KEY WORDS OF MODERN ANTIFUNGAL THERAPY

SIMPLICITY

FIXED DOSAGE SCHEDULES

Vaginal candidosis 1 DAY
(2 caps. a.m. & p.m.)

Pityriasis versicolor 7 DAYS
(2 caps. once daily)

T. corporis, t. cruris, t. pedis, t. manus 15 DAYS*
(1 caps. daily)

Oral candidosis 15 DAYS
(1 caps. daily)

* Highly keratinized regions, as in *plantar* t. pedis or *palmar* t. manus, may require an additional 15 days' treatment.

When treating fungal infections topically, the medication is usually applied to the visible lesions only.
However, the infection may already be subclinically present at other sites of the body, waiting for a chance to start the trouble all over again.
Also, topical treatment must normally be continued until the lesions have completely disappeared. So patients may have to put up with several weeks or even months of inconvenience, often resulting in poor therapy compliance.

Much like antibiotics

Sporanox is distributed, just like an oral antibiotic, via the blood and so reaches all structures of the skin and the mucosa. And because Sporanox remains active in those tissues for a prolonged period of time, treatment can be stopped even before the lesions have clinically disappeared. This is why, in much the same way as antibiotics are being used, also fungal infections can now simply be treated with *short, fixed oral dosage 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

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

Note: This product is not yet available in all countries

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 dermatophytoses, pityriasis versicolor, fungal keratitis, oral candidosis and vulvovaginal candidosis. **Dosage and administration:** - Tinea corporis, t. cruris, t. pedis, t. manus: 1 capsule (100 mg) daily for 15 days; highly keratinized regions, as in plantar t. pedis and palmar t. manus, require 1 capsule (100 mg) daily for 30 days. - Pityriasis versicolor: 2 capsules (200 mg) once daily for 7 days. - Fungal keratitis: 2 capsules (200 mg) once daily for 21 days. - Oral candidosis: 1 capsule (100 mg) daily for 15 days. - Vulvovaginal candidosis: 2 capsules (200 mg) morning and evening for 1 day. **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 92/2372-I/AV8202-1

Health and the future

AUDIT IN ACTION

From a minority interest to an integral part of good medical practice, audit has come a long way. *Audit in Action* traces this development in a selection of articles originally published in the *BMJ*. Topics range from practical aspects of starting to audit to the wider aspects of achieving quality based on experience in the United States and Europe. The contributors are leaders in or experienced practitioners of audit. Covering audit both in hospitals and in general practice, *Audit in Action* is valuable reading for all those concerned to improve the quality of health care.

March 1992

UK £10·95; Abroad £13.00 (BMA members £9·95 or £12.00)

THE HEALTH DEBATE LIVE:
45 interviews for *Leading for Health*

When it set out to produce its manifesto for the National Health Service, the BMA sought a wide variety of perspectives. Representatives from hospitals, general practice, the BMA's craft committees, the royal colleges, parliament, regional health authorities, community and public health, education, health research, health economics, and management were interviewed on various issues integral to the health service. The resulting BMA document, *Leading for Health: a BMA Agenda for Health*, encompasses the often contrasting views and presents questions that need answering—a challenge for the association in the coming years. But what did people actually say in their interviews? The "off the top" thoughts of those interviewed can be more telling than formulated responses and carefully worked out positions on health issues, so the *BMJ* asked interviewees for permission to publish transcripts of their original comments. Most of them agreed, and this collection provides a lively and provocative contribution to the debate on the health service.

March 1992

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THE FUTURE OF GENERAL PRACTICE

General practitioners have recently had to cope with dramatic changes in their working conditions imposed on them by government policy. Like it or not, the pressure of constant change is going on, and general practitioners have to decide whether to influence its direction or simply to be overtaken by it. *The Future of General Practice* discusses what general practice should be and how it should be funded. Authors, who include general practitioners and health policy analysts, discuss topics at the heart of this debate, including research, audit, list sizes, fundholding, and general practitioners' educational needs.

March 1992

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THE HEALTH OF THE NATION: THE BMJ VIEW
Edited by Richard Smith, Editor, *BMJ*

"... a strategy imposed by the government which takes no heed of the views of those who will have to implement it ... is valueless".

So writes William Waldegrave, Secretary of State for Health, in his introduction to *The Health of the Nation*, the government's consultative document that sets out a strategy for improving the health of the English. Taking Mr Waldegrave at his word on wanting to listen to everybody, the *BMJ* commissioned a series of articles that explain the views of some of those most concerned. Contributors discuss each of the 16 key areas defined in the strategy and suggest other subjects that might qualify as key areas. Furthermore, the articles will be useful beyond the borders of England because most developed countries are now setting strategies to improve health.

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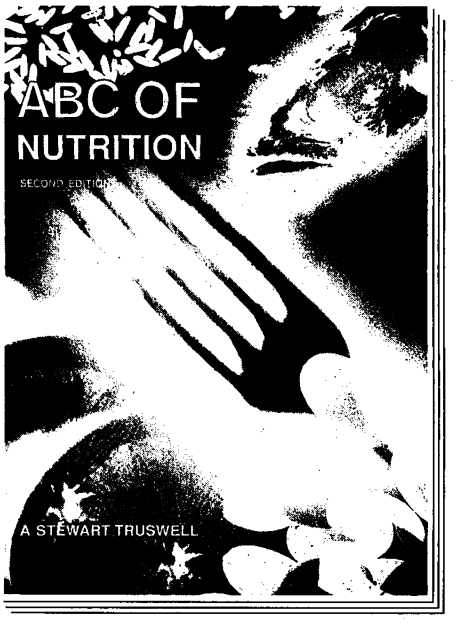

"Value judgments about food are being made all the time—they are nearly always subjective and usually wrong." A Stewart-Truswell, Boden professor of human nutrition at the University of Sydney, separates fact from fallacy in the *ABC of Nutrition*. This fully revised and updated edition offers the general medical reader a refreshingly down to earth review of all aspects of nutrition—from anorexia to obesity, infant feeding to dietary guides for the elderly—and will be invaluable for doctors and other medical professionals wishing to advise patients about their eating habits.

Reviews of the first edition

"Truswell . . . has written *the* introductory textbook for students of nutrition at any level . . . All physicians, medical students, nurses, nursing students, dieticians, dietician students, and those interested in nutrition education should have a copy of this book."
American Journal of Clinical Nutrition

"I for one will recommend this excellent book for medical undergraduates and . . . any general practitioner . . ."
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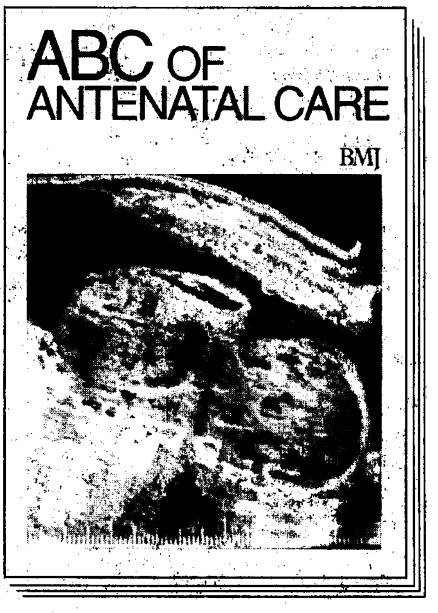

Healthy women with normal pregnancies need little formal care; those at risk of damage to their own or their baby's health need the best of scientific medicine. The aim of antenatal care is to distinguish between these two groups, giving those who need it the full range of diagnostic and therapeutic 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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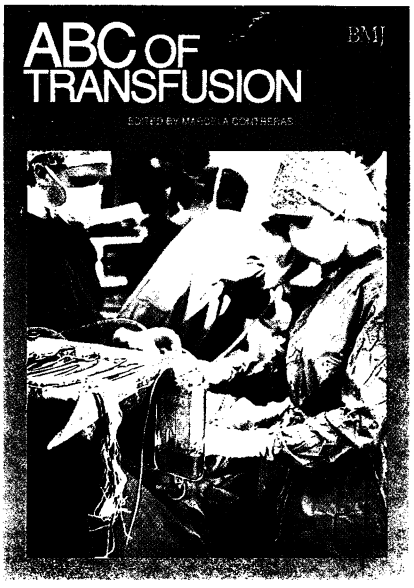

"... excellent for teaching purposes ... a good example of how to present a subject in a clear and pithy fashion."
Canadian Medical Association

"... highly recommended for personal purchase as well as departmental and ward libraries."
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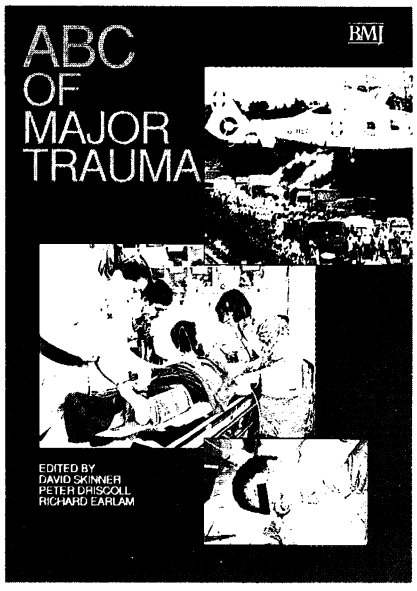

"... crammed with current information ... an excellent book which makes a major contribution to trauma care ... authors and editors are to be congratulated."
BASICS

"... an excellent manual for those dealing with trauma. Until now there has been no concise text of this sort ..."
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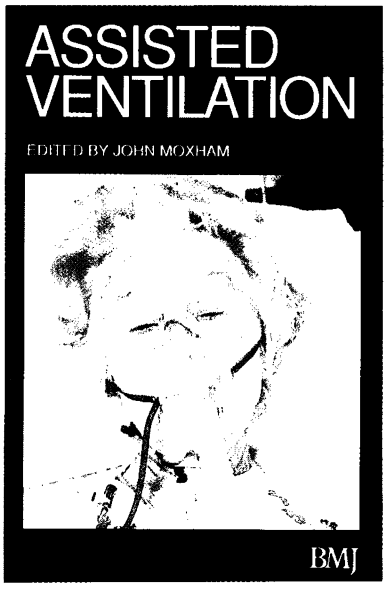

Many doctors, including those in training, care for patients in the intensive care unit. Too often such doctors do not know the details of ventilation techniques; yet if they are to feel at home on the intensive care unit they must be familiar with all aspects of assisted ventilation.

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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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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.