For Sinusitis and URI

Deconamine® SR
Agrees:
You Should
Be Able To
Prescribe Any
Antibiotic
You Want.

Deconamine® SR has no known contraindications with any antibiotic...

Surprisingly, this is not true of all antihistamine/decongestants.

Deconamine® SR
(chlorpheniramine maleate, 8 mg/d-pseudoephedrine HCl, 120 mg)
SUSTAINED-RELEASE capsules Rx Only

Clears Nasal Congestion • Promotes Sinus Drainage

Deconamine® SR offers onset of action within 1 hour. Surprisingly, even some of the newer antihistamine/decongestants do not deliver this rapid onset of action. Balanced antihistamine/decongestant therapy for effective, long-acting relief of sinusitis symptoms.

- Mild CNS effect
- Low sedation¹
- Lowest reported cardiotoxicity profile²

Chlorpheniramine has been rated as having a low drowsiness factor. However, all cold/flu/allergy medications may cause drowsiness in certain individuals. So, it is advisable to avoid driving a motor vehicle, operating machinery, or drinking alcoholic beverages while taking this or any similar product.

Your Prescription Makes A World Of Difference

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Announcing
The American Medical Association
Morris Fishbein Fellowship

July 1, 1996, through June 30, 1997

Applications are now being taken for the Morris Fishbein Fellowship in Medical Editing sponsored by the American Medical Association. Physicians interested in making a substantial commitment to medical editing are invited to apply for this full-time 1-year fellowship program.

Work With JAMA
The successful candidate will work with the editorial and production staff of The Journal of the American Medical Association in all facets of editing and publishing a major weekly journal. At the completion of the program, it is expected that the candidate will be proficient in manuscript review and selection, issue makeup, copy editing and styling, art and layout of articles, issue planning and managing, in addition to the many other elements of journal production.

He/she will also be conversant with marketing and advertising procedures.

Stipend
A stipend of $40,000 will be provided to the successful candidate to cover the 1-year period.

Application Forms
For an application blank, please write to Richard M. Glass, MD, Deputy Editor, The Journal of the American Medical Association, 515 N State St, Chicago, IL 60610.

Deadline for Applying
Completed applications should be forwarded as soon as possible and must be received no later than December 15, 1995.

Publishing
The candidate must have proven writing ability at the time of application, since he/she will be required during the course of the year to prepare articles for publication. Although the fellow will work under the supervision of a physician-editor, ability to work independently is a must.

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BRIEF SUMMARY

INDICATIONS AND USAGE

Ambien (zolpidem tartrate) is indicated for the short-term treatment of insomnia characterized by difficulty in falling asleep or staying asleep. It should be used for no more than 4 to 10 days and, if use is to be prolonged, the patient should be reevaluated. Ambien should not be prescribed in quantities exceeding 1-month supply to any given patient (see Warnings).

CONTRAINDICATIONS

None known.

WARNINGS

Since sleep disturbances might be a presenting manifestation of a physical and/or psychiatric syndrome, treatment of insomnia with Ambien should be limited to 7 to 10 days and, if use is to be prolonged, the patient should be reevaluated. The failure of insomnia to remit after 7 to 10 days of treatment suggests the existence of a primary psychiatric illness which should be evaluated. Worsening of insomnia or existing anxiety may result. When used for extended periods or at high doses, Ambien has been associated with the development of rebound insomnia and withdrawal symptoms (eg, restlessness, irritability, nervousness, and difficulty falling asleep) when abruptly discontinued in patients with a history of drug dependence. Abrupt discontinuation of high doses in these patients may lead to rebound insomnia and other withdrawal phenomena, including hallucinations, paranoia, anxiety, dysphoria, combativeness, and akathisia. In studies of patients with a history of alcohol or drug dependence who were maintained on zolpidem, withdrawal symptoms were seen mainly in patients who received sedative/hypnotic drugs during pregnancy.

The use of Ambien in nursing mothers is not recommended. Lactation studies in women below the age of 18 have not been established.

ADVERSE REACTIONS

Associated with drug treatment: Approximately 4.4% of 1,701 patients who received zolpidem at all doses (1.25 to 10 mg) experienced at least one adverse event. Approximately 2.2% of the patients receiving 4 or more mg experienced an adverse event. The frequency of adverse events was similar in placebo-controlled and non-placebo-controlled studies. The incidence of adverse events seen in U.S. trials was similar to that seen in placebo-controlled European trials. In a 12-month study of 1,326 elderly patients with sleep disorders, no difference in the incidence of adverse events compared to placebo was seen at all doses (0.125 to 50 mg) in similar foreign trials discontinued treatment because of an adverse event. Of the patients discontinuing treatment from these trials, 15.1% had somnolence (1.1%), 7.3% had dizziness (1.6%), and 5.2% had headache (1.9%); 6% had vomiting (1.5%), and 0.6% had nausea.

Incidence of selected clinical trials:

Most common observed adverse events in short-term placebo-controlled clinical trials:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Placebo (268)</th>
<th>Ambien (267)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drowsiness</td>
<td>26 (10.3%)</td>
<td>104 (39.3%)</td>
</tr>
<tr>
<td>Somnolence</td>
<td>16 (6.0%)</td>
<td>34 (12.7%)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>11 (4.1%)</td>
<td>47 (17.7%)</td>
</tr>
<tr>
<td>Headache</td>
<td>10 (3.8%)</td>
<td>24 (9.0%)</td>
</tr>
<tr>
<td>Dizziness</td>
<td>9 (3.4%)</td>
<td>26 (9.7%)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>7 (2.6%)</td>
<td>13 (4.9%)</td>
</tr>
</tbody>
</table>

Incidence of selected adverse events in long-term placebo-controlled clinical trials (Percentage of patients reporting):

<table>
<thead>
<tr>
<th>Condition</th>
<th>Placebo (480)</th>
<th>Ambien (479)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drowsiness</td>
<td>26 (10.3%)</td>
<td>104 (39.3%)</td>
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<td>7 (2.6%)</td>
<td>13 (4.9%)</td>
</tr>
</tbody>
</table>

Drug Interactions:

CNS depressant effects: Zolpidem: When administered with benzodiazepines, hypnotics, or antihistamines, zolpidem may potentiate the sedative/hypnotic effects of such agents. Because of reports of its potential for abuse, zolpidem should not be used with alcohol or other drugs of abuse. Patients should be cautioned about the potential for such interactions when prescribed with sedative/hypnotics. The risk of dependence may be increased in patients with a history of drug or alcohol dependence and in elderly patients. Use in patients with hepatic impairment: Because of the potential for hepatic dysfunction, patients with severe hepatic impairment should be monitored closely.

Drug/Laboratory test interactions: Zolpidem is metabolized in the liver and may elevate plasma levels of other drugs (eg, cyclosporine) that are metabolized through the cytochrome CYP3A4 system. Serum levels of oral contraceptives may also be increased. Ambien should not be used in patients with liver disease. Although patients with hepatic impairment have been given Ambien at doses of 4 to 10 mg, the safety and efficacy of these doses in patients with hepatic impairment have not been studied. In patients with hepatic insufficiency, the plasma exposure of zolpidem was increased approximately fivefold compared to healthy volunteers. Although there were no significant changes in long-term sleep efficacy measures, short-term measures were reduced.

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From a unique chemical class of non-benzodiazepine sleep agents

More sleep
Total sleep time is significantly increased compared with placebo. Patients fall asleep quickly; generally within 20 to 30 minutes.¹³

Better sleep
Awakenings were reduced, compared to placebo.

Through the night
No evidence of increased wakefulness during the last third of the night. Normal sleep stages are generally preserved¹ (clinical significance unknown).

With no objective evidence of tolerance or rebound insomnia
In studies of up to 35 consecutive nights at recommended doses.¹²

Favorable safety and tolerability profile
Adverse events with dosages of ≤ 10 mg that were statistically significant vs placebo

<table>
<thead>
<tr>
<th></th>
<th>Short-term: ≤10 nights</th>
<th>Long-term: 28 to 35 nights</th>
</tr>
</thead>
<tbody>
<tr>
<td>drowsiness</td>
<td>2%</td>
<td>dizziness</td>
</tr>
<tr>
<td>dizziness</td>
<td>1%</td>
<td>drugged</td>
</tr>
<tr>
<td>diarrhea</td>
<td>1%</td>
<td>feelings</td>
</tr>
</tbody>
</table>

In the short-term treatment of insomnia

First in a unique chemical class of non-benzodiazepine sleep agents

Please see references and brief summary of prescribing information on the last page of this advertisement.
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Please see brief summary of prescribing information on adjacent page.

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NABUMETONE
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Because Brontex contains codeine, some patients may experience dizziness, sedation, nausea, emesis, and constipation. Please see brief summary of prescribing information on next page.

* In a recent survey among 100 cough sufferers who took Brontex tablets and a prescription cough liquid in the past 12 months. Survey conducted via geographically dispersed pharmacies. 73% of patients expressed a preference for the tablet form, 24% of patients expressed a preference for liquid form, and 3% of patients expressed no preference for either form. Data on file.

† The most commonly prescribed dose of codeine/guaifenesin products is 1 teaspoon (10 drops). Recommended adult dosage for most codeine/guaifenesin products is 2 teaspoons every 4 hours.
Effective cough relief in a tablet form that patients prefer more than 2:1.

At a 10 mg codeine dose, only Brontex provides a therapeutic level of an expectorant (per Federal guidelines). Competitors' liquids don't.

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- Please see summary of prescribing information below.
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National Health Council December Events

What?
December 13: The National Health Council's 75th Anniversary Gala Reception
December 14: The 42nd National Health Forum

Where?
Hyatt Regency Capitol Hill, Washington, DC

When?
December 13: Diamond Anniversary Gala Reception 5:30-7:30 pm
December 14: 42nd National Health Forum on "Quality Managed Care: Meeting the Needs of High-Risk Patients and Populations"—8:45 am until 5:00 pm

Who?
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For more details, call NHC on 202-785-3910 or FAX this completed form to 202-785-5923

TO: Joseph C. Isaacs, President
VIA FAX: 202-785-5923
National Health Council
1730 M Street, NW #500
Washington, DC 20036

Congratulations on the 1995 events celebrating the 75th anniversary of the National Health Council.
Please send me more information about the two terrific events planned for December 13 and 14!

Name _____________________ Title _____________________
Organization _____________________ Position _____________________
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City _____________________ State _____ Zip __________ + ________

☐ Please ensure that I receive an invitation to both the 75th Anniversary Gala Reception on December 13 and the 42nd National Health Forum.

☐ I am interested in Sponsorship of the 42nd National Health Forum.

☐ I am interested in the Commemorative Journal to be released during the 75th Anniversary. I understand that it will feature historical vignettes highlighting progress in healthcare over the past 75 years. Please send more details.
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What you should know before you sign a physician employment contract.

Most suits brought by medical entities for breach of contract allege violation of covenants not to compete, also known as restrictive covenants. Physicians entering their first employment following residency training too often anticipate a permanent career relationship and sign contracts containing restrictive covenants. These may result in a severe economic hardship for the physician if the physician is forced to relocate after a brief period of employment.

How to Negotiate a Physician's Employment Contract, just published by the American Medical Association (AMA), provides an extensive review of cases involving judicial treatment of restrictive covenants and numerous other issues physicians and employers need to know before signing an employment contract. These include compensation, essential information about the Americans with Disabilities Act, impact of income taxes on various forms of compensation and an overview of the Stark II self-referral legislation.

A basic specimen form of a physician's employment agreement, a checklist for preparing an employment contract and an array of optional and alternative clauses are also included.

Written for both employers and physicians, this new publication offers a road map for exploring every critical aspect of a contract and for paving the way to a satisfactory relationship between employer and employee. Published June, 1995. 43 pages.

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AT&T Capital Corporation – We Give Your Business The Credit It Deserves
Over the past 15 years, eight large, controlled clinical trials of antihypertensive therapy in the elderly have clearly documented that treatment is associated with a reduction in the incidence of strokes. The meta-analysis of these data reported in the article by Pearce et al clearly demonstrates a reduction of 18% in the incidence of coronary heart disease, a 35% reduction in the incidence of strokes, and a significant reduction in mortality rate, along with a blood pressure reduction of 15/6 mm Hg (systolic/diastolic) over approximately a 5-year period. Further analysis of these results suggests that diuretics and β-blockers were equally efficacious for stroke prevention, but diuretics may be superior in terms of reducing coronary heart disease events and the all-cause mortality rate.

The results of this meta-analysis as well as those of the Systolic Hypertension in the Elderly Program and the Medical Research Council Hypertension Trial support the concept that the practitioner should be more aggressive in lowering blood pressure in the geriatric population. Furthermore, the treatment of systolic hypertension, which is relatively common in this population, is as important, if not more critical, in the treatment of diastolic hypertension.

Based on the available data, it appears that therapy with low-dose diuretics (25 mg or less of hydrochlorothiazide) should be the cornerstone of therapy for both systolic and diastolic hypertension in the elderly. Indeed, low-dose diuretic therapy is generally well tolerated and does not cause clinically relevant metabolic problems in this population. In contrast to negative notions held in the past regarding compliance and tolerance issues in antihypertensive therapy, we now know that compliance is at least as good as it is in younger individuals. Thus, we have relatively inexpensive, generally well tolerated antihypertensive medications that have been proven to reduce the incidence of stroke and coronary events and the all-cause mortality rate. Unfortunately, this information has not been adequately conveyed to many practitioners who still do not appreciate the tremendous benefits of treating elevated blood pressures in the most rapidly growing patient population in the United States and other Westernized countries: the elderly.

James R. Sowers, MD
Wayne State University School of Medicine
Detroit, Mich

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We thank Sheila M. McNab, Buys Ballot Laboratory, University of Utrecht (the Netherlands) for translating this article into English and Didi M. W. Kriegsman, Vrije Universiteit Amsterdam (the Netherlands), for her statistical advice.

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