

# Resolving writer's block

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## ABSTRACT

**PROBLEM BEING ADDRESSED** Writer's block, or a distinctly uncomfortable inability to write, can interfere with professional productivity.

**OBJECTIVE OF PROGRAM** To identify writer's block and to outline suggestions for its early diagnosis, treatment, and prevention.

**MAIN COMPONENTS OF PROGRAM** Once the diagnosis has been established, a stepwise approach to care is recommended. Mild blockage can be resolved by evaluating and revising expectations, conducting a task analysis, and giving oneself positive feedback. Moderate blockage can be addressed by creative exercises, such as brainstorming and role-playing. Recalcitrant blockage can be resolved with therapy. Writer's block can be prevented by taking opportunities to write at the beginning of projects, working with a supportive group of people, and cultivating an ongoing interest in writing.

**CONCLUSIONS** Writer's block is a highly treatable condition. A systematic approach can help to alleviate anxiety, build confidence, and give people the information they need to work productively.

## RÉSUMÉ

**PROBLÈME** L'angoisse de la page blanche, ou incapacité clairement gênante d'écrire, peut entraver la productivité professionnelle.

**OBJECTIF DU PROGRAMME** Identifier l'angoisse de la page blanche et suggérer des moyens diagnostiques, thérapeutiques et préventifs d'intervention précoce.

**PRINCIPALES COMPOSANTES DU PROGRAMME** Lorsque le diagnostic est posé, recommander une approche par étapes. Une évaluation et une révision des attentes, une analyse des tâches et un autofeedback positif peuvent soulager la forme légère de cette angoisse. La forme modérée fera appel à des exercices de création comme le remue-méninges et le jeu de rôle. L'angoisse réfractaire nécessitera une thérapie. Des occasions d'écrire offertes au début des projets, travailler avec un groupe de soutien et cultiver un intérêt soutenu pour l'écriture sont aussi très profitables.

**CONCLUSIONS** L'angoisse de la page blanche est une affection qui se traite facilement. Une approche systématique atténuera l'anxiété, rebâtira la confiance et offrira aux individus l'information dont ils ont besoin pour produire efficacement.

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*Cet article a fait l'objet d'une évaluation externe.*

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**W**riter's block has been informally referred to as "white page terror" and can be defined as a distinctly uncomfortable inability to write. Why does writer's block happen? What can be done when it occurs, and what steps can be taken to prevent it? This article will address these three questions.

Despite the popular view that writer's block is a relatively common problem, surprisingly little has been written on it in the medical literature. A MEDLINE search uncovered only three articles written in medical journals over the past 10 years; two were case studies,<sup>1,2</sup> and one was an editorial that concluded: "writer's block is... a serious ailment that may kill clinical scholarship and the medical profession."<sup>3</sup> My own experience, insights gained from talking with authors at writing workshops over the past few years, and a broader literature search lead me to disagree. By exploring books on the topic, the nursing literature, the Internet, and PsycINFO (for psychological abstracts), I found consistent suggestions for how to deal with writer's block.

Psychologists who have worked in this area conclude that writer's block is "not a difficult problem demanding extraordinary therapies."<sup>4</sup> Writer's block can be resolved. This article could be useful for anyone who has had difficulty writing, be it a discharge summary or a doctoral thesis. I will focus, however, on physicians writing articles for medical journals.

### Why does writer's block occur?

Writer's block is generally considered to be a stress reaction that paralyzes the ability to put thoughts into words. Medical writer and editor Elizabeth Whalen suggests that writer's block is an example of a "right brain-left brain" conflict.<sup>5</sup> The right, or creative, side of the brain, seeks to create (in this case, write). This induces the left, or analytic, side of the brain to anticipate all the problems that this action could entail, causing it to go into "overdrive" and inhibit the ability to write. An analogy might be someone who wants to drive a car on a trip. Although the car is in gear and the foot is on the gas pedal, the person is not going anywhere because anticipatory anxiety has compelled the driver to put on the emergency brake.

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### What can be done?

When you find yourself unable to write, it is important to stop and take stock. Accept the fact that writer's block happens and that it often strikes when you least expect it. Virtually every writer experiences it sooner or later, to a greater or lesser degree; this is not a cataclysmic event. It is only a glitch: rather than write a paper (as originally planned), it is now time to deal with this block systematically and effectively.

You might find it useful to think about the approach to writer's block as early diagnosis, treatment, and secondary prevention (to decrease the chance of recurrence). Treatment varies with the severity of your blockage, which can be mild, moderate, or recalcitrant (**Table 1**).

### Early diagnosis

Writer's block can present in subtle ways. There are so many demands on physicians that it is easy to think there is simply no time for writing. You might stare at the blank computer screen for 30 seconds, then suddenly remember 16 other things you have to do. Procrastination is also relatively common. It might take some introspection to acknowledge that you are really avoiding having to write. But, let's say you are prepared to admit that you simply do not want, or feel unable, to write. An important first step has been taken: you have identified a problem. You suspect you have writer's block.

First, reassure yourself that this problem can be successfully resolved with time, patience, and appropriate remediation. But before launching into a treatment plan, make sure you have made the right diagnosis. Look at the writing project you have set for yourself: are you truly interested in it? If not, consider abandoning it or delegating it to someone else. Genuine interest is a great motivator. If you decide you really do want to undertake the writing project but simply have been unable to, then you must dissolve the blockage. Sometimes all you need is a bit of a nudge to get over the block. Other times it is more difficult to work through. A progressive approach is in order; if one suggestion does not work, you simply go on to the next.

### Treatment

**Mild blockage.** Writer's block is often rooted in unrealistic expectations<sup>6</sup>; you need to be very honest in considering this possibility. Unrealistic expectations can take two forms: you either think you can write massive amounts in a single sitting or you think you can write a perfect document the first time through. Had you planned to write up your research report in

**Table 1. Strategies for overcoming writer's block****EARLY DIAGNOSIS**

Identify what is occurring

Reassure yourself that this is a temporary setback

Examine your level of interest in the project

**TREATMENT**

## Mild blockage

- Assess the appropriateness of your expectations
- Give yourself permission to be imperfect (write a draft)
- Break down the work into manageable tasks
- Sidestep what blocks you
- Give yourself positive feedback
- Optimize your conditions for writing

## Moderate blockage

- Address "imposter syndrome"
- "Talk through" your work
- Try "visioning"
- Try "mind-mapping"
- Take a break, seek laughter and relaxation

## Recalcitrant blockage

- Consider cognitive restructuring
- Consider a system of negative consequences

**PREVENTION**

Write before you have to (start early)

Work in a supportive group

Make promises to others

Draw upon previous work (eg, a grant application)

Nurture an interest in writing

Use resources for writers

one afternoon? Had you hoped to write something that would need no revision? While attractive at first glance (think of all the time that would be saved!), these scenarios actually set up expectations that are virtually impossible to reach. And if, unconsciously, you rebel against these expectations, writing will come to a halt.

If this is true for you, it is important to relinquish your perfectionist streak and set more realistic goals. Give yourself permission to be less than perfect. Tell yourself that you just want to write a first draft. Reassure yourself that it is okay that your first effort is not great; you can improve it later. And then it is always easier to revise than it is to draft.

*Cultivate patience:* Think of yourself as a sculptor. Most sculptors "see" what they want to produce in a raw stone. Yet they do not complete the top and then work down so that by the time they reach the base of the sculpture their creation is complete. Rather, they make a rough but complete outline of the form they want to create from the stone and then they go over it again and again, until it is finally completed.

Based on the theory that it is the blankness of the page (or screen) that is stultifying, you can do some simple, mechanical, mindless things. Begin with the title page. If you get stuck on the title, don't worry. Just put down a word or two associated with your study; you can work on it later. Then put yourself down as author, add other authors' names if applicable, affiliations, and where correspondence or requests for reprints should be sent. Then put in the usual headings of a scientific article: Structured Abstract, Introduction, Methods, Results, Discussion. When the page is not blank anymore, this could be enough to decrease your anxiety so you can begin to fill it in.

*Analyze tasks:* This tactic leads to the next element of the treatment strategy: task analysis.<sup>6</sup> It is useful to break down writing projects into discrete steps. You need to establish realistic expectations. Do not schedule 7 hours of uninterrupted writing. Set up a specific schedule that gives you a reasonable amount of time to finish a discrete section; a couple of hours to write the first draft of an introduction, for example. One expert recommends setting a goal of writing three pages daily.<sup>4</sup>

*Schedule breaks:* In his book, *The Writer's Way*, Rawlins<sup>7</sup> suggests ways to avoid blocking. Be flexible and creative. If you find yourself struggling over a sentence, write a note to yourself like "to rework" or "add details later" and carry on. If you get stalled writing a section, like the Introduction, try the Methods or another section that you find more immediately appealing. There is no need to begin at the beginning and write an article in sequence. Sidestep what blocks you. You can fix it later. This method will let you develop momentum with your writing and let the creative juices of the right side of the brain flow.

It is important to encourage yourself. Give yourself positive feedback. Reward yourself even for minor progress. Rosenberg and Lah<sup>6</sup> describe both overt and covert reinforcements. Overt reinforcements are rewards that one plans after completion of a task, such as going to a movie or taking a weekend off. Covert reinforcements conjure mental images that keep you motivated. For example, you could envision that your article has been completed and published and a colleague comes up to congratulate you on your excellent work.

**Assess writing conditions:** Finally, it is always good to assess your writing conditions to see whether they might be improved. Are you frequently interrupted? Do you work in a noisy, stuffy, or cold environment? These conditions are not conducive to productivity. Try to create a quiet and comfortable location for writing, ideally where you will do nothing but write.<sup>4</sup>

If all these suggestions do not help, do not worry. You simply need to go on to the next level of treatment.

**Moderate blockage.** If your writer's block does not resolve with the simple measures noted above, take stock again. Rawlins<sup>7</sup> suggests that blocked writers can suffer from "imposter syndrome." Do you feel like you are not really a writer? There are two (diametrically opposed) ways to deal with this. You can either play with the idea, and pretend that you are, in fact, someone else, or can use several methods to "find your own voice" in order to assert yourself as a "real" writer.

One of the suggested strategies in Peter Elbow's book, *Writing with Power*,<sup>8</sup> is to envision that you are someone else writing this paper. For example, imagine that you are the president of a health-related organization and you have been asked to prepare a brief for the Ministry of Health. Or imagine that you are someone you have always admired, and imagine how he or she would go about writing the project. Elbow<sup>8</sup> suggests that, by pulling yourself out of your usual perspective, you can sidestep your preoccupation with the writing block and start thinking directly about the subject again. Alternatively, you can go back to successful roles you played in the past. If you were a good student, for example, imagine that you are sitting down for an essay examination: You have 1 hour to write on your topic. You are seated and ready. The teacher states, "You may begin."

One of the most common ways to find your voice as an author is to "talk through" your work. The best way to do this is to find a sympathetic ear. Call your friends and ask them to let you explain your research project to them. The ideal person is not well versed in your area of work. Good medical writing includes clear explanations in terms that those who are not experts in the field can understand.

Alternatively, simply imagine that you are explaining this concept to a friend, one who likes you and is truly interested in your work. You might want to tape this conversation and then transcribe it. Or you could write it as a letter; begin: "Dear Julie" (and delete the salutation later). The goal is to decrease stress; a real or imagined reassuring and supportive audience will cultivate your confidence to proceed.

Let's say even this does not work. You need to break the logjam. You can try the creative exercise developed by Whalen called mind mapping.<sup>5</sup> This exercise bypasses the left (analytic or critical) side of the brain and allows you to access more directly the right (or creative) side. Take a sheet of paper and place it horizontally to change the routine way you relate to the blank page. Then, quickly jot down any thought on your research that comes to mind. This "stream of consciousness" exercise needs no logic, no defined Introduction, Methods, and Results sections. Just write down whatever comes to mind. Often this exercise begins slowly. Then suddenly the ideas begin to flow and you will find yourself writing faster and faster. This is a good sign; the dam has broken. Once all your thoughts are written down, look at your sheet. You might see a link between two thoughts. Draw a line connecting the two thoughts. Continue this process. Your left brain will get into gear now and start to organize these thoughts. You will find the paper has started to fall into place.

Occasionally, none of these suggestions works; what then? Never despair. You could simply need a break. Turn off the computer and call it a day. Go for a walk. Listen to music. Seek out a friend and share a few jokes. Laugh at yourself. Lighten up. Then the next day, try again. By then things might have unconsciously worked themselves out.

These techniques work for most people. If your problem is more deeply entrenched, you have to ask yourself what else could be at work that might explain an inordinate resistance to writing. Seek counseling. Take heart; you will not be the first. And the good news is that professional intervention is often successful.

**Recalcitrant blockage.** Professional counseling for writer's block offers at least two basic approaches; cognitive therapy and behavioural therapy. Cognitive therapy often involves developing insights into your personality structure. You might identify rigid rules or unrealistic expectations that block productivity and can then get therapy to alter these blocks.<sup>9</sup> I found no clinical study of the effectiveness of this approach.

Boice<sup>4</sup> describes a behavioural treatment of writer's block offered to 26 academicians. All had unfinished profession-related writing projects. Some were untenured and faced the possibility of losing their positions if they did not start publishing consistently. All signed a contract in which they agreed to establish a good writing environment, to schedule five periods weekly during which they would aim to complete three typewritten pages of work per period, to graph the

**Table 2. Resources for physicians who write****AMERICAN MEDICAL WRITERS ASSOCIATION**

This large organization with membership extending into Canada and Europe whose goal is to "promote standards of excellence in medical communication" offers an extensive educational program.

Address: AMWA, 9650 Rockville Pike,  
Bethesda, MD 20814 USA  
Telephone: (301) 493-0003  
Fax: (301) 493-6384  
email: [amwa@amwa.org](mailto:amwa@amwa.org)

**THE INTERNET***Writer's Block*

An on-line journal describes itself as "the creative reference for today's writers." None of the issues posted on the Internet specifically addressed writer's block; there were several articles, including one on how computers affect the work of writers; book reviews; and humorous prose.

Web address: <http://www.niva.com/writblok/>  
email: [w-block@niva.com](mailto:w-block@niva.com)

*Dissolving Writer's Block*

This is part of a general writer's guide that also includes information on grammar and punctuation.

Web address:  
<http://www.transaction.net/web/tutor/text/dissolve.html>

number of pages produced per period over the 22-week intervention, and to endure "negative contingencies"; \$15 of their personal funds would be sent to an organization that subjects had chosen as "hated" for every day in which they did not meet their goal of writing three pages. There were two periods of negative contingencies lasting 7 to 10 weeks. During the 22 weeks, there was a baseline measure, a negative contingency period, a break, and another contingency period.

The results were remarkable. Of the 26 participants, six dropped out citing lack of time or lack of interest in writing or charting. During the periods of negative contingencies, productivity consistently rose. As productivity rose, anxiety levels about writing decreased. Seventeen of the 20 subjects published at least one article in a journal or chapter in a book within 6 months of completing the treatment; most continued to write regularly in the 6 months after completing the treatment.

**Prevention**

Anyone who has experienced writer's block will readily tell you they have no desire to experience it again. Fortunately, you can do several things to prevent it.

The key to prevention is to minimize anxiety about writing, and the best way to do this is to "write as you go." For example, there is no reason why the Introduction and the Methods sections of your paper cannot be written as soon as you receive notice that you have been awarded the research grant. In fact, most of the Introduction and Methods sections can be taken from the grant application.

Another suggestion is to write the structured abstract before you have gathered a single piece of data. You can even write two structured abstracts: one for positive results, one for negative results. You can simply leave blank the spots where the numbers will appear and alter the conclusions depending on the results. The advantage of this approach is that it gives a clear focus for your research. Most people collect more data than they need to address the research question. Faced with the sheer volume of data, you can easily get lost if you haven't created a clear path through it all.

Research is often done in teams; therefore, writing can be shared. Take advantage of this factor by finding a supportive group of people with whom to work. Create a number of mini-deadlines for your tasks and then make commitments to the other members of the team. Most people are more likely to meet their commitments to others than their own vague promises to themselves.

Cultivate an interest in writing. Read books on medical writing<sup>10,11</sup> and writing in general.<sup>12,13</sup> Visit relevant on-line sites on the Internet and sign up for a workshop or conference that offers instruction in medical writing. You can join an organization like the American Medical Writers Association to take courses in this area. **Table 2** identifies how to reach this organization and other on-line resources.

**Conclusion**

Just think what a gift you would give yourself if, when the day came that the initial draft of the paper had to be prepared, you brought out the title page, structured abstract, Introduction, and Methods for the paper. You could have even convinced one of the other authors in your group to write the Results and another to check all the references. Then only the Discussion need be drafted. Although this is not a mindless task, it pales in comparison with having to write the entire paper.

**Key point**

Writers' block, whether mild, moderate, or recalcitrant, can be effectively treated.

Writer's block can be resolved. Far from being an insidious threat to academic medicine, it is a common and temporary condition that can be addressed effectively. A systematic approach to this problem can alleviate anxiety, build confidence, and give you the proper environment and knowledge you need to work productively. ♦

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 Powder for oral suspension, 125 mg/5 mL and 250 mg/5 mL  
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**ACTIONS AND CLINICAL PHARMACOLOGY** CEFZIL is a semi synthetic broad spectrum cephalosporin antibiotic intended for oral administration. It has *in vitro* activity against a broad range of gram positive and gram negative bacteria. Its bactericidal action results from inhibition of cell-wall synthesis. **INDICATIONS AND CLINICAL USE** For the treatment of the following infections caused by susceptible strains of the designated microorganisms: **UPPER RESPIRATORY TRACT:** Pharyngitis/tonsillitis caused by group A  $\beta$ -hemolytic (GABHS) *Streptococcus pyogenes*. **Otitis media** caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Moraxella (Branhamella) catarrhalis*. **Acute sinusitis** (beta-lactamase positive and negative strains) and *Moraxella (Branhamella) catarrhalis*. **SKIN AND SKIN STRUCTURE:** **Uncomplicated skin and skin-structure infections** caused by *Staphylococcus aureus* (including penicillinase-producing strains) and *Streptococcus pyogenes*. **URINARY TRACT:** **Uncomplicated urinary tract infections** (including acute cystitis) caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Proteus mirabilis*. Cultures and susceptibility studies should be performed when appropriate. **CONTRAINDICATIONS** In patients with known allergy to cephalosporins or to any component of the cefprozil preparations. **WARNINGS BEFORE INSTITUTING THERAPY, MAKE CAREFUL INQUIRY TO DETERMINE WHETHER THE PATIENT HAS HAD PREVIOUS HYPERSENSITIVITY REACTIONS TO CEFZIL, CEPHALOSPORINS, PENICILLINS, OR OTHER DRUGS. IF GIVEN TO PENICILLIN-SENSITIVE PATIENTS, CAUTION SHOULD BE EXERCISED BECAUSE CROSS-SENSITIVITY AMONG BETA-LACTAM ANTIBIOTICS HAS BEEN CLEARLY DOCUMENTED.** If an allergic reaction to CEFZIL occurs, discontinue the drug. Serious acute hypersensitivity reactions may require treatment with epinephrine and other emergency measures, including oxygen, intravenous fluids, intravenous antihistamines, corticosteroids, pressor amines, and airway management, as clinically indicated. Treatment with antibacterial agents alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of "antibiotic-associated colitis". Pseudomembranous colitis is associated with the use of broad spectrum antibiotics (including macrolides, semisynthetic penicillins and cephalosporins) and may range in severity from mild to life-threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the administration of antibacterial agents. After diagnosing pseudomembranous colitis, initiate therapeutic measures. Mild cases usually respond to drug discontinuation alone. In moderate to severe cases, consideration should be given to management with fluids and electrolytes, protein supplementation, and treatment with an oral antibacterial drug effective against *C. difficile* (e.g., metronidazole). **PRECAUTIONS General:** Evaluate renal status before and during therapy, especially in seriously ill patients. In patients with known or suspected renal impairment (see DOSAGE AND ADMINISTRATION), careful clinical observation and appropriate laboratory studies should be done prior to and during therapy. Reduce total daily dose in patients with creatinine clearance values  $\leq$  30 mL/min because high and/or prolonged plasma antibiotic concentrations can occur from usual doses. Give with caution to patients receiving concurrent treatment with potent diuretics since these agents are suspected of adversely affecting renal function. Prolonged use of CEFZIL may result in the overgrowth of nonsusceptible organisms. Observe patient carefully. If superinfection occurs during therapy, appropriate measures should be taken. Positive direct Coombs tests have been reported during treatment with cephalosporin antibiotics.


**Drug Interactions** Nephrotoxicity reported following concomitant administration of aminoglycoside antibiotics and cephalosporin antibiotics. Concomitant administration of probenecid doubled the AUC for cefprozil. If an aminoglycoside is used concurrently with cefprozil, especially if high dosages of the former are used or if therapy is prolonged, monitor renal function because of the potential nephrotoxicity and ototoxicity of aminoglycoside antibiotics. **Drug/Laboratory Test Interactions** Cephalosporin antibiotics may produce a false positive reaction for glucose in the urine with copper reduction tests (Benedict's or Fehling's solution or with Clinitest tablets), but not with enzyme-based tests (glucose oxidase) for glycosuria. A false negative reaction may occur in the ferricyanide test for blood glucose. The presence of cefprozil in the blood does not interfere with the assay of plasma or urine creatinine by the alkaline picrate method. **Use in Pregnancy:** Use only if the potential benefit justifies the potential risk. **Nursing Mothers:** Caution should be exercised. Consider temporary discontinuation of nursing and use of formula feeding. **Pediatric Use:** Safety and effectiveness in children below the age of 6 months not established. Accumulation of other cephalosporin antibiotics reported in newborn infants. **Geriatric Use:** Reduction of dose or frequency of administration may be indicated. **ADVERSE REACTIONS** Similar to those observed with other orally administered cephalosporins. Cefprozil was usually well tolerated in controlled clinical trials. Approximately 2% of patients discontinued cefprozil therapy due to adverse events. The most common adverse events: **Gastrointestinal:** Diarrhea (2.7%), nausea (2.3%), vomiting (1.4%), and abdominal pain (0.9%). **Hepatobiliary:** cholestatic jaundice reported rarely. **Hypersensitivity:** Rash (1.2%), erythema (0.1%), pruritus (0.3%) and urticaria (0.07%) reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. **CNS:** Dizziness, hyperactivity, headache, nervousness, insomnia, confusion, and drowsiness reported rarely (< 1%) and causal relationship is uncertain. All were reversible. **Other:** Genital pruritus (0.8%) and vaginitis (0.7%). **Laboratory Abnormalities** Transitory abnormalities have been reported as follows: **Hematology:** Elevations of AST, ALT, alkaline phosphatase, and bilirubin. **Hematopoietic:** Transiently decreased leukocyte count and eosinophilia. **Renal:** Slight elevations in BUN and serum creatinine. **Adverse reactions reported from post-marketing experience and which were not seen in the clinical trials** include serum sickness, pseudomembranous colitis, Stevens Johnson syndrome and exfoliative dermatitis. The association between these events and CEFZIL administration is unknown. In addition to the adverse reactions listed above, the following adverse reactions and altered laboratory tests have been reported for cephalosporin-class antibiotics. Anaphylaxis, erythema multiforme, toxic epidermal necrolysis, fever, renal dysfunction, toxic nephropathy, aplastic anemia, hemolytic anemia, hemorrhage, prolonged prothrombin time, positive Coombs' tests, elevated LDH, pancytopenia, neutropenia, agranulocytosis, thrombocytopenia. Several cephalosporins have been implicated in triggering seizures, particularly in patients with renal impairment, when the dosage was not reduced. (See DOSAGE AND ADMINISTRATION). If seizures associated with drug therapy occur, discontinue drug. Anticonvulsant therapy can be given if clinically indicated. **DOSAGE AND ADMINISTRATION:** Administered orally (with or without food), in the treatment of infections due to susceptible bacteria in the following doses: **Adults (13 years and older)** Upper respiratory tract (pharyngitis/tonsillitis): 500 mg q24h. Acute sinusitis: 250 or 500 mg q12h. Skin & skin structure: 250 mg q12h or 500 mg q24h. Uncomplicated urinary tract: 500 mg q24h. **Children (2 years - 12 years)** Skin & skin structure: 20 mg/kg q24h. **Infants and children (6 months-12 years)** Otitis media: 15 mg/kg q12h. Upper respiratory tract (pharyngitis/tonsillitis): 7.5 mg/kg q12h. Acute sinusitis: 7.5 mg/kg

q12h or 15 mg/kg q12h. The maximum pediatric daily dose should not exceed the maximum daily dose recommended for adults (i.e. 1 g per day). **Duration of Therapy:** 10 to 15 days. Duration should be guided by the patient's clinical and bacteriological response. In the treatment of acute uncomplicated cystitis, a 7 day oral therapy is usually sufficient. In the treatment of infections due to *Streptococcus pyogenes*, administer a therapeutic dosage for at least 10 days. **Renal Impairment:** May be administered to renally impaired patients. No dosage adjustment is necessary for patients with creatinine clearance values > 30 mL/min. For those with creatinine clearance values  $\leq$  30 mL/min, 50% of the standard dose should be given at the standard dosing interval. Cefprozil is in part removed by hemodialysis; therefore, administer after the completion of hemodialysis. **PHARMACEUTICAL INFORMATION** **STORAGE:** Store tablets and powder for oral suspension at room temperature (15 - 30°C) and protect from light and excessive humidity. **RECONSTITUTION:** Prior to dispensing, the pharmacist must constitute the dry powder with water as follows:

CEFZIL powder for oral suspension	Bottle size (mL)	Diluent (water) added to bottle (mL)	Approximate available volume (mL)	Final concentration
125 mg/5 mL	75	54	75	125 mg/5 mL
	100	72	100	125 mg/5 mL
250 mg/5 mL	75	54	75	250 mg/5 mL
	100	72	100	250 mg/5 mL

For ease in preparation, the water can be added in two portions. Shake well after each addition and prior to use. **STORAGE OF RECONSTITUTED SUSPENSION:** Store the constituted CEFZIL oral suspension in the refrigerator (2°C - 8°C) for up to 14 days. Keep container tightly closed. Discard unused portion after 14 days. **AVAILABILITY:** CEFZIL (cefprozil) 250 mg tablets are light orange, caplet-shaped, film coated tablets embossed in red ink with 7720 and BMS 250. CEFZIL (cefprozil) 500 mg tablets are white, caplet-shaped, film coated tablets embossed in red ink with 7721 and BMS 500. CEFZIL 250 mg and 500 mg tablets are available in bottles of 100. CEFZIL powder for oral suspension contains cefprozil, in a bubble-gum flavored mixture, equivalent to 125 mg or 250 mg cefprozil per 5 mL of constituted solution. Available in bottles of 75 and 100 mL. Product Monograph available to physicians and pharmacists upon request.

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**Bristol-Myers Squibb**  
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