

Gantrisin® Pediatric Suspension

acetyl sulfisoxazole/Roche

Before prescribing, please consult complete product information, a summary of which follows:

INDICATIONS: Nonobstructed urinary tract infections (mainly cystitis, pyelitis, pyelonephritis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, staphylococcus, *P. mirabilis*, *P. vulgaris*). Acute otitis media due to *H. influenzae* (concomitantly with adequate doses of penicillin)

IMPORTANT NOTE: *In vitro* sensitivity tests not always reliable, must be coordinated with bacteriological and clinical response. Add aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms limits usefulness of antibacterial agents, especially in chronic and recurrent urinary infections. Maximum safe total sulfonamide blood level, 20 mg/100 ml; measure levels as variations may occur.

CONTRAINDICATIONS: Hypersensitivity to sulfonamides; infants less than 2 months of age; pregnancy at term and during the nursing period

WARNINGS: Safety in pregnancy not established. Do not use for group A beta-hemolytic streptococcal infections, as sequelae (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. CBC and urinalysis with careful microscopic examination should be performed frequently.

PRECAUTIONS: Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma. Hemolysis, frequently dose-related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.

ADVERSE REACTIONS: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia. *Miscellaneous reactions:* Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

DOSAGE: Contraindicated in infants under 2 months except in the treatment of congenital toxoplasmosis as adjunctive therapy with pyrimethamine

Usual adult dosage—2 to 4 Gm initially, then 4 to 8 Gm/24 hrs in 4 to 6 doses. *Usual dosage for infants over 2 months and children*— $\frac{1}{2}$ 24-hr dose initially, then 150 mg/kg/24 hrs in 4 to 6 doses; not over 6 Gm/24 hrs

HOW SUPPLIED: Tablets containing 0.5 Gm sulfisoxazole, white, scored—bottles of 100, 500 and 1000, drums of 5000. Tel-E-Dose® packages of 100. Prescription Paks of 100. Pediatric Suspension, containing, in each teaspoonful (5 ml), the equivalent of approximately 0.5 Gm sulfisoxazole in the form of acetyl sulfisoxazole; raspberry flavored—bottles of 4 oz and 16 oz (1 pint).

Syrup, containing, in each teaspoonful (5 ml), the equivalent of approximately 0.5 Gm sulfisoxazole in the form of acetyl sulfisoxazole; chocolate flavored—bottles of 16 oz (1 pint).

Letters to the Editor



The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Removal of Subungual Foreign Bodies

To the Editor:

Most physicians engaged in primary care will occasionally encounter the problem of wood splinters, thorns, or other similar foreign bodies lodged beneath the fingernail. Attempts at removal from this location can be painful and traumatic for the patient, and frustrating or time-consuming for the physician. The problem is commonly made more difficult by the fact that attempts to remove the foreign body prior to seeking medical attention usually have resulted in the breaking off of any portion remaining beyond the tip of the nail and/or driving the subungual portion well beyond the reach of most common office instruments. Standard solutions to this problem often involve splitting or removal of a portion of the nail, separation of the nail from the nail bed, and frequently require local anesthesia, such as a digital block.

An alternative approach, which has proved effective on four successive attempts, is atraumatic and

has not required an anesthetic, even with small children. The method involves fashioning a tiny hook from a 25- or 27-gauge hypodermic needle. This is accomplished by carefully bending the tip with the aid of a small hemostat or needle holder. The length of the barb produced should be about equal to the diameter of the needle. This small instrument can then be atraumatically introduced along the same subungual track made by the foreign body until a portion of the object can be snared and slowly withdrawn or teased out from under the nail. The smaller the size of the barb, the more direct the angle of force when traction is applied. The only other requirement is a certain degree of patient cooperation. The time involved has usually been no more than a few minutes.

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