JANUARY 1994 VOLUME 43 NUMBER 1

diabetes

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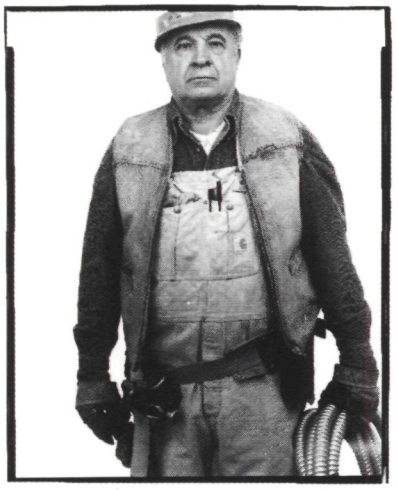
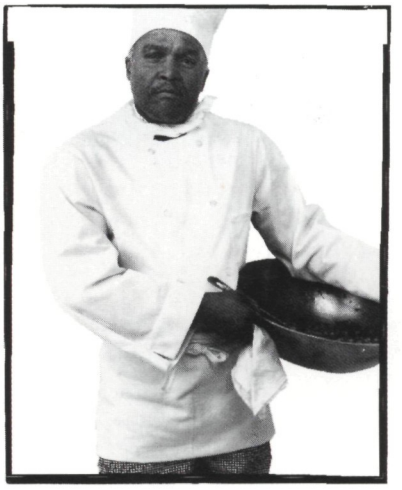
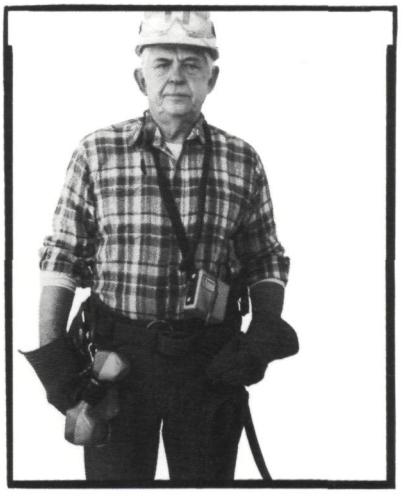




FOR TYPE II DIABETICS LIFE IS DEMANDING ENOUGH...



TODAY'S LIFE DEMANDS
INSULIN ON DEMAND

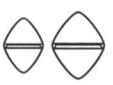
GLUCOTROL® (glipizide) provides patients with insulin when needed, responding on demand to meals and rising blood sugar.[1]

GLUCOTROL, with insulin on demand, controls blood sugar quickly and effectively—all day and all night.[1]

GLUCOTROL works in response to meals; returning insulin to near-normal levels once the meal challenge subsides.[1,2]

When diet alone fails in NIDDM...*

Glucotrol®
(glipizide) 5-mg and 10-mg Scored Tablets

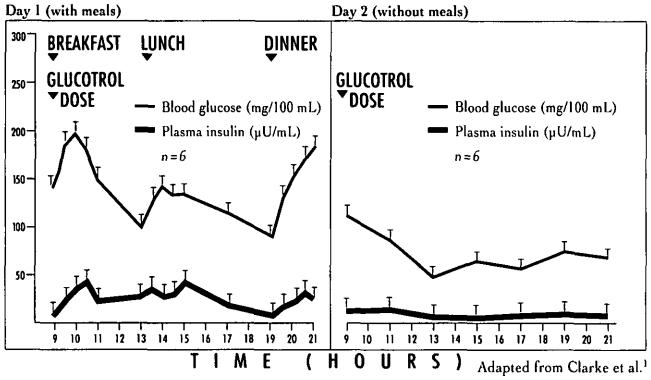


* Non–insulin-dependent diabetes mellitus.
As with all sulfonylureas, hypoglycemia may occur.

Pfizer Pratt Pharmaceuticals

Please see brief summary of prescribing information on last page.

INSULIN ON DEMAND RESPONDS TO MEALS— AND REMAINS AT BASAL LEVELS DURING FASTING



Adapted from Clarke et al.[1]

The effect of fasting on mean blood sugar and plasma insulin levels was measured in a 2-day study of six NIDDM patients whose blood sugar levels had been controlled by a single daily dose of 5 to 10 mg of GLUCOTROL. On the first day, patients were served three meals. On the second, they received no food. Patients received their usual dose of GLUCOTROL at the start of each day.[1]

REFERENCES: 1. Clarke BF, Corrall RJM, Azzopardi J, Bhalla IP, Fraser DM, Duncan LJP. Clinical observations on glipizide: efficacy, duration of activity, and safety. In: *Glipizide: A Worldwide Review.* Princeton, NJ: Excerpta Medica; 1984:234-247. **2.** Goebel R, Leb G. Effects of glyburide and glipizide on levels of immunoreactive insulin and blood sugar. In: *Glipizide: A Worldwide Review.* Princeton, NJ: Excerpta Medica; 1984:9-15.

Brief Summary of Prescribing Information

INDICATIONS AND USAGE: GLUCOTROL is indicated as an adjunct to diet for the control of hyperglycemia in patients with non-insulin-dependent diabetes mellitus (NIDDM, type II) *after an adequate trial of dietary therapy has proved unsatisfactory.*

CONTRAINDICATIONS: GLUCOTROL is contraindicated in patients with known hypersensitivity to the drug or with diabetic ketoacidosis, with or without coma, which should be treated with insulin.

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 overall 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 GLUCOTROL 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: Renal and Hepatic Disease: The metabolism and excretion of GLUCOTROL may be slowed in patients with impaired renal and/or hepatic function. Hypoglycemia may be prolonged in such patients should it occur.

Hypoglycemia: All sulfonylureas are capable of producing severe hypoglycemia. Proper patient selection, dosage, and instructions are important to avoid hypoglycemia. Renal or hepatic insufficiency may increase the risk of 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 or people 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.

Loss of Control of Blood Glucose: A loss of control may occur in diabetic patients exposed to stress such as fever, trauma, infection or surgery. It may then be necessary to discontinue GLUCOTROL and administer insulin.

Laboratory Tests: Blood and urine glucose should be monitored periodically. Measurement of glycosylated hemoglobin may be useful.

Information for Patients: *Patients should be informed of the potential risks and advantages of* GLUCOTROL, *of alternative modes of* therapy, as well as the importance of adhering to dietary instructions, of a regular exercise program, and of regular testing of urine and/or blood glucose. The risks of hypoglycemia, its symptoms and treatment, and conditions that predispose to its development should be explained to patients and responsible family members. Primary and secondary failure should also be explained.

Drug Interactions: The hypoglycemic action of sulfonylureas may be potentiated by certain drugs including nonsteroidal anti-inflammatory agents, some azoles, and other drugs that are highly protein bound, salicylates, sulfonamides, chloramphenicol, probenecid, *coumarins, monoamine oxidase inhibitors, and beta-adrenergic blocking agents. In vitro studies indicate that GLUCOTROL binds* differently than tolbutamide and does not interact with salicylate or dicumarol. However, caution must be exercised in extrapolating these findings to a clinical situation. Certain drugs tend to produce hyperglycemia and may lead to loss of control, including the thiazides and other diuretics, corticosteroids, phenothiazines, thyroid products, estrogens, oral contraceptives, phenytoin, nicotinic acid, sympathomimetics, calcium channel blocking drugs, and isoniazid. A potential interaction between oral miconazole and oral hypoglycemic agents leading to severe hypoglycemia has been reported. Whether this interaction also occurs with the intravenous, topical, or vaginal preparations of miconazole is not known. The effect of concomitant administration of DIFLUCAN (fluconazole) and GLUCOTROL has been demonstrated in a placebo-controlled crossover study in normal volunteers. All subjects received GLUCOTROL alone and following treatment with 100 mg of DIFLUCAN as a single daily oral dose for 7 days. The mean percentage increase in the GLUCOTROL AUC after fluconazole administration was 56.9% (range: 35 to 81).

Carcinogenesis, Mutagenesis, Impairment of Fertility: A 20-month study in rats and an 18-month study in mice at doses up to 75 times the maximum human dose revealed no evidence of drug-related carcinogenicity. Bacterial and *in vivo* mutagenicity tests were uniformly negative. Studies in rats of both sexes at doses up to 75 times the human dose showed no effects on fertility.

Pregnancy: Pregnancy Category C: GLUCOTROL (glipizide) was found to be mildly fetotoxic in rat reproductive studies at all dose levels (5-50 mg/kg). This fetotoxicity has been similarly noted with other sulfonylureas, such as tolbutamide and tolazamide. The effect is perinatal and believed to be directly related to the pharmacologic (hypoglycemic) action of GLUCOTROL. In studies in rats and rabbits no teratogenic effects were found. There are no adequate and well-controlled studies in pregnant women. GLUCOTROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Because recent information suggests that abnormal blood glucose levels during pregnancy are associated with a higher incidence of congenital abnormalities, many experts recommend that insulin be used during pregnancy to maintain blood glucose levels as close to normal as possible.

Nonteratogenic Effects: Prolonged severe hypoglycemia has been reported in neonates born to mothers who were receiving a sulfonylurea drug at the time of delivery. This has been reported more frequently with the use of agents with prolonged half-lives. GLUCOTROL should be discontinued at least one month before the expected delivery date.

Nursing Mothers: Since some sulfonylurea drugs are known to be excreted in human milk, insulin therapy should be considered if nursing is to be continued.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: *In controlled studies, the frequency of serious adverse reactions reported was very low. Of 702 patients,* 11.8% reported adverse reactions and in only 1.5% was GLUCOTROL discontinued.

Hypoglycemia: See PRECAUTIONS and OVERDOSAGE sections.

Gastrointestinal: Gastrointestinal disturbances, the most common, were reported with the following approximate incidence: nausea and diarrhea, one in 70; constipation and gastralgia, one in 100. They appear to be dose-related and may disappear on division or reduction of dosage. Cholestatic jaundice may occur rarely with sulfonylureas: GLUCOTROL should be discontinued if this occurs.

Dermatologic: Allergic skin reactions including erythema, morbilliform or maculopapular eruptions, urticaria, pruritus, and eczema have been reported in about one in 70 patients. These may be transient and may disappear despite continued use of GLUCOTROL; if skin reactions persist, the drug should be discontinued. Porphyria cutanea tarda and photosensitivity reactions have been reported with sulfonylureas.

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

Metabolic: Hepatic porphyria and disulfiram-like alcohol reactions have been reported with sulfonylureas. Clinical experience to date has shown that GLUCOTROL has an extremely low incidence of disulfiram-like reactions.

Endocrine Reactions: Cases of hyponatremia and the syndrome of inappropriate antidiuretic hormone (SIADH) secretion have been reported with this and other sulfonylureas.

Miscellaneous: Dizziness, drowsiness, and headache have each been reported in about one in fifty patients treated with GLUCOTROL. They are usually transient and seldom require discontinuance of therapy.

OVERDOSAGE: Overdosage of sulfonylureas including GLUCOTROL can produce hypoglycemia. If hypoglycemic coma is diagnosed or suspected, the patient should be given a rapid intravenous injection of concentrated (50%) glucose solution. This should be followed by a continuous infusion of a more dilute (10%) glucose solution at a rate that will maintain the blood glucose at a level above 100 mg/dL. Patients should be closely monitored for a minimum of 24 to 48 hours since hypoglycemia may recur after apparent clinical recovery. Clearance of GLUCOTROL from plasma would be prolonged in persons with liver disease. Because of the extensive protein binding of GLUCOTROL, dialysis is unlikely to be of benefit.

DOSAGE AND ADMINISTRATION: There is no fixed dosage regimen for the management of diabetes mellitus with GLUCOTROL; in general, it should be given approximately 30 minutes before a meal to achieve the greatest reduction in postprandial hyperglycemia.

Initial Dose: The recommended starting dose is 5 mg before breakfast. Geriatric patients or those with liver disease may be started on 2.5 mg. Dosage adjustments should ordinarily be in increments of 2.5–5 mg, as determined by blood glucose response. At least several days should elapse between titration steps.

Maximum Dose: *The maximum recommended total daily dose is 40 mg.*

Maintenance: Some patients may be effectively controlled on a once-a-day regimen, while others show better response with divided dosing. Total daily doses above 15 mg should ordinarily be divided.

HOW SUPPLIED: GLUCOTROL tablets are white, dye-free, scored, diamond-shaped, and imprinted as follows:

5 mg—Pfizer 411; 10 mg—Pfizer 412.

5 mg Bottles: 100's (NDC 0049-4110-66), (NDC 59012-411-66); 500's (NDC 0049-4110-73), (NDC 59012-411-73); Unit Dose 100's (NDC 0049-4110-41), (NDC 59012-411-41).

10 mg Bottles: 100's (NDC 0049-4120-66), (NDC 59012-412-66); 500's (NDC 0049-4120-73), (NDC 59012-412-73); Unit Dose 100's (NDC 0049-4120-41), (NDC 59012-412-41).

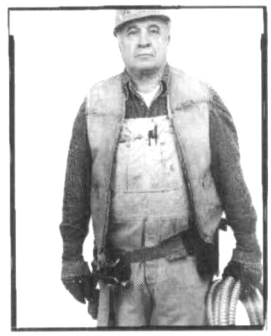
CAUTION: Federal law prohibits dispensing without prescription.

More detailed professional information available on request.

Revised Jan. 1993

FOR TYPE II DIABETES,

TODAY'S LIFE DEMANDS INSULIN ON DEMAND



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Pfizer Pratt Pharmaceuticals

diabetes

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Mission Statements for *Diabetes* and *Diabetes Care*

***Diabetes* publishes original research about the physiology and pathophysiology of diabetes mellitus. Submitted manuscripts can report any aspect of laboratory, animal, or human research. Emphasis is on investigative reports focusing on areas such as the pathogenesis of diabetes and its complications, normal and pathologic pancreatic islet function and intermediary metabolism, pharmacological mechanisms of drug and hormone action, and biochemical and molecular aspects of normal and abnormal biological processes. Studies in the areas of diabetes education or the application of accepted therapeutic and diagnostic approaches to patients with diabetes mellitus are not published.**

***Diabetes Care* is a journal for the health-care practitioner that is intended to increase knowledge, stimulate research, and promote better management of people with diabetes mellitus. To achieve these goals, the journal publishes original articles on human studies in the areas of epidemiology, clinical trials, behavioral medicine, nutrition, education, health-care delivery, medical economics, and clinical care. The journal also publishes clinically relevant review articles, clinical observations, letters to the editor, and public health/medical news or points of view. Topics covered are of interest to clinically oriented physicians, researchers, epidemiologists, psychologists, diabetes educators, and other professionals.**

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Manuscripts should be prepared in accordance with the requirements specified in the document "Uniform Requirements for Manuscripts Submitted to Biomedical Journals," *New England Journal of Medicine* 324:424–428, 1991. "Instructions for Authors" containing specifications for manuscript preparation appears in the January and July issues.

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JANUARY AUTHOR INDEX
(Volume 43, Number 1)

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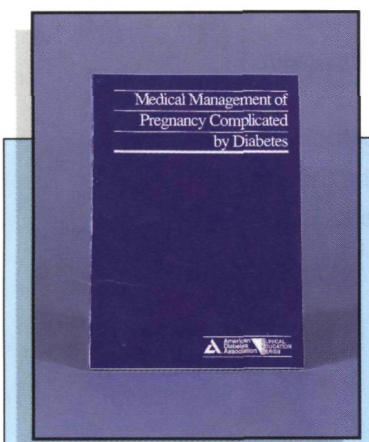
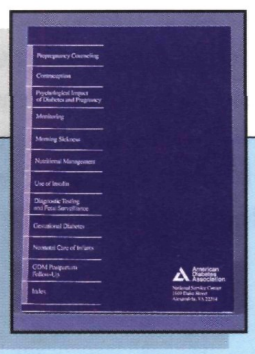
- GDM Postpartum Follow-Up





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American Diabetes Association's

41st Annual Advanced Postgraduate Course

January 28 - 30, 1994

The Westin Hotel at Copley Square, Boston, Massachusetts

FRIDAY, JANUARY 28

General Session—Atherosclerosis and Diabetes Mellitus

The Epidemiology of Diabetes and Other Risk Factors for Cardiovascular Disease

The Topography of Obesity and the Risk for Coronary Heart Disease

Diabetes and Basic Mechanisms of Atherosclerosis

The Relationship Between Diabetes, Dyslipidemia, and Coronary Heart Disease

Plaque Regression: Will it Work for Patients with Diabetes?

Management of Diabetic Dyslipidemia

Concurrent Workshops

Diabetic Nephropathy: Prevention/Treatment

Diabetic Neuropathy

Diabetic Foot Care

Nutritional Issues in the Management of NIDDM

Dietary Supplements (Antioxidants and Magnesium) in the Treatment of Atherosclerosis

New Forms of Therapy for Diabetes: Insulin, Insulin-like Sensitizers, Aminoguanidine

SATURDAY, JANUARY 29

General Session—DCCT Follow-up

Additional Insights from the Diabetes Control and Complications Trial (DCCT)

Complications/Adverse Effects

Application: IDDM

Implications: NIDDM

The Economics: Cost/Benefit of Intensive Therapy

Concurrent Workshops

Management of Thyroid Nodules

Prevention and Treatment of Osteoporosis

Management of Pituitary Tumors

Dietary Recommendations and Carbohydrate Counting

Insulin Management: What Are the Options?

Educational Strategies: What Works Best?

Postgraduate Course Satellite Conference

Strategies for Implementing Tight Control in Patients with Type I and Type II Diabetes

When: January 26-27, 1994

Where: The Westin Hotel at Copley Square, Boston, MA

Sponsors: The American Diabetes Association's Council on Behavioral Medicine and Psychology and The National Institutes of Health's National Institute of Diabetes and Digestive and Kidney Diseases

Program Overview: The DCCT results have made it clear that tight metabolic control prevents and/or reduces the occurrence of the complications of diabetes. There is now a need to focus on how to achieve tight control across diverse patient groups. This conference will focus on the identification of barriers to achieving tight control and practical strategies for overcoming these barriers. The program will include interactive discussions with conference speakers, as well as hands-on small group workshops.

For more information:
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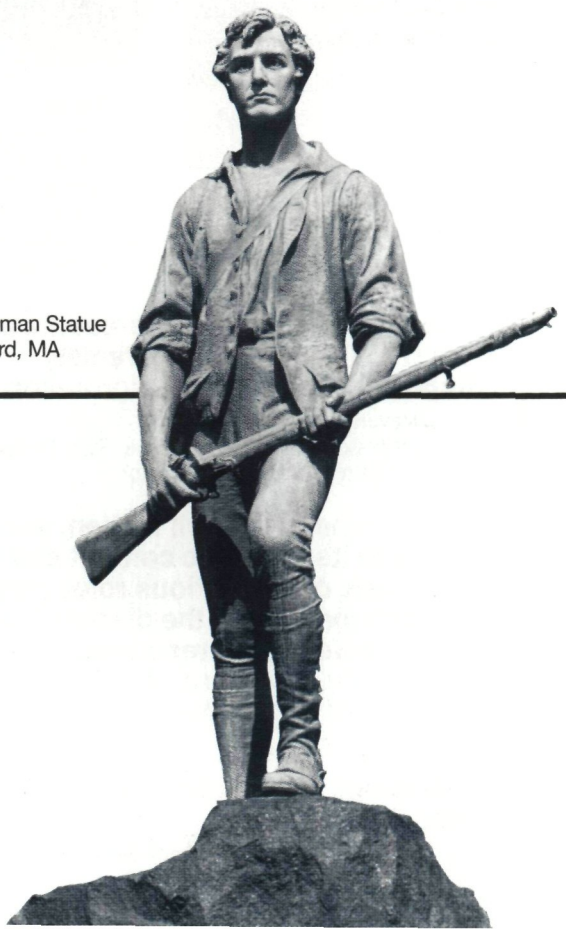
(see address/phone number at right).



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A highlight of the 41st Annual Advanced Postgraduate Course is the latest information on follow-up from the DCCT. The most up-to-date findings in clinically based research on topics in diabetes will also be presented by leading experts in the field. In addition, sessions focussing on endocrinology issues other than diabetes will be featured throughout the program. Call now for registration information, and join your colleagues for this outstanding educational opportunity!

American Diabetes Association®

SUNDAY, JANUARY 30

Concurrent Sessions —

Specific Topics in Endocrinology

Thyroid Disease in Pregnancy

The Role of Biochemical Evaluation in the Treatment of Osteoporosis

Medullary Thyroid Cancer

Endocrinology of Prostatic Disease

Polycystic Ovary Syndrome

Complicated Diabetes: Dealing with Concurrent Health Issues

The Relationship of Thyroid Disease to Diabetes

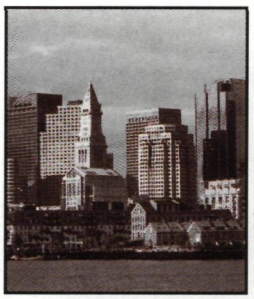
Diabetes Throughout the Hormonal Lifecycle of the Woman

Adaptive Diabetes Education for the Visually Impaired Patient

Concurrent Workshops

Presentation of the American Diabetes Association's Revised Nutritional Recommendations

The Role of the Diabetes Educator in Health Care Reform



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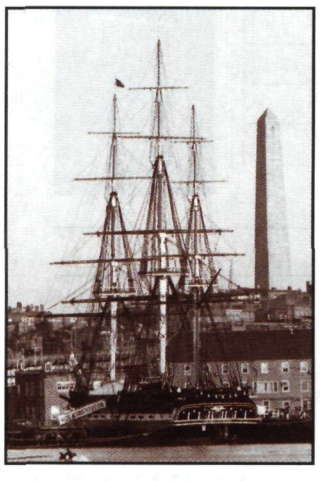

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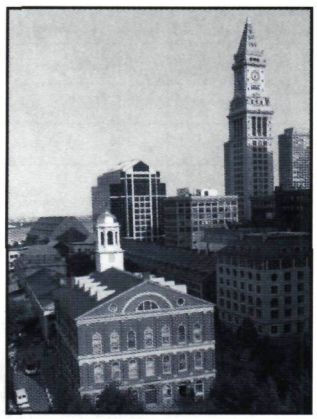

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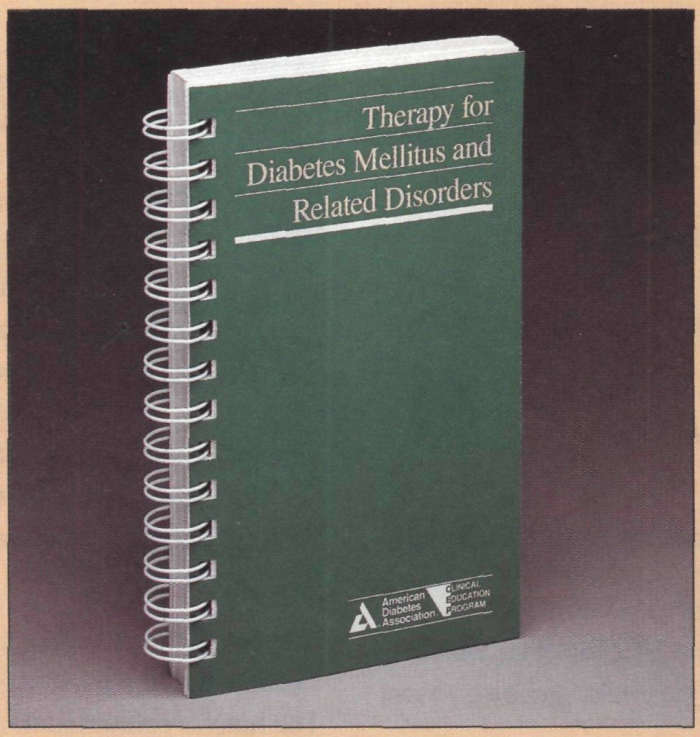

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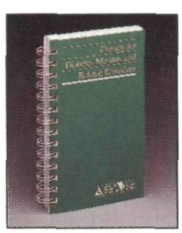
Add shipping & handling (use chart)	$_____
GRAND TOTAL	$_____

Shipping & Handling Chart

Up to $5.00 ..... add $1.75	$25.01-$50.00 ..... add $5.50
$5.01-$10.00 ..... add $3.00	over $50.00 ..... add 10% of order
$10.01-$25.00 ..... add $4.50	



Name _____

Address _____

City _____ State _____ Zip _____

P02J14

Send your check or money order payable to:

American Diabetes Association®
1970 Chain Bridge Road
McLean, VA 22109-0592

Allow 6-8 weeks for delivery. Add $3.00 to shipping & handling for each additional shipping address. Foreign orders must be paid in U.S. funds, drawn on a U.S. bank. Prices subject to change without notice.