WOULD YOU BELIEVE THIS MAN IF HE TOLD YOU TO STOP SMOKING?

You're a doctor who continues to smoke, yet you're constantly urging your patients to quit. It's critical that they believe you because of the increased risk of heart attack and stroke. You see it every day, yet you continue smoking. And your patients know it.

You have your credibility.

Don't let it go up in a puff of smoke.
Once-a-day MAXZIDE™
Tiamterene 75 mg/Hydrochlorothiazide 50 mg/Lederle

THE FIRST AND ONLY REPLACEMENT FOR THE LESS BIOAVAILABLE TRIAMTERENE/HYDROCHLOROTHIAZIDE FORMULATION ... PROVEN SUPERIOR IN BIOAVAILABILITY

Please see last page of this advertisement for brief summary of prescribing information.
SUPERIOR DRUG DELIVERY AND ABSORPTION — TABLET TO TABLET, PATIENT TO PATIENT

MAXZIDE is optimally bioavailable and consistently delivers the prescribed dose of 75 mg triamterene and 50 mg hydrochlorothiazide. Dyazide®, on the other hand, exhibits poor bioavailability. When given in equivalent doses, Dyazide delivers approximately half the amount of hydrochlorothiazide as MAXZIDE. Similarly, two Dyazide capsules deliver less than half the amount of triamterene as one MAXZIDE tablet.¹

---

![Graphs showing percent dose of hydrochlorothiazide and triamterene recovered from urine over 72 hours in subjects given single oral doses.](image)

---

¹Data from a study of 24 subjects.

²HydroDIURIL is the registered trademark of Merck & Co., Inc., for hydrochlorothiazide.
A CLINICALLY SAFE AND EFFECTIVE ALTERNATIVE IN POTASSIUM-SPARING ANTIHYPERTENSIVE THERAPY

FOR PATIENTS ON HYDROCHLOROTHIAZIDE WHO DEVELOP HYPOKALEMIA

FOR NEWLY DIAGNOSED PATIENTS IN WHOM THE DEVELOPMENT OF HYPOKALEMIA CANNOT BE RISKED

FOR PATIENTS TRANSFERRED FROM DYAZIDE

In a transfer safety study, patients taking up to four Dyazide capsules daily were effectively transferred to MAXZIDE q.d. with no compromise in clinical condition.²

PROVEN FORMULATION MAXIMIZES POTASSIUM-SPARING EFFECT OF TRIAMTERENE

In a clinical dose-response evaluation, 75 mg triamterene daily most successfully corrected the hypokalemic effect of repeated daily doses of 50 mg hydrochlorothiazide.³

---

Dose-response evaluation of triamterene’s potassium-sparing activity in patients rendered hypokalemic with long-term daily doses of 50 mg hydrochlorothiazide


*Data from a study of 49 patients.

*Trademark of SK&F Co., Carolina, P.R.
ECONOMICAL, ONCE-A-DAY POTASSIUM-SPARING ANTIHYPERTENSIVE THERAPY

BRIEF SUMMARY

Practise and review insert for pre-sheeting information.

INDICATIONS AND USAGE: MAXZIDE is indicated for the treatment of hypertension of whatever origin which is unresponsive to diet alone or other antihypertensive drugs. (See CLINICAL PHARMACOLOGY.) It is also indicated for those patients who require a thiazide diuretic and it is used in treatment and prevention of potassium depletion in digitalis preparations or with a history of cardiac arrhythmias, etc. This fixed combination drug is not useful in the treatment of other potassium-sparing diuretics. In whom the development of hypokalemia cannot be ruled out. MAXZIDE may be used alone or in combination with other antihypertensive agents, including other potassium-sparing diuretics. Hypokalemia is more likely to occur in patients with renal impairment and when concurrent use of antacids, corticosteroids, or ACTH, amphotericin B or after prolonged thiazide therapy. However, hypokalemia of this type is usually prevented by the triamterene component of MAXZIDE. Hydrochlorothiazide is contraindicated in patients with compromised renal function. The renal clearances of hydrochlorothiazide, the pharmacologically active component of triamterene, and the sulfate ester of hydroxytriamterene have not been seen. The dose of hydrochlorothiazide must be reduced in patients with impaired renal function. (See DOSAGE AND ADMINISTRATION.)

WARNINGS: Hypokalemia

Abnormal elevation of serum potassium levels (greater than or equal to 5.5 mEq/L) or serum potassium levels greater than 5.5 mEq/L may be caused by dietary deficiencies, especially in elderly patients, patients with impaired renal function. Electrolyte imbalance and BUN increases Patients receiving potassium-sparing diuretics are at increased risk of developing hyperkalemia. Electrolyte imbalance and hypokalemia are especially important when the patient is vomiting or receiving parenteral fluids, e.g., glucose with a rapid acting insulin preparation. This is probably not the result of renal toxicity but is secondary to a reversible reduction of the glomerular filtration rate or a depletion of the intravascular fluid volume. Periodic BUN and creatinine determinations should be made in patients with compromised renal function. The renal clearances of hydrochlorothiazide, the pharmacologically active component of triamterene, and the sulfate ester of hydroxytriamterene have not been seen. The dose of hydrochlorothiazide in patients with impaired renal function should be reduced. These patients should not receive this drug without further laboratory tests. In whom the development of hypokalemia cannot be risked (e.g., patients on digitalis preparations or with a history of cardiac arrhythmias, etc.). This fixed combination drug is not useful in the treatment of other potassium-sparing diuretics. This may lead to the appearance of megaloablastosis in instances where folic acid stores are diminished. In such patients, periodic blood evaluations are recommended. Hyperuricemia: Hyperuricemia may occur or acute gout may be precipitated in certain patients receiving thiazide therapy. Metabolic and Endocrine Effects: The thiazides may decrease serum PRL levels without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Pathological changes in the parathyroid gland with hypercalcemia and hyperophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

Intestinal symptoms in diabetic patients may be increased, decreased or unchanged. Little information is available on the use of thiazides in patients with diabetes mellitus. However, thiazide therapy has been shown to reduce blood pressure in such patients. However, thiazide therapy may also cause dryness of mouth. This may be particularly important in patients with impaired renal function. If hyperkalemia is suspected, warning signs include paresthesias, muscular weakness, fatigue, fasciculated paralysis of the extremities, bradycardia and shock. In patients requiring sodium or potassium supplementation, the plasma levels of potassium should be observed closely. The common complications of hyperkalemia such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

In whom the development of hypokalemia cannot be risked (e.g., patients on digitalis preparations or with a history of cardiac arrhythmias, etc.). This fixed combination drug is not useful in the treatment of other potassium-sparing diuretics. Possible exacerbation or activation of systemic lupus erythematosus by thiazides has been reported. Drug interactions: Hyperkalemia may lead to the appearance of megaloablastosis in instances where folic acid stores are diminished. In such patients, periodic blood evaluations are recommended. Hyperuricemia: Hyperuricemia may occur or acute gout may be precipitated in certain patients receiving thiazide therapy. Metabolic and Endocrine Effects: The thiazides may decrease serum PRL levels without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Pathological changes in the parathyroid gland with hypercalcemia and hyperophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

Intestinal symptoms in diabetic patients may be increased, decreased or unchanged. Little information is available on the use of thiazides in patients with diabetes mellitus. However, thiazide therapy has been shown to reduce blood pressure in such patients. However, thiazide therapy may also cause dryness of mouth. This may be particularly important in patients with impaired renal function. If hyperkalemia is suspected, warning signs include paresthesias, muscular weakness, fatigue, fasciculated paralysis of the extremities, bradycardia and shock. In patients requiring sodium or potassium supplementation, the plasma levels of potassium should be observed closely. The common complications of hyperkalemia such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

In whom the development of hypokalemia cannot be risked (e.g., patients on digitalis preparations or with a history of cardiac arrhythmias, etc.). This fixed combination drug is not useful in the treatment of other potassium-sparing diuretics. In whom the development of hypokalemia cannot be risked (e.g., patients on digitalis preparations or with a history of cardiac arrhythmias, etc.). This fixed combination drug is not useful in the treatment of other potassium-sparing diuretics. In whom the development of hypokalemia cannot be risked (e.g., patients on digitalis preparations or with a history of cardiac arrhythmias, etc.). This fixed combination drug is not useful in the treatment of other potassium-sparing diuretics. In whom the development of hypokalemia cannot be risked (e.g., patients on digitalis preparations or with a history of cardiac arrhythmias, etc.). This fixed combination drug is not useful in the treatment of other potassium-sparing diuretics.

The common complications of hyperkalemia such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

In whom the development of hypokalemia cannot be risked (e.g., patients on digitalis preparations or with a history of cardiac arrhythmias, etc.). This fixed combination drug is not useful in the treatment of other potassium-sparing diuretics. In whom the development of hypokalemia cannot be risked (e.g., patients on digitalis preparations or with a history of cardiac arrhythmias, etc.). This fixed combination drug is not useful in the treatment of other potassium-sparing diuretics.

The common complications of hyperkalemia such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

In whom the development of hypokalemia cannot be risked (e.g., patients on digitalis preparations or with a history of cardiac arrhythmias, etc.). This fixed combination drug is not useful in the treatment of other potassium-sparing diuretics. In whom the development of hypokalemia cannot be risked (e.g., patients on digitalis preparations or with a history of cardiac arrhythmias, etc.). This fixed combination drug is not useful in the treatment of other potassium-sparing diuretics. In whom the development of hypokalemia cannot be risked (e.g., patients on digitalis preparations or with a history of cardiac arrhythmias, etc.). This fixed combination drug is not useful in the treatment of other potassium-sparing diuretics.

The common complications of hyperkalemia such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

In whom the development of hypokalemia cannot be risked (e.g., patients on digitalis preparations or with a history of cardiac arrhythmias, etc.). This fixed combination drug is not useful in the treatment of other potassium-sparing diuretics. In whom the development of hypokalemia cannot be risked (e.g., patients on digitalis preparations or with a history of cardiac arrhythmias, etc.). This fixed combination drug is not useful in the treatment of other potassium-sparing diuretics. In whom the development of hypokalemia cannot be risked (e.g., patients on digitalis preparations or with a history of cardiac arrhythmias, etc.). This fixed combination drug is not useful in the treatment of other potassium-sparing diuretics.
**STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION**

Required by 39 U.S.C. 3685

1. TITLE OF PUBLICATION

   HYPERTENSION

2. PUBLICATION NO.

   01 94 91 1 x

3. DATE OF FILING

   9/30/85

4. FREQUENCY OF ISSUE

   BIMONTHLY

5. COMPLETE MAILING ADDRESS OF KNOWN OFFICE OF PUBLICATION (Street, City, County, State and ZIP Code) (Not printers)

   AMERICAN HEART ASSOCIATION, 7320 GREENVILLE AVE., DALLAS TX 75231

6. COMPLETE MAILING ADDRESS OF THE HEADQUARTERS OF GENERAL BUSINESS OFFICES OF THE PUBLISHER (Not printers)

   SAME

7. FULL NAMES AND COMPLETE MAILING ADDRESS OF PUBLISHER, EDITOR, AND MANAGING EDITOR (This item MUST NOT be blank)

   PUBLISHER (Name and Complete Mailing Address)

   AMERICAN HEART ASSOCIATION, 7320 GREENVILLE AVE., DALLAS, TX 75231

   EDITOR (Name and Complete Mailing Address)

   MASSACHUSETTS GENERAL HOSPITAL - CARDIAC UNIT

   EDGAR HABER, M.D. JACKSON 13 RM 1325, BOSTON MA 02114

   MANAGING EDITOR (Name and Complete Mailing Address)

   CHARLES RIVER PARK

   NANCY PHINNEY 7 WHITTIER PLACE, SUITE 106, BOSTON MA 02116

8. OWNER (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Item must be completed.)

   FULL NAME

   AMERICAN HEART ASSOCIATION

   COMPLETE MAILING ADDRESS

   7320 GREENVILLE AVE., DALLAS, TX 75231

9. FOR COMPLETION BY NONPROFIT ORGANIZATIONS AUTHORIZED TO MAIL AT SPECIAL RATES (Section 423.12 DMF only)

   The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes (Check one)

   (1) HAS NOT CHANGED DURING PRECEDING 12 MONTHS

   (2) HAS CHANGED DURING PRECEDING 12 MONTHS

   (If changed, publisher must submit explanation of change with this statement.)

10. EXTENT AND NATURE OF CIRCULATION

     AVERAGE NO. COPIES EACH ISSUE DURING PRECEDING 12 MONTHS

     ACTUAL NO. COPIES OF SINGLE ISSUE PUBLISHED NEAREST TO FILING DATE

     A. TOTAL NO. COPIES (Net Press Run)

        4,648

        4,819

     B. PAID CIRCULATION

        1. Sales through dealers and carriers, street vendors and counter sales

           —

        2. Mail Subscription

           3,261

           2,693

     C. TOTAL PAID CIRCULATION (Sum of 10B1 and 10B2)

        3,261

        2,693

     D. FREE DISTRIBUTION BY MAIL, CARRIER OR OTHER MEANS

        SAMPLES, COMPLIMENTARY, AND OTHER FREE COPIES

        196

        181

     E. TOTAL DISTRIBUTION (Sum of C and D)

        3,457

        2,874

     F. COPIES NOT DISTRIBUTED

        1. Office use, left over, unaccounted, spoiled after printing

           1,191

           1,945

        2. Return from News Agents

           —

           —

     G. TOTAL (Sum of E, F1 and 2—should equal net press run shown in A)

        4,648

        4,819

11. I certify that the statements made by me above are correct and complete

    SIGNATURE AND TITLE OF EDITOR, PUBLISHER, BUSINESS MANAGER, OR OWNER

    Vicki Addison, Publisher

(See instruction on reverse)
BEHIND THE FACE OF HYPERTENSION
New evidence for central control
For the elderly hypertensive

"...with increasing age, norepinephrine response to posture and exercise increases."¹

Effective central control of blood pressure

Catapres®
(clonidine HCl)
Hypertension

Tablets of 0.1, 0.2, 0.3 mg

Please see last page for brief summary, including warnings, precautions, and adverse reactions.
New evidence for central control

**BEHIND THE FACE OF HYPERTENSION**

**Catapres®**

*(clonidine hydrochloride)*

**Tablets of 0.1, 0.2, 0.3 mg**

**Indication:** The drug is indicated in the treatment of hypertension. As an anti-hypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

**Warnings:** Tolerance may develop in some patients necessitating a reevaluation of therapy.

**Usage in Pregnancy:** In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

**Usage in Children:** No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

**Precautions:** When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

**Adverse Reactions:** The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, nausea, loss of appetite, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase, congestive heart failure, Raynaud’s phenomenon: vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs’ test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

**Overdosage:** Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres (clonidine hydrochloride) overdosage.

**How Supplied:** Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000 and unit dose package of 100. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information. Under license from Boehringer Ingelheim International GmbH.

**Reference:**


---

Boehringer Ingelheim
Boehringer Ingelheim Ltd.
Ridgefield, CT 06877
Advertisers' Index

Boehringer Ingelheim Pharmaceuticals .................. 24, 25, 26
Columbus Instruments ........................................ 13
Ives Laboratories ............................................. 14, 15, 16
Knoll Pharmaceutical .......................................... 28, 29, 30
Lederle Laboratories ......................................... 19, 20, 21, 22
Marion Laboratories .......................................... 11, 12
Miles Pharmaceuticals ........................................ 17, 18
The Ohio Bureau of Employment Services ............... 13
Pfizer Laboratories ........................................... 8, 9, 10, Cover 3, Cover 4
Smith Kline Beckman ......................................... Cover 2
Spacelabs, Inc. ................................................ 7
Wyeth Laboratories ............................................ 4, 5, 6

Vicki Sullivan
Scientific Publishing Director

Barbara Stephens
Fulfillment Manager

Deborah Conrad
Advertising Production Manager

American Heart Association, 7320 Greenville Avenue, Dallas, Texas 75231

Advertising Sales
Pharmaceutical Media Inc.
130 Madison Ave.
New York, NY 10016
(212) 685-5010

All possible care is taken in preparing this index. AHA is not responsible for errors or omissions.
On nitrates, but angina still strikes...
After a nitrate, add ISOPTIN® (verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin… for more comprehensive antianginal protection without side effects which may cramp an active life style.

ISOPTIN. Added antianginal protection without beta-blocker side effects.
Contraindications: Severe left ventricular dysfunction (see Warnings), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. Warnings: ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., 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. (See Precautions.) Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitals and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under Precautions.) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitals). Treatment is usually D.C. cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1st AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1st or progressive 2nd or 3rd AV block requires a dosage reduction or, rarely, discontinuation and institution of an appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (HCM) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2nd AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. Precautions: ISOPTIN 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 excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitals toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Discontinuation should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. Adverse Reactions: Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See Warnings.) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ephelis, buzzing, gynecomastia, psychic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramps, shortness of breath, claudication, hair loss, macules, spotty menstruation. How Supplied: ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984.
Initial therapy should start hypertensive patients

Brief Summary
MINIPRESS® (prazosin hydrochloride) Capsules
For Oral Use

MINIPRESS® (prazosin hydrochloride) is a specific alpha-adrenergic blocking agent indicated in the treatment of hypertension. As an antihypertensive drug, it is mild to moderate in activity. It can be used as the first drug in a patient's regimen or may be employed as a general treatment program in conjunction with a diuretic and/or other antihypertensive drugs as needed to properly control the patient's hypertension.

WARNINGS: Minipress may cause syncope with sudden loss of consciousness. In doses of 2 mg or greater, there have been reported associations with syncope, suggesting that the risk of syncope increases with the dose of MINIPRESS. Postural hypotension can occur, particularly when the drug is started or increased at initiation of therapy or during treatment. Syncope episodes have usually occurred within 30 to 90 minutes after the initial dose of the drug; occasionally, they have been reported in association with rapid dosage increases or the introduction of another antihypertensive drug into the regimen of a patient taking high doses of MINIPRESS. The incidence of syncope episodes is approximately 1% in patients given an initial dose of 2 mg or greater. Clinical trials conducted during the investigational phase of this drug suggest that syncope episodes can be minimized by limiting the initial dose of the drug to 1 mg, by subsequently increasing the dosage slowly, and by introducing any additional antihypertensive drugs into the patient's regimen with caution. (See DOSAGE AND ADMINISTRATION.) Hypotension may develop in patients given MINIPRESS who are also receiving a beta-blocker such as propranolol. If syncope occurs, the patient should be placed in the supine position and treated supportive as necessary. This adverse effect is self-limiting and most cases do not recur after the initial period of therapy or during subsequent dose increase.

Patients should always be started on the 1 mg capsule of MINIPRESS. The 2 and 5 mg capsules are not indicated for initial therapy. More than two of the commonly observed adverse reactions are rarely observed and are sometimes associated with lowering of blood pressure, namely, dizziness and lightheadedness. The patient should be advised about these possible adverse effects and advised to measure and record their blood pressure twice daily. The patient should also be cautioned to avoid situations where injury could result should syncope occur during the initiation or titration of the drug.

Usage in Pregnancy: Although no teratogenic effects were seen in animal testing, the safety of MINIPRESS in pregnancy has not been established. MINIPRESS is not recommended for prophylaxis women unless the potential benefits outweigh the potential risks to the fetus.

Usage in Children: No clinical experience is available with the use of MINIPRESS in children.

ADVERSE REACTIONS: The most common reactions associated with MINIPRESS are dizziness, vertigo, headache, drowsiness, 0.5%; rash, pruritus, alopecia, lichen planus.

Central Nervous System: Nervousness, vertigo, depression, dizziness, fatigue, headache.

Gastrointestinal: Nausea, vomiting, diarrhea, constipation, hiccups.

Skin: Urticaria, rash, erythema multiforme, angioedema, maculopapular or morbilliform eruptions.

Other: Syncope, flushing, chest pain, heartburn.


HOW SUPPLIED: MINIPRESS is available in 1 mg white, 2 mg pink and white, and 5 mg blue and white #437 capsules in bottles of 250, 1000, and unit dose institutional packages of 100, 250, and 500 mg of prazosin hydrochloride.

More detailed information is available on request.

© 1983, Pfizer Inc.

Minipress®
Capsules 1 mg, 2 mg, 5 mg
(prazosin HCl)
For Initial Therapy in Hypertension

Pfizer LABORATORIES DIVISION
PFIZER INC.
Initial therapy should start hypertensive patients off right

Minipress® for initial therapy
(prazosin HCl)
- Is effective when used alone
- Does not cause a significant incidence of sexual impotence, although it has been reported
- Does not adversely affect blood lipids
- Does not lower heart rate, cardiac output or work capacity
- Does not induce potassium wasting
- The most common side effects with Minipress, generally mild and transient, are: dizziness, headache, drowsiness, palpitations, nausea. Syncope (sudden loss of consciousness) has been reported in about 0.15% of patients at the recommended initial dose of 1 mg.

*Minipress is not indicated for the treatment of hyperlipidemia.

Please see Minipress brief summary on adjacent page