

ROTER

IN PEPTIC DISORDERS

does more than just relieve pain



Each tablet contains: Bismuth
Subnitrate Roter (350 mg.),
Magnesium Carbonate (400 mg.),
Sodium Bicarbonate (200 mg.) and
Cortex Rhamni Frangulae (25 mg.).

Packings: Tins of 40 and 120, also
dispensing sizes, 360 and 720
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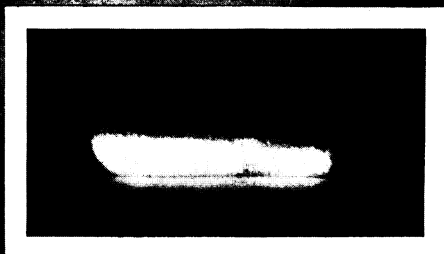
ROTER tablets quickly overcome the pain and discomfort of minor gastric disturbances, but their true value is most evident in their control and frequent healing of peptic ulcer in both the early and the advanced or chronic stages. With Roter therapy, hospitalisation or surgery is mostly avoided; the patient remains ambulant and uncommitted to a restricted or prescribed diet; and recurring medical attention is usually obviated. Roter is worth remembering for your "gastric" patients.

Literature will be supplied on request from:-

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new-
DUOGASTRONE®

introduces direct
healing for
duodenal
ulcers



DUOGASTRONE[®]

introduces specific therapy for duodenal ulcers

DUOGASTRONE has a direct, rapid healing action which can obviate the need for symptomatic medication, bed rest and dietary restriction in the treatment of duodenal ulcers.

The active constituent, carbenoxolone sodium, has been described as the only drug to heal gastric ulcers.¹ Now, by means of a specially designed 'positioned release' capsule, DUOGASTRONE delivers this unique active healing agent directly to the site of duodenal ulceration. Absorbing moisture from the stomach, the DUOGASTRONE capsule swells to a size which prevents its passage through the pyloric canal. At the pyloric antrum – the pressure of the sphincter and the intracapsular pressure combine to break open the capsule – releasing a concentrated solution of carbenoxolone sodium directly into the duodenum.²

Patients feel the benefit of DUOGASTRONE therapy within a few days. Freed from distressing symptoms they go about their normal activities whilst healing proceeds. Objective improvement – as evidenced by disappearance of the ulcer crater – is often seen within four weeks.³

Including the published results of a double-blind trial² the over-all success rate with DUOGASTRONE was 87%.

DUOGASTRONE capsules, each containing 50 mg carbenoxolone sodium. Containers of 28 capsules.

References

¹ Gut (1965) 6:19.

² Practitioner (1967) 199:109.

Additional information on request from:



Berk Pharmaceuticals Limited, Godalming, Surrey

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**CAVED-(S) THE LIQUORICE THERAPY,
NO SIDE EFFECTS EVER REPORTED i.e., OEDEMA,
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More than 10 written up Hospital Trials, including four
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Good results obtained with all age groups and chronic cases.

**Offers safe ambulant treatment without diet,
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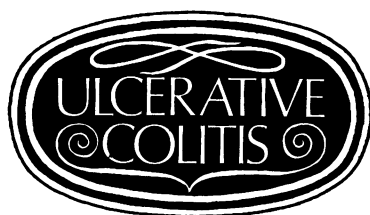
Very good in vivo acid control. Powerful spasmolytic action.
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Early warning campaign page vii

"Ulcerative colitis is one of the greatly misunderstood diseases of today. It is mistakenly thought to be rare only because it is not recognised often in its early stages. This is unfortunate, as many patients respond well to medical treatment if the disease is recognised in time. With proper management, most of them can avoid surgery."¹

"It is also felt that the incidence is increasing."²

As with any disease, early diagnosis and immediate initiation of definitive therapy is essential. Prompt action will reduce the number of fulminating cases and benefit both the patient and the physician. To secure earlier hospital referrals general practitioners are now being alerted by an extensive information campaign detailing the symptoms of the disease.

The acute attack page vi

"Ulcerative colitis is a formidable disease which carries a greatly increased risk of death throughout the whole period of follow up."³

The rational approach to therapy of ulcerative colitis is to use a drug with a specific affinity for connective tissue especially the colonic submucosa. Salazopyrin is such a drug. ⁴ Results of Salazopyrin treatment are often dramatically successful. ⁵

The relapse page viii

Details of "the first demonstration in a formal trial that any treatment reduces the relapse-rate in ulcerative colitis."⁶

1. Postgrad. Med., 1960, 28, 157

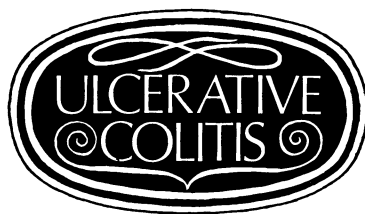
2. Proc. roy. Soc. Med., 1966, 59, 369

3. Gut, 1963, 4, 299

4. Acta Med. scand., 1963, 173, 61 and 391

5. From Gastroenterology Vol II, W. B. Saunders Company Philadelphia 1964, p. 863

6. Lancet, 1965, i, 185



The acute attack

Achieving Remission

Salazopyrin has a marked affinity for connective tissues. Very high concentrations of Salazopyrin are found in the intestines and intestinal lumen, and unlike ordinary sulphonamides, Salazopyrin exhibits a prolonged retention in the colonic submucosa. ¹

The results of Salazopyrin treatment of ulcerative colitis are often dramatic. Within two or three days, the number of stools decreases, abdominal cramps disappear, the fever subsides and the appetite improves. ²

The auxiliary rôle of steroids in fulminating cases must not be overlooked, but their action is essentially suppressive rather than curative. ³ Successful results are reported with the combined use of Salazopyrin and steroids. ^{4, 5}

However, the mild and moderate acute attacks are best treated with Salazopyrin alone. ^{6, 7}

A high percentage of patients respond to medical treatment but more than 80% will have a relapse within one year unless treatment is continued beyond the acute attack. ⁸ (see following pages)

Dosage for the Acute Attack

Two to four tablets (1 g to 2 g) four to six times daily. The dosage should be adjusted according to the patient's needs. This is decreased to the maintenance dose (2 g daily) as the patient improves. At any indication of a relapse, however, the dosage should be increased to the maximum tolerated level.

1. Acta Med. scand., 1963, **173**, 61 and 391

2. From Gastroenterology Vol II, W. B. Saunders Company Philadelphia 1964, p.863

3. New Engl. J. Med., 1964, **271**, 891

4. Brit. med. J., 1962, *ii*, 1708

5. Dallas Med. J., 1964, **50**, 240

6. Proc. roy. Soc. Med., 1960, **53**, 647

7. Gut, 1960, **1**, 217

8. Gut, 1963, **4**, 299

The patient with ulcerative colitis is usually pale, tense, depressed and exceedingly disturbed emotionally.

He is weak and beset by many problems (some real and some imaginary).

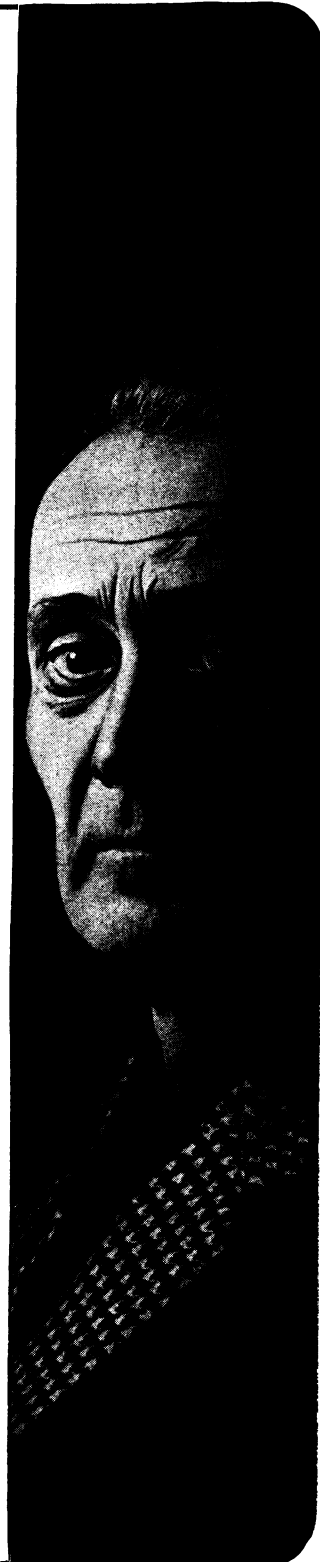
His intestines are inflamed and infected. He passes very frequent bloody and pus-ridden stools. One bowel action often precedes another. He may exhibit rectal tenesmus.

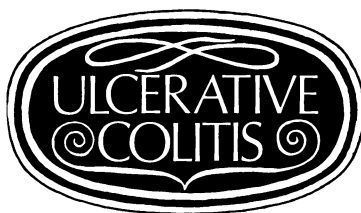
The condition will also manifest itself by loss of weight, anorexia, anaemia, abdominal cramps and fever.

Examination reveals malnutrition, dehydration, abdominal tenderness and increased bowel sounds. The rectal mucosa has a granular feel.

Mild and moderate cases may only have some of these symptoms.

THIS NOTICE IS CURRENTLY
BEING BROUGHT TO THE ATTENTION
OF GENERAL PRACTITIONERS
WITH THE OBJECT OF CREATING
GREATER AWARENESS OF
ULCERATIVE COLITIS





The relapse

Maintaining Remission

Most ulcerative colitis patients will respond to medical treatment but more than 80% will have a relapse within 1 year unless the treatment is continued beyond the acute attack.

Salazopyrin is the *only* preparation which is suitable for the long-term treatment of the ulcerative colitis patient.

"This is the first demonstration in a formal trial that any treatment reduces the relapse rate in ulcerative colitis . . . it therefore appears preferable to systemic corticosteroids, for this purpose.

24 (out of 34) patients remained in symptomatic remission for a year while taking 2 g of Salazopyrin daily whereas only 8 (out of 33) remained symptom free in the placebo group.

22 out of the 24 patients on Salazopyrin who remained in remission at the end of the trial had a non-haemorrhagic mucosa which, in many cases, appeared normal.

. . . only 3 patients out of 34 had to discontinue treatment because of side-effects.

In the patients treated with Salazopyrin, there was no difference in the haemoglobin level before and after treatment; but the mean white-cell count was lower after 6 months or a year than at the start of the treatment, though in no patient was it less than 4500 per c. mm."

Lancet, 1965, i, 185

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Salazopyrin (sulphasalazine) is available as both the plain 0.5g tablet or as the 0.5g En-tablet. The latter is enteric coated and has been specifically designed for use in the patient who may exhibit gastro-intestinal intolerance to the plain tablet.
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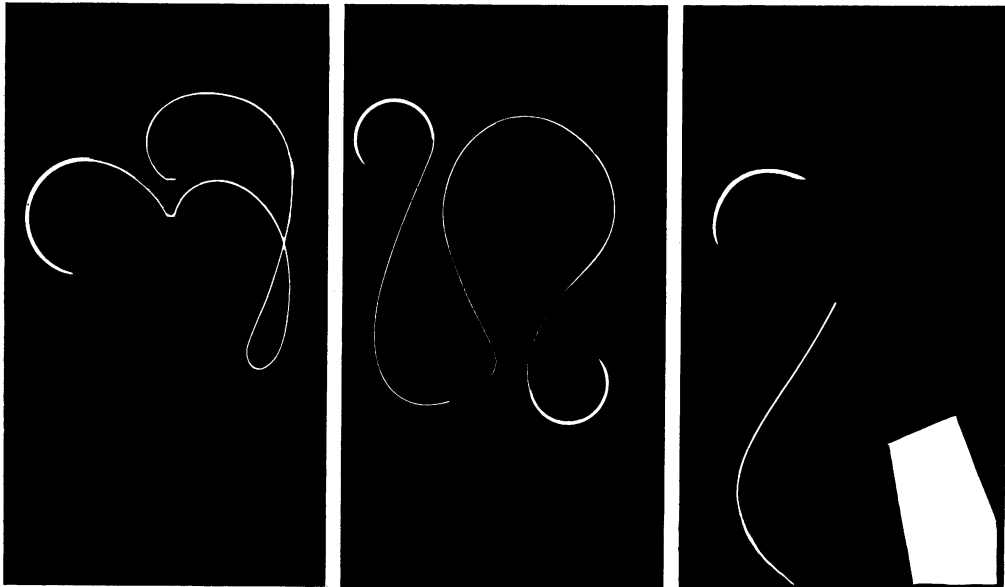
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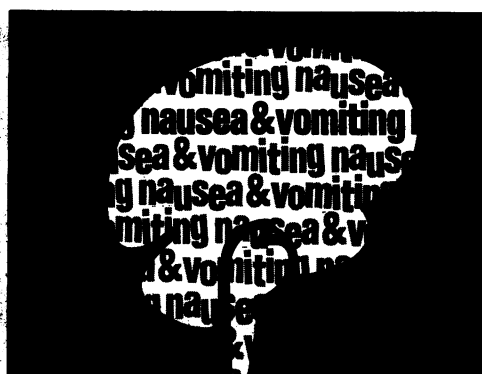
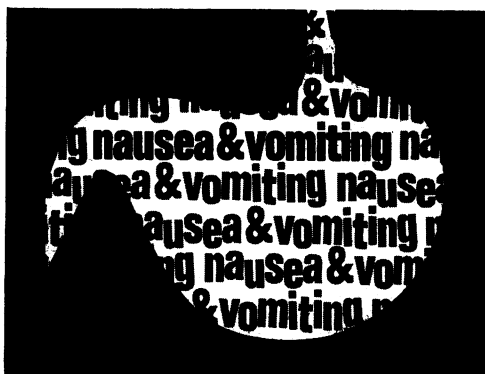
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- ☐ Maxolon rapidly controls vomiting, whether due to local or blood-borne irritants.
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- ☐ Maxolon does not sedate at the recommended dose.
- ☐ Maxolon neither affects gastric secretions nor causes dryness of the mouth.

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Nausea and vomiting due to:

- Gastro-intestinal disorders.
- Intolerance to essential drugs.
- Malignant disease.
- Uraemic conditions.
- Post-operative conditions.
- Deep X-ray or Cobalt therapy.

N.B. Maxolon is not so effective in vomiting of labyrinthine origin such as travel sickness, vertigo and Ménière's disease.

Contra-indications: Although animal tests in several mammalian species have shown no teratogenic effects, Maxolon, like all new drugs,

is not recommended during the early weeks of pregnancy.

Precaution: As both Maxolon and the phenothiazines may occasionally cause benign transient dystonia, care should be exercised in the event of both drugs being prescribed concurrently.

Dosage:

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Oral: 1 tablet (10mg.) or two teaspoonfuls (10mg.) of syrup, three times daily.

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Children:

5-14 years, $\frac{1}{2}$ -1 teaspoonful of syrup (2.5-5mg.), three times daily.

Information on other dosages is available on request from the Company's Medical Department.

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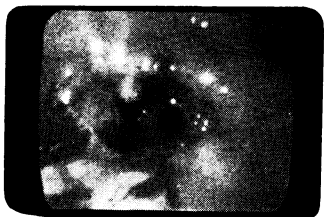
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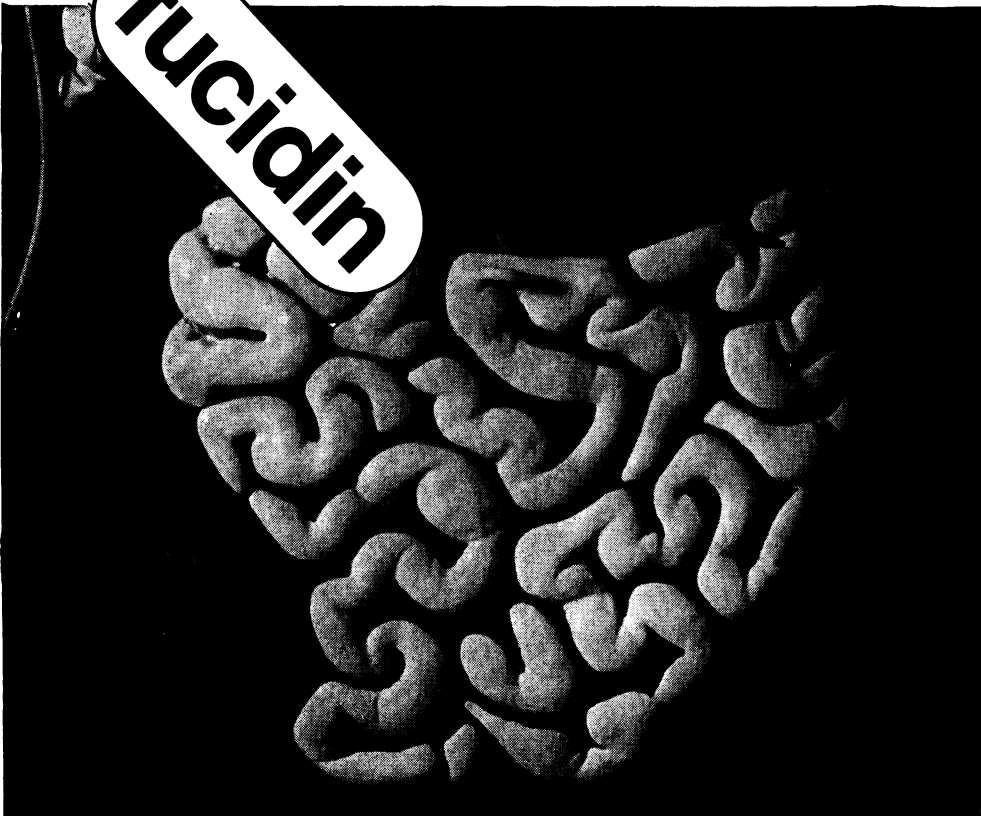
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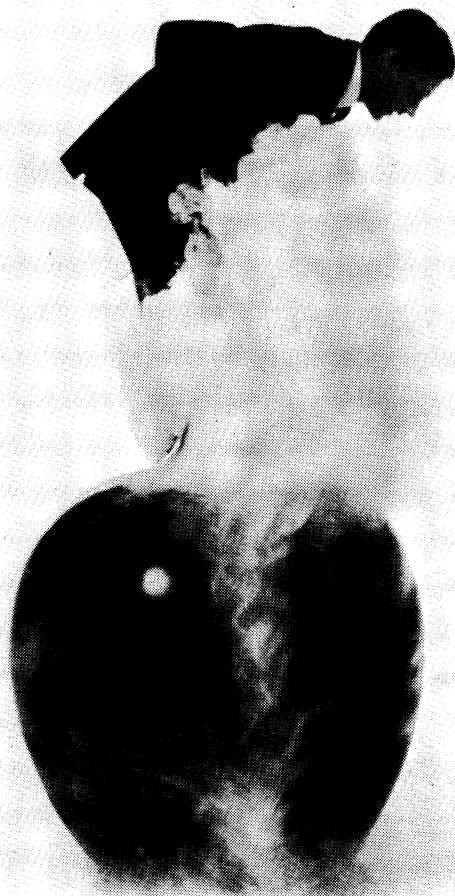
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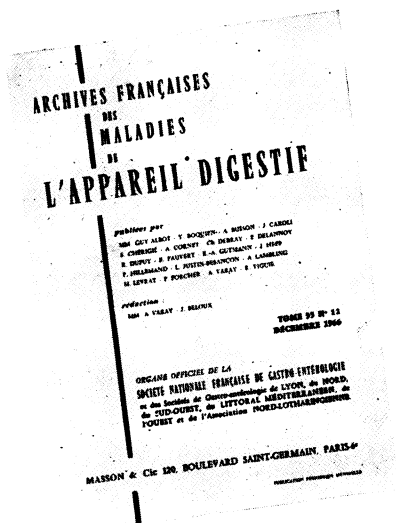
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References: (1) *Nutritio et Dieta* 1961; **3**, 89.
(2) *Lancet* 1959, **2** 849; 1960 **1**, 336.
(3) *Ugeskrift f. Læger* 1960, **122**, 1229.

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¹ (1958) *Ann. Inst. Pasteur* **95**, 194.

² (1959) *J. Bact.* **78**, 477.

³ (1957) *Klin. Wschr.* **35**, 198.

⁴ (1959) *Medizinische* **7**, 296.

⁵ (1957) *Lancet* (i), 899.



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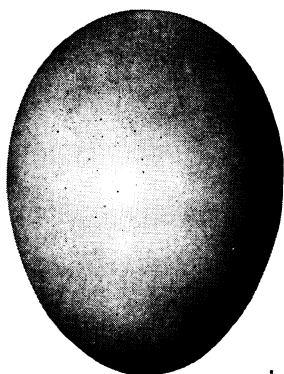
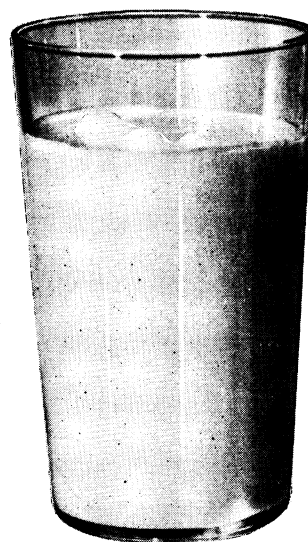
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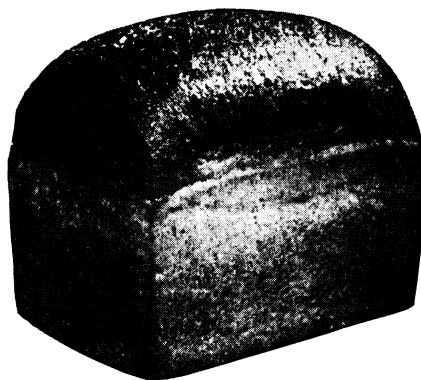


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References: *Diseases of Children* (1964), Blackwell, Oxford. *Diseases of Infancy and Childhood*. 8th Edn. (1962), Churchill, London. *Lancet* (1960), 1, 365. *Brit. Med. J.* (1958), 2, 1039

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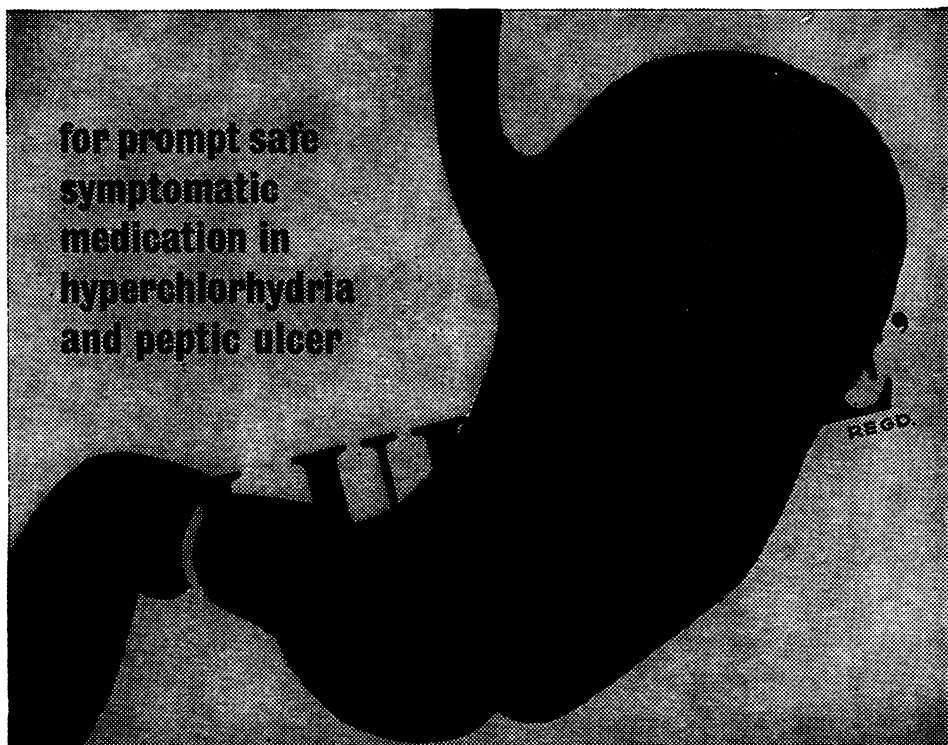
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