Cyclosporin is known to cause hyperuricemia which may subsequently cause gouty nephropathy and graft dysfunction. The purpose of this study was to evaluate the frequency and predisposing factors of hyperuricemia in cyclosporin-treated patients within one year of kidney transplantation and uricosuric efficacy of benzbromarone. The patients who were treated with cyclosporin after kidney transplantation in 1998 and 1999 were investigated retrospectively. Among the 76 patients in cyclosporin-treated patients in 1998, hyperuricemia occurred in 55 patients (72.4%) and the mean time from kidney transplantation to occurrence of hyperuricemia was 5.0?.0 months. These patients were not treated with any medication for hyperuricemia. In 1999, 22 patients were treated with benzbromarone for hyperuricemia and their mean time from kidney transplantation to occurrence of hyperuricemia was 4.5? 0.4 months. Acute rejection developed in one patient (4.8%) out of 21 normo-uricemic patients in 1998, and 11 patients (20.0%) out of 55 hyperuricemic patients in 1998. The difference of rejection rate in these two groups was significant (p=0.001). There was no difference of rejection rate between before and after treatment of benzbromarone. Hyperuricemic patients showed significantly higher serum creatinine levels than patients with normal uric acid levels (p=0.006). Benzbromarone decreased serum uric acid levels from 8.6?.3mg/dl to 5.1?.0mg/dl (p=0.001) and thereby normalized serum uric acid in all of 22 patients. Reduced serum uric acid levels were maintained at 3.0?.4mg/dl once serum uric acid levels were normalized. Except for one patient (4.5%) who experienced diarrhea, no significant side effect was noted.

[PA2-3] [10/18/2001 (Thr) 14:00 - 17:00 / Hall D]

A Comparison of Effects of Alendronate and Calcitriol Combined with Estrogen Replacement Therapy in Postmenopausal Osteoporotic Patients

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The purpose of this study was to evaluate the effects of alendronate and calcitriol combined with hormone replacement therapy in postmenopausal osteoporotic women. Seventy-nine postmenopausal women who visited Kangnam St.Mary's Hospital were assessed to evaluate the impacts of each drug on bone mineral density and bone metabolism. Group I was composed of 20 women who received estrogen only, Group II was composed of 28 women who received estrogen with addition of calcitriol (0.5㎍ daily), and Group III was composed of 31 women who received estrogen with addition of alendronate (10mg daily). In all subjects, bone mineral density (BMD) was measured in the lumbar vertebrae (L2-4) and femur neck using dual energy absorptiometry (DEXA), and serum osteocalcin, serum total alkaline phosphatase and urine deoxypyridinoline were measured at the beginning of the treatment and after 12 months of treatment. BMD of the lumbar vertebrae in Group II increased significantly compared to basal level at 12 months, but not in Group I and III. As for BMD of the femur neck, it increased significantly during the treatment in Group I and Group II, but not in Group III. Serum osteocalcin in Group III decreased significantly at 12 months of treatment compared with Group I and II. Serum alkaline phosphatase in Group I and III decreased significantly at 12 months of treatment compared with Group I. Urine deoxypyridinoline in Group I, Group II and Group III decreased but was statistically insignificant. From the above results, it might be suggested that the combined therapy (estrogen with daily addition of alendronate or Calcitriol) is more effective than the estrogen therapy only for the protection of decreasing bone mineral density in the postmenopausal women.

[PA2-4] [10/18/2001 (Thr) 14:00 - 17:00 / Hall D]

A Comparison of Platinum-Based Combination Chemotherapy in Patient with Non-Small Cell Lung Cancer

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Non-small cell lung cancer(NSCLC) remains the leading cause of cancer related death and 5-year survival rate is approximately 10-15%. Platinum-based chemotherapy has been demonstrated to improve survival in advanced NSCLC. Platinum-based paclitaxel and gemcitabine combination therapy considered moderately active regimen in patients with advanced NSCLC and warrants comparison with existing platinum-based regimen in randomized trial. The aim of this study was to evaluate toxicity and efficacy of platinum-based paclitaxel and gemcitabine combination therapy.
The medical charts of fifty-six patients with NSCLC, who met selection criteria from January 2000 to March 2001, were reviewed retrospectively. They received one of three regimens greater than 2 cycles up to 7 cycles, paclitaxel (140mg/m2) and cisplatin (60mg/m2), paclitaxel (120mg/m2) and carboplatin (300mg/m2), gemcitabine (1000mg/m2) and cisplatin (60mg/m2). Data collection and analysis included baseline characteristics, hematologic and non-hematologic toxicity profiles according to WHO toxicity criteria and overall response according to clinician's opinion on basis of clinical results.
As results, WHO grade above 2 hematologic toxicity occurred high in gemcitabine/cisplatin arm(9.6%) compared with other two arms (paclitaxel/cisplatin 2.8% vs. paclitaxel/carboplatin 5.8%). WHO grade above 2 non-hematologic GI toxicity occurred high in paclitaxel/carboplatin arm(5.2%) compared with other two arms (paclitaxel/cisplatin 3.4% vs. gemcitabine/cisplatin 2.5%). WHO grade above 2 non-hematologic excluding GI toxicity occurred high in paclitaxel/cisplatin arm(8.8%) compared with other two arms (paclitaxel/carboplatin 7.9% vs. gemcitabine/cisplatin 2.6%). Common side effects included nausea/vomiting, peripheral neuropathy and alopecia. Comparing toxicity profiles for the three regimens revealed no significant difference. Overall response rate was 22% for paclitaxel/cisplatin arm, 31% for paclitaxel/carboplatin arm, and 15% for gemcitabine/cisplatin arm. Comparing response rate for the three arms revealed no significant difference. The median survival period was 12.2 months for paclitaxel/cisplatin arm, 18.3 months for paclitaxel/carboplatin arm, and 8.3 months for gemcitabine/cisplatin arm. Comparing survival for the three arms revealed no significant difference. There were several limitations of this study, uncontrolled baseline disease, baseline toxicity, number of patient and number of effective cycles for the treatment group. Further well-designed study is required and pharmacist's role in ADR monitoring should be emphasized.

[PA2-5] [10/18/2001 (Thr) 14:00 - 17:00 / Hall D]

A Comparison of Lovastatin and Simvastatin in Treatment of Hyperlipidemia

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Hypercholesterolemia is one of main causes of coronary heart disease(CHD). Clinical trials demonstrated that lowering serum cholesterol levels would reduce incidence of new cardiovascular events and mortality by primary or secondary preventions. The objective of this retrospective study was to compare efficacy and side effects of lovastatin and simvastatin in treatement of hypercholesterolemia. In Boramae Hospital, patients were included when they have taken lovastatin 20㎎ or simvastatin 10㎎ for 52 weeks with laboratory monitoring for cholesterol at baseline, 3, 6 and 12 month period. As results, total 128 outpatients were included with their total cholesterol level ≥240㎎/㎗ and triglyceride level <400㎎/㎗ at baseline. Total cholesterol and LDL cholesterol of lovastatin group(n=60) and simvastatin group(n=68) were significantly reduced from baseline(p=0.001). Lovastatin maximally reduced total cholesterol by 23.9%, triglyceride by 12.3%, LDL cholesterol by 36.1% and increased HDL cholesterol by 7.8% and simvastatin reduced by 24.1%, 20.5%, 34.3% respectively and HDL increased by 11.2%. There were no significant differences between lovastatin and simvastatin in mean percent change of lipid levels at 12, 24 and 52 weeks from baseline. Cumulative percentage of patients reaching the target LDL cholesterol concentration by 24 weeks was 61.7% in lovastatin and 64.7% in simvastatin. Average time to reach the target LDL goal was 100.1 days in lovastatin and 99.8 days in simvastatin.
Both lovastatin and simvastatin also significantly reduced total cholesterol and LDL cholesterol in all three subgroups (diabetes mellitus group, hypertension group, and coronary heart disease group), but there was no significant difference in efficacy between lovastatin and simvastatin. In this study, treatment efficacy in patients with coronary heart disease was lower than other patients. Considering clinical importance of secondary prevention, more intensive treatment is necessary to decrease LDL cholesterol level of 100㎎/㎗ or lower in patients with coronary heart disease or other clinical