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## **Pediamycin advertisement.**

[s.l.]: [s.n.], 1965

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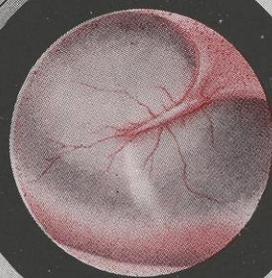
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# on target in otitis media

Otitis media is “one of the most common infections of childhood,”<sup>1</sup> and a common complication of the acute respiratory infections of infants and young children.<sup>2,3</sup> It is seen most frequently during the first two years of life, and occurs more commonly in older children than in adults.<sup>2</sup>



# Pediamycin™

## erythromycin ethyl succinate, Ross

**Pediamycin: Active\* against the common causative bacteria in otitis media:**<sup>4-7</sup> pneumococci, H. influenzae, hemolytic streptococci.

Pneumococci are the most frequent cause of otitis media in both infants and children.<sup>4-7</sup>

H. influenzae is the second most common pathogen in children up to age five. Beyond that age, hemolytic streptococci appear to be more commonly the cause than H. influenzae.<sup>4-7</sup>

Distribution of bacteria isolated from 811 cases of otitis media, according to age<sup>7</sup>

	0-1 year (171 cases)	1-4 years (435 cases)	5 years (205 cases)
beta hemolytic streptococci	6%	25%	46%
pneumococci	59%	43%	47%
H. influenzae	19%	22%	1%
other or sterile	16%	10%	6%

\*If improvement does not occur with antibiotic therapy, myringotomy may be indicated.<sup>9</sup>

**Indications:** Pediamycin is indicated for the great majority of everyday bacterial infections in infants and children. Infections susceptible to erythromycin are primarily those caused by the gram-positive cocci—staphylococci (most strains), pneumococci and streptococci, including enterococci. It is also active against other pathogens such as *Corynebacterium*, *Hemophilus*, *Clostridium*, *Neisseria*, *Treponema pallidum*, some large viruses and *Mycoplasma pneumoniae* (Eaton agent). It is advisable to establish the susceptibility of infecting pathogens when practical. Therapeutic levels should be maintained for 10 days in the treatment of streptococcal infections to prevent rheumatic fever and glomerulonephritis.

**Contraindication:** Known hypersensitivity to erythromycin.

**Precautions, Side Effects:** Side effects are infrequent. Occasionally, mild abdominal discomfort, nausea or vomiting may occur; it is generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. If hypersensitivity is encountered, appropriate countermeasures (e.g., epinephrine, steroids, etc.) should be administered and the drug withdrawn. Overgrowth of nonsusceptible organisms is rare; if it should occur, withdraw the drug and institute appropriate treatment.

**Administration and Dosage:** The recommended dosage of Pediamycin for infants and young children is 15 mg to 25 mg per pound of body weight per day in four or five divided doses. For larger children the adult dosage of 1 to 2 grams per day, depending on the severity of the infection, is recommended. For full therapeutic effect, Chewable tablet should not be swallowed whole.

**Supply: For infants: Pediamycin Drops:** erythromycin ethyl succinate granules for oral suspension, cherry-

flavored, 30 ml bottles, 100 mg of erythromycin activity per dropperful (2.5 ml), calibrated dropper included in package.

**For small children: Pediamycin Suspension:** erythromycin ethyl succinate granules for oral suspension, cherry-flavored, 60 ml and 90 ml bottles, 200 mg erythromycin activity per teaspoonful (5 ml), full and half teaspoon measure included in package.

**For children: Pediamycin Chewable:** erythromycin ethyl succinate chewable tablet, scored, cherry-flavored, 200 mg erythromycin activity. For professional identification each tablet bears the Ross R and list number 205.

**References:** 1. De Weese, D. D., and Saunders, W. H.: *Textbook of Otolaryngology*, St. Louis, The C. V. Mosby Company, 1960, p. 343. 2. Daly, J. F., in *Pediatrics*, ed. 13, Holt, L. E., McIntosh, R., and Barnett, H. L., eds., New York, Appleton-Century-Crofts, Inc., 1962, p. 370. 3. Van Dishoeck, H. A. E., et al.: *Acta Otolaryng.* (Stockholm) 50:250, 1959. 4. Coffey, J. D.; Booth, H. N., and Martin, A. D.: *Pediatrics* 38:25, July, 1966. 5. Lahikainen, E. A.: *Acta Otolaryng.*, Suppl. 103-109, p. 27. 6. Feingold, M., et al.: *Amer. J. Dis. Child.* 111:361, 1966. 7. Mortimer, E. A., Jr., and Watterson, R. L.: *Pediatrics* 17:359, 1956. 8. Strong, M. A., and Vaughan, C. W., in *Current Pediatric Therapy*, Gellis, S. S., and Kagan, B. M., eds., Philadelphia, W. B. Saunders Company, 1964, p. 481.



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