A better alternative for hypertensives who are going bananas...
Effective antihypertensive therapy...without the bananas.

Spare your patients the rigors of dietary K\(^+\) supplementation.

Spare your patients the extra cost— in calories, sodium and dollars.

**DYAZIDE**

25 mg Hydrochlorothiazide/50 mg Triamterene/SKF

Before prescribing, see complete prescribing information in SK&F CO. literature or PDR. The following is a brief summary.

### Warning

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be recalculated as conditions in each patient warrant.

### Contraindications

Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, severe potassium depletion, or hyperkalemia. Pre-existing elevated serum potassium. Renal insufficiency. Significant, sustained elevation of serum potassium levels. Previous history of allergic reactions to thiazide diuretics or sulfonamide derived drugs.

### Warnings

Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill with urine volume less than one liter/day. the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K\(^+\) levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K\(^+\) intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including total or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If the infant is premature, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in infants and children, or with a history of allergy or bronchial asthma. Possible exacerbation of symptoms (eg, gout) have been reported with thiazide diuretics.

### Precautions

The bioavailability of the hydrochlorothiazide component of Dyazide is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser bioavailability of thiazide could lead to increased serum potassium levels. However, extensive clinical experience with Thiazide suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium, use with caution with Dyazide. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin (ACTH)). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other symptomatic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and hypoglycemia, cholestasis, rash, nephrogenic diabetes insipidus, angioedema, Stevens-Johnson syndrome, toxic epidermal necrolysis, and dermatitis herpetiformis. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, Dyazide should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on Dyazide when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal antiinflammatory agents with Dyazide. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulins may be altered), hyperuricemia and gouty diathesis (in hypouricemia) decreasing alka1 reserve with possible metabolic acidosis. Dyazide interferes with fluorometric measurement of glucuronide. Hypokalemia is uncommon with Dyazide, but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and Dyazide should laboratory values reveal elevated serum potassium. Chloride deficiency may occur as well as diastolic hypotension. Concurrent use with chlorpropamide may increase the risk of severe hypotension. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Dyazide should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

### Adverse Reactions

Muscle cramps, weakness, dizziness, headache, dry mouth, anorexia, rash, urticaria, photosensitivity purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances, postural hypotension may be aggravated by alcohol, barbiturates, or narcotics. Nervousness, yelling, tinnitus, dysuria, arthralgias, arthritis, myalgias, back pain, abdominal pain, malaise, skin pruritus, skin eruptions, myalgia, paresthesias, anorexia, hypoglycemia, fatigue, asthenia, rhinitis, sinusitis, rhinorrhea, accidental injury, seborrhea, sweating, bronchospasm, dyspnea, vomiting, convulsions, chills, fever, fever, malaise, myalgia, polyuria, polydipsia, collagen vascular disease, alopecia, delirium, enuresis, sinusitis, sore throat, catarrhal rhinitis, rash, urticaria, pruritus, eczema, alopecia, toothache, myalgia, anorexia, nausea, vomiting, diarrhea, constipation, abdominal pain, back pain, chest pain, breast tenderness, palpitations, tachycardia, atrial fibrillation, angina, hyperglycemia, hyperuricemia, gout, hyperuricemia, hypercholesterolemia, hypertriglyceridemia, hyperglycemia, glycosuria, dysuria, azotemia, alkali reserve, possible metabolic acidosis. Dyazide interferes with tubocurarine. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin (ACTH)). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other symptomatic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and hypoglycemia, cholestasis, rash, nephrogenic diabetes insipidus, angioedema, Stevens-Johnson syndrome, toxic epidermal necrolysis, and dermatitis herpetiformis. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, Dyazide should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on Dyazide when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal antiinflammatory agents with Dyazide. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulins may be altered), hyperuricemia and gouty diathesis (in hypouricemia) decreasing alkali reserve with possible metabolic acidosis. Dyazide interferes with fluorometric measurement of glucuronide. Hypokalemia is uncommon with Dyazide, but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and Dyazide should laboratory values reveal elevated serum potassium. Chloride deficiency may occur as well as diastolic hypotension. Concurrent use with chlorpropamide may increase the risk of severe hypotension. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Dyazide should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

### Specific Tests

Monitor electrolytes, hematocrit, blood glucose, blood urea nitrogen, creatinine, uric acid levels. Monitor for symptoms of hypokalemia, hyperkalemia, hypomagnesemia, hyperglycemia, gout, hyperuricemia, gouty diathesis (in hypouricemia) decreasing alkali reserve with possible metabolic acidosis. Dyazide interferes with the action of nondepolarizing muscle relaxants such as tubocurarine. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin (ACTH)). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other symptomatic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and hypoglycemia, cholestasis, rash, nephrogenic diabetes insipidus, angioedema, Stevens-Johnson syndrome, toxic epidermal necrolysis, and dermatitis herpetiformis. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, Dyazide should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on Dyazide when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal antiinflammatory agents with Dyazide. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulins may be altered), hyperuricemia and gouty diathesis (in hypouricemia) decreasing alkali reserve with possible metabolic acidosis. Dyazide interferes with fluorometric measurement of glucuronide. Hypokalemia is uncommon with Dyazide, but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and Dyazide should laboratory values reveal elevated serum potassium. Chloride deficiency may occur as well as diastolic hypotension. Concurrent use with chlorpropamide may increase the risk of severe hypotension. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Dyazide should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.
CARDIAC OUTPUT COMPUTER
+ IBM-PC
FOR HUMANS AND RATS

*CARDIOMAX* plus IBM-PC Computer measures, prints on printer and stores on the disc for future recall: *Cardiac Output* *Stroke Volume* *Heart Rate* *Systolic, Diastolic, Mean Blood Pressures* *Blood and Injectate Temperatures* *Graphic pictures of Dilution Curve, Blood Pressure and ECG waveforms* *Calculates and prints Dilution Curve's Appearance, Elevation, Mean Concentration and Mean Dilution Times.

*C*HELP

COMPUTER-THERMOMETER

16 CHANNEL THERMOCOUPLE THERMOMETER
RS-232 COMPUTER INTERFACE
COMES COMPLETE WITH SOFTWARE FOR APP.E II* OR IBM-PC*-XT

* ACCURACY 0.1 °C
* RESOLUTION 0.015 °C
* RANGE 0°C to 50°C for biological applications. (Other ranges from -200°C to 1000°C are available.)
* ELECTRICAL ISOLATION of inputs to 2000 volts. Low leakage-less than 10μA. FDA registered for human use.
* All data from 16 channels may be displayed, printed and stored to disc in ten seconds.
* INCLUDES PLOTTING PROGRAM. (temperature versus time)
* Use standard "T" thermocouples - a wide variety of medical probes available.
  (intravenous, implantable, skin, rectal, oral, needle etc.)

*Apple and IBM are trademarks of their respective companies
For the Varied Faces of Angina

AN IMPROVED QUALITY OF LIFE
PROCARDIA® (nifedipine) means your mixed angina patients will have significant reduction in angina attacks and nitroglycerin consumption. And they can be more active—both working and at leisure.

feeling better...doing more

Please see PROCARDIA® (nifedipine) brief summary on next page.
PROCARDIA
(NIFEDIPINE)
Capsules 10 mg and 20 mg

—Effective dosage range is 30-120 mg/day

For most patients, start with 10 mg i.d., and titrate over 7 to 14 days, using the patient’s blood pressure response, attack frequency, sublingual nitroglycerin intake and activity level as a guide. Titration may be more rapid (e.g., 3 days) if symptoms warrant and the patient is observed closely.

Because PROCARDIA decreases peripheral vascular resistance (occasional patients have had excessive hypotension), careful monitoring of blood pressure during initial administration and upward dosage titration is suggested, especially for patients taking other drugs known to lower blood pressure. Occasional patients have developed increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases.

—Offers a favorable safety profile

Most frequently reported side effects associated with PROCARDIA therapy, usually mild, are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%; palpitation in about 2%; syncope in about 0.5%.

Reference:
LOWER HIS BLOOD PRESSURE

NOT HIS PERFORMANCE

For a Brief Summary of Prescribing information, please see the last page of this advertisement.
FOR MANY HYPERTENSIVE PATIENTS
Start with Once-a-Day

VASOTEC®
(ENALAPRIL MALEATE | MSD)

Instead of a Beta Blocker

Certain CNS effects, such as impairment of memory, nightmares, or depression, have not been characteristic of VASOTEC.

Little or No Interference with Physical or Mental Activity
Certain subjective symptoms such as malaise and drowsiness, which may interfere with physical or mental activity, have not been characteristic of VASOTEC—a fact that may be related to the specificity of action of VASOTEC on the renin-angiotensin-aldosterone system.

VASOTEC is contraindicated in patients who are hypersensitive to this product.

Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with angiotensin-converting-enzyme (ACE) inhibitors, including VASOTEC (0.2% of patients treated with VASOTEC in clinical trials). In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. Angioedema associated with laryngeal edema may be fatal. Where there is involvement of the tongue, glottis, or larynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.

Excessive hypotension was rarely seen in uncomplicated hypertensive patients but is a possible consequence of enalapril use in severely salt/volume-depleted persons, such as those treated vigorously with diuretics or patients on dialysis. In using VASOTEC, consideration should be given to the fact that another ACE inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease, and the available data are insufficient to show that VASOTEC does not have a similar risk.

For a Brief Summary of Prescribing Information, please see the last page of this advertisement.

It May Change the Way Your Patients Feel on Antihypertensive Therapy
Hypotension: Patients on OJunHc Theopy: The hypertensive patients treated with ACE inhibitors, including VASOTEC, may be more likely to experience a significant and unusual drop in blood pressure in the first few days of therapy. In some cases, syncope (sudden, unexpected loss of consciousness with falling) may occur. If hypotension occurs, the patient should be placed in a supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given safely once the blood pressure has increased after volume expansion.

Neutropenia/Agranulocytosis: Another AEC inhibitor has been shown to cause agranulocytosis and a low neutrophil count, usually in patients with renal impairment, especially if they also have a history of neutropenia or agranulocytosis. VASOTEC, like other ACE inhibitors, may be associated with a low neutrophil count and a rare risk of agranulocytosis. The neutrophil count should be monitored in patients with renal impairment and on initiation of therapy with ACE inhibitors, including VASOTEC.

Hypotension: Patients on OJunHc Theopy: The hypertensive patients treated with ACE inhibitors, including VASOTEC, can be more likely to experience a significant and unusual drop in blood pressure in the first few days of therapy. In some cases, syncope (sudden, unexpected loss of consciousness with falling) may occur. If hypotension occurs, the patient should be placed in a supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given safely once the blood pressure has increased after volume expansion.

Hypersensitivity: Angioedema, which may be life-threatening, has been reported in patients receiving VASOTEC (0.2%). Angioedema has been reported to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. In postmarketing surveillance, the incidence of angioedema has been reported to be approximately 0.1% of patients treated with VASOTEC. VASOTEC should be discontinued and the patient observed. If angioedema occurs, the patient should be observed until the swelling resolves. In instances where swelling has been confined to the face and lips, the condition has resolved without treatment. Discontinue therapy if angioedema is suspected. If angioedema is mild, continue therapy, but patients should be observed for progression of symptoms.

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Instructions to Contributors

Original Contributions

Manuscripts reporting original research, Rapid Communications, Case Reports, Brief Reviews, and Letters to the Editor are considered for publication on the condition that they are contributed solely to Hypertension. Manuscripts should be submitted to: Edgar Haber, M.D., Editor-in-Chief, Hypertension, Charles River Park, 7 Whittier Place, Suite 106, Boston, Massachusetts 02114.

All manuscripts must be accompanied by a letter from all authors containing the following statement: "I (we) the undersigned author(s) hereby transfer, assign, or otherwise convey all copyright ownership of my (our) article . . . . . . . to the American Heart Association if this article is published in Hypertension. The material in the manuscript has not been published elsewhere and is not being considered for publication elsewhere in whole or in part."

Materials taken from other sources must be accompanied by a written statement from both author and publisher giving permission to the journal for reproduction. Articles submitted to Hypertension are considered with the understanding that all persons acknowledged have seen and approved mention of their names in the article. All sources of support for research should be cited.

Manuscripts

One original manuscript and three copies must be submitted. Manuscripts, including tables and figures, should be complete upon submission. Manuscripts should be typewritten on good quality paper, one side of the page only, with double spacing, and with liberal margins on all four sides.

The title page should include: name(s) of author(s) and hospital and academic affiliation(s), address for mailing proofs and phone number of corresponding author, short title to be used as running head, and from four to five key words (listed in order of importance) to be used as indexing terms. The title should not exceed 83 characters and should contain no abbreviations. References, figure legends, figures, and tables follow the text respectively. Pages should be numbered consecutively in the following order: title page, summary, text, references, figure legends, copies of figures, and tables.

Consult the CBE Style Manual, 5th ed. (Bethesda, MD: 1983). Abbreviations should be defined on first appearance in the text, tables, and figures. Generic names of drugs should be given.

Summary (Abstract)

The summary precedes the text of the article. It should be concise (not more than 250 words), informative, and suitable for use by abstracting services. It should be written as a concrete précis—not just a conceptual summary—and should state the objectives, the newly observed finding, and the conclusions drawn from these observations. Acronyms and abbreviations should be avoided.

Methods

For apparatus used in methods the name, city, state, and country of the manufacturer(s) should be supplied. For experimental animals, state the source, species, strain, number used and other pertinent descriptive characteristics. For human subjects or patients, describe their characteristics. When describing surgical procedures on animals, identify the preanesthetic and anesthetic agents used, and state the amount or concentration and the route and frequency of administration for each. Use of paralytic agents, such as curare or succinylcholine, are not acceptable substitutes for anesthetic agents. For other invasive procedures on animals, report the anesthetic or tranquillizing drugs used; if none were used, provide justification. When reporting studies on unanesthetized animals or on humans, indicate that the procedures followed were in accordance with institutional guidelines.

References


Authors are responsible for submitting references that are accurate and complete. All authors should be cited. The number of references should be limited to 10 if possible.

Personal communications, unpublished observations, and submitted manuscripts should be cited in the text as "(unpublished observations)." Abstracts may be cited only if they are the sole source and must be identified in the references as "Abstract." When including manuscripts accepted but not yet published, designate the journal followed by "(in press)." For articles that are cited as "in press," a copy of the cited article is requested.

Tables

Manuscripts must be submitted in triplicate. Each table with its title should be typed on a separate sheet of paper. Tables should be given an arabic number and a brief informative title. Horizontal rules should be drawn above and below the column headings and at the bottom of the table; elsewhere horizontal rules should be omitted and extra space used instead to delineate sections. No vertical rules should be used. Footnotes should be designated within the table and explained below in this order: *, †, ‡, §, ¶, **, ††, ‡‡, . . . .

Illustrations

Copies of the figures must be submitted in triplicate and included as part of the manuscript. Figure legends should be compiled on a separate page. Two sets of original art should be included. Figures should be enclosed in separate envelopes and should not be mounted on cardboard. No clips should be used. The back of each figure should have an arabic number, name of author(s), and manuscript title. The top of the figure should be indicated. Authors are responsible for the cost of color illustrations.

Figures should be reproducible as one-column-wide printed illustrations, if possible. Good glossy photographic prints should be submitted in sizes that have a close relationship to the width of one column of this journal (3½ inches). Original drawings should be prepared with black India ink and then photographed for submission. No typewriter or computer type should be used. The size of the lettering should be such that when reduced, the height of the characters will be 1.5–1.75 mm (2.5–3.0 mm on halftones).

Rapid Communications

The Editors will consider for publication as a rapid communication manuscripts thought by the author(s) to be of unusual scientific value and importance. Papers submitted as a rapid communication must report original, complete, and definitive research of particular significance to the field and, if acceptable, will be published approximately 2 months prior to longer manuscripts accepted on the same date. The Editors will make a decision on the manuscript within 2 weeks of its receipt. Referees will critique manuscripts by phone. The cover letter accompanying the manuscript must request that the manuscript be considered as a rapid communication. Such a manuscript must not exceed 10 double-spaced typewritten pages. Authors are asked to submit a list of five possible reviewers with the manuscript. A paper rejected as a rapid communication may be resubmitted as a routine manuscript and will be considered on a de novo basis.

Case Reports

Case reports must add important, new information to clinical experience. Negative information should not be detailed. Case reports should be brief. Length should not exceed 12 double-spaced pages, including references. The review process to determine suitability for publication will be the same as that for research manuscripts.

Brief Reviews

In addition to reports of original research, Hypertension will publish Brief Reviews summarizing the present state of knowledge concerning a particular aspect of a special field. Brief reviews are generally solicited, but authors may send in titles and abstracts for consideration. These reviews should be evenhanded and should cover the field selected thoroughly. The work of all relevant contributors should be cited. The length should not exceed 24 double-spaced pages. The review process to determine suitability for publication will be the same as that for research manuscripts.

Processing Fee

In keeping with the policies of the American Heart Association, a manuscript processing fee of $50 should be submitted to the Journal with the manuscript at the time of the initial submission. If the cost represents a hardship to an author it will be waived upon request without prejudicing the review process. Revised manuscripts submitted within 1 year of the previous decision do not require an additional fee. This fee is payable in U.S. currency by check or money order to the American Heart Association. To receive proper credit for payment indicate manuscript number if known. Indicate Hypertension on the face of the check.

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