

HIV Therapy Is Often Suboptimal in Women

BY TIMOTHY F. KIRN
Sacramento Bureau

LOS ANGELES — Only about half of women in the United States infected with HIV and receiving antiretroviral therapy are started on the proper regimen, according to a study presented at the 14th Conference on Retroviruses and Opportunistic Infections.

A previous, similar study of men reported that only 3% of infected males starting antiretroviral therapy (ART) are started on an inappropriate regimen, said Jennifer Cocohoba, Pharm.D., who, in a poster at the meeting, presented the data she and her colleagues analyzed.

However, “the good news is that the trend appears to be decreasing over time,” she said in an interview.

The cohort analyzed was a subset of 217 women in the Women’s Interagency HIV Study (WIHS) who had initiated ART since April 1998, and were not pregnant.

The WIHS collects data at six sites across the country from HIV-infected women who are fairly representative of all women being treated with ART, said Dr. Cocohoba, of the National HIV/AIDS Clinicians’ Consultation Center at San Francisco General Hospital, in an interview.

In their study, the ART regimen the women received when they began treatment was compared with the Department of Health and Human Services’ guidelines at that time. Only 53% were started on the

preferred regimen or a recommended alternative, and 30% were started on a regimen that was not recommended but not considered contraindicated.

Of the remaining 17%, 6% were on a contraindicated dual-drug regimen, 6% were on a contraindicated monotherapy regimen, and 5% were on a therapy that was contraindicated because of drug interactions.

When looking at the response to therapy in relation to the regimens, the study

found that the women who were started on an appropriate regimen had a mean increase in CD4 T cells of more than 100 cells/mcL, whereas those on an unlisted or inappropriate regimen had a mean CD4 T-cell increase of only 30 cells/mcL.

“This finding is not that surprising,” Dr. Cocohoba said in the interview. Being started on an improper regimen also could compromise the women’s response to other regimens later on if they develop resistance and need to switch, she noted. ■

Antibiotics Overprescribed For Rhinosinusitis

Antibiotics are prescribed in 83% of physician visits for acute rhinosinusitis and in 70% of visits for chronic rhinosinusitis, far more than is indicated by the expected rates of bacterial infection, reported Hadley J. Sharp and her associates at the University of Nebraska Medical Center, Omaha.

The investigators examined national trends in rhinosinusitis treatment using data from a probability sample of nearly 6,000 visits for ambulatory medical care to physicians’ offices, hospital outpatient departments, and emergency departments.

The data were collected prospectively by the National Center for Health Statistics from 1999 through 2002, and represent more than an estimated 3 million annual visits for acute and 14 million visits for chronic rhinosinusitis.

Physicians ordered, supplied, administered, or continued at least one prescription antibiotic in 83% of visits for acute rhinosinusitis, representing an estimated 2.5 million cases, and in 70% of visits for chronic rhinosinusitis, representing an estimated 11.6 million cases.

Appropriately, penicillins—mainly amoxicillin and amoxicillin-clavulanate—were the most commonly prescribed antibiotics for both forms of sinusitis, given in about 30% of visits for each disorder.

Unexpectedly, erythromycins, lincosamides, and macrolides comprised the second most commonly used type of antibiotics, and they were prescribed in 24% of visits for acute and 14% of visits for chronic sinusitis. These agents have a lower clinical and bacteriologic efficacy than cephalosporins, sulfonamides, and trimethoprim (Arch. Otolaryngol. Head Neck Surg. 2007;133:260-5).

—Mary Ann Moon

Plan your patients’ transition to an HFA MDI

- In response to the December 2008 withdrawal of generic albuterol CFC MDIs—**production is diminishing early in 2007**^{1,2}
- Your patients currently on a CFC MDI will need to be transitioned to an HFA MDI or other medication
- As there is no generic substitute for any HFA MDI,³ **a new prescription will be required** for patients transitioning from CFC MDIs
- The FDA anticipates adequate supplies of MDIs during the transition period¹

In the treatment or prevention of bronchospasm

THERE’S ONE HFA INHALER THAT’S SEPARATE FROM THE REST

It’s time to choose XOPENEX HFA—
with *only* the therapeutically active (R)-isomer⁴

- Rapid onset of action for relief of bronchospasm^{*4}
- Beta-adrenergic-mediated adverse events are low and comparable to placebo⁴
- The co-pay difference for XOPENEX HFA is *pennies per day* compared with albuterol HFA MDIs⁵

For more information, visit xopenex.com
or call 1-877-SEPRACOR.

*The median onset time of a 15% increase in FEV₁ for XOPENEX HFA Inhalation Aerosol on Day 1 was 5.5 to 10.2 minutes for adult patients and 4.5 minutes for pediatric patients. Please refer to prescribing information.



Xopenex HFA
(levalbuterol tartrate) Inhalation Aerosol

Indication

XOPENEX HFA® (levalbuterol tartrate) Inhalation Aerosol is indicated for the treatment or prevention of bronchospasm in adults, adolescents, and children 4 years of age and older with reversible obstructive airway disease.

Important Safety Information

Xopenex HFA® (levalbuterol tartrate) Inhalation Aerosol is contraindicated in patients with a history of hypersensitivity to levalbuterol, racemic albuterol, or any other component of XOPENEX HFA. XOPENEX HFA and other β-agonists can produce paradoxical bronchospasm, which may be life threatening. If additional adrenergic drugs, including other short-acting sympathomimetic bronchodilators or epinephrine, are to be administered by any route, they should be used with caution to avoid deleterious cardiovascular effects. Due to the cardiovascular side effects associated with β-agonists, caution is generally recommended for patients with cardiovascular disorders (especially coronary insufficiency, cardiac arrhythmias, and hypertension), diabetes, hyperthyroidism, or convulsive disorders. Do not exceed the recommended dose. Fatalities

have been reported in association with excessive use of inhaled sympathomimetic drugs in patients with asthma. Please refer to the full prescribing information regarding potential drug interactions with β-blockers, diuretics, digoxin, or MAOI and tricyclic antidepressants.

In patients aged 4 to 11 years, the most common adverse events (occurring in ≥2% of patients receiving XOPENEX HFA at 90 mcg and more frequently than patients receiving placebo) were vomiting, accidental injury, pharyngitis, and bronchitis.

In patients 12 years and older, the most common adverse events (occurring in ≥2% of patients receiving XOPENEX HFA at 90 mcg and more frequently than patients receiving placebo) were asthma, pharyngitis, rhinitis, pain, and dizziness.

References: 1. US Food and Drug Administration. Center for Drug Evaluation and Research. Questions and answers on final rule of albuterol MDIs. Available at: <http://www.fda.gov/cder/mdl/mdlfaq.htm>. Accessed October 23, 2006. 2. Schering-Plough stakeholder letter. Important information on the availability of albuterol CFC inhalers. Kenilworth, NJ. October 2006. 3. US Food and Drug Administration. Center for Drug Evaluation and Research. Approved drug products with therapeutic equivalence evaluations (the “Orange Book”). 26th ed. Available at: <http://www.accessdata.fda.gov/scripts/cder/ob/docs/tempai.cfm>. Accessed November 28, 2006. 4. Xopenex HFA Prescribing Information. 5. Verispan PDDA. Moving Annual Total. Average number of canisters per year. March 2005–April 2006.

SEPRACOR © 2006 SEPRACOR INC., MARLBOROUGH, MA 01752 All rights reserved. 12/06 XOP-352-06

Please see brief summary of prescribing information for XOPENEX HFA Inhalation Aerosol.

65SRX756