The improved absorption profile of the microemulsion oral formulation of cyclosporin may avoid the need for intravenous administration in the early post-transplantation phase, and in patients with impaired absorption due to biliary diversion or cholestasis.[17] This may reduce treatment costs.

References

1. Noble S, Markham A. Cyclosporin. A review of the pharmacokinetic properties, clinical efficacy and tolerability of a microemulsion-based formulation (Neoral®). Drugs 1995; 50 (5): 924-41
2. Burke JF, Pirsch JD, Ramos E, et al. Long-term efficacy and safety of cyclosporine in renal transplant recipients. N Engl J Med 1994; 331: 358-63
3. Almond PS, Matas A, Gillingham K, et al. Risk factors for chronic rejection in renal allograft recipients. Transplantation 1993; 55: 752-7
4. Kahan BD. Cyclosporine. N Engl J Med 1989; 321: 1725-38
5. Vonderscher J, Meinzer A. Rationale for the development of Sandimmune Neoral. Transplant Proc 1994 Oct; 26: 2925-7
6. Kahan BD, Dunn J, Fitts C, et al. Reduced inter- and intrasubject variability in cyclosporine pharmacokinetics in renal transplant recipients treated with a microemulsion formulation in conjunction with fasting, low-fat meals, or high-fat meals. Transplantation 1995 Feb 27; 59: 505-511
7. Freeman D, Grant D, Levy G, et al. Pharmacokinetics of a new oral formulation of cyclosporine in liver transplant recipients. Ther Drug Monit 1995; 17: 213-6
8. Frei U, Taesch S, Niese D. Use of Sandimmun Neoral in renal transplant patients. Transplant Proc 1994 Oct; 26: 2928-31 (Study in 2 parts. Pt A)
9. Neumayer HH, Färber L, Haller P, et al. Substitution of conventional cyclosporin with a new microemulsion formulation in renal transplant patients: results after 1 year. Nephrol Dial Transplant 1996; 11: 165-172
10. Pollak R. The Neoral™ vs Sandimmune® soft-gelatin capsule randomized multicenter three-month double-blind trial (N-103): tolerability and safety profiles. In: Neoral™: The new Microemulsion Formulation of Cyclosporine, Special Report, May 1995. Cedar Knolls, New Jersey, USA: World Medical Press, 1995: 19-27
11. Niese D, on behalf of the International Sandimmun Neoral Study Group. A double-blind randomized study of Sandimmun Neoral versus Sandimmun in new renal transplant recipients: results after 12 months. Transplant Proc 1995 Apr; 27: 1849-56
12. Levy G, Altraif I, Rezieg M. et al. Cyclosporine Neoral in liver transplant recipients. Transplant Proc 1994 Dec; 26: 3184-7
13. Svendsen U, Larsen K, Allermand H, et al. Neoral conversion study: shift from Sandimmune classic formulation to Sandimmmune Neoral in heart and lung transplant patients. Transplant Proc 1995 Dec; 27: 3477
14. Neumayer HH. Cyclosporin as microemulsion – is it a new drug? Nephrol Dial Transplant 1996; 11: 19-20
15. Keown P, Lawen JG, Landsberg D, et al. Economic analysis of Sandimmune Neoral in Canada in stable renal transplant patients. Transplant Proc 1995 Apr; 27: 1845-8
16. Tsunoda SM and Aweeka FT. The use of therapeutic drug monitoring to optimise immunosuppressive therapy. Clin Pharmacokinet 1996 Feb; 30 (2): 107-40
17. Friman S, Bäckman L. A new microemulsion formulation of cyclosporin. Pharmacokinetic and clinical features. Clin Pharmacokinet 1996 Mar; 30 (3): 181-93

Addendum

New data show survival advantage for paclitaxel combination

Subsequent to publication of the article entitled 'Paclitaxel: a promising addition to the antineoplastic armamentarium' [Drug Ther Perspect 1995 Feb 20; 5(3): 1-5], data have become available to answer the questions posed as to whether paclitaxel would offer meaningful improvements in patient survival compared with standard therapies for advanced ovarian cancer, and whether it had a place in the initial treatment of this disease.

Results from a recent randomised phase III study of the Gynecologic Oncology Group provide strong evidence that combining paclitaxel with cisplatin improves progression-free and overall survival compared with cyclophosphamide plus cisplatin as initial therapy in women with advanced ovarian cancer.[1] Thus, these data suggest this paclitaxel/cisplatin combination should now be considered standard therapy for women with advanced ovarian cancer.[2]

Women in this study received intravenous (IV) cisplatin 75 mg/m^2 (infused at a rate of 1 mg/min) combined with either paclitaxel 135 mg/m^2 (administered as an infusion over 24 hours) or IV cyclophosphamide 750 mg/m^2 once every 3 weeks for a total of 6 courses.[1]

Overall, the median survival of paclitaxel/cisplatin recipients was 38 months (95% confidence interval; 32 to 44 months) compared with 24 months (95% CI; 21 to 30 months) for cyclophosphamide/cisplatin recipients.

Toxicity tended to be more severe in the paclitaxel/cisplatin group, but it was considered clinically manageable.[1] Paclitaxel recipients received premedication with dexamethasone, diphenhydramine and an H_2-antagonist.

References

1. McGuire WP, Hoskins WJ, Brady MF, et al. Cyclophosphamide and cisplatin compared with paclitaxel and cisplatin in patients with stage III and stage IV ovarian cancer. N Engl J Med 1996 Jan 4; 334(1): 1-6
2. Neijt JP. New therapy for ovarian cancer [editorial]. N Engl J Med 1996 Jan 4; 334(1): 50

1172-0360/96/00006-008/$01.00