

Basal Cell Carcinoma in an Elderly Patient

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Rockford, Illinois

DR. GEORGE H. THOMSON (*Assistant to the Director, Office for Family Practice*): I would like to introduce this discussion of the complexities of a simple problem by reading a note from a daughter of one of our patients. "Thank you for seeing that our mother was treated for the cancer of her face. We saw her this past week and the spot has healed beautifully." Their mother, Maude, is an elderly woman who was hospitalized for care of a basal cell carcinoma of her face. Now, Dr. Gould, you were the admitting resident, will you present your findings on Maude's admission to the hospital.

DR. JOSEPH E. ROSS (*Assistant Director, Office for Family Practice*): Dr. Thomson, before we proceed, you have introduced today's patient by her first name. We are reminded frequently that we should not address our patients in such familiar terms as a first name. Would you care to comment?

DR. THOMSON: The subject has received much recent coverage in medical literature and even more in Ann Landers' columns. How you should respond will depend on the style you and your patients adopt. In our village we get to know everyone and his pet dog by first name or nickname. The informality spreads to everyone calling me "Doc," but that has been true since I was five years old and made calls with my father. I would feel uncomfortable addressing most of my patients by their surnames.

How you address your patients should be based on whatever system ensures the most effective communication. As we go on, you will see presented a serious problem of communication with this patient because of her dementia. She spends most of her days in a commons room with about 20 others who have a greater or lesser degree of mental senility. Classically, these patients develop a retrograde memory loss. Each patient in such a condition responds best to his or her child-

hood given name or nickname, possibly for the same reason I respond more readily among friends to Doc than to George. Further, in the patient's environment, addressing each person with "Mister," "Miss," or "Missus" would produce a constant sibilant dissonance. You should develop your own style based on what your patients teach you, not what I might tell you. In our village, however, if you were always to use surnames, you would be ostracized as too aloof.

Now, Dr. Gould, you may present the problems of the patient.

DR. SUSAN GOULD (*Third-Year Resident in Family Practice*): Because we had discussed the problems before admission, I was only partly surprised when I first saw Maude. I knew that she was 90 years old, would not be oriented, and might be belligerent. However, she was totally uncooperative, combative, and incoherent. She was lying in a fetal position with the covers over her head. This mental status had been present for at least five years. She had moderate kyphosis, which was especially noticeable when she was sitting in a wheelchair. Although she was thin, her color and strength showed her to be in an excellent nutritional state.

Over the next four days I was able to do a complete physical examination, piecemeal though it was. I could not find any evidence of serious systemic disease.

Her skin presented two problems. She had multiple senile keratoses over her face, neck, and upper half of her body, which she constantly rubbed and picked, keeping many of them inflamed. They were all benign in appearance, but on the left side of her nose there was a 1.5-cm ulcerated lesion with a heaped-up border surrounding a nonhealing crater. The lesion had been present for one year. The appearance was that of the textbook lesion of a basal cell carcinoma. The depth was still shallow, and it did not involve the underlying bone or nasal mucosa.

The plan was to sedate her sufficiently so she could receive radiotherapy to the nose lesion.

DR. THOMSON: In the older British literature you

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INDICATIONS AND USAGE: HALCION Tablets are indicated in the short-term management of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings, and/or early morning awakenings.

It is recommended that HALCION not be prescribed in quantities exceeding a one-month supply.

CONTRAINDICATIONS: Patients with known hypersensitivity to this drug or other benzodiazepines.

HALCION is contraindicated in pregnant women due to potential fetal damage. Patients likely to become pregnant while receiving HALCION should be warned of the potential risk to the fetus.

WARNINGS: Overdosage may occur at four times the maximum recommended therapeutic dose. Patients should be cautioned not to exceed prescribed dosage.

Because of its depressant CNS effects, patients should be cautioned against engaging in hazardous occupations requiring complete mental alertness and also about the simultaneous ingestion of alcohol and other CNS depressant drugs.

Anterograde amnesia and paradoxical reactions have been reported with HALCION and some other benzodiazepines.

PRECAUTIONS: General: In elderly and/or debilitated patients, treatment should be initiated at 0.125 mg to decrease the possibility of development of oversedation, dizziness, or impaired coordination. Caution should be exercised in patients with signs or symptoms of depression which could be intensified by hypnotic drugs. Suicidal tendencies and intentional overdosage is more common in these patients. The usual precautions should be observed in patients with impaired renal or hepatic function and chronic pulmonary insufficiency. Information for Patients: Alert patients about: (a) consumption of alcohol and drugs, (b) possible fetal abnormalities, (c) operating machinery or driving, (d) not increasing prescribed dosage, (e) possible worsening of sleep after discontinuing HALCION. Laboratory Tests: Not ordinarily required in otherwise healthy patients. Drug Interactions: Additive CNS depressant effects with other psychotropics, anticonvulsants, antihistamines, ethanol, and other CNS depressants. Pharmacokinetic interactions of benzodiazepines with other drugs have been reported.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of carcinogenic potential was observed in mice during a 24-month study with HALCION in doses up to 4000 times the human dose. Pregnancy: Benzodiazepines may cause fetal damage if administered during pregnancy. The child born of a mother who is on benzodiazepines may be at some risk for withdrawal symptoms and neonatal flaccidity during the postnatal period. Nursing Mothers: Administration to nursing mothers is not recommended. Pediatric Use: Safety and efficacy in children below the age of 18 have not been established.

ADVERSE REACTIONS: During placebo-controlled clinical studies in which 1003 patients received HALCION Tablets, the most troublesome side effects were extensions of the pharmacologic activity of HALCION, e.g. drowsiness, dizziness, or lightheadedness.

	HALCION 1003	Placebo 997
Number of Patients		
% of Patients Reporting:		
Central Nervous System		
Drowsiness	14.0	6.4
Headache	9.7	8.4
Dizziness	7.8	3.1
Nervousness	5.2	4.5
Lightheadedness	4.9	0.9
Coordination Disorder/Ataxia	4.6	0.8
Gastrointestinal		
Nausea/Vomiting	4.6	3.7

In addition, the following adverse events have been reported less frequently (i.e., 0.9-0.5%): euphoria, tachycardia, tiredness, confusional states/memory impairment, cramps/pain, depression, visual disturbances.

Rare (i.e., less than 0.5%) adverse reactions included constipation, taste alterations, diarrhea, dry mouth, dermatitis/allergy, dreaming/nightmares, insomnia, paresthesia, tinnitus, dysesthesia, weakness, congestion, death from hepatic failure in a patient also receiving diuretic drugs.

The following adverse events have been reported in association with the use of benzodiazepines: dystonia, irritability, anorexia, fatigue, sedation, slurred speech, jaundice, pruritus, dysarthria, changes in libido, menstrual irregularities, incontinence and urinary retention.

As with all benzodiazepines, paradoxical reactions such as stimulation, agitation, increased muscle spasticity, sleep disturbances, hallucinations and other adverse behavioral effects may occur rarely and in a random fashion. Should these occur, use of the drug should be discontinued.

No laboratory changes were considered to be of physiological significance.

When treatment is protracted, periodic blood counts, urinalysis and blood chemistry analyses are advisable.

Minor changes in EEG patterns, usually low-voltage fast activity have been observed in patients during HALCION therapy and are of no known significance.

DRUG ABUSE AND DEPENDENCE: Controlled Substance: HALCION Tablets are a Controlled Substance in Schedule IV. Abuse and Dependence: Withdrawal symptoms have occurred following abrupt discontinuance of benzodiazepines. Patients with a history of seizures are at particular risk. Addiction-prone patients should be closely monitored. Repeat prescriptions should be limited to those under medical supervision.

OVERDOSAGE: Because of the potency of triazolam, overdosage may occur at 2 mg, four times the maximum recommended therapeutic dose (0.5 mg). Manifestations of overdosage include somnolence, confusion, impaired coordination, slurred speech, and ultimately, coma. Respiration, pulse, and blood pressure should be monitored and supported by general measures when necessary. Immediate gastric lavage should be performed. Multiple agents may have been ingested.

Store at controlled room temperature 15°-30°C (59°-86°F).

Caution: Federal law prohibits dispensing without prescription.

B-2-S

References:

- Walsh JK, Muehlbach MJ, Schweitzer PK: Acute administration of triazolam for the daytime sleep of rotating shift workers. *Sleep* 1984;7:223-229.
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BASAL CELL CARCINOMA

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will find that basal cell carcinomas were called rodent ulcers. A graduate of 50 years ago was asked about these lesions on an oral examination, and he said they got the name because "they just sit there and gnaw and gnaw." To understand the concern about Maude's nose, I would like to ask Dr. Johnson to describe the natural history of such lesions.

DR. LEBARON P. JOHNSON (*Director, Office for Family Practice*): Those of us who had the experience of seeing never-treated skid-row patients in our early training have the responsibility to interpret the far-advanced natural history of such diseases as this to those of you who may never see such a lesion.

I found it difficult to find a color atlas that showed terminal lesions. Apparently, photographic and printing technology came along after successful means of treatment. As a result, there is a dearth of good pictures of endstage lesions.¹ Even then, such pictures cannot stimulate the five senses for understanding the unrelenting pathological progression of a rodent ulcer.

It is because we have become proficient in treating basal cell lesions that we have very few examples of advanced disease to show students and residents today. Five-year cures should be expected in 100 percent of lesions of the size described here. If not treated, however, the central ulcer would deepen and ulcerate more within a few months. This progression would be accompanied by secondary infections with the borders becoming inflamed and itchy and painful. Basal cell lesions enlarge by relentless continuity. They do not metastasize to remote areas by lymphatic or hematogenous spread.^{2,3} They do "gnaw" away. They have no respect for any tissue. Within two years I would expect there would be a doubling of the size and depth of this tumor. It would have eroded the ala of the bone, completely demolishing the skin on through to the mucosa. One would be able to see the mucosa of the septum through the hole in the side of her nose. The mucosa overlying the front of the turbinates would be starting to ulcerate. By the time the tumor invades bone or mucous membranes, there is no turning back its course. Attempts to excise beyond the tumor border in these tissues are very disappointing.

Within three to four years a horrible-looking, infected, and draining cavity large enough to hold a ping-pong ball would have grown. In spite of the total local destruction of tissues, there is little systemic effect. The patient's eventual death is rarely directly attributable to even the most virulent lesions. Respite from the progressive erosion usually comes from heart failure, kidney failure, or other complications of old age, not from the cancer.

DR. ROSS: This last point was one of many issues that arose when I first saw the patient in the nursing home, where she has been cared for the past five years. Does a relatively slow-growing tumor need to

be treated in a person who already is 90 years old? Another way to ask the question is, "What is the life expectancy of a 90-year-old lady?" From the United States Life Tables, I have found that on an average she could be expected to live over five years.⁴ From Dr. Johnson's description one should conclude that treatment was indicated.

In addition, Dr. Gould's investigation found only two known risk factors: her kyphosis and dementia. There is some evidence that longevity in the elderly is inversely related to the kyphotic angle, but not in a calculable way. Her dementia has placed her in a controlled environment of care, and she receives better nutrition and more physical stimulation than when she was living at home.

Therefore, one cannot say that she is either too old or too sick to withstand treatment.

A RESIDENT: What about the Moh's chemo-surgery technique used by plastic surgeons where the lesion is totally excised under guidance from the pathologist doing sections during the surgery? It sounds as if her general condition could tolerate an anesthetic.

DR. ROSS: After the excision down to normal tissue, the defect would have to be covered by a skin graft. I could not imagine this poor lady leaving the graft alone for six hours, let alone the 16 days or so needed for it to grow.

A RESIDENT: Then what about using some of these chemotherapy preparations such as fluorouracil in gel or colloidal suspension?

DR. ROSS: The problem would be the same as for postoperative care of a skin graft, only worse. She would pick off the agent, or more likely, spread it around. I believe she would have severe conjunctivitis within a week, and the usual course of such a treatment is daily application for 10 to 12 weeks.

A RESIDENT: Does one ever use electrodesiccation or electrocautery on a basal cell cancer rather than the x-ray procedure or the ways just mentioned? That would be a one-shot type of treatment.

DR. JOHNSON: I can answer that from experience. Electrocautery or desiccation is a way to treat a very small lesion, say 2 or 3 mm in size, though it may not be the best way. The goal of treatment is to eradicate the lesion completely and create a safe margin surrounding it. A word of caution about the desiccator, however. The energy of the spark may extend much farther than appears at the time of the procedure. I have seen sloughing of charred tissue for as much as 3 or 4 mm beyond my directed burning. It is very hazardous to use a desiccator where the underlying mucous membrane could be damaged by the scattered current, as over the nose. The same is true on the eyelid and to a certain extent over the cartilage of the nose or ear. Because of the cautious approach needed, an adequate

depth of desiccation may not be obtained, and there is no way to know it until you get a recurrence.^{2,3}

DR. THOMSON: I met with Maude's three daughters and the director of nursing at the Medina Nursing Center where Maude lives. We reviewed the issues we have discussed here. It was agreed that treatment was indicated to prevent progression of the lesion. One daughter is a nurse, and one has worked in a family physician's office for about 40 years. They knew the prognosis without explanation. The third daughter lived closest and would have had to provide transportation if required; she felt unable to handle Maude by herself if frequent trips for treatment were needed. The director of nursing said there was no way she could assure care for a skin graft or the chemotherapy routine without restraints and sedation. We all agreed that these were not appropriate options. Nursing care policy at Medina is no restraints. With all of her fighting nature, Maude has never been restrained.

The Medina Nursing Center is in a rural village, 25 miles from the tertiary hospital. I talked to Dr. Joel Busse, the Director of Radiation Oncology at the hospital, and described the lesion. Would he be willing to schedule a time to treat this cancer in the shortest time possible? He was very cooperative. Without seeing the patient and relying only on my clinical judgment, he scheduled four treatment sessions over a five-day period. He planned to see her at the first session, look at the lesion to ensure the plan was appropriate, and then start the precalculated 800 rad per treatment, which would require the patient to hold still for seven minutes with each treatment. Maude could have the first treatment Monday afternoon and the last treatment on Friday.

Hospital admission was planned by Dr. Ross, the daughters scheduled their shared role, the nursing center readied her for transfer, and Drs. Ross and Gould were waiting.

DR. ROSS: We had discussed the problem before Maude was admitted and decided we would use a sedation combination we find works well in our pediatrics practice. Maude weighs approximately 115 pounds, and we gave her 50 mg of Demerol, 25 mg of Phenergan, and 25 mg of Thorazine intramuscularly one-half hour before she was scheduled to be transported to Dr. Busse's department. This dosage was considered to be safe, and it worked so well we did not vary it for her three subsequent treatment sessions.

DR. GOULD: I did most of my examinations while Maude was still under sedation. She did not once strike out at me. The only noncooperation at any time in her care was on the part of the floor duty nurses, who felt that my doing a pelvic examination in her bed was more than such an old lady should have to endure. I wonder whether it was more the inconvenience to

them rather than their concern for the patient. I must admit I was not a dedicated team member until I had heard about the life expectancy data that Dr. Ross presented. It certainly changed some of my perspectives on geriatrics and influenced my reasoning so much that I now believe all physicians should keep available a copy of this table of average life expectancy of people over 80 years of age.

DR. THOMSON: For the healthy, ambulatory, cooperative, elderly patient with an early basal cell carcinoma, the family physician has several options at his disposal. In this instance they were very limited and costly, but I believe the results were worth the \$1,600 total expense incurred by inpatient treatment of such a small lesion.

The treatment of Maude's cancer could not have been done without the understanding and cooperation of the family, the nursing home, the hospital, our training program, and Dr. Busse. There is one final lesson here that may have escaped your attention.

A respect for clinical judgment can be gained just as well by a family physician as a tertiary care specialist. To do even a small biopsy would have opened this lesion for the patient to pick. Dr. Busse assumed from my description and from my experience that he could be assured the assessment was correct. He said that if his clinical judgment matched mine, we would go ahead with the treatment plan. Therefore, Maude's little rodent ulcer is now gone, but we do not have a pathology report. Dr. Gould says this bothers her. Maybe I can allay some of her discomfort.

Most, if not all, family practice residencies use the problem-oriented medical record (POMR). This system was introduced by Dr. Lawrence Weed in his classical article entitled, "Records that Guide and Teach."⁵ The crux of his idea was that the primary responsibility of the physician is to solve problems for the patient. If there is a *sine qua non* of family medicine, it is that the physician be a problem solver, even if without an established diagnosis. It is not necessary that all patients die in electrolyte balance, nor is it necessary that a pathological diagnosis be on every chart.

References

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3. Helm F: Cancer Dermatology. Philadelphia, Lea & Febiger, 1979
4. Life Insurance Fact Book. Washington, DC, American Council of Life Insurance, 1984
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BRIEF SUMMARY DIABINESE® (chlorpropamide) TABLETS, USP

CONTRAINDICATIONS

DIABINESE is contraindicated in patients with:
1. Known hypersensitivity to the drug.
2. Diabetic ketoacidosis, with or without coma. This condition should be treated with insulin.

WARNINGS

SPECIAL WARNING ON INCREASED RISK OF CARDIOVASCULAR MORTALITY

The administration of oral hypoglycemic drugs has been reported to be associated with increased cardiovascular mortality as compared to treatment with diet alone or diet plus insulin. This warning is based on the study conducted by the University Group Diabetes Program (UGDP), a long-term prospective clinical trial designed to evaluate the effectiveness of glucose-lowering drugs in preventing or delaying vascular complications in patients with non-insulin-dependent diabetes. The study involved 823 patients who were randomly assigned to one of four treatment groups (Diabetes, 19 [supp. 2]:747-830, 1970).

UGDP reported that patients treated for 5 to 8 years with diet plus a fixed dose of tolbutamide (1.5 grams per day) had a rate of cardiovascular mortality approximately 2½ times that of patients treated with diet alone. A significant increase in total mortality was not observed, but the use of tolbutamide was discontinued based on the increase in cardiovascular mortality, thus limiting the opportunity for the study to show an increase in overall mortality. Despite controversy regarding the interpretation of these results, the findings of the UGDP study provide an adequate basis for this warning. The patient should be informed of the potential risks and advantages of DIABINESE and of alternative modes of therapy.

Although only one drug in the sulfonylurea class (tolbutamide) was included in this study, it is prudent from a safety standpoint to consider that this warning may also apply to other oral hypoglycemic drugs in this class, in view of their close similarities in mode of action and chemical structure.

PRECAUTIONS

General

Hypoglycemia: All sulfonylurea drugs are capable of producing severe hypoglycemia. Proper patient selection, dosage, and instructions are important to avoid hypoglycemic episodes. Renal or hepatic insufficiency may cause elevated blood levels of DIABINESE and the latter may also diminish gluconeogenic capacity, both of which increase the risk of serious hypoglycemic reactions. Elderly, debilitated or malnourished patients, and those with adrenal or pituitary insufficiency are particularly susceptible to the hypoglycemic action of glucose-lowering drugs. Hypoglycemia may be difficult to recognize in the elderly, and in people who are taking beta-adrenergic blocking drugs. Hypoglycemia is more likely to occur when caloric intake is deficient, after severe or prolonged exercise, when alcohol is ingested, or when more than one glucose-lowering drug is used.

Because of the long half-life of chlorpropamide, patients who become hypoglycemic during therapy require careful supervision of the dose and frequent feedings for at least 3 to 5 days. Hospitalization and intravenous glucose may be necessary.

Loss of control of blood glucose: When a patient stabilized on any diabetic regimen is exposed to stress such as fever, trauma, infection, or surgery, a loss of control may occur. At such times, it may be necessary to discontinue DIABINESE and administer insulin.

The effectiveness of any oral hypoglycemic drug, including DIABINESE, in lowering blood glucose to a desired level decreases in many patients over a period of time, which may be due to progression of the severity of the diabetes or to diminished responsiveness to the drug. This phenomenon is known as secondary failure, to distinguish it from primary failure in which the drug is ineffective in an individual patient when first given.

ADVERSE REACTIONS

Hypoglycemia: See PRECAUTIONS section.

Gastrointestinal Reactions: Cholestatic jaundice may occur rarely. DIABINESE should be discontinued if this occurs. Gastrointestinal disturbances are the most common reactions, nausea has been reported in less than 5% of patients, and diarrhea, vomiting, anorexia, and hunger in less than 2%. Other gastrointestinal disturbances have occurred in less than 1% of patients including proctocolitis. They tend to be dose related and may disappear when dosage is reduced.

Dermatologic Reactions: Pruritus has been reported in less than 3% of patients. Other allergic skin reactions, e.g., urticaria and maculopapular eruptions have been reported in approximately 1% or less of patients. These may be transient and may disappear despite continued use of DIABINESE. If skin reactions persist the drug should be discontinued.

Porphyria cutanea tarda and photosensitized reactions have been reported with sulfonylureas. Skin eruptions rarely progressing to erythema multiforme and exfoliative dermatitis have also been reported.

Hematologic Reactions: Leukopenia, agranulocytosis, thrombocytopenia, hemolytic anemia, aplastic anemia, pancytopenia and eosinophilia have been reported with sulfonylureas.

Metabolic Reactions: Hepatic porphyria and disulfiram-like reactions have been reported with DIABINESE.

Endocrine Reactions: On rare occasions, chlorpropamide has caused a reaction identical to the syndrome of inappropriate antidiuretic hormone (ADH) secretion. The features of this syndrome result from excessive water retention and include hyponatremia, low serum osmolality, and high urine osmolality.

DOSEAGE AND ADMINISTRATION

There is no fixed dosage regimen for the management of diabetes mellitus with DIABINESE or any other hypoglycemic agent. In addition to the usual monitoring of urinary glucose, the patient's blood glucose must also be monitored periodically to determine the minimum effective dose for the patient; to detect primary failure, and to detect secondary failure. Glycosylated hemoglobin levels may also be of value in monitoring the patient's response to therapy.

The total daily dosage is generally taken at a single time each morning with breakfast. Occasionally cases of gastrointestinal intolerance may be relieved by dividing the daily dosage. A **LOADING OR PRIMING DOSE IS NOT NECESSARY AND SHOULD NOT BE USED.**

Initial Therapy: 1. The mild to moderately severe, middle-aged, stable, non-insulin-dependent diabetic patient should be started on 250 mg daily. Older patients should be started on smaller amounts of DIABINESE, in the range of 100 to 125 mg daily.

2. No transition period is necessary when transferring patients from other oral hypoglycemic agents to DIABINESE. The other agent may be discontinued abruptly and chlorpropamide started at once. In prescribing chlorpropamide, due consideration must be given to its greater potency.

Many mild to moderately severe, middle-aged, stable non-insulin-dependent diabetic patients receiving insulin can be placed directly on the oral drug and their insulin abruptly discontinued. For patients requiring more than 40 units of insulin daily, therapy with DIABINESE may be initiated with a 50 per cent reduction in insulin for the first few days, with subsequent further reductions dependent upon the response.

Five to seven days after the initial therapy, the blood level of chlorpropamide reaches a plateau. Dosage may subsequently be adjusted upward or downward by increments of not more than 50 to 125 mg at intervals of three to five days to obtain optimal control. More frequent adjustments are usually undesirable.

Maintenance Therapy: Most moderately severe, middle-aged, stable non-insulin-dependent diabetic patients are controlled by approximately 250 mg daily. Many investigators have found that some milder diabetics do well on daily doses of 100 mg or less. Many of the more severe diabetics may require 500 mg daily for adequate control. PATIENTS WHO DO NOT RESPOND COMPLETELY TO 500 MG DAILY WILL USUALLY NOT RESPOND TO HIGHER DOSES. MAINTENANCE DOSES ABOVE 750 MG DAILY SHOULD BE AVOIDED.

HOW SUPPLIED

Blue, "D"-shaped, scored tablets in strengths of 100 mg, tablet code 393; (100's, NDC# 0663-3930-66; 500's, NDC# 0663-3930-73; and 100 unit dose of 10 x 10, NDC# 0663-3930-41) and 250 mg, tablet code 394; (100's, NDC# 0663-3940-66; 250's, NDC# 0663-3940-71; 1000's, NDC# 0663-3940-82; 100 unit dose of 10 x 10, NDC# 0663-3940-41; and 30's D-Pak, NDC# 0663-3940-30).

RECOMMENDED STORAGE: Store below 86°F (30°C).

CAUTION: Federal law prohibits dispensing without prescription.

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