

**VELOSEF 250 CAPSULES**  
**VELOSEF 500 CAPSULES**  
**Cephadrine Capsules**  
**VELOSEF 125 FOR ORAL SUSPENSION**  
**VELOSEF 250 FOR ORAL SUSPENSION**  
**Cephadrine for Oral Suspension**  
**VELOSEF FOR INJECTION, 500 mg and 1.0 g**  
**Cephadrine for Injection**

**ACTION:** Cephadrine is a semi-synthetic, cephalosporin antibiotic exhibiting bactericidal activity through inhibition of cell-wall synthesis.

**INDICATIONS:** Infections in the respiratory and genitourinary tracts, and in the skin and soft tissues, due to susceptible organisms. Sensitivity tests should be performed; therapy may be instituted before receiving the results.

**CONTRAINDICATIONS:** Hypersensitivity to the cephalosporin group of antibiotics.

**WARNINGS:** There is evidence of partial cross-allergenicity between the penicillins and the cephalosporins. Therefore, cephadrine should be used with caution in patients with known hypersensitivity to penicillins.

Antibiotics, including cephadrine, should be used cautiously and only when absolutely necessary in patients with a history of allergies, particularly to drugs.

**Usage during pregnancy and lactation:**

Safety for use of this product during pregnancy has not been established. Cephadrine is secreted in breast milk.

**PRECAUTIONS:** Patients should be observed carefully during therapy. Allergic reactions require discontinuation of VELOSEF and appropriate treatment.

Prolonged use of VELOSEF may result in overgrowth of non-susceptible organisms; appropriate measures should be instituted. During long-term therapy, hematology, renal and hepatic functions should be monitored periodically. Patients with known or suspected renal impairment should be observed carefully since cephadrine may accumulate in the serum and tissues unless dosage is suitably reduced. See DOSAGE AND ADMINISTRATION section.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy, e.g., the incision and drainage of abscesses. After treatment with cephalosporins, a false-positive reaction for glucose in the urine may occur, but not with enzyme-based tests. A false-positive Coombs' test has also been reported.

VELOSEF for Injection is physically compatible with most commonly used intravenous fluids and electrolyte solutions (e.g. Dextrose Injection, Sodium Chloride Injection or M/6 Sodium Lactate). However, it is not compatible with Lactated Ringer's Solution or other calcium-containing infusion fluids.

**ADVERSE REACTIONS:** Usually limited to gastrointestinal disturbances and occasional hypersensitivity, but may include hematological and hepatobiliary disturbances, as well as elevated BUN, LDH and serum creatinine, superinfection, vaginitis and joint pains. Thrombophlebitis following I.V. injection and sterile abscesses after I.M. injection have occurred.

Only occasionally have adverse reactions been severe enough to warrant cessation of therapy.

**DOSAGE AND ADMINISTRATION:** The presence of food in the gastrointestinal tract delays absorption and reduces the peak serum level but does not affect the total amount of cephadrine absorbed.

VELOSEF Capsules and VELOSEF for Oral Suspension.

Adults: Respiratory tract infections: 250 mg, q6h or 500 mg q12h. Pneumococcal lobar pneumonia: 500 mg, q6h or 1 g q12h.

Genitourinary tract infections: 500 mg, q6h or 1 g q12h. Prolonged therapy is advisable for the treatment of prostatitis and epididymitis. Skin or soft tissue infections: 250 mg q6h or 500 mg q12h.

Children: 25 to 50 mg/kg/day, in two or four equally divided and spaced doses, e.g.:

**VELOSEF for Oral Suspension**

Child's Weight	125 mg/5 ml	250 mg/5 ml
10 kg (22 lbs)	½ to 1 tsp, q6h or 1 to 2 tsp, q12h	—
20 kg (44 lbs)	1 to 2 tsp, q6h or 2 to 4 tsp, q12h	½ to 1 tsp, q6h or 1 to 2 tsp, q12h
40 kg (88 lbs)	—	1 to 2 tsp, q6h or 2 to 4 tsp, q12h

Smaller doses than those indicated above should not be used. For otitis media due to *H. influenzae*, doses from 75 to 100 mg/kg/day are recommended.

Maximum daily dose should not exceed 4 g.

VELOSEF for Injection: For use in moderate, severe or life threatening infections or where oral therapy is not possible. Adult daily dose range is 2-4 g, depending on the infection. In children, a daily dose of 50-100 mg/kg is recommended.

**All patients: all formulations.**

Larger doses (up to 1 g q6h in adults or up to 25 mg/kg q6h in children) may be given for severe or chronic infections: maximum daily dose should not exceed 4 g. Therapy should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or evidence of bacterial eradication has been obtained. In infections caused by hemolytic streptococci, a minimum 10-day-treatment period is recommended. Stubborn infections may require treatment for several weeks with frequent bacteriological and clinical appraisal.

A modified dosage schedule in patients with decreased renal function is necessary. Each patient should be considered individually; the following schedule is recommended as a guideline. Initial loading dose: 750 mg. Maintenance dose: 500 mg at the time intervals listed below:

Creatinine Clearance (ml/min/1.73m <sup>2</sup> )	Time Interval
> 20 ml/min	6-12 hours
15-19 ml/min	12-24 hours
10-14 ml/min	24-40 hours
5-9 ml/min	40-50 hours
< 5 ml/min	50-70 hours

**DOSAGE FORMS:** Capsules of 250 mg and 500 mg in bottles of 50, and bottles of VELOSEF 125 and 250 for Oral Suspension which, after reconstitution, provide 100 ml of a pleasantly flavoured suspension containing 25 mg/ml and 50 mg/ml respectively.

VELOSEF for Injection is provided as a sterile powder for reconstitution in vials containing 500 mg or 1.0 g. Consult Product Monograph or Package insert for reconstitution procedure.

Product Monograph available to physicians and pharmacists on request.



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at this time a differential diagnosis as follows: chiropractic is of no value, is of limited value or is of extreme value. Each of these diagnoses requires a different approach to management. As in other day-to-day problems facing medical doctors, the solution to the chiropractic problem lies in proper diagnosis, which, in turn, is dependent on a complete investigation of and direct contact with the problem. It is this contact with chiropractors that I have been advocating.

SCOTT HALDEMAN, DC, M SC, PH D, MD  
 Medical intern  
 Vancouver General Hospital  
 Vancouver, BC

**Treatment for travelling athletes**

*To the editor:* The sports medicine interest group of the Canadian Physiotherapy Association is attempting to compile a booklet listing doctors, therapists and clinics specifically interested in sports medicine and willing to treat athletes travelling in Canada. We hope to make the booklet available to provincial and national sports federations for use by athletes who may need treatment while travelling in this country.

Would any readers who are interested please send their names, addresses and telephone numbers to us at the address below?

LINDA MASON, DIP PT  
 PEGGY WOYTIUK, DIP PT  
 Sports medicine interest group  
 Canadian Physiotherapy Association  
 13020 - 113th Ave.  
 Edmonton, Alta.  
 T5M 2X1

**Warfare denied**

*To the editor:* We bring your attention to a serious error in your association news column of Oct. 9, 1976, which contains the following unfortunate assertion:

One of the complicating factors in the decision as to whether to cooperate or not with Statistics Canada is that a power struggle is taking place within the federal government bureaucracy. The health division of Statistics Canada and the statistics division of the health department are engaged in internecine warfare to control some health statistics...

We, who are in an excellent position to know what relationship prevails between the two departments, deny the existence of any "power struggle" or "internecine warfare" over the control of some health statistics. Such a misrepresentation is completely irresponsible and does a serious injustice to our respective personnel who have conducted themselves in a spirit of harmonious cooperation. May we point out also that we co-chair an active interdepartmental committee on health statistics which

serves as a medium for close collaboration between our two departments.

With reference to the issue of a medical manpower data bank that stimulated the remarks in your association news column, we would like to stress the importance for the future, not only of close cooperation between our own two agencies, but also of the need for active collaboration and cooperation with the provinces, provincial licensing authorities and with the Canadian Medical Association and other professional organizations.

J. HAUSER  
 Director  
 Health division  
 Statistics Canada

W.A. MENNIE  
 Director  
 Health economics and statistics  
 Health and Welfare Canada

**British legislation affecting returning physicians**

*To the editor:* I would like to draw the attention of your readers to important legislation that has recently been enacted in the British House of Commons. This could seriously affect British graduates now in Canada who, in the long-term future, are considering a return to Britain.

Except for those at present in practice and those who have only recently left general practice, applicants for principal positions in National Health Service general practice will have to satisfy the provisions of the National Health (1976) Vocational Training Bill. This bill stipulates that such applicants will have suitable experience or training or equivalent experience, presumably equal to a 3-year training course now being introduced into British hospitals to prepare new graduates for family practice. It appears that, although the bill has been passed, the regulations have yet to be drawn up. It also appears that British graduates who have not completed 3 years' formal training beyond their 1-year internship will find themselves obliged, if they wish to take up general practice again, to occupy very lowly paid posts at senior house officer level at a salary of between \$130 and \$150 per week; these posts would be garnished with such fringe benefits as compulsory single residence.

May I urge such intending repatriates to write to the British Medical Association in London to remind them of their responsibilities toward those of us overseas? It is frustrating to leave home without your key, but it is even worse to get back and find the locks have been changed.

MYLES F. HARRIS, MD  
 La Cuculière, Roullours  
 Vire  
 Normandie  
 France