NORVASC®
(amlodipine besylate)

© 1995, Pfizer Inc.

Please see brief summary of prescribing information on last page.
HIGH RATE OF SUCCESS IN AN NIH-SPONSORED STUDY

83% of hypertensive patients—the highest percentage—remained on initial therapy with NORVASC® (amlodipine besylate) after 4 years; nearly all patients were on the 5-mg starting dose.

LOW RATE OF DISCONTINUATION

ONLY 1.5% of patients in placebo-controlled studies (n=1730) discontinued therapy due to adverse effects.

PROVEN SAFETY

No negative inotropic effects at clinical doses in hemodynamic studies.*

No clinically significant effect on cardiac conduction or heart rate.**

*Similar hemodynamic findings, however, have been observed with agents possessing significant negative inotropic effects.

**5-mg and 10-mg tablets

Once-Daily NORVASC® (amlodipine besylate)

EFFICACY AND SAFETY THAT'S EASY TO LIVE WITH
In hypertension or angina, convenient once-daily dosing

• The usual starting dose is 5 mg in hypertension or angina.
  — In hypertension, small, fragile, or elderly individuals or patients with hepatic insufficiency may be started on 2.5 mg once daily.
• Titration can proceed to 10 mg.
  — Most angina patients will require 10 mg.
• Can be taken with or without food.
• The most common side effects are headache and edema.

Once-Daily NORVASC (amlodipine besylate)

Efficacy and safety that's easy to live with

References

In hypertension or angina, convenient once-daily dosing

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Once-Daily NORVASC (amlodipine besylate)

Efficacy and safety that's easy to live with

References
INSTRUCTIONS TO AUTHORS

Send manuscripts to the Editor:

Jared J. Grantham, M.D.
JASN
University of Kansas Medical Center
3901 Rainbow Blvd.
Kansas City, Kansas 66160-7361

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:

- clinical nephrology
- 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 summarize 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 two 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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These signatures, that must accompany the cover letter, indicate that each author approved the final version of the manuscript and is prepared to take public responsibility for the work.

It is the policy of the Journal to expedite the review process. Authors will receive within 10 days of receipt at the editorial office, acknowledgment that their manuscript has been forwarded to an associate editor and reviewing editors. Manuscripts that are judged by a panel of screening editors to fall outside the range of interest of the readership or that fail to satisfy technical requirements will be promptly returned to the authors without further review. In order to reduce postage expense, manuscripts sent to outside reviewers as privileged communications will be destroyed and not returned to the authors. Glossy prints and photographs from rejected manuscripts will be returned to authors. Authors who have not received formal notification of manuscript review status 21 days following acknowledged receipt at the editorial office are encouraged to contact the editorial office for a status report.

Manuscript Preparation

- Submit an original manuscript and three photocopies, typed double-spaced in letter-quality print on one side only of standard (8½ × 11 inch) white bond paper.
- Manuscripts submitted as Concise Reports and Comprehensive Studies should be organized as follows: title page, abstract, introduction, methods, results, discussion, acknowledgments, tables, legends to figures, and references. Comments should contain: title page; introductory paragraph; methods, results and discussion; acknowledgments; table or figure legend; and references. A brief
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 graphite 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 accord 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 standardized 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 or 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.

* **Journal articles, abstracts and books**: List all authors when six or fewer; when seven or more, list only the first three and add et al. Journal names should be abbreviated according to the BIOSIS list of serials.


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The journal does not assume responsibility for errors in conversion of customized software, newly released software, and special characters. Mathematics and tabular material will be processed in the traditional manner.

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2. Send three sets of glossy print figures: each manuscript set should contain photocopies of figures.

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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Choosing a hemodialysis catheterization route can present a troubling clinical dilemma. On one hand, you may want to sidestep the risk of subclavian stenosis by using the internal jugular (IJ) vein. But on the other hand, the IJ approach could put your patient at increased risk of catheter-related infection—which is especially significant since hemodialysis patients already have one of the highest rates of catheter-related bacteremia.

Adding to the problem is the fact that each infection can cost $16,000 to treat, lengthen stays by days and weeks, and increase patient discomfort.

Now there’s an ideal solution: Arrow’s new IJ hemodialysis catheter with ARROWgard Blue* and its molecularly bonded antiseptic surface treatment.

Independent research has shown that ARROWgard Blue* reduces the incidence of bacteremia in central venous catheters by up to 80 percent—so choosing ARROWgard Blue* now can dramatically reduce the morbidity, mortality, and expense these infections can cause later.

Beyond its colonization-resistant surface, Arrow’s IJ hemodialysis catheter does even more. It combines the pliability of the Arrow Blue FlexTip* with the exceptional indwelling characteristics of Arrow polyurethane. Its sturdy extension lines curve to one side for increased patient comfort and easier maintenance. Its movable suture ring facilitates thorough cleaning.

Add the Arrow* Raulerson Syringe** for simpler spring-wire placement, the Arrow UserGard™ injection cap system for essentially needle-free sticks and the SharpsAway™ needle disposal cup for extra security, and you have perhaps the most intelligently designed IJ hemodialysis catheter kit on the market.

To learn more about Arrow’s new IJ hemodialysis catheter and how ARROWgard Blue* can save your hospital thousands of dollars a year in infection control costs, call your Arrow representative or contact us directly by calling 800 523-8416 or 610 378-0131.
Abbreviations and Symbols

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tr>
<td>A (not OD)</td>
<td>absorbance (A = \log 1/T)</td>
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<tr>
<td>ADP</td>
<td>adenosine diphosphate</td>
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<td>AMP</td>
<td>adenosine monophosphate</td>
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<td>ATN</td>
<td>acute tubular necrosis</td>
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<td>ATP</td>
<td>adenosine triphosphate</td>
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<td>AMPase, ADPase, ATPase</td>
<td>adenosine phosphatases</td>
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<td>standard atmosphere</td>
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<td>BSA</td>
<td>bovine serum albumin</td>
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<td>becquerel</td>
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<td>blood urea nitrogen</td>
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<td>Celsius</td>
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<td>cAMP, cGMP, etc.</td>
<td>cyclic AMP, cyclic GMP, etc.</td>
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<tr>
<td>cDNA</td>
<td>complementary DNA</td>
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<tr>
<td>cm, cm², cm³</td>
<td>centimeters</td>
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<td>CMP, CDP, CTP</td>
<td>cytidine phosphates</td>
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<td>r</td>
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<td>counts per minute</td>
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<td>cps</td>
<td>counts per second</td>
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<td>deoxyribonucleic acid</td>
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<td>DPN or NAD</td>
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<td>milligrams/mL</td>
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<td>N</td>
<td>normal (concentration); number (statistics)</td>
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<td>NMR</td>
<td>nicotinamide mononucleotide</td>
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<td>Ni</td>
<td>nuclear magnetic resonance</td>
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<td>Ω</td>
<td>ohm</td>
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<td>osM</td>
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<td>p</td>
<td>inorganic phosphate</td>
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<tr>
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<td>pico-</td>
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<tr>
<td>p₄</td>
<td>para-, in chemical name</td>
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<tr>
<td>%</td>
<td>per cent</td>
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<tr>
<td>PRA</td>
<td>plasma renin activity</td>
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<td>radioimmunoassay</td>
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<td>S</td>
<td>Siema, Sverdberg unit</td>
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<td>standard deviation</td>
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<td>t test</td>
<td>Student's &quot;t&quot; test</td>
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<td>sc</td>
<td>subcutaneous (ly)</td>
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<td>SUN</td>
<td>serum urea nitrogen</td>
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<td>T₂₁₂</td>
<td>throphophoryridine nucleotide</td>
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<tr>
<td>TPFH or NADH</td>
<td>triphosphoryridine nucleotide, reduced</td>
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<tr>
<td>Tris</td>
<td>form of</td>
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<tr>
<td>TPA or NADP⁺</td>
<td>tris (hydroxymethyl) aminomethane</td>
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<td>transfer RNA</td>
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<td>uridine phosphates</td>
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<td>vol/vol</td>
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<tr>
<td>wt/vol</td>
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<td>weight ratio</td>
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<tr>
<td>x</td>
<td>mean</td>
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<td>XMP, XDP, XTP</td>
<td>xanthosine phosphates</td>
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<td>yr</td>
<td>year</td>
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</table>
Application for Membership

Name of Applicant

LAST  FIRST  MIDDLE

PREFERRED MAILING ADDRESS

CITY  STATE  ZIP CODE

BUSINESS ADDRESS (if not listed above)

CITY  STATE  ZIP CODE

( )  ( )

BUSINESS TELEPHONE  BUSINESS FAX

Date of Birth  Sex  Country of Citizenship

If you reside in the U.S., but are not a U.S. citizen, please state type of visa

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

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

Professional Education and Training (College and Graduate Schools)

Institutional Name/Address  Degrees  Dates

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

Institutional Name/Address  Position  Preceptor(s)  Inclusive Dates

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

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

List other societies to which you belong.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Provide names and addresses of three persons from whom letters of reference may be requested if needed.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The first year dues (payable to the ASN in U.S. funds) of $100 for active members or $115 for corresponding members should accompany this completed application. If you would like to pay by Visa or MasterCard, please list the cardholder’s name, number and expiration date below:

☐ Visa  ☐ MasterCard

Cardholder’s Name *(please type or print)*  Signature

Card Number  Expiration Date

☐ Check here if you are applying for Corresponding Membership. Corresponding Membership is available to those who meet the qualifications for Active Membership, but are not residents of North or Central America. Corresponding Members will receive all Society mailing and member discounts, but they do not have the right to vote or hold office.

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

An Early Warning Sign of Acute Renal Tubular Injury
Nephrologists depend on rather crude indicators of renal dysfunction to guide therapy in a host of renal disorders. A detectable decrease in creatinine clearance may not be obvious until a major fraction of renal parenchyma has been destroyed. While so-called "micro-albuminuria" (low but abnormally elevated rates of increased albumin excretion) is an improved forecaster of a glomerular filtration disorder, especially in diabetes mellitus, nephrologists also need equivalents of the plasma prostate specific antigen test to signal small increases in renal mass or the serum transaminase test for hepatitis to announce subtle forms of renal inflammation.

A candidate for such an early warning sign of acute tubular injury is reported by Fink and colleagues in this issue of JASN. Bone marrow transplantation is associated with a very high rate of acute renal failure under the best of circumstances (see also Leblond et al., this issue). N-acetyl-β-D-glucosaminidase (NAG), a lysosomal enzyme too large to undergo ready glomerular filtration, was found to be excreted in increased amounts in the urine of all patients who had received bone marrow transplants, whether they were azotemic or not. Thus, increased excretion of NAG could be a sensitive indicator of trouble in the proximal tubules well before the damage is serious enough to decrease GFR or cause acute renal damage.

Apoptosis Strikes Again! This Time in Dialysis Membranes
There is something about apoptosis—programmed cell death—that stirs a nephrologist’s soul and imagination. A report by Carracedo and colleagues in this issue of JASN adds a new dimension to the biocompatibility discussion by demonstrating that exposure of either circulating human mononuclear cells or a human mononuclear cell line to a bioincompatible dialysis membrane (cuprophan) leads to cell aggregation and apoptotic cell death. Conversely, a biocompatible membrane (polyacrylonitrile) did not induce these effects. Cuprophan-triggered apoptosis was increased by cell pretreatment with a phorbol ester and was largely blocked by staurosporin, suggesting that apoptosis utilized a phosphokinase-C-dependent pathway. The involvement of endonucleases in apoptosis was suggested by the finding that ZnSO₄ induced protection. This interesting study suggests that there may be differences in the rate of programmed death after exposure of cells to different types of dialysis membranes.
For documented iron-deficiency anemia
not amenable to oral therapy

The direct route to rapid iron replacement
IRON FAST
About 40 percent of iron from IV iron dextran was bound to transferrin 11 hours after IV administration.1*
A therapeutic response can be seen in a few days as an increase in reticulocyte count.2**

IRON UTILIZED
IV iron dextran supplies enough iron to permit RBC formation greater than 50 mL/day and repletion of iron stores.3*

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.
1A study of 488 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 anaphylactoid and eight severe delayed reactions. There were no deaths.
3Hamstra RD. Blood MBI, Schuchet AL. Intravenous iron dextran in clinical medicine. JAMA. 1980;244(17):1716-1717.

Schein Pharmaceutical

For documented iron-deficiency anemia not amenable to oral therapy

INFEd® Iron Dextran Injection, USP 50 mg/mL
Replaces Iron Rapidly

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Now in convenient, easy-to-use vials
**INF-4**

**THROMBECTOMY**

**REFERENCES**

The use of antiplatelet and antithrombotic agents has resulted in a reduction of stroke risk after acute ischemic stroke. However, the risk of recurrence is still significant, particularly in patients with peripheral arterial disease. The use of antiplatelet and antithrombotic agents in this population is crucial for reducing the risk of recurrent stroke and improving outcomes. This article discusses the current evidence and recommendations for the use of antiplatelet and antithrombotic agents in patients with peripheral arterial disease.

**CONTRIBUTIONS**

The contributions of each author are recognized in the manuscript.

**INDICATIONS AND RISKS**

This section outlines the indications for the use of antiplatelet and antithrombotic agents and the potential risks and side effects associated with their use.

**Adverse Reactions**

Many adverse reactions associated with the use of antiplatelet and antithrombotic agents are noted in this section.

**ADDITIONAL INFORMATION**

Further information and references related to antiplatelet and antithrombotic agents are provided in this section.

**TABULAR DATA**

This table provides a summary of the evidence for the use of antiplatelet and antithrombotic agents in peripheral arterial disease.

---

<table>
<thead>
<tr>
<th>Patient Population</th>
<th>Recommended Dose (mg)</th>
<th>Dose (mg)</th>
<th>Effectiveness</th>
<th>Adverse Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute ischemic stroke</td>
<td>500</td>
<td>369</td>
<td>33%</td>
<td>10%</td>
</tr>
<tr>
<td>Chronic stable angina</td>
<td>100</td>
<td>75</td>
<td>28%</td>
<td>15%</td>
</tr>
<tr>
<td>Peripheral arterial disease</td>
<td>75</td>
<td>25</td>
<td>25%</td>
<td>15%</td>
</tr>
</tbody>
</table>

---

**CONCLUSIONS**

The use of antiplatelet and antithrombotic agents in peripheral arterial disease is crucial for reducing the risk of recurrent stroke and improving outcomes. Further research is needed to determine the optimal dose and duration of therapy for these patients.
Black and Older Hypertensives Are Similar, Yet Different.

So Are Calcium Channel Blockers.

"Eddie P. and Victor D. have more in common than harness racing."
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

---

**Once-A-Day**

**Adalat® CC**

**nifedipine**

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%
Real Economic Value

- Lower Average Wholesale Price (AWP)* than frequently-prescribed, once-daily calcium channel blockers
- Adalat CC is not indicated for angina. It should be taken on an empty stomach. As with all distinct pharmacologic entities, switching from one to another necessitates careful titration and patient monitoring.

Real Value for Real People with Hypertension

Projected annual savings* per hypertensive patient for recommended initial doses of frequently-prescribed, once-daily calcium channel blockers*12

<table>
<thead>
<tr>
<th>Medication</th>
<th>Cost of annual therapy based on initial dose</th>
<th>Potential annual patient savings with Adalat® CC*</th>
<th>Percent potential annual patient savings with Adalat® CC*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adalat® CC</td>
<td>$317.70</td>
<td>$132.00</td>
<td>29%</td>
</tr>
<tr>
<td>Procardia XL®</td>
<td>$449.64</td>
<td>$119.57</td>
<td>27%</td>
</tr>
<tr>
<td>Cardizem® CD</td>
<td>$437.27</td>
<td>$112.56</td>
<td>26%</td>
</tr>
<tr>
<td>Norvasc®</td>
<td>$430.26</td>
<td>$94.24</td>
<td>23%</td>
</tr>
<tr>
<td>Calan® SR</td>
<td>$411.94</td>
<td>$75.26</td>
<td>19%</td>
</tr>
<tr>
<td>Verelan®</td>
<td>$392.96</td>
<td>$61.39</td>
<td>16%</td>
</tr>
</tbody>
</table>

Procardia XL (nifedipine) and Norvasc (amlodipine besylate) are registered trademarks of Pfizer Labs Division, Pfizer Inc. Cardizem CD (diltiazem HCl), Calan SR (verapamil HCl), Verelan (verapamil HCl), and Dilacor XR (diltiazem HCl) are registered trademarks of Marion Merrell Dow Inc., G.D. Searle & Co., Lederle Laboratories, a Division of American Cyanamid Co., and Rhône-Poulenc Rorer Pharmaceuticals Inc., respectively.

* Calculations based on suggested Average Wholesale Price (AWP).12 AWP is from a published price list and may or may not represent the actual price to pharmacists or consumers.

Real Value for Real People with Hypertension

“Save up to $132* a year? I could get the awning for my mobile home.”

“What can I do with $132*? I'd buy an air conditioner for the bedroom.”

Please see brief summary of Prescribing Information on next page.
Once-A-Day

Adalat®

nifedipine

RELEASED

TABLETS

30mg, 60mg & 90mg

BRIEF SUMMARY

CONFIDENTIAL.

P3500061/S

3/95

INDICATION AND USAGE: ADALAT CC is indicated for the treatment of hypertension. It may be used alone or in combination with other antihypertensive agents.

CONTRAINDICATIONS:

ADALAT CC is contraindicated in patients with a history of hypersensitivity to nifedipine.

WARNINGS:

1. Excessive Hypotension: Although in most patients the hypotensive effect of nifedipine is modest and well tolerated, occasionally patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during the initial dose adjustment phase, and may be more likely in patients using combination beta-blockers. Severe hypotension and/or increased fluid volume requirements may have been reported in rare instances in patients treated with a beta-blocking agent and who underwent coronary artery bypass surgery using high dose inhalation anesthetics. In these patients, nifedipine was added to a background regimen of furosemide, the purpose being to optimize renal function in preoperative preparation. This regimen has been shown to raise blood pressure and diuresis. Hypovolemia and fluid depletion might be less important in these patients, who are already volume depleted and sodium depleted. As anesthetic agents were discontinued, hypotension occurred.

2. Nitrate Intolerance: ADALAT CC contains nitrate. This drug may be contraindicated in patients with a history of sensitivity to nitrate drugs.

3. Flushing: ADALAT CC may cause flushing. Inverse relation of degree of flushing to nifedipine dose has been observed. This may be lessened by presccting ADALAT CC 30 mg or 60 mg tablets only. In patients taking 90 mg tablets, the flushing may be more severe. It may be necessary to discontinue ADALAT CC if flushing is not controlled.

4. Severe Hypotension: ADALAT CC is not indicated for treatment of severe hypotension.

5. Hypotension and/or Increased Fluid Volume Requirements: ADALAT CC may increase the likelihood of congestive heart failure, particularly in patients with right ventricular dysfunction, or in patients with constrictive pericardial disease.

6. Patients with Significant Renal Impairment: ADALAT CC is not indicated for patients with renal impairment.

7. Patients with Marked Hepatic Dysfunction: ADALAT CC is not indicated for patients with marked hepatic dysfunction.

8. Patients with Cardiac Pacemakers: ADALAT CC is not indicated for patients with cardiac pacemakers.

9. Use of ADALAT CC in Patients with Severe Underlying Renal Disease: ADALAT CC is not indicated for patients with severe underlying renal disease.

10. Use of ADALAT CC in Patients with Severe Underlying Hepatic Disease: ADALAT CC is not indicated for patients with severe underlying hepatic disease.

11. Use of ADALAT CC in Patients with Severe Underlying Cardiac Disease: ADALAT CC is not indicated for patients with severe underlying cardiac disease.

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13. Use of ADALAT CC in Patients with Severe Underlying Endocrine Disease: ADALAT CC is not indicated for patients with severe underlying endocrine disease.

14. Use of ADALAT CC in Patients with Severe Underlying Metabolic Disease: ADALAT CC is not indicated for patients with severe underlying metabolic disease.

15. Use of ADALAT CC in Patients with Severe Underlying Neurological Disease: ADALAT CC is not indicated for patients with severe underlying neurological disease.

16. Use of ADALAT CC in Patients with Severe Underlying Psychiatric Disease: ADALAT CC is not indicated for patients with severe underlying psychiatric disease.

17. Use of ADALAT CC in Patients with Severe Underlying Ophthalmological Disease: ADALAT CC is not indicated for patients with severe underlying ophthalmological disease.

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