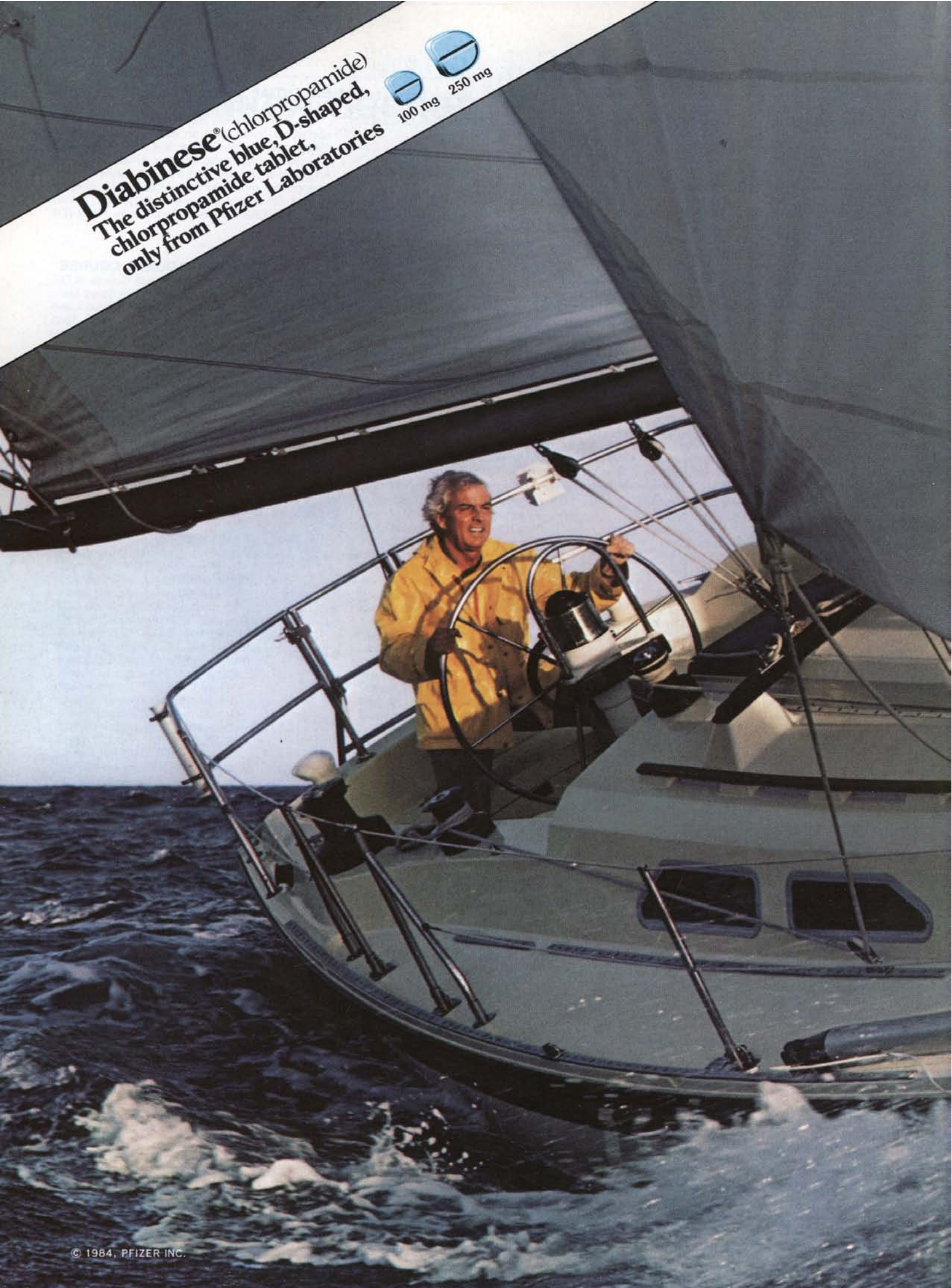

Diabinese®(chlorpropamide)
The distinctive blue, D-shaped, chlorpropamide tablet, only from Pfizer Laboratories
100 mg
250 mg
© 1984, PFIZER INC.

Holding Course...

for continued control of the NIDDM patient.

Control of blood sugar requires a day-to-day, week-to-week vigil, particularly when diet alone has failed in NIDDM. Once control has been successfully achieved with diet and Diabinese® (chlorpropamide), the logical course is to continue the regimen.

Diabinese is the most widely prescribed oral diabetic agent in the United States.

As with all sulfonylureas, hypoglycemia may occur with Diabinese, but less frequently than with insulin therapy.

Diabinese effectively controls hyperglycemia...

- known to stimulate beta cells to produce insulin[1,2]
- normalizes hepatic glucose production[2]
- postulated to increase the number of insulin receptors[3]
- postulated to enhance the postreceptor action of insulin[4]

The Diabinese D-Pak helps patients remember and keep track of the convenient once-a-day regimen... which encourages compliance.

To be sure your patients who are controlled on Diabinese continue to receive the familiar blue, D-shaped tablet, specify:

- *Do not substitute,*
- *Medically necessary,* or
- *Dispense as written,*

depending on the state in which you practice.

When diet alone fails...

Diet & Diabinese®

(chlorpropamide) Tablets 100 mg, 250 mg and D-Pak

A proven regimen...continue it with confidence.

Pfizer LABORATORIES DIVISION
PFIZER INC.

Leaders in Oral Diabetic Therapy

Please see references and Diabinese® Brief Summary on following page.

Diet & Diabinese®
(chlorpropamide) Tablets 100 mg, 250 mg and D-Pak

References: 1. Clarke BF: The management of maturity-onset diabetes: clinical experience with chlorpropamide, in: *Individualizing Therapy in Maturity-Onset Diabetes*, New York, Science and Medicine Publishing Co., Inc., 1979, pp 57-65. **2.** Best JD, Judzewitsch RG, Pfeifer MA: The effect of chronic sulfonylurea therapy on hepatic glucose production in non-insulin-dependent diabetes. *Diabetes* 31:333-338, 1982. **3.** Olefsky JM, Reaven GM: Effects of sulfonylurea therapy on insulin binding to mononuclear leukocytes of diabetic patients. *Am J Med* 60:89-95, 1976. **4.** Salhanick AI, Konowitz P, Amatruda JM: Potentiation of insulin action by a sulfonylurea in primary cultures of hepatocytes from normal and diabetic rats. *Diabetes* 32:206-212, 1983.

BRIEF SUMMARY
DIABINESE® (chlorpropamide) TABLETS, USP

CONTRAINDICATIONS

DIABINESE is contraindicated in patients with:
1. Known hypersensitivity to the drug.
2. Diabetic ketoacidosis, with or without coma. This condition should be treated with insulin.

WARNINGS

SPECIAL WARNING ON INCREASED RISK OF CARDIOVASCULAR MORTALITY

The administration of oral hypoglycemic drugs has been reported to be associated with increased cardiovascular mortality as compared to treatment with diet alone or diet plus insulin. This warning is based on the study conducted by the University Group Diabetes Program (UGDP), a long-term prospective clinical trial designed to evaluate the effectiveness of glucose-lowering drugs in preventing or delaying vascular complications in patients with non-insulin-dependent diabetes. The study involved 823 patients who were randomly assigned to one of four treatment groups (*Diabetes*, 19 (supp. 2):747-830, 1970).

UGDP reported that patients treated for 5 to 8 years with diet plus a fixed dose of tolbutamide (1.5 grams per day) had a rate of cardiovascular mortality approximately 2½ times that of patients treated with diet alone. A significant increase in total mortality was not observed, but the use of tolbutamide was discontinued based on the increase in cardiovascular mortality, thus limiting the opportunity for the study to show an increase in over-all mortality. Despite controversy regarding the interpretation of these results, the findings of the UGDP study provide an adequate basis for this warning. The patient should be informed of the potential risks and advantages of DIABINESE and of alternative modes of therapy.

Although only one drug in the sulfonylurea class (tolbutamide) was included in this study, it is prudent from a safety standpoint to consider that this warning may also apply to other oral hypoglycemic drugs in this class, in view of their close similarities in mode of action and chemical structure.

PRECAUTIONS

General

Hypoglycemia: All sulfonylurea drugs are capable of producing severe hypoglycemia. Proper patient selection, dosage, and instructions are important to avoid hypoglycemic episodes. Renal or hepatic insufficiency may cause elevated blood levels of DIABINESE and the latter may also diminish gluconeogenic capacity, both of which increase the risk of serious hypoglycemic reactions. Elderly, debilitated or malnourished patients, and those with adrenal or pituitary insufficiency are particularly susceptible to the hypoglycemic action of glucose-lowering drugs. Hypoglycemia may be difficult to recognize in the elderly, and in people who are taking beta-adrenergic blocking drugs. Hypoglycemia is more likely to occur when caloric intake is deficient, after severe or prolonged exercise, when alcohol is ingested, or when more than one glucose-lowering drug is used.

Because of the long half-life of chlorpropamide, patients who become hypoglycemic during therapy require careful supervision of the dose and frequent feedings for at least 3 to 5 days. Hospitalization and intravenous glucose may be necessary.

Loss of control of blood glucose: When a patient stabilized on any diabetic regimen is exposed to stress such as fever, trauma, infection, or surgery, a loss of control may occur. At such times, it may be necessary to discontinue DIABINESE and administer insulin.

The effectiveness of any oral hypoglycemic drug, including DIABINESE, in lowering blood glucose to a desired level decreases in many patients over a period of time, which may be due to progression of the severity of the diabetes or to diminished responsiveness to the drug. This phenomenon is known as secondary failure, to distinguish it from primary failure in which the drug is ineffective in an individual patient when first given.

ADVERSE REACTIONS

Hypoglycemia: See PRECAUTIONS section.

Gastrointestinal Reactions: Cholestatic jaundice may occur rarely; DIABINESE should be discontinued if this occurs. Gastrointestinal disturbances are the most common reactions; nausea has been reported in less than 5% of patients, and diarrhea, vomiting, anorexia, and hunger in less than 2%. Other gastrointestinal disturbances have occurred in less than 1% of patients including proctocolitis. They tend to be dose related and may disappear when dosage is reduced.

Dermatologic Reactions: Pruritus has been reported in less than 3% of patients. Other allergic skin reactions, e.g., urticaria and maculopapular eruptions have been reported in approximately 1% or less of patients. These may be transient and may disappear despite continued use of DIABINESE; if skin reactions persist the drug should be discontinued.

Porphyria cutanea tarda and photosensitivity reactions have been reported with sulfonylureas.

Skin eruptions rarely progressing to erythema multiforme and exfoliative dermatitis have also been reported.

Hematologic Reactions: Leukopenia, agranulocytosis, thrombocytopenia, hemolytic anemia, aplastic anemia, pancytopenia and eosinophilia have been reported with sulfonylureas.

Metabolic Reactions: Hepatic porphyria and disulfiram-like reactions have been reported with DIABINESE.

Endocrine Reactions: On rare occasions, chlorpropamide has caused a reaction identical to the syndrome of inappropriate antidiuretic hormone (ADH) secretion. The features of this syndrome result from excessive water retention and include hyponatremia, low serum osmolality, and high urine osmolity.

DOSAGE AND ADMINISTRATION

There is no fixed dosage regimen for the management of diabetes mellitus with DIABINESE or any other hypoglycemic agent. In addition to the usual monitoring of urinary glucose, the patient's blood glucose must also be monitored periodically to determine the minimum effective dose for the patient; to detect primary failure, and to detect secondary failure. Glycosylated hemoglobin levels may also be of value in monitoring the patient's response to therapy.

The total daily dosage is generally taken at a single time each morning with breakfast. Occasionally cases of gastrointestinal intolerance may be relieved by dividing the daily dosage. A LOADING OR PRIMING DOSE IS NOT NECESSARY AND SHOULD NOT BE USED.

Initial Therapy: 1. The mild to moderately severe, middle-aged, stable, non-insulin-dependent diabetic patient should be started on 250 mg daily. Older patients should be started on smaller amounts of DIABINESE, in the range of 100 to 125 mg daily.

2. No transition period is necessary when transferring patients from other oral hypoglycemic agents to DIABINESE. The other agent may be discontinued abruptly and chlorpropamide started at once. In prescribing chlorpropamide, due consideration must be given to its greater potency.

Many mild to moderately severe, middle-aged, stable non-insulin-dependent diabetic patients receiving insulin can be placed directly on the oral drug and their insulin abruptly discontinued. For patients requiring more than 40 units of insulin daily, therapy with DIABINESE may be initiated with a 50 per cent reduction in insulin for the first few days, with subsequent further reductions dependent upon the response.

Five to seven days after the initial therapy, the blood level of chlorpropamide reaches a plateau. Dosage may subsequently be adjusted upward or downward by increments of not more than 50 to 125 mg at intervals of three to five days to obtain optimal control. More frequent adjustments are usually undesirable.

Maintenance Therapy: Most moderately severe, middle-aged, stable non-insulin-dependent diabetic patients are controlled by approximately 250 mg daily. Many investigators have found that some milder diabetics do well on daily doses of 100 mg or less. Many of the more severe diabetics may require 500 mg daily for adequate control. PATIENTS WHO DO NOT RESPOND COMPLETELY TO 500 MG DAILY WILL USUALLY NOT RESPOND TO HIGHER DOSES. MAINTENANCE DOSES ABOVE 750 MG DAILY SHOULD BE AVOIDED.

SUPPLY: Blue, 'D'-shaped, scored tablets in strengths of 100 mg, tablet code 393; (100's, NDC# 0663-3930-66, 500's, NDC# 0663-3930-73; and 100 unit dose of 10 x 10, NDC# 0663-3930-41) and 250 mg, tablet code 394; (100's, NDC# 0663-3940-66; 250's, NDC# 0663-3940-71; 1000's, NDC# 0663-3940-82; 100 unit dose of 10 x 10, NDC# 0663-3940-41; and 28's D-Pak, NDC# 0663-3940-28).

RECOMMENDED STORAGE: Store below 86°F (30°C).

CAUTION: Federal law prohibits dispensing without prescription.

Pfizer **LABORATORIES DIVISION**
PFIZER INC

A 22100 E

Diabetologia

Clinical and Experimental Diabetes and Metabolism
Organ of the European Association for the Study of Diabetes (EASD)

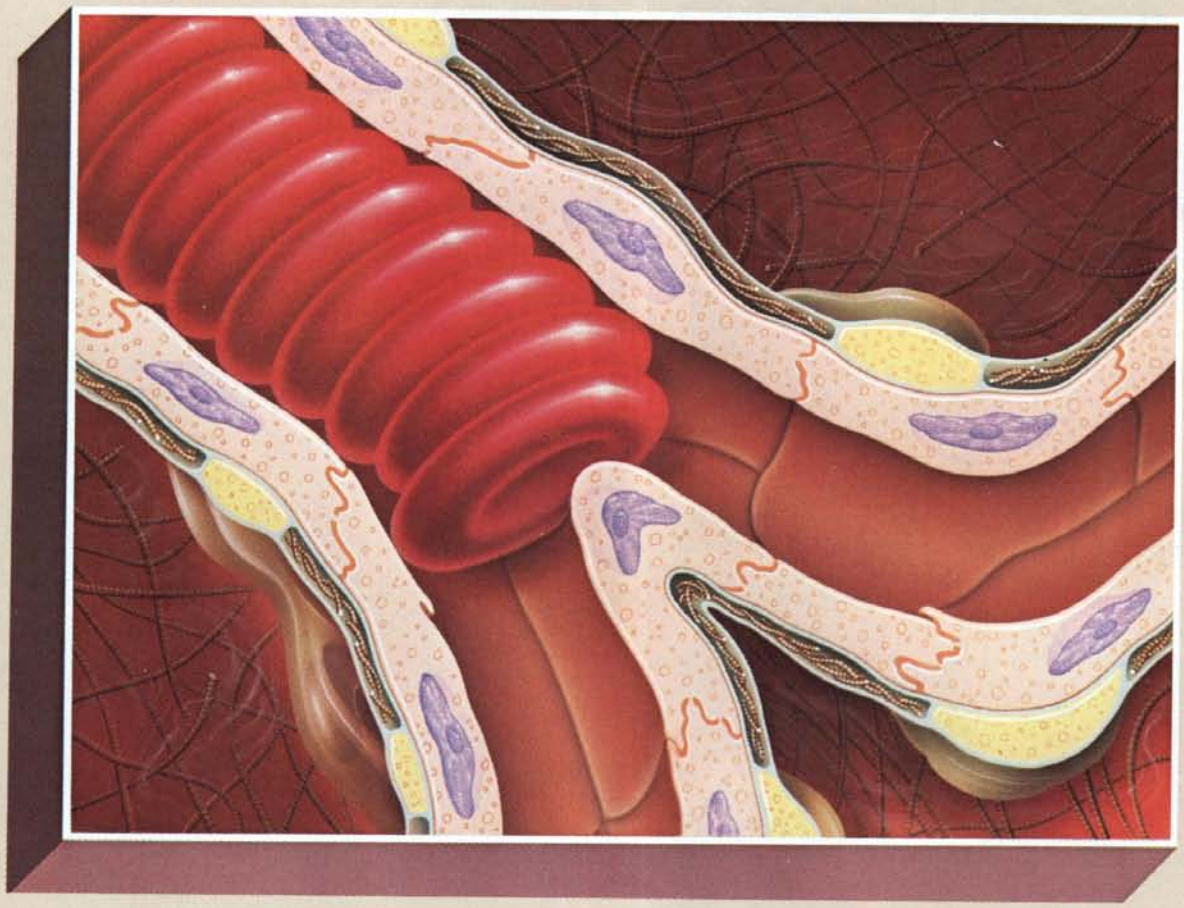
Volume 28 Number 6 June 1985

Indexed in Current Contents

Springer International

125 Diabetologia - ISSN 0012-186X DBTGAJ 28 (6) 315-388 (1985)

Why peripheral vasodilators fail to improve microcirculatory blood flow



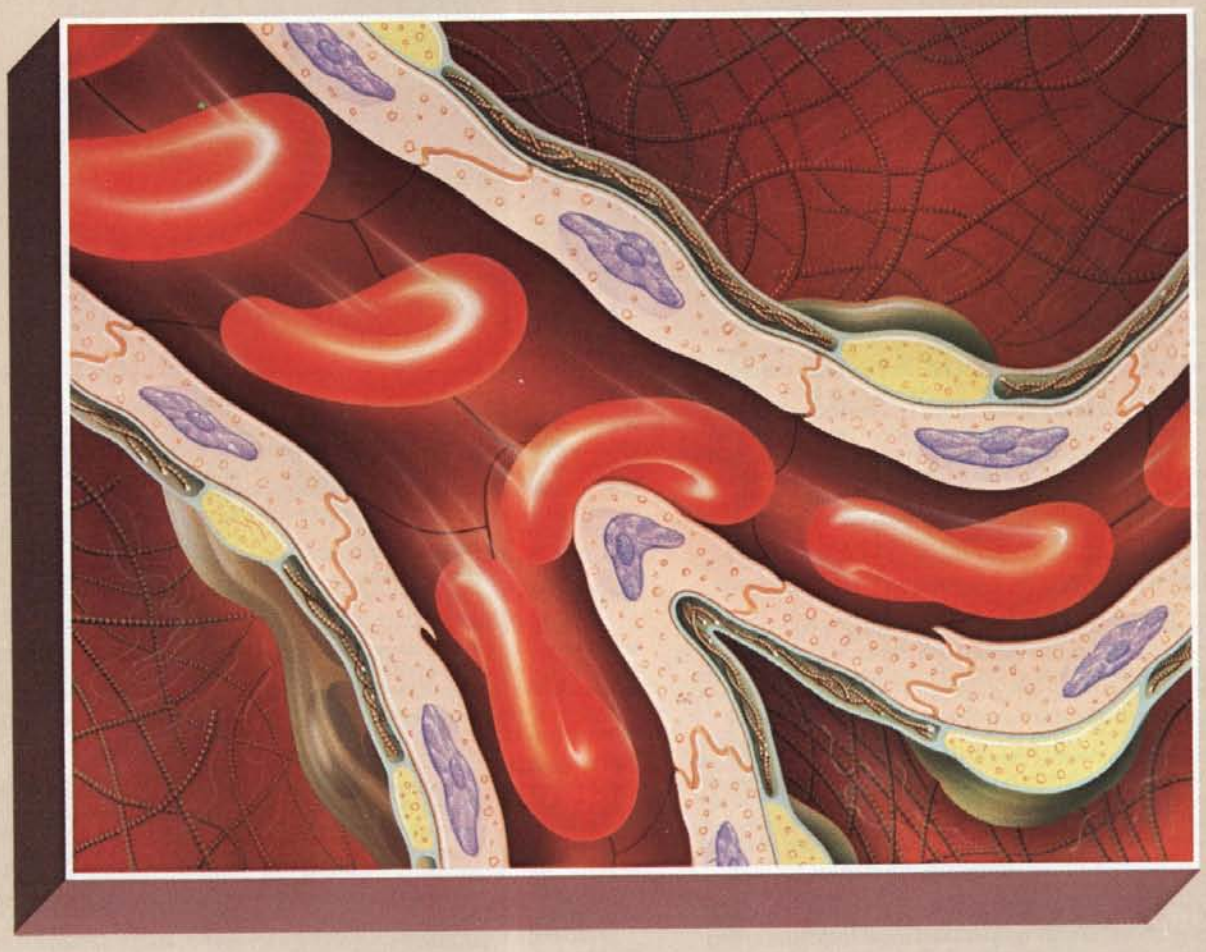
In chronic occlusive arterial disease, reduced blood flow downstream of a stenosis results in additional changes that further decrease efficient flow in the microcirculation.

Red blood cells become less flexible, impairing their normal capacity to pass through capillaries often less than half of the cells' diameter.[1] In addition, blood viscosity is increased.[2]

As flow through the microcirculation becomes more sluggish, acids and metabolites accumulate. Reduced tissue oxygenation results in painful claudication that limits the distance patients can walk.

Peripheral vasodilators cannot affect flow through arteries already maximally dilated, or through those with fixed stenoses. In addition, these agents do not increase the flexibility of red cells or decrease blood viscosity. Microcirculatory blood flow and tissue oxygenation do not improve.

...and how only Trental® succeeds.
(pentoxifylline)



Improves red blood cell flexibility

Trental® is not a vasodilator, not an anticoagulant, and not related to aspirin or dipyridamole. Trental® increases the flexibility of red cells, thereby improving their capacity to pass through capillaries. Blood viscosity is also reduced, decreasing resistance and improving perfusion of the ischemic microcirculation. As a result, tissue oxygenation is increased.

Trental® has been shown to significantly increase oxygenation in the calf muscles of patients with intermittent claudication.[3]

Well tolerated

Side effects with Trental® are usually mild, transient, and generally confined to reversible CNS or GI effects.

Trental® is compatible for concurrent use with antihypertensive, beta-blocker, digitalis, diuretic, antidiabetic, and antiarrhythmic regimens. (See full prescribing information.)

While the clinical benefits of Trental® may be seen within two to four weeks, it is recommended that treatment be continued for at least eight weeks. To maintain clinical benefit, continued therapy is necessary.

The usual dose of Trental® is one 400-mg tablet taken three times a day with meals.

Trental®
(pentoxifylline) 400 mg Tablets

The first proven-effective agent for intermittent claudication

Trental® can improve function and symptoms but is not intended to replace more definitive therapy such as surgery.

See following page for references and brief summary of prescribing information.

References:
1. Reid HL, et al: Impaired red cell deformability in peripheral vascular disease. *Lancet 1*:666-667, 1967.
2. Dormandy JA, et al: Clinical, haemodynamic, rheological, and biochemical findings in 126 patients with intermittent claudication. *Br Med J 4*:576-581, 1973.
3. Ehrly AM: Effects of orally administered pentoxifylline on muscular oxygen pressure in patients with intermittent claudication. *IRCS Med Sci 10*:401-402, 1982.

Trental® (pentoxifylline) Tablets, 400 mg

A brief summary of the Prescribing Information follows.

INDICATIONS AND USAGE:
Trental® (pentoxifylline) is indicated for the treatment of patients with intermittent claudication on the basis of chronic occlusive arterial disease of the limbs. Trental® (pentoxifylline) can improve function and symptoms but is not intended to replace more definitive therapy, such as surgical bypass, or removal of arterial obstructions when treating peripheral vascular disease.

CONTRAINDICATIONS:
Trental® (pentoxifylline) should not be used in patients who have previously exhibited intolerance to this product or methylxanthines such as caffeine, theophylline, and theobromine.

PRECAUTIONS:
General: Patients with chronic occlusive arterial disease of the limbs frequently show other manifestations of arteriosclerotic disease. Trental® (pentoxifylline) has been used safely for treatment of peripheral arterial disease in patients with concurrent coronary artery and cerebrovascular diseases, but there have been occasional reports of angina, hypotension, and arrhythmia. Controlled trials do not show that Trental® (pentoxifylline) causes such adverse effects more often than placebo, but, as it is a methylxanthine derivative, it is possible some individuals will experience such responses.

Drug Interactions: Although a causal relationship has not been established, there have been reports of bleeding and/or prolonged prothrombin time in patients treated with Trental® (pentoxifylline) with and without anticoagulants or platelet aggregation inhibitors. Patients on warfarin should have more frequent monitoring of prothrombin times, while patients with other risk factors complicated by hemorrhage (e.g., recent surgery, peptic ulceration) should have periodic examinations for bleeding including hematocrit and/or hemoglobin. Trental® (pentoxifylline) has been used concurrently with antihypertensive drugs, beta blockers, digitalis, diuretics, antidiabetic agents, and antiarrhythmics, without observed problems. Small decreases in blood pressure have been observed in some patients treated with Trental® (pentoxifylline); periodic systemic blood pressure monitoring is recommended for patients receiving concomitant antihypertensive therapy. If indicated, dosage of the antihypertensive agents should be reduced.

Carcinogenesis, Mutagenesis and Impairment of Fertility: Long-term studies of the carcinogenic potential of pentoxifylline were conducted in mice and rats by dietary administration of the drug at doses up to approximately 24 times (570 mg/kg) the maximum recommended human daily dose (MRHD) of 24 mg/kg for 18 months in mice and 18 months in rats with an additional 6 months without drug exposure in the latter. No carcinogenic potential for pentoxifylline was noted in the mouse study. In the rat study, there was a statistically significant increase in benign mammary fibroadenomas in females in the high dose group (24 X MRHD). The relevance of this finding to human use is uncertain since this was only a marginal statistically significant increase for a tumor that is common in aged rats. Pentoxifylline was devoid of mutagenic activity in various strains of *Salmonella* (Ames test) when tested in the presence and absence of metabolic activation.

Pregnancy: Category C. Teratogenic studies have been performed in rats and rabbits at oral doses up to about 25 and 10 times the maximum recommended human daily dose (MRHD) of 24 mg/kg, respectively. No evidence of fetal malformation was observed. Increased resorption was seen in rats at 25 times MRHD. There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, Trental® (pentoxifylline) should be used during pregnancy only if clearly needed.

Nursing Mothers: Pentoxifylline and its metabolites are excreted in human milk. Because of the potential for tumorigenicity shown for pentoxifylline in rats, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children below the age of 18 years have not been established.

ADVERSE REACTIONS:
Clinical trials were conducted using either controlled-release Trental® (pentoxifylline) tablets for up to 60 weeks or immediate-release Trental® (pentoxifylline) capsules for up to 24 weeks. Dosage ranges in the tablet studies were 400 mg bid to tid and in the capsule studies, 200-400 mg tid.

The table summarizes the incidence (in percent) of adverse reactions considered drug related, as well as the numbers of patients who received controlled-release Trental® (pentoxifylline) tablets, immediate-release Trental® (pentoxifylline) capsules, or the corresponding placebos. The incidence of adverse reactions was higher in the capsule studies (where dose related increases were seen in digestive and nervous system side effects) than in the tablet studies. Studies with the capsule include domestic experience, whereas studies with the controlled-release tablets were conducted outside the U.S. The table indicates that in the tablet studies few patients discontinued because of adverse effects.

INCIDENCE (%) OF SIDE EFFECTS

	Controlled-Release Tablets		Immediate-Release Capsules	
	Trental®	Placebo	Trental®	Placebo
(Numbers of Patients at Risk)	(321)	(128)	(177)	(138)
Discontinued for Side Effect	3.1	0	9.6	7.2
CARDIOVASCULAR SYSTEM				
Angina/Chest Pain	0.3	—	1.1	2.2
Arrhythmia/Palpitation	—	—	1.7	0.7
Flushing	—	—	2.3	0.7
DIGESTIVE SYSTEM				
Abdominal Discomfort	—	—	4.0	1.4
Belching/Flatus/Bloating	0.6	—	9.0	3.6
Diarrhea	—	—	3.4	2.9
Dyspepsia	2.8	4.7	9.6	2.9
Nausea	2.2	0.8	28.8	8.7
Vomiting	1.2	—	4.5	0.7
NERVOUS SYSTEM				
Agitation/Nervousness	—	—	1.7	0.7
Dizziness	1.9	3.1	11.9	4.3
Drowsiness	—	—	1.1	5.8
Headache	1.2	1.6	6.2	5.8
Insomnia	—	—	2.3	2.2
Tremor	0.3	0.8	—	—
Blurred Vision	—	—	2.3	1.4

Trental® (pentoxifylline) has been marketed in Europe and elsewhere since 1972. In addition to the above symptoms, the following have been reported spontaneously since marketing, or occurred in other clinical trials with an incidence of less than 1%; the causal relationship was uncertain: Cardiovascular—dyspnea, edema, hypotension; Digestive—anorexia, cholecystitis, constipation, dry mouth/thirst; Nervous—anxiety, confusion; Respiratory—epistaxis, flu-like symptoms, laryngitis, nasal congestion; Skin and Appendages—brittle fingernails, pruritus, rash, urticaria; Special Senses—blurred vision, conjunctivitis, earache, scotoma; and Miscellaneous—bad taste, excessive salivation, leukopenia, malaise, sore throat/swollen neck glands, weight change.

A few rare events have been reported spontaneously worldwide since marketing in 1972. Although they occurred under circumstances in which a causal relationship with pentoxifylline could not be established, they are listed to serve as information for physicians: Cardiovascular—angina, arrhythmia, tachycardia; Digestive—hepatitis, jaundice; and Hemic and Lymphatic—decreased serum fibrinogen, pancytopenia, purpura, thrombocytopenia.

OVERDOSAGE:
Overdosage with Trental® (pentoxifylline) has been reported in children and adults. Symptoms appear to be dose related. A report from a poison control center on 44 patients taking overdoses of enteric-coated pentoxifylline tablets noted that symptoms usually occurred 4-5 hours after ingestion and lasted about 12 hours. The highest amount ingested was 80 mg/kg; flushing, hypotension, convulsions, somnolence, loss of consciousness, fever, and agitation occurred. All patients recovered.

In addition to symptomatic treatment and gastric lavage, special attention must be given to supporting respiration, maintaining systemic blood pressure, and controlling convulsions. Activated charcoal has been used to adsorb pentoxifylline in patients who have overdosed.

DOSAGE AND ADMINISTRATION:
The usual dosage of Trental® (pentoxifylline) in controlled-release tablet form is one tablet (400 mg) three times a day with meals.

While the effect of Trental® (pentoxifylline) may be seen within 2 to 4 weeks, it is recommended that treatment be continued for at least 8 weeks. Efficacy has been demonstrated in double-blind clinical studies of 6 months duration.

Digestive and central nervous system side effects are dose related. If patients develop these side effects it is recommended that the dosage be lowered to one tablet twice a day (800 mg/day). If side effects persist at this lower dosage, the administration of Trental® (pentoxifylline) should be discontinued.

Hoechst-Roussel Pharmaceuticals Inc.
Somerville, New Jersey 08876

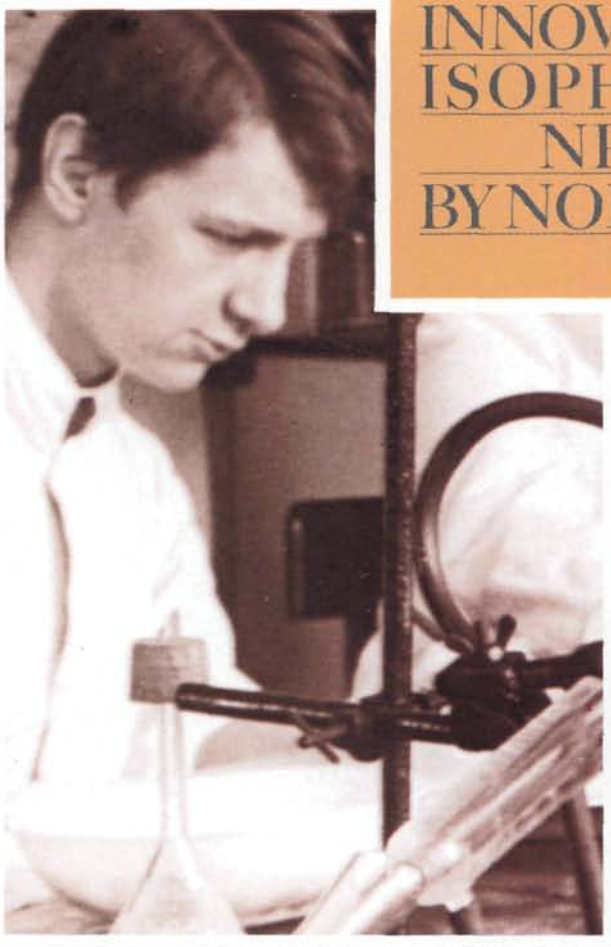
Hoechst

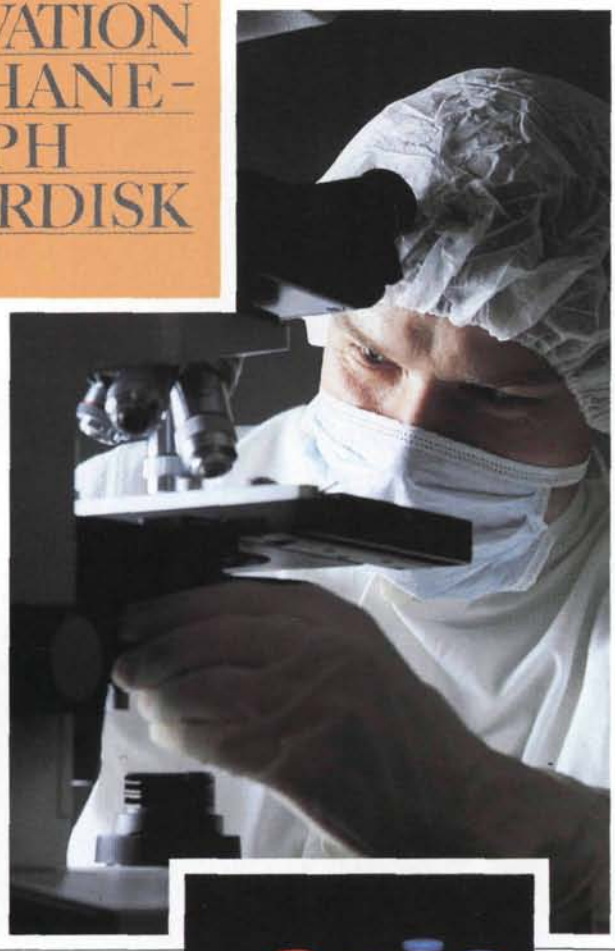
Trental®
(pentoxifylline)
TABLETS, 400 mg

The first proven-effective agent for intermittent claudication

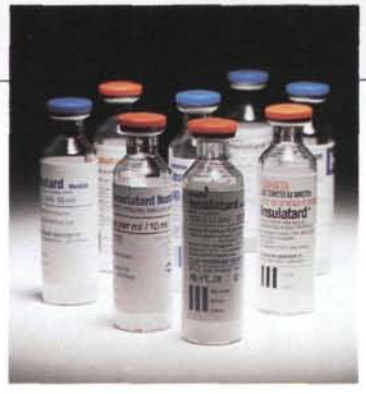
Q7383-685

50 YEARS OF INNOVATION ISOPHANE-NPH BY NORDISK





Lund & Raffel.



Insulin became more than just insulin when Nordisk invented the first retarded-action insulin preparation, Protamine Insulin.

50 years of innovation have turned that insulin into the world's most-used intermediate-acting insulin preparation: Isophane NPH insulin.

Innovation means application of the most advanced manufacturing, formulation, and analytical techniques to ensure a unique microcrystalline suspension.

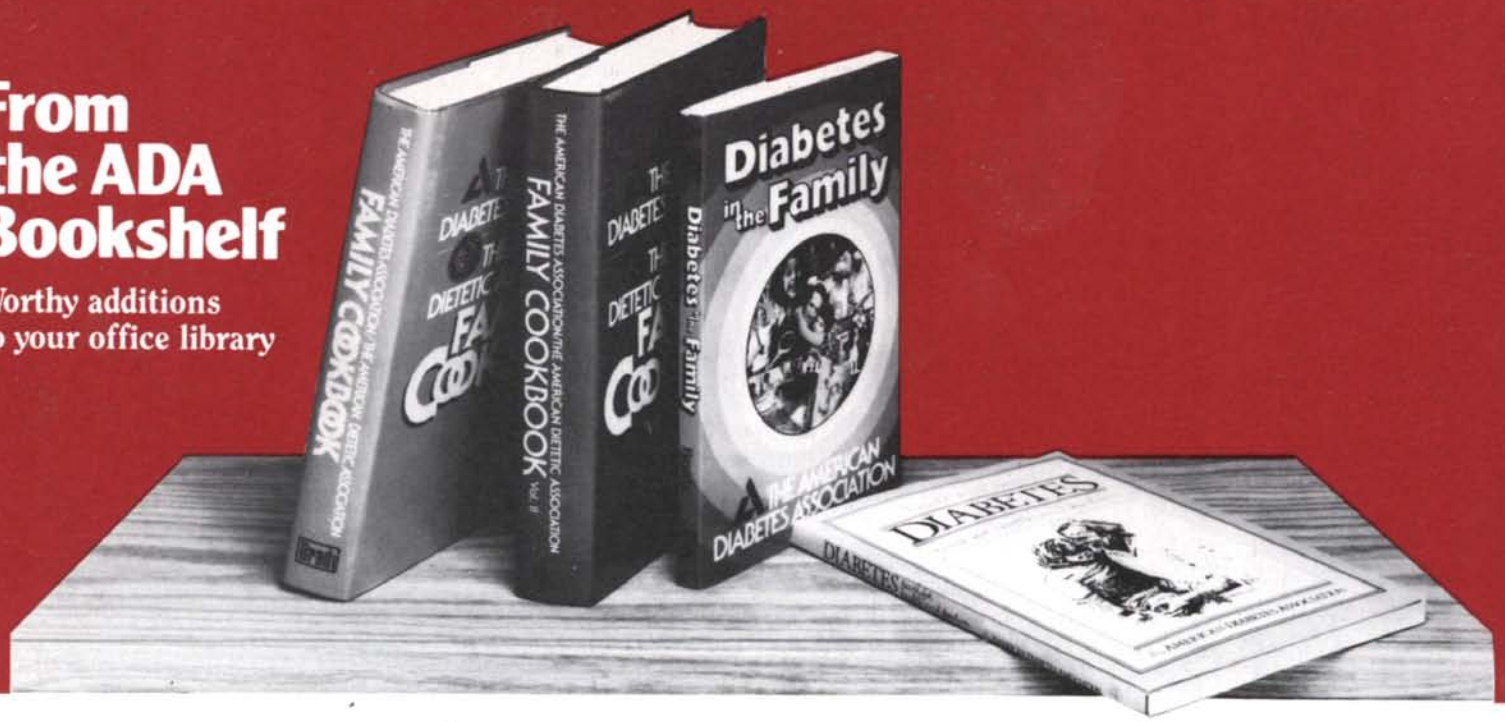
Isophane NPH, as invented and made by Nordisk, means unsurpassed stability: mix it with regular soluble insulin and it will retain its original timing without changing that of the soluble insulin. Use the mixture immediately or later, stability is retained. Or use one of the Nordisk standard mixtures for convenience.

Nordisk

Nordisk Gentofte A/S (Denmark) is the manufacturing division of Nordisk Insulinlaboratorium, a foundation by Danish Royal Charter established in 1923 comprising also Hagedorn Research Laboratory and Steno Memorial Hospital.

From the ADA Bookshelf

Worthy additions to your office library



Diabetes in the Family

From the American Diabetes Association

Here is all the information you and your family need. This comprehensive reference book on diabetes addresses your questions, concerns, and hopes for the future with accurate and up-to-date information. Chapters on the nature of diabetes and adjusting to it . . . information on daily care, diet, testing, exercise, stress . . . lifetime considerations such as careers, marriage, travel, pregnancy . . . how to be prepared for emergencies . . . diabetes and the family and much more. Over 200 pages of valuable diabetes data.

Diabetes: Reach for Health and Freedom

By Dorothea F. Sims

"All who read *Diabetes: Reach for Health and Freedom* should try to emulate its philosophy and learn its science."

—from the Foreword by Dr. Fred Whitehouse, President, American Diabetes Association, 1978-1979

A warm, sensitive approach to living with diabetes, this book discusses the daily management of both insulin-dependent and non-insulin-dependent diabetes. Covering the importance of exercise, testing, the dangers of complications, and the skills you need to meet the lifelong challenge of diabetes, you'll find the practical advice you need to live your life fully.

The American Diabetes Association/ The American Dietetic Association

FAMILY COOKBOOK

With the *ADA/ADA Family Cookbooks,* add zest to meal times with more delicious recipes than you ever thought possible. Fully endorsed by the American Diabetes Association and The American Dietetic Association, *Family Cookbook Volumes 1 and 2* provide delicious, wholesome recipes for anyone, not just people with diabetes. Both bring you a wealth of practical advice on nutrition including the complete nutrient and exchange breakdown for one-serving portions and calorie content.

Volume 1

- 250 delicious recipes
- The basics of good nutrition and meal planning
- Calculating exchanges from food labels and recipes
- Tips on dining out, fast foods, drinking alcohol
- Special-occasion menus

Volume 2

- 206 brand new taste-tempting recipes
- How to safely start and follow an exercise program
- Exciting new dishes from ethnic cuisines
- New and updated information on nutrition
- Exchanges for the most popular foods of Mexican, Jewish, Black American, Indian, and Oriental cuisine

Order Form

Yes! Please send me:	Price includes postage	Qty	Total
☐ ***Diabetes in the Family, hardcover,*** $14.95 *($12.95 plus $2.00 postage & handling)*	x $14.95 =	____	_____
☐ ***Diabetes in the Family, paperback,*** $11.20 *($9.95 plus $1.25 postage & handling)*	x $11.20 =	____	_____
☐ ***Diabetes: Reach for Health and Freedom,*** $11.70 *($9.95 plus $1.75 postage & handling)*	x $11.70 =	____	_____
☐ ***Family Cookbook, vol. 1,*** $17.45 *($14.95 plus $2.50 postage & handling)*	x $17.45 =	____	_____
☐ ***Family Cookbook, vol. 2,*** $18.45 *($15.95 plus $2.50 postage & handling)*	x $18.45 =	____	_____
☐ ***Cookbook set, vols. 1 & 2,*** $34.40 *($30.90 plus $3.50 postage & handling)*	x $34.40 =	____	_____

I enclose $_____ for the books I've checked.

Name _____

Street _____

City _____

State _____ Zip _____

Send your order to: American Diabetes Association, P.O. Box 6534, Church Street Station, New York, NY 10249

"I always wished my Glucometer® were easier to use. Now it is."

FREE
GLUCOSCAN™ Meter
Call For Details

Actual Glucometer Reflectance Photometer and GLUCOSCAN/GM Test Strip user.

"Monitoring my blood glucose regularly helps me stay in control. But until I started using GLUCOSCAN™/GM test strips in my Glucometer,® the job wasn't that easy.

What a difference!

I don't have to bother with washing the test strip anymore. Now I just blot it.

Smaller reagent pads are great, too, because I can get a good test with a lot less blood than before.

And the test strips are individually foil-wrapped, so they stay fresh longer, and I can easily carry some with me anytime.

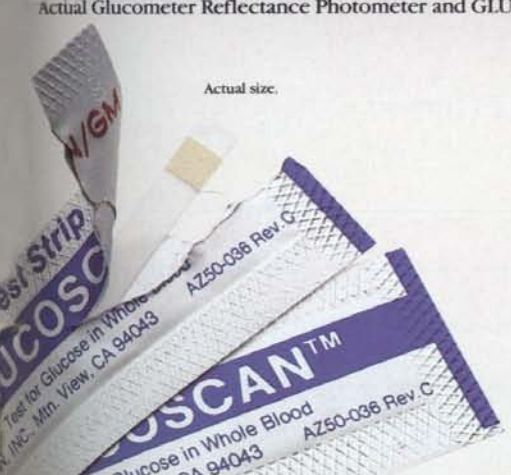
Blood glucose monitoring lets me be in charge of my well-being.

GLUCOSCAN/GM test strips make it that much easier."

To find out how your patients can enjoy the convenience of GLUCOSCAN/GM Test Strips with absolutely no risk, call toll-free for the name of the LifeScan Distributor nearest you. Their first order carries a full money-back guarantee.

Nationwide (800) 227-8862
California (800) 982-6132

Actual size.



GLUCOSCAN™/GM Test Strips

LIFESCAN INC.
1025 Terra Bella Ave.
Mountain View, CA 94043

Glucometer Reflectance Photometer is a registered trademark of the Ames Division, Miles Laboratories.

The Diabetes Research and Education Foundation, Inc. is soliciting grant requests for promising initiatives in the field of diabetes research and education. The Foundation is an independent, non-profit organization with a Board of Trustees comprised of specialists in diabetes research, clinical practice, pharmacy and patient education. The Board meets twice per year to review grant requests and disburse awards. Individual grant awards are currently limited to $20,000.

To be considered at the next meeting, which is scheduled for late November, grant applications must be received by September 30, 1985. Applications can be obtained by writing to:

Diabetes Research and Education Foundation, Inc.
P.O. Box 6168
Bridgewater, N.J. 08807-9998
ATTENTION: Herbert Rosenkilde, M.D., Executive Director

Q6987-685

MAKE TAX TIME EASIER ON YOURSELF NEXT YEAR

READ ABOUT THE SUBSTANTIAL TAX BENEFITS AND LIFETIME INCOME AVAILABLE FROM THE AMERICAN DIABETES ASSOCIATION'S POOLED INCOME FUND

_____ Please send me a free brochure on the Pooled Income Fund
_____ I would like information on other forms of planned giving
_____ I would like a representative to provide additional information

NAME _____
ADDRESS _____
_____
TELEPHONE _____

American Diabetes Association
Two Park Avenue
New York, NY 10016
Attn: Fund Raising Department

Written for the patient with diabetes, **Diabetes '85** is a quarterly, easy-to-read newsletter offering tips on living with diabetes, news updates, recipes, descriptions of common treatment approaches, and sources to turn to for more information.

You can receive office copies of Diabetes '85 by returning this form.

509DJ

PLEASE SEND ME:
(Check one) ☐ 5 copies or ☐ 10 copies or _____ copies
(fill in amount)

Name _____
(Please print)
Address _____
City _____
State _____ Zip _____

At Owen Mumford we believe that necessity is the mother of invention

Autolet®

Device for painless blood letting.
Helping diabetics everywhere.

Owen Mumford Ltd.
Medical Division

Brook Hill, Woodstock,
Oxfordshire OX7 1TU, England.
Telephone: Woodstock (0993) 812021
Telex: 837864 Ommlet G

ACTRAPID
HUMAN

Novolin™ R
HUMAN INSULIN
(semi-synthetic) Injection (Regular) 100 units/ml

MONOTARD ®
HUMAN

Novolin™ L
HUMAN INSULIN
(semi-synthetic) Zinc Suspension (Lente®) 100 units/ml

NEW

Novolin™ N
HUMAN INSULIN
(semi-synthetic) Isophane Suspension (NPH) 100 units/ml

Novolin™ is Human Insulin

Novolin™ is a new name and licensed trademark of Novo Industri A/S

SQUIBB®
NOVO™

394-507

December, 1984