KEY WORDS OF MODERN ANTIFUNGAL THERAPY

5

THE REASSURING FACTOR:

NO REDISTRIBUTION...

After oral intake, itraconazole is delivered to the skin: **1.** by excretion via the sebaceous glands and **2.** by passive diffusion from the blood into the keratinocytes in the epidermis. Its antifungal activity in the epidermis continues for a full epidermal cycle (4 weeks) after the end of therapy, as its lipophilic structure prevents redistribution via the bloodstream.

Fungi and yeasts are notorious for their ability to entrench themselves in what may be called *the outside:* the skin, nails, hair and mucosa.
As for antifungal therapy, an effective way to reach all parts of that outside is via *the inside,* i.e. by the systemic route.

Ideally, an oral antimycotic should quickly disappear from the bloodstream and firmly establish itself in keratinous and mucosal tissues. And preferably, having reached its destination, *it should remain in those tissues and not be released back into the bloodstream.*

This is precisely what happens with itraconazole (Sporanox). Because of its lipophilic structure, it is strongly attracted to the epithelial cells, from where it will only be eliminated — *and only towards the outside* — as those cells gradually desquamate. During all that time its antifungal activity continues.

In fact, this strong fixation to — and inside — the outside tissues is what now permits the use of short, fixed, oral antifungal treatment schedules.

Sporanox*

ITRACONAZOLE 100 mg

SHORT AND SIMPLE ORAL THERAPY

(See prescribing information below)
Basic dose in dermatology: 1 capsule (100 mg) once daily for 15 days
Standard dose in vaginal candidosis: 2 x 2 capsules (400 mg) for 1 day only

Note: This product is not yet available in all countries.

*** Trademarks: SPORANOX, SEMPERA, TRISPORAL**

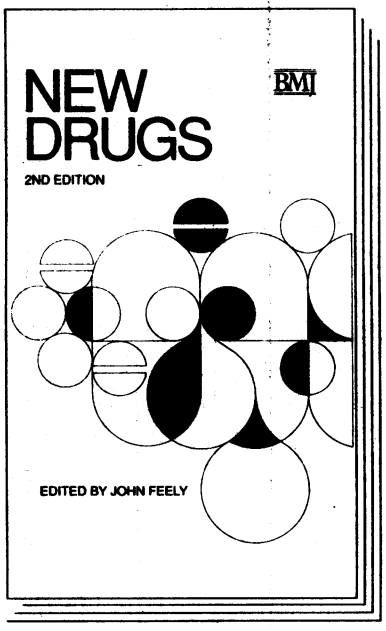
JANSSEN PHARMACEUTICA
B-2340 Beerse, Belgium
expertise in antimycotic research

Properties: Sporanox (itraconazole), a triazole derivative, is orally active against infections with dermatophytes (*Trichophyton* spp., *Microsporum* spp., *Epidermophyton floccosum*), yeasts (*Candida* spp., *Pityrosporum* spp.), *Aspergillus* spp. and various other yeasts and fungi. **Indications:** Sporanox (itraconazole) is indicated for vulvovaginal candidosis, pityriasis versicolor, dermatophytoses, fungal keratitis and oral candidosis. **Dosage and administration:** Vulvovaginal candidosis: 2 capsules (200 mg) morning and evening for 1 day; pityriasis versicolor: 2 capsules (200 mg) once daily for 7 days; tinea corporis, tinea cruris, tinea pedis, tinea manus: 1 capsule (100 mg) daily for 15 days; highly keratinized regions, as in plantar tinea pedis and palmar tinea manus, require 1 capsule (100 mg) daily for 30 days. Oral candidosis: 1 capsule (100 mg) daily for 15 days. Fungal keratitis: 2 capsules (200 mg) once daily for 21 days. **Contra-indications:** Sporanox (itraconazole) is contra-indicated during pregnancy. **Warnings and precautions:** Although clinically Sporanox (itraconazole) has not been associated with hepatic dysfunction, it is advisable not to give this drug to patients with a known history of liver disease. **Nursing mothers:** It is recommended not to breast feed whilst taking Sporanox (itraconazole). **Drug interactions:** Sporanox (itraconazole) should not be given concomitantly with rifampicin.

Full prescribing information is available on request.

INT 91/2296.5/AV9110-5

What's best for patients?

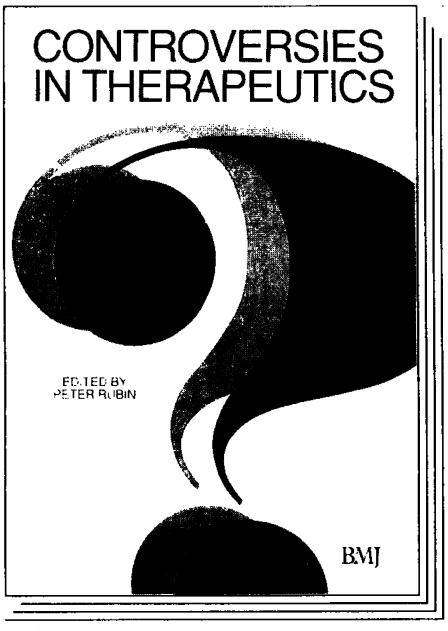


New drugs are continually being developed and knowledge about existing drugs is constantly expanding, so it is essential, but difficult, for doctors to keep up to date with the latest developments. *New Drugs* describes the most important therapeutic advances of the past decade and discusses the drugs that will be in common use in the 1990s. Completely revised and updated, this second edition has been expanded to include 11 additional chapters. Its coverage of practical aspects of drug use, avoidance of adverse reactions and interactions, and prescribing at extremes of age makes it an invaluable guide for busy practitioners who want to get the best out of the new drugs currently available.

Chapters include: **Adverse reactions to drugs • Calcium antagonists • Diuretic treatment • Antiarrhythmic drugs • Insulin • Lipid lowering drugs • Antidepressant drugs • Centrally acting drugs • Controlling symptoms in advanced cancer**

Second edition April 1991

UK £14.95; Abroad £18.00 (BMA members £13.95 or £17.00)



Doctors do not always agree on what is the right treatment even for quite common conditions. Often definitive clinical trials have not been performed and no one knows for sure the best way to treat. *Controversies in Therapeutics* looks at some problems that arise in general practice. For each one it offers two different approaches; and Peter Rubin, professor of therapeutics and consultant physician at the University Hospital of Nottingham, provides an editorial comment on these which summarises the prevailing views and helps you to make up your own mind. Written by academic experts with everyday clinical experience, *Controversies in Therapeutics* is a must for all physicians and general practitioners—both those who think they know it all and those who know they don't.

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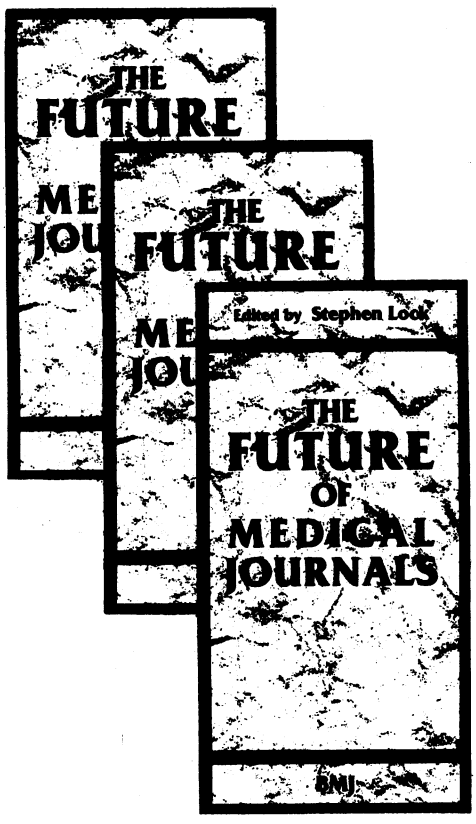

The future is bright

"Many articles are neither read nor cited; indeed many articles are poor. In general many journals seem to be of little practical help to clinicians facing problems at the bedside."
"... in the course of a year at least half the journals on the shelves are never looked at at all."
"Most editors ... are 'half nun, half whore.'"
"... in the 300 years of their existence journals have done little to examine their own practices."
"What *are* editors?"
"'If an editor does not please himself,' he used to say, 'he will not please anybody.'"
"Defensive editing we do not need."
"Medical journals in developing countries are, with very few exceptions, unattractive."
"I believe that the future for general medical journals—particularly those published in English—is bright. They will undoubtedly change, but they will not disappear."

The debate was lively and the opinions conflicting and forcefully expressed when, to mark its 150 year past, the *BMJ* decided to join with other general medical journals in examining their perhaps not too certain future. At a conference at Leeds Castle editors of major general medical journals throughout the world, with experts in information science, sociology, and epidemiology, discussed the functions and effectiveness of modern journals, and debated possible choices for development. Edited by Stephen Lock, *The Future of Medical Journals* is a unique compilation of papers on this important but little analysed aspect of medical science.

September 1991
UK £14.95; Abroad £17.50 (BMA members £13.95 or £16.50)

Peer review is one of the key processes at several stages of scientific research, applications for a research grant, assessing an abstract of a contribution submitted to a meeting of a scientific society, and refereeing a paper for publication in a journal. Without publication, which entails such preliminary validation (continued afterwards by the journal's general and specialist readers), science cannot advance. And ensuring that peer review is as accurate, fair, and quick as possible is one of the principal tasks of most scientific editors.

Third impression 1991 (with new introduction)
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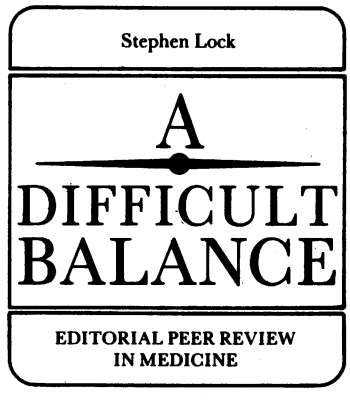

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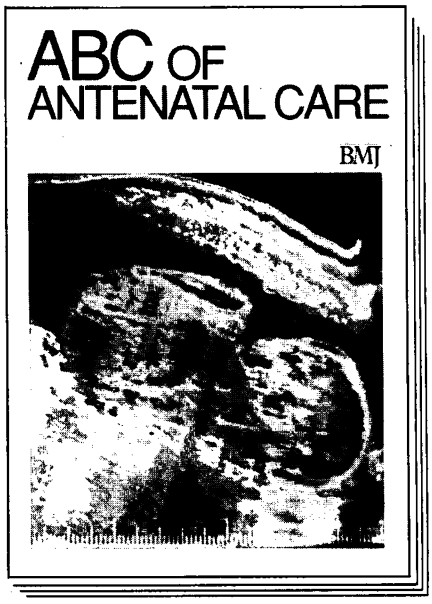

Healthy women with normal pregnancies need little formal care; those at risk of damage to their own or their baby's health need the best of scientific medicine. The aim of antenatal care is to distinguish between these two groups, giving those who need it the full range of diagnostic and therapeutic measures while avoiding unnecessary intervention in those whose pregnancy proceeds normally. In the *ABC of Antenatal Care* Geoffrey Chamberlain, professor and chairman of the department of obstetrics and gynaecology at St George's Hospital Medical School, London, outlines the practicalities of routine antenatal care and the management of the major medical problems that may arise. Originally published as a series of articles in the *BMJ*, this manual discusses with common sense and humour the background to current practice and indicates how it could be improved in the 1990s.

Chapters include

- Normal antenatal management
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January 1992

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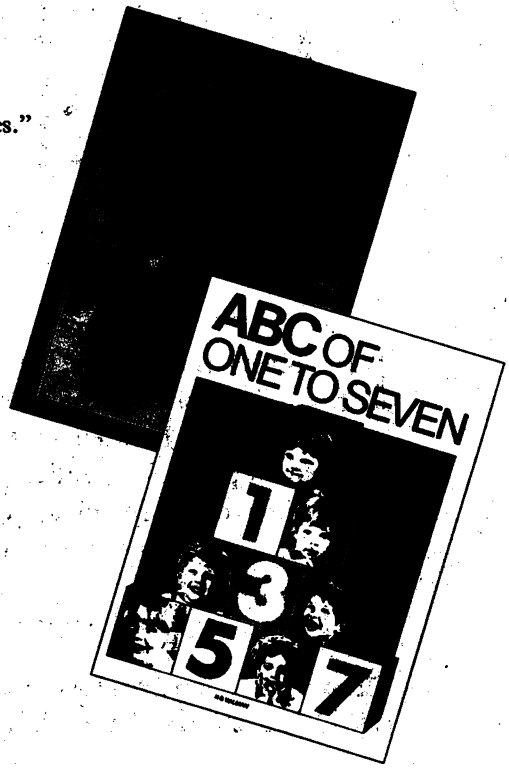

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gastric distress & oesophagitis

hyperacidity or dysmotility?

Most complaints of gastric distress, as well as oesophagitis, are conventionally attributed to hyperacidity in the stomach. However, the contemporary view in gastroenterology holds that most upper G.I. problems, including heartburn, postprandial fullness, early satiety, abdominal distension and epigastric discomfort, are commonly motility related.[1-3] And this stands to reason. After all, proper peristalsis is a physiological necessity for our digestive process.

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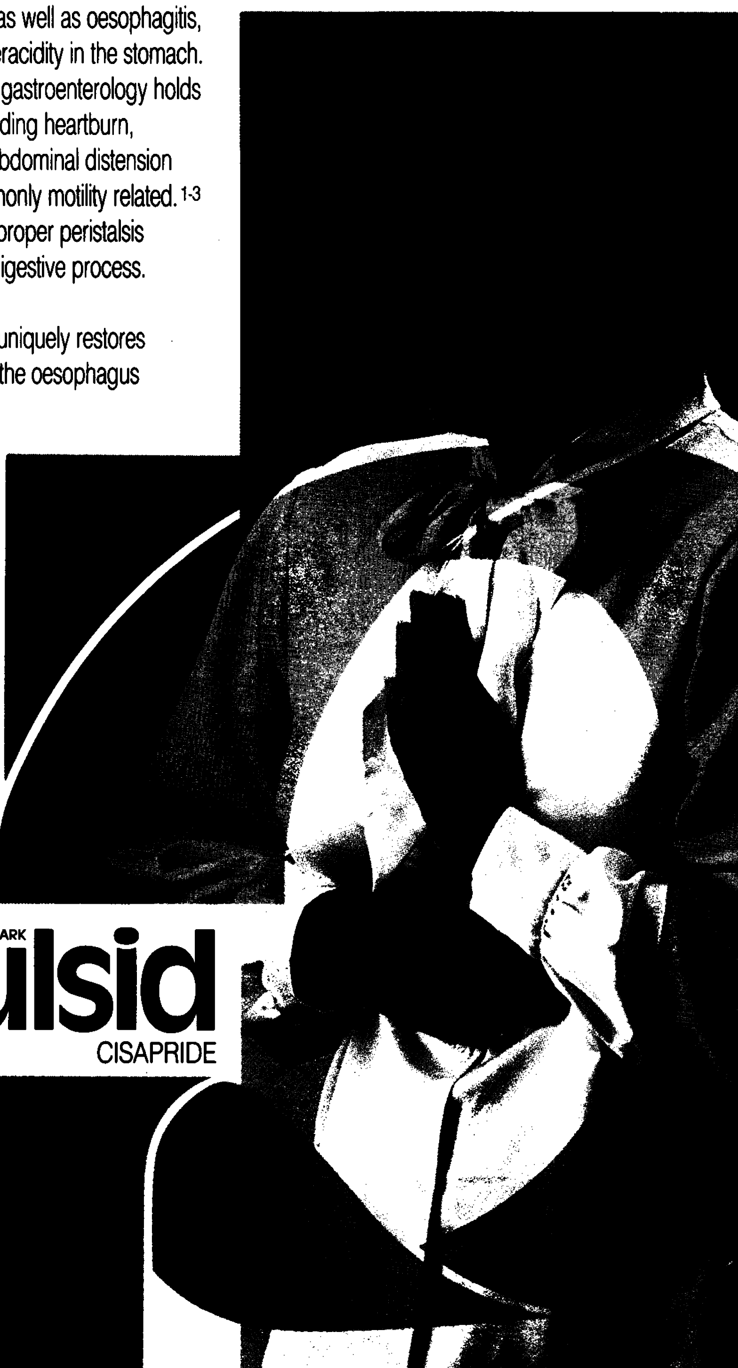

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References: 1. Knuff, J.E., *et al.*: Dig. Dis. Sci. 29, 194 (1984); 2. Kahrilas, J.P., *et al.*: Gastroenterology 91, 897 (1986); 3. Malagelada, J.R., *et al.*: Gastroenterol. 88, 1223 (1985); 4. Ceccatelli, P., *et al.*: Gut 29, 631 (1988); 5. Collins, B.J., *et al.*: Hepato-Gastroenterol. 34, 113 (1987); 6. Jian, R., *et al.*: Dig. Dis. Sci. 34, 657 (1989).

Prescribing information - Prepulsid (cisapride) is a gastro-intestinal prokinetic agent. Prepulsid enhances and co-ordinates gastro-intestinal propulsive motility, thereby preventing stasis and reflux. **Therapeutic indications**: 1. Gastroparesis. 2. Symptoms of X-ray or endoscopy negative upper digestive discomfort. 3. Gastro-oesophageal reflux disorders, including oesophagitis. 4. Intestinal pseudo-obstruction. **Contra-indications**: No absolute contra-indications are known. **Precautions**: *Pregnancy*: Although, in animals, there is no effect on primary fertility, no primary embryotoxic and no teratogenic effect, the anticipated therapeutic benefits should be weighed against the potential hazards before Prepulsid is given during pregnancy, especially during the first trimester. *Nursing mothers*: Although the excretion in breast milk is minimal, nursing mothers are advised not to breast feed while taking Prepulsid. *Driving and machine-operating ability*: Prepulsid does not affect psychomotor function and does not induce sedation or drowsiness. Prepulsid may, however, accelerate the absorption of central nervous system depressants, such as barbiturates and alcohol. Caution should therefore be exercised when Prepulsid is administered with these drugs. **Interactions**: - The acceleration by Prepulsid of gastric emptying may affect the rate of absorption of drugs: absorption of drugs from the stomach may be diminished, whereas absorption of drugs from the small bowel may be accelerated (e.g. benzodiazepines, anticoagulants, paracetamol, H_2-blockers). - In patients receiving anticoagulants, the coagulation times may somewhat increase. It is advisable to check the coagulation time one week after the start of Prepulsid treatment to adapt the anticoagulant dose if necessary. - The effects of Prepulsid on gastro-intestinal motility are, for the most part, antagonized by anticholinergic drugs. - In hepatic and renal insufficiency, it is recommended to halve the initial daily dose. Subsequently, this dose can be adapted, depending on the therapeutic effects or possible side-effects. - In the elderly, steady-state plasma levels are generally higher, due to a moderate prolongation of the elimination half-life. Therapeutic doses, however, are similar to those used in younger patients. - In the case of drugs that require individual titration, it may be useful to monitor plasma levels of such drugs when Prepulsid is associated. **Adverse reactions**: In line with the pharmacological activity of Prepulsid, transient abdominal cramping, borborygmi and diarrhoea may occur. Mild and transient headache or lightheadedness have been reported occasionally. When diarrhoea occurs in babies or infants, the dose should be reduced. There have been isolated reports of convulsive seizures without clearcut relationship to Prepulsid. **Dosage**: - Adults: according to the severity of the condition, 5 or 10 mg of Prepulsid, 2 to 4 times daily, to be taken as tablets or as oral suspension (the full plastic 5-ml spoon contains 5 mg). As a rule the following doses have proven adequate: • less severe conditions: 5 mg t.i.d. (dose can be doubled); • severe conditions (gastroparesis, oesophagitis, refractory constipation): 10 mg t.i.d. to 10 mg q.i.d. (before the 3 main meals and before retiring). - Infants and children: on the average 0.2 mg/kg per intake, 3 to 4 times daily. For the suspension, intakes are indicated on the dosing pipet as a function of body weight.

Full prescribing information available on request.

Note: Prepulsid (cisapride) is not yet available in all countries and not all indications have been approved everywhere.