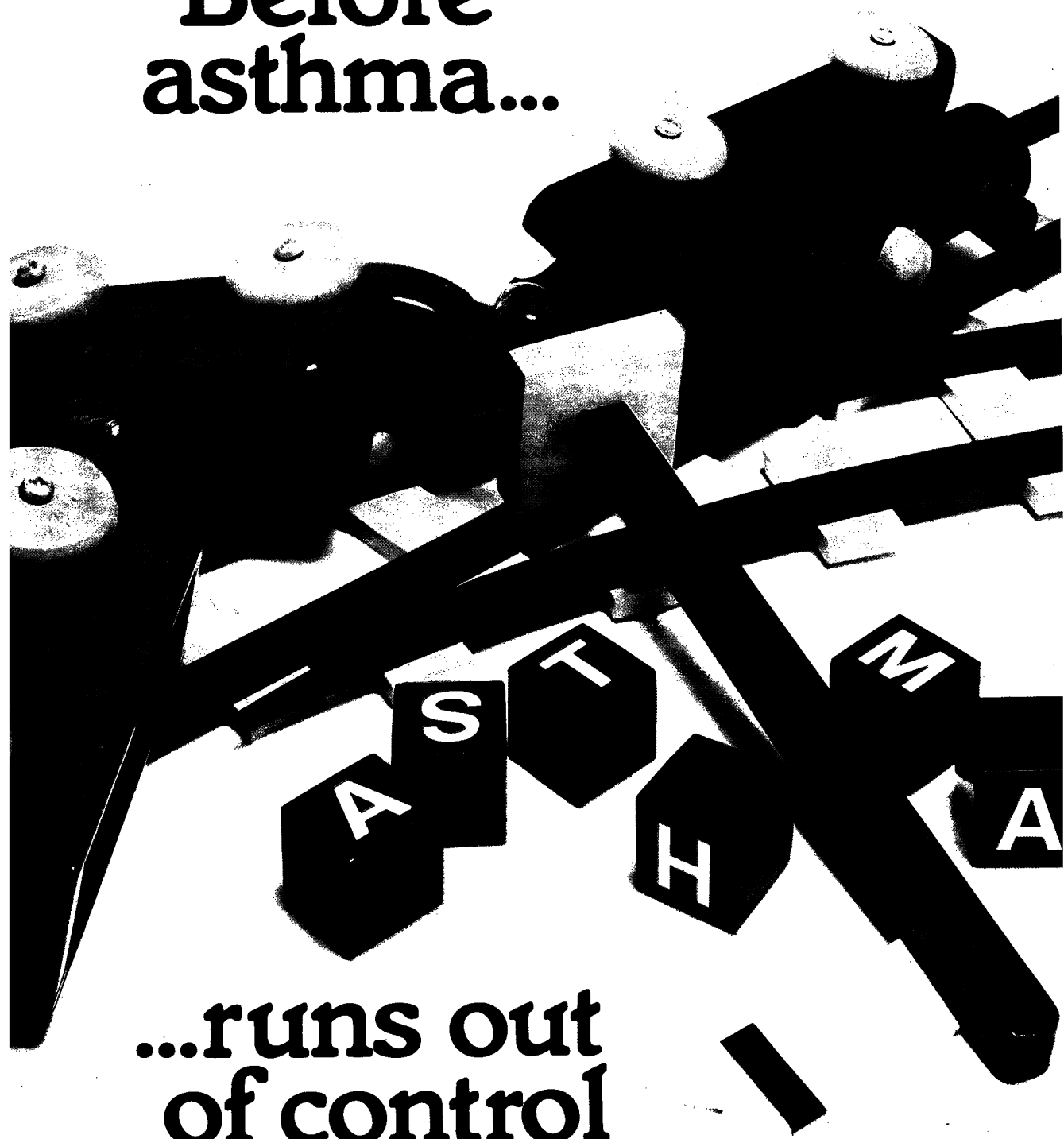


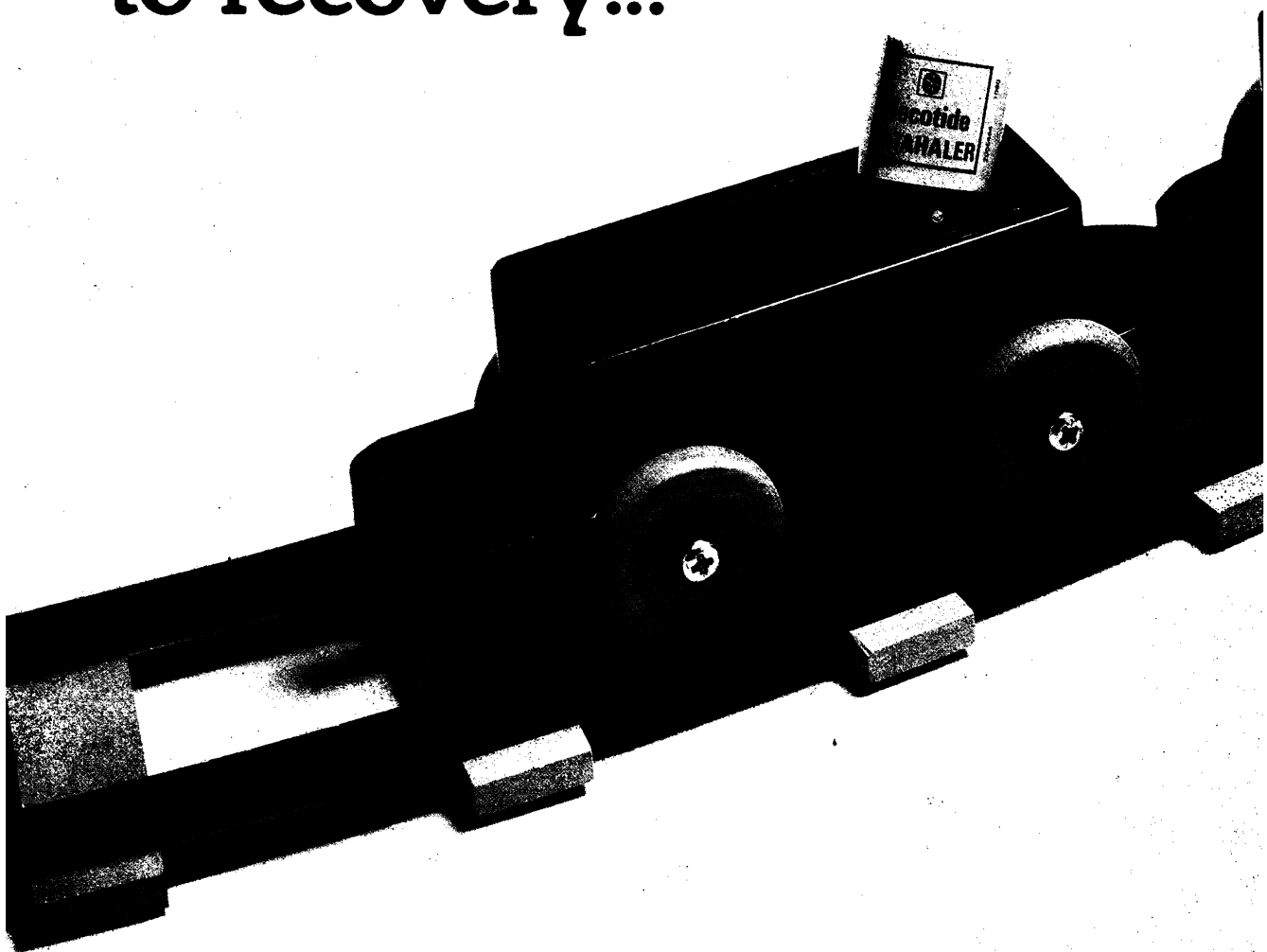
**Before
asthma...**



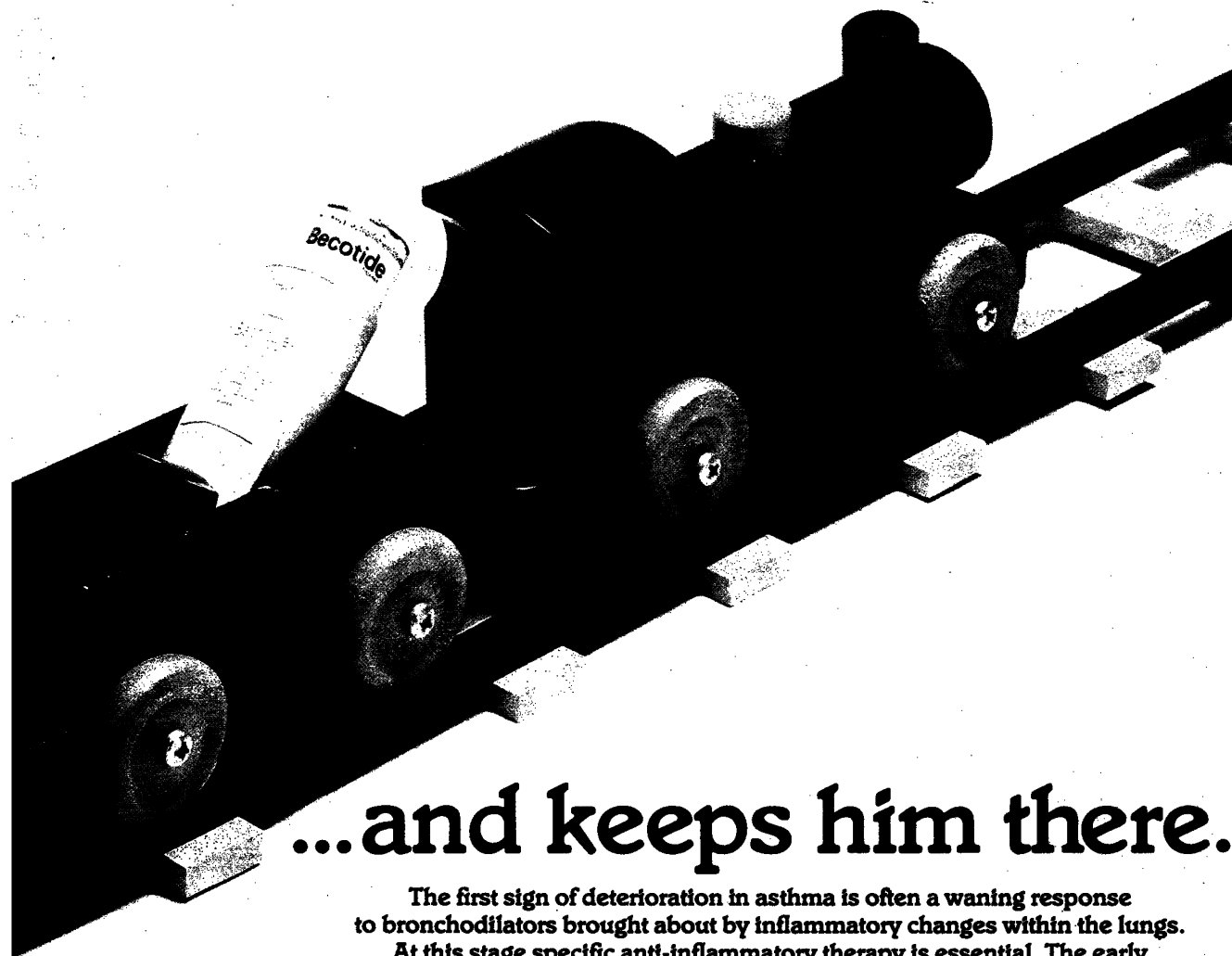
**...runs out
of control**

TWICE DAILY
INHALED
Becotide
(Beclomethasone Dipropionate BP)

puts the asthmatic
back on the rails
to recovery...



Prescribing information Uses: Bronchial asthma especially in patients whose asthma is not adequately controlled by bronchodilators and patients with severe asthma who would otherwise be dependent on systemic corticosteroids or adrenocorticotrophic hormone (ACTH) or its synthetic equivalent. **Dosage and administration:** Using Becotide Inhaler - *Adults:* four inhalations twice a day or two inhalations four times a day is the usual maintenance dose. In severe cases dosage may be started at twelve to sixteen inhalations per day and subsequently reduced when the patient begins to respond. *Children:* one or two inhalations two to four times daily according to the response. Using Becotide Rotacaps - *Adults:* two 200 micrograms Becotide Rotacaps twice a day or one 200 micrograms Becotide Rotacap four times a day is the usual maintenance dose. *Children:* one or two 100 micrograms Becotide Rotacaps two to four times daily according to the response. For optimum results inhaled Becotide should be administered regularly. **Contra-indications:** No specific contra-indications to inhaled Becotide are known but special care is necessary in patients with active or quiescent pulmonary tuberculosis. **Precautions:** Inadequate response after the first week of inhaled Becotide therapy suggests that excessive mucus is preventing penetration of inhaled drug to the target area. A short course of systemic steroid in relatively high dosage should be given and therapy with inhaled Becotide continued. Unnecessary administration of drugs during the first trimester of pregnancy is undesirable. When transferring patients to Becotide from systemic steroid therapy the possibility of adrenocortical suppression should be considered and patients given a supply of oral steroids for use during periods of stress. Please refer to the detailed procedure described in the data sheets for Becotide Inhaler and Becotide Rotacaps. **Side effects:** Occasional candidiasis of the mouth and throat (thrush)



...and keeps him there.

The first sign of deterioration in asthma is often a waning response to bronchodilators brought about by inflammatory changes within the lungs.

At this stage specific anti-inflammatory therapy is essential. The early addition of Inhaled Becotide is indicated to control the inflammatory process, to restore lung function and the response to bronchodilators.

Regular twice daily prophylaxis with Becotide in combination with Inhaled Ventolin maintains lung function and prevents further deterioration.

**TWICE DAILY
INHALED**

Becotide

(Beclomethasone Dipropionate BP)

**the sooner the better
in asthma control**

occurs in some patients, particularly those with high blood levels of Candida precipitins. Topical therapy with antifungal agents usually clears the condition without withdrawal of Becotide. Presentation and Basic NHS cost: Becotide Inhaler is a metered-dose aerosol delivering 50 micrograms Beclomethasone Dipropionate BP per actuation. Each canister contains 200 inhalations. Basic NHS cost £4.77. Becotide Rotacaps 100 micrograms and 200 micrograms, each contain a mixture of the stated amount of microfine Beclomethasone Dipropionate BP and larger particle lactose in buff/colourless or brown/colourless hard gelatine cartridges, respectively. Containers of 100. Basic NHS cost £7.26 and £9.47 respectively. Becotide Rotahaler, for use in conjunction with Becotide Rotacaps. Basic NHS cost 78p. Product licence numbers: Becotide Inhaler 0045/0089, Becotide Rotacaps 100 micrograms 0045/0119, Becotide Rotacaps 200 micrograms 0045/0120



Further information is available on request from:

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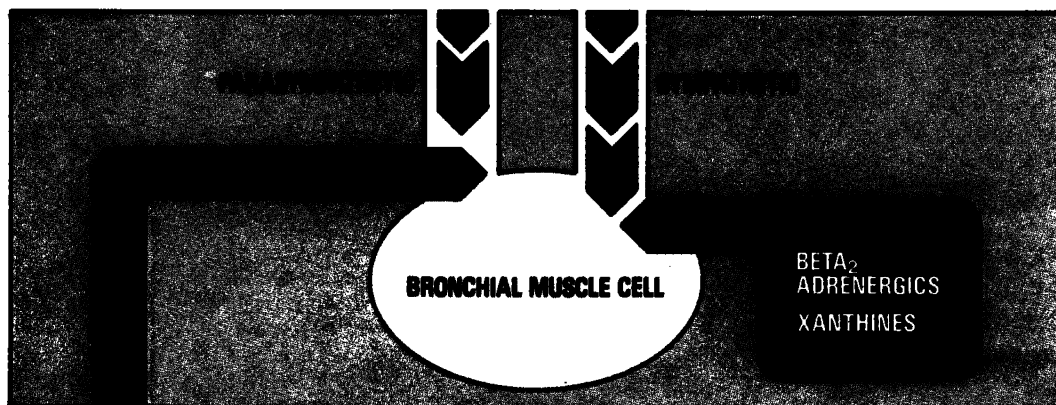
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 ipratropium bromide
 and add more life
 to your wheezy patients



PRESCRIBING INFORMATION Presentation Atrovent metered dose inhaler containing 200 doses, each delivering ipratropium bromide 0.02mg. Atrovent nebuliser solution — an aqueous solution of ipratropium bromide 0.025% (0.25mg/ml) for administration by inhalation. **Action** Anticholinergic bronchodilator **Indications** Metered dose inhaler: chronic reversible airways obstruction, particularly in chronic bronchitis. Nebuliser solution: reversible airways obstruction **Contra-indications, Precautions and Warnings** Contra-indication: hypersensitivity to atropine. Caution in glaucoma, prostatic hypertrophy and pregnancy, especially the first trimester. Do not spray into the eyes. Patients should be advised to seek medical advice if a reduced response becomes apparent. Anticholinergic side-effects are unlikely at therapeutic doses. **Dosage** Metered dose inhaler Adults usually 1 or 2 puffs, 3 or 4 times daily, although some patients need up to 4 puffs at a time to obtain maximum benefit during early treatment. Children 5-12 years: usually 1 or 2 puffs 3 times daily. Under 6 years: usually 1 puff 3 times daily. Nebuliser solution: May be administered from an intermittent positive pressure ventilator or from suitable nebulisers. Adults: 0.1-0.5mg (0.4-2.0ml) up to 4 times daily. Single doses of 2.0mg have been safely given. Children 5-14 years: 0.1-0.5mg (0.4-2.0ml) up to 3 times daily. Single doses of 1.0mg have been safely given. These volumes may be diluted with sterile sodium chloride 0.9% solution. **Pack sizes and basic NHS price (UK only).** Metered dose inhaler: 10ml vial complete with mouthpiece £4.00. Nebuliser solution: 20ml bottle with integral dropper £1.56. Prices correct at time of printing. Atrovent metered dose inhaler PL 0015/0043. Atrovent nebuliser solution PL 0015/0078. Boehringer Ingelheim Ltd, Bracknell, Berkshire RG12 4YS. For full prescribing information please see data sheet. 1. Ward MJ, Macfarlane JT, Davies D. Treatment of acute severe asthma with intravenous aminophylline and nebulised ipratropium bromide after salbutamol. Thorax 1982; 37: 785



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Diazepam-without the needle

the needle

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Status Epilepticus- no need

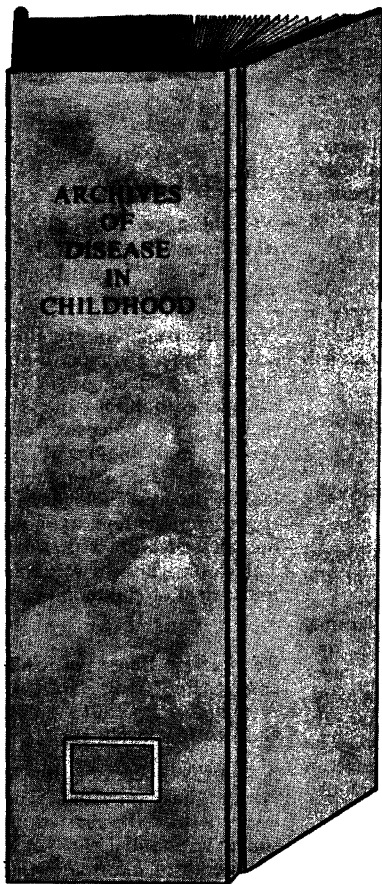
Febrile convulsions—no need

Minor procedure shall not be used

There are two strings: `5` and `5.0`.

Prescribing Guidelines

[illegible]



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Paediatric Immunology

Edited by **J.F. Soothill** MA, MD, BChir, FRCP, FRCPath, *Hugh Greenwood Professor of Immunology, Institute of Child Health, and Consultant, The Hospital for Sick Children, London*; **A.R. Hayward** PhD, MB, BS, MRCP, *Associate Professor of Paediatrics, University of Colorado Medical Centre, Denver*; and **C.B.S. Wood** MB, BChir, FRCP, *Professor of Child Health, St. Bartholomew's Hospital Medical Schools*

The book is divided into two sections: the first stresses the developmental concepts of immunology of interest to paediatricians; and the second outlines the mechanisms, diagnosis and treatment of immunological diseases of children in terms of immunodeficiency and allergy, and by organ systems. General subjects such as maternal-foetal relationships, immunization, immunological aspects of infant feeding, tissue type and disease are considered from the standpoint of paediatric immunology. Although the book has been designed specifically for allergists, there is much in it of considerable value to specialists in other fields.

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PEDIATRIC RESEARCH

Volume 17, No. 1

January 1983

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- Growth and Maturation of Patients with Turner's Syndrome**
E. PARK, J. D. BAILEY, AND C. A. COWELL (Toronto, Ontario, Canada) The effect of estrogen treatment on skeletal and sexual maturation were examined in 116 patients with female phenotype and at least one major feature of Turner's syndrome, associated with an X chromosome abnormality.
- Early Ontogeny of Iodocompound-Processing Neural Systems in Rat Brain**
F. L. CRUTCHFIELD AND M. B. DRATMAN (Philadelphia, Pennsylvania) Iodocompounds reaching the brain of nursing rats become discretely distributed in different brain regions and progressively more localized in synaptosomes.
- Mammary Amylase: a Possible Alternate Pathway of Carbohydrate Digestion in Infancy**
L. A. HEITLINGER, P. C. LEE, W. D. DILLON, AND E. LEBENTHAL (Buffalo, New York) The results of this study indicate that amylase could retain a significant proportion of its original activity after exposure to acid and pepsin in the stomach of young infants.
- Review Article. Interactions of Determinants in the Ontogeny of the Gastrointestinal Tract: a Unified Concept**
E. LEBENTHAL AND P. C. LEE (Buffalo, New York) The authors correlate the results of studies of *in utero* and postnatal development in animal models to provide a unified concept for further investigation in the area of developmental gastroenterology.
- Chronic Tyrosinemia Associated with 4-Hydroxyphenylpyruvate Dioxygenase Deficiency with Acute Intermittent Ataxia and without Visceral and Bone Involvement**
O. GIARDINI, A. CANTANI, N. G. KENNAWAY, AND P. D'EUFEMIA (Rome, Italy and Portland, Oregon) The authors describe a patient who presents a unique form of tyrosinemia.
- Mucus Glycoproteins Secreted by Respiratory Epithelial Tissue from Cystic Fibrosis Patients**
R. C. FRATES, JR., T. T. KAIZU, AND J. A. LAST (Davis, California) Secretion rates of labeled mucus glycoproteins from airway tissue explants of patients with cystic fibrosis were 3-6 times higher than those samples from normal subjects.
- Sleep Respiratory Instability in Term Neonates under Hyperthermic Conditions: Age, Sex, Type of Feeding, and Rapid Eye Movements**
A. STEINSCHNEIDER AND S. WEINSTEIN (Baltimore, Maryland) The authors report that respiratory rate decreased with age and was greater during non REM sleep and in formula-fed infants.
- L-Proline Transport by Isolated Renal Tubules from Newborn and Adult Rats**
S. M. HWANG, M. A. SERABIAN, K. S. ROTH, AND S. SEGAL (Philadelphia, Pennsylvania) These data indicate that the higher proline excretion by newborn animals is not the consequence of impaired uptake or absence of a component that mediates proline influx. The authors suggest that higher proline excretion must be related to other factor involved in transcellular movement of proline from the tubule lumen to the peritubular capillary.
- Measurement of Serum Alpha-Fetoprotein in Early Infancy: Utilization of Dried Specimens**
G. J. MIZEJEWSKI, T. P. CARTER, D. W. BEBLOWSKI, AND R. BELLISARIO (Albany, New York) Baseline L-fetoprotein concentration are determined in dried blood specimens of newborns up to 30 days of age.
- Influence of Exogenous Glucagon on Fetal Glucose Metabolism and Ketone Production**
A. F. PHILIPPS, J. W. DUBIN, P. J. MATTY, AND J. R. RAYE (Farmington, Connecticut) Elevated plasma glucagon concentrations in the fetus is reported to cause acute hyperglycemia but, unlike the adult, does not induce significant ketogenesis.
- Chemotactic Receptor of Cord Blood Granulocytes to the Synthesized Chemotactic Peptide *N*-Formyl-Methionyl-Leucyl-Phenylalanine**
H. NUNOI, F. ENDO, S. CHIKAZAWA, T. NAMIKAWA, AND I. MATSUDA (Kumamoto, Japan) Chemotactic mobility of cord blood granulocytes was studied under varying concentrations of a synthesized chemotactic peptide. The maximal chemotactic mobility was found at a concentration of 2×10^{-7} M in cord blood granulocytes and 1×10^{-7} M in adult blood granulocytes
-

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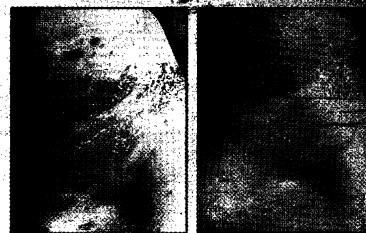
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