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usually don't add to the coffers, merely drain them—and are well worth it in most cases). That input is critical to helping you make retirement decisions.

A plan for retirement won't work if you want to stay at home and do nothing but garden at age 65, while your spouse wants to travel continuously; you and your spouse will need to be on the same page when formulating your plan. So start developing that roadmap early with the people in your life who likely will be part of your future. You should also remember that retirement can be tough on a life partner who isn't used to your being at home 24/7. There could be some trying times if both of you are not in agreement with the plan.

You should consider not only when to retire (remember, that date could be a moving target, depending on how much you still enjoy being in the game and how capable you still are), but also where and under what circumstances. Perhaps you want to work part time for a few years and gradually wind down. Perhaps you can't wait to leave and will do so as soon as you can (of course, if that's the case, maybe now would be the time to consider a different field).

Would you want to become a locum tenens doctor who travels periodically to join and help out younger colleagues? Would you want to develop a career in consulting if you are business savvy? All these options should be considered, and above all, mapped out far in advance.

The American Academy of Pediatrics' Senior Section has done a lot to make us think about Pediatric Wellness as well as making an exit plan earlier rather than later. It merits investigation and learning from its members' collective wisdom.

It is not too early to start developing your plan while you are in your 30s. Further, as your interests develop and change, different routes can be considered. I have never lost the love of private general practice, but other pediatric colleagues have moved into a different arena: Some have joined industry as experts in the pharmaceutical world, some have joined the insurance industry, and some have developed entirely nonmedical careers. The point is that interests—and needs—do change, so you and your planning partners must be flexible.

Maybe teaching is your cup of tea—and a second career (or retirement career) may include academia. Perhaps volunteerism is something you want—working at a Children's Hospital might be fun, especially without the pressure to develop a differential diagnosis and figure out the dilemma. All these have possibilities for a pediatrician leaving practice.

One piece of advice I would give all retiring pediatricians: Continue your ties with the AAP. Your state chapter can always use the wisdom of a seasoned veteran of our profession, and with retirement comes the flexibility to be available to testify in your state capital on short notice. While you are practicing full time, whether in private practice, clinics, academia, or industry, it is difficult to break away for those last-minute hearings; with retirement, you have more options with fewer restrictions on your time (although that isn't always the case) and can represent your state's pediatricians at those hearings. Don't worry about preparing for such occasions—your chapter and national AAP can provide talking points to help you be as knowledgeable as you want. Stay involved because I guarantee that you will be needed. And, perhaps the most important thing for you—after years of being an essential part of so many people's lives—is to still feel productive and needed!

Perhaps one reason this article is a bit shorter than most is the fact that I am still a bit reluctant to face the reality that I will leave my practice someday. I already have ideas about what to do that are concordant with my wife's thoughts. I haven't gotten all the details figured out—they are still in flux—but the direction is there. I started a bit late with the formulation of the plan—probably in my mid-40s. But I also haven't waited until my late 50s like some. Consider what you both want, and even maybe when you want it. Talk to professionals to help you realize your goal; recognize that it can be a moving target. And then, after all that, enjoy the moment knowing that you have a satisfying future in store. ■

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Vigamox®

(moxifloxacin hydrochloride ophthalmic solution) 0.5% as base

DESCRIPTION: VIGAMOX® (moxifloxacin HCl ophthalmic solution) 0.5% is a sterile ophthalmic solution. It is an 8-methoxy fluoroquinolone anti-infective for topical ophthalmic use.

Clinical Studies: In two randomized, double-masked, multicenter, controlled clinical trials in which patients were dosed 3 times a day for 4 days, VIGAMOX® solution produced clinical cures on day 5-6 in 66% to 69% of patients treated for bacterial conjunctivitis. Microbiological success rates for the eradication of the baseline pathogens ranged from 84% to 94%. Please note that microbiologic eradication does not always correlate with clinical outcome in anti-infective trials.

INDICATIONS AND USAGE: VIGAMOX® solution is indicated for the treatment of bacterial conjunctivitis caused by susceptible strains of the following organisms:

Aerobic Gram-positive microorganisms:

*Corynebacterium species**, *Micrococcus luteus**, *Staphylococcus aureus*, *Staphylococcus epidermidis*, *Staphylococcus haemolyticus*, *Staphylococcus hominis*, *Staphylococcus warneri**, *Streptococcus pneumoniae*, *Streptococcus* viridans group

Aerobic Gram-negative microorganisms:

*Acinetobacter lwoffii**, *Haemophilus influenzae*, *Haemophilus parainfluenzae**

Other microorganisms:

Chlamydia trachomatis

*Efficacy for this organism was studied in fewer than 10 infections.

CONTRAINDICATIONS: VIGAMOX® (moxifloxacin HCl ophthalmic solution) is contraindicated in patients with a history of hypersensitivity to moxifloxacin, to other quinolones, or to any of the components in this medication.

WARNINGS: NOT FOR INJECTION.

VIGAMOX® solution should not be injected subconjunctivally, nor should it be introduced directly into the anterior chamber of the eye.

In patients receiving systemically administered quinolones, including moxifloxacin, serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported, some following the first dose. Some reactions were accompanied by cardiovascular collapse, loss of consciousness, angioedema (including laryngeal, pharyngeal or facial edema), airway obstruction, dyspnea, urticaria, and itching. If an allergic reaction to moxifloxacin occurs, discontinue use of the drug. Serious acute hypersensitivity reactions may require immediate emergency treatment. Oxygen and airway management should be administered as clinically indicated.

PRECAUTIONS: General: As with other anti-infectives, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. If superinfection occurs, discontinue use and institute alternative therapy. Whenever clinical judgment dictates, the patient should be examined with the aid of magnification, such as slit-lamp biomicroscopy, and, where appropriate, fluorescein staining. Patients should be advised not to wear contact lenses if they have signs and symptoms of bacterial conjunctivitis.

Information for Patients: Avoid contaminating the applicator tip with material from the eye, fingers or other source.

Systemically administered quinolones including moxifloxacin have been associated with hypersensitivity reactions, even following a single dose. Discontinue use immediately and contact your physician at the first sign of a rash or allergic reaction.

Drug Interactions: Drug-drug interaction studies have not been conducted with VIGAMOX® solution. *In vitro* studies indicate that moxifloxacin does not inhibit CYP3A4, CYP2D6, CYP2C9, CYP2C19, or CYP1A2 indicating that moxifloxacin is unlikely to alter the pharmacokinetics of drugs metabolized by these cytochrome P450 isozymes.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals to determine the carcinogenic potential of moxifloxacin have not been performed. However, in an accelerated study with initiators and promoters, moxifloxacin was not carcinogenic in rats following up to 38 weeks of oral dosing at 500 mg/kg/day (approximately 21,700 times the highest recommended total daily human ophthalmic dose for a 50 kg person, on a mg/kg basis). Moxifloxacin was not mutagenic in four bacterial strains used in the Ames *Salmonella* reversion assay. As with other quinolones, the positive response observed with moxifloxacin in strain TA 102 using the same assay may be due to the inhibition of DNA gyrase. Moxifloxacin was not mutagenic in the CHO/HGPRT mammalian cell gene mutation assay. An equivocal result was obtained in the same assay when v79 cells were used. Moxifloxacin was clastogenic in the v79 chromosome aberration assay, but it did not induce unscheduled DNA synthesis in cultured rat hepatocytes. There was no evidence of genotoxicity *in vivo* in a micronucleus test or a dominant lethal test in mice.

Moxifloxacin had no effect on fertility in male and female rats at oral doses as high as 500 mg/kg/day, approximately 21,700 times the highest recommended total daily human ophthalmic dose. At 500 mg/kg orally, there were slight effects on sperm morphology (head-tail separation) in male rats and on the estrous cycle in female rats.

Pregnancy:

Teratogenic Effects. Pregnancy Category C: Moxifloxacin was not teratogenic when administered to pregnant rats during organogenesis at oral doses as high as 500 mg/kg/day (approximately 21,700 times the highest recommended total daily human ophthalmic dose); however, decreased fetal body weights and slightly delayed fetal skeletal development were observed. There was no evidence of teratogenicity when pregnant Cynomolgus monkeys were given oral doses as high as 100 mg/kg/day (approximately 4,300 times the highest recommended total daily human ophthalmic dose). An increased incidence of smaller fetuses was observed at 100 mg/kg/day.

Since there are no adequate and well-controlled studies in pregnant women, VIGAMOX® solution should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Moxifloxacin has not been measured in human milk, although it can be presumed to be excreted in human milk. Caution should be exercised when VIGAMOX® solution is administered to a nursing mother.

Pediatric Use: The safety and effectiveness of VIGAMOX® solution in infants below 1 year of age have not been established.

There is no evidence that the ophthalmic administration of VIGAMOX® has any effect on weight bearing joints, even though oral administration of some quinolones has been shown to cause arthropathy in immature animals.

Geriatric Use: No overall differences in safety and effectiveness have been observed between elderly and younger patients.

ADVERSE REACTIONS: The most frequently reported ocular adverse events were conjunctivitis, decreased visual acuity, dry eye, keratitis, ocular discomfort, ocular hyperemia, ocular pain, ocular pruritus, subconjunctival hemorrhage, and tearing. These events occurred in approximately 1-6% of patients. Nonocular adverse events reported at a rate of 1-4% were fever, increased cough, infection, otitis media, pharyngitis, rash, and rhinitis.

Reference:
1. Data on file. Alcon Laboratories, Inc. 2005.

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