

ON THE BEAT

Cardiologists on the Move

Dr. Roberta G. Williams is stepping down as chair of pediatrics at the University of Southern California, Los Angeles, Keck School of Medicine and will begin a yearlong sabbatical at the university April 1 to study the economics of life cycle coverage for patients with chronic childhood illnesses.

"I guess this is delayed gratification," the pediatric cardiologist told *CARDIOLOGY NEWS*, citing her decades-long interest in the economics of health care delivery for patients with congenital heart disease.

Dr. Williams, who is also vice president for pediatrics and academic affairs at Childrens Hospital Los Angeles, said she will "turn over the reins" to **Dr. D. Brent Polk**, a researcher and pediatric gastroenterologist at Vanderbilt University in Nashville, Tenn.

Dr. Polk will succeed her as chair of both pediatric departments, and as vice president of academic affairs at Childrens Hospital.

Dr. Williams will be joined in her sabbatical by Dana P. Goldman, Ph.D., di-

rector of the Leonard D. Schaeffer Center for Health Policy and Economics at the University of Southern California, and Darius N. Lakdawalla, Ph.D., associate professor at USC's School of Policy, Planning, and Development.

In addition to her interest in health policy, Dr. Williams has been involved in the field of echocardiography since the early 1970s, when she received pediatric cardiology training during a fellowship at Boston Children's Hospital. She went on to direct the hospital's echocardiography lab and became medical director of its cardiothoracic intensive care ser-

vice. From there, she became chief of pediatric cardiology at the University of California, Los Angeles. In 1995, she returned to her alma mater, the University of North Carolina at Chapel Hill (where she had received her medical degree in 1968), to chair the pediatrics department. She joined USC in 2000.

The author of two books on echocardiography, Dr. Williams received the Gifted Teacher Award from the American College of Cardiology in 2002, and has been recognized by the Society of Pediatric Echocardiography for lifetime achievement.

Grants Focus on Wellness, Smoker 'Quitlines'

The federal government has granted states and territories \$119 million to reduce tobacco use, increase physical activity, and fight obesity, the Health and Human Services department announced.

The grants are funded by the American Recovery and Reinvestment Act, also known as the stimulus package.

The money will go to programs aimed at prevention and wellness, HHS Secretary Kathleen Sebelius said at a press conference.

"Prevention is a 'best buy' for health," Dr. Thomas Frieden, director of the Centers for Disease Control and Prevention, said at the conference. The CDC will help states implement the grants.

The awards were made in three major categories: policy and environmental changes; innovative programs; and to-



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DR. FRIEDEN

bacco cessation/telephone-based "quitlines." All 50 states, the District of Columbia, and Puerto Rico will receive funding to expand quitlines.

Dr. Frieden called the lines "highly cost effective," noting that tobacco-related disease is the No. 1 cause of preventable death, and that two-thirds of smokers want to quit, but haven't found the right motivation or program.

Innovative programs in 13 states will receive money for 15 projects. Among those states, Mississippi will receive \$3 million to fund a statewide smoke-free air policy and Rhode Island will receive \$3 million to fund a program to help elderly residents age at home. These programs will likely serve as models for other states, said Ms. Sebelius.

For details, visit www.cdc.gov/chronicdisease/recovery.

—Alicia Ault

Atacand®

candesartan cilexetil

TABLETS

Warning: USE IN PREGNANCY:

When used in pregnancy during the second and third trimesters, drugs that act directly on the renin-angiotensin system can cause injury and even death to the developing fetus. When pregnancy is detected, ATACAND should be discontinued as soon as possible [see WARNINGS AND PRECAUTIONS, Fetal/Neonatal Morbidity and Mortality].

BRIEF SUMMARY Before prescribing, please see full Prescribing Information for ATACAND (candesartan cilexetil).

INDICATIONS AND USAGE

Hypertension ATACAND is indicated for the treatment of hypertension in adults and children 1 to <17 years of age. It may be used alone or in combination with other antihypertensive agents.

Heart Failure ATACAND is indicated for the treatment of heart failure (NYHA class II-IV) in adults with left ventricular systolic dysfunction (ejection fraction $\leq 40\%$) to reduce cardiovascular death and to reduce heart failure hospitalizations [see **CLINICAL STUDIES** in full Prescribing Information (14.2)]. ATACAND also has an added effect on these outcomes when used with an ACE inhibitor.

DOSE AND ADMINISTRATION

Adult Hypertension Dosage must be individualized. Blood pressure response is dose related over the range of 2 to 32 mg. The usual recommended starting dose of ATACAND is 16 mg once daily when it is used as monotherapy in patients who are not volume depleted. ATACAND can be administered once or twice daily with total daily doses ranging from 8 mg to 32 mg. Larger doses do not appear to have a greater effect, and there is relatively little experience with such doses. Most of the antihypertensive effect is present within 2 weeks, and maximal blood pressure reduction is generally obtained within 4 to 6 weeks of treatment with ATACAND. No initial dosage adjustment is necessary for elderly patients, for patients with mildly impaired renal function, or for patients with mildly impaired hepatic function [see **CLINICAL PHARMACOLOGY** in full Prescribing Information (12.3)]. In patients with moderate hepatic impairment, consideration should be given to initiation of ATACAND at a lower dose [see **CLINICAL PHARMACOLOGY** in full Prescribing Information (12.3)]. For patients with possible depletion of intravascular volume (eg, patients treated with diuretics, particularly those with impaired renal function), ATACAND should be initiated under close medical supervision and consideration should be given to administration of a lower dose [see **WARNINGS AND PRECAUTIONS**]. ATACAND may be administered with or without food. If blood pressure is not controlled by ATACAND alone, a diuretic may be added. ATACAND may be administered with other antihypertensive agents.

Pediatric Hypertension 1 to <17 Years of age ATACAND may be administered once daily or divided into two equal doses. Adjust the dosage according to blood pressure response. For patients with possible depletion of intravascular volume (eg, patients treated with diuretics, particularly those with impaired renal function), initiate ATACAND under close medical supervision and consider administration of a lower dose [see **WARNINGS AND PRECAUTIONS**]. Children 1 to <6 years of age: The dose range is 0.05 to 0.4 mg/kg per day. The recommended starting dose is 0.20 mg/kg (oral suspension). Children 6 to <17 years of age: For those less than 50 kg, the dose range is 2 to 16 mg per day. The recommended starting dose is 4 to 8 mg. For those greater than 50 kg, the dose range is 4 to 32 mg per day. The recommended starting dose is 8 to 16 mg. Doses above 0.4 mg/kg (1 to <6 year olds) or 32 mg (6 to <17 year olds) have not been studied in pediatric patients [see **CLINICAL STUDIES** in full Prescribing Information (14.1)]. An antihypertensive effect is usually present within 2 weeks, with full effect generally obtained within 4 weeks of treatment with ATACAND. Children <1 year of age must not receive ATACAND for hypertension. All pediatric patients with a glomerular filtration rate less than 30 mL/min/1.73m² should not receive ATACAND since ATACAND has not been studied in this population [see **WARNINGS AND PRECAUTIONS**]. For children who cannot swallow tablets, an oral suspension may be substituted [see **Preparation of Oral Suspension**]. **Preparation of Oral Suspension:** ATACAND oral suspension can be prepared in concentrations within the range of 0.1 to 2.0 mg/mL. Typically, a concentration of 1 mg/mL will be suitable for the prescribed dose. Any strength of ATACAND tablets can be used in the preparation of the suspension. Follow the steps below for preparation of the suspension. The number of tablets and volume of vehicle specified below will yield 160 mL of a 1 mg/mL suspension. • Prepare the vehicle by adding equal volumes of *Ora-Plus® (80 mL) and *Ora-Sweet SF® (80 mL) or, alternatively, use *†Ora-Blend SF® (160 mL). • Add a small amount of vehicle to the required number of ATACAND tablets (five 32 mg tablets) and grind into a smooth paste using a mortar and pestle. • Add the paste to a preparation vessel of suitable size. • Rinse the mortar and pestle clean using the vehicle and add this to the vessel. Repeat, if necessary. • Prepare the final volume by adding the remaining vehicle. • Mix thoroughly. • Dispense into suitably sized amber PET bottles. • Label with an expiry date of 100 days and include the following instructions: Store at room temperature (below 30°C/86°F). Use within 30 days after first opening. Do not use after the expiry date stated on the bottle. Do not freeze. Shake well before each use.

* Ora-Plus®, Ora-Sweet SF®, and Ora-Blend SF® are registered trademarks of Paddock Laboratories, Inc.

† Supplied as a 50/50% pre-mix of Ora-Plus® and Ora-Sweet SF®.

Adult Heart Failure

The recommended initial dose for treating heart failure is 4 mg once daily. The target dose is 32 mg once daily, which is achieved by doubling the dose at approximately 2-week intervals, as tolerated by the patient.

CONTRAINDICATIONS

ATACAND is contraindicated in patients who are hypersensitive to any component of this product.

WARNINGS AND PRECAUTIONS

Fetal/Neonatal Morbidity and Mortality Drugs that act directly on the renin-angiotensin system can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature in patients who were taking angiotensin-converting enzyme inhibitors. Post-marketing experience has identified reports of fetal and neonatal toxicity in babies born to women treated with ATACAND during pregnancy. When pregnancy is detected, ATACAND should be discontinued as soon as possible. The use of drugs that act directly on the renin-angiotensin system during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to exposure to the drug. These adverse effects do not appear to have resulted from intrauterine drug exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to an angiotensin II receptor antagonist only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should have the patient discontinue the use of ATACAND as soon as possible. Rarely (probably less often than once in every thousand pregnancies), no alternative to a drug acting on the renin-angiotensin system will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intra-uterine environment. If oligohydramnios is observed, ATACAND should be discontinued unless it is considered life saving for the mother. Contraction stress testing (CST), a nonstress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury. Infants with histories of *in utero* exposure to an angiotensin II receptor antagonist should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Oral doses ≥ 10 mg of candesartan cilexetil/kg/day administered to pregnant rats during late gestation and continued through lactation were associated with reduced survival and an increased incidence of hydronephrosis in the offspring. The 10-mg/kg/day dose in rats is approximately 2.8 times the maximum recommended daily human dose (MRHD) of 32 mg on a mg/m² basis (comparison assumes human body weight of 50 kg). Candesartan cilexetil given to pregnant rabbits at an oral dose of 3 mg/kg/day (approximately 1.7 times the MRHD on a mg/m² basis) caused maternal toxicity (decreased body weight and death) but, in surviving dams, had no adverse effects on fetal survival, fetal weight, or external, visceral, or skeletal development. No maternal toxicity or adverse effects on fetal development were observed when oral doses up to 1000 mg of candesartan cilexetil/kg/day (approximately 138 times the MRHD on a mg/m² basis) were administered to pregnant mice.

Morbidity in Infants Children <1 year of age must not receive ATACAND for hypertension. The consequences of administering drugs that act directly on the renin-angiotensin system (RAS) can have effects on the development of immature kidneys.

Hypotension In adult or children patients with an activated renin-angiotensin system, such as volume- and/or salt-depleted patients (eg, those being treated with diuretics), symptomatic hypotension may occur. These conditions should be corrected prior to administration of ATACAND, or the treatment should start under close medical supervision [see **DOSE AND ADMINISTRATION**]. If hypotension occurs, the patients should be placed in the supine position and, if necessary, given an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further treatment which usually can be continued without difficulty once the blood pressure has stabilized. Caution should be observed when initiating therapy in patients with heart failure. Patients with heart failure given ATACAND commonly have some reduction in blood pressure. In patients with symptomatic hypotension this may require temporarily reducing the dose of ATACAND, or diuretic, or both, and volume repletion. In the CHARM program, hypotension was reported in 18.8% of patients on ATACAND versus 9.8% of patients on placebo. The incidence of hypotension leading to drug discontinuation in ATACAND-treated patients was 4.1% compared with 2.0% in placebo-treated patients. Monitoring of blood pressure is recommended during dose escalation and periodically thereafter. **Major Surgery/Anesthesia** Hypotension may occur during major surgery and anesthesia in patients treated with angiotensin II receptor antagonists, including ATACAND, due to blockade of the renin-angiotensin system. Very rarely, hypotension may be severe such that it may warrant the use of intravenous fluids and/or vasopressors.

Impaired Hepatic Function Based on pharmacokinetic data which demonstrate significant increases in candesartan AUC and C_{max} in patients with moderate hepatic impairment, a lower initiating dose should be considered for patients with moderate hepatic impairment [see **CLINICAL PHARMACOLOGY** in full Prescribing Information (12.3)].

Renal Function Deterioration As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in some individuals treated with ATACAND. In patients whose renal function may depend upon the activity of the renin-angiotensin-aldosterone system (eg, patients with severe heart failure), treatment with angiotensin-converting enzyme inhibitors and angiotensin receptor antagonists has been associated with oliguria and/or progressive azotemia and (rarely) with acute renal failure and/or death. Similar results may be anticipated in patients treated with ATACAND [see **CLINICAL PHARMACOLOGY** in full Prescribing Information (12.3)]. In studies of ACE inhibitors in patients with unilateral or bilateral renal artery stenosis, increases in serum creatinine or blood urea nitrogen (BUN) have been reported. There has been no long-term use of ATACAND in patients with unilateral or bilateral renal artery stenosis, but similar results may be expected. In