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when urinary
tract
infections
present
a therapeutic
challenge...

CHLOROMYCETIN®

(chloramphenicol, Parke-Davis)

Often recurrent... often resistant to treatment, urinary tract infections are among the most frequent and troublesome types of infections seen in clinical practice.^{1,2} In such infections, successful therapy is usually dependent on identification and susceptibility testing of invading organisms, administration of appropriate antibacterial agents, and correction of obstruction or other underlying pathology.

Of these agents, one author reports: "Chloramphenicol still has the widest and most effective activity range against infections of the urinary tract. It is particularly useful against the coliform group, certain *Proteus* species, the micrococci and the enterococci."¹ CHLOROMYCETIN is of particular value in the management of urinary tract infections caused by *Escherichia coli* and *Acrobacter aerogenes*.³ In addition to these clinical findings, the wide antibacterial range of CHLOROMYCETIN continues to be confirmed by recent *in vitro* studies.⁴⁻⁶

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals[®] of 250 mg., in bottles of 16 and 100. See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections, such as colds, influenza, or viral infections of the throat, or as a prophylactic agent. **Precautions:** It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Mahne, F. J., Jr.: *Mil. Med.* 125:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* 34:187, 1959. (3) Ullman, A.: *Delaware M. J.* 32:97, 1960. (4) Peterdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* 108:48, 1961. (5) Julliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* 10: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* 11:392, 1960.

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