

sexual precocity and masculinization of young females and that labeling with respect to Elipten does not cover all claimed adverse reactions. We are studying these questions raised by the Food and Drug Administration and have agreed to their request that we immediately withdraw all supplies of Elipten from the market.

Because all Elipten stock is being withdrawn, your patients will not be able to refill their present supplies. However, the Food and Drug Administration has agreed that we furnish physicians who request it sufficient supplies to permit patients now on Elipten to be tapered off and transferred to other anticonvulsant therapy. In this connection we draw to your attention the following precaution stated in our Elipten labeling:

"At no time should anticonvulsant drugs be abruptly withdrawn, as this may precipitate a marked increase in frequency of seizures or even status epilepticus."

On the basis of your own experience and in the light of this recall, we trust that you will be able to make whatever adjustments in your patients' therapeutic regimen you deem advisable.

Any stock of Elipten in your possession should be returned to CIBA Pharmaceutical Company, 556 Morris Avenue, Summit, New Jersey, Attention: Return Goods Department.

Sincerely,

C. H. SULLIVAN, M.D.,
Director, Drug Regulatory Affairs.

EATON LABORATORIES,
DIVISION OF THE NORWICH PHARMACAL CO.
Norwich, N.Y., January 18, 1966.

URGENT: DRUG RECALL, FURACIN OPHTHALMIC LIQUID

DEAR DOCTOR: Several recently manufactured lots of Furacin Ophthalmic Liquid have had a significant decrease in potency since the date of manufacture. Please destroy any samples in your possession.

We have temporarily suspended all sales of this product and have withdrawn all existing stock from the market. We have resolved the difficulty and will resume distribution shortly. In the meantime, prescriptions for this product will not be filled and its use should be discontinued.

This notice pertains to Furacin Ophthalmic Liquid only, not to Furacin Ophthalmic Ointment.

We regret that this is necessary. We shall continue to expend our best efforts to assure you of safe and effective products, always resolving any doubts in favor of your patient's safety and better treatment.

EATON LABORATORIES.

LEDERLE LABORATORIES,
DIVISION, AMERICAN CYANAMID Co.,
PEARL RIVER, N.Y.,
PARKE, DAVIS & Co.,
DETROIT, MICH.,
ROCHE LABORATORIES,
DIVISION OF HOFFMANN-LA ROCHE INC.,
NUTLEY, N.J.,
January 11, 1966.

DRUG WARNING

DEAR DOCTOR: Since 1957 to date, reports in the medical literature have been accumulating concerning the occurrence of Stevens-Johnson syndrome (erythema multiforme exudativum) associated with the use of long-acting sulfonamides.

This is a serious complication since it carries a mortality rate of approximately 25 per cent. To date, 116 cases of Stevens-Johnson syndrome (including 81 cases from the United States) have been reported in association with the use of long-acting sulfonamides. Almost two-thirds of the reported cases were children. In addition to the Stevens-Johnson syndrome, it is also known that serious blood dyscrasias, including aplastic anemia, agranulocytosis, pancytopenia and thrombocytopenia can occur. We are, therefore, taking this opportunity to bring