have occurred at rates greater than or equal to 10%: constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypertension (2.5%), edema (19%), headache (2.7%), rash (12%), CHF/pulmonary edema (18%), fatigue (17%), bradycardia (14%), cough (5%), dyspepsia (7.3%), ankle edema (14%), edema (5%), flushing (4.6%), flushing (4.6%), elevated liver enzymes (see WARNINGS).

The following reactions, reported in 10% or less of patients, occurred under conditions (open trials, marketing experience) where a causal relationship is uncertain.


Manufactured by
Lederle
LEREDLE LABORATORIES DIVISION
American Cyanamid Company
Pearl River, NY 10965

Printed in USA

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June 1990
There’s something more deadly than colon cancer.

Guidelines for detecting colon cancer:

1. A digital rectal examination every year after 40.
2. A stool blood test every year after 50.
3. A sigmoidoscopy every three to five years after 50.

In the past, the only agreement physicians had on guidelines for detecting colon cancer was that there was no agreement. Recently, physicians from the American Cancer Society and the National Cancer Institute gathered in a conference and agreed on specific guidelines. We recommend you follow them for asymptomatic patients over 40. Because when detected in its earliest stages, colon cancer is 90% curable. Now it’s your decision.
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