

SEPTRA*

(Trimethoprim + Sulfamethoxazole)

- sequentially blocks two different bacterial enzymes (both vital for bacterial survival)
- double blockade activity discourages development of resistance
- achieves rapid, high blood levels; significant levels in lung tissue and sputum
- well tolerated by most patients
- convenient b.i.d. tablet dosage
- licorice-flavored suspension well accepted by children

SEPTRA Rx Summary

INDICATIONS AND CLINICAL USES: Indicated for the following infections when caused by susceptible organisms:

URINARY TRACT INFECTIONS — acute, recurrent and chronic.
GENITAL TRACT INFECTIONS — uncomplicated gonococcal urethritis.

UPPER AND LOWER RESPIRATORY TRACT INFECTIONS — particularly chronic bronchitis and acute and chronic otitis media.

GASTROINTESTINAL TRACT INFECTIONS.

SKIN AND SOFT TISSUE INFECTIONS.

SEPTRA is not indicated in infections caused by *Pseudomonas*, *Mycoplasma* or viruses. This drug has not yet been fully evaluated in streptococcal infections.

CONTRAINDICATIONS: Patients with evidence of marked liver parenchymal damage, blood dyscrasias, known hypersensitivity to trimethoprim or sulfonamides, marked renal impairment where repeated serum assays cannot be carried out, premature or newborn babies during the first few weeks of life. For the time being SEPTRA is contraindicated during pregnancy. If pregnancy cannot be excluded, the possible risks should be balanced against the expected therapeutic effect.

PRECAUTIONS: As with other sulfonamide preparations, critical appraisal of benefit versus risk should be made in patients with liver damage, renal damage, urinary obstruction, blood dyscrasias, allergies or bronchial asthma. The possibility of a superinfection with a non-sensitive organism should be borne in mind.

DOSE AND ADMINISTRATION: Adults and children over 12 years.

Standard dosage: Two tablets twice daily (morning and evening).
Minimum dosage and dosage for long-term treatment: One tablet twice daily.

Maximum dosage:

Overwhelming infections: Three tablets twice daily.

Uncomplicated gonorrhoea: Two tablets four times daily for two days.

Children 12 years and under:¹

Young children should receive a dose according to biological age:

Children under 2 years: 2.5 ml pediatric suspension twice daily.

Children 2 to 5 years: One to two pediatric tablets or 2.5 to 5 ml pediatric suspension twice daily.

Children 6 to 12 years: Two to four pediatric tablets or 5 to 10 ml pediatric suspension or one adult tablet twice daily.

¹ In children this corresponds to an approximate dose of 6 mg trimethoprim/kg body weight/day, plus 30 mg sulfamethoxazole/kg body weight/day, divided into two equal doses.

DOSE FORMS: SEPTRA TABLETS, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole, and coded WELL-COME Y2B. Bottles of 100 and 500, and unit dose packs of 100.

SEPTRA PEDIATRIC SUSPENSION, each teaspoonful (5 ml) containing 40 mg trimethoprim and 200 mg sulfamethoxazole. Bottles of 100 and 400 ml.

SEPTRA PEDIATRIC TABLETS, each containing 20 mg trimethoprim and 100 mg sulfamethoxazole, and coded WELLCOME H4B. Bottles of 100.

Product monograph available on request.

Product monograph available on request.

 **Burrighs Wellcome Ltd.**
LaSalle, Que.

*Trade Mark

W-4046

you do not see him again for months. I have now treated several patients, with a success rate never before achieved. Should this method prove successful in other hands, it would be possible to reduce the morbidity and the social stigma of otitis media. It would also minimize hospital care and surgery.

R. GLEN GREEN, MD, CM
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Reference

1. BAIRD KA: *The Human Body and Bacteria*, Riverside, NJ, Bruce, 1968

Vitamin B₁₂ in late-onset psychosis of childhood

To the editor: I have recently found vitamin B₁₂ to be effective in treating children with late-onset psychosis.

An 11 year-old girl, referred because of inability to get along with her peers, which had led to expulsion from a Girl Guides camp, showed typical features of late-onset psychosis.¹ She had heard voices calling her name in the basement of her home and had attributed them to "somebody playing tricks" on her. She claimed that other children were preparing to attack her and saying "bad things" behind her back. On passing a total stranger in the street she asserted that she knew from his facial expression that he hated her. At home she was irritable, moody and uncooperative. She read the same fairy stories repeatedly and her drawing of a human figure was that of a queen in crown and robes. Her academic record was excellent and her intelligence quotient was 145 on the Peabody Picture Vocabulary Test.

Because she refused to take any medication apart from vitamins, I prescribed vitamin B₁₂ in an easily ingested form, not expecting that it would influence the psychosis. The plan was to substitute trifluoperazine when the habit of taking drugs twice daily had been established. On follow-up, after she had taken crystalline vitamin B₁₂ (Redisol), 75 µg *bid* for 4 weeks, the delusions and hallucinations had ceased. Her mother described the results of treatment as "amazing" and said "It's like having a different child in the house. I used to dread her coming in but now it's a happy home."

This striking improvement has been maintained for more than 12 months and vitamin B₁₂, 75 to 125 µg *bid*, is the only medication that has been administered. When the drug has been discontinued or the dosage much reduced, the parents have observed that the patient becomes moody and irritable within a few days.

Patients with late-onset psychosis usually respond to long-term treatment with phenothiazines, but since vitamin B₁₂ produces no side effects or toxic reactions a trial of this drug for 2 or 3 weeks is recommended. Recent experience with other patients suggests that

a combination of vitamin B₁₂ and trifluoperazine is effective when there is an unsatisfactory response to the vitamin alone.

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Reference

1. KOLVIN I: Studies in the childhood psychoses — diagnostic criteria and classifications. *Br J Psychiatry* 118: 381, 1971

CMA archives

To the editor: The editorial "CMA Archives" by A.W. Andison, curator of archives (*Can Med Assoc J* 113: 602, 1975), is an excellent summary of certain activities of the regional subcommittee of past presidents in the field of archives and history. As Dr. Andison points out, the CMA collection of volumes on Canadian medical history should be much more comprehensive than it is, and it is my purpose to emphasize his plea for donations to fill the yawning gaps.

It is quite possible that on the bookshelves of readers of the Journal are dusty volumes relating to the medical history of this country and its regions, many of them written by Canadian physicians. Out of print or otherwise unobtainable, these books would be welcome additions to the archives.

To illustrate, we require such classics as "Aequanimitas and Other Essays", "Life of William Osler" by Harvey Cushing, "Notes pour servir à l'histoire de la médecine dans le Bas-Canada depuis la fondation de Québec jusqu'au commencement du XIXe siècle" by Michael Joseph Ahern, "History of the Montreal Clinical Society" by Mordecai Etzioni, "A History of the medical profession of the county of Ontario" by Thomas Kaiser, "The scalpel and the sword: the story of Dr. Norman Bethune" by Ted Allan, "Henry Norman Bethune" by Roderick Stewart, and "Wilfred Grenfell; his life and work" by J. Lennox Kerr.

The above list is by no means comprehensive, and it should be clear that the appeal does not relate to your old textbooks on anatomy or physiology but to historical works with significant Canadian content. Also, it is not our desire to accumulate duplicate volumes.

Enquiries and offers should be addressed to Dr. A.W. Andison, CMA House, PO Box 8650, Ottawa, ON K1G 0G8. Such a worthy cause might even persuade me to part with a few treasures.

A.D. KELLY, MB
Honorary secretary
CMA committee on archives