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CNS SPECTRUMS®

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7

Mechanisms and Presentations of Catatonia

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* *Individual responses to ARICEPT® may include improvement, stabilization, or decline.*

† The most common adverse events in pivotal clinical trials with ARICEPT® were nausea, diarrhea, insomnia, vomiting, muscle cramps, fatigue, and anorexia. Pivotal clinical trials of ARICEPT® have shown no increase, relative to placebo, in the incidence of either peptic ulcer disease or gastrointestinal bleeding. Nevertheless, cholinesterase inhibitors may be expected to increase gastric acid secretion. Therefore, patients (especially those at increased risk for developing ulcers—eg, having a history of ulcer disease, receiving concurrent nonsteroidal anti-inflammatory drugs) should be monitored closely for gastrointestinal bleeding. In pivotal clinical trials, syncopal episodes have been reported in association with ARICEPT® (2% vs 1% for placebo).

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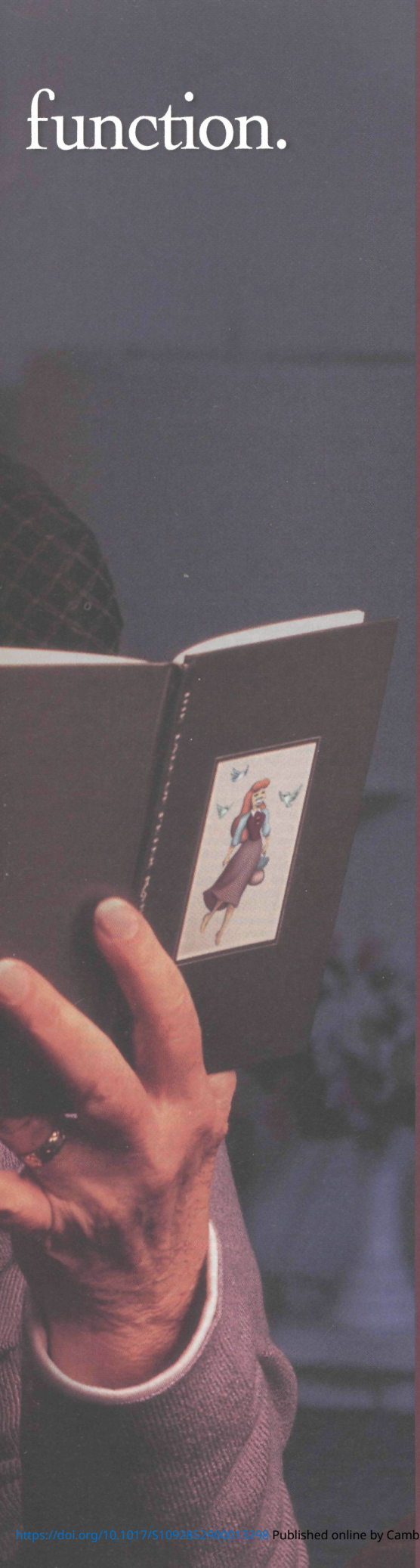

function.

She sees it as a bedtime story.

ARICEPT®. Helping to make a difference for people living with Alzheimer's

- Slows the worsening of symptoms*
- Proven to maintain cognition in placebo-controlled studies
- Well tolerated†
- Proven safety profile
- Once-daily dosing
- 3 years of real-world use

ONCE-A-DAY

ARICEPT®

(donepezil HCl)

5-MG AND 10-MG TABLETS

THERAPY TO REMEMBER™

Please see brief summary of prescribing information on adjacent page.

EL208A99CR

ARICEPT® (Donepezil Hydrochloride Tablets)

Brief Summary – see package insert for full prescribing information. **INDICATIONS AND USAGE** ARICEPT® is indicated *for the treatment of mild to moderate dementia of the Alzheimer's type.* **CONTRAINDICATIONS** ARICEPT® is contraindicated in patients with known hypersensitivity to donepezil hydrochloride or to piperidine derivatives. **WARNINGS** ***Anesthesia:*** ARICEPT®, as a cholinesterase inhibitor, is likely to exaggerate succinylcholine-type muscle relaxation during anesthesia. ***Cardiovascular Conditions:*** Because of their pharmacological action, cholinesterase inhibitors may have vagotonic effects on heart rate (e.g., bradycardia). The potential for this action may be particularly important to patients with "sick sinus syndrome" or other supraventricular cardiac conduction conditions. Syncopal episodes have been reported in association with the use of ARICEPT®. ***Gastrointestinal Conditions:*** Through their primary action, cholinesterase inhibitors may be expected to increase gastric acid secretion due to increased cholinergic activity. Therefore, patients should be monitored closely for symptoms of active or occult gastrointestinal bleeding, especially those at increased risk for developing ulcers, e.g., those with a history of ulcer disease or those receiving concurrent nonsteroidal anti-inflammatory drugs (NSAIDS). Clinical studies of ARICEPT® have shown no increase, relative to placebo, in the incidence of either peptic ulcer disease or gastrointestinal bleeding. ARICEPT®, as a predictable consequence of its pharmacological properties, has been shown to produce diarrhea, nausea and vomiting. These effects, when they occur, appear more frequently with the 10 mg/day dose than with the 5 mg/day dose. In most cases, these effects have been mild and transient, sometimes lasting one to three weeks, and have resolved during continued use of ARICEPT®. ***Genitourinary:*** Although not observed in clinical trials of ARICEPT®, cholinomimetics may cause bladder outflow obstruction. ***Neurological Conditions:*** Seizures: Cholinomimetics are believed to have some potential to cause generalized convulsions. However, seizure activity also may be a manifestation of Alzheimer's Disease. ***Pulmonary Conditions:*** Because of their cholinomimetic actions, cholinesterase inhibitors should be prescribed with care to patients with a history of asthma or obstructive pulmonary disease. **PRECAUTIONS Drug-Drug Interactions *Drugs Highly Bound to Plasma Proteins:*** Drug displacement studies have been performed *in vitro* between this highly bound drug (96%) and other drugs such as furosemide, digoxin, and warfarin. ARICEPT® at concentrations of 0.3-10 µg/mL did not affect the binding of furosemide (5 µg/mL), digoxin (2 ng/mL), and warfarin (3 µg/mL) to human albumin. Similarly, the binding of ARICEPT® to human albumin was not affected by furosemide, digoxin, and warfarin. ***Effect of ARICEPT® on the Metabolism of Other Drugs:*** No *in vivo* clinical trials have investigated the effect of ARICEPT® on the clearance of drugs metabolized by CYP 3A4 (e.g. cisapride, terfenadine) or by CYP 2D6 (e.g. imipramine). However, *in vitro* studies show a low rate of binding to these enzymes (mean K_I about 50-130 µM), that, given the therapeutic plasma concentrations of donepezil (164 nM), indicates little likelihood of interference. Whether ARICEPT® has any potential for enzyme induction is not known. ***Effect of Other Drugs on the Metabolism of ARICEPT®:*** Ketoconazole and quinidine, inhibitors of CYP450, 3A4 and 2D6, respectively, inhibit donepezil metabolism *in vitro*. Whether there is a clinical effect of these inhibitors is not known. Inducers of CYP 2D6 and CYP 3A4 (e.g., phenytoin, carbamazepine, dexamethasone, rifampin, and phenobarbital) could increase the rate of elimination of ARICEPT®. ***Use with Anticholinergics:*** Because of their mechanism of action, cholinesterase inhibitors have the potential to interfere with the activity of anticholinergic medications. ***Use with Cholinomimetics and Other Cholinesterase Inhibitors:*** A synergistic effect may be expected when cholinesterase inhibitors are given concurrently with succinylcholine, similar neuromuscular blocking agents or cholinergic agonists such as bethanechol. **Carcinogenesis, Mutagenesis, Impairment of Fertility** Carcinogenicity studies of donepezil have not been completed. Donepezil was not mutagenic in the Ames reverse mutation assay in bacteria. In the chromosome aberration test in cultures of Chinese hamster lung (CHL) cells, some clastogenic effects were observed. Donepezil was not clastogenic in the *in vivo* mouse micronucleus test. Donepezil had no effect on fertility in rats at doses up to 10 mg/kg/day (approximately 8 times the maximum recommended human dose on a mg/m² basis). **Pregnancy *Pregnancy Category C:*** Teratology studies conducted in pregnant rats at doses up to 16 mg/kg/day (approximately 13 times the maximum recommended human dose on a mg/m² basis) and in pregnant rabbits at doses up to 10 mg/kg/day (approximately 16 times the maximum recommended human dose on a mg/m² basis) did not disclose any evidence for a teratogenic potential of donepezil. However, in a study in which pregnant rats were given up to 10 mg/kg/day (approximately 8 times the maximum recommended human dose on a mg/m² basis) from day 17 of gestation through day 20 postpartum, there was a slight increase in still births and a slight decrease in pup survival through day 4 postpartum at this dose; the next lower dose tested was 3 mg/kg/day. There are no adequate or well-controlled studies in pregnant women. ARICEPT® should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Nursing Mothers** It is not known whether donepezil is excreted in human breast milk. ARICEPT® has no indication for use in nursing mothers. **Pediatric Use** There are no adequate and well-controlled trials to document the safety and efficacy of ARICEPT® in any illness occurring in children. **ADVERSE REACTIONS Adverse Events Leading to Discontinuation** The rates of discontinuation from controlled clinical trials of ARICEPT® due to adverse events for the ARICEPT® 5 mg/day treatment groups were comparable to those of placebo-treatment groups at approximately 5%. The rate of discontinuation of patients who received 7-day escalations from 5 mg/day to 10 mg/day, was higher at 13%. The most common adverse events leading to discontinuation, defined as those occurring in at least 2% of patients and at twice the incidence seen in placebo patients, are shown in Table 1.

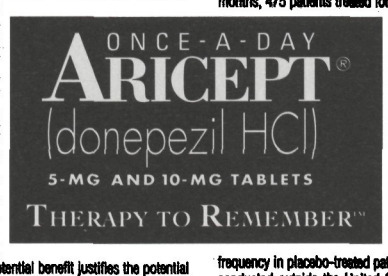

Table 1. Most Frequent Adverse Events Leading to Withdrawal from Controlled Clinical Trials by Dose Group

Dose Group	Placebo	5 mg/day ARICEPT®	10 mg/day ARICEPT®
Patients Randomized	355	350	315
Event/%Discontinuing			
Nausea	1%	1%	3%
Diarrhea	0%	<1%	3%
Vomiting	<1%	<1%	2%

Most Frequent Adverse Clinical Events Seen in Association with the Use of ARICEPT® The most common adverse events, defined as those occurring at a frequency of at least 5% in patients receiving 10 mg/day and twice the placebo rate, are largely predicted by ARICEPT®'s cholinomimetic effects. These include nausea, diarrhea, insomnia, vomiting, muscle cramp, fatigue and anorexia. These adverse events were often of mild intensity and transient, resolving during continued ARICEPT® treatment without the need for dose modification. There is evidence to suggest that the frequency of these common adverse events may be affected by the rate of titration. An open-label study was conducted with 269 patients who received placebo in the 15- and 30-week studies. These patients were titrated to a dose of 10 mg/day over a 6-week period. The rates of common adverse events were lower than those seen in patients titrated to 10 mg/day over one week in the controlled clinical trials and were comparable to those seen in patients on 5 mg/day. See Table 2 for a comparison of the most common adverse events following one and six week titration regimens.

Table 2. Comparison of Rates of Adverse Events in Patients Titrated to 10 mg/day Over 1 and 6 Weeks

Adverse Event	Placebo (n=315)	No titration 5 mg/day (n=311)	One-week titration 10 mg/day (n=315)	Six-week titration 10 mg/day (n=269)
Nausea	6%	5%	19%	6%
Diarrhea	5%	8%	15%	9%
Insomnia	6%	6%	14%	6%
Fatigue	3%	4%	8%	3%
Vomiting	3%	3%	8%	5%
Muscle cramps	2%	6%	8%	3%
Anorexia	2%	3%	7%	3%

Adverse Events Reported in Controlled Trials The events cited reflect experience gained under closely monitored conditions of clinical trials in a highly selected patient population. In actual clinical practice or in other clinical trials, these frequency estimates may not apply, as the conditions of use, reporting behavior, and the kinds of patients treated may differ. Table 3 lists treatment emergent signs and symptoms that were reported in at least 2% of patients in placebo-controlled trials who received ARICEPT® and for which the rate of occurrence was greater for ARICEPT® assigned than placebo assigned patients. In general, adverse events occurred more frequently in female patients and with advancing age.

Table 3. Adverse Events Reported in Controlled Clinical Trials in at Least 2% of Patients Receiving ARICEPT® (donepezil HCl) and at a Higher Frequency than Placebo-treated Patients

Body System/Adverse Event	Placebo (n=355)	ARICEPT® (n=747)
Percent of Patients with any Adverse Event	72	74
Body as a Whole		
Headache	9	10
Pain, various locations	8	9
Accident	6	7
Fatigue	3	5
Cardiovascular System		
Syncope	1	2
Digestive System		
Nausea	6	11
Diarrhea	5	10
Vomiting	3	5
Anorexia	2	4
Hemic and Lymphatic System		
Ecchymosis	3	4
Metabolic and Nutritional Systems		
Weight Decrease	1	3
Musculoskeletal System		
Muscle Cramps	2	6
Arthritis	1	2
Nervous System		
Insomnia	6	9
Dizziness	6	8
Depression	<1	3
Abnormal Dreams	0	3
Somnolence	<1	2
Urogenital System		
Frequent Urination	1	2

Other Adverse Events Observed During Clinical Trials ARICEPT® has been administered to over 1700 individuals during clinical trials worldwide. Approximately 1200 of these patients have been treated for at least 3 months and more than 1000 patients have been treated for at least 6 months. Controlled and uncontrolled trials in the United States included approximately 900 patients. In regards to the highest dose of 10 mg/day, this population includes 650 patients treated for 3 months, 475 patients treated for 6 months and 116 patients treated for over 1 year. The range of patient exposure is from 1 to 1214 days. Treatment emergent signs and symptoms that occurred during 3 controlled clinical trials and two open-label trials in the United States were recorded as adverse events by the clinical investigators using terminology of their own choosing. To provide an overall estimate of the proportion of individuals having similar types of events, the events were grouped into a smaller number of standardized categories using a modified COSTART dictionary and event frequencies were calculated across all studies. These categories are used in the listing below. The frequencies represent the proportion of 900 patients from these trials who experienced that event while receiving ARICEPT®. All adverse events occurring at least twice are included, except for those already listed in Tables 2 or 3, COSTART terms too general to be informative, or events less likely to be drug caused. Events are classified by body system and listed using the following definitions: *frequent adverse events* — those occurring in at least 1/100 patients; *infrequent adverse events* — those occurring in 1/100 to 1/1000 patients. These adverse events are not necessarily related to ARICEPT® treatment and in most cases were observed at a similar frequency in placebo-treated patients in the controlled studies. No important additional adverse events were seen in studies conducted outside the United States. **Body as a Whole:** *Frequent:* influenza, chest pain, toothache; *Infrequent:* fever, edema face, periorbital edema, hernia hiatal, abscess, cellulitis, chills, generalized coldness, head fullness, listlessness. **Cardiovascular System:** *Frequent:* hypertension, vasodilation, atrial fibrillation, hot flashes, hypotension; *Infrequent:* angina pectoris, postural hypotension, myocardial infarction, AV block (first degree), congestive heart failure, arteritis, bradycardia, peripheral vascular disease, supraventricular tachycardia, deep vein thrombosis. **Digestive System:** *Frequent:* fecal incontinence, gastrointestinal bleeding, bloating, epigastric pain; *Infrequent:* eructation, gingivitis, increased appetite, flatulence, periodontal abscess, cholelithiasis, diverticulitis, drooling, dry mouth, fever sore, gastritis, irritable colon, tongue edema, epigastric distress, gastroenteritis, increased transaminases, hemorrhoids, ileus, increased thirst, jaundice, melena, polydipsia, duodenal ulcer, stomach ulcer. **Endocrine System:** *Infrequent:* diabetes mellitus, goiter. **Hemic and Lymphatic System:** *Infrequent:* anemia, thrombocythemia, thrombocytopenia, eosinophilia, erythrocytopenia. **Metabolic and Nutritional Disorders:** *Frequent:* dehydration; *Infrequent:* gout, hypokalemia, increased creatine kinase, hyperglycemia, weight increase, increased lactate dehydrogenase. **Musculoskeletal System:** *Frequent:* bone fracture; *Infrequent:* muscle weakness, muscle fasciculation. **Nervous System:** *Frequent:* delusions, tremor, irritability, paresthesia, aggression, vertigo, ataxia, increased libido, restlessness, abnormal crying, nervousness, aphasia; *Infrequent:* cerebrovascular accident, intracranial hemorrhage, transient ischemic attack, emotional lability, neuralgia, coldness (localized), muscle spasm, dysphoria, gait abnormality, hypertonia, hypokinesia, neurodermatitis, numbness (localized), paranoia, dysarthria, dysphasia, hostility, decreased libido, melancholia, emotional withdrawal, nystagmus, pacing. **Respiratory System:** *Frequent:* dyspnea, sore throat, bronchitis; *Infrequent:* epistaxis, post nasal drip, pneumonia, hyperventilation, pulmonary congestion, wheezing, hypoxia, pharyngitis, pleurisy, pulmonary collapse, sleep apnea, snoring. **Skin and Appendages:** *Frequent:* pruritus, diaphoresis, urticaria; *Infrequent:* dermatitis, erythema, skin discoloration, hyperkeratosis, alopecia, fungal dermatitis, herpes zoster, hirsutism, skin striae, night sweats, skin ulcer. **Special Senses:** *Frequent:* cataract, eye irritation, vision blurred; *Infrequent:* dry eyes, glaucoma, earache, tinnitus, blepharitis, decreased hearing, retinal hemorrhage, otitis externa, otitis media, bad taste, conjunctival hemorrhage, ear buzzing, motion sickness, spots before eyes. **Urogenital System:** *Frequent:* urinary incontinence, nocturia; *Infrequent:* dysuria, hematuria, urinary urgency, metrorrhagia, cystitis, enuresis, prostate hypertrophy, pyelonephritis, inability to empty bladder, breast fibroadenosis, fibrocystic breast, mastitis, pyuria, renal failure, vaginitis. **Postintroduction Reports** Voluntary reports of adverse events temporally associated with ARICEPT® that have been received since market introduction that are not listed above, and that there is inadequate data to determine the causal relationship with the drug include the following: abdominal pain, agitation, cholecystitis, confusion, convulsions, hallucinations, heart block (all types), hemolytic anemia, hepatitis, hyponatremia, pancreatitis, and rash. **OVERDOSAGE Because strategies for the management of overdose are continually evolving, it is advisable to contact a Poison Control Center to determine the latest recommendations for the management of an overdose of any drug.** As in any case of overdose, general supportive measures should be utilized. Overdosage with cholinesterase inhibitors can result in cholinergic crisis characterized by severe nausea, vomiting, salivation, sweating, bradycardia, hypotension, respiratory depression, collapse and convulsions. Increasing muscle weakness is a possibility and may result in death if respiratory muscles are involved. Tertiary anticholinergics such as atropine may be used as an antidote for ARICEPT® overdosage. Intravenous atropine sulfate titrated to effect is recommended: an initial dose of 1.0 to 2.0 mg IV with subsequent doses based upon clinical response. Atypical responses in blood pressure and heart rate have been reported with other cholinomimetics when co-administered with quaternary anticholinergics such as glycopyrrolate. It is not known whether ARICEPT® and/or its metabolites can be removed by dialysis (hemodialysis, peritoneal dialysis, or hemofiltration). Dose-related signs of toxicity in animals included reduced spontaneous movement, prone position, staggering gait, lacrimation, clonic convulsions, depressed respiration, salivation, miosis, tremors, fasciculation and lower body surface temperature. **DOSAGE AND ADMINISTRATION** The dosages of ARICEPT® shown to be effective in controlled clinical trials are 5 mg and 10 mg administered once per day. Controlled clinical trials indicated that the 10 mg dose, with a one week titration, is likely to be associated with a higher incidence of cholinergic adverse events than the 5 mg dose. Because steady state is not achieved for 15 days and because the incidence of such effects may be influenced by the rate of dose escalation, treatment with a dose of 10 mg should not be contemplated until patients have been on a daily dose of 5 mg for 4 to 6 weeks. Whether or not to employ a dose of 10 mg is a matter of prescriber and patient preference. ARICEPT® should be taken in the evening, just prior to retiring, and may be taken with or without food.

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Pfizer U.S. Pharmaceuticals New York, NY 10017

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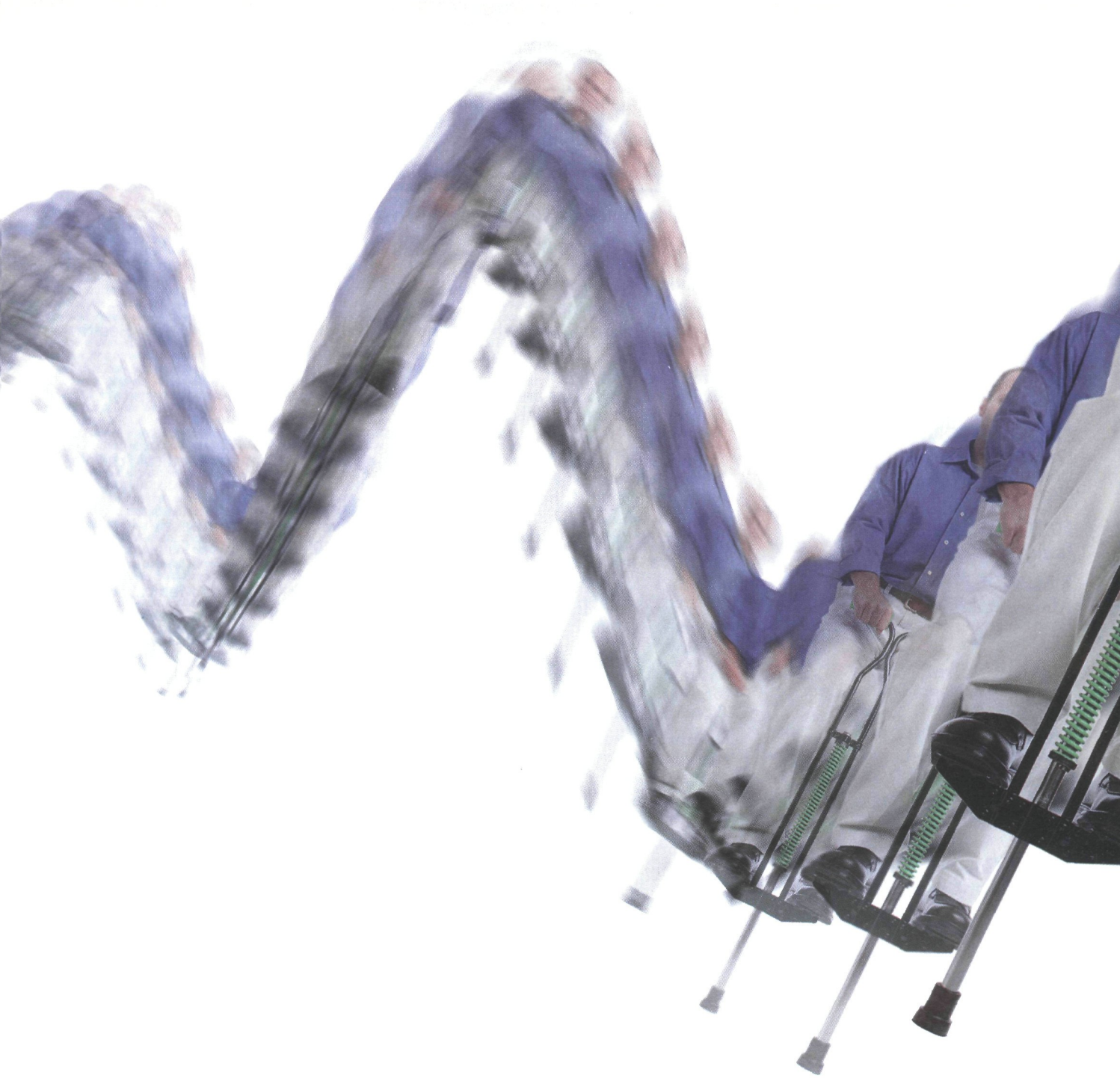

Why expose your patients to the "ups and downs" of traditional carbamazepine therapy?

Peak-to-trough fluctuations in patients receiving immediate-release carbamazepine three times daily can be as great as 2.5 fold[1]

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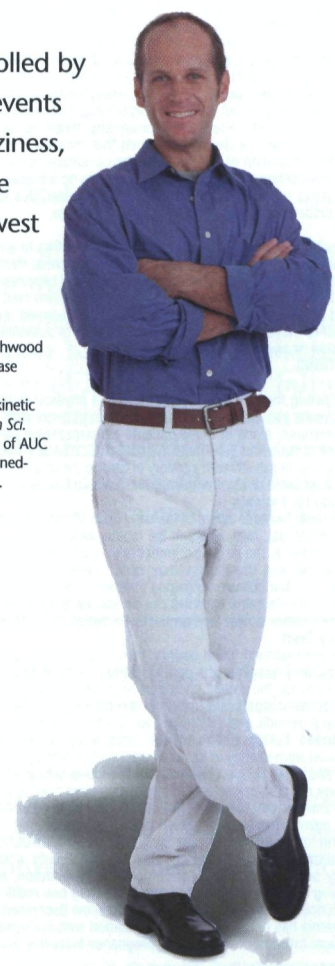
Switch to Carbatrol®—Second-generation delivery system design that targets the limitations of conventional carbamazepine[1-6]

- Bioequivalent to immediate-release carbamazepine dosed rigidly Q6h[3]
- Peak-to-trough fluctuations are not compromised[3,4]
- Smooth, consistent plasma concentrations[3,4]
- Extensive drug dispersion, dissolution, and absorption[2]
- Predictable bioavailability[5]
- BID dosing[6]
- No generic equivalent[2]

Absence seizures (petit mal) do not appear to be controlled by carbamazepine. The most frequently reported adverse events (particularly during the initial phases of therapy) are dizziness, drowsiness, unsteadiness, nausea, and vomiting. Adverse events can be minimized by initiating therapy at the lowest possible effective dose.

References: **1.** Jensen PK, Moller A, Gram L, Jenson NO, Dam M. Pharmacokinetic comparison of two carbamazepine slow-release formulations. *Acta Neurol Scand.* 1990;82:135-137. **2.** Data on file, Shire Richwood Inc. **3.** Garnett WR, Levy B, McLean AM, et al. Pharmacokinetic evaluation of twice-daily extended-release carbamazepine (CBZ) and four-times-daily immediate-release CBZ in patients with epilepsy. *Epilepsia.* 1998;39(3):274-279. **4.** Stevens RE, Limsakun T, Evans G, Mason DH. Controlled, multidose, pharmacokinetic evaluation of two extended-release carbamazepine formulations (Carbatrol® and Tegretol-XR®). *J Pharm Sci.* 1998;87(12):1531-1534. **5.** Mahmood I, Chamberlin N. A limited sampling method for the estimation of AUC and C_{max} of carbamazepine and carbamazepine epoxide following a single and multiple dose of a sustained-release product. *Br J Clin Pharmacol.* 1998;45:241-246. **6.** Carbatrol package insert, Shire Richwood Inc.

Please see brief summary of prescribing information on adjacent pages.



Carbatrol®

carbamazepine extended-release capsules

200 mg capsule ~ 300 mg capsule

COMFORTABLY PREDICTABLE

https://doi.org/10.1017/S1092852900013298 Published online by Cambridge University Press

CARBATROL®

(carbamazepine extended-release capsules)
200 mg and 300 mg

Brief Summary Prescribing Information

WARNING

APLASTIC ANEMIA AND AGRANULOCYTOSIS HAVE BEEN REPORTED IN ASSOCIATION WITH THE USE OF CARBAMAZEPINE. DATA FROM A POPULATION-BASED CASE-CONTROL STUDY DEMONSTRATE THAT THE RISK OF DEVELOPING THESE REACTIONS IS 5-8 TIMES GREATER THAN IN THE GENERAL POPULATION. HOWEVER, THE OVERALL RISK OF THESE REACTIONS IN THE UNTREATED GENERAL POPULATION IS LOW. APPROXIMATELY SIX PATIENTS PER ONE MILLION POPULATION PER YEAR FOR AGRANULOCYTOSIS AND TWO PATIENTS PER ONE MILLION POPULATION PER YEAR FOR APLASTIC ANEMIA.

ALTHOUGH REPORTS OF TRANSIENT OR PERSISTENT DECREASED PLATELET OR WHITE BLOOD CELL COUNTS ARE NOT UNCOMMON IN ASSOCIATION WITH THE USE OF CARBAMAZEPINE, DATA ARE NOT AVAILABLE TO ESTIMATE ACCURATELY THEIR INCIDENCE OR OUTCOME. HOWEVER, THE VAST MAJORITY OF THE CASES OF LEUKOPENIA HAVE NOT PROGRESSED TO THE MORE SERIOUS CONDITIONS OF APLASTIC ANEMIA OR AGRANULOCYTOSIS.

BECAUSE OF THE VERY LOW INCIDENCE OF AGRANULOCYTOSIS AND APLASTIC ANEMIA, THE VAST MAJORITY OF MINOR HEMATOLOGIC CHANGES OBSERVED IN MONITORING OF PATIENTS ON CARBAMAZEPINE ARE UNLIKELY TO SIGNAL THE OCCURRENCE OF EITHER ABNORMALITY. NONETHELESS, COMPLETE PRETREATMENT HEMATOLOGICAL TESTING SHOULD BE OBTAINED AS A BASELINE. IF A PATIENT IN THE COURSE OF TREATMENT EXHIBITS LOW OR DECREASED WHITE BLOOD CELL OR PLATELET COUNTS, THE PATIENT SHOULD BE MONITORED CLOSELY. DISCONTINUATION OF THE DRUG SHOULD BE CONSIDERED IF ANY EVIDENCE OF SIGNIFICANT BONE MARROW DEPRESSION DEVELOPS.

Before prescribing Carbatrol, the physician should be thoroughly familiar with the details of the full prescribing information, particularly regarding use with other drugs, especially those which accentuate toxicity potential.

INDICATIONS AND USAGE

Epilepsy

Carbatrol* is indicated for use as an anticonvulsant drug. Evidence supporting efficacy of carbamazepine as an anticonvulsant was derived from active drug-controlled studies that enrolled patients with the following seizure types:

1. Partial seizures with complex symptomatology (psychomotor, temporal lobe). Patients with these seizures appear to show greater improvements than those with other types.
2. Generalized tonic-clonic seizures (grand mal).
3. Mixed seizure patterns which include the above, or other partial or generalized seizures. Absence seizures (petit mal) do not appear to be controlled by carbamazepine (see PRECAUTIONS, General).

Trigeminal Neuralgia

Carbatrol is indicated in the treatment of the pain associated with true trigeminal neuralgia. Beneficial results have also been reported in glossopharyngeal neuralgia. This drug is not a simple analgesic and should not be used for the relief of trivial aches or pains.

CONTRAINDICATIONS

Carbamazepine should not be used in patients with a history of previous bone marrow depression, hypersensitivity to the drug, or known sensitivity to any of the tricyclic compounds, such as amitriptyline, desipramine, imipramine, protriptyline and nortriptyline. Likewise, on theoretical grounds its use with monoamine oxidase inhibitors is not recommended. Before administration of carbamazepine, MAO inhibitors should be discontinued for a minimum of 14 days, or longer if the clinical situation permits.

WARNINGS

Usage in Pregnancy

Carbamazepine can cause fetal harm when administered to a pregnant woman.

Epidemiological data suggest that there may be an association between the use of carbamazepine during pregnancy and congenital malformations, including spina bifida. The prescribing physician will wish to weigh the benefits of therapy against the risks in treating or counseling women of childbearing potential. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus. Retrospective case reviews suggest that, compared with monotherapy, there may be a higher prevalence of teratogenic effects associated with the use of anticonvulsants in combination therapy.

In humans, transplacental passage of carbamazepine is rapid (30-60 minutes), and the drug is accumulated in the fetal tissues, with higher levels found in liver and kidney than in brain and lung.

Carbamazepine has been shown to have adverse effects in reproduction studies in rats when given orally in dosages 10-25 times the maximum human daily dosage (MHDD) of 1200 mg on a mg/kg basis or 1.5-4 times the MHDD on a mg/m² basis. In rat teratology studies, 2 of 135 offspring showed kinked ribs at 250 mg/kg and 4 of 119 offspring at 650 mg/kg showed other anomalies (cleft palate, 1; talipes, 1; anophthalmos, 2). In reproduction studies in rats, nursing offspring demonstrated a lack of weight gain and an unkempt appearance at a maternal dosage level of 200 mg/kg. Antiepileptic drugs should not be discontinued abruptly in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and threat to life. In individual cases where the severity and frequency of the seizure disorder are such that removal of medication does not pose a serious threat to the patient, *discontinuation of the drug may be considered prior to and during pregnancy, although it cannot be* said with any confidence that even minor seizures do not pose some hazard to the developing embryo or fetus. Tests to detect defects using current accepted procedures should be considered a part of routine prenatal care in childbearing women receiving carbamazepine.

General

Patients with a history of adverse hematologic reaction to any drug may be particularly at risk.

Severe dermatologic reactions, including toxic epidermal necrolysis (Lyell's syndrome) and Stevens-Johnson syndrome have been reported with carbamazepine. These reactions have been extremely rare. However, a few fatalities have been reported. Carbamazepine has shown mild anticholinergic activity; therefore, patients with increased intraocular pressure should be closely observed during therapy. Because of the relationship of the drug to other tricyclic compounds, the possibility of activation of a latent psychosis and, in elderly patients, of confusion or agitation should be considered.

PRECAUTIONS

General

Before initiating therapy, a detailed history and physical examination should be made.

Carbamazepine should be used with caution in patients with a mixed seizure disorder that includes atypical absence seizures, since in these patients carbamazepine has been associated with increased frequency of generalized convulsions (see INDICATIONS AND USAGE).Therapy should be prescribed only after critical benefit-to-risk appraisal in patients with a history of cardiac, hepatic, or renal damage; adverse hematologic reaction to other drugs; or interrupted courses of therapy with carbamazepine.

Information for Patients

Patients should be made aware of the early toxic signs and symptoms of a potential hematologic problem, such as fever, sore throat, rash, ulcers in the mouth, easy bruising, petechial or purpuric hemorrhage, and should be advised to report to the physician immediately if any such signs or symptoms appear.

Since dizziness and drowsiness may occur, patients should be cautioned about the hazards of operating machinery or automobiles or engaging in other potentially dangerous tasks.

If necessary, the Carbatrol capsules can be opened and the contents sprinkled over food, such as a teaspoon of applesauce or other similar food products. Carbatrol capsules or their contents should not be crushed or chewed.

Laboratory Tests

Complete pretreatment blood counts, including platelets and possibly reticulocytes and serum iron, should be obtained as a baseline. If a patient in the course of treatment exhibits low or decreased white blood cell or platelet counts, the patient should be monitored closely. Discontinuation of the drug should be considered if any evidence of significant bone marrow depression develops.

Baseline and periodic evaluations of liver function, particularly in patients with a history of liver disease, must be performed during treatment with this drug since liver damage may occur. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.

Baseline and periodic eye examinations, including slit-lamp, funduscopy, and tonometry, are recommended since many phenothiazines and related drugs have been shown to cause eye changes.

Baseline and periodic complete urinalysis and BUN determinations are recommended for patients treated with this agent because of observed renal dysfunction.

Monitoring of blood levels (see CLINICAL PHARMACOLOGY) has increased the efficacy and safety of anticonvulsants. This monitoring may be particularly useful in cases of dramatic increase in seizure frequency and for verification of compliance. In addition, measurement of drug serum levels may aid in determining the cause of toxicity when more than one medication is being used.

Thyroid function tests have been reported to show decreased values with carbamazepine administered alone. Hyponatremia has been reported in association with carbamazepine use, either alone or in combination with other drugs. Interference with some pregnancy tests has been reported.

Drug Interactions

Clinically meaningful drug interactions have occurred with concomitant medications and include, but are not limited to the following:

Agents that may affect carbamazepine plasma levels:

CYP 3A4 inhibitors inhibit carbamazepine metabolism and can thus increase plasma carbamazepine levels. Drugs that have been shown, or would be expected, to increase plasma carbamazepine levels include:

cimetidine, danazol, diltiazem, macrolides, erythromycin, troleandomycin, clarithromycin, fluoxetine, loratadine, terfenadine, isoniazid, niacinamide, nicotinamide, propoxyphene, ketoconazole, itraconazole, verapamil, valproate.*

CYP 3A4 inducers can increase the rate of carbamazepine metabolism and can thus decrease plasma carbamazepine levels. Drugs that have been shown, or would be expected, to decrease plasma carbamazepine levels include:

cisplatin, doxorubicin HCL, felbamate, rifampin*, phenobarbital, phenytoin, primidone, theophylline.

Effect of carbamazepine on plasma levels of concomitant agents:

Carbatrol increases levels of clomipramine HCL, phenytoin and primidone.

Carbatrol induces hepatic CYP activity. Carbatrol causes, or would be expected to cause decreased levels of the following:

acetaminophen, alprazolam, clonazepam, clozapine, dicumarol, doxycycline, ethosuximide, haloperidol, methsuximide, oral contraceptives, phensuximide, phenytoin, theophylline, valproate, warfarin.

The doses of these drugs may therefore have to be increased when carbamazepine is added to the therapeutic *regimen. Concomitant administration of carbamazepine and lithium may increase the risk of neurotoxic side* effects. Alterations of thyroid function have been reported in combination therapy with other anticonvulsant medications. Breakthrough bleeding has been reported among patients receiving concomitant oral contraceptives and their reliability may be adversely affected.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Administration of carbamazepine to Sprague-Dawley rats for two years in the diet at doses of 25, 75, and 250 mg/kg/day (low dose approximately 0.2 times the maximum human daily dose of 1200 mg on a mg/m² basis), resulted in a dose-related increase in the incidence of hepatocellular tumors in females and of benign interstitial cell adenomas in the testes of males.

Carbamazepine must, therefore, be considered to be carcinogenic in Sprague-Dawley rats. Bacterial and mammalian mutagenicity studies using carbamazepine produced negative results. The significance of these findings relative to the use of carbamazepine in humans is, at present, unknown.

Usage in Pregnancy

Pregnancy Category D (See WARNINGS)

Labor and Delivery

The effect of carbamazepine on human labor and delivery is unknown.

Nursing Mothers

Carbamazepine and its epoxide metabolite are transferred to breast milk and during lactation. The concentrations of carbamazepine and its epoxide metabolite are approximately 50% of the maternal plasma concentration. Because of the potential for serious adverse reactions in nursing infants from carbamazepine, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

Substantial evidence of carbamazepine effectiveness for use in the management of children with epilepsy (see INDICATIONS for specific seizure types) is derived from clinical investigations performed in adults and from studies in several *in vitro* systems which support the conclusion that (1) the pathogenic mechanisms underlying seizure propagation are essentially identical in adults and children, and (2) the mechanism of action of carbamazepine in treating seizures is essentially identical in adults and children. Taken as a whole, this information supports a conclusion that the generally acceptable therapeutic range of total carbamazepine in plasma (i.e., 4-12 µg/mL) is the same in children and adults. The evidence assembled was primarily obtained from short-term use of carbamazepine. The safety of carbamazepine in children has been systematically studied up to 6 months. No longer term data from clinical trials is available.

Geriatric Use

No systematic studies in geriatric patients have been conducted.

Adverse Reactions

General: If adverse reactions are of such severity that the drug must be discontinued, the physician must be aware that abrupt discontinuation of any anticonvulsant drug in a responsive patient with epilepsy may lead to seizures or even status epilepticus with its life-threatening hazards.

The most severe adverse reactions previously observed with carbamazepine were reported in the hemopoietic system (see BOX WARNING), the skin, and the cardiovascular system.

The most frequently observed adverse reactions, particularly during the initial phases of therapy, are dizziness, drowsiness, unsteadiness, nausea, and vomiting. To minimize the possibility of such reactions, therapy should be initiated at the lowest dosage recommended.

The following additional adverse reactions were previously reported with carbamazepine:

Hemopoietic System: Aplastic anemia, agranulocytosis, pancytopenia, bone marrow depression, thrombocytopenia, leukopenia, leukocytosis, eosinophilia, acute intermittent porphyria.

Skin: *Pruritic and erythematous rashes, urticaria, toxic epidermal necrolysis (Lyell's syndrome) (see* WARNINGS), Stevens-Johnson syndrome (see WARNINGS), photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, erythema multiforme and nodosum, purpura, aggravation of disseminated lupus erythematosus, alopecia, and diaphoresis. In certain cases, discontinuation of therapy may be necessary. Isolated cases of hirsutism have been reported, but a causal relationship is not clear.

Cardiovascular System: Congestive heart failure, edema, aggravation of hypertension, hypotension, syncope and collapse, aggravation of coronary artery disease, arrhythmias and AV block, thrombophlebitis, thromboembolism, and adenopathy or lymphadenopathy. Some of these cardiovascular complications have resulted in fatalities. Myocardial infarction has been associated with other tricyclic compounds.

Liver: Abnormalities in liver function tests, cholestatic and hepatocellular jaundice, hepatitis.

Respiratory System: Pulmonary hypersensitivity characterized by fever, dyspnea, pneumonitis, or pneumonia.

Genitourinary System: Urinary frequency, acute urinary retention, oliguria with elevated blood pressure, azotemia, renal failure, and impotence. Albuminuria, glycosuria, elevated BUN, and microscopic deposits in the urine have also been reported. Testicular atrophy occurred in rats receiving carbamazepine orally from 4-52 weeks at dosage levels of 50-400 mg/kg/day. Additionally, rats receiving carbamazepine in the diet for 2 years at dosage levels of 25, 75, and 250 mg/kg/day had a dose-related incidence of testicular atrophy and aspermatogenesis. In dogs, it produced a brownish discoloration, presumably a metabolite, in the urinary bladder at dosage levels of 50 mg/kg/day and higher. Relevance of these findings to humans is unknown.

Nervous System: Dizziness, drowsiness, disturbances of coordination, confusion, headache, fatigue, blurred vision, visual hallucinations, transient diplopia, oculomotor disturbances, nystagmus, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, tinnitus, and hyperacusis.

There have been reports of associated paralysis and other symptoms of cerebral arterial insufficiency, but the exact relationship of these reactions to the drug has not been established.

Isolated cases of neuroleptic malignant syndrome have been reported with concomitant use of psychotropic drugs.

Digestive System: Nausea, vomiting, gastric distress and abdominal pain, diarrhea, constipation, anorexia, and dryness of the mouth and pharynx, including glossitis and stomatitis.

Eyes: Scattered punctate cortical lens opacities, as well as conjunctivitis, have been reported. Although a direct causal relationship has not been established, many phenothiazines and related drugs have been shown to cause eye changes.

Musculoskeletal System: Aching joints and muscles, and leg cramps.

Metabolism: Fever and chills, inappropriate antidiuretic hormone (ADH) secretion syndrome has been reported. Cases of frank water intoxication, with decreased serum sodium (hyponatremia) and confusion have been reported in association with carbamazepine use (see PRECAUTIONS, Laboratory Tests). Decreased levels of plasma calcium have been reported.

Other: Isolated cases of a lupus erythematosus-like syndrome have been reported. There have been occasional reports of elevated levels of cholesterol, HDL cholesterol, and triglycerides in patients taking anticonvulsants. A case of aseptic meningitis, accompanied by myoclonus and peripheral eosinophilia, has been reported in a patient taking carbamazepine in combination with other medications. The patient was successfully dechallenged, and the meningitis reappeared upon rechallenge with carbamazepine.

*increased levels of the active 10, 11-epoxide

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AN INTEGRATED HYPOTHESIS

page 26

"It is clear that no single neurochemical system has been shown to be responsible for either catatonia or NMS. The universal field hypothesis declares that it is the interaction of these systems that is responsible for catatonia and NMS. Furthermore, the hypothesis states that there must be some predisposition in the individual patient at the neurochemical level for the development of catatonia and NMS. We might therefore conclude that at the neurochemical level, these patients already have low $GABA_A$ activity, high $5\text{-}HT_{1A}$ receptor activity, low activity at D_2 dopamine systems, or alterations at the NMDA receptor in the glutamate system. The universal field hypothesis is based upon models proposed for catatonia by Lauterbach. He notes that each of these systems—D_2, $GABA_A$, $5\text{-}HT_{1A}$, and NMDA—has dynamic influence over circuits involved in catatonia so that perturbation of any one of these receptors can push the balance of systems toward or away from catatonia. In NMS, reduction of dopamine activity at the D_2 receptor by D_2 antagonists may be the primary pathogenesis of the syndrome in which $GABA_A$, $5\text{-}HT_{1A}$, and NMDA play a necessary, secondary role."

THE UNDERLYING NETWORK

page 34

"Catatonic patients are well able to initiate movements, but they are apparently unable to terminate the movement once initiated in an appropriate way. In contrast to initiation neural networks, the study of underlying termination of movements has been neglected in the research to date. In healthy individuals, termination of movements is believed to involve the right posterior parietal cortex, because the registration and on-line monitoring of the respective spatial position of the movement may be of central importance for an appropriate termination. Since findings in imaging and neuropsychology indicate a relationship between deficits in visual-constructive functions and decreased rCBF in the right posterior parietal cortex, alterations in the right posterior parietal cortical function may account for the deficit in termination of movements in catatonia that result in the motor symptom of posturing. This assumption is further supported by our findings in late MRCPs as well as fMRI, reflecting alterations in termination rather than initiation. If registration and on-line monitoring of the spatial position of movements (as related to right posterior parietal cortical function) are deficient in catatonia, this should lead to an unawareness of the respective spatial position. This is indeed the case since catatonic patients (unlike Parkinson's disease patients) suffer from anosognosia of posturing."

THE CATATONIA-MANIA MIX

page 48

"The symptom distribution in the total sample of mixed manics suggests that catatonic symptoms in mixed mania are mainly restricted to those associated with motor arousal or inhibition (eg, iterations, verbigerations, jerky movements, mutism), whereas symptoms of catalepsy (eg, waxy flexibility, posturing) and with the exception of exaggerated responsiveness, symptoms of disturbance of volition (eg, gegenhalten, automatic obedience) do not occur to a significant degree. In fact, based on the severity ratings of mutism, motor excitement, and verbigerations alone, catatonic mixed manics were classified into those who would need ACU admission and those who would not. Verbigerations and other symptoms of speech disturbance are considered one of the hallmarks of catatonia and are reported to be neglected in modern catatonia research. The authors' findings confirm this observation."

HASTENING RECOVERY

page 54

"If benzodiazepines prove beneficial in hastening recovery in NMS, available models of action may explain the mechanisms. Benzodiazepines increase dopamine activity by indirect actions involving γ-aminobutyric acid systems in nuclei of the basal ganglia, including both the striatum and substantia nigra. Dopamine deficiency or blockade has been hypothesized in the pathogenesis of NMS, and benzodiazepines are known to antagonize some adverse motor effects of dopamine-blocking neuroleptic drugs. A weakness of the dopamine hypothesis in NMS is its failure to account for the rarity of this syndrome among large numbers of patients prescribed neuroleptics, and the observation that NMS may not recur following neuroleptic reexposure."

A UNITARY PATHOLOGICAL DISORDER

page 58

"The authors hypothesize that the hyperdopaminergic state allegedly linked to schizophrenia may in fact protect schizophrenic patients from the marked neuroleptic-induced dopamine receptor blockade that possibly underlies the development of NMS. It would follow, therefore, that if NMS and catatonia share a similar pathophysiology (namely, that both represent a hypodopaminergic state), then this may also account for the infrequent occurrence of the catatonic syndrome in schizophrenic patients."

DIFFERENTIATING SIGNS?

page 66

"If catatonic signs are less prominent in medical catatonias, one would expect differences in the total rating scale scores, but total scores from the BFCRS and MRS are remarkably similar between these groups. These findings suggest that catatonic signs do not differ between these two groups. This similar presentation may be due to a similar pathophysiology shared by medical and psychiatric catatonias."

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References: **1.** Pelham WE, Aronoff HR, Midlam JK, et al. A comparison of Ritalin and Adderall: efficacy and time-course in children with attention-deficit/hyperactivity disorder. *Pediatrics* [serial online]. 1999;103:e43. Available at: http://www.pediatrics.org/. **2.** Pliszka S, Browne RG, Wynne SK, et al. Comparing Adderall and methylphenidate in ADHD. *J Am Acad Child Adolesc Psychiatry.* 2000;39(5):619-626. **3.** Pelham WE, Gnagy EM, Chronis MA, et al. A comparison of morning-only and morning/late afternoon Adderall to morning-only, twice-daily, and three times-daily methylphenidate in children with attention-deficit/hyperactivity disorder. *Pediatrics.* 1999;104(6):1300-1311. **4.** IMS, National Prescription Audit, January through December 1999. **5.** Data on file, Shire Richwood Inc.

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5 mg, 10 mg, 20 mg & 30 mg TABLETS
(Mixed Salts of a Single-Entity Amphetamine Product)
Dextroamphetamine Sulfate Amphetamine Sulfate
Dextroamphetamine Saccharate Amphetamine Aspartate

ADDERALL® TABLETS BRIEF SUMMARY

AMPHETAMINES HAVE A HIGH POTENTIAL FOR ABUSE. ADMINISTRATION OF AMPHETAMINES FOR PROLONGED PERIODS OF TIME MAY LEAD TO DRUG DEPENDENCE AND MUST BE AVOIDED. PARTICULAR ATTENTION SHOULD BE PAID TO THE POSSIBILITY OF SUBJECTS OBTAINING AMPHETAMINES FOR NON-THERAPEUTIC USE OR DISTRIBUTION TO OTHERS, AND THE DRUGS SHOULD BE PRESCRIBED OR DISPENSED SPARINGLY.

INDICATIONS: Attention Deficit Disorder with Hyperactivity: ADDERALL is indicated as an integral part of a total treatment program which typically includes other remedial measures (psychological, educational, social) for a stabilizing effect in children with behavioral syndrome characterized by the following group of developmentally inappropriate symptoms: moderate to severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity. The diagnosis of this syndrome should not be made with finality when these symptoms are only of comparatively recent origin. Nonlocalizing (soft) neurological signs, learning disability and abnormal EEG may or may not be present, and a diagnosis of central nervous system dysfunction may or may not be warranted. **In Narcolepsy: CONTRAINDICATIONS:** Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result). **WARNINGS:** Clinical experience suggests that in psychotic children, administration of amphetamine may exacerbate symptoms of behavior disturbance and thought disorder. Data are inadequate to determine whether chronic administration of amphetamine may be associated with growth inhibition; therefore, growth should be monitored during treatment. **Usage in Nursing Mothers:** Amphetamines are excreted in human milk. Mothers taking amphetamines should be advised to refrain from nursing. **PRECAUTIONS: General:** Caution is to be exercised in prescribing amphetamines for patients with even mild hypertension. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. **Information for Patients:** Amphetamines may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or vehicles; the patient should therefore be cautioned accordingly. **Drug Interactions:** *Acidifying agents* - Gastrointestinal acidifying agents (guanethidine, reserpine, glutamic acid HCl, ascorbic acid, fruit juices, etc.) lower absorption of amphetamines. *Urinary acidifying agents* - (ammonium chloride, sodium acid phosphate, etc.) Increase the concentration of the ionized species of the amphetamine molecule, thereby increasing urinary excretion. Both groups of agents lower blood levels and efficacy of amphetamines. *Adrenergic blockers* - Adrenergic blockers are inhibited by amphetamines. *Alkalinizing agents* - Gastrointestinal alkalinizing agents (sodium bicarbonate, etc.) increase absorption of amphetamines. Urinary alkalinizing agents (acetazolamide, some thiazides) increase the concentration of the non-ionized species of the amphetamine molecule, thereby decreasing urinary excretion. Both groups of agents increase blood levels and therefore potentiate the actions of amphetamines. *Antidepressants, tricyclic* - Amphetamines may enhance the activity of tricyclic or sympathomimetic agents; d-amphetamine with desipramine or protriptyline and possibly other tricyclics cause striking and sustained increases in the concentration of d-amphetamine in the brain; cardiovascular effects can be potentiated. *MAO inhibitors* - MAOI antidepressants, as well as a metabolite of furazolidone, slow amphetamine metabolism. This slowing potentiates amphetamines, increasing their effect on the release of norepinephrine and other monoamines from adrenergic nerve endings; this can cause headaches and other signs of hypertensive crisis. A variety of neurological toxic effects and malignant hyperpyrexia can occur, sometimes with fatal results. *Antihistamines* - Amphetamines may counteract the sedative effect of antihistamines. *Antihypertensives* - Amphetamines may antagonize the hypotensive effects of antihypertensives. *Chlorpromazine* - Chlorpromazine blocks dopamine and norepinephrine reuptake, thus inhibiting the central stimulant effects of amphetamines, and can be used to treat amphetamine poisoning. *Ethosuximide* - Amphetamines may delay intestinal absorption of ethosuximide. *Haloperidol* - Haloperidol blocks dopamine and norepinephrine reuptake, thus inhibiting the central stimulant effects of amphetamines. *Lithium carbonate* - The anorectic and stimulatory effects of amphetamines may be inhibited by lithium carbonate. *Meperidine* - Amphetamines potentiate the analgesic effect of meperidine. *Methenamine therapy* - Urinary excretion of amphetamines is increased, and efficacy is reduced, by acidifying agents used in methenamine therapy. *Norepinephrine* - Amphetamines enhance the adrenergic effect of norepinephrine. *Phenobarbital* - Amphetamines may delay intestinal absorption of phenobarbital; co-administration of phenobarbital may produce a synergistic anticonvulsant action. *Phenytoin* - Amphetamines may delay intestinal absorption of phenytoin; co-administration of phenytoin may produce a synergistic anticonvulsant action. *Propoxyphene* - In cases of propoxyphene overdosage, amphetamine CNS stimulation is potentiated and fatal convulsions can occur. *Veratrum alkaloids* - Amphetamines inhibit the hypotensive effect of veratrum alkaloids. **Drug/Laboratory Test Interactions:** • Amphetamines can cause a significant elevation in plasma corticosteroid levels. This increase is greatest in the evening. • Amphetamines may interfere with urinary steroid determinations. **Carcinogenesis/Mutagenesis:** Mutagenicity studies and long-term studies in animals to determine the carcinogenic potential of amphetamine, have not been performed. **Pregnancy - Teratogenic Effects:** Pregnancy Category C. Amphetamine has been shown to have embryotoxic and teratogenic effects when administered to A/Jax mice and C57BL mice in doses approximately 41 times the maximum human dose. Embryotoxic effects were not seen in New Zealand white rabbits given the drug in doses 7 times the human dose nor in rats given 12.5 times the maximum human dose. While there are no adequate and well-controlled studies in pregnant women, there has been one report of severe congenital bony deformity, tracheoesophageal fistula, and anal atresia (vater association) in a baby born to a woman who took dextroamphetamine sulfate with lovastatin during the first trimester of pregnancy. Amphetamines should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Nonteratogenic Effects:** Infants born to mothers dependent on amphetamines have an increased risk of premature delivery and low birth weight. Also, these infants may experience symptoms of withdrawal as demonstrated by dysphoria, including agitation, and significant lassitude. **Pediatric Use:** Long-term effects of amphetamines in children have not been well established. Amphetamines are not recommended for use in children under 3 years of age with Attention Deficit Disorder with Hyperactivity described under INDICATIONS AND USAGE. Amphetamines have been reported to exacerbate motor and phonic tics and Tourette's syndrome. Therefore, clinical evaluation for tics and Tourette's syndrome in children and their families should precede use of stimulant medications. Drug treatment is not indicated in all cases of Attention Deficit Disorder with Hyperactivity and should be considered only in light of the complete history and evaluation of the child. The decision to prescribe amphetamines should depend on the physician's assessment of the chronicity and severity of the child's symptoms and their appropriateness for his/her age. Prescription should not depend solely on the presence of one or more of the behavioral characteristics. When these symptoms are associated with acute stress reactions, treatment with amphetamines is usually not indicated. **ADVERSE REACTIONS: Cardiovascular:** Palpitations, tachycardia, elevation of blood pressure. There have been isolated reports of cardiomyopathy associated with chronic amphetamine use. **Central Nervous System:** Psychotic episodes at recommended doses (rare), overstimulation, restlessness, dizziness, insomnia, euphoria, dyskinesia, dysphoria, tremor, headache, exacerbation of motor and phonic tics and Tourette's syndrome. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances. Anorexia and weight loss may occur as undesirable effects when amphetamines are used for other than the anorectic effect. **Allergic:** Urticaria. **Endocrine:** Impotence, changes in libido. **DRUG ABUSE AND DEPENDENCE:** Dextroamphetamine sulfate is a Schedule II controlled substance. Amphetamines have been extensively abused. Tolerance, extreme psychological dependence, and severe social disability have occurred. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with amphetamines include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia. This is rare with oral amphetamines. **OVERDOSAGE:** Individual patient response to amphetamines varies widely. While toxic symptoms occasionally occur as an idiosyncrasy at doses as low as 2 mg, they are rare with doses of less than 15 mg; 30 mg can produce severe reactions, yet doses of 400 to 500 mg are not necessarily fatal. In rats, the oral LD_{50} of dextroamphetamine sulfate is 96.8 mg/kg. **Symptoms:** Manifestations of acute overdosage with amphetamines include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states, hyperpyrexia and rhabdomyolysis. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning is usually preceded by convulsions and coma. **Treatment:** Consult with a Certified Poison Control Center for up to date guidance and advice. Management of acute amphetamine intoxication is largely symptomatic and includes gastric lavage, administration of activated charcoal, administration of a cathartic and sedation. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases amphetamine excretion, but is believed to increase risk of acute renal failure if myoglobinuria is present. If acute, severe hypertension complicates amphetamine overdosage, administration of intravenous phentolamine (Regitine®, Novartis) has been suggested. However, a gradual drop in blood pressure will usually result when sufficient sedation has been achieved. Chlorpromazine antagonizes the central stimulant effects of amphetamines and can be used to treat amphetamine intoxication. **DOSAGE AND ADMINISTRATION:** Regardless of indication, amphetamines should be administered at the lowest effective dosage and dosage should be individually adjusted. Late evening doses should be avoided because of the resulting insomnia. **Attention Deficit Disorder with Hyperactivity:** Not recommended for children under 3 years of age. In children from 3 to 5 years of age, start with 2.5 mg daily; daily dosage may be raised in increments of 2.5 mg at weekly intervals until optimal response is obtained. In children 6 years of age and older, start with 5 mg once or twice daily; daily dosage may be raised in increments of 5 mg at weekly intervals until optimal response is obtained. Only in rare cases will it be necessary to exceed a total of 40 mg per day. Give first dose on awakening; additional doses (1 or 2) at intervals of 4 to 6 hours. Where possible, drug administration should be interrupted occasionally to determine if there is a recurrence of behavioral symptoms sufficient to require continued therapy. **Narcolepsy:** Usual dose 5 mg to 60 mg per day in divided doses, depending on the individual patient response. Narcolepsy seldom occurs in children under 12 years of age; however, when it does, dextroamphetamine sulfate may be used. The suggested initial dose for patients aged 6-12 is 5 mg daily; daily dose may be raised in increments of 5 mg at weekly intervals until optimal response is obtained. In patients 12 years of age and older, start with 10 mg daily; daily dosage may be raised in increments of 10 mg at weekly intervals until optimal response is obtained. If bothersome adverse reactions appear (e.g., insomnia or anorexia), dosage should be reduced. Give first dose on awakening; additional doses (1 or 2) at intervals of 4 to 6 hours. **Rx only.**

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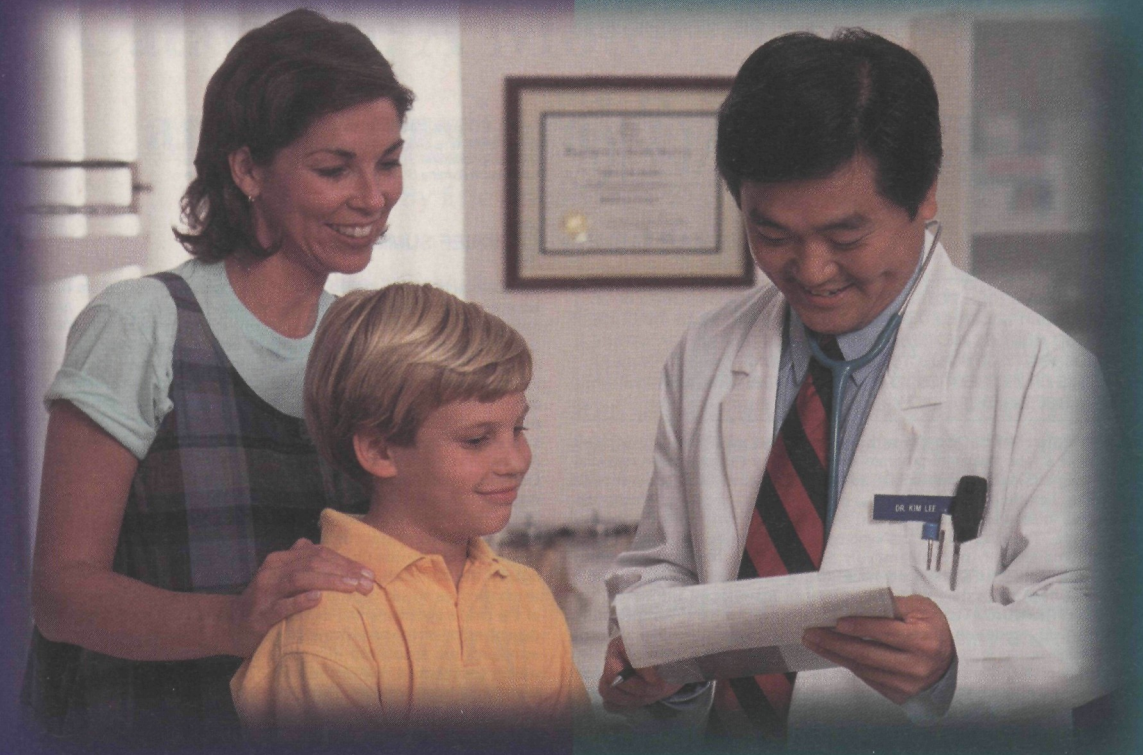
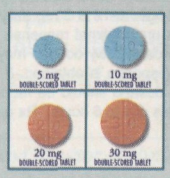


Why make the switch to ADDERALL®?

- On average, ADDERALL is more effective than Ritalin® ($p<0.001$)[1]
- ADDERALL was favored 3 to 1 over Ritalin by clinical staff for continued medication[1]
- Ritalin patients were rated more deviant than ADDERALL, particularly on lower doses[1]
- ADDERALL scored better than MPH on Clinical Global Impression (CGI) improvement ($p<0.05$)[2]
- There were significantly more responders in the ADDERALL group than the MPH group ($p<0.01$)[2]
- ADDERALL showed better scores than MPH for both inattention and hyperactivity ($p<0.05$)[2]
- Clinical staff clearly preferred ADDERALL over MPH for continuation of treatment[3]
- ADDERALL is dispensed for more ADHD patients than Ritalin[4]
- ADDERALL is safe—low incidence of spontaneously reported adverse events[5]

ADDERALL is generally well tolerated—adverse reactions have seldom been reported (most frequently reported adverse reactions include anorexia, insomnia, stomach pain, headache, irritability, and weight loss).

As with most psychostimulants indicated for ADHD, the possibility of growth suppression and the potential for precipitating motor tics and Tourette's syndrome exist with ADDERALL treatment and, in rare cases, exacerbations of psychosis have been reported. Since amphetamines may have a high potential for abuse, ADDERALL should only be prescribed as part of an overall multimodal treatment program for ADHD with close physician supervision.



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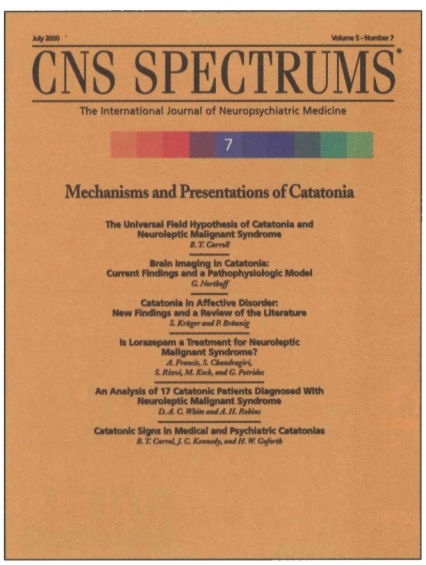

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Departments/Monthly Columns

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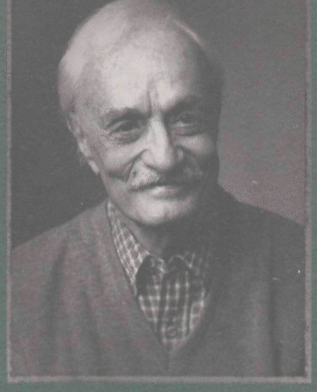
Custom-tailored dosing

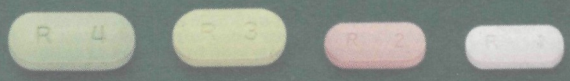
In two 6- to 8-week placebo-controlled clinical trials, spontaneously reported, treatment-emergent adverse events with an incidence of 5% or greater in at least one of the RISPERDAL groups and at least twice that of placebo were: anxiety, somnolence, extrapyramidal symptoms, dizziness, constipation, nausea, dyspepsia, rhinitis, rash, and tachycardia.

EPS with RISPERDAL, while dose-dependent, are comparable to placebo at doses ≤6 mg/day and differ significantly from placebo at doses >6 mg/day. Prescribing should be consistent with the need to minimize the risk of tardive dyskinesia; if its signs and symptoms appear, discontinuation of RISPERDAL should be considered.

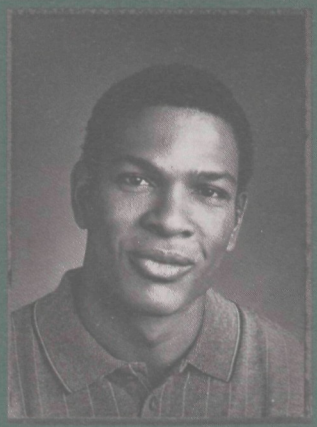
Orthostatic hypotension was reported infrequently (<1%) in clinical trials; its risk may be minimized by following the recommended RISPERDAL dose titration regimen.



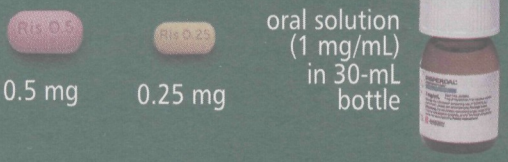
Fitted to everyone



4 mg 3 mg 2 mg 1 mg



from young adults



0.5 mg 0.25 mg

oral solution (1 mg/mL) in 30-mL bottle

to special populations*

*Patients who are elderly or who are renally or hepatically impaired.

Reference:
1. IMS America, 12/99.

Please see brief summary of Prescribing Information on adjacent page.

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Risperdal®
tablets and oral solution 1 mg/mL RISPERIDONE

The #1 prescribed antipsychotic[1]

JANSSEN PHARMACEUTICA PRODUCTS, L.P.

01-RS-708 July 2000

https://doi.org/10.1017/S1092852900013298 Published online by Cambridge University Press

Risperdal®

tablets and oral solution 1 mg/mL

RISPERIDONE

BEFORE PRESCRIBING, PLEASE CONSULT COMPLETE PRESCRIBING INFORMATION OF WHICH THE FOLLOWING IS A BRIEF SUMMARY.

INDICATIONS AND USAGE

RISPERDAL® (risperidone) is indicated for the management of the manifestations of psychotic disorders.

CONTRAINDICATIONS

RISPERDAL® (risperidone) is contraindicated in patients with a known hypersensitivity to the product.

WARNINGS

Neuroleptic Malignant Syndrome (NMS)

A potentially fatal symptom complex sometimes referred to as Neuroleptic Malignant Syndrome (NMS) has been reported in association with antipsychotic drugs. If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. The patient should be carefully monitored, since recurrences of NMS have been reported.

Tardive Dyskinesia

A syndrome of potentially irreversible, involuntary, dyskinetic movements may develop in patients treated with antipsychotic drugs. Whether antipsychotic drug products differ in their potential to cause tardive dyskinesia is unknown.

If signs and symptoms of tardive dyskinesia appear in a patient on RISPERDAL®, drug discontinuation should be considered. However, some patients may require treatment with RISPERDAL® despite the presence of the syndrome.

Potential for Proarrhythmic Effects: Risperidone and/or 9-hydroxyrisperidone appears to lengthen the QT interval in some patients, although there is no average increase in treated patients, even at 12-16 mg/day, well above the recommended dose. Other drugs that prolong the QT interval have been associated with the occurrence of torsades de pointes, a life-threatening arrythmia. Bradycardia, electrolyte imbalance, concomitant use with other drugs that prolong QT, or the presence of congenital prolongation in QT can increase the risk for occurrence of this arrhythmia.

PRECAUTIONS

General

Orthostatic Hypotension: RISPERDAL® (risperidone) may induce orthostatic hypotension associated with dizziness, tachycardia, and in some patients, syncope, especially during the initial dose-titration period, probably reflecting its alpha-adrenergic antagonistic properties. Syncope was reported in 0.2% (6/2607) of RISPERDAL® treated patients in phase 2-3 studies. The risk of orthostatic hypotension and syncope may be minimized by limiting the initial dose to 2 mg total (either QD or 1 mg BID) in normal adults and 0.5 mg BID in the elderly and patients with renal or hepatic impairment (See DOSAGE AND ADMINISTRATION). Monitoring of orthostatic vital signs should be considered in patients for whom this is of concern. A dose reduction should be considered if hypotension occurs. RISPERDAL® should be used with particular caution in patients with known cardiovascular disease (history of myocardial infarction or ischemia, heart failure, or conduction abnormalities), cerebrovascular disease, and conditions which would predispose patients to hypotension e.g., dehydration and hypovolemia. Clinically significant hypotension has been observed with concomitant use of RISPERDAL® and antihypertensive medication.

Seizures: RISPERDAL® should be used cautiously in patients with a history of seizures.

Dysphagia: Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in patients with advanced Alzheimer's dementia. RISPERDAL® and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia.

Hyperprolactinemia: As with other drugs that antagonize dopamine D_2 receptors, risperidone elevates prolactin levels and the elevation persists during chronic administration. Neither clinical studies nor epidemiologic studies conducted to date have shown an association between chronic administration of this class of drugs and tumorigenesis in humans; the available evidence is considered too limited to be conclusive at this time.

Potential for Cognitive and Motor Impairment: Somnolence was a commonly reported adverse event associated with RISPERDAL® treatment, especially when ascertained by direct questioning of patients. This adverse event is dose related. Patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that RISPERDAL® therapy does not affect them adversely.

Priapism: Rare cases of priapism have been reported.

Thrombotic Thrombocytopenic Purpura (TTP): A single case of TTP was reported in a 28 year-old female patient receiving RISPERDAL® in a large, open premarketing experience (approximately 1300 patients). She experienced jaundice, fever, and bruising, but eventually recovered after receiving plasmapheresis. The relationship to RISPERDAL® therapy is unknown.

Antiemetic effect: Risperidone has an antiemetic effect in animals; this effect may also occur in humans, and may mask signs and symptoms of overdosage with certain drugs or of conditions such as intestinal obstruction, Reye's syndrome, and brain tumor.

Body Temperature Regulation: Disruption of body temperature regulation has been attributed to antipsychotic agents. Caution is advised when prescribing for patients who will be exposed to temperature extremes.

Suicide: The possibility of a suicide attempt is inherent in schizophrenia, and close supervision of high risk patients should accompany drug therapy.

Use in Patients with Concomitant Illness: Clinical experience with RISPERDAL® in patients with certain concomitant systemic illnesses is limited. Caution is advisable in using RISPERDAL® in patients with diseases or conditions that could affect metabolism or hemodynamic responses.

Because of the risks of orthostatic hypotension and QT prolongation, caution should be observed in cardiac patients (See WARNINGS and PRECAUTIONS).

Increased plasma concentrations of risperidone and 9-hydroxyrisperidone occur in patients with severe renal impairment and in patients with severe hepatic impairment. A lower starting dose should be used in such patients.

Information for Patients

Physicians are advised to consult full prescribing information to review issues to be discussed with patients for whom they prescribe RISPERDAL®.

Drug Interactions

The interactions of RISPERDAL® and other drugs have not been systematically evaluated. Given the primary CNS effects of risperidone, caution should be used when RISPERDAL® is taken in combination with other centrally acting drugs and alcohol. RISPERDAL® may antagonize the effects of levodopa and dopamine agonists. Chronic administration of carbamazepine with risperidone may increase the clearance of risperidone. Chronic administration of clozapine with risperidone may decrease the clearance of risperidone.

Fluoxetine may increase the plasma concentration of the anti-psychotic fraction (risperidone plus 9-hydroxyrisperidone) by raising the concentration of risperidone, although not the active metabolite, 9-hydroxyrisperidone.

Drugs that Inhibit Cytochrome $P_{450}IID_6$ and Other P_{450} Isozymes: Risperidone is metabolized to 9-hydroxyrisperidone by cytochrome $P_{450}IID_6$, an enzyme that is polymorphic in the population and that can be inhibited by a variety of psychotropic and other drugs (See CLINICAL PHARMACOLOGY). Drug interactions that reduce the metabolism of risperidone to 9-hydroxyrisperidone would increase the plasma concentrations of risperidone and lower the concentrations of 9-hydroxyrisperidone. Analysis of clinical studies involving a modest number of poor metabolizers (n=70) does not suggest that poor and extensive metabolizers have different rates of adverse effects. No comparison of effectiveness in the two groups has been made.

In vitro studies showed that drugs metabolized by other P_{450} isozymes, including 1A1, 1A2, IIC9, MP, and IIIA4, are only weak inhibitors of risperidone metabolism.

Drugs Metabolized by Cytochrome $P_{450}IID_6$: In vitro studies indicate that risperidone is a relatively weak inhibitor of cytochrome $P_{450}IID_6$. Therefore, RISPERDAL® is not expected to substantially inhibit the clearance of drugs that are metabolized by this enzymatic pathway. However, clinical data to confirm this expectation are not available.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis: Carcinogenicity studies were conducted in Swiss albino mice and Wistar rats. Risperidone was administered in the diet at doses of 0.63, 2.5, and 10 mg/kg for 18 months to mice and for 25 months to rats. These doses are equivalent to 2.4, 9.4 and 37.5 times the maximum human dose (16 mg/day) on a mg/kg basis or 0.2, 0.75 and 3 times the maximum human dose (mice) or 0.4, 1.5, and 6 times the maximum human dose (rats) on a mg/m² basis. There were statistically significant increases in pituitary gland adenomas, endocrine pancreas adenomas and mammary gland adenocarcinomas.

These findings are considered to be prolactin medicated. The relevance for human risk of the findings of prolactin-mediated endocrine tumors in rodents is unknown (See Hyperprolactinemia under PRECAUTIONS, GENERAL).

Mutagenesis: No evidence of mutagenic potential for risperidone was found.

Impairment of Fertility: Risperidone (0.16 to 5 mg/kg) was shown to impair mating, but not fertility, in Wistar rats in three reproductive studies at doses 0.1 to 3 times the maximum recommended human dose on a mg/m² basis.

Pregnancy

Pregnancy Category C: There are no adequate and well-controlled studies in pregnant women.

RISPERDAL® should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Labor and Delivery

The effect of RISPERDAL® on labor and delivery in humans is unknown.

Nursing Mothers

It is not known whether or not risperidone is excreted in human milk. Women receiving RISPERDAL® should not breast feed.

Pediatric Use

Safety and effectiveness in children have not been established.

Geriatric Use

Clinical studies of RISPERDAL® did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently from younger patients. Other reported clinical experience has not identified differences in responses between elderly and younger patients. In general, a lower starting dose is recommended for an elderly patient, reflecting a decreased pharmacokinetic clearance in the elderly, as well as a greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy (See CLINICAL PHARMACOLOGY and DOSAGE AND ADMINISTRATION). While elderly patients exhibit a greater tendency to orthostatic hypotension, its risk in the elderly may be minimized by limiting the initial dose to 0.5 mg BID followed by careful titration (See PRECAUTIONS). Monitoring of orthostatic vital signs should be considered in patients for whom this is of concern.

This drug is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function (See DOSAGE AND ADMINISTRATION).

ADVERSE REACTIONS

Associated with Discontinuation of Treatment

Approximately 9% percent (244/2607) of RISPERDAL® (risperidone)-treated patients in phase 2-3 studies discontinued treatment due to an adverse event, compared with about 7% on placebo and 10% on active control drugs. The more common events (≥ 0.3%) associated with discontinuation and considered to be possibly or probably drug-related included: extrapyramidal symptoms, dizziness, hyperkinesia, somnolence, and nausea.

Incidence in Controlled Trials

Commonly Observed Adverse Events in Controlled Clinical Trials: In two 6- to 8-week placebo-controlled trials, spontaneously-reported, treatment-emergent adverse events with an incidence of 5% or greater in at least one of the RISPERDAL® groups and at least twice that of placebo were: anxiety, somnolence, extrapyramidal symptoms, dizziness, constipation, nausea, dyspepsia, rhinitis, rash, and tachycardia.

Adverse events were also elicited in one of these two trials (i.e., in the fixed-dose trial comparing RISPERDAL® at doses of 2, 6, 10, and 16 mg/day with placebo) utilizing a checklist for detecting adverse events, a method that is more sensitive than spontaneous reporting. By this method, the following additional common and drug-related adverse events were present at least 5% and twice the rate of placebo: increased dream activity, increased duration of sleep, accommodation disturbances, reduced salivation, micturition disturbances, diarrhea, weight gain, menorrhagia, diminished sexual desire, erectile dysfunction, ejaculatory dysfunction, and orgastic dysfunction.

The following adverse events occurred at an incidence of 1% or more, and were at least as frequent among RISPERDAL® treated patients treated at doses of ≤10 mg/day than among placebo-treated patients in the pooled results of two 6- to 8-week controlled trials: ***Psychiatric Disorders:*** insomnia, agitation, anxiety, somnolence, aggressive reaction. ***Nervous System:*** extrapyramidal symptoms[1], headache, dizziness. ***Gastrointestinal System:*** constipation, nausea, dyspepsia, vomiting, abdominal pain, saliva increased, toothache. ***Respiratory System:*** rhinitis, coughing, sinusitis, pharyngitis, dyspnea. ***Body as a Whole:*** back pain, chest pain, fever. ***Dermatological:*** rash, dry skin, seborrhea. ***Infections:*** upper respiratory. ***Visual:*** abnormal vision. ***Musculo-Skeletal:*** arthralgia. ***Cardiovascular:*** tachycardia.

[1] Includes tremor, dystonia, hypokinesia, hypertonia, hyperkinesia, oculogyric crisis, ataxia, abnormal gait, involuntary muscle contractions, hyporeflexia, akathisia, and extrapyramidal disorders.

Dose Dependency of Adverse Events:

Data from two fixed dose trials provided evidence of dose-relatedness for extrapyramidal symptoms associated with risperidone treatment. These symptoms include: sleepiness, increased duration of sleep, accommodation disturbances, orthostatic dizziness, palpitations, weight gain, erectile dysfunction, ejaculatory dysfunction, orgastic dysfunction, asthenia/lassitude/increased fatigueability, and increased pigmentation.

Vital Sign Changes: RISPERDAL® is associated with orthostatic hypotension and tachycardia (See PRECAUTIONS).

Weight Changes: A statistically significantly greater incidence of weight gain for RISPERDAL® (18%) compared to placebo (9%).

Laboratory Changes: A between group comparison for 6- to 8-week placebo-controlled trials revealed no statistically significant RISPERDAL®/placebo differences in the proportions of patients experiencing potentially important changes in routine serum chemistry, hematology, or urinalysis parameters. Similarly, there were no RISPERDAL®/placebo differences in the incidence of discontinuations for changes in serum chemistry, hematology, or urinalysis. However, RISPERDAL® administration was associated with increases in serum prolactin (See PRECAUTIONS).

ECG Changes: The electrocardiograms of approximately 380 patients who received RISPERDAL® and 120 patients who received placebo in two double-blind, placebo-controlled trials were evaluated and revealed one finding of potential concern; i.e., 8 patients taking RISPERDAL® whose baseline QTc interval was less than 450 msec were observed to have QTc intervals greater than 450 msec during treatment (See WARNINGS). Changes of this type were not seen among about 120 placebo patients, but were seen in patients receiving haloperidol (3/126).

Other Events Observed During the Pre-Marketing Evaluation of RISPERDAL®

During its premarketing assessment, multiple doses of RISPERDAL® (risperidone) were administered to 2607 patients in phase 2 and 3 studies and the following reactions were reported: (Note: frequent adverse events are those occurring in at least 1/100 patients. Infrequent adverse events are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in fewer than 1/1000 patients. It is important to emphasize that, although the events reported occurred during treatment with RISPERDAL®, they were not necessarily caused by it.)

Psychiatric Disorders: *Frequent:* increased dream activity*, diminished sexual desire*, nervousness. *Infrequent:* impaired concentration, depression, apathy, catatonic reaction, euphoria, increased libido, amnesia. *Rare:* emotional lability, nightmares, delirium, withdrawal syndrome, yawning.

Central and Peripheral Nervous System Disorders: *Frequent:* increased sleep duration*. *Infrequent:* dysarthria, vertigo, stupor, paraesthesia, confusion. *Rare:* aphasia, cholinergic syndrome, hypoesthesia, tongue paralysis, leg cramps, torticollis, hypotonia, coma, migraine, hyperreflexia, choreoathetosis.

Gastro-Intestinal Disorders: *Frequent:* anorexia, reduced salivation*. *Infrequent:* flatulence, diarrhea, increased appetite, stomatitis, melena, dysphagia, hemorrhoids, gastritis. *Rare:* fecal incontinence, eructation, gastroesophageal reflux, gastroenteritis, esophagitis, tongue discoloration, cholelithiasis, tongue edema, diverticulitis, gingivitis, discolored feces, GI hemorrhage, hematemesis.

Body as a Whole/General Disorders: *Frequent:* fatigue. *Infrequent:* edema, rigors, malaise, influenza-like symptoms. *Rare:* pallor, enlarged abdomen, allergic reaction, ascites, sarcoidosis, flushing.

Respiratory System Disorders: *Infrequent:* hyperventilation, bronchospasm, pneumonia, stridor. *Rare:* asthma, increased sputum, aspiration.

Skin and Appendage Disorders: *Frequent:* increased pigmentation*, photosensitivity*. *Infrequent:* increased sweating, acne, decreased sweating, alopecia, hyperkeratosis, pruritus, skin exfoliation. *Rare:* bullous eruption, skin ulceration, aggravated psoriasis, furunculosis, verruca, dermatitis lichenoid, hypertrichosis, genital pruritus, urticaria.

Cardiovascular Disorders: *Infrequent:* palpitation, hypertension, hypotension, AV block, myocardial infarction. *Rare:* ventricular tachycardia, angina pectoris, premature atrial contractions, T wave inversions, ventricular extrasystoles, ST depression, myocarditis.

Vision Disorders: *Infrequent:* abnormal accommodation, xerophthalmia. *Rare:* diplopia, eye pain, blepharitis, photopsia, photophobia, abnormal lacrimation.

Metabolic and Nutritional Disorders: *Infrequent:* hyponatremia, weight increase, creatine phosphokinase increase, thirst, weight decrease, diabetes mellitus. *Rare:* decreased serum iron, cachexia, dehydration, hypokalemia, hypoproteinemia, hyperphosphatemia, hypertriglyceridemia, hyperuricemia, hypoglycemia.

Urinary System Disorders: *Frequent:* polyuria/polydipsia*. *Infrequent:* urinary incontinence, hematuria, dysuria. *Rare:* urinary retention, cystitis, renal insufficiency.

Musculo-skeletal System Disorders: *Infrequent:* myalgia. *Rare:* arthrosis, synostosis, bursitis, arthritis, skeletal pain.

Reproductive Disorders, Female: *Frequent:* menorrhagia*, orgastic dysfunction*, dry vagina*. *Infrequent:* nonpuerperal lactation, amenorrhea, female breast pain, leukorrhea, mastitis, dysmenorrhea, female perineal pain, intermenstrual bleeding, vaginal hemorrhage.

Liver and Biliary System Disorders: *Infrequent:* increased SGOT, increased SGPT. *Rare:* hepatic failure, cholestatic hepatitis, cholecystitis, cholelithiasis, hepatitis, hepatocellular damage.

Platelet, Bleeding and Clotting Disorders: *Infrequent:* epistaxis, purpura. *Rare:* hemorrhage, superficial phlebitis, thrombophlebitis, thrombocytopenia.

Hearing and Vestibular Disorders: *Rare:* tinnitus, hyperacusis, decreased hearing.

Red Blood Cell Disorders: *Infrequent:* anemia, hypochromic anemia. *Rare:* normocytic anemia.

Reproductive Disorders, Male: *Frequent:* erectile dysfunction*. *Infrequent:* ejaculation failure.

White Cell and Resistance Disorders: *Rare:* leukocytosis, lymphadenopathy, leucopenia, Pelger-Huet anomaly.

Endocrine Disorders: *Rare:* gynecomastia, male breast pain, antidiuretic hormone disorder.

Special Senses: *Rare:* bitter taste.

* Incidence based on elicited reports.

Postintroduction Reports: Adverse events reported since market introduction which were temporally (but not necessarily causally) related to RISPERDAL® therapy, include the following: anaphylactic reaction, angioedema, apnea, atrial fibrillation, cerebrovascular disorder, diabetes mellitus aggravated, including diabetic ketoacidosis, intestinal obstruction, jaundice, mania, pancreatitis, Parkinson's disease aggravated, pulmonary embolism. There have been rare reports of sudden death and/or cardiopulmonary arrest in patients receiving RISPERDAL®. A causal relationship with RISPERDAL® has not been established. It is important to note that sudden and unexpected death may occur in psychotic patients whether they remain untreated or whether they are treated with other antipsychotic drugs.

DRUG ABUSE AND DEPENDENCE

Controlled Substance Class: RISPERDAL® (risperidone) is not a controlled substance.

For information on symptoms and treatment of overdosage, see full prescribing information.

More detailed professional information is available upon request.

US Patent 4,804,663
July 1998, May 1999

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