























	COMPLAINT & TREATMENT NOTES		DRUGS OF CHOICE		USUAL DOSE Adult / Pediatric (Daily MAXIMUM)	\$ / pkg	COMMENTS 	
			GENERIC NAME <small>Pregnancy 7,8,9,10,11 category ↓</small>	TRADE NAME				
COLDS	CONGESTION ♦ nasal decongestants: Cochrane Review ⁷³ : single dose in adults moderately effective for cold (13% ↓ symptoms); not for children (especially <2yrs) with common cold (reports of CNS & CV SE's) ♦ oral – limited data, especially in children ⁷⁶ ♦ limit nasal preps to 3-7 days to avoid problems with rebound congestion (≤ 3 days with phenylephrine) ♦ antihistamines of questionable benefit in common cold ⁷² ; anticholinergic activity provides extra drying (? benefit) ♦ saline drops/spray: option; some effect ♦ sinus saline irrigation (Neti Pots): option ♦ thin film forms: handy, different ingredients	ORAL	♦ Pseudoephedrine   -diverted for meth. labs	SUDAFED (12hr formulation and pediatric tabs also available)	60mg q4-6h or 120mg q12h; MAX 240mg/d 2-5 yrs: 15mg q4-6h; MAX 60mg/day 6-11 yrs: 30mg q4-6h; MAX 120mg/d	6-8	♦ SE = insomnia, tremor, irritability & headache ♦ oral decongestant: caution in pts with ↑ BP, heart Dx, β-blockers ⁵⁶ , hyperthyroidism, diabetes, glaucoma ^{narrow angle} & prostatic hypertrophy ♦ nasal agents : less systemic absorption & SE (Phenylpropranolamine: products withdrawn; ↑ d stroke rare in ♀ <50yrs) ⁸⁴ COMBINATION PRODUCTS : generally not recommended - less flexibility in dosing, more adverse effects ; however, convenient for multiple symptoms e.g. acute sinusitis & associated headache { ADVIL COLD & SINUS ibuprofen 200mg + pseudoephedrine 30mg} ♦ decongestant + antihistamine 1 st Gen most common, some benefit in acute cough due to common cold & cough due to post-nasal drip ¹³ (effective in older children & adults, but not in <6yrs ^{72,76}) ♦ expectorant + cough suppressant may not be rational ♦ Some products have 4 drugs in one formulation: e.g. TYLENOL COLD (acetaminophen, chlorpheniramine, pseudoephedrine, DM) ♦ Pediatric Cautions: lack of efficacy data; toxicity & overdose potential if using multiple cold products ⇒ Health Canada & FDA: not to use cough & cold products in kids <2yr old ²⁰⁰⁷ ; companies say <4yr. ♦ sugar & alcohol in some products may be of concern in diabetes & kids (some >14 kcal/dose) ♦ Codeine preps: SE = drowsiness, nausea, constipation; not recommended in asthmatics; caution if breastfeeding ♦ Rx Salbutamol VENTOLIN may help: cough if also airway obstruction in acute bronchitis ^{44,15} ; or for cough due to chronic bronchitis. ¹³ in general, products designated with: DM contain Dextromethorphan (suppressant) D contain a decongestant E contain an expectorant (ie. Guaifenesin)	
			♦ Phenylephrine  (Note: short acting)	DIMETAPP [▼] Cold Versions DRISTAN reg tabs	10mg q4h; MAX 60mg/day 2-5 yrs: 2.5mg q4h; MAX 15mg/day 6-11 yrs: 5mg q4h; MAX 30mg/day	5-7		
			NASAL	♦ Oxymetazoline 	DRISTAN LONG LASTING NASAL MIST	2-3 drops or sprays q10-12h up to BID MAX 2 applications/24hrs Adults: 0.05% Peds: 0.025% ≥2yr 2drop		5-7
				♦ Xylometazoline 	OTRIVIN	2-3 drops or sprays q8-10h up to TID Adults: 0.1% Peds: 0.05% ≥6month 2 drop		5-7
				♦ Saline Nasal Spray 	SALINEX [▼] 	1 spray TID-QID PRN		5
				♦ Nasal Phenylephrine (eg. REGULAR DRISTAN NASAL MIST) not recommended - short duration, frequent admin, rebound congestion more likely				9
	COUGH ♦ acute (ie. <3-8wks duration) usually due to self-limiting viral infection ♦ chronic ^{13,86} (>8wk) usually symptom of underlying resolvable cause: -drugs (ACEI's - persists <4wks after stopping) -GERD, asthma, COPD (smokers), allergy - postnasal drip (UACS) upper airway cough syndrome Treat underlying cause; interim use of antitussives may be warranted. ♦ hydration: oral liquids & humidified air ♦ honey: Age 2-5: ½ teaspoonful; Avoid in infants: botulism ♦ Rx prep (↑ codeine doses- TYLENOL #3); (hydrocodone ^{combos} - Tussionex , Novahistex DH) (hydrocodone: HYCODAN 5mg ^C tab; 1mg/ml susp)	Evidence for clinical effectiveness of OTC products in acute cough is limited & conflicting. ^{12,74,92}	♦ Dextromethorphan (DM)   abuse concerns ¹¹⁷	BENLYN DM [▼] {12hr formulations: BENLYN DM 12hr , DELSYM DM 12hr... 2 tsp (60mg) po BID}	10-20mg q4h; 30mg q6-8h MAX 120mg/d 2-5yrs: 2.5-5mg q4h or 7.5mg q6-8h; MAX 30mg/d; 6-11yrs: 5-10mg q4h or 15mg q6-8h; MAX 60mg/d	6-10		
			♦ Guaifenesin - not a suppressant but reduces viscosity & may aid in expectoration of sputum	ROBITUSSIN (plain)	200-400mg q4-6h; MAX 2.4g/day 2-5 yrs: 50-100mg q4-6h; MAX 600 mg/day 6-11 yrs: 100-200mg q4-6h; MAX 1.2 g/day	6-10		
			♦ Codeine – avail. OTC in 3.3mg/tsp liquid formulas with ≥ 2 other active ingredients (eg. Benlyn Codeine , Robitussin with Codeine) 	Effective dose of codeine = 10-20mg q4h; MAX 120mg/d 2-5 yrs: 1-1.5mg/kg/d (use calibrated syringe for measuring); 6-11 yrs: 5-10mg q4-6h; MAX 60mg/d. Contraindicated: <2yrs. Label dosing guidelines of most OTC [codiene containing] cough syrups results in subtherapeutic levels of codeine in adults. Effective dose of hydrocodone ^{more potent.} ≥12yrs 5mg q4-6h prn; 2-12yrs: 1mg - 2.5mg q4-8h; MAX 15mg/day (use calibrated syringe for measuring)		5-9		
			♦ Diphenhydramine also option					
ALLERGY –SYSTEMIC ^{5,16-24,99,142} ♦ oral antihistamines relieve all (to some extent) allergic symptoms except nasal congestion (exceptions: desloratadine ²⁵ & cetirizine ²⁶ may aid congestion). If acute congestion, consider short-term oral decongestant (avoid topical decongestants). ♦ ↑ efficacy if used prophylactically {Terfenadine SELDANE , astemizole HISMANAL no longer marketed due to rare risk of arrhythmias} ♦ Rx SINGULAR ²⁷ ²⁸ ²⁹ - less effective than INCS; ²⁷⁻²⁹	1st Generation oral: ♦ Chlorpheniramine  ♦ Diphenhydramine  2nd Generation oral: ♦ Cetirizine ^{hydroxyzine metabolite} Useful: nasal congestion, sedating @ 1 doses  ♦ Fexofenadine ^{terfenadine metabolite} DI: grapefruit & other juices, antacids   ♦ Loratadine  -possibly sedating @ 1 doses  ♦ Desloratadine ^{loratadine metabolite} Useful: nasal congestion ²² -possibly sedating @ 1 doses 	CHLORTRIPOLON [▼] (12hr Repetabs also – 1 tab (12mg) po BID; syrup; tabs)	4mg q4-6h; 4-8mg @hs; MAX 24mg/day 2-5yrs: 1mg q4-6h; MAX 6mg/d 6-11 yrs: 2mg q4-6h; MAX 12mg/d	8-12				
		BENADRYL [▼] syrup, cap, tab -esp. for anaphylactic reactions	25-50mg q4-6h; MAX 150mg/day 2-5yrs: 6.25mg q4-6h; MAX 25mg/d 6-11 yrs: 12.5mg q4-6h; MAX 75mg/d 5-10mg OD; 2-5yrs: 2.5mg OD-BID	6-8				
		REACTINE [▼] tab ^C ; syrup	60mg BID or 120mg OD 6-11yrs: 30mg BID; <6yr not recommended	10-15				
		ALLEGRA [▼] tabs	10mg OD (kids >30kg: 10mg od) 2-9yrs: 5mg OD (tabs: tasteless & chewable)	10-15				
		CLARITIN [▼] reg. & dissolve tabs; syrup	10mg OD (kids >30kg: 10mg od) 2-9yrs: 5mg OD (tabs: tasteless & chewable)	12-15				
		AERIUS 5mg tabs, liquid	5mg OD 2-5yr: 1.25mg OD; 6-11yr: 2.5mg	18				
		Also remember environmental factor modification!						
		Rx Intranasal Steroid (INCS) : (for allergic rhinitis) Beclomethasone [†] , FLONASE [†] , NASOCORT [†] , NASONEX [†] , RHINOCORT [†] , RHINALAR [†] ; others see INCS chart. Rx anticholinergic nasal for rhinorrhea: ATROVENT [†] .						
		Rx Ophthalmics : H ₁ blockers: LIVOSTIN [▼] expiry 30day (also Livostin nasal [†]), EMADINE [†] ; H ₁ & Mast Cell: ZADITOR [†] , PATANOL [†] ; Mast Cell ^{slow onset} : ALOMIDE [†] , ALOCRIL [†] .						
		♦ Avoid OTC topical decongestants due to rebound (Vasocon-A , Naphcon-A , Albalon-A [▼] ...) ♦ may require short term oral decongestants ♦ Saline/Lubricating Sprays/Drops	♦ Sodium cromoglycate  CROMOLYN OPTICROM [▼] Mast cell stabilizer	Adults & ≥2yr: 1 spray each nostril QID ^{3,5} 1-2 eye drops qid ^{expiry in 1 month after opened}	15-17			
	♦ Saline solution  ♦ Methylcellulose... 	Use, wash out & flush as necessary - also EYELUBE [▼]	7 9					

Rx = non-OTC products available by prescription in Canada; see page 85 for description of additional abbreviations

	COMPLAINT & TREATMENT NOTES	DRUGS OF CHOICE	USUAL DOSE Adult / Pediatrics (Daily MAXIMUM)	\$	COMMENTS	
GASTRO-INTESTINAL	DYSPEPSIA ^{35,36,57} (non-ulcer) <ul style="list-style-type: none"> antacids & OTC histamine-2 receptor antagonists (H2RAs) effective for mild-moderate episodic heartburn & GERD; more severe cases require appropriate assessment + Rx therapy important to avoid precipitating and aggravating factors (eg. stop smoking) persistent symptoms should be self-medicated for no longer than 2wks before seeking medical evaluation 	Antacids/Protectants <ul style="list-style-type: none"> Magnesium-aluminum hydroxide antacids B Pepcid Complete = (famotidine/calcium carb. magnesium hydroxide; 10 tabs ≈ \$9) <ul style="list-style-type: none"> Alginates B OTC H2RAs <ul style="list-style-type: none"> Famotidine B Ranitidine B 	MAALOX MYLANTA In both tablet & liquid form; liquid most efficacious. <ul style="list-style-type: none"> GAVISCON PEPCID AC ZANTAC 75 	4-10 8-12 6-10 4-6	• Mg+Al antacids preferred as constipating effect of Al ⁺ counterbalanced by laxative effect of Mg ⁺ ; AVOID Sodium Bicarbonate products • Pregnancy : antacids & alginates preferred • antacids interfere with absorption of some drugs (bisphosphonates, digoxin, iron, tetracyclines & quinolone antibiotics); space 2hrs apart • OTC H2RAs comparable but NOT superior to antacids for episodic heartburn & GERD • ranitidine may ↑ blood alcohol level • dyspepsia may be drug induced : e.g. alendronate, amiodarone, antibiotics eg. erythromycin..., acarbose, herbs, iron, K ⁺ tabs, metformin, orlistat, NSAIDs, steroids & theophylline	
	CONSTIPATION ^{37,65,101,120,123,137} <ul style="list-style-type: none"> ensure adequate FIBRE (~25g/day); slowly ↑ intake of fruits & vegetables; begin with 1-2 TBSP/day wheat bran & ↑ up to 2-4 TBSP/day with FLUID adequate FLUID INTAKE & regular EXERCISE ¹⁴⁵ is important rule out impaction; treat underlying causes where possible may be drug-induced (anticholinergics, analgesics esp. opiates, antacids with Al⁺, calcium and iron supplements, high dose diuretics, clonidine, calcium channel blockers esp. verapamil, & tricyclic antidepressants) 	Bulk forming (fiber) <ul style="list-style-type: none"> Psyllium, other B Stool softeners <ul style="list-style-type: none"> Docusate C Stimulant : tend to ↑ cramps <ul style="list-style-type: none"> Senna: benign melanosis coli C Bisacodyl C Osmotic <ul style="list-style-type: none"> GLYCERIN } C MOM } C phosphate } C Lactulose: Poorly absorbed sugar B Bismuth Subsalicylate C 	METAMUCIL ^{psyllium} PRODIEM ^{polycarbophil cap or methylcellulose powder} *New fiber products: inulin FiberSure, BeneFiber COLACE [↓] SENOKOT [↓] , EXLAX SENOKOT-S [↓] + docusate DULCOLAX [↓] GLYCERIN ^{supp} Milk of Magnesia [↓] FLEET ^(oral & enema) CHRONULAC, gen [↓] PEPTO-BISMOL ^{gen}	4.5-20g/day [↑] gradually with adequate fluid (bacteria degrade fiber → gas & bloating possible) 1-2 caps OD-BID (not laxative per se & not effective except for softening) 1-2 tabs OD-BID (if OD, give at HS) 5-15mg tab HS/OD; 10mg supp OD for immediate relief 15-30mls OD-BID for immediate relief 15-30mls OD-BID	8-18 4-8 5-10 5-10 4 5-10 7 30	• bulk-forming ^{agents} , stool softeners, lactulose & polyethylene glycol OK for chronic use; stimulant, other osmotic preps for short-term occasional use (1-2 days duration, one course/wk) EXCEPT stimulants useful with chronic opioid therapy • Pregnancy : bulk, lactulose & docusate preferred • SE : bloating, abdominal discomfort, flatulence common with most; stimulants & osmotics can cause cramping, abdominal pain & diarrhea. Abuse & habit forming potential. • ONSET : bulking & softening agents work over days; lactulose & sorbitol in 24-48hrs; stimulants & MOM within hrs (overnight); Oral Fleet ¹⁵⁴ , suppositories & GOLYTELY [↓] within ~1hr.
	DIARRHEA <ul style="list-style-type: none"> common CAUSES = infections, food, water, drugs (antibiotics, acarbose, chemotherapy, cholinergics, laxatives, Mg⁺, misoprostol & orlistat, SSRIs), lactose intolerance & IBS rehydration ¹¹⁴ critical esp. in infants & elderly; PEDIALYTE [↓] suitable for infants (Home made option: 1 tsp salt+8 tsp sugar in 1 liter water.); GATORADE suitable for mild-moderate dehydration in adults OTC therapy is for mild-moderate cases only (ie. otherwise healthy adult, no fever, <2days duration, no blood) antibiotic-induced usually self-limiting; live culture yogurt ^{100 million bacteria/gram} or if prolonged/severe, assess for C. difficile Other: probiotics may help; po Zinc in developing countries ^{WHO} 	Probiotics (<i>Saccharomyces boulardii</i> FLORASTOR ; <i>Lactobacillus rhamnosus</i> GG CULTURELLE ; probiotic mixtures): ↓ the development of antibiotic-associated diarrhea. Only <i>S. boulardii</i> ^{1g od} effective for <i>C. difficile</i> diarrhea. ¹⁶⁵ Also caution if immunocompromised & concerns with lack of live bacteria in some products. <ul style="list-style-type: none"> Loperamide B 	IMODIUM ^{gen}	Tx: 30ml or 2 tabs q30mins x 8doses/d Prophylaxis Travelers Diarrhea: QID Contraindicated in children esp <3yrs	5-10 8-12	• antidiarrheals are contraindicated in <2yrs ; treatment of infantile diarrhea should be rehydration & appropriate dietary measures, treatment of underlying causes • AVOID sorbitol, xylitol, lactose, any food triggers • Traveller's Diarrhea prevention: Dukoral Vaccine (for cholera & E. coli). <i>Boil it, Cook it, Peel it or Forget it!</i> • bismuth subsalicylate can turn tongue & stools black; beware salicylate overdose & Reye's Sx • kaolin not particularly effective but attapulgite (KAOPECTATE B) of limited usefulness for symptoms; psyllium(METAMUCIL B) also useful for symptom control - absorbs fluids, adds bulk • avoid loperamide if dysenteric symptoms or high fever; can lead to retention of pathogens
		Irritable Bowel Syndrome (IBS) ^{58-61,106} is characterized by disordered intestinal motility & alternating bouts of constipation & diarrhea. Organic causes must be ruled out. Therapy is symptomatic (loperamide for diarrhea, fiber for constipation, antispasmodics if indicated). Lifestyle changes are as important as drug therapy (avoid food triggers, adequate diet, fibre, fluids & exercise, reducing stress); underlying psychosocial co-morbidity should also be treated. Rx products such as antidepressants (Elavil), antispasmodics (Buscopan, Bentylol [⊗] , Modulon [⊗] , Dicetel [⊗] , Zelnorm [⊗] for constipation, FDA D/C Mar 2007 but now avail. for specific criteria, ⁸²) may help.	Rx preps: codeine & LOMOTIL available			
PAIN	PAIN RELIEF – GENERAL <ul style="list-style-type: none"> for conditions self-limiting and of short duration including: lower back, dental, headache Caution: many strengths, formulations and combination products available 	<ul style="list-style-type: none"> Acetaminophen B ASA C/D Ibuprofen B/D 	TYLENOL ^{gen} Acetaminophen available in many combo products. Ensure total MAX <4grams/day. ASPIRIN [↓] , ANACIN ^{gen} ADVIL [↓] , MOTRIN [↓] ^{gen}	6-9 5-9 50-100 t 8-10 6-8	• for more complete discussion of analgesic agents, see other Rx Files Comparative Charts : NSAIDs and other Analgesics Opiates Migraine Treatment & Prophylaxis Back Pain • maximum OTC ibuprofen dose provides analgesia but anti-inflammatory effect requires ≥1600mg/day - regular Caution : chronic use can lead to rebound headache; NSAIDs: ↑ heart failure & hypertension, ↑GI ulcers. • non drug treatments (massage, hot/cold therapy, resuming activity, physiotherapy...) are sometimes useful	
	Codeine available OTC only in combination products (eg. TYLENOL #1, ATASOL 8) or ASA (eg. 222s) in a dose of 8mg codeine /tablet					

DERMATOLOGY	COMPLAINT & TREATMENT NOTES	DRUGS OF CHOICE	USUAL DOSE Adult / Pediatrics (Daily MAXIMUM)	\$	COMMENTS OTC Products
	<p>ACNE (noninflammatory; papulopustular)^{38-40,87-89} Mild – moderate cases may be treated with OTC preps & non-drug therapy:</p> <ul style="list-style-type: none"> ♦ balanced diet (but food “triggers” do not directly affect acne) ♦ wash ≤ BID (mild soap/soapless cleanser) ♦ wash hair frequently & keep off the face & forehead ♦ use oil-free cosmetics ♦ control stress factors ♦ avoid picking & squeezing lesions to prevent scarring ♦ while somewhat useful to cosmetically dry oily skin, antiseptic cleansers often ineffective (as surface bacteria not causative agent), costly & irritate skin 	<p>♦ Benzoyl Peroxide (BP) 2.5-5% OTC in lotions, creams, gels (>5% products by Rx only)</p> <p>♦ Glycolic Acid (eg. alpha hydroxy acid)</p> <p>♦ Salicylic Acid (SA)- up to 5%</p>	<p>BENZAGEL ▼ 2.5, 5% lotion and gel (wash and soap also available)</p> <p>NeoStrata..., Reversa...</p> <p>ACNEX ▼ CLEARASIL OXY CONTROL lotion, 1 or 2%</p>	<p>General Directions:</p> <ul style="list-style-type: none"> ♦ begin with water based lotion or cream with BP 2.5% (or maybe SA) ♦ apply at HS after washing, increase to BID if needed; wash off in am ♦ allow a trial of 6-8wks; if no improvement increase to BP 5% lotion or cream at hs (can ↑ to BID) or can use water based BP gel ♦ if no improvement, consider Rx products: topical antibiotics ^{eryc & clindamycin} or oral; oral contraceptives Tri-Cyclen, Alesse, Diane-35 ✕, Stieva-A ^{comedogenic}, Differin ▼ fast onset & less skin irritation but expensive, Tazorac ▼ effective but skin irritation & expensive, or Accutane ^{severe} ✕ nodulocystic cases; monitor for lipid & liver effects) 	<p>8-15</p> <p>25</p> <p>8-10</p>
<p>FUNGAL Infections ^{41-44, 100} (acute, superficial)</p> <p>♦ Athlete’s Foot (Tinea pedis)</p> <p>♦ Jock Itch (Tinea cruris)</p> <p>♦ Ringworm (Tinea corporis)</p> <p>Nvstatin ▼ – 2nd choice as must be applied 3-4x daily; treats yeast (candida, pityrosporum) but not dermatophyte fungi, thus not useful for most cases of jock itch, athlete’s foot or ringworm</p> <p>♦ Candidiasis -Vaginal -Cochrane Review: no difference in effectiveness of oral Rx vs intra-vaginal OTC routes; oral route often preferred by pts.⁷¹ -fluconazole 150mg po weekly effective in ↓ recurrent vaginal candidiasis but expensive & DIs possible⁹³</p>	<p>♦ Clotrimazole 1% cream</p> <p>♦ Miconazole 2% cream</p> <p>Rx: Terbinafine (LAMISIL) 1% cream or 1% spray soln: Apply BID x1-2 wks (Max 4wks) \$23/30g</p> <p>♦ Tolnaftate – slightly less effective, higher recurrence</p>	<p>CANESTEN ▼ ^B ^C</p> <p>MICATIN ▼ ^C</p> <p>TINACTIN ▼ – crm, aerosol, powder ^U</p> <p>CANESTEN ▼ ^{1,3,6 day} ^B</p> <p>MONISTAT ▼ ^{1,3,7 day} ^C</p>	<p>Apply BID (am + hs) x 2-6weeks</p> <p>Apply to affected as well as surrounding area. Continue application for at least 1 week after symptoms disappear to ensure eradication (10-14 days preferred)</p> <p>Vaginal: Insert one applicatorful or one vag supp at hs x 1-7 days; apply cream to external perineum & vulvar area BID</p>	<p>7-13</p> <p>8-14</p> <p>9-14</p> <p>16-18</p> <p>14-16</p>	<p>♦ keep area clean and dry (use non-scented talc or medicated powder as prophylaxis)</p> <p>♦ do not share towels or personal items</p> <p>♦ improve ventilation of affected area –wear loose clothing, cotton fabrics etc</p> <p>♦ launder affected linens and clothing in hot water; dry in hot dryer or line dry to expose to UV rays</p> <p>♦ foul odor may indicate secondary bacterial infection</p> <p>♦ if recurring tinea ^{pedis & cruris} → possibly a sign of toenail infection requiring Rx systemic therapy</p> <p>♦ Rx systemic products: Diflucan, Fulvicin U/F, Nizoral [☞], Lamisil & Sporanox [☞], Terazol may be needed, esp. for non-responsive/non-albicans infections.</p> <p>Vaginal candidiasis</p> <p>♦ 1-3 days regimens as effective as 6-7days with better compliance; recurrent resistant cases may need 3-4weeks therapy</p> <p>♦ dietary yogurt (with live culture) or oral bacilli caps may help restore Lactobacilli colonization, but not prevent post-antibiotic vulvovaginitis⁹⁴</p>
<p>Diaper – see below; usually secondary infection after 2-3days of general diaper dermatitis (shiny red patches with satellite lesions; can affect folds)</p>					
<p>DERMATITIS - mild-moderate Atopic ^{45,46,112,116} (eczema) – unknown cause</p> <ul style="list-style-type: none"> ♦ hydration therapy ♦ itch control ♦ simple emollients underutilized!!! <p>Contact – allergens & irritants ^{eg. nickel, detergents 163}</p> <ul style="list-style-type: none"> ♦ acute – cool compress (+/- astringent eg. Buro-Sol solution) ♦ chronic – hydration as per atopic <p>Diaper – prevention key:</p> <ul style="list-style-type: none"> ♦ change diapers often; keep area clean and dry; ♦ disposable diapers with gel often better than cloth ♦ avoid baby wipes (irritating) and use wash cloth and water ♦ increase air exposure time ♦ use protectants as prophylaxis ♦ avoid potent corticosteroids!!! 	<p>♦ Hydrating creams, lotions</p> <p>♦ Colloidal oatmeal preps</p> <p>♦ Petroleum jelly</p> <p>♦ Hydrocortisone ½ %</p> <p>♦ Oral Antihistamines (limited efficacy; 1st gen H1 preferred; ATARAX ^{RS} useful for itch, sedation effect); H2’s also option</p> <p>♦ Aluminum acetate (astringent) compresses</p> <p>♦ anti-staphylococcal</p> <p>♦ Petroleum jelly</p> <p>♦ Baby or talc powder (avoid use of corn starch)</p> <p>♦ Zinc Oxide cream, paste</p> <p>♦ Hydrocortisone ½ %</p> <p>♦ Antifungals (clotrimazole, miconazole)</p>	<p>Lubriderm, Nutraderm, Moisturel, Sarna-P, Uremol</p> <p>AVEENO BATH VASELINE; (PREVEX) CORTATE ▼ ^{see comments}</p> <p>Chlorpheniramine</p> <p>Diphenhydramine ^B ^B</p> <p>Cetirizine ²⁴ ^B</p> <p>BURO-SOL COMPRESS ▼</p> <p>VASELINE</p> <p>ZINCOFAX ▼, PENATEN CORTATE ▼</p> <p>CANESTEN ▼ ^B ^C</p> <p>MICATIN ▼ ^C</p>	<p>Apply BID-QID</p> <p>Use in the bath as directed</p> <p>See allergy section; 1st gen: effective for both ^{allergic & non allergic rash} but sedating ^{give @ hs &} thus esp. useful for non-allergic rash ^{eg. eczema}. 2nd gen: less useful for non allergic ^{rash} but ↓ sedation; useful for allergic rash ^{eg. hives & bites}.</p> <p>If oozing vesicles, apply BURO-SOL for 10 minutes 3-4x/day; otherwise cool H2O or saline compresses for 20min 4-6x/day.</p> <p>Protectants should be applied liberally to diaper area with each change; for steroids and antifungals (for candidal cases) – may rub in small amount to affected area, cover with protectant (may alternate between steroid and antifungal rather than mixing together which dilutes both)</p>	<p>8-12</p> <p>~400ml</p> <p>8-14</p> <p>3-5</p> <p>5-8</p> <p>8-12</p> <p>18</p> <p>8-10</p> <p>10-12</p> <p>3-5</p> <p>5-10</p> <p>5-8</p> <p>7-10</p> <p>7-10</p>	<p>Non drug treatment:</p> <ul style="list-style-type: none"> ♦ avoid known triggers, irritants, stress; minimize soap use & hot water contact (bathing, showering) ♦ cool room temp with adequate humidity ♦ loose cotton clothing; avoid wool & synthetics ♦ use laundry soap vs detergent; double rinse cycle (or vinegar in the rinse for diapers); avoid fabric softener <p>Topical corticosteroids (eg. hydrocortisone CORTATE, clobetasone SPECTRO ECZEMA CARE):</p> <p>Use lowest effective potency for as short duration as possible (Rx strength may be required for flare-ups and acute contact dermatitis; apply sparingly BID and change to hydrating lubricants once acute symptoms under control)</p> <p>Rx products: topical corticosteroids (Betaderm, Diprosone, Dermovate); non-steroidal anti-inflammatories (Protopic [☞], Elidel [☞]); antibiotics (Fucidin ^{2%} Cr/Oint, Cloxacillin, Bactroban)</p>

	COMPLAINT & TREATMENT	DRUGS OF CHOICE	USUAL DOSE Adult / Pediatrics	\$	COMMENTS
DERM.	PLANTAR WARTS 47-49,70 -hard, flat with black pinpoint specks in center ♦20-30% resolve within 6 months without tx and 65% within 2yrs ♦removal desirable often due to pain and to reduce spread of infection Rx: Cantharone Plus ▼ also an option.	Salicylic Acid (SA) 12-40% ♦gels, collodions, plasters, discs, pads (weaker preps: less pain but require more reapplication) COMPOUND W Plus (30% liquid; 40% pads) DUOFORTE 27% gel ▼ DUOFILM 40% patch SCHOLLS Wart Remover 40% disks Laser therapy: expensive & sometimes painful. ??Zinc 10mg/kg od ~60d ⁸⁴ ??Duct tape: 6days on, 12hrs off; repeat x 5-10 cycles may work ⁶⁶	♦Apply daily @hs (patch & disk q48h) until all warty tissue is removed; Presoak area in warm water, then pare away any overlying kera-toma & dead tissue before applying ♦may take 8-12 weeks for resolution (more concentrated SA preps used by specialists)	10-15 17 20 /14 20	♦If diabetes/vascular disorder do not self treat ♦Rx: Podophyllin & cantharidin CANTHARONE ▼ effective single application; delayed ~24hr pain & blistering ♦Cauterization or freezing with liquid nitrogen faster & more efficacious but often more painful ♦Avoid walking barefoot (eg. in pool area). ♦OTC cryotherapy
	HEAD LICE (P. capitis) 50-51,124 ♦Notify & examine all contacts to prevent reinfestation cvcle: ↑resistance. ♦Reinfestation prevention: nit removal; bedding, clothing, etc.: wash & dry (with heat >15mins), dry clean or seal in plastic bag for ~14 days; vacuum affected rooms; soak combs & brushes in disinfectant solution x 1hr or hot water (65°C for 10min) ♦Discourage "no nit" school policies CDN 124	♦Permethrin 1% Cream Rinse NIX KWELLADA-P ▼ Cream Rinse: Apply to washed, towel dried hair. Saturate hair & scalp, wait 10 min, rinse. ♦Pyrethrins & Piperonyl Butoxide R & C Shampoo ▼ Apply & saturate dry hair & scalp, wait 10 min, slowly add water to lather, rinse. ♦Lindane 1% Shampoo Generic ▼ Apply-saturate dry hair & scalp, massage x4 min., add H2O slowly - lather, massage x4 min. then rinse. ♦SH-206 - see comments SH-206 Shampoo ▼ ♦Isopropyl myristate 50% RESULTZ ▼-see comments	♦Apply as directed; REPEAT in 7 days. ♦Apply as directed; REPEAT in 7 days. ♦Apply as directed; REPEAT in 7 days. ♦Apply as directed; REPEAT in 48 hrs. ♦Apply as directed; REPEAT in 7 days.	11-14 9 9 10 13	♦Do not sit in bath water as hair is being rinsed. ♦R & C Efficacy: 45% on 1 st application; 94% on 2 nd ♦CI: Permethrin or Pyrethrins: allergy ragweed or chrysanthemum ♦Lindane: neurotoxicity/seizure ¹³³ -ingestion or ↑↑ use; ♦CI: young kids, pregnancy, if nursing, elderly, skin dx ♦Long/thick hair pts may require 2 x ~50ml bottles ♦Tea Tree Oil: lack of evidence; contact dermatitis ♦SH-206: a "natural product" lacking data ; contains acetic acid, citronella, camphor & sodium lauryl ether sulphate ♦Resultz: dissolves wax louse exoskeleton; for age ≥4yr on SPDP plan; avoid in eyes, may stain fabric, new & limited trial data.
VITAMINS & MINERALS	VITAMINS/SUPPLEMENTS 129 In otherwise healthy subjects, supplementation recommended in: ♦Breast-fed infants - Vitamin D 400IU/d ♦Deficient intake or Malabsorption ⁸¹ ♦Pregnancy - Ca ⁺⁺ , Vit D, folate , iron (possible with diet alone), MV esp in developing countries ⁵² ♦Vegetarians - Ca ⁺⁺ , Vit B12, D, Iron? ♦Alcoholic - Vit B's; multivit. (MV)? ♦Women with heavy menses - Iron ♦Non-milk drinkers - Ca ⁺⁺ , Vit D ♦Elderly ¹²⁶ (esp. if poor diet) -B12,D;Ca+MV? ♦if on steroids/phenytoin -Vit D, Ca ⁺⁺ ♦HIV -Multivit.(B's,C,E & folic) ^{91,107}	Vitamin Products Vit D ₃ : D-VI-SOL 400 IU/ml ▼ Baby Ddrops 400 IU/drop ; (=10ug cholecalciferol) Children's: Flintstones Extra C ▼ chewable CENTRUM JUNIOR ▼ Pregnancy: MATERNA ▼ Fe ⁺⁺ 27mg, Folic 1mg & Vit A 1500iu. PregVit folic S R ⁹⁰ ; ORIFER F Vd/c by co Fe ⁺⁺ 60mg, Folic 0.8mg & Vit A 1500iu. {Iron/Folic/Vit C: PALAFER CF Fe ⁺⁺ 100mg; Folic 0.5mg; Vit C 200mg } B & C Vitamins: BEMINAL C FORTIS ♦well formulated multivitamins (MV) with both regular and age 50+ formulations: -CENTRUM; ONE-A-DAY; PARAMETTES -house brands: most retailers have products comparable to brand name at lower cost	RDA Recommended Daily Allowance in Adults: Fat Soluble Vitamins Replace if low fat diet e.g. orlistat patients A (retinol) 700 ² -900 ³ ug (~3000 IU) Beta carotene - 6000 ug (~10000 IU) D 200-400 IU; 600 IU if >70yr {2006 CND Osteoporosis Guidelines ⁶ : 400 IU men & ♀ <50yr; 800 IU if >50yrs } D3-cholecalciferol often preferable to D2 ergocalciferol CND Cancer Society → High risk, Adults fall & winter: 1000iu. Max 2000iu/d E 22 IU (15mg) RRR-α-tocopherol natural (= 67 IU (30mg) of all-rac-α-tocopherol ^{synthetic}) ¹ Water Soluble Vitamins B1 (thiamine) ~1.2 mg B2 (riboflavin) ~1.3 mg B3 (niacin) ~15 mg B6 (pyridoxine) ~1.5mg replace ~25mg if on isoniazid B12 (cyanocobalamin) 2.4 ug terminal ileum {OTC: CENTRUM SELECT 25ug* R ⁹ ; 1008250* & 1200ug tab; \$10mo ¹⁰⁴⁻¹¹⁵ } C (ascorbic acid) ¹⁰⁰ 75-90 mg (Juice ≤100mg) Folic Acid ¹⁶⁶ 400 ug → Replace if pregnant esp if on anticonvulsants, on methotrexate, phenytoin, or if malabsorption Sx. Pantothenic acid 5 mg Minerals (elemental amounts) Fe⁺⁺ 8 mg (men & ♀ post menopausal) 18 mg (women <50yrs) {Treatment: 2-3mg/kg/day e.g. Ferrous Sulfate 300mg (=60mg Fe ⁺⁺) po BID-TID } Peds Fe ⁺⁺ : Treatment 6mg/kg/d; Proph 0.5-2mg/kg/d Ca⁺⁺ 1000 mg (adults); 1500 mg for postmenopausal ♀ & ♂ >50yrs ⁶ Mg⁺⁺ 310-420 mg Zn⁺ 8-11 mg (evidence inconclusive in common cold ⁷⁵ , ?eye ⁸⁵ ; ?pneumonia & diarrhea ¹²⁷)	15 8-12 15-20 Vit B & C 8-12 /60 tab Multivite 10-12 /3 month Fe ⁺⁺ 5-10 /60 tab 12-15 for 30 tab SR products Ca ⁺⁺ 5-12 /100tab Multivite 10-12 /3 month	GENERAL SUPPLEMENTATION 103 ♦vitamins not a substitute for healthy diet ♦NO proven benefit to "mega dose" supplements unless true deficiency; excess water soluble vitamins (Bs & C) are lost in the urine, while fat-soluble (A,D,E,K) can accumulate ⇒ toxicity. Also- ↑↑ Vit A: ↑lung ca in smokers ^{78,96} & may ↑ fracture risk ^{80,95} ANTI-OXIDANTS: no proven heart benefit for supplemental Vit E, C, beta-Carotene & Selenium ^{53,54,90,108,161} ; Vit E: Alzheimer's limited evidence ^{67,68,79} & no benefit in mild cognitive impairment ¹⁰⁵ & may impair statin benefit ⁶⁹ ; nicotinamide not prevent diabetes ⁸³ ; some evidence that dietary sources of antioxidants may ↓ heart risk. Vit E may ↑mortality ^{97,98} , ↑heart failure ¹⁰² & not ↓cancer in ♀ ¹²² . Antioxidants & zinc may ↓ eye macular degeneration. IRON: best on an empty stomach (or HS) but GI SE common so OK to take with food but absorption ↓ by ≤50% (Vit. C >200-1000mg ↑ absorption). SR & enteric forms may cause less GI effects but expensive & poorly absorbed. Tx ~3 months to replace iron stores. Lower dose in anemic elderly may be ok. ¹¹³ CALCIUM (DI: ↓ levels of iron, quinolones, tetracyclines, thyroid meds etc.) ♦can only absorb ~500mg Ca ⁺⁺ at once so best to split dose (ie. 1 tab BID); ♦Ca carbonate better with food so take with meal (if necessary one bedtime dose is acceptable). Excessive intake → milk alkali syndrome. ♦Citrate form - ↑ absorption if achlorhydria , ?less GI SE & ↓ kidney stones, but caution if ↓ renal fx ♦if natural source Ca ⁺⁺ , use reputable product as lead contamination possible esp. with off-shore health food products ♦Microcrystalline hydroxapatite concentrate -MCHC: Ca ⁺⁺ from veal bone ♦Foods Ca ⁺⁺ : Milk 1 cup=300mg, cheese 30g=200mg, tofu 1/2 cup=200mg
	IRON (Fe⁺⁺) SUPPLEMENTS ♦iron products: use on Dr's advice ¹¹³ ♦amount of iron in multivitamins OK for chronic daily use; breast-fed infants ≥6mo require Fe ⁺⁺ (cereals or supplement)	Ferrous sulfate ▼ (300mg tab = 60mg Fe ⁺⁺) Fer-in-Sol drops ▼-s20 (75mg/ml = 15mg Fe ⁺⁺) Ferrous sulfate syrup ▼ (30mg/ml = 6mg Fe ⁺⁺) Ferrous gluconate ▼ (300mg tab = 35mg Fe ⁺⁺) Ferrous fumarate ▼ (300mg tab = 99mg Fe ⁺⁺) ♦ Calcium carbonate least expensive & highest percentage of avail. elemental Ca ⁺⁺ (take with food): - calcium carbonate ▼ = 40% elemental Ca ⁺⁺ eg. OSCAL ▼ (1250mg = 500mg elemental Ca ⁺⁺) TUMS chew (Reg=200mg, Extra=300mg, Ultra=400mg Ca ⁺⁺) ▼ Combo products: eg. Cal-500-D ▼ & Oscal D 500 ▼ - calcium citrate = 21% elemental Ca ⁺⁺ - calcium lactate = 13% elemental Ca ⁺⁺ - calcium gluconate = 9% elemental Ca ⁺⁺ ♦ General multivitamin good source of vitamin D (most have ≥400IU/tablet) ♦ Milk: 1 cup = 300mg Ca ⁺⁺ & 100 IU Vit D 30g cheese = 200mg Ca ⁺⁺ ; Tofu 120g = 150mg Ca ⁺⁺	Calcium & Vitamin D 109-111 ♦adequate intake important throughout life (consider age, bisphosphonates, etc.) ♦Vit D essential to ↑ active Ca ⁺⁺ absorption & use; low in most North Americans esp. above 55th parallel due to ↓ sun. ⁶² blocked by SPF-8 (15mins of sun may produce >10,000IU D ₃ /day) Vit D → cod liver oil, herring, salmon, sardines & tuna (25hydroxy Vit D level >75nmol/l may be optimal) ♦magnesium supplements not required as deficiency rare (dietary intake sufficient); no proven bone benefit, but laxative effect may counteract constipation from Ca ⁺⁺ ♦↑ Vit A → bone loss & interferes with Vit D	15 8-12 15-20 Vit B & C 8-12 /60 tab Multivite 10-12 /3 month Fe ⁺⁺ 5-10 /60 tab 12-15 for 30 tab SR products Ca ⁺⁺ 5-12 /100tab Multivite 10-12 /3 month	IRON: best on an empty stomach (or HS) but GI SE common so OK to take with food but absorption ↓ by ≤50% (Vit. C >200-1000mg ↑ absorption). SR & enteric forms may cause less GI effects but expensive & poorly absorbed. Tx ~3 months to replace iron stores. Lower dose in anemic elderly may be ok. ¹¹³ CALCIUM (DI: ↓ levels of iron, quinolones, tetracyclines, thyroid meds etc.) ♦can only absorb ~500mg Ca ⁺⁺ at once so best to split dose (ie. 1 tab BID); ♦Ca carbonate better with food so take with meal (if necessary one bedtime dose is acceptable). Excessive intake → milk alkali syndrome. ♦Citrate form - ↑ absorption if achlorhydria , ?less GI SE & ↓ kidney stones, but caution if ↓ renal fx ♦if natural source Ca ⁺⁺ , use reputable product as lead contamination possible esp. with off-shore health food products ♦Microcrystalline hydroxapatite concentrate -MCHC: Ca ⁺⁺ from veal bone ♦Foods Ca ⁺⁺ : Milk 1 cup=300mg, cheese 30g=200mg, tofu 1/2 cup=200mg

↓ = dose for renal dysfx ♀ = female ♂ = non formulary in Sask. ◻ = EDS ▼ = covered by NIHB
 BP = blood pressure COPD = chronic obstructive pulmonary disease CI = contraindication d = days
 DI = drug interaction Dx = disease GERD = gastroesophageal reflux disease h = hours hs = bedtime
 Rx = prescription SE = side effect SR = sustained release tsp = teaspoon ~5ml tbsps = tablespoons ~15ml
 tx = treatment wk = weeks yr = year; ♂ = scored; Cost Range: low-end price - generic or smaller size

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169. Poston L, et al. Vitamins in Pre-eclampsia (VIP) Trial Consortium. **Vitamin C and vitamin E** in pregnant women at risk for pre-eclampsia (VIP trial): randomised placebo-controlled trial. *Lancet*. 2006 Apr 8;367(9517):1145-54. (InfoPOEMs: Supplementation with vitamins C and E during pregnancy does not reduce the risk of pre-eclampsia but does increase the risk of low birth weight. (LOE = 1b))
170. DHA Supplementation during Pregnancy & Lactation. *Pharmacist's Letter* Aug,2006.
171. Pharmacist's Letter. **Vitamin D and Calcium**: Not just for Bones anymore . July 2007.
172. InfoPOEM Feb08: Honey for cough. {A single dose of honey is effective at decreasing cough severity and sleep disruption in children with cough due to uncomplicated upper respiratory infections. Please remember that honey should never be given to infants because of the risk of botulism. (LOE = 2b) }
173. Paul IM, Beiler J, McMonagle A, Shaffer ML, Duda L, Berlin CM Jr. Effect of **honey**, dextromethorphan, and no treatment on nocturnal cough and sleep quality for coughing children and their parents. *Arch Pediatr Adolesc Med*. 2007 Dec;161(12):1140-6.
174. Smith SM, Schroeder K, Fahey T. Over-the-counter medications for acute cough in children and adults in ambulatory settings. *Cochrane Database of Systematic Reviews* 1999, Issue 1. Art. No.: CD001831. DOI: 10.1002/14651858.CD001831.pub3. {Acute cough is a common and troublesome symptom in people who suffer from acute upper respiratory tract infection (URTI). Many people self-prescribe over-the-counter (OTC) cough preparations and health practitioners often recommend their use for the initial treatment of cough. The results of this review suggest that there is no good evidence for or against the effectiveness of OTC medications in acute cough. The results of this review have to be interpreted with caution because the number of studies in each category of cough preparations was small. Many studies were of low quality and very different from each other, making evaluation of overall efficacy difficult. <http://www.cochrane.org/reviews/en/ab001831.html> }
175. Pynnonen MA, Mukerji SS, Kim HM, Adams ME, Terrell JE. Nasal saline for chronic sinonasal symptoms: a randomized controlled trial. *Arch Otolaryngol Head Neck Surg*. 2007 Nov;133(11):1115-20. Nasal irrigation (nasal washing) using a stream of normal saline, is more effective in decreasing general nasal or sinus symptoms than saline spray. The saline can be made at home, purchased as a kit, or administered using a neti pot. Direct your patients to an online source of video (eg, www.youtube.com) to see how it is administered. (LOE = 1b)
176. Aisen PS, Schneider LS, Sano M, et al. Alzheimer Disease Cooperative Study (ADCS). High-dose **B vitamin supplementation** and cognitive decline in Alzheimer disease: a randomized controlled trial. *JAMA*. 2008 Oct 15;300(15):1774-83. This regimen of high-dose B vitamin supplements does not slow **cognitive decline** in individuals with mild to moderate AD.

Additional Pediatric Dosing Information for Physicians & Pharmacists (from 2008-2009 Formulary – The Hospital for Sick Children (Toronto, Canada))

Aluminum & Magnesium Hydroxide	infant	2.5-5ml po q1-2h
	child	5-15ml po after meals & qhs
Bisacodyl		0.3mg/kg/dose po 6-12h before desired effect
Dextromethorphan		1mg/kg/day (÷ q6-8h)
Dimenhydrinate		5mg/kg/day po/IV/IM/pr (÷ q6h)
Diphenhydramine		5mg/kg/day po/IV/IM (÷ q6h)
Docusate Sodium		5mg/kg/day po (÷ q6-8h or single daily dose)
Iron – Treatment		6mg Fe ⁺⁺ /kg/day po OD (or ÷ TID)
Iron – Prophylaxis		0.5-2mg Fe ⁺⁺ /kg/day given OD (or ÷ BID-TID)
Lactulose - for Constipation		5-10ml/day po OD (double daily dose till stool produced)
Mineral Oil (Heavy)		1ml/kg/dose po HS (Avoid in <1 yr old)
Magnesium Hydroxide (MgOH) 80mg/ml (33mg elemental Magnesium/ml)		20-40 mg elemental Magnesium/kg/day po (÷ TID) –for treatment of hypomagnesemia
Pseudoephedrine:	<2yrs	4mg/kg/day (÷ q6h prn)
Ranitidine – Treatment		5-8mg/kg/day po (÷ q8-12h) x8 weeks
Ranitidine – Maintenance		2.5-5mg/kg/day (given OD or divided bid)
Senna Syrup	2-5yrs	3-5ml/dose qhs
	6-12yrs	5-10ml/dose qhs
Senna Tablet	6-12yrs	1-2 tablets/dose po qhs
Sorbitol Syrup 70%		1.5-2ml/kg/dose po (Max 150ml/dose)

Taste of some medications – MgOH, docusate, lactulose - may be masked by giving with milk (chocolate mix), juice or infant formula.