The evidence is stacked in its favour

Established efficacy in both hypertension and angina

A reliable choice for good tolerability in both young and elderly patients[1]

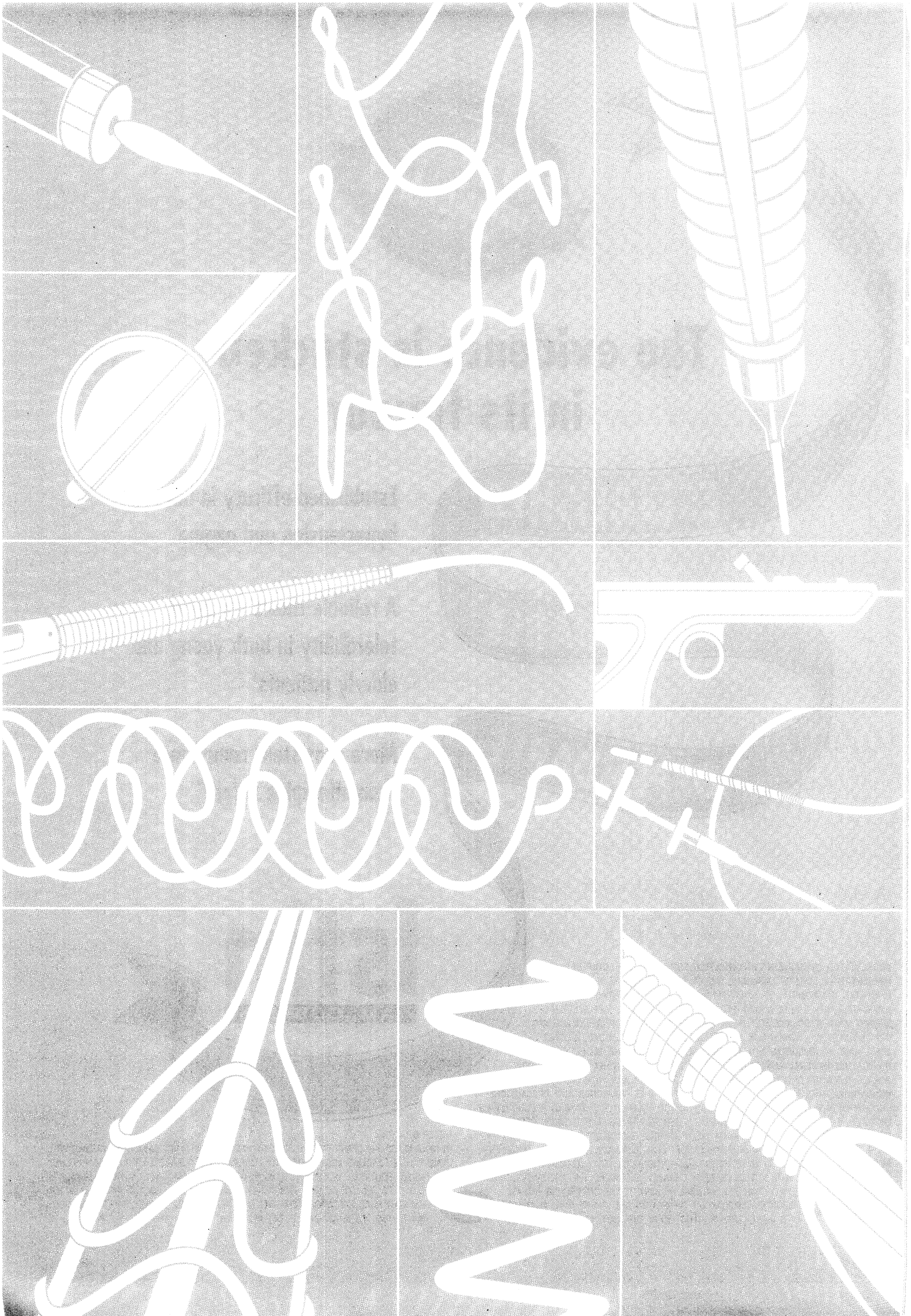
More consistent compliance than nifedipine retard[2]

TM

AMLODIPINE

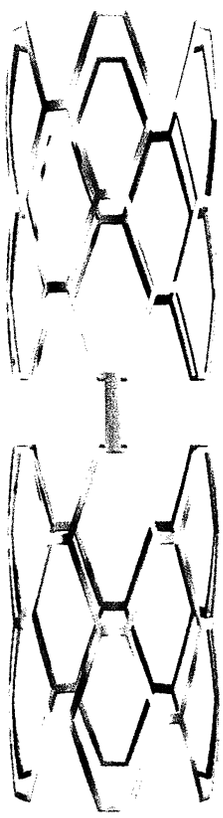
ABBREVIATED PRESCRIBING INFORMATION FOR ISTIN™ (AMLODIPINE): UK. PRESENTATION: TABLETS CONTAINING 5MG OR 10MG AMLODIPINE. **INDICATIONS:** FIRST-LINE TREATMENT OF HYPERTENSION AND MYOCARDIAL ISCHAEMIA ASSOCIATED WITH STABLE ANGINA PECTORIS OR VASOSPASTIC (PRINZMETAL'S OR VARIANT) ANGINA. **DOSAGE:** FOR HYPERTENSION AND ANGINA, INITIAL DOSAGE 5MG ORALLY ONCE DAILY WHICH MAY BE INCREASED TO A MAXIMUM DAILY DOSAGE OF 10MG. **USE IN CHILDREN:** NOT RECOMMENDED. **USE IN THE ELDERLY:** NORMAL DOSAGE. **USE IN RENAL IMPAIRMENT:** NORMAL DOSAGE. **USE IN HEPATIC IMPAIRMENT:** DOSAGE RECOMMENDATIONS HAVE NOT BEEN ESTABLISHED; USE WITH CAUTION. **CONTRA-INDICATIONS:** KNOWN SENSITIVITY TO DIHYDROPYRIDINES. **WARNINGS AND PRECAUTIONS:** PREGNANCY AND LACTATION: ISTIN SHOULD NOT BE ADMINISTERED DURING PREGNANCY OR LACTATION, OR TO WOMEN OF CHILD-BEARING POTENTIAL UNLESS EFFECTIVE CONTRACEPTION IS USED. **SIDE-EFFECTS:** OEDEMA, HEADACHE, FLUSHING, DIZZINESS, NAUSEA, PALPITATIONS, FATIGUE, ABDOMINAL PAIN AND SOMNOLENCE. LESS COMMONLY, PRURITUS, DYSPNOEA, ASTHENIA, MUSCLE CRAMPS AND DYSPEPSIA. RASH, AND RARELY ERYTHEMA MULTIFORME HAVE BEEN OBSERVED. AS WITH OTHER CALCIUM CHANNEL BLOCKERS, THE FOLLOWING, WHICH CANNOT BE DISTINGUISHED FROM THE NATURAL HISTORY OF THE UNDERLYING DISEASE HAVE BEEN RARELY REPORTED: MYOCARDIAL INFARCTION AND CHEST PAIN. **FURTHER INFORMATION:** STUDIES HAVE SHOWN THAT ISTIN DID NOT LEAD TO CLINICAL DETERIORATION IN NYHA CLASS II-III HEART FAILURE. STUDIES HAVE NOT BEEN PERFORMED IN PATIENTS WITH CLASS IV HEART FAILURE. **LEGAL CATEGORY:** POM. **PACKAGE QUANTITIES AND BASIC NHS COST:** 5MG TABLETS CALENDAR PACK OF 28 £11.85 (PL 0057/0297): 10MG TABLETS CALENDAR PACK OF 28 £17.70 (PL 0057/0298). FURTHER INFORMATION ON REQUEST. **PFIZER LIMITED**, RAMSGATE ROAD, SANDWICH, KENT CT13 9NJ. **REFERENCES: 1.** CROSS BW ET AL. BR J CLIN PRACT, 1993, *47*(5): 237-240. **2.** DETRY JR. CLIN CARDIOL, 1994, *17* (SUPPL III): 12-16.

Pfizer



Which of these devices has been proven effective in reducing restenosis?

Recently, more than 15 new devices, including a variety of stents, atherectomy catheters, and ablative lasers, have undergone clinical investigation. But only one, the PALMAZ-SCHATZ™ balloon-expandable STENT, has been proven capable of reducing the rate of restenosis.[1-3]



Johnson & Johnson
INTERVENTIONAL SYSTEMS
Opening the Way in Interventional Medicine

1. Spaedy TJ, Wilensky RL. Coronary stenting. *ACC Curr J Rev* 1994; 6:59-62.
2. Fischman DL, Leon MB, Baim DS, et al. A randomized comparison of coronary-stent placement and balloon angioplasty in the treatment of coronary artery disease. *N Engl J Med* 1994; 331:496-501.
3. Serruys PW, de Jaegere P, Kiemeneij F, et al. A comparison of balloon-expandable-stent implantation with balloon angioplasty in patients with coronary artery disease. *N Engl J Med* 1994; 331:489-495

See package insert for full product information.

PML101

NOW AVAILABLE FOR ANGINA

ONCE-DAILY

Adalat® LA

nifedipine 30mg & 60mg

FOR HYPERTENSION AND NOW ANGINA

MORE ADVANCED THAN ADALAT RETARD

HAS REDUCED SIDE-EFFECTS[1]

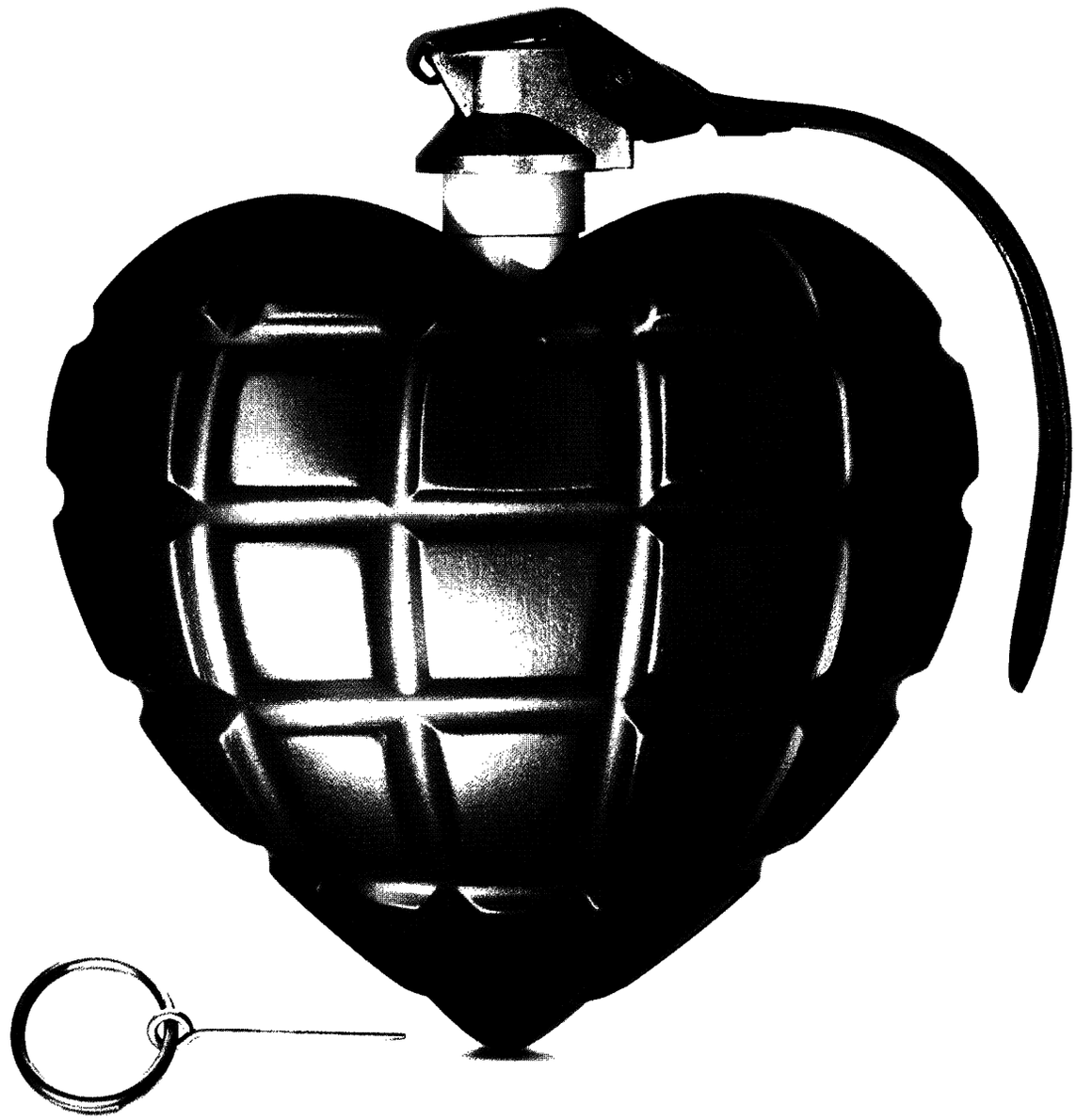
A SMOOTHER PLASMA PROFILE[2]

AND COMES IN A ONCE-DAILY DOSE

Modalim® Prescribing Information
Presentation White, capsule-shaped tablets embossed MODALIM on one side with a breakline on the other, each containing 100mg ciprofibrate. **Uses:** For the treatment of primary hyperlipidaemia resistant to appropriate dietary management, including hypercholesterolaemia, hypertriglyceridaemia and combined hyperlipidaemia. In the Fredrickson classification, this includes types IIa, IIb, III and IV. **Dosage** *Adults:* One tablet (100mg ciprofibrate) per day. *Elderly patients:* As for adults but see precautions and warnings. *Use in impaired renal function:* In moderate renal impairment it is recommended that dosage be reduced to one tablet every other day. Patients should be carefully monitored. MODALIM should not be used in severe renal impairment. *Use in children:* Not recommended since safety and efficacy in children have not been established. **Contra-indications:** Severe hepatic impairment, severe renal impairment, pregnancy and lactation. **Use in Pregnancy and Lactation:** There is no evidence that ciprofibrate is teratogenic, but there were signs of toxicity at high doses in teratogenicity tests in animals, and ciprofibrate has been shown to be excreted in breast milk in rats. In the absence of data on its use in human pregnancy or lactation, Modalim is contraindicated during pregnancy and in nursing mothers. **Precautions:** The daily dose should not exceed 100mg, doses of 200mg or more have been associated with a high risk of muscle related side effects. Use with caution in patients with impaired renal or hepatic function. If, after several months therapy, serum lipid concentrations are not satisfactorily controlled, additional or different therapeutic measures should be considered. **Interactions:** Ciprofibrate is highly protein bound and therefore likely to displace other drugs from plasma protein binding sites. MODALIM has been shown to potentiate the effect of warfarin indicating that concomitant oral anticoagulant therapy should be given at reduced dosage and adjusted according to prothrombin time. Although there are no specific data, it is likely that ciprofibrate will also potentiate the action of oral hypoglycaemic agents and its action may be affected by oral contraceptives. As with other fibrates, the concomitant use of Modalim with HMG-CoA reductase inhibitors, or other fibrates, may predispose patients to myopathy. **Side effects:** There have been occasional reports of headache, vertigo, rashes and gastrointestinal symptoms including nausea, vomiting, diarrhoea and dyspepsia. Generally these side effects were mild to moderate in nature and occurred early on, becoming less frequent as treatment progressed. Isolated cases of pneumonitis have been reported. As with other drugs of this class, a low incidence of myalgia, elevation of serum creatine phosphokinase, impotence, hair loss and rare cases of rhabdomyolysis, have been reported. Dizziness, drowsiness or tiredness have only rarely been reported in association with MODALIM. It is therefore unlikely to affect ability to drive or to use machinery. Abnormal liver function tests have been observed occasionally. Periodic liver function tests are recommended. MODALIM should be halted if liver enzyme abnormalities persist. **NHS Price** £13.38 per pack of 28 tablets. **Legal Category:** POM PL11723/0050 Modalim is a registered trademark.

Modalim is a registered trademark.
Further information is available from:
Sanofi Winthrop Ltd, One Onslow Street,
Guildford, Surrey, GU1 4YS
Telephone: (01483) 505515
Fax: (01483) 35432
Date of Preparation: December 1995
5603A

MIXED HYPERLIPIDAEMIA - A GREATER RISK OF CHD THAN RAISED CHOLESTEROL ALONE



ONCE DAILY

Modalim®

ciprofibrate

FOR THE CONTROL OF MIXED HYPERLIPIDAEMIA

ZOCOR® (simvastatin, MSD)

ABRIDGED PRODUCT INFORMATION

Refer to Data Sheet before prescribing.

PRESENTATION

Peach, oval-shaped, film-coated tablets, marked 'ZOCOR 10' on one side, containing 10 mg simvastatin, MSD.

Tan, oval-shaped, film-coated tablets, marked 'ZOCOR 20' on one side, containing 20 mg simvastatin, MSD.

INDICATIONS

Primary hypercholesterolaemia unresponsive to diet and other non-pharmacological measures.

In patients with coronary heart disease and a plasma cholesterol level of 5.5 mmol l or greater, to

- reduce risk of mortality
- reduce risk of coronary death and non-fatal myocardial infarction
- reduce risk for undergoing myocardial revascularising procedures (CABG and PTCA)
- slow the progression of coronary atherosclerosis, including reducing development of new lesions and new total occlusions.

DOSAGE AND ADMINISTRATION

Hypercholesterolaemia

Initially 10 mg *nocte*; dose range 10–40 mg once daily *nocte*.

Maximum therapeutic response occurs within four to six weeks. Consider dose reduction if total serum cholesterol level falls below 3.6 mmol l or if LDL cholesterol falls below 1.94 mmol l. (See Data Sheet for full dosage instructions.) A standard cholesterol-lowering diet should be continued.

Coronary heart disease

Starting dose 20 mg day *nocte*. Adjustment of dose as above.

Concomitant therapy: 'Zocor' is effective alone or in combination with bile-acid sequestrants. In patients taking immunosuppressants concomitantly with 'Zocor', the maximum recommended dosage is 10 mg day (see below).

Impaired renal function: In patients with severe renal insufficiency (creatinine clearance < 30 ml min), dosages above 10 mg day should be carefully considered and, if deemed necessary, implemented cautiously.

Elderly patients: Modification of dose should not be necessary.

Children: Studies to show safety and efficacy have not been done.

CONTRA-INDICATIONS

Hypersensitivity to this product; active liver disease or unexplained persistent elevations of serum transaminases; porphyria; pregnancy and breast-feeding; women of childbearing potential unless adequately protected by non-hormonal methods.

PRECAUTIONS

Homozygous familial hypercholesterolaemia: 'Zocor' is unlikely to be effective.

Hypertriglyceridaemia: 'Zocor' is not indicated where hypertriglyceridaemia is the abnormality of most concern.

Hepatic effects: Initial and periodic liver-function monitoring recommended. Discontinue if persistent enzyme elevations occur, particularly if they rise to three times the upper limit of normal. Caution in patients with a history of liver disease and/or alcoholism.

Muscle effects: Clinically insignificant transient mild elevations of creatine phosphokinase have been seen. Therapy with HMG-CoA reductase inhibitors has rarely been associated with myopathy (<0.1%). Myopathy should be considered in any patient with marked elevations of creatine phosphokinase (CPK) levels (≥10 times the upper limit of normal) or with diffuse myalgias, muscle tenderness and such marked elevations of CPK levels. The patient should be asked to promptly report unexplained muscle pain, tenderness or weakness. The risk of myopathy with HMG-CoA reductase inhibitors is known to be increased by concomitant immunosuppressive therapy including cyclosporine, by concomitant therapy with a fibric acid derivative or lipid-lowering doses of nicotinic acid, and believed to be enhanced by itraconazole. There have been rare reports of severe rhabdomyolysis with secondary acute renal failure. Therefore, the benefits and risks of using simvastatin concomitantly with immunosuppressive or

fibrate drugs, lipid-lowering doses of nicotinic acid, or itraconazole and other systemic azole antifungal derivatives should be carefully considered.

Pregnancy: Contra-indicated. One month should elapse between ending therapy with 'Zocor' and planned conception.

Paediatric use: Safety and effectiveness in children have not been established.

Drug interactions: Care should be taken in patients on concomitant lipid-lowering therapy, particularly fibrates or nicotinic acid derivatives or itraconazole or immunosuppressive therapies, as they are at increased risk of myopathy. In two clinical studies, 'Zocor' modestly potentiated the anticoagulant effect of warfarin; patients taking coumarin derivatives should have their prothrombin time determined prior to therapy with 'Zocor' and monitored as usual. Slight elevation in digoxin levels has been seen when co-administered with 'Zocor'.

SIDE EFFECTS

Side effects reported most frequently in controlled clinical trials, abdominal pain, constipation, flatulence, asthenia, and headache. Rarely, myopathy. Side effects reported either in long-term extension studies or in marketed use: nausea, diarrhoea, rash, dyspepsia, pruritus, alopecia, dizziness, muscle cramps, myalgia, pancreatitis, paraesthesia, peripheral neuropathy, vomiting, and anaemia. Rarely, rhabdomyolysis and hepatitis jaundice occurred. An apparent hypersensitivity syndrome has been reported rarely which has included some of the following features: angioedema, lupus-like syndrome, polymyalgia rheumatica, vasculitis, thrombocytopenia, eosinophilia, ESR increased, arthritis, arthralgia, urticaria, fever, flushing, dyspnoea, and malaise. Marked and persistent increased serum transaminases have been reported infrequently. Elevated alkaline phosphatase and γ-glutamyl transpeptidase have been reported. Liver-function test abnormalities have generally been mild and transient. Increases in CPK (muscle derived) have been reported. Side effects reported but where a causal relationship to 'Zocor' is not established: depression, erythema multiforme including Stevens-Johnson syndrome, leucopenia, and purpura.

PACKAGE QUANTITIES AND BASIC NHS COST

10 mg tablets, £18.29 for 28-tablet calendar pack
20 mg tablets, £31.09 for 28-tablet calendar pack

Product licence numbers:
10 mg tablets, 0025 0241; 20 mg tablets, 0025 0242

Product licence holder: Merck Sharp & Dohme Limited, Hertford Road, Hoddesdon, Hertfordshire, EN11 9BU.

POM Date of review: August 1995.

® denotes registered trademark of Merck & Co., Inc., Whitehouse Station, NJ, USA.

ZOCOR®

(simvastatin, MSD)

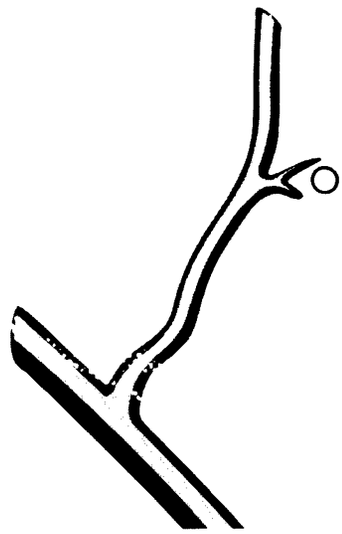
Improving survival in post-MI and angina patients

MSD

Merck Sharp & Dohme Limited
Hertford Road, Hoddesdon, Hertfordshire, EN11 9BU

08-96 ZCR.95.GB.70195.J. A

A Modern Therapeutic Alternative to Intravenous Nitrates



Venous access without the drip

- As effective as intravenous nitrates[1,2]
- Easy and convenient to administer
- Can provide major cost savings without compromising patient care[3]

SUSCARD® BUCCAL

controlled release glyceryl trinitrate

Abbreviated Prescribing Information

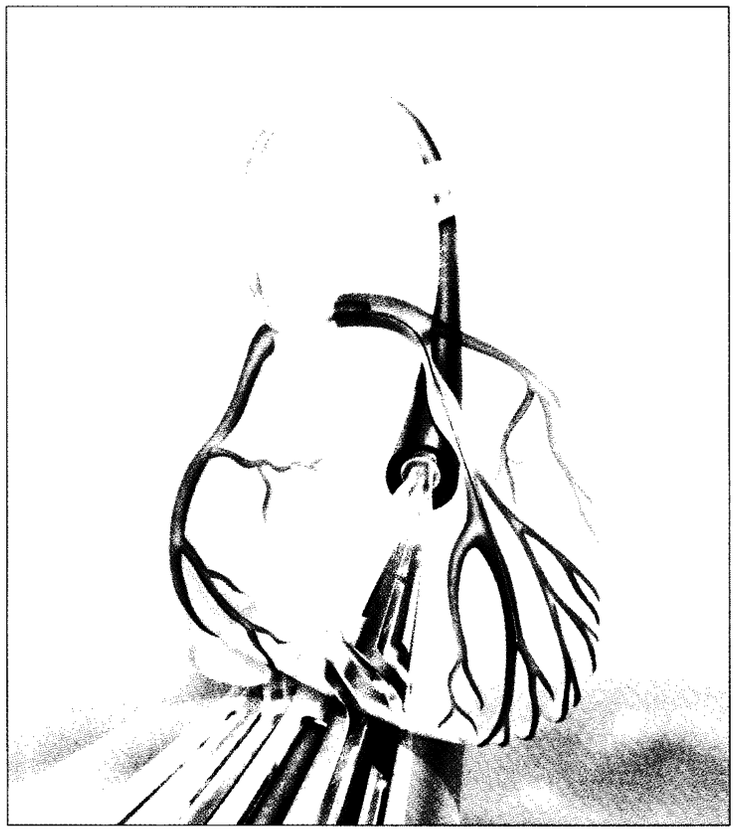
Presentation White biconvex sustained release tablets of glyceryl trinitrate for buccal administration, each tablet marked with dosage strength on one face. **Uses** The management and treatment of angina pectoris. The in-patient management of unstable angina. Acute and Congestive cardiac failure. **Administration** Place the tablet high up between the upper lip and gum to either side of the front teeth. The tablets should NOT be placed under the tongue, nor intentionally swallowed or chewed. **Dosage** Angina: Starting dose of 2mg, administered (a) p.r.n. to abort the acute attack (b) prior to encountering an angina precipitating stimulus (c) t.i.d., or as determined by tablet dissolution rate for chronic therapy. The dosage can be increased to 3mg and then 5mg if necessary. Unstable Angina: dosage should be rapidly titrated upwards in order to relieve and prevent symptoms. Acute Heart Failure: 5mg repeated until symptoms abate. Congestive Cardiac Failure: Start with 5mg t.i.d. increasing to 10mg (2 x 5mg) over three to four days if required. **Warnings and Precautions** As for glyceryl trinitrate. Do not use in patients with marked anaemia, head trauma, cerebral haemorrhage, or closed angle glaucoma. Only use in pregnant women and lactating mothers if essential. **Side effects** Predominantly headache and facial flushing (if severe tablet can be removed). Toxic effects of glyceryl trinitrate include vomiting, restlessness, cyanosis, methaemoglobinaemia and syncope. **Presentation and Product Licence Numbers and Basic NHS Prices** Suscard (100 tablets) **1mg** - £9.82 PL0108 0067 PA 100 33 1 **2mg**-£14.19, PL0108 0069 PA 100 33 3 **3mg**-£20.48 PL0108/0073 PA100 33 5 **5mg**-£27.88 PL 0108 007' PA100 33 6. **Legal Category** P. **Date of preparation** October 1993. Full prescribing information available on request from Pharmax Ltd., Bexley, Kent, DA5 1NX.

References 1. Lahiri et al., Am. J. Noninvas. Cardiol. 1989; 3:281-289. **2.** Dellborg M. et al, 1991 Buccal vs Intravenous Nitroglycerin in Unstable Angina. Eur J Clin Pharmacol 41:5-9. **3.** Data on file, Pharmax Ltd.

PHARMAX

Pharmax Limited, Bexley, Kent DA5 1NX.

A New Beginning In Coronary Medicine



The PALMAZ-SCHATZ™ balloon-expandable STENT introduces a new era for selected patients with symptomatic ischemic heart disease

Reduces Incidence of Restenosis

Implantation of the PALMAZ-SCHATZ stent reduces the incidence of restenosis compared to angioplasty alone.[1,2]

Increases Success Rate of Angioplasty

The procedural success rate of angioplasty performed with the PALMAZ-SCHATZ stent is higher than that of angioplasty alone.[2]

Extensive Clinical Experience

Over 75,000 PALMAZ-SCHATZ stents have been successfully implanted in patients worldwide.

Yields Higher Rates of Event-free Survival

In patients treated with the PALMAZ-SCHATZ coronary stent, 87% with *de novo* lesions survived event-free for one year after implantation.[3]

New Spiral Stent Offers Improved Strength

The newest PALMAZ-SCHATZ stent incorporates a spiral articulation for improved radial strength.

To learn more about the PALMAZ-SCHATZ stent and training programs for stent implantation, contact your JJIS representative.

[1] Serruys PW, de Jaegere P, Kiemeneij F, et al. A comparison of balloon-expandable-stent implantation with balloon angioplasty in patients with coronary artery disease. *N Engl J Med* 1994; 331:489-495.

[2] Fischman DL, Leon MB, Baim DS, et al. A randomized comparison of coronary-stent placement and balloon angioplasty in the treatment of coronary artery disease. *N Engl J Med* 1994; 331:496-501.

[3] Savage MP, Fischman DL, Schatz RA, et al. Long-term angiographic and clinical outcome after implantation of a balloon-expandable stent in the native coronary circulation. *JACC* 1994; 24:1267-1272.

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INTERVENTIONAL SYSTEMS
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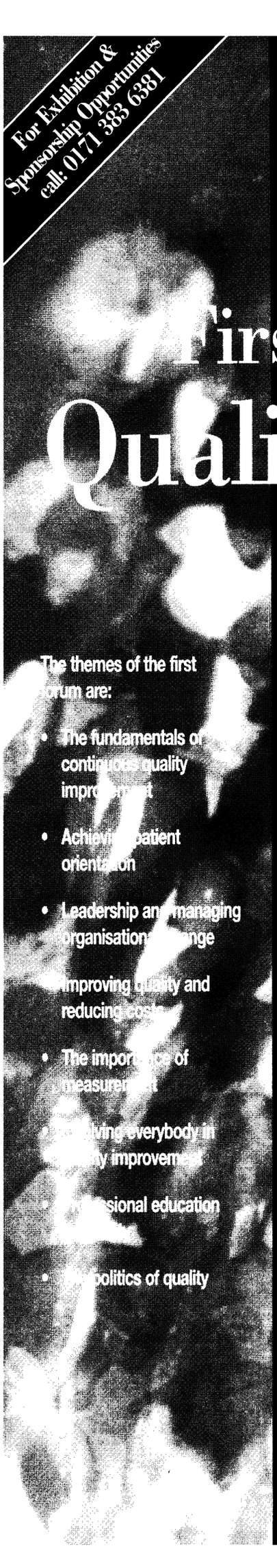
INSTITUTE *for* HEALTHCARE IMPROVEMENT

First European Forum on Quality Improvement in Health Care



The themes of the first forum are:

- The fundamentals of continuous quality improvement
- Achieving patient orientation
- Leadership and managing organisational change
- Improving quality and reducing costs
- The importance of measurement
- Involving everybody in quality improvement
- Professional education
- The politics of quality

QEII Conference Centre, London, 7,8,9 March 1996

Chaired by: Mats Brommels, Helsinki, Finland; Christian Koeck, Vienna, Austria; Martin McNicol, London, UK

Bringing quality improvement to the heart of European health care.

This first European forum will allow the exchange of ideas on quality improvement in health care and provide education.

The forum will consist of plenary lectures, parallel seminars and workshops, panel discussions, and short educational courses. Open to all, the forum is aimed at: Doctors, nurses, other health professionals, health managers, quality managers and government officials responsible for health care. It will benefit both beginners and those experienced in quality improvement.

The European Forum has been developed from the United States National Forum on Quality Improvement in Health Care, which is now in its seventh year and attracts over 1500 health professionals annually.

The programme committee for the conference is:
Don Berwick (Boston, US), Gayle Capazzalo (Houston, US), Dieter Conen (Aarau, Switzerland), Michael Deighan (Edinburgh, UK), Ulises Ruiz-Ferrandiz (Madrid, Spain), Alexandra Giraud (Paris, France), Richard Grol (Maastricht, Netherlands), Eva Hammershoy (Copenhagen, Denmark), Gill Harvey (Bristol, UK), Egil Haugland (Norway), Fiona Moss (London, UK), John Ovretveit (Gottenberg, Sweden), Paul Quaethoven (Heverlee, Belgium), Richard Smith (London, UK), Christof Veit (Hamburg, Germany), Peter Wilcock (Bournemouth, UK).

For more information, complete the form below:

First European Forum on Quality Improvement in Health Care

7, 8, 9 March 1996

Please send me more information on attending the conference

Name: .....

Position: .....

Address: .....

.....

..... Postcode: .....

Tel: ..... Fax: .....

Please return to Clare Moloney, BMA Conference Unit, BMA House, Tavistock Square, London WC1H 9JP, UK

Fax: +44(0)171 383 6663 Tel: +44(0)171 383 6478 email: 100632.1404@compuserve.com

A College of the University of London

Royal Postgraduate Medical School

Hammersmith Echocardiology

3 - 7 June 1996

A week long course of contemporary echocardiography designed for cardiologists, cardiac technicians and general physicians. This course is geared to those who want to improve their general knowledge and keep up to date with the ever expanding ultrasound modalities. This intensive course will consist of lectures from world-wide experts in the field and discussions on controversial subjects.

The following topics will be covered: Physics of modern ultrasound technology * Comprehensive trans-oesophageal echocardiography and colour flow mapping * Congenital heart disease * Stress echocardiography * Echo in coronary heart disease * Valvular heart disease * Endocarditis * Ventricular function and quantitative echocardiography * Video tape demonstrations *

Speakers will include:

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Professor JRTC Roelandt (Netherlands)	Professor R Erbel (Essen)
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Mr G Leech (London)	Dr I Simpson (Southampton)
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Mr P Smith (London)	Dr J Gibbs (Leeds)
Dr P Nihoyannopoulos (London)	Dr G Sutherland (Edinburgh)
Dr R Hall (Cardiff)	Professor Celia Oakley (London)
Dr F Ten Cate (Netherlands)	Dr SY Ho (London)
Dr A Reddington (London)	Professor C Visser (Netherlands)
Dr S Hunter (Newcastle)	Dr M Rigby (London)
Dr G Williams (Leeds)	

Course organiser: Dr P Nihoyannopoulos MD, FACC, FESC

Course fee: £400.00
(£370.00 - UK NHS Employees and members of BSE)

Further details from: Wolfson Conference Centre
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Telephone: 0181 740 3117
0181 740 3245

Fax: 0181 740 4950

E-mail: wcc@rpms.ac.uk

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Imperial College

National Heart & Lung Institute and Royal Brompton Hospital

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11 - 14 June, 1996

Courses Organisers

Dr P Collins & Professor R H Anderson

Topics to be discussed

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Heart Failure
Molecular Biology and Genetics
Preventive Cardiology
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Dr P Barton	Prof S Marston
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Dr J Cleveland	Dr K Schwartz
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Dr D Gibson	Dr U Sigwart
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Course Fee:

Technicians and Nurses: £250.00
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This course has been awarded 19 CME Credits

Enquiries should be made to: Imperial College School of Medicine at the National Heart & Lung Institute, Dovehouse Street, London SW3 6LY
Telephone: (+44) 171 351 8172 (24 hr answering service),
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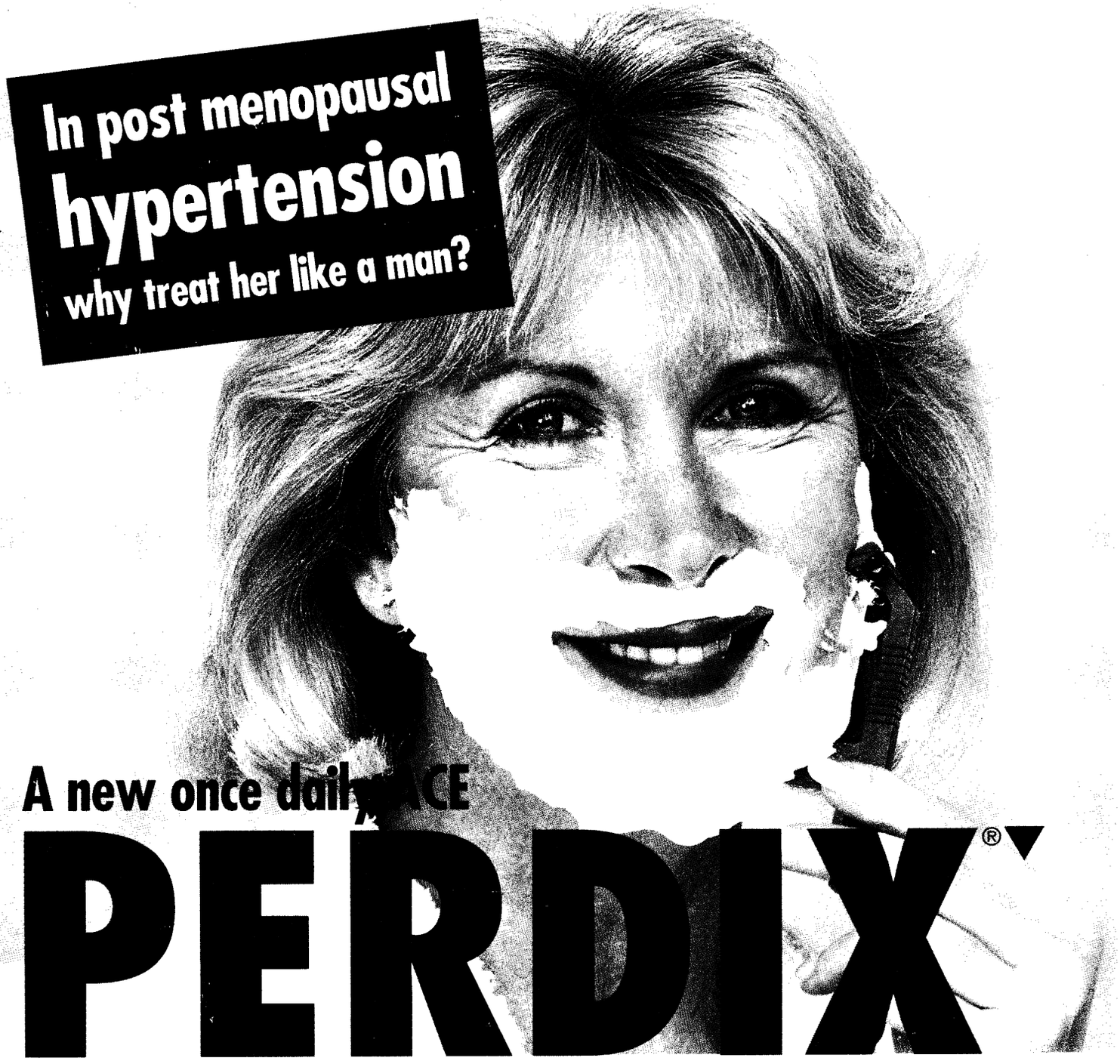
The National Heart and Lung Institute operates a NO SMOKING policy.

The College is striving towards Equal Opportunities.

At the leading edge of research, innovation and learning



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PERDIX®▼

Moexipril

Heart disease is the single largest killer of women in the UK.[1] Hypertension is found frequently in post menopausal women. It has been shown that Perdix controls hypertension and is metabolically neutral in post menopausal women treated with HRT.[2]

Perdix® ▼ 7.5mg and 15mg Tablets. Prescribing Information.
Refer to Summary of Product Characteristics before prescribing. Presentation: Tablets containing 7.5mg and 15mg moexipril hydrochloride. **Uses:** Treatment of hypertension as monotherapy. Second line therapy for the treatment of hypertension in combination with diuretics or calcium antagonists. **Dosage and Administration:** *Untreated Patients:* in patients with uncomplicated essential hypertension the recommended initial dose is 7.5mg once a day. Adjust dosage according to response. Usual dosage range is 15 to 30mg per day as a single daily dose. Doses over 30mg have been used, but do not appear to give a greater effect. If blood pressure is not controlled with Perdix alone, a low dose of a diuretic may be added. *Diuretic treated patients:* symptomatic hypotension may occur occasionally following the initial dose of Perdix. Discontinue diuretic 2-3 days before starting Perdix to reduce the likelihood of hypotension. Adjust dosage of Perdix according to response. Resume diuretic later if required. *Nifedipine treated patients:* initial dose of 3.75mg recommended. *Elderly:* initial dose of 3.75mg followed by titration to optimal response. *Children:* not recommended. *Renal failure:* if creatinine clearance ≤40ml/min, initial dosage should be 3.75mg. *Hepatic cirrhosis:* initial dosage of 3.75mg is recommended. *Afro-Caribbean patients:* may show a reduced therapeutic response. **Contra-indications:** Hypersensitivity to moexipril hydrochloride. History of angioedema following treatment with ACE inhibitors. Pregnancy and lactation. **Special warnings and precautions for use: Warnings:** *Angioedema:* angioedema involving the extremities, face, lips, mucous membranes, tongue, glottis or larynx has been reported in patients treated with ACE inhibitors. Discontinue treatment with Perdix and institute appropriate therapy immediately. *Hypotension:* Perdix can cause symptomatic hypotension, most commonly in volume and/or salt-depleted patients. Correct before initiating therapy with Perdix. *Neutropenia/agranulocytosis:* agranulocytosis and bone marrow depression may result particularly in patients with renal impairment and a collagen-vascular disease. **Precautions:** Changes in renal function may be anticipated in susceptible individuals. Increases in blood urea nitrogen and serum creatinine may occur in hypertensive patients on diuretic therapy and more commonly those with renal artery stenosis in a solitary kidney or bilateral renal artery stenosis. Dosage reduction of Perdix and/or discontinuation of the diuretic may be required. Hyperkalaemia occurs rarely. Risk factors include renal insufficiency, diabetes mellitus, and concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes. Patients with hepatic cirrhosis may develop elevated plasma levels of moexipril hydrochloride. In patients undergoing surgery or during anaesthesia with agents that produce hypotension, Perdix will block the angiotensin II formation that could otherwise occur secondary to compensatory renin release. **Interactions:** Combination with diuretics or other antihypertensive agents may have a potentiating effect. Potassium loss caused by thiazide diuretics may be attenuated. Concurrent use of potassium supplements or potassium sparing diuretics may lead to elevated serum potassium. Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving ACE inhibitors during lithium therapy. **Side effects:** include cough, headache, dizziness, fatigue, flushing, and rash. Less commonly, symptomatic hypotension, postural hypotension, syncope, chest pain, angina/myocardial infarction, palpitations, rhythm disturbances and cerebrovascular accident. Increases in serum creatinine levels. Abdominal pain, dyspepsia, constipation, nausea, vomiting, diarrhoea, appetite/weight change, dry mouth, pancreatitis, hepatitis. Upper respiratory infection, pharyngitis, sinusitis/rhinitis, bronchospasm, dyspnoea. Renal insufficiency. Hypersensitivity reactions, drowsiness, sleep disturbances, nervousness, mood changes, anxiety. Also angioedema, taste disturbances, tinnitus, sweating, flu syndrome, malaise, arthralgia, myalgia. **Pharmaceutical precautions:** Store in a dry place below 25°C. **Legal category:** POM. **Package quantities and prices:** Perdix 7.5mg: calendar packs of 28 tablets £8.50; Perdix 15mg: calendar packs of 28 tablets £9.80. **Product licence numbers:** Perdix 7.5mg – 4438/0033. Perdix 15mg – 4438/0034. **Product licence holder:** Schwarz Pharma Ltd., Schwarz House, East Street, Chesham, Bucks. HP5 1DG. Telephone: 01494 772071. Fax: 01494 773934. **Date of preparation:** September 1995 (389). **Further information is available from the licence holder:** Schwarz Pharma Limited, East Street, Chesham, Bucks. HP5 1DG. **References: 1.** British Heart Foundation, 1995. **2.** Data on file 02.

SCHWARZ

PERDIX▼
Moexipril

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