

Keflex®
cephalexin

Brief Summary. Consult the package literature for prescribing information.

Indications: Keflex is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Respiratory tract infections caused by *Streptococcus (Diplococcus) pneumoniae* and group A beta-hemolytic streptococci (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. Keflex is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of Keflex in the subsequent prevention of rheumatic fever are not available at present.)

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

Contraindication: Keflex is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflex.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Precautions: Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflex occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflex may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Keflex should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflex, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Adverse Reactions: Gastrointestinal—The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Nausea, vomiting, dyspepsia, and abdominal pain have also occurred.

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Keflex.

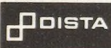
Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Eosinophilia, neutropenia, and slight elevations in SGOT and SGPT have been reported.

[070880R]

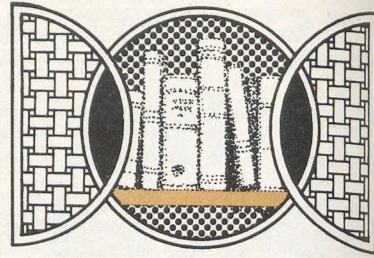
Additional information available to the profession on request from Distal Products Company, Division of Eli Lilly and Company, Indianapolis, Indiana 46285.

100227



Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Book Reviews



FAMLI Family Medicine Literature Index, Volume 1, No. 1. Dorothy Fitzgerald (ed). *The World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) in cooperation with the National Library of Medicine, London, Ont., Canada, 1980, 47 pp., \$40.00 (annual subscription, United States and Canada - \$50.00 elsewhere).*

FAMLI is a periodical rather than a book, published quarterly. This review is based on volume 1, No. 1, dated March 1980. FAMLI should prove a boon to authors and researchers in the field of family medicine. It is, as the title indicates, a family medicine literature index, organized in the format of *Index Medicus*, using the same subject headings. There are two sections. Section 1, the MEDLARS section, indexes the family medicine literature published in journals referred to by *Index Medicus*. The culling of the pertinent family practice information from the vast amount of material in the *Index Medicus* is accomplished by a search strategy developed by the WONCA Bibliography Committee and the staff of the National Library of Medicine.

The second part, the Supplement section, indexes twelve family medicine journals that are not referred to by *Index Medicus*, including family practice publications from New Zealand to Germany. North American journals in this section include *Canadian Family Physician*, *Continuing Education for the Family Phy-*

sician, *Patient Care*, and *Update*.

Credentials and expertise of the organizers of this publication are extremely impressive. No medical library should be without this publication, and individuals having any occasion to review or search family practice literature will undoubtedly want an individual copy at their fingertips. As a family practice educator interested in research, I consider this publication to be one of the major contributions to family practice since the inception of the discipline.

Herbert L. Tindall, MD
Lancaster, Pennsylvania

Guidelines for Graded Exercise Testing and Exercise Prescription (2nd Edition). American College of Sports Medicine. Lea & Febiger, Philadelphia, 1980, 151 pp., \$6.50 (paper).

Prepared by an apparently diverse and large committee of the American College of Sports Medicine, this text is recommended for all who evaluate, prescribe, or teach about exercise. Easily read in a short time, it contains much practical clinical information that may be found quickly during the decision making process for exercise evaluation or prescription. On the other hand, the individual seeking in-depth knowledge about exercise physiology must search elsewhere, for this book is not intended to be a reference source. It could serve as an excellent course outline text for

Continued on page 414

Diet & Diabinese® (chlorpropamide) 100-mg and 250-mg Tablets

A proven regimen for effective control of blood sugar.

BRIEF SUMMARY DIABINESE® (chlorpropamide) Tablets

Contraindications: Diabinese is not indicated in patients having juvenile or growth-onset diabetes mellitus, severe or unstable "brittle" diabetes, and diabetes complicated by ketosis and acidosis, diabetic coma, major surgery, severe infection, or severe trauma. Diabinese is contraindicated during pregnancy. Serious consideration should be given to the potential hazard of its use in women of childbearing age who may become pregnant.

Diabinese is contraindicated in patients with serious impairment of hepatic, renal, or thyroid function.

Precautions: Use chlorpropamide with caution with barbiturates, in patients with Addison's disease or in those ingesting: alcohol, antibacterial sulfonamides, phenylbutazone, salicylates, probenecid, dicoumarol or MAO inhibitors.

Warnings: DIABINESE (CHLORPROPAMIDE) SHOULD NOT BE USED IN JUVENILE DIABETES OR IN DIABETES COMPLICATED BY ACIDOSIS, COMA, SEVERE INFECTION, MAJOR SURGICAL PROCEDURES, SEVERE TRAUMA, SEVERE DIARRHEA, NAUSEA AND VOMITING, ETC. HYPOLYCEMIA, IF IT OCCURS, MAY BE PROLONGED.

Adverse Reactions: Usually dose-related and generally respond to reduction or withdrawal of therapy. Generally transient and not of a serious nature and include anorexia, nausea, vomiting and gastrointestinal intolerance, weakness and paresthesias.

Certain untoward reactions associated with idiosyncrasy or hypersensitivity have occasionally occurred, including jaundice (rarely associated with severe diarrhea and bleeding), skin eruptions rarely progressing to erythema multiforme and exfoliative dermatitis, and probably depression of formed elements of the blood. With a few exceptions, these manifestations have been mild and readily reversible on the withdrawal of the drug.

Diabinese should be discontinued promptly when the development of sensitivity is suspected. Jaundice has been reported, and is usually promptly reversible on discontinuance of therapy. THE OCCURRENCE OF PROGRESSIVE ALKALINE PHOSPHATASE ELEVATION SHOULD SUGGEST THE POSSIBILITY OF INCIPENT JAUNDICE AND CONSTITUTES AN INDICATION FOR WITHDRAWAL OF THE DRUG.

Leukopenia, thrombocytopenia and mild anemia, which occur occasionally, are generally benign and revert to normal, following cessation of the drug.

Cases of aplastic anemia and agranulocytosis, generally similar to blood dyscrasias associated with other sulfonylureas, have been reported.

BECAUSE OF THE PROLONGED HYPOLYCEMIC ACTION OF DIABINESE, PATIENTS WHO BECOME HYPOLYCEMIC DURING THERAPY WITH THIS DRUG REQUIRE CLOSE SUPERVISION FOR A MINIMUM PERIOD OF 3 TO 5 DAYS, during which time frequent feedings or glucose administration are essential. The anorectic patient or the profoundly hypoglycemic patient should be hospitalized.

Rare cases of phototoxic reactions have been reported. Edema associated with hyponatremia has been infrequently reported. It is usually readily reversible when medication is discontinued.

Dosage: The mild to moderately severe, middle-aged, stable diabetic should be started on 250 mg daily. Because the geriatric diabetic patient appears to be more sensitive to the hypoglycemic effect of sulfonylurea drugs, older patients should be started on smaller amounts of Diabinese, in the range of 100 to 125 mg daily.

After five to seven days following initiation of therapy, dosage may be adjusted upward or downward in increments of 50 to 125 mg at intervals of three to five days. Patients who do not respond completely to 500 mg daily will usually not respond to higher doses. Maintenance doses above 750 mg daily should be avoided.

Supply: 100 mg and 250 mg, blue, 'D'-shaped, scored tablets.

More detailed professional information available on request.

Pfizer LABORATORIES DIVISION
PFIZER INC.

Leaders in Oral Diabetic Therapy

© 1981, PFIZER INC.

BOOK REVIEWS

Continued from page 354

persons being trained as preventive and rehabilitative exercise program specialists. Family physicians, as well as resident physicians, could benefit themselves and their patients by careful reading of this text. Medical students are unlikely to find it useful, unless they have an interest in sports medicine, but would benefit from reading it.

One very important point made in this book is that when performing an exercise test to determine exercise limitations in a patient on medication, the medication should not be stopped. The objective of such a test is to evaluate adequacy of disease or symptom control and to prescribe exercise appropriate to the results of therapy or to be able to change therapy. Discontinuation of therapy prior to testing subverts the purpose of such a study.

The appendices which occupy 35 percent of the book are useful reminders to everyone of the need for informed consent, medical referral, and drug effects. The list of drugs that affect exercise is helpful but not complete. All in all, we believe this small book would be a helpful addition to a physician's library.

T. E. Temple, Jr., MD
St. George T. Lee, Jr., MD
Newport News, Virginia

The Physician's Practice. John M. Eisenberg, Sankey V. Williams, Ellen S. Smith (eds). John Wiley & Sons, New York, 1980, 274 pp., \$18.50.

The intent of this reference book is to provide the practicing physician and physicians about to enter practice with an introduction to the organizational, financial, and legal aspects of practicing medicine.

The organization of the text is excellent, addressing all the major

issues of the practice of medicine, including chapters on the utilization of other health professionals. The chapters on the structure and functioning of a medical practice provide a clear and complete outline to prepare physicians entering practice with the issues to be considered in selecting or establishing a practice.

Two chapters devoted to the principles of management, planning, directing, organizational design, and change seem out of place for the scope of this book. An effort is made to introduce management models and theory, which would be better presented in a text devoted to the subject.

In general, however, the book is useful for the physician about to enter practice as a reference guide to the complex areas that need to be addressed in the conduct of the practice of medicine.

Merrill N. Werblun, MD
San Bernardino, California

Archives of Family Practice 1980 (Volume 1). John P. Geyman (ed). Appleton-Century-Crofts, New York, 1980, 413 pp, \$16.50.

In the Preface the editor states quite specifically the objectives to be accomplished in the first in a series of annual volumes, entitled *Archives of Family Practice*. The current volume focuses on three content areas: (1) evolution of family practice as a specialty, (2) undergraduate education in family medicine, and (3) clinical research in family practice. All of these topics are covered by a collection of papers in both full and abstract forms.

The editor has succeeded admirably in accomplishing his objective. He has culled through a mass of lit-

Continued on page 420

275 MG TABLETS
Anaprox[®]
(NAPROXEN SODIUM)
DOSAGE / STAT 275 275 / THEN 275
2 tab q 6-8h, prn

Brief Summary

Indications: Relief of mild to moderate pain; treatment of primary dysmenorrhea.

Contraindications: Hypersensitivity to the drug. Do not give to patients in whom aspirin or other non-steroidal anti-inflammatory drugs induce the syndrome of asthma, rhinitis, or urticaria.

Warnings: Gastrointestinal bleeding, sometimes severe, and occasionally fatal, has been reported in patients receiving the drug. Among 960 patients treated for rheumatoid arthritis or osteoarthritis, 16 cases of peptic ulceration were reported. More than half were on concomitant corticosteroid and/or salicylate therapy and about a third had a prior history of peptic ulcer. Gastrointestinal bleeding, including nine potentially serious cases, was also reported. These were not always preceded by premonitory gastrointestinal symptoms. Although most of the patients with serious bleeding were receiving concomitant therapy and had a history of peptic ulcer disease, the drug has the potential for causing gastrointestinal bleeding on its own. Administer to patients with active gastric and duodenal ulcers only under close supervision.

Precautions: General: ANAPROX[®] (NAPROXEN SODIUM) SHOULD NOT BE USED CONCOMITANTLY WITH THE RELATED DRUG NAPROSYN[®] (NAPROXEN) SINCE THEY BOTH CIRCULATE IN PLASMA AS THE NAPROXEN ANION.

In chronic studies in laboratory animals, the drug has caused nephritis. Glomerular nephritis, interstitial nephritis and nephrotic syndrome have been reported. Asymptomatic elevations of BUN and serum creatinine have also been reported; in patients with impaired renal function, the elevations may be clinically important. Use with great caution in patients with significantly impaired renal function. Monitoring of serum creatinine and/or creatinine clearance is advised in these patients.

If steroid dosage is reduced or eliminated during therapy, do so slowly and observe patients closely for adverse effects, including adrenal insufficiency and exacerbation of arthritis symptoms.

Determine hemoglobin values frequently for patients with initial values of 10 grams or less who receive long-term therapy.

Peripheral edema has been observed in some patients. Each tablet contains approximately 25 mg (1 mEq) sodium, which should be considered in patients whose overall intake of sodium must be markedly restricted. Use with caution in patients with fluid retention, hypertension or heart failure.

The antipyretic and anti-inflammatory activities of the drug may reduce fever and inflammation, thus diminishing their utility as diagnostic signs.

Conduct ophthalmic studies soon after starting therapy and at periodic intervals if the drug is used for an extended period.

Information for Patients: Caution should be exercised by patients whose activities require alertness if they experience drowsiness, dizziness, vertigo or depression during therapy.

Drug Interactions: Naproxen anion may displace other albumin-bound drugs from their binding sites and could likewise be displaced itself. Studies failed to show that the drug significantly affects prothrombin times when administered to individuals on coumarin-type anticoagulants but use caution, since interactions have been seen with other nonsteroidal agents of this class. Observe patients receiving the drug and a hydantoin, sulfonamide or sulfonyleurea for signs of toxicity to these drugs.

Probenecid given concurrently increases naproxen anion plasma levels and extends its plasma half-life significantly.

Drug/Laboratory Test Interactions: The drug may decrease platelet aggregation and prolong bleeding time.

The drug may result in increased urinary values for 17-ketogenic steroids because of an interaction between the drug and/or its metabolites with m-dinitrobenzene used in this assay. Temporarily discontinue therapy with the drug for 72 hours before adrenal function tests are performed.

The drug may interfere with some urinary assays of 5-hydroxy indoleacetic acid (5HIAA).

Carcinogenesis: A two-year study in rats to evaluate the carcinogenic potential of the drug showed no evidence of carcinogenicity.

Pregnancy: Teratogenic Effects: Pregnancy Category B. Do not use during pregnancy unless clearly needed. Avoid use during late pregnancy.

Non-teratogenic Effects: In rats, pregnancy was prolonged when the drug was given before the onset of labor; labor was protracted when it was given after labor had begun.

Nursing Mothers: Avoid use in nursing mothers.

Pediatric Use: Pediatric dosage has not been established.

Adverse Reactions:

Incidence Greater Than 1%: Gastrointestinal: The most frequent complaints related to the gastrointestinal tract: constipation,* heartburn,* abdominal pain,* nausea,* dyspepsia, diarrhea, stomatitis.

Central Nervous System: Headache,* dizziness,* drowsiness,* light-headedness, vertigo.

Dermatologic: Itching (pruritus)* skin eruptions,* ecchymoses,* sweating, purpura.

Special Senses: Tinnitus,* hearing disturbances, visual disturbances.

Cardiovascular: Edema,* dyspnea,* palpitations.

General: Thirst.

*Incidence of reported reaction 3%-9%. Reactions seen in less than 3% of the patients are unmarked.

Incidence Less Than 1%: Probable Causal Relationship: Congestive heart failure, renal disease, glomerular nephritis, interstitial nephritis, nephrotic syndrome, abnormal liver function tests, hematuria, jaundice, thrombocytopenia, leukopenia, granulocytopenia, gastrointestinal bleeding, peptic ulceration with bleeding and/or perforation, hematemesis, melena, vomiting, eosinophilia, pyrexia (chills and fever), skin rashes, menstrual disorders, myalgia and muscle weakness, alopecia, inability to concentrate, depression, malaise, dream abnormalities. **Causal Relationship Unknown:** Angioneurotic edema, agranulocytosis, aplastic anemia, hemolytic anemia, hypoglycemia, hyperglycemia, urticaria.

Overdosage: May be characterized by drowsiness, heartburn, indigestion, nausea or vomiting. Life-threatening dose is not known.

If patient ingests many tablets, empty stomach and employ usual supportive measures. Animal studies suggest that the prompt administration of 5 grams of activated charcoal would tend to reduce markedly drug absorption. It is not known if the drug is dialyzable.

Dosage and Administration for Mild to Moderate Pain and Dysmenorrhea: The recommended starting dose is two 275 mg tablets, followed by one 275 mg tablet every 6 to 8 hours, as required. The total daily dose should not exceed 5 tablets (1375 mg).

BOOK REVIEWS

Continued from page 414

erature in the three content areas and has selected those papers which best express past and current thinking in those areas.

The book is well organized and very readable. There is, of course, a variation in the style used by the different authors of the papers. This does not provide any significant distraction, however.

The current volume is a must for all family medicine educators and should be of great interest to any serious student of the subject, including medical students, family practice residents, and practicing family physicians.

William L. Stewart, MD
University of Florida
Gainesville

Let The Patient Decide (Volume 1). Louis Shattuck Baer. Westminster Press, Philadelphia, 1978, 156 pp., \$4.95.

Few books written for patients may also be recommended for physicians, but this is such a volume. Subtitled "A Doctor's Advice to Older Persons," the book sets forth in concise form the author's observations on the relationship between the physician and patient over four decades of practice. It is written from the standpoint of a family physician, although Dr. Baer is qualified in internal medicine. He states: "I have watched science make it increasingly hard for you and me to die a natural death in an American hospital."

Dr. Baer is a physician who too frequently has been enjoined to do everything he could by the family of the patient who is too ill to seriously share in the decision about the method of treatment. The rou-

Continued on page 422



SYNTEX PUERTO RICO, INC.
HUMACAO, P.R. 00661

Continued from page 420

tine care of most serious illnesses, even in the seventh, eighth, and ninth decades of life, employs intravenous fluids, antibiotics, mechanical cardiopulmonary support, control of shock, and renal dialysis. If all these measures fail, the patient will often be resuscitated, not once, but as many times as is deemed desirable by the attending physician.

This volume goes beyond right-to-die laws and living wills and sets forth the proposition that these matters are too important and serious to be left to chance or left to the decision of the attending physician without prior consultation with the patient. Such decisions can be made in a practical, realistic manner by patients cooperating with their physicians prior to the grinding fatal illness by discussing what therapy is available and how it should be employed.

Dr. Baer has some strong feelings about nursing homes and the conditions under which he would like to be admitted to a nursing home. He encourages his patients also to do some thinking to limit their therapy and to outline what modalities are available and how they might be employed.

This family physician makes a strong case for patient participation in the decisions affecting their lives. He certainly has the strength of his convictions; as he reiterates in the book, he wears a Medic Alert bracelet which states: "Positively no resuscitation, no IV, no injection, and no intubation."

The concern of the family physician, who respects his patients' wishes about medical care and joins with them in making the care the most expedient and realistic for the individual, is that the health

care delivery process is one of joining with the patient to reach optimum health care. These are all good reasons why this book should appeal to family physicians. Medical students, resident physicians, and ancillary family practice personnel would also benefit from reviewing this short volume. It is written as a series of anecdotes from Dr. Baer's own practice, which serve to illustrate how he arrived at the position that he now sets forth. There are no illustrations in the book, but there are a number of quotations at the beginning of each chapter indicating that the concern about dying and the conditions of death have long been with us and is certainly not the exclusive prerogative of physicians.

To any physician who, when caring for his patient, has examined the problems surrounding death and dying, to any physician who has had second thoughts about the management of a particularly difficult case in which the patient was unable to participate in the decisions regarding therapy of an ultimately fatal disease, to any family member who has had thoughts concerning the highly scientific, intensely technologic improvements in medical care that all too frequently have not been accompanied by similar advances in understanding, compassion, involvement, and concern for the patient, to the family physician who believes that the essence of family medicine is to be knowledgeable and understanding, a source of knowledge, and a responsible helper for patients, this book provides the beginning toward carrying out patients' wishes and applying logic to an otherwise illogical, impersonal, technologic dilemma.

Richard C. Barnett, MD
Santa Rosa, California

ACTIFED-C® EXPECTORANT

INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Lacking substantial evidence of effectiveness as a fixed combination." For the symptomatic relief of cough in conditions such as: the common cold, acute bronchitis, allergic asthma, bronchiolitis, croup, emphysema, tracheobronchitis.

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS:

Use in Newborn or Premature Infants: This drug should not be used in newborn or premature infants.

Use in Nursing Mothers: Because of the higher risk of antihistamines, codeine and sympathomimetic amines for infants generally and for newborn and premature in particular, Actifed-C Expectorant therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease: Antihistamines should **NOT** be used to treat lower respiratory tract symptoms including asthma.

Actifed-C Expectorant is also contraindicated in the following conditions:

Hypersensitivity to: 1) Triprolidine Hydrochloride and other antihistamines of similar chemical structure; 2) sympathomimetic amines including pseudoephedrine; and/or 3) any of the other ingredients.

Monoamine oxidase inhibitor therapy (see Drug Interaction Section).

WARNINGS: Actifed-C Expectorant should be used with considerable caution in patients with:

Increased intraocular pressure (Narrow angle glaucoma)	Hypertension
Stenosing peptic ulcer	Diabetes mellitus
Pyloroduodenal obstruction	Ischemic heart disease
Symptomatic prostatic hypertrophy	Hyperthyroidism
Bladder neck obstruction	

Sympathomimetics may produce central nervous stimulation with convulsions or cardiovascular collapse with accompanying hypotension.

Codeine can produce drug dependence of the morphine type, and therefore has the potential of being abused.

Use in Children: As in adults, the combination of an antihistamine and sympathomimetic amine can elicit either mild stimulation or mild sedation in children.

While it is difficult to predict the result of an *overdose* of a combination of triprolidine, pseudoephedrine, and codeine the following is known about the individual components:

In infants and children especially, antihistamine in overdose may cause hallucination, convulsion or death. Large doses of pseudoephedrine are known to cause weakness, lightheadedness, nausea and/or vomiting. An overdose of codeine may cause CNS depression with muscular twitching and convulsion, weakness, disturbed vision, dyspnea, respiratory depression, collapse and coma.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants: Triprolidine and codeine phosphate have additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness: Patients should be warned about engaging in activities requiring mental alertness as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation and hypotension in elderly patients. Overdoses of sympathomimetics in this age group may cause hallucinations, convulsions, CNS depression, and death.

PRECAUTIONS: Actifed-C Expectorant should be used with caution in patients with: history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension.

DRUG INTERACTIONS: MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines and overall effects of sympathomimetics. Sympathomimetics may reduce the antihypertensive effects of methyl dopa, decamylamine, reserpine, and veratrum alkaloids.

The CNS depressant effect of triprolidine hydrochloride and codeine phosphate may be additive with that of other CNS depressants.

ADVERSE REACTIONS:

- General:** Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose and throat.
- Cardiovascular System:** Hypotension, headache, palpitations, tachycardia, extrasystoles.
- Haematologic System:** Hemolytic anemia, thrombocytopenia, agranulocytosis.
- Nervous System:** Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions, CNS depression, hallucination.
- G.I. System:** Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.
- G.U. System:** Urinary frequency, difficult urination, urinary retention, early menses.
- Respiratory System:** Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

NOTE: Guaiifenesin has been shown to produce a color interference with certain clinical laboratory determinations of 5-hydroxyindoleacetic acid (5-HIAA) and vanillylmandelic acid (VMA).

HOW SUPPLIED: Bottles of 1 pint, 1 gallon and 4 oz. Unit of Use: Bottle with Child Resistant Cap.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709