
New Orleans, Louisiana
October 13–16, 1987

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Guest Editor
THE 1988 JOINT NATIONAL COMMITTEE ON HIGH BLOOD PRESSURE (JNC IV) RECOMMENDS CALCIUM ANTAGONISTS AS FIRST-LINE THERAPY

Recommended first-line therapy

ONCE-A-DAY Calan® SR (verapamil HCl) 240mg SUSTAINED-RELEASE CAPLETS

The only calcium antagonist indicated for hypertension

Please see adjoining page for a brief summary of complete prescribing information.
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CALAN® SR (verapamil HCl) MEETS NEWLY EXPANDED

© 1988, Searle & Co.
Recommended first-line therapy

- Fulfills treatment fundamentals with effective and safe monotherapy
- Once-a-day dosing and excellent side-effects profile conform with JNC IV guidelines regarding compliance and life-style

Helps protect vital organ function

- **Promotes cardiovascular performance:** Reduces left ventricular hypertrophy (LVH) and rarely affects lipid levels, thus meeting JNC IV long-term goals
- **Preserves renal perfusion:** Maintains renal blood flow and glomerular filtration rate, and reduces renal vascular resistance to help maintain renal function

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Verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil therapy, which can result in digitalis toxicity, should be avoided in patients with hepatic cirrhosis. The combination should be used only with caution and close monitoring. Decreased metoprolol clearance may occur with combined use. Chronic verapamil treatment can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular junction. Verapamil is not recommended for use in patients with severe left ventricular dysfunction, hypotension or cardiogenic shock, sick sinus syndrome, second- or third-degree AV block, atrial flutter or atrial fibrillation and an accessory bypass tract, known hypersensitivity to verapamil HCl.

*Some patients may require b.i.d. dosing.

**Contraindications:**

- Hypersensitivity to verapamil HCl.
- Accessory bypass tract (eg, WPW or LGL syndromes), known hypersensitivity to verapamil HCl.
- Second- or third-degree AV block (if no pacemaker is present), atrial flutter or atrial fibrillation and an accessory bypass tract (eg, WPW or LGL syndromes).
- Hypotension < 90 mm Hg or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.
- Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block.
- AV block may occur (2nd- and 3rd-degree, 0.8%).

**Warnings:**

- Verapamil should be avoided in patients with severe LV dysfunction (eg, pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.
- Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypertension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving IV verapamil (or digoxin). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%).

**Precautions:**

- Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility, there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol clearance may occur with combined use. Chronic verapamil treatment can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored.
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**Once-a-Day Calan SR**

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therapy which can result in toxicity. In patients with hepatic cirrhosis, verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy. Monitoring is required to ensure that toxic levels are not reached. The combination should be used only with caution and close monitoring. Decreased metoprolol clearance may occur with combined use.

**Contraindications:**
- Severe LV dysfunction (see Warnings), hypotension, systolic pressure < 90 mm Hg, or cardiogenic shock.
- Sick sinus syndrome (if no pacemaker is present).
- 2nd- or 3rd-degree AV block (if no pacemaker is present).

**Warnings:**
- Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring should be commenced in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

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**Contraindications:**
- Severe left ventricular dysfunction, hypotension or cardiogenic shock, sick sinus syndrome, second- or third-degree AV block, atrial flutter or atrial fibrillation and an accessory bypass tract, known hypersensitivity to verapamil HCl.

**Warnings:**
- Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring should be commenced in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

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