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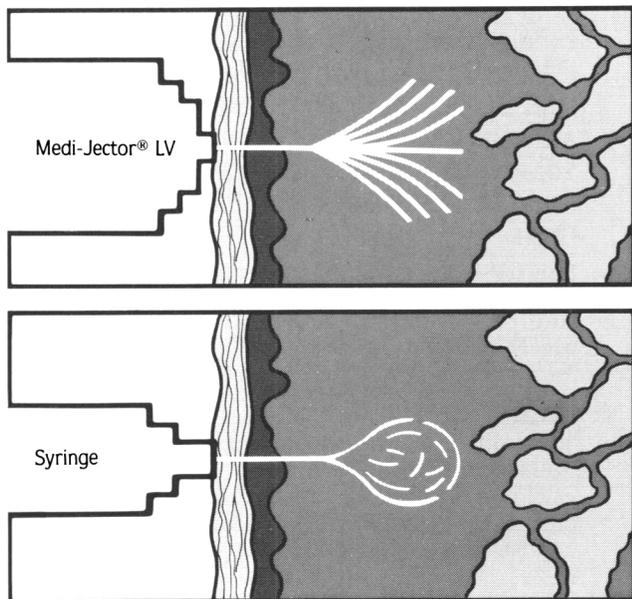
# Your patients may not have a choice about taking insulin.

## They should have a choice about how they take it.

“It’s not so bad; you’ll get used to the needle.”

What else could you tell the diabetic who must take insulin? After all, taking insulin is life-sustaining to many, while for others it is the best way to control blood sugar and retard or prevent life-threatening complications. Your challenge is to obtain maximum compliance, for effective control.

The reality, however, is that puncturing the skin with a needle is neither normal nor something to look forward to with anything but resignation, and for various psychosocial or physical reasons something that can be painful.



Even patients must tell themselves,

“It’s not so bad.” How else could they cope with up to 1,000 punctures a year?

How many of your patients would rather live without needle injections and still have the maximum benefit of insulin therapy?

Medi-Jector®  
Needleless Injection:  
a better choice  
for compliance,  
control and  
comfort.

The development of Medi-Jector’s needleless injection technology has paralleled the evolution of modern diabetes management, with its goal of improved control facilitated by self blood glucose monitoring and multiple daily doses of insulin.

The prospect of multiple daily injections cannot be pleasant for patients who have found one shot a day to be painful, or for patients who have never taken insulin before. Such fear of needle punctures can result in a detrimental compliance problem.

Medi-Jector is a precision, mechanically-powered injection device, proven in over seven years of patient use by thousands of diabetics.

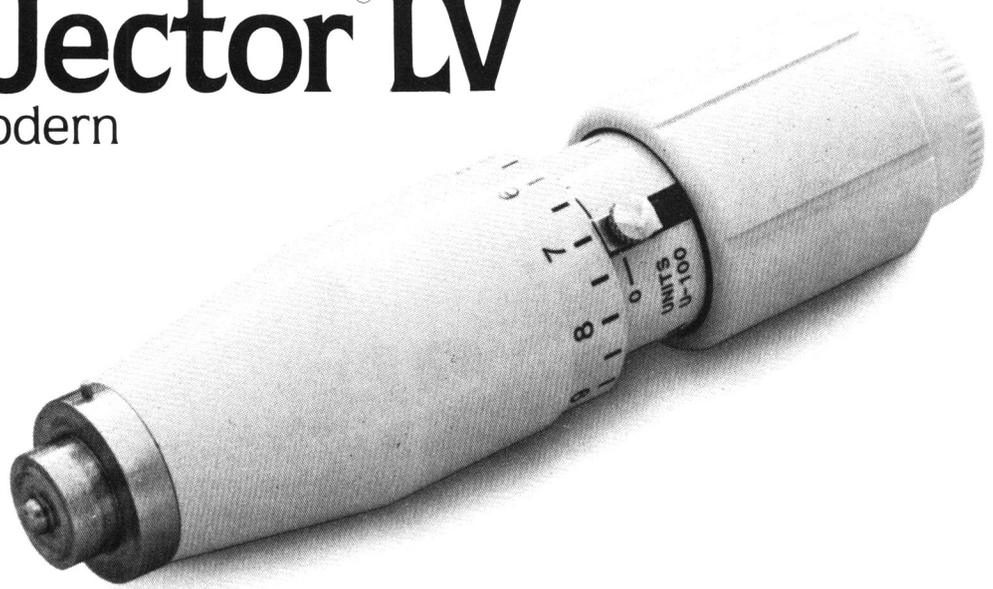
Medi-Jector forces insulin, under pressure, through a tiny orifice which produces a liquid column that is **one-third** the size of the smallest needle. After penetration, the insulin is rapidly dispersed through the planes of least resistance as a fine spray. Penetration depth is adjustable to accommodate individual and site-to-site variation in skin resistance. Nothing touches the patient but the tiny column of insulin. Compared to needle injections, there is less tissue trauma, greater insulin dispersion and improved absorption. Most important, the injection sensation is virtually undetectable.

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# New Medi-Jector<sup>®</sup> LV

designed for modern  
insulin therapy

Derata Corporation, a pioneer in the research and development of insulin jet injector systems, designed its third generation system to meet the needs of modern multiple insulin injection therapy.



Medi-Jector LV delivers up to 50 units of U-100 (single or mixed doses) with unequalled comfort. Confirmed accuracy (tenths of a unit) delivers precise doses, time after time.

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years of economical, effective insulin delivery with a comfort unequalled by insulin syringes.

**Wouldn't your patients appreciate the opportunity to compare Medi-Jector LV with the needle, and then choose? Show them the modern alternative, then let them choose.**

**Discover why your patients deserve to have the Medi-Jector choice — call us at 1-800-328-3074. We will provide you with complete information and the name of your local distributor.**

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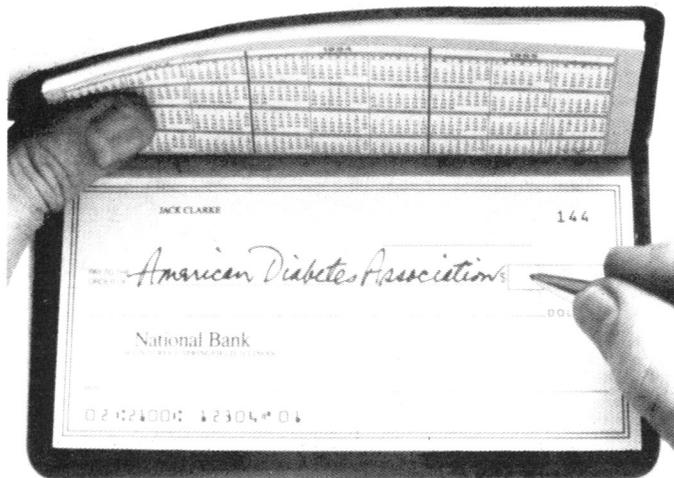
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**FIGHT SOME OF THE WORST DISEASES OF OUR TIME.**  
Support the American Diabetes Association.

**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 has 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 osmolality.

### 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. Occasional 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.

### HOW SUPPLIED

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 30's D-Pak, NDC# 0663-3940-30).

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

**CAUTION:** Federal law prohibits dispensing without prescription.

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## For the money saved with generic chlorpropamide, your patient couldn't even call your office.

Diabinese® (chlorpropamide) costs about 20¢ to 25¢\* a day more than generic chlorpropamide—less than most local pay phone calls.

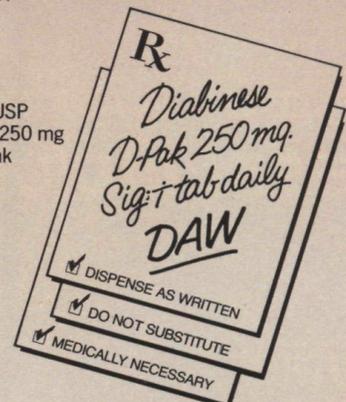
For your patients who have been doing well on Diabinese, why change?

To be sure there's no change from Diabinese, specify: Dispense As Written, Do Not Substitute, or Medically Necessary, depending on the state in which you practice.

**DIABINESE**® Tablets, USP  
(chlorpropamide) 100 mg, 250 mg and D-Pak

\*Source: PDS Alpha, New Product Tracking Report, Pharmaceutical Data Services, February 1985.

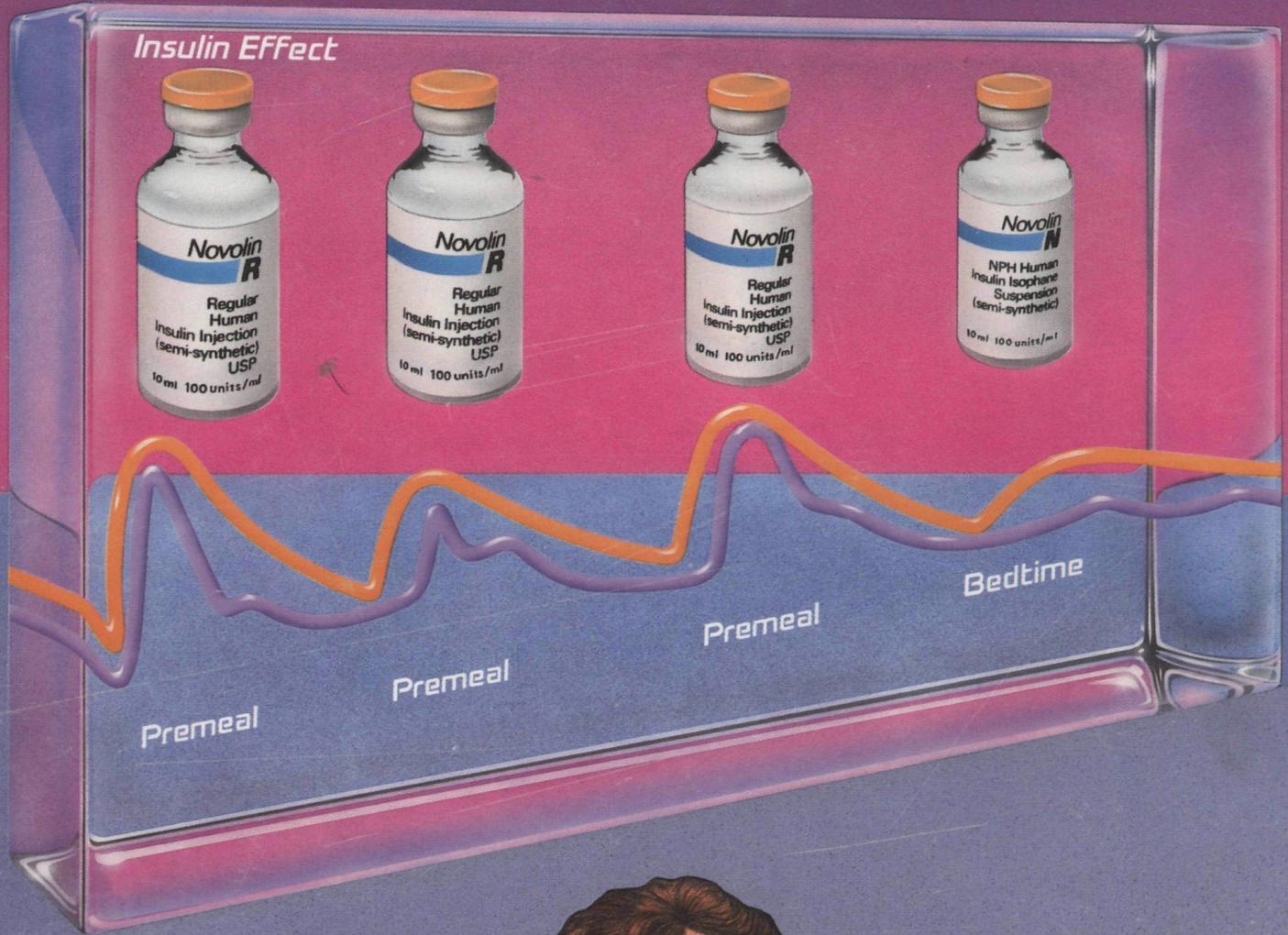
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Please see Diabinese® (chlorpropamide) brief summary on preceding page.

# Contemporary Insulin Therapy

The Goal: to approximate the non-diabetic physiology as closely as possible



**Artist's Interpretation:**  
Insulin profile in non-diabetic subjects  
Insulin profile following preprandial injections of Novolin® R and Novolin® N as basal overnight therapy

Achieved with:  
**Basal/Bolus Therapy and**

**Novolin®**  
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