PROTONIX® I.V.
(Pantoprazole Sodium) For Injection

Wyeth®

Diagnosis at a Glance

By Brian R. Irwin, DO, Kerry A. Peters, MD, and Alan Jon Smally, MD, FACEP

Case 1

A five-year-old Bolivian boy is evaluated during an international medical clinic in his rural village. He, like all his fellow villagers, has never seen a physician before. Since birth, he has been experiencing recurrent, lingering respiratory infections, sometimes featuring a productive cough with foul-smelling sputum. He and other family members have recently had scabies and are at risk for parasitic infections, which run rampant in this locale. Physical examination reveals no rash, with the exception of a punctate lesion near the sternal notch that exudes purulent material when expressed. The only other abnormalities are cervical adenopathy and a soft, subtle mass lateral to the patient's cricoid that is mobile and moves with swallowing. The boy's oropharynx, lungs, and nose are unremarkable.

Case submitted by Dr. Irwin

What is your diagnosis?

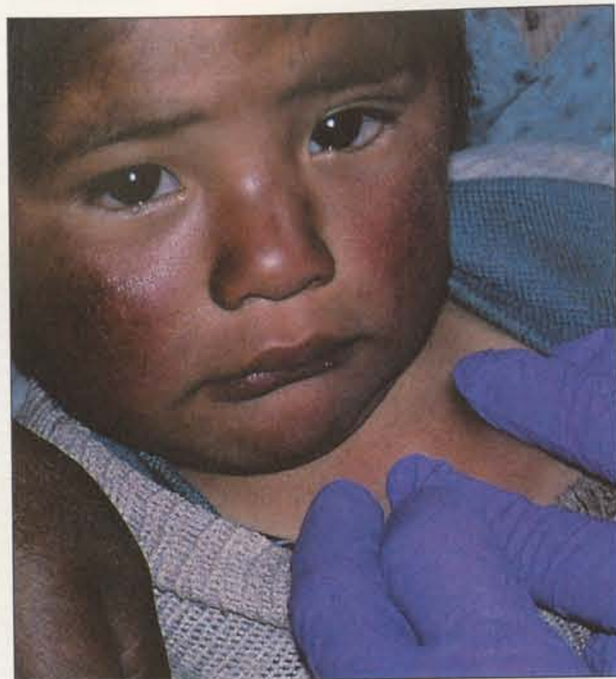
Case 2

A 32-year-old man presents to the emergency department with a clinically apparent fracture of his left wrist. He is in moderate to severe pain. The nurse places an intravenous (IV) catheter in his right antecubital area and administers 5 mg of morphine by IV push. Shortly thereafter the patient develops itching above the catheter and the rash shown at left, along with a very mild generalized pruritus. The attending physician is asked if epinephrine, antihistamines, and corticosteroids are indicated.

Case submitted by Drs. Peters and Smally

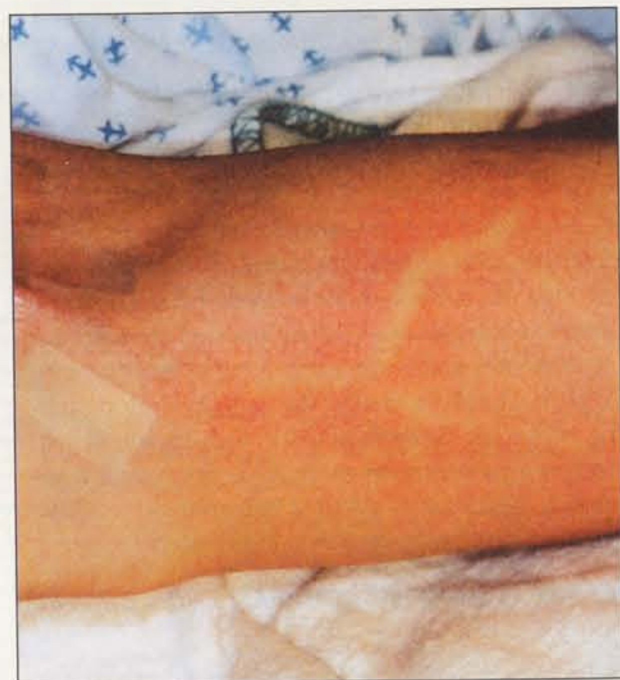
What is your diagnosis?

Turn page for answers



CASE 1

This patient had a thyroglossal duct cyst and sinus. The limited resources of a goodwill clinic in a remote location precluded any testing, but with a punctate skin lesion a parasitic or worm infection was also likely, so he was treated with anthelmintics in addition to a broad-spectrum antibiotic. He was brought to a surgeon in La Paz who incised the fluctuant mass and discovered a sinus tract running from the sternal notch to the underside of the boy's tongue, which had been missed in the initial examination. Thyroglossal cysts result from the failure of the first, second, and sometimes third and fourth branchial clefts to fuse during the first two months of embryonic development. Most cysts are infected with mixed flora or gram-positive organisms. Occasionally, tracts connect to the oropharynx, where aspiration of material can lead to respiratory infection.



CASE 2

The photo demonstrates an itchy, dendritic reaction that developed along the course of a vein shortly after the injection of morphine. Although it may be confused with an allergy, this is actually a pseudoallergy because it does not involve the release of IgE and is distinguished by the predominance of local findings without systemic manifestations such as nausea, vomiting, hypotension, or angioedema. It is more likely to occur when larger amounts of morphine are given more rapidly. Recognizing this presentation as a nonallergic cutaneous reaction permits symptomatic treatment, avoids unnecessary or potentially dangerous interventions, and allows further use of morphine (or other narcotics). Treatment is with reassurance, cool compresses, and systemic antihistamines. These reactions may be prevented by slower administration of a more dilute morphine solution or by the use of an analgesic that does not cause histamine release, such as fentanyl.

Dr. Irwin is a physician in private practice at Saco River Medical Group in Conway, New Hampshire. Dr. Peters is an attending physician at Cape Cod Hospital in Hyannis, Massachusetts. Dr. Smally is an associate professor in the department of traumatology and emergency medicine at Hartford Hospital and the University of Connecticut School of Medicine in Hartford.

First-Line Response

Empiric therapy for complicated intra-abdominal and skin/skin structure infections

INVANZ®
(ertapenem sodium) IV/IM

- Excellent clinical efficacy
- Demonstrated gram-positive, gram-negative, and anaerobic coverage
- QD monotherapy

INVANZ is indicated for the treatment of adult patients with moderate to severe:

Complicated intra-abdominal infections due to *Escherichia coli, Clostridium clostridioforme, Eubacterium lentum, Peptostreptococcus* species, *Bacteroides fragilis, B distasonis, B ovatus, B thetaiotaomicron,* or *B uniformis.*

Complicated skin/skin structure infections due to *Staphylococcus aureus* (methicillin-susceptible strains only), *Streptococcus pyogenes, Escherichia coli,* or *Peptostreptococcus* species.

Appropriate specimens for bacteriological examination should be obtained in order to isolate and identify the causative organisms and to determine their susceptibility to INVANZ. Therapy with INVANZ may be initiated empirically before results of these tests are known; once results become available, antimicrobial therapy should be adjusted accordingly.

To reduce the development of drug-resistant bacteria and maintain the effectiveness of INVANZ and other antibacterial drugs, INVANZ should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria.

INVANZ is contraindicated in patients with known hypersensitivity to any component of this product or to other drugs in the same class or in patients who have demonstrated anaphylactic reactions to beta-lactams.

Due to the use of lidocaine HCl as a diluent, INVANZ administered intramuscularly is contraindicated in patients with a known hypersensitivity to local anesthetics of the amide type. (Refer to the prescribing information for lidocaine HCl.)

Seizures and other CNS adverse experiences have been reported during treatment with INVANZ.

During clinical trials, the most common drug-related adverse experiences in patients treated with INVANZ, including those who were switched to therapy with an oral antimicrobial, were diarrhea (5.5%), infused vein complication (3.7%), nausea (3.1%), headache (2.2%), vaginitis in females (2.1%), phlebitis/thrombophlebitis (1.3%), and vomiting (1.1%).

Before prescribing INVANZ, please read the Brief Summary of the Prescribing Information on the adjacent page.

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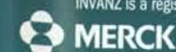
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