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NORVASC®
(amlodipine besylate)
Binds twice as much phosphate as equivalent amounts of calcium carbonate.\textsuperscript{1,2}

- Reimbursable under Medicaid and other state and private insurance programs.
- Tablets are swallowed, not chewed.
- No threat of aluminum toxicity.\textsuperscript{3,4}

PhosLo\textsuperscript{\textregistered} 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.


Editors: 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 4000.

Contraindications: Patients with hypercalcemia.

Indications and Usage: PhosLo\textsuperscript{\textregistered} 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\textsuperscript{\textregistered}. Serum calcium levels should be monitored when PhosLo\textsuperscript{\textregistered} therapy is started and periodically established. Safety in the elderly: no increased incidence of adverse reactions has been noted in patients over 65 years of age.

Precautions: Serum calcium and phosphate levels should be closely monitored. PhosLo\textsuperscript{\textregistered} should be taken with meals to minimize the mixing of calcium with dietary phosphate.

Adverse Reactions: On occasion, patients have developed nausea while taking PhosLo\textsuperscript{\textregistered}, 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 this patient takes other calcium supplements or calcitonin.
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.1,6
A therapeutic response can be seen in a few days as an increase in reticulocyte count.2,6

IRON UTILIZED
IV iron dextran supplies enough iron to permit RBC formation greater than 50 mL/day and repletion of iron stores.3,7

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 461 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.


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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.
**INDICATIONS:***

Patients with iron deficiency anemia or intramuscular injections of iron dextran are indicated for treatment of patients with documented iron deficiency in whom oral administration is unabsorbable or impossible. Administration of iron by intravenous routes is not feasible. MDS should be used only to the product. All adrenals are not absorbed with iron deficiency.

**WARNINGS:***

A risk of cardiovascular death may be associated with the intramuscular injection of iron-dextran complexes. Such complexes have been found under experimental conditions to produce asparagine when large doses of dextran is expected repeatedly at the same site given to rats, mice, and monkeys, and possibly in humans. The risk has been shown to depend on the concentration of the detectable iron. Large intravenous doses of as such used with total dose titrations (TDD), have been associated with an increased incidence of adverse reactions. Many adverse effects reported by delayed (2-7 days) reactions (1.5-2 months) reactions and/or death of the following priority to the cardiovascular system: tachycardia, chest pain, chest discomfort, moderate to high fever, headache, malaise, myalgia, nausea, and vomiting. The one-time intramuscular injection (i.m.) reported in addition to the following intramuscular injection and generally outside 3-7 days. These reactions are not known. The potential for a pseudoallergic reaction to iron dextran is high risk.

The maximum daily dose should not exceed 2 ml iron dextran. This iron dextran is contraindicated in patients with a history of severe anaphylactic or skin reactions.

It should not be used during the acute phase of infectious kidney disease.

Administration of iron or intravenous therapy with iron-poor iron will cause excess storage of iron with the consequent possibility of exogenous hemosiderosis. Such iron overload is particularly apt to occur in patients with hemosiderosis and other hemosiderosis associated diseases. The intramuscular injection of iron dextran should be used with caution. The patient's medical condition and the severity of the anemia should be considered in the treatment decision. MDS should be used only to the product. All adrenals are not absorbed with iron deficiency.

**PRECAUTIONS:***

Patients with iron deficiency anemia should be observed for a week after successful treatment as well as the therapeutic doses of iron dextran injections. Therefore, administration of subsequent test doses during therapy should be considered (See DOSAGE AND ADMINISTRATION).

Epinephrine should always be immediately available in the event of acute hypersensitivity reactions. (Usual adult dose 0.5-1 ml of 1% epinephrine, 0.042 ml of 0.2 mg/kg of body weight may be used to treat anaphylactic reactions associated with the use of iron dextran in patients who may respond adequately to epinephrine, but not to other or similar beta-receptor agonists are required to manage patients and children.) Patients with hemorrhagic anemia may have an acute exacerbation of anaphylactic shock and swelling following the administration of iron-dextran. Reactions may occur in children and have been reported in children. The intramuscular injection of iron dextran in neonates has been associated with an increased incidence of gram-negative sepsis, possibly due to the administration of iron-dextran. Infusion For Pediatric Patients: Should be observed if the potential adverse reactions associated with the use of iron-dextran. Rare blood tests (TITD or LD) (1-2 ml) or more) have been commonly known in adults, with a known iron from a blood sample drawn from 4 hours after administration. The iron dextran is not available to determine changes in serum iron levels of serum calcium and decreases in levels of serum calcium. Serum iron determinations (especially by colorimetric assays) may not be meaningful for 3 weeks following the administration of iron dextran injection.

Serum ferritin peaks approximately 7 to 9 days after intramuscular doses of iron dextran and slowly returns to baseline after about 3 weeks.

Examination of the bone marrow for iron stores may not be meaningful for prolonged periods following iron dextran therapy because of the redistribution of iron and iron storage in the reticuloendothelial system.

Bone marrows involving 8-10% of dextran have shown to decrease, increase, and activity in the interval, coupled with the intramuscular injection of iron dextran. Increased iron stores with this iron dextran injection has not changed.

Bone marrows with TCD-staining negative bone seeking agents, in the presence of high ferritin levels or following iron dextran injection, and iron dextran administration results in an increased activity, and decreased iron and bolus iron use.

**Contraindications:***

Iron deficiency anemia. Inability to absorb iron from food. Administration of iron dextran is not glucosamine in infants who are being given iron dextran therapy. Iron should be considered for premature infants who are being given iron dextran therapy. Iron should be considered for premature infants and children with low birthweight, iron deficiency, and iron deficiency anemia.

**Precautions:***

It is advisable to administer Iron to children younger than 12 months of age.

**ADVERSE REACTIONS:***

Most of the adverse reactions associated with the use of iron dextran in large doses in the presence of a high ferritin level or in the presence of a high ferritin level. The reactions are no difference in well-controlled clinical trials in pregnant women. Iron dextran should be used by the potential only if the patient has a history of anaphylactic or skin reactions to iron dextran.

**Pleasant Tres:***

Various animal studies and studies in pregnant humans have demonstrated inconclusive results with respect to the potential transfer of iron dextran as iron dextran. It appears that some iron does reach the fetus, but the form in which it is transported is not known.

**Hemolysis:***

Caution should be exercised when MDS is administered to a nursing woman. Transfusions of unirradiated iron dextran are contraindicated in hemolytic disease.

**Pediatric Use:***

Not recommended for use in infants under 4 months of age. (See DOSAGE AND ADMINISTRATION.)

**Lactation:***

Iron dextran does not appear to be transferred to milk in the breast milk. Bone marrow involvement with the use of iron dextran in children has been reported. Preterm neonates and iron stores in premature infants are not available to determine changes in serum iron levels of serum calcium and decreases in levels of serum calcium.

**Adverse Effects:***

Iron deficiency anemia. Iron deficiency anemia is the most common cause of anemia. Iron deficiency anemia is common in infants and children, particularly in those who are born prematurely. Iron deficiency anemia is the most common cause of anemia in infants and children, particularly in those who are born prematurely.

**Bleeding:***

Various animal studies and studies in pregnant humans have demonstrated inconclusive results with respect to the potential transfer of iron dextran as iron dextran. It appears that some iron does reach the fetus, but the form in which it is transported is not known.

**Hemolysis:***

Caution should be exercised when MDS is administered to a nursing woman. Transfusions of unirradiated iron dextran are contraindicated in hemolytic disease.

**Pediatric Use:***

Not recommended for use in infants under 4 months of age. (See DOSAGE AND ADMINISTRATION.)

**Lactation:***

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**Adverse Effects:***

Iron deficiency anemia. Iron deficiency anemia is the most common cause of anemia. Iron deficiency anemia is common in infants and children, particularly in those who are born prematurely. Iron deficiency anemia is the most common cause of anemia in infants and children, particularly in those who are born prematurely.
Introducing
the new wave in
growth hormone
therapy
THE LIQUID SO
New Nutropin AQ™
[somatropin (rDNA origin) injection]

May improve dosing accuracy
Eliminates reconstitution
Reduces product waste
Leading the way in growth hormone therapy

Indicated for the long-term treatment of children with growth failure due to a lack of adequate endogenous growth hormone secretion and the treatment of children who have growth failure associated with chronic renal insufficiency up to the time of renal transplantation.
Therapeutic regimens requiring reconstitution are more complicated, which may lead to dosing errors that may go undetected until a patient's follow-up visit to his or her physician.

By eliminating reconstitution, Nutropin AQ greatly simplifies the preparation of growth hormone, which in turn may reduce training time.

Nutropin AQ can be used for 28 days after initial vial entry, compared to 14 days for reconstituted lyophilized growth hormone, resulting in less product waste for some patients.

Genentech has made a long-term commitment to offer the latest advances in growth management products and programs to the pediatric endocrinology and nephrology communities. Nutropin AQ is the most recent example of our commitment.

Patients being treated with this and other growth hormone products, and/or their parents, should be informed of the potential benefits and risks associated with growth hormone therapy.

- Intracranial hypertension (with papilledema, visual changes, headache, nausea, and/or vomiting) has been reported in a small number of patients treated with growth hormone.
- Patients should be advised to seek prompt medical attention if allergic reactions occur.
- Testing for antibodies to human growth hormone should be carried out in any patient who fails to respond to therapy.
- Patients should be encouraged to report the development of a limp or complaints of hip or knee pain.
- Leukemia has been reported in a small number of growth hormone-deficient patients treated with growth hormone; however, experts cannot conclude that growth hormone therapy is responsible for these occurrences. The risk, if any, remains to be established.
- Growth hormone should not be used in subjects with closed epiphyses or in patients with active neoplasia.

For more information on Nutropin AQ, please contact your Genentech sales representative.
May improve dosing accuracy...

Eliminates reconstitution...

Reduces product waste...

Leading the way in growth hormone therapy....

New Nutropin AQ™
[somatropin (rDNA origin) injection]
**Nutropin® (somatropin [DNA origin])**

**DESCRIPTION**
Nutropin® (somatropin, DNA origin) is a human growth hormone (hGH) produced by recombinant DNA technology. Nutropin® has 174 amino acids and a molecular weight of 22,123 daltons. Nutropin® is a heterogenous mixture of growth hormone growth factors that can be secreted in the presence of pituitary-derived growth hormone. The protein is purified by a specific laboratory process in a column that is then preconcentrated into a sterile, protein solution. Nutropin® is a highly purified preparation. Biological potency is determined by measuring the increase in height of 7 to 12-year-old children with short stature. Nutropin® contains no more than 1% of other somatomedin C, which is a constituent of growth hormone. Nutropin® is a form of recombinant growth hormone, and its biological activity is based on the amino acid sequence of growth hormone.

**CLINICAL PHARMACOLOGY**

**Actions and Effects**

**Growth Hormone**

Nutropin® has been demonstrated to be effective in the treatment of children who lack adequate endogenous growth hormone secretion with Nutropin®The administration of growth hormone to children who lack adequate endogenous growth hormone secretion at various ages has led to increases in mean height and weight, growth and overall skeletal development. Nutropin® is effective in the treatment of children who lack adequate endogenous growth hormone secretion.

**Bone Density**

Children and adults with chronic renal failure (CRF) tend to have decreased clearance as compared to normal. However, no hGH accumulation has been reported in children with CRF. In adults with CRF, there is a reduction in growth hormone clearance. However, this effect is not significant enough to cause clinical problems.

**Growth Hormone**

Intravenous administration of Nutropin® has been demonstrated to be safe and effective. Nutropin® has been demonstrated to be effective in the treatment of children who lack adequate endogenous growth hormone secretion. Nutropin® has been demonstrated to be effective in the treatment of children who lack adequate endogenous growth hormone secretion at various ages has led to increases in mean height and weight, growth and overall skeletal development. Nutropin® is effective in the treatment of children who lack adequate endogenous growth hormone secretion.

**PHARMACOKINETICS**

**Absorption**

Nutropin® is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption. Nutropin® is a form of recombinant growth hormone, and its biological activity is based on the amino acid sequence of growth hormone.

**Distribution**

Nutropin® is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption.

**Metabolism**

Nutropin® is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption.

**Excretion**

Nutropin® is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption.

**ADVERSE REACTIONS**

**Local Reactions**

The most common adverse reactions reported were injection-site reactions (11% of patients). The following adverse events have been reported with the use of hGH: injection-site reaction, pain, swelling, redness, and the use of the product. The product is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption. The product is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption.

**Systemic Adverse Reactions**

The most common adverse reactions reported with the use of hGH are injection-site reactions (11% of patients). The following adverse events have been reported with the use of hGH: injection-site reaction, pain, swelling, redness, and the use of the product. The product is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption. The product is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption.

**SPECIAL POPULATIONS**

**Pediatric Patients**

Intravenous administration of Nutropin® does not appear to affect the growth or development of the product. The product is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption.

**Geriatric Patients**

Nutropin® is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption. The product is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption.

**Patients With Renal Impairment**

Nutropin® is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption. The product is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption.

**Patients With Diabetes Mellitus**

Nutropin® is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption. The product is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption.

**Patients With Thyroid Disease**

Nutropin® is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption. The product is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption.

**Hormone Resistance**

Nutropin® is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption. The product is administered subcutaneously. The product is rapidly absorbed in the plasma membrane of the cells. The onset of response is variable in nature, as is the rate of response and the rate of absorption.

**OVERDOSAGE**

**Symptoms**

The symptoms of hGH overdose are as follows: dizziness, headache, nausea, vomiting, stomachache, gastrointestinal distress, hypertension, tachycardia, tachypnea, flushing, and hyperglycemia.

**Treatment**

The treatment of hGH overdose includes supportive therapy, such as decreasing the rate of infusion, discontinuing the treatment, and administering fluids and electrolytes. If necessary, atropine and/or corticosteroids may be administered. In severe cases, mechanical ventilation may be required. In severe cases, mechanical ventilation may be required. In severe cases, mechanical ventilation may be required. In severe cases, mechanical ventilation may be required.
Their iron therapy shouldn’t be:

**Recommend SLOW FE™ for 60% fewer GI side effects.**

On average, your dialysis patients spend roughly 500 tough hours dialyzing each year. So why should they spend 1 extra minute with GI upset? Consider SLOW FE. It's been clinically proven to reduce GI side effects compared to other leading iron supplements—including a rate of constipation almost 69% less than Feosol® and 61% less than immediate-release ferrous sulfate. That's because SLOW FE delivers iron directly to the duodenum and jejunum, which increases absorption and reduces the incidence of side effects. SLOW FE also restores hemoglobin levels 2 1/2 times faster than Feosol.3

Also available: SLOW FE™ Slow Release Iron + Folic Acid.


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Compliance and Calcijex® (Calcitriol Injection):
A clinical advantage as significant as the therapy itself.

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You have seen it all too often: the dialysis patient who is unable or unwilling to follow your calcitriol therapy regimen.

But because Calcijex is administered by injection at the end of each dialysis session, it ensures complete patient compliance with your calcitriol therapy plan. Even patients with many medications can be assured of appropriate Calcijex therapy.

Injectable Calcijex also delivers a high peak serum level of calcitriol which affords important pharmacokinetic benefits, especially in the early stages of renal osteodystrophy.¹

At your request, your Abbott Renal Care representative can review current opinion and practices regarding compliance and high peak serum levels in calcitriol therapy. Your representative also has details of upcoming symposia and other events that will further broaden the information base available to you and your staff.

BRIEF SUMMARY

Calcijex® (calcitriol injection) is indicated in the management of hypocalcemia in patients undergoing chronic renal dialysis. It has been shown to significantly reduce elevated parathyroid hormone levels. Reduction of PTH has been shown to result in an improvement in renal osteodystrophy.

INDICATIONS AND USAGE

Calcijex® (calcitriol injection) is indicated in the management of hypocalcemia in patients undergoing chronic renal dialysis. It has been shown to significantly reduce elevated parathyroid hormone levels. Reduction of PTH has been shown to result in an improvement in renal osteodystrophy.

CONTRAINDICATIONS

Calcijex® (calcitriol injection) should not be given to patients with hypercalcemia or evidence of vitamin D toxicity.

WARNINGS

Since calcitriol is the most potent metabolite of vitamin D available, vitamin D and its derivatives should be withheld during treatment. A non-aluminum phosphate-binding compound should be used to control serum phosphorus levels in patients undergoing dialysis.

Overdose of any form of vitamin D is dangerous (see also OVERDOSAGE). Progressive hypercalcemia due to overdosage of vitamin D and its metabolites may be so severe as to require emergency attention. Chronic hypercalcemia can lead to generalized vascular calcification, nephrocalcinosis and other soft-tissue calcification. The serum calcium times phosphate (Ca × P) product should not be allowed to exceed 70. Radiographic evaluation of suspect anatomical regions may be useful in the early detection of this condition.

PRECAUTIONS

1. General

Excessive dosage of Calcijex® (calcitriol injection) induces hypercalcemia and in some instances hypercalcitriaemia. Therefore, early in treatment during dosage adjustment, serum calcium and phosphorus should be determined at least twice weekly. Should hypercalcemia develop, the drug should be discontinued immediately.

2. Information for the Patient

The patient and his or her parents should be informed about adherence to instructions about diet and calcium supplementation and avoidance of the use of unapproved non-prescription drugs, including magnesium-containing antacids. Patients should also be carefully informed about the symptoms of hypercalcemia (see ADVERSE REACTIONS).

3. Laboratory Tests

Serum calcium, phosphorus, magnesium and alkaline phosphatase and 24-hour urinary calcium and phosphorus should be determined periodically. During the initial phase of the medication, serum calcium and phosphorus should be determined more frequently (twice weekly).

4. Drug Interactions

Magnesium-containing antacid and Calcijex should not be used concomitantly, because such use may lead to the development of hypermagnesemia.

5. Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term studies in animals have not been performed to evaluate the carcinogenic potential of Calcijex (calcitriol injection). There was no evidence of mutagenicity as studied by the Ames Method. No significant effects of calcitriol on fertility were reported using oral Calcitriol.

6. Use in Pregnancy: Pregnancy Category C

Calcitriol given orally has been reported to be teratogenic in rabbits when given in doses 4 to 15 times the dose recommended for human use.

All 15 fetuses in 3 litters at these doses showed external and skeletal abnormalities. However, none of the other 22 litters (156 controls) showed significant abnormalities compared with controls. Teratology studies in rats showed no evidence of teratogenic potential. There are no adequate and well-controlled studies in pregnant women. Calcijex should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

7. Nursing Mothers

It is not known whether this drug is secreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from calcitriol, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

8. Pediatric Use

Safety and efficacy of Calcijex in children have not been established.

ADVERSE REACTIONS

Adverse effects of Calcijex® (calcitriol injection) are, in general, similar to those encountered with excessive vitamin D intake. The early and late signs and symptoms of vitamin D intoxication associated with hypercalcemia include:

1. Early

Weakness, headache, somnolence, nausea, vomiting, dry mouth, constipation, muscle pain, bone pain and metallic taste.

2. Late

Polyuria, polydipsia, anorexia, weight loss, nocturia, conjunctivitis (calcitic), pancreatitis, phlebitis, rhabdomyolysis, hyperthermia, decreased libido, elevated BUN, albuminuria, hypercalcemia, elevated SGOT and SGPT, epptic calcification, hypercalcemia, cardiac arrhythmias and, rarely, overt psychosis.

Occasional mild pain on injection has been observed.

OVERDOSAGE

Administration of Calcijex® (calcitriol injection) to patients in excess of their requirements can cause hypercalcemia, hypercalcitriaemia and hyperphosphataemia. High intake of calcium and phosphate concomitant with Calcijex may lead to similar abnormalities.

1. Treatment of Hypercalcemia and Overdose in Patients on Hemodialysis

General treatment of hypercalcemia (greater than 1 mgl/l above the upper limit of normal range) consists of immediate discontinuation of Calcijex therapy, institution of a low calcium diet and withdrawal of calcium supplements. Serum calcium levels should be determined daily until normalisation ensues. Hypercalcemia usually resolves in two to seven days. When serum calcium levels have returned to within normal limits, Calcijex therapy may be recommenced at a dose 0.5 mcg less than prior therapy. Serum calcium levels should be obtained at least twice weekly after all dosage changes.

Persistent or markedly elevated serum calcium levels may be corrected by dialysis against a calcium-free dialysate.

2. Treatment of Accidental Overdose of Calcitriol Injection

The treatment of acute accidental overdosage of Calcijex should consist of general supportive measures. Serial serum electrolyte determinations (especially calcium), rate of urinary calcium excretion and assessment of the electrocardiographic abnormalities due to hypercalcemia should be obtained. Such monitoring is critical in patients receiving digitalis. Discontinuation of supplemental calcium and low calcium diet are also indicated in accidental overdose. Due to the relatively short duration of the pharmacological action of calcitriol, further measures are probably unnecessary. Should, however, persistent and markedly elevated serum calcium levels occur, there are a variety of therapeutic alternatives which may be considered. Depending on the patients' underlying condition, these include the use of drugs such as phosphates and corticosteroids as well as measures to induce an appropriate forced diuresis. The use of peritoneal dialysis against a calcium-free dialysate has also been reported.

HOW SUPPLIED

Calcijex® (calcitriol injection) is supplied in 1 mL ampuls containing 1 mcg (Lot No. 1230) or 2 mcg (Lot No. 1120). Protect from light.

Store at controlled room temperature 15° to 30°C (59° to 86°F).

Caution: Federal (USA) law prohibits dispensing without prescription. See complete Professional Use information before prescribing.

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TUMS costs only 8¢ a tablet, which is comparable to generics and less expensive than other brands of calcium.‡

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(Chewable calcium carbonate)
A Superior Source of Calcium

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There's a powerful attraction between quality and clinical results.

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Introducing a high quality, highly consistent, and clinically tested intravenous iron from a leader in quality parenterals.

The safety and efficacy of new DEXFERRUM have been established with ESRD patients on Epoetin alfa in controlled, multi-center trials.

American Regent Laboratories, known for quality parenterals throughout the U.S., supports the dialysis community with services such as a reimbursement hotline and a patient assistance program. Our clinical support specialists are dedicated to helping you achieve optimum patient outcomes.

Now you can prescribe injectable iron with a new measure of confidence. Because with new DEXFERRUM, the connection between quality care and clinical results is virtually inseparable.

The parenteral use of iron-carbohydrate complexes has resulted in anaphylactic-type reactions and death. Therefore, DEXFERRUM should not be administered to patients amenable to oral iron therapy.
New DEXFERRUM®
(IRON DEXTRAN INJECTION, USP)
The quality choice.

Please see brief summary of the prescribing information on the following page.
DEXFERRUM®
(IRON DEXTRAN INJECTION, USP)

WARNING
THE PARENTERAL USE OF COMPLEXES OF IRON AND CARBOHYDRATES HAS RESULTED IN ANAPHYLACTIC-TYPE REACTIONS. DEATHS ASSOCIATED WITH SUCH ADMINISTRATION HAVE BEEN REPORTED. THEREFORE, DEXFERRUM® SHOULD BE USED ONLY IN THOSE PATIENTS IN WHOM THE INDICATIONS HAVE BEEN CLEARLY ESTABLISHED AND LABORATORY INVESTIGATIONS CONFIRM AN IRON DEFICIENT STATE NOT AMENABLE TO ORAL IRON THERAPY.

DESCRIPTION: DEXFERRUM® (IRON DEXTRAN INJECTION, USP) is a dark brown, slightly viscous sterile liquid complex of ferric hydroxide and a low molecular weight dextran derivative for intravenous use. Each ml contains: 50 mg elemental iron as an iron dextran complex. Sodium chloride may be added for tonicity. Vetrex for injection q.s. pH adjusted to 2.2 - 6.5 with hydrochloric acid and, if necessary, sodium hydroxide. Sterile, nonpyrogenic. Therapeutic Class: Hematotic.

INDICATIONS AND USAGE: DexFerrum is indicated for treatment of patients with documented iron deficiency in whom oral administration is unsatisfactory or impossible.

CONTRAINDICATIONS: Hypersensitivity to the product. All anemias not associated with iron deficiency.

WARNINGS: See BOXED WARNING.

A risk of carcinogenesis may attend the intramuscular injection of iron-carbohydrate complexes. Such complexes have been found under experimental conditions to produce sarcoma when large doses or small doses injected repeatedly at the same site were given to rats, mice, and rabbits, and possibly in hamsters. The long latent period between the injection of a potential carcinogen and the appearance of a tumor makes it impossible to measure accurately the risk in man. There have, however, been several reports in the literature describing tumors at the injection site in humans who had previously received intramuscular injections of iron-carbohydrate complexes. Large intravenous doses, such as used with total dose infusions (TDI), have been associated with an increased incidence of adverse effects. The adverse effects frequently are delayed (1-2 days) reactions typified by one or more of the following symptoms: arthralgia, backache, chills, dizziness, moderate to high fever, headache, malaise, myalgia, nausea, and vomiting. The onset is usually 24-48 hours after administration and symptoms generally subside within 3-4 days. The etiology of these reactions is not known. The potential for a delayed reaction must be considered when estimating the risk/benefit of treatment. The maximum daily dose should not exceed 2 ml undiluted iron dextran. This preparation should be used with extreme care in patients with serious impairment of liver function.

It should not be used during the acute phase of infectious kidney disease. Adverse reactions experienced following administration of DexFerrum may exacerbate cardiovascular complications in patients with pre-existing cardiovascular disease.

PRECAUTIONS: General: Unwarranted therapy with parenteral iron will cause excess storage of iron with the consequent possibilities of exogenous hemosiderosis. Such iron overload is particularly apt to occur in patients with hemoglobinopathies and other refractory anemias that might be erroneously diagnosed as iron deficiency anemia.

DexFerrum should be used with caution in individuals with histories of significant allergies and/or asthma. Anaphylaxis and other hypersensitivity reactions have been reported after unwarranted test doses or doses following use of iron dextran injection. Therefore, administration of subsequent test doses during therapy should be considered. (See DOSAGE AND ADMINISTRATION: Administration.)

Epinephrine should be immediately available in the event of acute hypersensitivity reactions. (Usual adult dose: 0.5 ml of a 1:1000 solution, by subcutaneous or intramuscular injection.)

Preparations containing sodium sulfite should be avoided in patients with sulfite-sensitive asthma. Patients with rheumatoid arthritis may have an acute exacerbation of joint pain and swelling following the administration of DexFerrum.

Information For Patients: Patients should be advised of the potential adverse reactions associated with the use of DexFerrum.

Drug/Laboratory Test Interactions: Large doses of iron dextran (5 ml or more) have been reported to give a brown color to serum from a blood sample drawn 4 hours after administration. The drug may cause falsely elevated values of serum bilirubin and falsely decreased values of serum calcium.

Serum iron determinations (especially by calorimetric assay) may not be meaningful for 3 weeks following the administration of iron dextran.

Serum ferritin levels slowly return to baseline after about 3 weeks.

Examination of the bone marrow for iron stores may not be meaningful for prolonged periods following iron dextran therapy because residual iron dextran may remain in the reticuloendothelial cells.

Bone scans with 99mTc-labeled bone seeking agents, in the presence of high serum ferritin levels or following iron dextran infusion, have been reported to show reduction of bony uptake, marked renal activity, and excessive blood pool and soft tissue accumulation.

Carcinogenesis, Mutagenesis, Impairment Of Fertility: See WARNINGS.

Pregnancy: Teratogenic Effects. Pregnancy Category C: Iron dextran has been shown to teratogenic in mice and rats. Toxicity to the embryo/fetal has not been determined in rats and/or mice. Infusions containing 50 mg of elemental iron/kg or less have been administered to pregnant rabbits, rats, and hamsters without evidence of harm. Therefore, DexFerrum should be used during pregnancy only if the potential benefit justifies the potential risks to the fetus.

Placental Transfer: Various animal studies and studies in pregnant humans have demonstrated invariable results with respect to the placental transfer of iron dextran in iron deficient. It appears that some iron does reach the fetus, but the form in which it crosses the placenta is not clear.

Puerperal Use: Iron dextran is not cleared from the maternal circulation and is excreted in human milk.

Pediatric Use: Not recommended for use in infants under 4 months of age (See DOSAGE AND ADMINISTRATION).

ADVERSE REACTIONS: Severe/Fatal: Anaphylactic reactions have been reported with the use of iron dextran injection; on occasions these reactions have been fatal. Such reactions, which occur most often within the first several minutes of administration, have been generally characterized by sudden onset of respiratory difficulty and/or cardiovascular collapse. (See boxed WARNING and PRECAUTIONS: General, pertaining to immediate availability of epinephrine.)

Cardiovascular: Chest pain, chest tightness, shock, hypotension, hypertension, tachycardia, flushing, and/or hypertension may occur from too rapid injections by the intravenous route.

Dermatologic: Urticaria, pruritus, purpura, rash.

Gastrointestinal: Abdominal pain, nausea, vomiting, diarrhea.

Hematologic/Lymphatic: Leukopenia, lymphopenia.

Musculoskeletal/Soft Tissue: Arthritis, arthralgia, may represent reactivation in patients with quiescent rheumatoid arthritis - See PRECAUTIONS: General, myalgia; backache; sterile abscess; brown skin and/or underlying tissue discoloration (staining); cellulitis; swelling; inflammation; local phlebitis at or near intravenous injection site.

Neurologic: Convulsions, seizures, syncope, headache, weakness, unresponsiveness, porencephaly, febrile episodes, chills, dizziness, disorientation, numbness.

Respiratory: Respiratory arrest, dyspnea, bronchospasm.

Urologic: Hematuria.

Delayed Reactions: Arthralgia, backache, chills, dizziness, fever, headache, malaise, myalgia, nausea, vomiting (See WARNINGS).

Miscellaneous: Febrile episodes, sweats, shivering, chills, malaise, altered taste.

DOSAGE AND ADMINISTRATION: Oral iron should be discontinued prior to administration of DexFerrum. DexFerrum should not be administered intramuscularly.

Administration: Intravenous Injection: PRIOR TO RECEIVING THEIR FIRST DEXFERRUM THERAPEUTIC DOSE, ALL PATIENTS SHOULD BE GIVEN AN INTRAVENOUS TEST DOSE OF 0.5 ml. (See PRECAUTIONS: General.) THE TEST DOSE SHOULD BE ADMINISTERED AT A GRADUAL RATE OVER AT LEAST 5 MINUTES.

See full prescribing information for instructions on administration and dosage.

NOTE: Do not mix DexFerrum with other medications or add to parenteral nutrition solutions for intravenous infusion.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever the solution and container permit.

HOW SUPPLIED: DexFerrum® (Iron Dextran Injection, USP) containing 50 mg of elemental iron (as Fe) is available in 2 ml single dose vials (for intravenous use) in cartons of 10 (NDC 0517-2324-10).

Store at controlled room temperature 15° - 30°C (59° - 86°F).

CAUTION: Federal law prohibits dispensing without prescription.

See product package insert for full prescribing information.

INDICATIONS:

AMERICAN REGENT LABORATORIES, INC.
One Luitpold Drive, Shirley, New York 11967
Phone: (800) 645-1706, Fax: (516) 924-1731
http://www.luitpold.com

DEXFERRUM Reimbursement Hotline: (800) 282-7712*
*In Washington, D.C., metropolitan area: (202) 942-2453.
A new era in cyclosporine therapy starts here...
INNOVATION
Through Microemulsion
Unique Cyclosporine Formulation Offers Increased Bioavailability With Comparable Safety*

Now, Neoral® therapy is available for prophylaxis of organ rejection in kidney, liver, and heart allogeneic transplant recipients. Neoral offers you increased bioavailability, while adverse effects* are comparable to those seen with Sandimmune therapy when the dosage of the two drugs is adjusted to achieve the same cyclosporine blood trough concentrations. Intrasubject variability of the area under the concentration-versus-time curve (%CV) in renal transplant recipients was 9% to 21% for Neoral and 19% to 26% for Sandimmune® (cyclosporine). Today, the Neoral combination of microemulsion technology and comparable safety* offers an important option for providing cyclosporine to your transplant recipients.

*The principal adverse reactions of cyclosporine therapy are renal dysfunction, tremor, hirsutism, hypertension, and gum hyperplasia.

Innovation Through Microemulsion

Neoral®
cyclosporine capsules and oral solution for microemulsion
JASN
The Journal of the American Society of Nephrology

Frequency: One volume per year, beginning in January.

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For information on American Society of Nephrology membership, contact: Sherri Mara at (202) 857-1190.

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Unique Cyclosporine Formulation Offers Increased Bioavailability With Comparable Safety*

Now, Neoral® therapy is available for prophylaxis of organ rejection in kidney, liver, and heart allogeneic transplant recipients. Neoral offers you increased bioavailability, while adverse effects* are comparable to those seen with Sandimmune therapy when the dosage of the two drugs is adjusted to achieve the same cyclosporine blood trough concentrations. Intrasubject variability of the area under the concentration-versus-time curve (%CV) in renal transplant recipients was 9% to 21% for Neoral and 19% to 26% for Sandimmune® (cyclosporine). Today, the Neoral combination of microemulsion technology and comparable safety* offers an important option for providing cyclosporine to your transplant recipients.

*The principal adverse reactions of cyclosporine therapy are renal dysfunction, tremor, hirsutism, hypertension, and gum hyperplasia.

Innovation Through Microemulsion

NEORAL®
cyclosporine capsules and oral solution for microemulsion
Routine monitoring is required and dosage adjustments may be necessary in both de novo patients and maintenance patients converted from Sandimmune® (cyclosporine) to Neoral®.

- For de novo transplant recipients, start with the same Neoral dosage you would use with Sandimmune.
- For maintenance patients, conversion to Neoral is generally safe and well tolerated
  - Start with a simple 1:1 dosage conversion to Neoral (see boxed warning)
  - Adjust the Neoral dosage to attain preconversion blood trough concentrations

In controlled studies, the nature, severity, and incidence of the adverse events that were observed in transplant recipients treated with Neoral were comparable with those of patients who received Sandimmune in those same studies when the dosage of the two drugs was adjusted to achieve the same cyclosporine blood trough concentrations. The principal adverse reactions of cyclosporine therapy are renal dysfunction, tremor, hirsutism, hypertension, and gum hyperplasia.

Reference

**WARNING**

Only physicians experienced in immunosuppressive therapy and management of organ transplant patients should prescribe Neoral®. Patients receiving the drug should be managed in facilities equipped and staffed with adequate laboratory and supportive medical resources. The physician responsible for maintenance therapy should have complete information requisite for the follow-up of the patient.

Neoral® may be administered with other immunosuppressive agents. Increased susceptibility to infection and the possible development of lymphoma and other neoplasms may result from the degree of immunosuppression.

**Innovation Through Microemulsion**

Neoral® Soft Gelatin Capsules (cyclosporine capsules for microemulsion) and Neoral® Oral Solution (cyclosporine oral solution for microemulsion) have increased bioavailability in comparison to Sandimmune® Soft Gelatin Capsules (cyclosporine capsules, USP) and Sandimmune® Oral Solution (cyclosporine oral solution, USP). Neoral® and Sandimmune® are not bioequivalent and cannot be used interchangeably without physician supervision. It is recommended that cyclosporine blood concentrations be monitored in patients taking Neoral® and that dose adjustments be made in order to avoid toxicity due to high concentrations and possible organ rejection due to low concentrations. For a given trough concentration, cyclosporine exposure will be greater with Neoral® than with Sandimmune®. If a patient who is receiving exceptionally high doses of Sandimmune® is converted to Neoral®, particular caution should be exercised. Comparison of blood concentrations in the published literature with blood concentrations obtained using current assays must be done with detailed knowledge of the assay methods employed. (See Blood Concentration Monitoring under DOSAGE AND ADMINISTRATION.)
INDICATIONS AND USAGE: Neoral is indicated for the prophylaxis of organ rejection in kidney, liver, and heart transplant recipients. Neoral has been used in combination with azathioprine and/or corticosteroids.

WARNING: Neoral is contraindicated in patients with a hypersensitivity to cyclosporine or to any of the ingredients of the formulation.

ADVERSE REACTIONS: Neoral causes nephrotoxicity and hepatotoxicity when used in high doses. It is not unusual for serum creatinine and BUN levels to be elevated during cyclosporine therapy. These elevations are dose related; therefore, do not exceed the recommended dosage. Serum creatinine and BUN levels should be monitored closely, and the dose adjusted if elevations occur, to avoid toxicity due to high concentrations and possible organ rejection due to low concentrations.

Cyclosporine is metabolized by the cytochrome P-450 (CYP3A4) family of enzymes. The use of concomitant agents that are substrates, inhibitors, or inducers of CYP3A4 may affect the pharmacokinetics and/or pharmacodynamics of cyclosporine. Therefore, the dose of cyclosporine in the absence of other medications may need to be increased or decreased, or monitoring for dose adjustment may be required due to the potential change in cyclosporine levels. See Drug Interactions for a list of additional considerations.

TRIPLE PROVIDER SUMMARY: Neoral is a safe, effective, and widely used immunosuppressive agent in transplant therapy. It is effective in the prevention of organ rejection in kidney, liver, heart, and lung transplantation. It is also effective in the treatment of some autoimmune diseases, such as lupus and rheumatoid arthritis.

DOSAGE AND ADMINISTRATION: Neoral is administered orally with or without food. It should be stored at room temperature and protected from moisture. It is available as capsules or microemulsion capsules. The capsules should be swallowed whole, and the microemulsion capsules should be swallowed whole or chewed.

ADDITIONAL INFORMATION: Neoral is contraindicated in patients with a hypersensitivity to cyclosporine or to any of the ingredients of the formulation.

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We discovered it.
We tested it.
We introduced it.
We improved it.
We understand it.
We trust it.
We stand by it.

In 1975, Bayer AG introduced Adalat® (nifedipine) in Europe. We've since made the Adalat brand available in several formulations around the world, and nifedipine has been in clinical use for over twenty years. Backed by a worldwide clinical database of tens of thousands of patients and hundreds of clinical studies, the Adalat brand today provides therapy for millions of patients* around the globe.

In the United States, the one to prescribe is...

Once-A-Day
Adalat® CC nifedipine
EXTENDED RELEASE TABLETS
30mg, 60mg & 90mg
Providing a World of Confidence for Hypertension Control

Frequency and type of side effects, eg, peripheral edema, headache, flushing/heat sensation, dizziness and fatigue/asthenia, are typical of dihydropyridine calcium channel blockers. Please see brief summary of Prescribing Information on following page.

*Data on file, Bayer Corporation, Pharmaceutical Division.
ADALAT CC was well tolerated when administered in combination with a beta blocker in 187 hypertensive patients in a placebo-controlled clinical trial. However, there have been no long-term hypertensive patients reporting that the combination of adalat CC and beta-adrenergic blocking drugs may have the incidence of a larger percentage, higher dose of beta blockers, or in patients with sudden deterioration in renal function, or if there is a major interaction between digoxin and ADALAT CC, it is recommended that digoxin be monitored and adjusted, and discontinuing ADALAT CC to avoid possible one- or more digitals level of digoxin.

ADALAT CC is indicated as monotherapy or in combination with a beta blocker. ADALAT CC has been shown to be more effective than placebo in reducing the number of patients who required therapy and in patients with sphygmomanometrically, effective blood pressure reduction was seen after 2 to 4 weeks of therapy. ADALAT CC tablets are indicated for the treatment of mild to moderate hypertension.

ADALAT CC is indicated in patients with sudden deterioration in renal function, or if there is a major interaction between digoxin and ADALAT CC, it is recommended that digoxin be monitored and adjusted, and discontinuing ADALAT CC to avoid possible one- or more digitals level of digoxin.

ADALAT CC is indicated for the treatment of mild to moderate hypertension.

ADALAT CC is indicated for the treatment of mild to moderate hypertension.
INSTRUCTIONS TO AUTHORS

Send manuscripts to the editor:
C. Craig Tisher, M.D.
J. Am. Soc. Nephrol.
Division of Nephrology
Box 100224
University of Florida
Gainesville, Florida 32610

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 kidney 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
- cell and transport physiology
- pathology and immunology
- cell and molecular biology
- pathophysiology of renal disease
- hormones, autacoids and growth factors
- hemodynamics, hypertension and vascular regulation
- dialysis
- transplantation
- epidemiology and outcomes research
- mineral metabolism and bone disease
- molecular medicine, genetics, and development

General Information
Original manuscripts are of two types: Regular Articles and Brief Communications. Regular Articles are traditional full length papers that address research questions with exhaustive experimental design and methodology. Brief Communications should contain not more than 2000 words (including abstract, figures, tables and references) describing important new observations in nephrology.

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 the correspondent. The cover letter should include a statement explaining why the research is especially important. The Journal office may solicit editorials to accompany articles that are especially newsworthy or controversial.

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The purpose of this series is to provide 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 not exceed 15 double-spaced typed pages and should include:

- A brief focused patient presentation and, if pertinent, inclusion of a radiologic or histologic figure
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- An overview of the etiology and the pathogenic 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
- A reference list of 20 or fewer citations

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• Use generic names of drugs.

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4. Include all authors' personal signatures.

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

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# Abbreviations and Symbols

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<tr>
<th>Abbreviation</th>
<th>Description</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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<tr>
<td>AMP</td>
<td>adenosine monophosphate</td>
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<tr>
<td>ATN</td>
<td>acute tubular necrosis</td>
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<tr>
<td>ATP</td>
<td>adenosine triphosphate</td>
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<td>AMPase, ADPase, ATPase</td>
<td>adenosine phosphatase</td>
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<td>atm</td>
<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>coulomb</td>
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<td>Celcius</td>
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<td>cAMP, cGMP, etc.</td>
<td>cyclic AMP, cyclic GMP, etc.</td>
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<td>cDNA</td>
<td>complementary DNA</td>
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<tr>
<td>cm, cm², cm³</td>
<td>centimeters, mm², mm³</td>
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<td>CMF, CDP, CTP</td>
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<td>r</td>
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<td>cps</td>
<td>counts per second</td>
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<td>D</td>
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<td>O-(diethylaminoethyl) cellulose</td>
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<td>deoxyribonucleic acid</td>
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<td>DPN or NAD</td>
<td>dephosphopyridine nucleotide</td>
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<td>probability</td>
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<tr>
<td>XMP, XDP, XTP</td>
<td>xanthosine phosphates</td>
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The American Society of Nephrology is pleased to announce that C. Craig Tisher, M.D., has been elected Editor of The Journal of the American Society of Nephrology. Beginning July 1, 1996, Dr. Tisher will assume the editorship from Jared J. Grantham, M.D., who has served as Editor since the Journal's inception in 1990.

Since 1980, Dr. Tisher has served as Professor of Medicine and Pathology and Chief of the Division of Nephrology, Hypertension, and Transplantation at the University of Florida, Gainesville. He is also Professor of Anatomy and Cell Biology and a member of the department’s doctoral research faculty.

Beginning July 1, 1996, all JASN manuscript submissions should be sent to the following address:

C. Craig Tisher, M.D.
Editor
The Journal of the American Society of Nephrology
Division of Nephrology
University of Florida
P.O. Box 100224
Gainesville, FL 32610-0224

Ms. Bonnie O’Brien will continue as Managing Editor for the Journal, and requests for further information should be directed to her at (913)588-7605 [fax: (913)588-7606; e-mail: bobrien@kumc.edu] until August 1, 1996. All manuscripts that are currently under review will continue to be managed by Dr. Grantham.

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**Business Address (if not listed above)**

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Training in Nephrology (Give inclusive dates for residences, fellowships, other relevant postgraduate education.)

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

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Please return your completed application with the first year’s dues (see below) payable to the ASN in U.S. funds.

$125—ACTIVE MEMBERSHIP for residents of North or Central America.

$140—CORRESPONDING MEMBERSHIP for those who meet the qualifications for Active Membership, but are not residents of North or Central America. Corresponding Members will receive all Society mailings and member discounts, but do not have the right to vote or hold office.

If you would like to pay by Visa or MasterCard, please list the cardholder’s name, number and expiration date below:

- [ ] Visa  [ ] MasterCard

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