There's More To EPOGEN* (Epoetin alfa) Than Epoetin Alfa.

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Why supplement their iron supplement?

Recommend SLOW FE® for 60% fewer GI side effects

SLOW FE has been clinically shown to reduce the chance of GI side effects vs Feosol®,* and immediate-release ferrous sulfate—including a rate of constipation almost 69% less than Feosol® and 61% less than immediate-release ferrous sulfate.² That's because SLOW FE targets iron delivery directly to the duodenum and jejunum. SLOW FE also restores hemoglobin levels 2½ times faster than Feosol.³ In addition, SLOW FE costs only 20¢ a tablet.†


* Feosol is a registered trademark of SmithKline Consumer Healthcare, L.P.
† Based on 100 cases; IBL, Oct. 1994.

Iron that needs no supplement

©1994, Ciba-Geigy Corporation
PhosLo® is indicated for control of hyperphosphatemia in end-stage renal disease. Patients with higher-than-normal serum calcium levels should be closely monitored and their dose adjusted or terminated to bring levels to normal.


Description: PhosLo® (Calcium Acetate) is a phosphate binder that reduces the absorption of dietary phosphate. Each white round tablet contains 667 mg of calcium acetate (anhydrous) equal to 169 mg calcium, and 10 mg of the inert binder, polyethylene glycol 8000.

Contraindications: Patients with hypercalcemia.

Indications and Usage: PhosLo® is indicated for the control of hyperphosphatemia in end-stage renal disease (ESRD) and does not promote aluminum absorption.

Warnings: Patients with ESRD may develop hypercalcemia when given calcium with meals. No other calcium supplements should be given concurrently with PhosLo®. Serum calcium levels should be monitored when PhosLo® therapy is started and periodically established. Safety in the elderly: No increased incidence of adverse reactions has been noted in patients over 85 years of age.

Precautions: Serum calcium and phosphate levels should be closely monitored. PhosLo® should be taken with meals to insure the mixing of calcium with dietary phosphate.

Adverse Reactions: On occasion, patients have developed nausea while taking PhosLo®, but the relationship of this adverse reaction to the drug is unclear as nausea often occurs in patients with end-stage renal disease. Mild hypercalcemia may occur in some patients, but it is easily controlled by reduction in dose or by temporarily discontinuing therapy.

Drug Interactions: The potential for hypercalcemia is increased if the patient takes other calcium supplements or calcitriol.
IRON FAST
About 40 percent of iron from IV iron dextran was bound to transferrin 11 hours after IV administration.*A
A therapeutic response can be seen in a few days as an increase in reticulocyte count.**

IRON UTILIZED
IV iron dextran supplies enough iron to permit RBC formation greater than 50 mL/day and repletion of iron stores.***

IRON CONTROL
Total iron dose to restore normal hemoglobin and provide adequate replenishment of iron stores can be determined and administered by professionals to assure accurate delivery to patients.

Test Dose: Prior to receiving their first INFED® (Iron Dextran Injection, USP 50 mg/mL) therapeutic dose, all patients should be given an intravenous or intramuscular test dose of 0.5 mL. (See PRECAUTIONS: General section of the prescribing information.) The IV test dose should be administered at a gradual rate over at least 30 seconds. Although anaphylactic reactions known to occur following INFED® administration are usually evident within a few minutes, or sooner, it is recommended that a period of an hour or longer elapse before the remainder of the initial therapeutic dose is given. Other hypersensitivity reactions include dyspnea, urticaria, other rashes and itching. Please see prescribing information under Warnings, Precautions and Adverse Reactions for a complete listing of side effects.

Iron Dextran Injection should be used with extreme care in patients with serious impairment of liver function and with caution in individuals with histories of significant allergies and/or asthma.

IRON CLAD
INFED® is reimbursable therapy for iron-deficiency anemia.

*Study done in general population.
**A study of 481 subjects who received 2,099 IV iron dextran injections indicates this result. Each injection usually contained 250 to 500 mg of iron dextran, administered at a rate of less than 100 mg/min. Side effects observed: three life-threatening immediate anaphylactic and eight severe delayed reactions. There were no deaths.


For documented iron-deficiency anemia not amenable to oral therapy

INFED® Now in convenient, easy-to-use vials
Iron Dextran Injection, USP 50 mg/mL
Replaces Iron Rapidly

Please see prescribing information including the boxed WARNING on following page.
AFTER SUTURING FROM DRSNUC: INFLAM.

**DESCRIPTION:** Rho (D) Immune Globulin (Human) is a serum protein that contains antibodies against the Rh antigen D.

**INDICATIONS:**
- Used for prophylaxis to prevent HDFN in Rh D-negative mothers who have received Rh-positive fetal cells through a previous pregnancy or transfusion.
- Used for treatment of Rh sensitization in Rh D-negative mothers during subsequent pregnancies.

**CONTRAINDICATIONS:**
- Hypersensitivity to Rh immune globulin.
- Pregnancy with Rh D-negative fetus.

**ADVERSE REACTIONS:**
- Local effects: Pain, swelling, redness, itching, induration, macules.
- Systemic effects: Rash, pruritus, urticaria, fever, chills, nausea, vomiting, headache, dizziness, hypertension.
- Rare: Anaphylaxis, tingling, respiratory distress, urticaria, angioedema, hypotension.

**WARNINGS:**
- Use in patients with a history of anaphylaxis or severe hypersensitivity reactions to Rh immune globulin.
- Use with caution in patients with a history of hypotension.

**DOSAGE AND ADMINISTRATION:**
- Adults: 300 units per injection.
- Children: 150 units per kg of body weight.

**PRECAUTIONS:**
- Use with caution in patients with a history of anaphylaxis or severe hypersensitivity reactions to Rh immune globulin.
- Use with caution in patients with a history of hypotension.

**INTERACTIONS:**
- No significant drug interactions have been reported.

**RECOMMENDATIONS:**
- Administer as a single dose.
- Use within 6 months of the first injection.

**PATIENT INSTRUCTIONS:**
- Instruct patients to report any signs of hypersensitivity reactions.
- Instruct patients to avoid contact with other pets or animals.

**STORAGE:**
- Store at 2-8°C (36-46°F) in the original carton.

**REFERENCES:**

**NOTES:**
- This information is based on the latest available data and may change as new information becomes available.
Black and Older Hypertensives Are Similar, Yet Different.

So Are Calcium Channel Blockers.

"Johnny K. and Mack L. share more than their love of the blues."
Consider the Similarities and the Differences Before Selecting a Calcium Channel Blocker.

**Consider pathophysiology**

Calcium channel blockers are well-suited to address the unique pathophysiology of black and older hypertensives, e.g.,

- Increased peripheral vascular resistance
- Low plasma renin activity

**Consider concomitant conditions**

- COPD
- Peripheral vascular disease
- Diabetes mellitus
- Osteoarthritis

**Consider therapeutic profile**

- Nifedipine, unlike verapamil, rarely causes constipation
- Nifedipine, unlike diltiazem or verapamil, rarely, if ever, affects AV conduction or SA automaticity
- Nifedipine, unlike diltiazem or verapamil, has only modest negative inotropic effects *in vitro* which rarely, if ever, are seen clinically

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**Once-A-Day**

Adalat® CC

**Extends Release Tablets**

30mg, 60mg & 90mg

---

**Real Therapeutic Value**

- Demonstrated efficacy in black and older hypertensives

**Real Human Value**

- Once-daily regimen that's convenient and well-tolerated
- Frequency and type of side effects are typical of dihydropyridine calcium channel blockers. The dose-dependent incidence of peripheral edema was 18%-29% vs. 10% for placebo and for headache was 16%-22% vs. 13% for placebo. Flushing/heat sensation, dizziness, and fatigue/asthenia were each reported at an incidence of 4%
Are You a Member?

The Council on the Kidney in Cardiovascular Disease is one of the American Heart Association's 14 Scientific Councils. These Councils represent bodies of scientific knowledge important to the mission of the AHA which is to reduce disability and death due to cardiovascular diseases and stroke.

An Invitation to Join

The Council on the Kidney in Cardiovascular Disease of the American Heart Association

As a member of the Council you will:
- Contribute your knowledge and expertise to the advancement of renal issues within the AHA.
- Participate as a valued volunteer in a dynamic national organization.
- Receive council newsletters and reduced subscription rates to the AHA's journals.
- Receive important information regarding research funding and patient education material.
- Receive reduced admission to the AHA Scientific Sessions and other Council-sponsored meetings.

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- Travel Awards
- Co-sponsorship (with ASN) of Young Investigator Award
- Co-sponsorship of Research Symposia

For Customer Service call (214) 706-1310 or FAX (214) 691-6342

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The Journal of the American Society of Nephrology will publish original manuscripts judged by peers to be of high quality and relevant to the broad field of Nephrology. Nephrology is an alliance of scientists and physicians who seek to understand the functions of the kidneys and the means to improve the medical care of individuals with renal disease. The strength and vitality of the discipline radiate, historically, from the dynamic interaction between the basic and the clinical sciences. The Journal strives to nurture this relationship by providing the means for communicating to nephrologists and others in related specialties critical information of broad significance in the field. Subjects appropriate for the Journal include, but are not restricted to:

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- renal and epithelial physiology
- biochemistry
- pathology and immunology
- cellular and molecular biology
- renal pathophysiology
- body fluid
- electrolyte and acid-base metabolism
- hypertension
- dialysis
- renal transplantation

General Information

Manuscripts are of four types: Concise Reports, Comprehensive Studies, Comments and Letters to the Editor.

Concise Reports should contain in not more than 2500 words (including abstract, figures, tables and references) important new observations of sufficient interest to nephrologists to warrant rapid publication. Comprehensive Studies are traditional full length papers that address research questions with exhaustive experimental design and methodology. Comments are brief reports limited to fewer than 1000 words (including introductory paragraph describing the origins and chief conclusions, one figure or table, and fewer than 15 references) that are preliminary, negative or confirmatory. Highly innovative technical advances will be considered. Letters to the Editor should be confined to brief scientific commentary about articles published in JASN or to topics of general interest to nephrologists. Reviews of basic and clinical topics of interest to the readership will be solicited by the editors.

In the cover letter, designate one author as correspondent. All coauthors should have contributed in substantial ways to the study and manuscript preparation.

Include in the cover letter a statement explaining why the research is especially important. It is at this stage that claims of new or novel findings (“This is the first . . .”) should be mentioned, not within the text of the paper. The journal office may solicit editorials to accompany articles that are especially newsworthy or controversial.

Include in the cover letter the names, addresses, telephone and areas of expertise of at least five individuals (peers) who may serve, at the discretion of the editors, as reviewers of the manuscript.

American Renal Training Centers

This series is to serve as a forum for concise yet comprehensive updates on a subject of current interest in clinical nephrology, centered around a patient presentation. The articles are to be authored by fellows in training under the guidance of a senior faculty member. The manuscripts should include:

- A brief focused patient presentation. If pertinent a radiologic or histologic figure can complement it.
- Background—not to exceed one paragraph.
- Review of clinical and pathologic presentation of the entity.
- An overview of the etiology and the pathogenetic mechanism of the disease.
- Review of therapeutic approaches.
- A summary—conclusion paragraph that contains a “take home message”, and if at all possible, reverts back to the patient.
- No more than three tables or figures that confer a critical message or summarise information from various sources.
- References should not exceed 20.
- The overall length of the communication should not exceed 15 double-spaced typewritten pages.

Copyright Transfer: Include one of the following statements on copyright interests signed by all authors.

"In consideration of the American Society of Nephrology’s taking action in reviewing and editing this submission, the author(s) undersigned hereby transfer(s), assign(s) or otherwise convey(s) all copyright ownership to the ASN in the event this work is published by the ASN.

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description of methods may be included in the table or figure legends. **Letters to the Editor** will be edited and shortened in consultation with the author.

* On the **title page** type the full names, highest academic degrees and affiliations of all the authors. The title should not exceed 100 characters and spaces. Include an abbreviated title of not more than 40 characters and spaces.

* **Abstract:** State the problem considered, methods, results, and conclusions in less than 250 words. List 5 index terms not included in the title.

* Use of Systeme International d'Unites (SI) for measurements is preferred throughout the manuscript. Factors for converting frequently used components can be found in JAMA (1989;262:200–202).

* Use generic names of drugs.

* Do not use abbreviations in the title or abstract. Define unusual abbreviations on the first use in the body of the manuscript. A list of accepted abbreviations can be found in the July and January issues of JASN.

* Text footnotes should be typed on a separate page.

* Foreign contributors, whose language is not English, should obtain help from colleagues who are proficient in scientific English.

* It is assumed that all clinical investigation described in the manuscript was conducted in accordance with the guidelines proposed in the Declaration of Helsinki. Document in the manuscript that informed consent was obtained.

* It is assumed that all animal experimentation described in the manuscript was conducted in accordance with the NIH Guide for the Care and Use of Laboratory Animals, and the manuscript should contain a statement to that effect.

**Tables:** Double-space on separate sheets of standard-sized white bond paper. Title all tables and number in order of appearance in the text. Footnotes may include methods in Concise Reports and Comments. Use superscript letters to indicate footnotes typed at the bottom of the table.

**Figures:** Include clear photocopies of the figures with the **original and each copy** of the manuscript as well as three sets of 5 × 7 inch glossy photographs for all line drawings, clearly labeled on the back. Graphs must be of professional quality: computer-generated graphs should be of laser quality. High contrast prints for roentgenographic photographs and electron micrographs are essential; halftones may be custom printed on special paper from engravings approved by the author and at the author's expense. Photomicrographs should be sized to fit one column (8 cm) or two columns (17 cm); the maximum plate size is 17 × 22 cm. Legends should state degree of magnification of scale bars should be used on the photograph and specified in the length.

**References:** Cite in numerical order, only one reference to a number. Citation of unpublished observations or personal communications (include separately permission to quote from appropriate individual) should be placed in the text in parentheses.

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3. Include in cover letter: a) copyright transfer statement. b) list of five candidates for peer review.

4. Include all authors' personal signatures.

5. Designate a corresponding author and provide a telephone number and address.

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STABILITY

Matters

Low Absorption . . . Is It Putting Some Transplant Patients in Jeopardy?

A diabetic renal transplant recipient has low cyclosporine bioavailability—a situation that puts the patient at risk for acute rejection—despite therapeutic trough blood levels and a mean Sandimmune dosage >4 mg/kg per day.

This type of posttransplantation management challenge can occur in diabetics, as well as in children, blacks, and pregnant women. These patients often share a common problem: suboptimal bioavailability of Sandimmune® (cyclosporine/Sandoz) due to insufficient absorption and/or increased clearance. This problem may put them at increased risk of acute and chronic rejection—as well as graft loss.1-6

Bioavailability appears to play a key role in predicting clinical outcome in transplant patients, as demonstrated in a study by Schroeder and colleagues.5 Based on a pharmacokinetic profile taken approximately 1 month posttransplantation, patients who later developed acute rejection displayed lower cyclosporine bioavailability than those who did not, despite the administration of a higher Sandimmune dosage.5 During most of the 5-year follow-up period, cyclosporine blood levels were also lower in patients who developed chronic rejection, compared with those who were rejection free, despite similar dosages.5

Increasing Sandimmune Dosages in “Low Absorbers” May Improve Outcome

When it comes to dosing Sandimmune® (cyclosporine/Sandoz), low absorbers—including diabetics, children, blacks, and pregnant women—may require higher mean dosages.14 For example, in a large-scale study of pregnant renal transplant recipients enrolled in The National Transplant Pregnancy Registry, those with stable graft function had higher mean Sandimmune dosages before, during, and after pregnancy compared with those with graft dysfunction. These patients also had higher birth-weight newborns and a decreased risk of graft loss within 2 years of delivery.6

Interestingly, mean Sandimmune dosages ≥4 mg/kg per day do not compromise safety. Over the long term, renal, cardiac, and liver transplant recipients have shown stable renal function at these mean optimal dosages.7-9

In short, when faced with the posttransplantation management challenge of low cyclosporine bioavailability, increasing the Sandimmune dosage may help achieve greater stability in thousands of transplant recipients.

Cyclosporine bioavailability: impact on acute and chronic rejection (N=95).5

AUC = Area under the time-vs.-concentration curve.

Because experience is critical

Please see references and brief summary of prescribing information on the following page.

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Indications: Cyclosporine is indicated primarily for the prophylaxis of organ rejection in kidney, heart, and lung allograft recipients. It is also used to treat various conditions such as chronic graft-versus-host disease, psoriasis, and Crohn's disease.

Contraindications: Patients with a history of hypersensitivity to cyclosporine or any other components of the medication should not be treated with this drug, including products with specific microencapsulation and cigarette smoking.

Warnings: Cyclosporine is associated with an increased risk of malignancy and effect on female fertility. It may also cause hypertension and neoplasms. Patients with a history of malignancy should not be treated with this drug.

Superior OR solution (cyclosporine oral solution, USP) is indicated in the prophylaxis of organ rejection in kidney, heart, and lung allograft recipients. It is also used to treat various conditions such as chronic graft-versus-host disease, psoriasis, and Crohn's disease.

Contraindications: Patients with a history of hypersensitivity to cyclosporine or any other components of the medication should not be treated with this drug, including products with specific microencapsulation and cigarette smoking.

Warnings: Cyclosporine is associated with an increased risk of malignancy and effect on female fertility. It may also cause hypertension and neoplasms. Patients with a history of malignancy should not be treated with this drug.
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Name of Applicant

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Present Hospital and/or University Appointments (titles and departmental affiliations)

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Primary Professional Identification, e.g., Internist, Biochemist, Physiologist, Urologist, etc.

________________________________________

Professional Education and Training (College and Graduate Schools)

Institutional Name/Address

Degrees

Dates

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Training in Nephrology (Give inclusive dates for residences, fellowships, other relevant post-graduate education)

Institutional Name/Address

Position

Preceptor(s)

Inclusive Dates

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(Over)
List your five *most significant* publications.

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Describe your clinical experiences as a specialist and consultant in kidney disease and related conditions that would provide basis for qualification of membership.

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List other societies to which you belong.

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American Society of Nephrology
1200 19th St, NW
Suite 300
Washington, DC 20036-2401
ARTICLES

The Birth of a Clinical Practice Guideline in Nephrology: Renal Transplant Candidate Evaluation

What is an appropriate evaluation for a patient who desires to have a renal allograft? Thanks to the Patient Care and Education Committee of the American Society of Nephrology, we now have the blueprint of a transplant evaluation guideline. This is a monumental contribution to the field, and although it was researched by many highly qualified transplant physicians, some nephrologists will undoubtedly disagree with material that has been included or argue that critical information has been omitted. It is, however, a start and a good one at that. JASN will be most interested to know the reaction of our readers and will provide an opportunity for dialogue in the “Letters to the Editor” section.

Megalin and Receptor-Associated Protein: A Renal Disease State Leads to the Discovery of New Molecules With Physiologic and Pathologic Functions

Membranous nephropathy is one scourge of the clinician: insidious, persistent, and all-to-often a pathologic curiosity that leads to kidney failure. Years ago, Heymann created a membranous-like lesion in the glomeruli of rats by parenterally injecting antigens derived from the proximal tubule. Heymann nephropathy (HN) has been the subject of countless research reports, culminating in two important articles in this issue of JASN. A review and an original article by Farquhar and her colleagues describes the structure and function, both physiologic and pathologic, of two proteins, megalin (formerly called gp330) and RAP (receptor-associated protein), which binds to megalin. Using an antibody to megalin that does not recognize RAP, the authors have shown that antibody specific for megalin induces the formation of subepithelial deposits and that antibodies eluted from these deposits recognize only megalin and not RAP. Thus, the studies demonstrate convincingly that megalin as well as RAP contains a nephritogenic epitope relevant to the formation of subendothelial deposits. A hypothesis is proposed for the sequence of events underlying the molecular mechanisms of immune deposit formation. In the last analysis, this model of human membranous nephropathy may have finally matured sufficiently to be useful in the development of strategies to interrupt the course of the disease.

Assessing Nutritional State with Bioelectrical Impedance Analysis

Malnutrition is common among dialysis patients, but methods to reliably assess nutritional state are difficult to apply and expensive. Body cell mass, the body compartment most relevant to nutrition and metabolism, was measured in stable hemodialysis patients by dual x-ray absorbiometry and D2O and NaBr isotope dilution and compared with bioelectrical impedance analysis (BIA). A high degree of correlation was obtained, and the coefficient of variation of repeated BIA measurements was quite low. BIA is advanced as a valid and reliable method for nutritional assessment in chronic hemodialysis.

Metabolic Explanation for Fatigue in Chronic Renal Failure

Abnormalities of muscle energy metabolism in chronic renal failure relate to alterations in the enzymes of the major energy-providing pathways, leading to oxidative metabolism. This potentially explains the muscle fatigue of uremia.

Mineral Metabolism, Blood Pressure, and Race in Pediatric End-Stage Renal Disease

Using the resource of the Growth Failure in Children with Renal Diseases Clinical Trial, it was shown that blood pressure, calcium and phosphorous, and parathyroid hormone correlations were different in black and white children with renal failure. Chronic renal failure imposes variations in the common interrelationship between mineral metabolism, blood pressure, and race in children.
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- The most common side effects are headache and edema

Brief Summary
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CONTRAINDICATIONS: NORVASC is contraindicated in patients with known sensitivity to amlodipine.

WARNINGS: Increased Angina and/or Hypertensive Interchange: Paradoxically, patients, particularly those with severe obstructive coronary artery disease, have developed documented increased frequency, duration and/or severity of anginal pain, and severe myocardial infarction following initial channel blocker therapy or at the time of dose increase. The mechanism of this effect has not been elucidated.

PRECAUTIONS: General: Since the vasodilatation induced by NORVASC is gradual in onset, acute hypotension has not been reported after one administration. Nonetheless, caution should be exercised when NORVASC is administered concomitantly with other antihypertensives, especially with beta-blockers. Intracoronary administration of NITRODILATE or any other peripheral vasodilator particularly in patients with severe aortic stenosis should be approached with caution and with continuous ECG monitoring. Use with Congestive Heart Failure: Although there were no clinical studies and a controlled trial of NITRODILATE in Class II-III heart failure patients have shown that NORVASC did not lead to clinical deterioration as measured by exercise tolerance, left ventricular function, and clinical symptomatology determined in clinical hypertension, patients have not been performed with NYHA Class II-III heart failure. In general, all channel blockers should be used with caution in patients with heart failure.

Beta-Blocker Withdrawal: NORVASC is not a beta-blocker and therefore gives no protection against the dangers of abrupt beta-blocker withdrawal. Any such withdrawal should be by gradual reduction of the dose of the beta-blocker.

Patients with Neonatal or Neonatal Failure: Since NORVASC is extensively metabolized by the liver and has a half-life (t½) of 11.6 hours in patients with impaired hepatic function, caution should be exercised when administering NORVASC to patients with severe hepatic impairment.

Drug Interactions: In vitro data in human plasma indicate that NORVASC has no effect on the protein binding of drugs tested (digoxin, phenytoin, warfarin, and indomethacin). Special studies have indicated that the co-administration of NORVASC with digoxin did not change serum digoxin levels or digoxin clearance in normal volunteers. That co-administration with cimetidine did not alter the pharmacokinetics of NORVASC, and that co-administration with warfarin did not change the warfarin prothrombin time.

In clinical trials, NORVASC has been safely administered with thiazide diuretics, beta-blockers, angiotensin converting enzyme inhibitors, long-acting nitrate, sublingual nitrates, digoxin, warfarin, non-steroidal anti- inflammatory drugs, antibiotics, and oral hypoglycemic drugs.

Drug/Laboratory Test Interactions: None known.

Caution: Pregnancy, Nursing Mothers, and Patients with Renal Function: Rare and mice treated with amlodipine (males 64 days and females 14 days prior to mating) at doses of up to 10 mg/m²/day (8 times the maximum recommended human dose of 10 mg on a mg/m² basis) were close to the maximum tolerated dose for mice but not rats. MENITY studies revealed no drug related effects at any gene or chromosomal levels. There was no effect on the ratio of males to females at 10 mg/m²/day and any angina patients in the test for two years, at concentrations calculated to provide daily dosage levels of 0.5, 1.25, and 2.5 mg/day/day showed no evidence of carcinogenicity. The highest dose (135 mg/m²/day) was to the maximum tolerated dose for mice but not rats.

Malignancy studies revealed no drug related effects at either the gene or chromosomal level.

Other adverse reactions which were not clearly dose related but were reported with an incidence greater than one in 100 placebo-controlled clinical trials include the following: headache (13.1%, compared with 7.6% placebo), fatigue (4.5%, compared with 2.4% placebo), nausea (1.2%, compared with 0.3% placebo), somnolence (1.6%, compared with 0.8% placebo), and dyspnea (1.1%, compared with 0.8% placebo).

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References

Pfizer

Labs • NHO • Pratt • Roerig
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More detailed professional information available on request.
American Society of Nephrology
Board Review Course

August 24-30, 1996

COURSE DIRECTOR: Robert G. Narins, M.D.

LOCATION: San Francisco
Sheraton Palace Hotel
2 New Montgomery Street
San Francisco, CA 94105

OBJECTIVE: This week-long, in-depth review of nephrology and hypertension can be used to prepare for the Nephrology Board examination (Nov. 1996) or as a timely and extensive update. CME credits will be provided.

FACULTY: Nationally renowned speakers will be selected for their teaching skills and past performance in similar courses.

SYLLABUS: Outlines of all lectures and copies of key slides will be provided.

FORMAT: Lectures, interactive workshops, computer-assisted programs, and special, small group question and answer sessions will be integrated into the program. Relevant physiology and pathophysiology will be blended with clinical discussions aimed at reviewing, updating and preparing for the 1996 Nephrology Boards.

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Conference Co-Chairs:
Eric G. Neilson, M.D.
Terry B. Strom, M.D.

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