Hypertension therapy that

Lessens the burden of "tolerable" side effects

Low-dose composition minimizes overall incidence of side effects[1]

- ZIAC avoids beta-blocker-associated side effects[1]
  - —The two most common side effects—dizziness (3.2%) and fatigue (3.0%)—occurred at rates comparable to placebo
- ZIAC has a low incidence of cough (1.5%), peripheral edema (0.9%), and headache (0.4%)—which occurred at rates comparable to placebo[2]

Up to 80% of patients controlled with equivalent efficacy regardless of age, race, or gender[1,3*]

ZIAC is contraindicated in patients in cardiogenic shock, overt cardiac failure, second- or third-degree AV block, marked sinus bradycardia, anuria, and hypersensitivity to either component of this product or to other sulfonamide-derived drugs.

*Clinical trial response rates were: 2.5 mg—61%; 5 mg—73%; 10 mg—80%.

Please see Brief Summary of Prescribing Information on adjacent page.

First-line therapy option

Lessen the side-effect burden

ZIAC®

(bisoprolol fumarate-hydrochlorothiazide)

2.5, 5, & 10 mg Tablets with 6.25 mg HCTZ

First-line therapy option

ZIAC®

(bisoprolol fumarate-hydrochlorothiazide)
2.5, 5, & 10 mg Tablets with 6.25 mg HCTZ

References:

1. DeQuattro V, Weir MR. Bisoprolol fumarate/hydrochlorothiazide 6.25 mg: a new low-dose option for first-line antihypertensive therapy. *Adv Ther.* 1993;10:197-206.
2. Data on file. Lederle Laboratories, Pearl River, NY.
3. Zachariah PK, Messerli FH, Mroczek W. Low-dose bisoprolol/ hydrochlorothiazide: an option in first-line, antihypertensive treatment. *Clin Ther.* 1993;15:779-787.

Brief Summary

ZIAC® (Bisoprolol Fumarate and Hydrochlorothiazide) Tablets

FOR FULL PRESCRIBING INFORMATION, PLEASE CONSULT PACKAGE INSERT.

DESCRIPTION

ZIAC (bisoprolol fumarate and hydrochlorothiazide) is indicated for the treatment of hypertension. It combines two antihypertensive agents in a once-daily dosage: a synthetic beta$_1$-selective (cardioselective) adrenoceptor blocking agent (bisoprolol fumarate) and a benzothiadiazine diuretic (hydrochlorothiazide).

CLINICAL PHARMACOLOGY

At doses ≥ 20 mg bisoprolol fumarate inhibits beta$_1$-adrenoreceptors located in bronchial and vascular musculature. To retain relative selectivity, it is important to use the lowest effective dose.

CONTRAINDICATIONS

Cardiogenic shock, overt cardiac failure (see **WARNINGS**), second- or third-degree AV block, marked sinus bradycardia, anuria, and hypersensitivity to either component of this product or to other sulfonamide-derived drugs.

WARNINGS

Cardiac Failure: Beta-blocking agents should be avoided in patients with overt congestive failure.
Patients Without a History of Cardiac Failure: Continued depression of the myocardium with beta-blockers can precipitate cardiac failure. At the first signs or symptoms of heart failure, discontinuation of ZIAC should be considered.
Abrupt Cessation of Therapy: Abrupt cessation of beta-blockers should be avoided. Even in patients without overt coronary artery disease, it may be advisable to taper therapy with ZIAC over approximately 1 week with the patient under careful observation. If withdrawal symptoms occur, beta-blocking agent therapy should be reinstituted, at least temporarily.
Peripheral Vascular Disease: Beta-blockers should be used with caution in patients with peripheral vascular disease.
Bronchospastic Disease: PATIENTS WITH BRONCHOSPASTIC PULMONARY DISEASE SHOULD, IN GENERAL, NOT RECEIVE BETA-BLOCKERS.
Anesthesia and Major Surgery: If used perioperatively, particular care should be taken when anesthetic agents that depress myocardial function, such as ether, cyclopropane, and trichloroethylene, are used.
Diabetes and Hypoglycemia: Beta-blockers may mask some of the manifestations of hypoglycemia, particularly tachycardia. Patients subject to spontaneous hypoglycemia, or diabetic patients receiving insulin or oral hypoglycemic agents, should be cautioned. Also, latent diabetes mellitus may become manifest and diabetic patients given thiazides may require adjustment of their insulin dose.
Thyrotoxicosis: Beta-adrenergic blockade may mask clinical signs of hyperthyroidism. Abrupt withdrawal of beta-blockade may be followed by an exacerbation of the symptoms of hyperthyroidism or may precipitate thyroid storm.
Renal Disease: Cumulative effects of the thiazides may develop in patients with impaired renal function. In such patients, thiazides may precipitate azotemia. In subjects with creatinine clearance less than 40 mL/min, the plasma half-life of bisoprolol fumarate is increased up to threefold, as compared to healthy subjects.
Hepatic Disease: ZIAC should be used with caution in patients with impaired hepatic function or progressive liver disease.

PRECAUTIONS

General: *Electrolyte and Fluid Balance Status:* Periodic determination of serum electrolytes should be performed, and patients should be observed for signs of fluid or electrolyte disturbances. Thiazides have been shown to increase the urinary excretion of magnesium; this may result in hypomagnesemia.

Hypokalemia may develop. Hypokalemia and hypomagnesemia can provoke ventricular arrhythmias or sensitize or exaggerate the response of the heart to the toxic effects of digitalis.

Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction rather than salt administration, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Parathyroid Disease: Calcium excretion is decreased by thiazides, and pathologic changes in the parathyroid glands, with hypercalcemia and hypophosphatemia, have been observed in a few patients on prolonged thiazide therapy.

Hyperuricemia: Hyperuricemia or acute gout may be precipitated in certain patients receiving thiazide diuretics. Bisoprolol fumarate, alone or in combination with HCTZ, has been associated with increases in uric acid.
Drug Interactions: ZIAC may potentiate the action of other antihypertensive agents used concomitantly. ZIAC should not be combined with other beta-blocking agents. In patients receiving concurrent therapy with clonidine, if therapy is to be discontinued, it is suggested that ZIAC be discontinued for several days before the withdrawal of clonidine.

ZIAC should be used with caution when myocardial depressants or inhibitors of AV conduction or antiarrhythmic agents are used concurrently.

Bisoprolol Fumarate: Concurrent use of rifampin increases the metabolic clearance of bisoprolol fumarate, shortening its elimination half-life. Pharmacokinetic studies document no clinically relevant interactions with other agents given concomitantly, including thiazide diuretics, digoxin and cimetidine. There was no effect of bisoprolol fumarate on prothrombin times in patients on stable doses of warfarin.

Risk of Anaphylactic Reaction: While taking beta-blockers, patients with a history of severe anaphylactic reaction may be more reactive to repeated challenge, either accidental, diagnostic, or therapeutic and may be unresponsive to the usual doses of epinephrine used to treat allergic reactions.

Hydrochlorothiazide: The following drugs may interact with thiazide diuretics. Alcohol, barbiturates, or narcotics — potentiation of orthostatic hypotension may occur. Dosage adjustment of the antidiabetic drugs (oral agents and insulin) may be required. Other antihypertensive drugs — additive effect or potentiation. Cholestyramine and colestipol resins — single doses of cholestyramine and colestipol resins bind the hydrochlorothiazide and reduce its absorption in the gastrointestinal tract by up to 85 percent and 43 percent, respectively. Corticosteroids, ACTH — intensified electrolyte depletion, particularly hypokalemia. Possible decreased response to pressor amines but not sufficient to preclude their use. Possible increased responsiveness to muscle relaxants, nondepolarizing. Generally, lithium should not be given with diuretics. Diuretic agents reduce the renal clearance of lithium and add a high risk of lithium toxicity. The administration of a nonsteroidal anti-inflammatory agent can reduce the diuretic, natriuretic, and antihypertensive effects of loop, potassium-sparing and thiazide diuretics.

In patients receiving thiazides, sensitivity reactions may occur with or without a history of allergy or bronchial asthma. Photosensitivity reactions and possible exacerbation or activation of systemic lupus erythematosus have been reported in patients receiving thiazides. The antihypertensive effects of thiazides may be enhanced in the post-sympathectomy patient.
Laboratory Test Interactions: Based on reports involving thiazides, ZIAC may decrease serum levels of protein-bound iodine without signs of thyroid disturbance. Because it includes a thiazide, ZIAC should be discontinued before carrying out tests for parathyroid function (see **PRECAUTIONS**–*Parathyroid Disease*).

ADVERSE REACTIONS

ZIAC: Bisoprolol fumarate/H6.25 mg is well tolerated in most patients. Most adverse effects (AEs) have been mild and transient. In more than 65,000 patients treated worldwide with bisoprolol fumarate, occurrences of bronchospasm have been rare. Discontinuation rates for AEs were similar for B/H6.25 mg and placebo-treated patients.

In the United States, 252 patients received bisoprolol fumarate (2.5, 5, 10, or 40 mg)/H6.25 mg and 144 patients received placebo in two controlled trials. In Study 1, bisoprolol fumarate 5/H6.25 mg was administered for 4 weeks. In Study 2, bisoprolol fumarate 2.5, 10 or 40/H6.25 mg was administered for 12 weeks. All adverse experiences, whether drug-related or not, and drug-related adverse experiences in patients treated with B2.5-10/H6.25 mg, reported during comparable, 4 week treatment periods by at least 2% of bisoprolol fumarate/H6.25 mg-treated patients (plus additional selected adverse experiences) are presented in the following table:

ZIAC® (Bisoprolol Fumarate and Hydrochlorothiazide) Tablets

Body System/ Adverse Experience	% of Patients with Adverse Experiences*			
	All Adverse Experiences		Drug-Related Adverse Experiences	
	Placebo† (n = 144) %	B2.5-40/H6.25† (n = 252) %	Placebo† (n = 144) %	B2.5-10/H6.25† (n = 221) %
Cardiovascular				
bradycardia	0.7	1.1	0.7	0.9
arrhythmia	1.4	0.4	0.0	0.0
peripheral ischemia	0.9	0.7	0.9	0.4
chest pain	0.7	1.8	0.7	0.9
Respiratory				
bronchospasm	0.0	0.0	0.0	0.0
cough	1.0	2.2	0.7	1.5
rhinitis	2.0	0.7	0.7	0.9
URI	2.3	2.1	0.0	0.0
Body as a Whole				
asthenia	0.0	0.0	0.0	0.0
fatigue	2.7	4.6	1.7	3.0
peripheral edema	0.7	1.1	0.7	0.9
Central Nervous System				
dizziness	1.8	5.1	1.8	3.2
headache	4.7	4.5	2.7	0.4
Musculoskeletal				
muscle cramps	0.7	1.2	0.7	1.1
myalgia	1.4	2.4	0.0	0.0
Psychiatric				
insomnia	2.4	1.1	2.0	1.2
somnolence	0.7	1.1	0.7	0.9
loss of libido	1.2	0.4	1.2	0.4
impotence	0.7	1.1	0.7	1.1
Gastrointestinal				
diarrhea	1.4	4.3	1.2	1.1
nausea	0.9	1.1	0.9	0.9
dyspepsia	0.7	1.2	0.7	0.9

* Averages adjusted to combine across studies.
† Combined across studies.

Other adverse experiences that have been reported with the individual components are listed below.
Bisoprolol Fumarate: In clinical trials worldwide, a variety of other AEs, in addition to those listed above, have been reported. While in many cases it is not known whether a causal relationship exists between bisoprolol and these AEs, they are listed to alert the physician to a possible relationship. *Central Nervous System:* Unsteadiness, vertigo, syncope, paresthesia, hyperesthesia, sleep disturbance/vivid dreams, depression, anxiety/restlessness, decreased concentration/memory. *Cardiovascular:* Palpitations and other rhythm disturbances, cold extremities, claudication, hypotension, orthostatic hypotension, chest pain, congestive heart failure. *Gastrointestinal:* Gastric/epigastric/abdominal pain, peptic ulcer, gastritis, vomiting, constipation, dry mouth. *Musculoskeletal:* Arthralgia, muscle/joint pain, back/neck pain, twitching/tremor. *Skin:* Rash, acne, eczema, psoriasis, skin irritation, pruritus, purpura, flushing, sweating, alopecia, dermatitis, exfoliative dermatitis (very rarely), cutaneous vasculitis. *Special Senses:* Visual disturbances, ocular pain/pressure, abnormal lacrimation, tinnitus, decreased hearing, earache, taste abnormalities. *Metabolic:* Gout. *Respiratory:* Asthma, bronchitis, dyspnea, pharyngitis, sinusitis. *Genitourinary:* Peyronie's disease (very rarely), cystitis, renal colic, polyuria. *General:* Malaise, edema, weight gain, angioedema.

In addition, a variety of adverse effects have been reported with other beta-adrenergic blocking agents and should be considered potential adverse effects: *Central Nervous System:* Reversible mental depression progressing to catatonia, hallucinations, an acute reversible syndrome characterized by disorientation to time and place, emotional lability, slightly clouded sensorium. *Allergic:* Fever, combined with aching and sore throat, laryngospasm, and respiratory distress. *Hematologic:* Agranulocytosis, thrombocytopenia. *Gastrointestinal:* Mesenteric arterial thrombosis and ischemic colitis. *Miscellaneous:* The oculomucocutaneous syndrome associated with the beta-blocker practolol has not been reported with bisoprolol fumarate during investigational use or extensive foreign marketing experience.
Hydrochlorothiazide: The following adverse experiences, in addition to those listed in the above table, have been reported with hydrochlorothiazide (generally with doses of 25 mg or greater). *General:* Weakness. *Central Nervous System:* Vertigo, paresthesia, restlessness. *Cardiovascular:* Orthostatic hypotension (may be potentiated by alcohol, barbiturates, or narcotics). *Gastrointestinal:* Anorexia, gastric irritation, cramping, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, cholecystitis, sialadenitis, dry mouth. *Musculoskeletal:* Muscle spasm. *Hypersensitive Reactions:* Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis and cutaneous vasculitis), fever, respiratory distress including pneumonitis and pulmonary edema, anaphylactic reactions. *Special Senses:* Transient blurred vision, xanthopsia. *Metabolic:* Gout. *Genitourinary:* Sexual dysfunction, renal failure, renal dysfunction, interstitial nephritis.

LABORATORY ABNORMALITIES

ZIAC: Because of the low dose of hydrochlorothiazide in ZIAC, adverse metabolic effects with B/H6.25 mg are less frequent and of smaller magnitude than with HCTZ 25 mg.

Treatment with both beta-blockers and thiazide diuretics is associated with increases in uric acid. Mean increases in serum triglycerides were observed in patients treated with bisoprolol fumarate and hydrochlorothiazide 6.25 mg. Total cholesterol was generally unaffected, but small decreases in HDL cholesterol were noted.

Other laboratory abnormalities that have been reported with the individual components are listed below.
Bisoprolol Fumarate: In clinical trials, the most frequently reported laboratory change was an increase in serum triglycerides, but this was not a consistent finding.

Sporadic liver test abnormalities have been reported. In the U.S. controlled trials experience with bisoprolol fumarate treatment for 4 to 12 weeks, the incidence of concomitant elevations in SGOT and SGPT of between 1 to 2 times normal was 3.9%, compared to 2.5% for placebo. No patient had concomitant elevations greater than twice normal.

In the long-term, uncontrolled experience with bisoprolol fumarate treatment for 6 to 18 months, the incidence of one or more concomitant elevations in SGOT and SGPT of between 1-2 times normal was 6.2%. The incidence of multiple occurrence was 1.9%. For concomitant elevations in SGOT and SGPT of greater than twice normal, the incidence was 1.5%. The incidence of multiple occurrences was 0.3%. In many cases these elevations were attributed to underlying disorders, or resolved during continued treatment with bisoprolol fumarate.

Other laboratory changes included small increases in uric acid, creatinine, BUN, serum potassium, glucose, and phosphorus and decreases in WBC and platelets. There have been occasional reports of eosinophilia. These were generally not of clinical importance and rarely resulted in discontinuation of bisoprolol fumarate.

As with other beta-blockers, ANA conversions have also been reported on bisoprolol fumarate. About 15% of patients in long-term studies converted to a positive titer, although about one-third of these patients subsequently reconverted to a negative titer while on continued therapy.
Hydrochlorothiazide: Hyperglycemia, glycosuria, hyperuricemia, hypokalemia and other electrolyte imbalances (see **PRECAUTIONS**), hyperlipidemia, hypercalcemia, leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia, and hemolytic anemia have been associated with HCTZ therapy.

See **DOSAGE AND ADMINISTRATION** section in package insert for complete dosing and precautionary information.

Lederle

LEDERLE LABORATORIES DIVISION
American Cyanamid Company
Pearl River, NY 10965

Under License of E. MERCK
Darmstadt, Germany

REV. 11/94
L-41535-94

Lederle

LEDERLE LABORATORIES DIVISION
American Cyanamid Company
Pearl River, NY 10965

Procter&Gamble PHARMACEUTICALS

65501R

The Pacific Northwest has always attracted independent thinkers.

We Give Them A Place To Practice Medicine.

Looking to the beautiful Pacific Northwest? Why not consider one of the region's most progressive and dynamic health care organizations — MultiCare Health System. Where you'll be able to exercise your own patient care values.

Choose your practice setting.

MultiCare offers everything from individual, community-based practices to large multi-specialty groups — located in the largest, most populated counties in Washington State's Puget Sound region. What's more, MultiCare will handle your practice management, so you can focus on providing personalized patient care.

The support of a diverse, progressive system.

MultiCare's comprehensive system includes two adult hospitals, a nationally recognized pediatric hospital, five day surgery sites, four urgent care centers, a large home health service, and industrial medicine and family practice residency programs. More than 100 primary care and subspecialty physicians have chosen to partner with MultiCare.

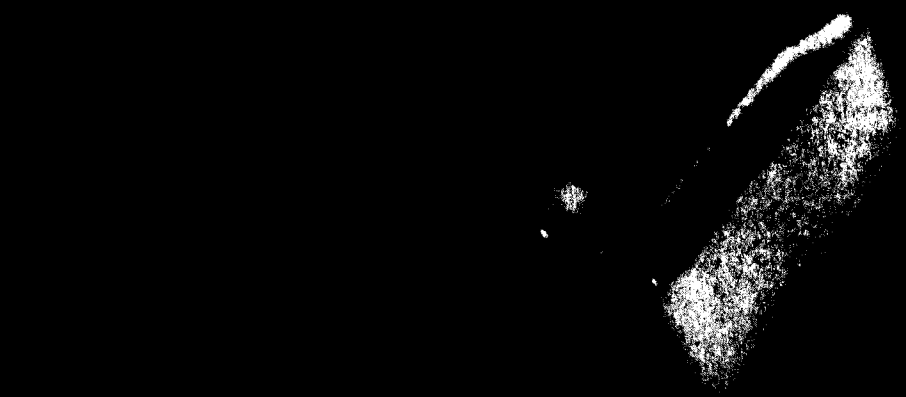
Find out more.

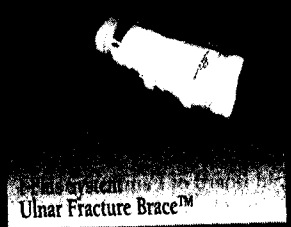
We have lots of attractive opportunities to offer you. So why not learn more? Call MultiCare Physician Services at (800) 621-0301.

MultiCare Health System

315 Martin Luther King Jr. Way
Tacoma, WA 98405
(800) 621-0301

Embrace Technology





The L-Plus System™ supports humeral and ulnar fractures while allowing full mobility. The new THUMZ'UP® thumb splint is effective in stabilizing an injured thumb MCP joint with little loss of hand use. All of these functional braces and splints are radiotransparent, lightweight and comfortable to wear.

Galveston Manufacturing offers other unique immobilization products. Embrace Technology - call 1-800-634-3309 today for a catalog!

GALVESTON MANUFACTURING

"Simple Solutions In Functional Bracing"

P.O. Box 551 • Santa Fe, Texas • 77517-0551
(409) 925-1891

INFORMATION FOR READERS

The Journal of the American Board of Family Practice

Official Publication of the American Board of Family Practice

EDITORIAL OFFICES

Journal of the American Board of Family Practice
Department of Family Medicine
Box 355304
University of Washington
Seattle, WA 98195
Phone: (206) 685-3993
Fax: (206) 543-8911

PUBLISHING OFFICES

MRA Publications, Inc.
2 Greenwich Office Park
Greenwich, CT 06831
Phone: (203) 629-3550
Fax: (203) 629-2536
J. Bradley MacKimm
Publishing Director
Anne Griffin
Manager, Advertising Production/Reprints
Ted Bergman
Art/Editorial Production Manager
Jane C. Monaghan
Editorial Director

ADVERTISING OFFICES

M. R. Mrvica Associates, Inc.
155 White Horse Pike
Berlin, NJ 08009
Phone: (609) 768-9360
Fax: (609) 753-0064

SUBSCRIPTION INFORMATION AND SERVICES

The *Journal of the American Board of Family Practice* is supplied free of charge to 54,900 Diplomates and Residents of the American Board of Family Practice. For information please contact:

American Board of Family Practice
2228 Young Drive
Lexington, KY 40505
Tel: (606) 269-5626
FAX: (606) 266-9699

All other subscribers please contact:

The *Journal of the American Board of Family Practice*
Subscription Department
2 Greenwich Office Park
Greenwich, CT 06831
(203) 629-3550
Fax: (203) 629-2536

SUBSCRIPTION RATES

	Domestic	International
Institutions	$60.00	$65.00
Physicians	$35.00	$45.00
Residents/Students	$20.00	$45.00

OTHER SUBSCRIPTION INFORMATION

Diplomates should make address changes on the form accompanying this issue and forward to the Lexington, Ky., address listed at left. All other subscribers should forward changes to the Greenwich, Conn., address listed at left. Changes must be received at least 6 weeks in advance of intended move. Please send new address, old address, and expected date of change.

ISSUES NOT RECEIVED

Missing issues will be replaced for up to three months from the issue date without charge. Diplomates and other subscribers who fail to notify the Lexington, Ky., or the Greenwich, Conn., office of address changes will not be eligible for free replacement issues. Claims beyond the three-month limit must be prepaid at the back-copy rates. Claims should be sent to either the Diplomate or regular subscriber address on this page.

BACK COPIES

If you wish to purchase back copies (issues published prior to your effective start date) of the *Journal of the American Board of Family Practice*, there is a charge of $12.50 per issue. Contact the Greenwich, Conn., address on this page for information.

REPRINTS

Individual copies of articles are available from the Greenwich, Conn., office. If you wish to order bulk reprints (minimum order of 100) please contact the Reprint Department, phone: (203) 629-3550, at the Greenwich, Conn., office.

COPYRIGHT

INDEXING

The *Journal of the American Board of Family Practice* is indexed in *Index Medicus*.

INFORMATION FOR AUTHORS

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.

Family Practice and the Health Care System. Articles reporting studies and scholarly commentary on changing trends and patterns of care in family practice, primary care, and the health care system.

Health Policy. Articles relating to specific health policy issues from a national perspective, usually invited from individuals with extensive health policy experience.

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 John P. Geyman, MD, Editor, the *Journal of the American Board of Family Practice*, Department of Family Medicine, School of Medicine, Box 355304, 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

Address all submissions to John P. Geyman, MD, Editor, *Journal of the American Board of Family Practice*, Department of Family Medicine, School of Medicine, Box 355304, University of Washington, Seattle, WA 98195.

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. The manuscript should be on 8 ½ × 11-inch paper, double-spaced throughout, with 1-inch margins. Include a copy of the manuscript on a computer disk, and indicate which software program is used.

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. In most instances authorship should be limited to 8 authors or fewer, all meeting the above criteria for authorship. Exceptions to these guidelines, especially those involving multisite collaborative research projects, should be discussed on a case-by-case basis with the editor.

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 keywords 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, World Perspective, or Family Practice and the Health Care System papers.

Abbreviations

Except for units of measurement, abbreviations are discouraged. 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

Morrow JD, Margolies GR, Rowland J, Roberts LJ 2nd. Evidence that histamine is the causative toxin of scombroid-fish poisoning. N Engl J Med 1991;324:716-20.

(Note that month and issue number are omitted when a journal has continuous pagination throughout a volume.)

Organization as Author

Clinical Experience Network (CEN). A large-scale, office-based study evaluates the use of a new class of nonsedating antihistamines. A report from CEN. J Am Board Fam Pract 1990;3:241-58.

Book

Rakel RE. Textbook of family practice. 4th ed. Philadelphia: WB Saunders, 1990.

Chapter in Book

Haynes RC Jr. Agents affecting calcification: calcium, parathyroid hormone, calcitonin, vitamin D, and other compounds. In: Gilman AG, Rall TW, Nies AS, Taylor P, editors. Goodman and Gilman's the pharmacological basis of therapeutics. 8th ed. New York: Pergamon Press, 1990.

Government Agency

Schwartz JL. Review and evaluation of smoking cessation methods: the United States and Canada, 1978-1985. Bethesda, MD: Department of Health and Human Services, 1987. (NIH publication no. 87-2940.)

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.

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 (eg, "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. 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

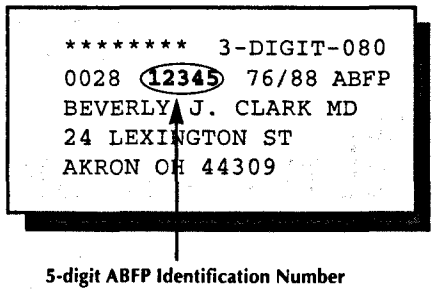
Transfer of copyright to the *Journal* is requested upon acceptance of the material for publication. Copyright transfer is required of all materials to be published in the *Journal* including Letters to the Editor and Book Reviews.

Reprints

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

ATTENTION

DIPLOMATES OF THE ABFP
ADDRESS CHANGE FORM



The Board prefers the use of *professional addresses,* because the address given will become your "address of record" with the Board and will be published in our Directory of Diplomates.

Current addresses for all Diplomates are necessary for communication from the Board relating to the Examinations, updated Recertification information, etc., as well as to ensure the receipt of the *Journal of the American Board of Family Practice.*

Name_____

Current Address	**New Address**
Street_____	Street _____
_____	_____
City/State_____	City/State_____
Zip Code_____	Zip Code_____

Effective Date of Change_____

Signature of Diplomate_____

ABFP Identification Number_____
(5-digit number above name on mailing label)

Year of Certification or Recertification_____

Return to: **The American Board of Family Practice**
2228 Young Drive
Lexington, KY 40505

ABFP Announcement

1ST RECERTIFICATION PROCESS FOR THE Certificate of Added Qualifications in Geriatric Medicine

FOR HOLDERS OF CERTIFICATES DATED 1988–1998

Pre-applications will automatically be sent to you: March 1996

Due date for return to ABFP: April 1, 1996

Examination Date: Wednesday, November 19, 1997

(If you have not received your pre-application by mid-March 1996, please notify our office.)

American Board of Family Practice
Geriatric Medicine
2228 Young Drive
Lexington, KY 40505-4294
(606) 269-5626 ext. 250;
fax (606) 266-4089