

Lorcet® 10/650

Each tablet contains: 10 mg hydrocodone bitartrate (Warning: May be habit-forming) and 650 mg acetaminophen.

Reference:

1. Data on file, Forest Laboratories, New York, NY.

BRIEF SUMMARY

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS: Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions. **PRECAUTIONS: Special Risk Patients:** As with any narcotic analgesic agent, Lorcet® 10/650 should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. The usual precautions should be observed and the possibility of respiratory depression should be kept in mind.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when Lorcet® 10/650 is used postoperatively and in patients with pulmonary disease. **Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, anxiolytic agents, or other CNS depressants (including alcohol) concomitantly with Lorcet® 10/650 may exhibit an additive CNS depression. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy: Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. Lorcet® 10/650 should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose. There is no consensus on the best method of managing withdrawal. Chlorpromazine 0.7 to 1 mg/kg q6h, and paregoric 2 to 4 drops/kg q4h, have been used to treat withdrawal symptoms in infants. The duration of therapy is 4 to 28 days, with the dosage decreased as tolerated.

Labor and Delivery: As with all narcotics, administration of Lorcet® 10/650 to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used. **Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from Lorcet® 10/650, 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: Safety and effectiveness in children have not been established. **ADVERSE REACTIONS:** The most frequently observed adverse reactions include lightheadedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include: **Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence, mood changes. **Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of Lorcet® 10/650 may produce constipation.

Genitourinary System: Urteral spasm, spasm of vesical sphincters and urinary retention have been reported. **Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated. **DRUG ABUSE AND DEPENDENCE:** Lorcet® 10/650 is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, Lorcet® 10/650 should be prescribed and administered with caution. However, psychic dependence is unlikely to develop when Lorcet® 10/650 is used for a short time for the treatment of pain.

OVERDOSAGE: Acetaminophen: Signs and Symptoms: In acute acetaminophen overdose, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion. **Hydrocodone:** Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdose, apnea, circulatory collapse, cardiac arrest and death may occur.

DOSEAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, it should be kept in mind that tolerance to hydrocodone can develop with continued use and that the incidence of untoward effects is dose related. The usual adult dosage is one tablet every four to six hours as needed for pain. The total 24 hour dose should not exceed 6 tablets. **CAUTION:** Federal law prohibits dispensing without prescription. A Schedule CII Controlled Substance. Manufactured by: MIKART, INC. ATLANTA, GA 30318 Manufactured for: UAD Laboratories Division of Forest Pharmaceuticals, Inc. Jackson, MS 39209 Rev. 11/92 Code 558A00

editorial comments

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Harvard researcher Walter C. Willett, MD, is calling on the food industry to gradually phase out the use of partially hydrogenated oils in their products. Similarly, a Washington, DC-based consumer group, the Center for Science in the Public Interest, has asked the Food and Drug Administration to require trans fatty acids to be included in the saturated fats category now listed on the new food labels.

A single dose of dexamethasone does not prevent morbidity in children who undergo tonsillectomy.

Laurie A. Ohlms, MD, found this regimen offered no benefit to the 69 children in a randomized, double-blind, placebo-controlled prospective study conducted at Children's Hospital in Boston. The children ranged in age from 3 years to 18 years and had undergone tonsillectomy with or without adenoidectomy.

No statistically significant differences in pain scores, nausea, emesis, halitosis, required analgesic medications, diet, or activity levels were noted between the treatment and control groups said Dr Ohlms at the convocation of the American Society of Pediatric Otolaryngology meeting and the American Otolological Society. These combined otolaryngological spring meetings were held in May in Palm Beach, Fla.

In a separate presentation, Paul R. Lambert, MD, of the University of Virginia, told meeting attendees that no correlation was found between the severity of sensorineural hearing loss and the duration of the disease, the presence of acquired cholesteatoma, middle ear mucosal disease, or ossicular damage.

Said Dr Lambert, "Chronic otitis media may cause sensorineural hearing loss, but in the vast majority of patients, this loss is not clinically significant."

His comments are based on a study of 70 patients who had undergone surgery for chronic ear infections between September 1973 and March 1993. All the patients had unilateral chronic otitis media with no history of head trauma, meningitis, posttraumatic tympanic membrane perforation, labyrinthine fistula, or other concomitant ear condition.

Patients with serous otitis media who have ventilation tubes inserted for long-term treatment may be at risk for perforated tympanic membranes. In a study of 103 children, Richard M. Bass, MD, found a 19% perforation rate among children who had tubes inserted for more than 1 year after tympanostomy tube extrusion. No perforations were found in the children who had the tubes in place for less than 1 year. None of the children had had previous middle ear surgery.

Thus Dr Bass recommends using the conservative approach—ventilation tubes inserted for short-term treatment—for patients without a history of middle ear surgery.

US pharmaceutical trials of the French abortion pill RU-486 are expected to begin this fall, with 2000 women to be enrolled at 12 clinical sites. These trials differ from the trial currently being conducted in San Francisco. In that trial, RU-486 is being tested as a morning-after contraceptive in 150 women.

The drug's French manufacturer Roussel Uclaf will supply the drug for the clinical trials. How-

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ever, the French manufacturer will transfer its patent without charge to the Population Council, a non-profit organization. The Population Council will then look for a US company to manufacture the drug.

Once a manufacturer is found for the drug, the Population Council must submit a new drug application to the US Food and Drug Administration.

FDA Commissioner David Kessler, MD, says that the review process could be expedited because the agency has seen preliminary results from the drug's use in Europe. If the entire process moves ahead without a hitch, RU-486 could be approved for use in the United States by 1996.

"Women should not think that pregnancy termination using a medical regimen [rather than a surgical one] will be simple," comments Dr Kessler. "It will not."

The pill is not administered beyond the 49th day of a missed period. The regimen requires several office visits. ♦

JAOA

a point in time

1954

Back through the pages of JAOA to July 1954

Forty years ago, JAOA Editor in chief Raymond P. Keesecker, DO, addressed the basic issues still facing today's editorial staff: how to expedite the manuscript review process while maintaining editorial integrity and still operate within the confines of established procedures and economic restraints:

The Journal of the American Osteopathic Association is the official scientific and clinical periodical of organized osteopathy. As such, it has become an authoritative professional publication of high standards and is so accepted from without as well as within the profession. Articles which appear in it are given a certain prestige. Demands upon it for space are considerable.

The official status of *The Journal* requires the publication of certain material which is documentary in type and archival in nature.

The "Manual of Procedure of the American Osteopathic Association," its official reference book, records that as early as July, 1933, the Board and House declared that osteopathy is and always has been a complete school of medicine. In the past 20 years following this statement of policy, our profession has moved resolutely forward to its full implementation, resulting in considerable modification of the content of our publications....

This policy, moreover, is a powerful factor in increasing space demands upon *The Journal*. Budgetary limitations forces [sic] the editors to exercise a judicious space assignment, a relational timing of the appearance of papers, and a careful balancing of copy.

Naturally, authors feel a sense of immediacy about the publication of their articles, an urgency readily understandable. The editors, however, must work on a planned program covering a year or more in advance. That does not mean that articles are scheduled a year before actual publication, but it does mean that articles must fit into a framework quite permanent in structure....When an article is found acceptable, its preparation for actual publication can be a considerable task, often involving months.

These [editorial] policies and practices...are set up to insure a periodical of high worth, of which osteopathic physicians may be rightly proud....No individual should be deprived of the right to validate his theories by means of publication. But publication in *The Journal* calls for the presentation of material in the terms of today's scientific methods and knowledge and not upon the basis of an author's enthusiasm.

The Journal's continuity with the past remains inviolate for it sets forth today no higher purpose than so perfectly stated by its first editor in its first issue: "[To provide a medium] wherein the best thought and latest scientific research of the profession may not only find expression but a place of permanent record."

(Journal policy and practice, JAOA 1954;53:629-631.)