DUALITY OF INTEREST DISCLOSURE FORM FOR AUTHORS OF ARTICLES IN AMERICAN DIABETES ASSOCIATION PUBLICATIONS

I have read the American Diabetes Association's Duality of Interest Policy Statement (found in the January and July issues of *Diabetes* and *Diabetes Care*), and I am indicating below that I have or have not had in the previous 12 months a relevant duality of interest with a company whose products or services are *directly* related to the subject matter of my manuscript. A relevant duality of interest includes employment, membership on the board of directors or any fiduciary relationship, membership on a scientific advisory panel or other standing scientific/ medical committee, ownership of stock, receipt of honoraria or consulting fees, or receipt of financial support or grants for research. Company is defined as a for-profit concern engaged in the development, manufacture, or sale of pharmaceutical or biomedical devices or supplies.

Each author must sign this form. (The form may be photocopied if needed.)

	Check each area that applies					
	Yes	No	Yes	No	Yes	No
Employment	____	____	____	____	____	____
Membership on an advisory panel, standing committee or board of directors	____	____	____	____	____	____
Stock shareholder	____	____	____	____	____	____
Honoraria or consulting fees	____	____	____	____	____	____
Grant/research support	____	____	____	____	____	____
Author (please type or print)	_____		_____		_____	
Signature	_____		_____		_____	
Date	_____		_____		_____	

For each item checked "yes," please list on a separate sheet of paper the third-party organization with whom you have relevant affiliations or interests. Please provide sufficient information to enable the American Diabetes Association to make an informed decision. Include *1*) the nature of the activity that is a relevant duality, *2*) the type of financial arrangement, if any, between you and the third party, and *3*) a description of the business or purpose of the third party. Please see the following sample disclosures.

SAMPLE DISCLOSURES FOR AUTHORS

Employment
I am employed by Exacta Pharmaceutical Company (6250 Longwood Avenue, Any City, Missouri). My employer manufactures and markets pharmaceuticals related to the treatment of diabetes and its complications.

Board Membership
I am on the board of directors of the Exacta Pharmaceutical Company, a manufacturer of pharmaceuticals related to the treatment of diabetes.

Stock Shareholder
I, or my immediate family, hold stock in the following companies that make products related to the treatment or management of diabetes and its complications:

XYZ Corporation
LMN Corporation

Honoraria or Consulting Fees
I have received honoraria for speaking engagements from the following:

XYZ Corporation
LMN Corporation

I am a paid consultant of the XYZ Corporation.

Grants
The XYZ Corporation is providing funds to my laboratory in order to conduct studies on a new drug to treat diabetic neuropathy.

By answering "yes" in any category, the Association will disclose the relevant duality of interest. The Association will make the disclosure by placing an asterisk by the author's name, and in a footnote describe the nature of the duality of interest, e.g., stock ownership or grant support, and the third party involved.

This form must be returned with your submission. Make additional copies as needed for all authors. Failure to complete the disclosure may delay or prevent publication of your article.

COPYRIGHT TRANSFER AND STATEMENT OF ORIGINALITY

We approve the submission of this paper to the American Diabetes Association for publication and have taken due care to ensure the integrity of this work. We confirm that neither the manuscript nor any part of it has been published or is under consideration for publication elsewhere (abstracts excluded). Any reference to or use of previously published material protected by copyright is explicitly acknowledged in the manuscript.

If this work was produced by an employee of the United States Government as part of his/her official duties, no copyright exists and therefore cannot be transferred. Any co-authors **not** employed by the federal government must sign the copyright transfer agreement.

If this work was produced for an employer as a "work made for hire," an authorized representative of that employer must sign on the appropriate line below.

The undersigned hereby assign copyright for the manuscript entitled

_____

_____

to the American Diabetes Association upon its acceptance for publication (attach an additional page for signatures if necessary; **all** authors must sign):

_____	_____
(Author)	(Author)
_____	_____
(Author)	(Author)
_____	_____
(Author)	(Author)

The above title constitutes a "work for hire;" as an authorized agent of the employer, I transfer copyright to the American Diabetes Association (no patent rights are transferred):

_____	_____
Agent	Title

This work was produced on behalf of the United States Government and therefore no copyright exists.

_____	_____
(Author)	(Author)
_____	_____
(Author)	(Author)

American Diabetes Association.

57th SCIENTIFIC SESSIONS

June 21 - 24, 1997 Boston, MA

Submission Deadline: Monday, January 6, 1997

ABSTRACT PREPARATION GUIDELINES

GENERAL INFORMATION

1. Abstracts must be received at the Association's National Center by Monday, January 6, 1997.

2. Abstracts are not eligible if the paper has been presented at another national or international meeting or has been accepted for publication before the abstract submission deadline and will be published prior to the 57th Scientific Sessions. Failure to notify the Association of the publication of an abstract will result in a moratorium on the submission of abstracts for all authors appearing on the abstract in question for one year.

3. The printed abstract must be an original, submitted on the original abstract forms found in this packet. Abstracts cannot be submitted via fax.

4. An individual (member or non-member) may appear on four abstracts as an author, but may only appear as first author on two abstracts. A member may appear as author, co-author, or sponsor. A non-member may appear as author or co-author, but not as a sponsor. Authors are not required to be members of the Association.

5. Originality of work, adequacy of data, and clarity of exposition are the determinants in the selection of abstracts. Make abstracts as informative as possible, including a brief statement of the purpose of the study or why it was done, the methods or what was done, the results observed, and the author(s)' conclusions based on the results. Actual data should be summarized. It is inadequate to state "The results will be discussed" or "The data will be presented." Tables may be used to present data (refer to #18 in the instructions)

6. The final decision with respect to selection, programming, and/or publication of any abstract will be made by the Association's Scientific Sessions Meeting Committee.

7. Accepted abstracts will be printed as submitted. Changes to abstracts will not be accepted after submission. They should be carefully written and edited prior to submission.

8. For additional abstract packets, or if you have questions about completing the abstract form, contact Sandy DeVault, American Diabetes Association, 1660 Duke Street, Alexandria, VA 22314-3447, USA; phone: 703/549-1500, ext. 2096; FAX: 703/683-1839; E-mail: sdevault@diabetes.org.

9. Oral presentations at the Scientific Sessions will be limited to ten minutes each to allow time for discussion.

10. Expenses associated with the submission and presentation of the abstract are the responsibility of the presenter.

11. Presenters must pay the registration fee for attendance at the Scientific Sessions. Presenters will be able to register at pre-registration rates. For more information on registration, contact the Meeting Services Department, American Diabetes Association, 1660 Duke Street, Alexandria, VA 22314-3447, USA; phone: (703) 549-1500, ext. 2453 or 2330; FAX: (703) 683-1351; E-mail: meetings@diabetes.org.

COMPLETING THE FORMS

12. Accepted abstracts will be reduced by 25% and photographed as submitted for publication in the 57th Abstract Book, the May supplement to *Diabetes*. We recommend using a font no smaller than 10 points.

13. The text must be clear, within the border of the form, and limited to the space provided. Use only a typewriter or laser printer, as the quality of dot matrix printers varies considerably. Those with text exceeding the border will not be accepted. Text glued or taped inside the border will be accepted. Please use the following tips when printing your abstract:

- If typed, use carbon ribbon or slightly used black silk ribbon (new ribbons smudge, old ones reproduce too faintly). Practice typing the abstract in a rectangle 4 3/16" (10.64 cm) X 6 3/16" (15.42 cm) before using the original form.
- If using a laser printer, please note that the page size of the form is not standard. A left margin of 1.15" (2.92 cm) and a right margin of 3.35" (8.51 cm) should keep the text within the border. Practice printing the abstract with these margins before using the original form.

14. Abstract headings must follow a specified format. The format is as follows (refer to the example below):

a. Headings should begin to the immediate right of the box located in the upper left corner of the abstract area.

b. The first letters of major words in the title should be capitalized. Do not use subtitles (e.g., Methods, Results) in the abstract body.

c. Author(s)' complete first and last name(s) should be listed and capitalized. Authors who appear on more than one abstract should list their names the same way on all.

d. Author(s) who are members of the Association's Professional Section must be indicated by an asterisk (*) after their name. No other identifying marks are permissible except as noted in "e." below.

e. Author(s) who indicate "yes" on the *Duality of Interest Disclosure Form* (see pg. 6) must include a notation after their name(s). Use the following to indicate the type of duality: **1**= any significant financial interest or other relationship with the manufacturer(s) of any commercial product(s) and/or providers(s) of commercial services discussed in the educational presentation; **2** = any significant financial interest or other relationship with any commercial supporters of the activity.

f. Do not list credentials, degrees, academic title(s) (e.g., MD, RN, RD), departments, divisions, or institutional affiliation(s) on the abstract form.

g. Include city and state (postal abbreviations) or country of origin of work; do not include street address and zip code.

Example of abstract heading:

☐ A Novel Form of Chelatin Prevents IDDM in BB Rats.
JOHN DOE[1], JAMES E. REASONER*, SUSAN SMITH[2], JANE FRIDAY[2], Alexandria, VA

15. The first line of the text of the abstract and first line of any subsequent paragraphs should be indented three spaces.

16. The use of standard abbreviations is requested. Examples include kg, g, mg, ml, L (liter), meq, m (meter), mM (millimoles per liter), / (per), and % (percent). Place special or unusual abbreviations in parentheses after the full word the first time it appears, then use the abbreviation throughout the rest of the abstract. Use numerals to indicate numbers, except when beginning sentences.

17. Nonproprietary (generic) names should be used the first time a drug is mentioned and typed in lowercase letters; names are always capitalized, for example, aspirin (Bufferin).

18. Simple tables or special symbols may be included if they fit within the border of the form. Material that cannot be typed should be drawn in India ink.

19. Do not include references, credits, or grant support information in the abstract.

20. The Scientific Sessions Meeting Committee will consider presentation preference when planning the program. An abstract marked as "Only" (see Forms, pages 3 and 5) indicates that the authors do not want an abstract considered for any other type of presentation. For example, if an abstract is marked as "Oral Only" and is not selected for an oral presentation, the committee will not place the abstract in a poster session. Marking an abstract as "Oral Only" will not guarantee its selection for the program.

21. Categories for the 57th Scientific Sessions are located on page 4. Indicate the appropriate category under which you wish to have the abstract reviewed on both Form A and Form B. The Scientific Sessions Meeting Committee reserves the right to move an abstract that has been inappropriately categorized without notifying the author(s).

22. The signature of an active member of the Professional Section of the American Diabetes Association is required to validate the abstract. Members who sponsor non-members should verify that the latter are conforming to the rules. A member is not limited to the number of abstracts he/she can sponsor.

23. All authors must read and sign the *Duality of Interest* form (page 6) and this form must be included with each abstract submitted. Please refer to #14e for instructions on noting dualities on the abstract form. When preparing abstracts, please allow enough time to have all authors sign the original form.

24. Provide the information requested for the corresponding author, who will receive notification of abstract status (#28).

25. If the research presented in this abstract has been supported, in whole or in part, by a grant from the American Diabetes Association, please indicate so by checking on the appropriate line. Accepted abstracts with Association funding will be highlighted in the Final Program of the 57th Scientific Sessions. The response provided to this question will not affect the acceptance of abstracts for the 57th Scientific Sessions.

26. Before mailing an abstract submission, use the checklist on page 7 to confirm that all instructions have been followed and all items have been included in the submission packet.

ACKNOWLEDGEMENT OF RECEIPT AND ABSTRACT STATUS

27. For acknowledgment that an abstract was received by the Association, you must provide a self-addressed, US stamped postal card addressed to the corresponding author. The reverse side of the card should indicate the title of the abstract. **Confirmation of receipt cannot be made by phone.**

28. A letter of notification and appropriate accompanying materials will be sent by mail to the corresponding author. In addition, all international correspondence will be sent by Internet E-mail or fax if the appropriate numbers are included on form A.

MAILING SUBMISSION

29. A non-refundable processing fee of US $35.00 and a completed payment form (see page 7) must accompany each abstract submitted to the American Diabetes Association. Payment must be in the form of a check or credit card. Checks must be in U.S. funds and drawn on a U.S. bank, and made payable to the *American Diabetes Association*. Major credit cards (American Express, VISA, MasterCard) are also accepted. Purchase orders and money orders will not be accepted.

30. The review of abstracts is blinded, therefore two forms must be submitted: one (1) for publication (Form A) with the title and author(s)' name(s) within the border of the form, and one (1) for review (Form B) without author information. Please refer to Abstract Forms A and B on pages 3 and 5 for further instructions.

31. Five (5) copies of the front only of each form must also be provided for processing.

32. Do not fold the originals or copies. They should be mailed FIRST CLASS or AIR MAIL, when applicable, and addressed as follows: Scientific Sessions Meeting Committee, American Diabetes Association, P.O. Box 26427, Alexandria, VA 22313-6427, USA. Abstracts sent by express mail should be addressed as follows: Scientific Sessions Meeting Committee, American Diabetes Association, 1660 Duke Street, Alexandria, VA 22314-3447, USA. When shipping express mail, do not ship for a Saturday arrival. **Abstracts submitted via fax will not be accepted for review.**

"LATE-BREAKING RESEARCH" ABSTRACTS

33. Late-breaking research abstracts will be peer-reviewed, and only those deemed **highly meritorious** will be accepted for presentation. Selected abstracts will be presented during the President's Poster Session. "Late-breaking research" abstracts will not be published in the Abstract Book, nor will they appear in the Final Program because of printing deadlines. Authors should use the forms and follow instructions found in this packet. The appropriate box on Form A must be check marked, and all submissions must be received by May 16, 1997. The processing fee for abstracts in this classification is $50. "Late-breaking research" abstracts must be sent to the attention of Sandy DeVault, American Diabetes Association, 1660 Duke Street, Alexandria, VA 22314-3447 USA. Notification of abstract status will be provided no later than May 30, 1997.

TYPE ABSTRACT WITHIN BOX

FOR OFFICE USE ONLY

Date Rec'd _____ PMT? _____

Abstract No. _____

Duality? ____ Y ____ N Signed? ____ Y ____ N

Record No. _____

Mean Score _____

American Diabetes Association.

FORM A

(For publication)

CHECK ONE (See #21):

- ☐ Poster Session Preferred
- ☐ Oral Session Preferred
- ☐ Poster Session Only
- ☐ Oral Only
- ☐ No Preference

The author's wishes will be followed if possible.

☐ I am submitting this abstract after January 6, 1997 as "late-breaking research" (See #33).

Abstract Category Number: _____
(Categories listed on pg 4)

IMPORTANT

This form must be signed by an active member of the Professional Section of the American Diabetes Association.

The instructions on pages 1 and 2 must be followed exactly for abstracts to be considered for review.

The sponsoring member agrees that the material submitted herein conforms with the instructions on pages 1 and 2.

_____
MEMBER SIGNATURE

_____
PRINTED NAME

List family name, first name, middle initial, credentials/degrees, address (including city/state/country/zip), and telephone/fax numbers of author who should receive correspondence (please type or print):

Family Name _____

First Name _____ MI _____

Credentials/Degrees _____ Department _____

Institution _____

Street Address _____

City _____ State _____ Country _____ Zip Code/Postal Code _____

Phones (include area code/country/city code): Work: _____ Fax: _____

Has this research been supported, in whole or in part, by a grant from the American Diabetes Association? ____Y____N

Internet E-mail address: _____ (International submitters must include for timely notification)

PLEASE LEAVE THIS AREA BLANK

1997 ABSTRACT CATEGORIES

Select **one** two-digit category number and enter it on the appropriate line on both Abstract Form A and Abstract Form B:

01 Clinical Diabetes
02 Complications, Hypoglycemia and Other
03 Complications, Macrovascular
04 Complications, Nephropathy
05 Complications, Neuropathy
06 Complications, Ocular
07 Diabetes Education
08 Epidemiology
09 Foot Care
10 Forms of Therapy/New Technology
11 Gene Regulation
12 Genetics
13 Health Care Delivery
14 Hormones, Not Insulin
15 Immunology
16 Insulin Action
17 Insulin Synthesis/Secretion
18 Lipids/Lipoproteins
19 Metabolism, in vitro
20 Metabolism, in vivo, animals
21 Metabolism, in vivo, humans
22 Nutrition/Obesity/Exercise
23 Pregnancy
24 Psychosocial/Behavioral Medicine
25 Signal Transduction
26 Transplantation

57th SS

ONLY TYPE ABSTRACT TITLE AND ABSTRACT WITHIN BOX; DO NOT TYPE AUTHOR(S)' NAMES OR LOCATION

Type only title to right of box:

FOR OFFICE USE ONLY

Abstract No. _____

American Diabetes Association.

FORM B

(For review)

CHECK ONE (See #21):

- ☐ Poster Session Preferred
- ☐ Oral Session Preferred
- ☐ Poster Session Only
- ☐ Oral Only
- ☐ No Preference

The author's wishes will be followed if possible.

☐ I am submitting this abstract after January 6, 1997 as "late-breaking research" (See #33).

Abstract Category Number:_____
(Categories listed on pg 4)

The American Diabetes Association's blinded abstract review process:

All abstracts submitted to the American Diabetes Association are peer-reviewed through a "blinded" review process. Reviewers are provided copies of the abstract form on this page (Abstract Form B). Please be certain that Abstract Form B does not include the author(s)' names or location(s). Be sure to indicate your presentation preference and the abstract category number on Abstract Form B as you have done on Abstract Form A. Abstract forms which do not comply with these guidelines or instructions on pages 1 and 2 will not be submitted for review. See Abstract Form B sample format below.

ONLY TYPE ABSTRACT TITLE AND ABSTRACT WITHIN BOX; DO NOT TYPE AUTHOR(S)' NAMES OR LOCATION

Type only title to right of box: Insulin-Mediated Mitogenic Signal Transduction Requires IRS-1.

Abstract data.....

57th SS

DUALITY OF INTEREST DISCLOSURE FORM

As a sponsor accredited by the ACCME, the American Diabetes Association must insure balance, independence, objectivity, and scientific rigor in all its individually sponsored or jointly sponsored educational activities. All presenters participating in a sponsored activity are expected to disclose to the activity audience any significant financial interest or other relationship **(1)** with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in an educational presentation and **(2)** with any commercial supporters of the activity. Significant financial interest or other relationship includes: employment (full or part-time); membership on the board of directors of any fiduciary relationship; membership on a scientific advisory panel, or other standing scientific/medical committee; stock ownership (shares of stock directly owned or controlled, including those owned or controlled by an immediate family member); all consultative or advisory arrangements for which monetary compensation is received; and grants/research support.

The intent of this disclosure is not to prevent a presenter with a significant financial or other relationship from making a presentation, but rather to provide listeners with information on which they can make their own judgments. It remains for the audience to determine whether the presenter's interests or relationships may influence the presentation with regard to exposition or conclusion. **Each author listed on an abstract must complete and return one of these forms. An author may decline to complete this form, and, in that event, cannot have his/her name on the abstract.**

TITLE OF THE ACTIVITY: 57TH ANNUAL SCIENTIFIC SESSIONS DATE: JUNE 21-24, 1997

ABSTRACT AUTHOR NAME: _____

TITLE OF ABSTRACT: _____

PLEASE COMPLETE BOTH SECTIONS I AND II:

I. Will your presentation include discussion of any commercial products or services that might be perceived as a duality of interest?

Yes _____ No _____ (If No, skip to question II)

If YES, do you have a financial interest or other relationship with the manufacturer(s) of any of the products or provider(s) of any of the services you intend to discuss?

Yes _____ No _____

If YES, please list the manufacturer(s) or provider(s) and describe the nature of the relationship(s): _____

_____

II. Do you have a relationship(s) with the commercial supporter(s) of this activity?

Yes ___ No ___ (*Answer "no" unless you have been notified of commercial support for this activity*).

If YES, please list the relevant commercial supporter(s) and describe the nature of the relationship(s): _____

_____

Signature _____ Date _____

Please photocopy this form and include a completed form for <u>each author</u> with the abstract submission

ADA will disclose the existence of any significant financial interest or other relationship in the Abstract Book and final program.

Submission of this form does not: 1) guarantee acceptance of the abstract for presentation (All abstracts are peer-reviewed and <u>not all</u> abstracts are accepted for presentation); or 2) influence the review of the abstracts (Reviewers are not provided copies of the signed *Duality of Interest Disclosure Form)*

ABSTRACT PREPARATION CHECKLIST

Two original abstract forms must be submitted as indicated in the Instructions for Preparation of Abstracts (see #3).

Before mailing, please check your abstract submission for the following:

For both Abstract Form A and Abstract Form B:

- ☐ Is the submission on original abstract forms? (#3)
- ☐ Does the heading of the abstract begin to the right of the box located in the left corner of the abstract border, and is the text of the abstract within the border? (#14a, #13)
- ☐ Are the first letters of major words in the title capitalized? (#14b)
- ☐ Have the instructions for the body of the abstract been followed, including indentation, abbreviation, nonproprietary names, tables, and references? (#15, #16, #17, #18, #19)
- ☐ Has the type of presentation preference been indicated? (forms A& B)
- ☐ Has the appropriate abstract category number been filled in? (forms A & B)

For Abstract Form A:

- ☐ Are author(s)' and co-author(s)' names capitalized, and do author(s)' complete first name(s) precede last name(s), in the heading? (#14c)
- ☐ Have asterisk(s) been used to designate active member(s) of the Professional Section of the Association in the heading? (#14d)
- ☐ Have appropriate numerals to indicate the existence of an author(s)' duality been included in the heading? (#14e)
- ☐ Have degrees, academic titles, institutional affiliations, street address, and zip code not been listed in the heading? (#14f, 14g)
- ☐ Has the form been signed by an active member of the Professional Section of the Association? (#22)
- ☐ Has the corresponding author information been provided, i.e., credentials, institution, and mailing address, as well as an E-mail address (if available) and a fax number? (#24, #28, Form A)
- ☐ Has the question regarding the funding of the abstract's research been answered? (#25, Form A)

For Abstract Form B:

- ☐ Have author(s)' name(s), city(ies) and state(s) been removed from the heading to "blind" the abstract? (#30, Form B)

For each abstract submission, have the following items been completed and included:

- ☐ Has each author read and signed the *Duality of Interest* form (back of the original Abstract Form B)? (#23)
- ☐ Has a self-addressed, stamped postal card been provided if acknowledgement is desired? (#27)
- ☐ Has a processing fee of US $35.00, payable by check to the American Diabetes Association, been enclosed with a payment form, or, has the appropriate credit card information on the payment form been completed and signed by the credit card holder? (#29)
- ☐ Have five copies of the front of each form been made and included in the submission packet? (#31)

"Late-breaking research" abstracts:

- ☐ Have the specific instructions for submission of "late-breaking research" abstracts been followed completely? (#33)

CUT ALONG DOTTED LINE

American Diabetes Association.

PAYMENT FORM

FOR OFFICE USE ONLY

Date Rec'd:_____

Processed By:_____

No. Submitted:_____

Include this form with your abstract submission.

Title of Abstract: _____

Name of Corresponding Author: _____

Method of Payment

_____I have enclosed a check in the amount of $_____ (US$35 regular or US$50 "late-breaking" for each abstract -- attach check to this form)

_____I authorize the American Diabetes Association to charge $_____ (US$35 regular or US$50 "late-breaking" for each abstract) to my credit card for my abstract processing fee.

☐ American Express ☐ VISA ☐ Mastercard

Card issued in name of (please print):_____

Card Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Exp. Date:_____

Signature:_____

57th SS

American Diabetes Association.

FUTURE MEETINGS

44th Annual Advanced Postgraduate Course
January 17 - 19, 1997
New Orleans Hilton Riverside Hotel
New Orleans, Louisiana

3rd Annual International Conference and Postgraduate Course
February 27 - March 2, 1997
Jamaica Grande Resort Hotel
Ocho Rios, Jamaica

Co-sponsored by the University of the West Indies Diabetes Outreach Project
and the American Diabetes Association

4th International Workshop on Gestational Diabetes Mellitus
March 14 - 16, 1997
Chicago, Illinois

57th Annual Meeting and Scientific Sessions
June 21 - 24, 1997
Boston, Massachusetts

58th Annual Meeting and Scientific Sessions
June 11 - 16, 1998
Chicago, Illinois

For more information and registration forms, contact the
American Diabetes Association, Meeting Services Department,
1660 Duke Street, Alexandria, VA 22314-3447 USA;
phone: (703) 549-1500, ext. 2330; fax: (703) 683-1351;
E-mail: meetings@diabetes.org

BRIEF SUMMARY
See package insert for full prescribing information

INDICATIONS AND USAGE:

Redux is indicated for the management of obesity including weight loss and maintenance of weight loss in patients on a reduced-calorie diet. Redux is recommended for obese patients with an initial body mass index ≥30 kg/m², or ≥27 kg/m² in the presence of other risk factors (e.g., hypertension, diabetes, hyperlipidemia).

The safety and effectiveness of Redux beyond 1 year have not been determined at this time.

CONTRAINDICATIONS:

In patients with diagnosed pulmonary hypertension (see **WARNINGS**); in patients receiving monoamine oxidase inhibitors (see **PRECAUTIONS**, ***Drug Interactions***); in patients with hypersensitivity to dexfenfluramine, fenfluramine, or related compounds.

WARNINGS:

Primary Pulmonary Hypertension. **A 2-year international (5 country) case-control (epidemiological) study identified 95 primary pulmonary hypertension (PPH) cases; 20 of these had been exposed to anorexigens in the past, and 9 of the 20 had been exposed to anorexigens for longer than three months. In this study, the use of anorexigens for longer than 3 months was associated with an increase in the risk of developing PPH (odds ratio = 9.1, 95% confidence interval = 2.6-31.5). This increased risk of PPH was concentrated in persons who had used the drugs within the preceding year; there was no significant increase in risk for persons who had taken the drugs more than 1 year ago or for persons who had used these agents for 3 months or less. In the general population, the yearly occurrence of PPH is estimated to be about 1-2 cases per 1,000,000 persons. Therefore, the case-control study indicated an estimated risk associated with the long-term use of anorexigen drugs of about 18 cases per million persons exposed per year. According to the case-control study, obesity itself (body mass index ≥30 kg/m²) was also associated with an increase of about two-fold in the risk of developing PPH.**

PPH is a serious condition; the 4-year survival rate has been reported to be 55%.

The initial symptom of pulmonary hypertension is generally dyspnea. Other initial symptoms include: angina pectoris, syncope, or lower extremity edema. ***Patients should be advised to report immediately any deterioration in exercise tolerance. Treatment should be discontinued in patients who develop new, unexplained symptoms of dyspnea, angina pectoris, syncope, or lower extremity edema. These patients should be evaluated for the etiology of these symptoms and the possible presence of pulmonary hypertension.***

Neurochemical Findings in Animals. Dexfenfluramine and its active metabolite are believed to reduce food intake via interactions with the serotoninergic neurotransmitter system. In animals, dexfenfluramine doses that result in brain concentrations approximately 10 times those seen in humans, produce prolonged reductions (weeks to months) in brain serotonin concentrations following cessation of dexfenfluramine. These reductions are accompanied by diminished visualization of serotoninergic neurons and decreased numbers of serotonin transporters. These results have been interpreted as either surrogate indicators of neurotoxicity or as an extension of the pharmacology of serotonin reuptake inhibitors. Resolution of differences in the interpretation may occur with further research.

Changes in brain serotonin concentrations following acute, high doses of dexfenfluramine have been noted in all animal species and with all routes of administration tested. These changes generally have been found to be reversible; however, the dose and brain concentration of drug may affect reversibility.

Studies employing experimental techniques that are independent of serotonin content could not detect neuronal damage at doses of dexfenfluramine in animals producing decreased brain serotonin concentrations. The observed neurochemical changes were not associated with persistent changes in animal behavior.

The relevance of the animal findings to humans is not known.

Miscellaneous. Organic causes of obesity (e.g., hypothyroidism) should be excluded before prescribing Redux.

Use with caution in patients with glaucoma.

PRECAUTIONS:

General. Because of Redux's potential to produce mild-to-moderate drowsiness, the patient's individual response should be assessed before engaging in activities requiring alertness. Redux may potentiate the sedative effects of alcohol or other drugs with CNS action. If symptoms of intolerance develop, (e.g., nausea and vomiting), reduce dosage or discontinue Redux.

Misuse Potential. As with any weight-loss agent, the potential exists for misuse in inappropriate patient populations (e.g., patients with anorexia nervosa or bulimia). See **INDICATIONS AND USAGE** for recommended prescribing guidelines.

Information for Patients. Inform patients that false-positive urine drug tests for amphetamines have been observed following Redux use. See ***Drug/Laboratory Test Interactions.***

Combination Therapy. The safety and efficacy of dexfenfluramine in combination with other weight-loss agents have not been studied; therefore, concomitant use is not recommended.

Use in Patients with Concomitant Illness. Weight loss has been associated with a reduction in hyperglycemia in obese diabetic patients, a reduction of blood pressure in obese hypertensive patients, and an improvement in the lipid profile in obese hyperlipidemic patients. When Redux is administered to such patients, there may be changes in their conditions and the medications used to treat them should be monitored, and adjusted if necessary.

Drug Interactions. In patients receiving nonselective monoamine oxidase inhibitors (MAOIs) (e.g., selegiline hydrochloride) in combination with serotoninergic agents (e.g., fluoxetine, fluvoxamine, paroxetine, sertraline, venlafaxine) there have been reports of serious, sometimes fatal, reactions. Because Redux is a serotonin releaser and reuptake inhibitor, do not use MAOIs concomitantly (see **CONTRAINDICATIONS**).

At least 14 days should elapse between discontinuation of an MAOI and initiation of Redux. At least 3 weeks should elapse between discontinuation of Redux and initiation of treatment with an MAOI.

A rare, but serious, constellation of symptoms, termed "serotonin syndrome," has been reported with the concomitant use of selective serotonin reuptake inhibitors (SSRIs) and agents for migraine therapy, such as Imitrex® (sumatriptan succinate) and dihydroergotamine. The syndrome requires immediate medical attention and may include one or more of the following symptoms: excitement, hypomania, restlessness, loss of consciousness, confusion, disorientation, anxiety, agitation, motor weakness, myoclonus, tremor, hemiballismus, hyperreflexia, ataxia, dysarthria, incoordination, hyperthermia, shivering, pupillary dilation, diaphoresis, emesis, and tachycardia.

Do not administer with other serotoninergic agents. The appropriate interval between administration of these agents and Redux has not been established.

The use of dexfenfluramine with other CNS-active drugs has not been systematically evaluated; use caution if such drugs are prescribed concurrently.

Drug/Laboratory Test Interactions. False-positive urine drug tests for amphetamines by ELISA have been observed following Redux use. Inform patients of this possible laboratory finding when undergoing urine drug screenings. Gas chromatography/mass spectroscopy can distinguish dexfenfluramine from amphetamines. See ***Information for Patients.***

Carcinogenesis, Mutagenesis, Impairment of Fertility. Studies in rats and mice have not shown a carcinogenic potential for dexfenfluramine at doses 4.8 and 5.8 times the daily human dose (calculated on a body surface area [mg/m²] basis). In pregnant rats, dexfenfluramine caused a significant reduction in the number of fetuses and live young. Dexfenfluramine has no detectable mutagenic activity as determined by several mutagenicity tests.

Pregnancy. *Teratogenic Effects–Pregnancy Category C.* Dexfenfluramine produced dose-related effects on reproduction and fertility in first-generation rats. In female rats, doses 2.5 and 5 times the daily human dose caused significant reductions in body weight and weight gain throughout pregnancy; the number of placental implantations and fetuses was reduced, there was a reduced number of live young, and delayed ossification was seen in the fetuses. No significant treatment-related adverse effects or abnormalities were observed in second- and third-generation rats.

Teratogenicity studies in rats and rabbits failed to show any treatment-related embryotoxicity or teratogenicity at doses up to 10 times the daily human dose.

There are no adequate and well-controlled studies in pregnant women. Redux is not recommended for pregnant women.

Nursing Mothers. Dexfenfluramine is excreted in rat milk; it is not known whether it is excreted in human milk. Therefore, do not administer Redux to a nursing woman.

Pediatric Use. Safety and effectiveness have not been established.

Geriatric Use. As with all CNS-active medications, exercise caution when treating elderly patients with Redux. Clinical studies did not include sufficient numbers of patients aged 65 or older to determine whether they respond differently than younger patients.

ADVERSE REACTIONS:

Commonly Observed. The most commonly observed, treatment-emergent adverse events associated with the use of Redux in double-blind, placebo-controlled clinical trials were diarrhea (17.5%), dry mouth (12.5%), and somnolence (7.1%). These and other commonly observed adverse reactions were generally mild and transient. (Commonly observed is defined as incidence of 5% or greater and incidence in dexfenfluramine group at least twice that of placebo group.)

Associated with Discontinuation of Treatment. Seven percent of the 1159 dexfenfluramine patients in clinical trials discontinued treatment due to an adverse event. The most common events resulting in discontinuation included asthenia, insomnia, headache, and depression. Five percent of the 1138 placebo-treated patients discontinued because of an adverse event.

Incidence in Controlled Clinical Trials. The following treatment-emergent adverse events occurred at a frequency of 2% or more among Redux-treated patients (n = 1159) and occurred at least as frequently as the placebo group (n = 1138), regardless of relationship to study medication. Patients may have experienced more than one type of adverse event.

BODY AS A WHOLE: Headache (16.1% vs. 15.5%), Asthenia (15.8% vs. 10.7%), Abdominal Pain (6.7% vs. 6.0%), Chills (2.9% vs. 1.2%), Accidental Injury (2.8% vs. 2.3%); GASTROINTESTINAL SYSTEM: Diarrhea (17.5% vs. 7.3%), Vomiting (3.2% vs. 2.9%); METABOLIC/NUTRITIONAL SYSTEM: Thirst (2.8% vs. 1.1%); NERVOUS SYSTEM: Insomnia (19.9% vs. 18.6%), Dry Mouth (12.5% vs. 5.0%), Somnolence (7.1% vs. 3.4%), Dizziness (5.5% vs. 4.0%), Depression (4.7% vs. 3.6%), Vertigo (3.1% vs. 1.7%), Emotional Lability (3.1% vs. 2.7%), Abnormal Dreams (2.0% vs. 1.4%), Thinking Abnormal (2.0% vs. 1.1%); RESPIRATORY SYSTEM: Pharyngitis (6.1% vs. 5.6%), Cough Increased (3.6% vs. 3.0%), Bronchitis (3.4% vs. 1.8%); SKIN/APPENDAGES: Rash (2.3% vs. 2.2%); UROGENITAL SYSTEM: Urinary Frequency (2.8% vs. 1.1%), Polyuria (2.1% vs. 1.0%).

Other Events Observed in Controlled Clinical Trials. The events below are classified within body system categories and enumerated in order of decreasing frequency using the following definitions. "Frequent" = events occurring in more than 1/100 patients but not described above because the frequency in dexfenfluramine-treated patients was less than that in placebo-treated patients or they occurred at a rate less than 2%; "Infrequent" = events occurring in 1/100 to 1/1000 patients; "Rare" = events occurring in only one patient during placebo-controlled clinical trials.

BODY AS A WHOLE—*Frequent:* infection, flu syndrome, pain, back pain, fever, allergic reaction. *Infrequent:* malaise, neck pain, chest pain, generalized edema, stress, face edema, neoplasm, pelvic pain. *Rare:* adenoma, immune system disorder, neck rigidity, suicide attempt. CARDIOVASCULAR SYSTEM—*Frequent:* hypertension, angina pectoris, palpitation, vasodilation, migraine. *Infrequent:* cardiovascular disorder, tachycardia, postural hypotension, hypotension, peripheral vascular disorder, syncope, arrhythmia, extrasystoles, hemorrhage, thrombophlebitis, varicose vein. *Rare:* heart block, pulmonary embolus, thrombosis. GASTROINTESTINAL SYSTEM—*Frequent:* constipation, nausea, dyspepsia, increased appetite, rectal disorder, gastritis, gastroenteritis, flatulence. *Infrequent:* colitis, eructation, gastrointestinal hemorrhage, enteritis, peptic ulcer, hepatitis, hepatomegaly. *Rare:* appendicitis, cholelithiasis, fecal incontinence, melena, mouth ulceration, pancreatitis, rectal hemorrhage, sialoadenitis. ENDOCRINE—*Infrequent:* goiter, diabetes mellitus, thyroid disorder. *Rare:* hypothyroidism. HEMIC AND LYMPHATIC SYSTEM—*Infrequent:* anemia, lymphedema. *Rare:* coagulation disorder, lymphadenopathy, polycythemia, thrombocythemia. METABOLIC AND NUTRITIONAL—*Infrequent:* edema, gout, hypoglycemia, hypokalemia. *Rare:* hyperglycemia, hyperkalemia, hyperlipemia, hyperuricemia. MUSCULOSKELETAL SYSTEM—*Frequent:* arthralgia, myalgia, arthritis. *Infrequent:* leg cramps, joint disorder, bone disorder, tenosynovitis, myasthenia, rheumatoid arthritis. *Rare:* bursitis, tetany. NERVOUS SYSTEM—*Frequent:* nervousness, anxiety, increased libido, hypertonia, paresthesia. *Infrequent:* tremor, amnesia, euphoria, decreased libido, incoordination, neuralgia, speech disorder, ataxia, hypokinesia, sleep disorder, abnormal gait, agitation, confusion, depersonalization, diplopia, hostility, hyperesthesia, hyperkinesia, peripheral neuritis. *Rare:* apathy, dementia, hallucinations, hypotonia, neuritis, neurosis, paralysis. RESPIRATORY SYSTEM—*Frequent:* rhinitis, sinusitis. *Infrequent:* asthma, dyspnea, epistaxis, laryngitis. *Rare:* apnea, hyperventilation. SKIN AND APPENDAGES—*Frequent:* sweating, alopecia, urticaria, pruritus. *Infrequent:* skin disorder, fungal dermatitis, hirsutism, eczema, psoriasis. *Rare:* skin hypertrophy. SPECIAL SENSES—*Frequent:* taste perversion, amblyopia. *Infrequent:* abnormal vision, conjunctivitis, eye disorder, glaucoma, tinnitus, vestibular disorder, dry eyes, mydriasis. *Rare:* abnormality of accommodation, anisocoria, lacrimation disorder, miosis, parosmia, retinal disorder. UROGENITAL SYSTEM—*Frequent:* menstrual disorder, urinary tract infection, nocturia, dysmenorrhea. *Infrequent:* amenorrhea, dysuria, oliguria, albuminuria, breast pain, kidney calculus, kidney pain. *Rare:* spontaneous abortion, threatened abortion, breast neoplasm, endometrial disorder, female lactation, hematuria, impotence, mastitis, nephritis, prostatic disorder, testis disorder, urinary incontinence, urinary retention, uterine hemorrhage.

In controlled clinical trials, there has been no consistent pattern of laboratory abnormalities in patients treated with dexfenfluramine.

Post-introduction Reports. Voluntary reports of adverse events temporally associated with dexfenfluramine that have been received since market introduction in countries other than the US, for which the association with the drug is unknown, and which are not included in descriptions of adverse events elsewhere in this labeling, include the following:

BODY AS A WHOLE—anaphylaxis, congenital anomaly, eventration, hypothermia, laryngeal edema, peritonitis, reaction aggravation, retroperitoneal fibrosis, scleroderma, sudden death. CARDIOVASCULAR SYSTEM—pulmonary hypertension (see **WARNINGS**), atrial fibrillation, cardiomyopathy, cerebral vasculitis, ECG abnormal, heart arrest, heart failure, myocardial infarction, myocarditis, shock, tachycardia, ventricular fibrillation, ventricular tachycardia. *DIGESTIVE SYSTEM*—dysphagia, gastrointestinal disorder, tongue disorder. *ENDOCRINE SYSTEM*—diabetic coma. *GASTROINTESTINAL SYSTEM*—hepatic failure, jaundice, liver damage. *HEMIC AND LYMPHATIC SYSTEM*—agranulocytosis, antinuclear antibody present, bone marrow depression, ecchymosis, hemolytic anemia, pancytopenia. *METABOLIC AND NUTRITIONAL*—dehydration, elevated lipases, increased prolactin, thyroid disease, weight increase. MUSCULOSKELETAL—myopathy. NERVOUS SYSTEM—antisocial reaction, apathy, cerebellar ataxia, cerebrovascular accident (including cerebral hemorrhage, cerebral infarction, cerebral ischemia and cochlear infarction), choreoathetosis, convulsions, decreased reflexes, delirium, drug dependence, dyslexia, encephalopathy, grand mal convulsions, Guillain-Barré syndrome, hemiplegia, hypoesthesia, manic-depressive psychosis, manic reaction, memory loss, meningism, meningitis, neuropathy, papilledema, paraplegia, personality disorder, reflexes increased, retrobulbar neuritis, schizophrenic reaction, stupor, subdural hematoma, twitch, withdrawal syndrome. RESPIRATORY SYSTEM—pulmonary hypertension (see **WARNINGS**), diffuse interstitial pneumonitis, dyspnea, hiccup, lung edema. SKIN AND APPENDAGES— angioedema, bullous eruption, erythema multiforme, lower extremity purpura, purpura annularis telangiectodes, Stevens-Johnson syndrome (erythema multiforme major). SPECIAL SENSES—ophthalmoplegia, photophobia, transitory deafness, visual field defects. UROGENITAL SYSTEM—breast enlargement, carcinoma (breast), carcinoma (cervix), ejaculation abnormal, gynecomastia, hypomenorrhea, kidney failure, placenta previa, urinary tract disorder.

Adverse Events Occurring After Discontinuation. In controlled clinical trials and/or in post-marketing reports, symptoms have been reported within a few days after discontinuation of Redux. These include one or more of the following: abdominal pain, anxiety, asthenia, delusion, depression, diarrhea, dizziness, hypertension, insomnia, nausea, and vomiting.

DRUG ABUSE AND DEPENDENCE:

Controlled Substance Class. Dexfenfluramine is a controlled substance in Schedule IV.

Abuse and Physical and Psychological Dependence. Dexfenfluramine is not an amphetamine or a stimulant. There is no evidence of addictive or drug-seeking behavior in pre-marketing clinical studies or animal models.

OVERDOSAGE:

Human Experience. Post-marketing experience in Europe over 10 years (8/84 through 12/94) in an estimated 10 million patients provided 66 instances of overdose (maximum dose per body mass of 54 mg/kg, maximum total dose of 1800 mg), including eight children 6 years of age or under. Three deaths have occurred in association with dexfenfluramine overdosage; the exact causes of death were unknown.

Symptoms associated with overdosage consisted mainly of agitation, drowsiness, mydriasis, sweating, shivering, nausea, and vomiting. Other symptoms observed with dexfenfluramine overdose and not noted under **ADVERSE REACTIONS** include cold sensation, excitation, nystagmus, garrulousness, delusions, bladder tenesmus, chattering teeth, abnormal reflexes, facial myoclonus, trismus, tonic-clonic seizures, impairment of consciousness, coma (stage 2-4), sinus bradycardia, repolarization abnormalities, right anterior hemiblock, polypnea, diffuse bronchial rales, and flushing.

Management of Overdose. Institute general supportive measures for oral drug overdose. Measures used in dexfenfluramine overdoses include aspiration of gastric contents, gastric lavage with activated charcoal, osmotic diuresis, forced acid diuresis, and careful monitoring of CNS or respiratory depression. The effectiveness of dialysis is not known. Follow patients closely until there is no further evidence of drug-related CNS effects. No specific therapy for overdose is known.

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