IN ESSENTIAL HYPERTENSION  TAKE CONTROL WITH...

PROTECTS
REDUCES
NEGligible
DOSED

Constipation, which can easily be managed in most patients, is the most frequently reported side effect of verapamil. Please see brief summary of Prescribing Information including CONTRAINDICATIONS, WARNINGS, and PRECAUTIONS on last page.
your hypertensive patients for 24 hours

The patented SODAS delivery system is engineered to control hypertension at the 24th hour, protecting against breakthrough hypertension—diminished control at the end of the dosing cycle.

wide variations in BP control

Ambulatory BP monitoring documents that VERELAN minimizes undesirable fluctuations of antihypertensive effect over 24 hours, providing excellent control throughout the dosing interval.

discontinuation due to side effects

Only 2.8% of patients discontinued therapy due to side effects in a double-blind, placebo-controlled study; no patients discontinued therapy due to constipation, headache, or edema (n = 107).

once daily at all doses

The SODAS delivery system provides for true qd dosing—up to 480 mg daily—with no food requirement, unlike some calcium channel blockers. VERELAN therapy is convenient and enhances compliance.
IN HYPERTENSION
SHIFT TO ONCE-A-DAY

VERELAN®
Verapamil HCl
PELLET-FILLED CAPSULES

ENGINEERED FOR THE CONTROL YOU WANT, THE PROTECTION THEY NEED.

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.

And now...

THE VERELAN PLEDGE

Following appropriate dose titration, VERELAN will control blood pressure at the 24th hour after dosing, or your patients will be reimbursed 100% of their out-of-pocket costs for their most recent VERELAN prescription. See your VERELAN representative for more details.

REFERENCES:

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 absorption of verapamil from the controlled-release VERELAN capsules.

Arteriographic block can occur in patients without preexisting condition defects (see WARNINGS).

Arteriographic block and/or ventricular fibrillation has been reported in patients with atrial flutter or atrial fibrillation and a class III antidyrrhythmic (see WARNINGS).

In patients with hepatic insufficiency, metabolism is delayed and elimination half-life prolonged up to 14 to 24 hours (see PRECAUTIONS), the volume of distribution is increased, and plasma clearance reduced to about 30% of normal.

CONTRAINDICATIONS

Severe LV dysfunction (see WARNINGS), hypertension (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 or an accessory bypass tract (eg, WPW syndrome, see WARNINGS), hyponatremia, or asthenia.

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. Control mild heart failure with optimal diuretics and duration before VERELAN is used. Verapamil may occasionally produce hypotension. Elevations of blood and plasma levels have been reported.

Several cases of neurocardiogenic injury have been reported. These cases of neurocardiogenic injury have been demonstrated to be provoked 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 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 digoxin). Because of this risk, oral verapamil is contraindicated in such patients. AV blocks may occur (second- or third-degree, 0.8%). Development of marked first-degree block or progression to second- or third-degree block requires reduction in dosage or, rarely, discontinuation and ablation of aortic stenosis. No serious arrhythmias have been seen in patients with abnormal ventricular conduction who were treated with verapamil.

PRECAUTIONS

Verapamil should be cautiously given 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 the QRS interval (see PRECAUTIONS). Verapamil may decrease neurocardiac transmission in patients with Duchenne muscular dystrophy and may prolong recovery from the neurocardiac block with digitalis. It may be necessary to discontinue verapamil in patients with digitalis-induced neurocardiac conduction defects. Combined therapy with beta adrenergic blockers and verapamil may result in additive antiarrhythmic effects on heart rate; arrhythmogenic conduction and/or cardiac contractility. Therefore, there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined use are unwarranted.

Rev. 1992

Manufactured by

Lederle LABORATORIES DIVISION
American Cyanamid Company
Pearl River, NY 10965

by ELAN PHARMACEUTICALS RESEARCH CORP
Gloucester, MA 02030

© 1992 Lederle Laboratories, A Division of American Cyanamid Company, Wayne, NJ 07470

April 1992
Printed in USA
5048-21

180 mg CAPSULES
NOW AVAILABLE
The Journal of the American Board of Family Practice welcomes for editorial review manuscripts that contribute to family practice as a clinical scientific discipline. High priority is given to reports of clinically relevant studies that have practical implications for improved patient care. Manuscripts are considered in relation to the extent to which they represent original work, their significance to the advancement of family medicine, and their interest to the practicing family physician. Some papers that are accepted by the Journal will be selected for an accompanying guest editorial or concurrent commentary by other invited authors addressing issues raised by the papers. The Journal publishes the following features:

Original Articles. Reports of original research, usually dealing with a clinical, health services, or other clinically relevant study.

Medical Practice. Scholarly articles that relate directly to clinical topics useful in everyday family practice, whether dealing with diagnostic or therapeutic roles of the family physician or reporting studies of what family physicians do in practice.

Clinical Review. In-depth reviews of specific clinical problems, disease entities, or treatment modalities; comprehensive and critical analysis of the literature is required (usual maximum length 5000 words).

Clinical Guidelines and Primary Care. Summaries of major clinical guidelines proposed by various specialty, governmental, or health care organizations, with critical commentary from a primary care perspective.

Special Articles. Articles in other areas that may relate to the role of the family physician, education for family practice, or other subjects important to family practice as a clinical specialty.

Brief Reports. Short reports of pilot studies or case reports with a teaching point of clinical relevance (usual length 1000–1500 words).

Family Practice—World Perspective. Papers reporting developments related to the practice or education of family physicians in various countries around the world (usual length 1200–1800 words).

Reflections in Family Practice. Papers in narrative or essay format that illuminate qualitative aspects of family practice, including such areas as ethical issues, the physician-patient relationship, or the diverse roles of the family physician.

Editorial. Focused opinion or commentary that bears on an issue relevant to the field. May or may not accompany an original article in the same issue (usual length 1000–1500 words).

Letters to the Editor. Observations, opinion, or comment on topics under discussion in the Journal, usually not to exceed 500 words.

Book Reviews. Books for review and book reviews should be sent to Dr. John P. Geyman, Editor, the Journal of the American Board of Family Practice, Department of Family Medicine (HQ-30), School of Medicine, University of Washington, Seattle, WA 98195.

The following guidelines are in accordance with the "Uniform Requirements for Manuscripts Submitted to Biomedical Journals." The current (fourth) edition was published in the February 7, 1991, issue of the New England Journal of Medicine.

MANUSCRIPT SUBMISSION

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 3 copies of the complete manuscript, including text pages, legends, tables, references, and glossy prints of figures. Only typed copy, on standard-sized typewriter paper and double-spaced throughout, with margins of at least 2.5 cm, is acceptable. Address all submissions to John P. Geyman, M.D., Editor, the Journal of the American Board of Family Practice, Department of Family Medicine (HQ-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. If authors acknowledge by name persons who provided important technical, advisory, or reviewer contributions, the corresponding author should sign the following statement: "I have obtained written permission from all persons named in the acknowledgment."

The Journal expects authors to take public responsibility for their manuscripts, including conception and design of the work, data analysis, writing, and review of the paper. Authors are expected to stand behind the validity of their data and, if asked by the Editor, to submit the actual data for editorial review with the manuscript.

The Journal also expects authors to disclose any commercial associations that might pose a conflict of interest in connection with the submitted article. Consultancies, stock ownership or other equity interests, patent-licensing arrangements, and other kinds of associations that might involve conflict of interest 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.

MANUSCRIPTS

Titles and Authors' Names

With the manuscript, provide a page giving the title of the paper; a running foot of fewer than 40 letter spaces; the name(s) of the author(s), including 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. All funding sources supporting the work should be routinely acknowledged on the title page, as should all institutional or corporate affiliations of the authors. Two to four key words should be submitted with the manuscripts to be used for purposes of classification by subject. Use terms from the Medical Subject Headings from Index Medicus when possible.
Abstracts
Use another page to provide an abstract of not more than 200 words. This abstract should be factual, not descriptive, with its content appropriate to the type of paper. For original articles reporting results of studies, a four-paragraph format should be used labeled Background, Methods, Results, and Conclusions. These should briefly describe, respectively, the object of the study, the methods used, the major results, and the author(s) conclusions. Abstracts are not necessary for Brief Reports or World Perspective papers.

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 list of 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.

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

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 6 or fewer; when there are 7 or more, list the first 6, then “et al.” Sample references are as follows:

Standard Journal Article
(List all authors, but if the number exceeds 6, give 6 followed by et al. Note that month and issue number are omitted when a journal has continuous pagination throughout a volume.)

Organization as Author

Book

Chapter in Book

Government Agency

Personal Communications
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 title for each. For footnotes, use the following symbols, in this sequence: *, †, ‡, §, ¶, ††, †‡, etc. 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 back 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. Photomicro-

graphs 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. Permissions forms are available from the Editor.

Legends for illustrations should be type-written (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.

Permissions
Every effort (short of changing the patient data) should be made by the authors to protect the anonymity of patients (and relatives) in any published work. If identification is unavoidable, informed consent should be obtained and attached with the submitted letter; in the case of minors or incompetent patients, consent should be obtained from relatives or guardians.

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.

Review and Action
Manuscripts are examined by the editorial staff and are usually sent to outside reviewers. Authors will remain anonymous to outside reviewers and vice versa. External statistical review will be accomplished where appropriate. Every effort will be made to complete the review process as expeditiously as possible.

Copyright Transfer Forms
Transfer of copyright to the Journal is requested upon acceptance of the material for publication. Copyright transfer is required of all materials to be published in the Journal, including Letters to the Editor and Book Reviews.

Reprints
Authors will receive reprint information and rates when they are sent their galley proofs. Reprints ordered at that time will be shipped about 3 weeks after the publication date.