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TITLE: EVALUATION OF SODIUM STIBOGLUCONATE (PENTOSTAM) AND

KETOCONAZOLE IN THE TREATMENT OF AMERICAN CUTANEOUS

LEISHMANIASIS

PRINCIPAL INVESTIGATOR: THOMAS R. NAVIN

PI ADDRESS: MERTU/Guatemala

c/o US Embassy APO Miami 34024

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## 19. ABSTRACT (continued)

stibogluconate, 4 (50%); ketoconazole 8 (80%); and placebo, 6 (38%). High dose sodium stibogluconate appears to be well tolerated and effective against infections caused by L. b. braziliensis but less so against infections caused by L. m. mexicana, and ketoconazole appears to be effective against infections caused by L. m. mexicana but less so for infections caused by L. b. braziliensis.

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### FOREWORD

Citations of commercial organizations and trade names in this report do not constitute an official Department of the Army endorsement or approval of the products or services of these organizations.

The investigator(s) have abided by the National Institutes of Health Guidelines for Research Involving Recombinant DNA Molecules (April 1982) and the Administrative Practices Supplements.

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# FIGURES

1.	Percent of patients who responded to treatment with sodium stibogluconate, ketoconazole, or placebo by week of follow-up examination
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3.	Percent of patients infected with $\underline{L}$ . $\underline{m}$ . $\underline{m}$ exicana who responded to treatment
4.	Change in lesion size from 2 weeks before to 13 weeks after starting therapy for patients infected with L. b. braziliensis
5.	Change in lesion size from 2 weeks before to 23 weeks after starting therapy for patients infected with L. m. mexicana

#### INTRODUCTION

The recommended treatment for American cutaneous leishmaniasis (ACL) is one of two available pentavalent antimony compounds, sodium stibogluconate (Pentostam, Burroughs Wellcome) and meglumine antimonate (Glucantime, Specia). Despite the wide use of these antimonials, little reliable information is available on their optimum dose or their toxicity at higher doses.

In 1990 we reported that for Guatemalan cutaneous leishmaniasis 850 mg of antimony (equivalent to approximately 15 mg antimony/kg) for 15 days was very well tolerated and produced a clinical and parasitological response in 73% of patients by 13 weeks. \1/Reactivation of infections during 12 months of follow-up in 9% of patients lowered the final response rate to 64%. Others have shown that patients can tolerate up to 20 mg antimony/kg/day for 20 days with only minimal hepatic and cardiac injury. \2--3/

In an attempt to improve on our previously reported response rate of 64% and to better characterize the toxicity of high dose antimony, in this study we treated patients with sodium stibogluconate (20 mg antimony/kg/day iv) for 20 days.

Despite the wide acceptance of antimonials in the treatment of leishmaniasis, there is a pressing need for alternative therapies. Antimonials are expensive and require parenteral injection. In this day of hepatitis and adult immunodeficiency syndrome, oral drugs are increasingly attractive. Studies in Panama have shown that ketoconazole is equally effective as moderate dose antimony for leishmaniasis caused by <u>Leishmania braziliensis panamensis</u>.\4/

Ketoconazole is an imidazole drug that has shown remarkable success in the treatment of superficial and systemic mycoses.\5/
Ketoconazole interferes with the biosynthesis of ergosterol, a major fungal sterol critical to membrane integrity, thus inhibiting the 14-demethylation of lanosterol, a precursor in the ergosterol pathway.

Blockage of this pathway results in ergosterol-poor organisms that are unable to maintain their plasma membranes. The selective effect of ketoconazole on fungi and Leishmania is due to the fact that ergosterol is of little importance to mammalian membranes, and cholesterol, the critical membrane sterol for mammals, is available from the diet.\6/

Ketoconazole has been used in clinical trials for mycotic infections since 1978, and more than 1 million patients have received the drug with few adverse effects. Although it appears to block adrenal steroid synthesis, no cases of hypoadrenalism have been reported. Skin rashes, nausea, vomiting, and anorexia have been the problems most commonly reported. Ketoconazole may interact with alcohol to increase susceptibility to nausea. Mild asymptomatic and reversible serum transaminase elevations have been observed in up to 15% of patients, but the incidence of serious hepatic injury has been estimated to be only 1 in 15,000 patients. \7/ Three deaths, all from hepatic failure, have been attributed to ketoconazole, for a mortality rate of 1 in 333,333 patients. Each person continued to take ketoconazole despite the appearance of jaundice. \8/

#### MATERIALS AND METHODS

## Patient population

Guatemalan males who sought treatment for suspected leishmaniasis at any of our 4 clinics were evaluated. Eligibility for the study included a confirmed diagnosis of leishmaniasis, no previous treatment with antimonials or imidazoles, no serious concomitant medical problems, and no visible evidence of mucosal involvement. In contrast to our 1990 clinical study, which involved only military personnel, this study included 21 civilians and 99 soldiers. Persons who met the study requirements were offered the opportunity to enter the study. Informed consent was obtained from each person.

#### Treatment groups

treatment groups: those receiving sodium stiboguconate (20 mg pentavalent antimony/kg/day iv for 20 days); those receiving ketoconazole (600 mg po each evening for 28 days); and those receiving placebo treatment. Half of the patients assigned to the placebo group received saline infusions similar to the sodium stibogluconate infusions, and half received tablets similar to ketoconazole.

#### Patient evaluation

Diagnosis of cutaneous leishmaniasis was made by thin smears of lesion scrapings or culture of lesion aspirates as described before. Only patients with positive cultures or clearly distinguishable amastigotes were entered into the study.

Isolates were characterized by isoenzyme electrophoresis as described before.\10/ The following enzymes were used: glucose phosphate isomerase, mannose phosphate isomerase, phosphogluconate dehydrogenase, phosphoglucomutase, and peptidase D.

Patients were evaluated at 1, 2, 3, 4, 6, 9, 13, 26, and 52
weeks after the start of therapy. Clinical response was defined as a
lesion that completely reepithelialized and had no evidence of
inflammation or induration. Aspirates for culture of all lesions and
scrapings of open lesions were taken at the end of therapy and at the
9-week follow-up examination. A reactivated lesion was defined as
the appearance of a lesion within or at the border of a previous
lesion; new lesions were defined as those that appeared after
treatment began and occurred away from any previous lesions. Since
most of our patients remained in the endemic area during and after
treatment, the appearance of new lesions was not necessarily taken as
evidence of treatment failure.

If a patient's lesion was not completely reepithelialized by the 13-week follow-up examination, the patient was removed from the study and treated with meglumine antimonate (20 mg antimony/kg/day) for 20 days. Patients with clinically healed but parasitologically positive lesions at the 9-week examination were not retreated.

Before beginning treatment, on the last day of treatment, and at the 9-week examination patients had the following tests performed: hemoglobin, hematocrit, platelet count, white blood cell count, aspartate aminotransferase, alanine aminotransferase, direct and indirect bilirubin, creatinine, and electrocardiogram. In addition, patients treated with antimony or placebo injections had the liver function tests repeated on days 7 and 14 and had the electrocardiograms repeated on days 2, 4, 7, 9, 11, 14, 16 and 18. Patients who received ketoconazole or placebo tablets also had liver function tests repeated on day 14.

#### RESULTS

#### Patient characteristics

Four patients who were eligible for the study and who were offered the chance to participate declined because they preferred not to receive experimental therapy.

One hundred and twenty study subjects were enrolled. Randomization successfully allocated patients with similar characteristics into the 3 treatment groups (Table 1.)

All but 2 of the 120 patients received their treatments without interruption. Both patients who prematurely interrupted their treatments were receiving ketoconazole (see the section below on adverse effects for details). For the purposes of data analysis, data on these 2 patients is not included.

Clinical and parasitological response

Figure 1 shows the response rates of patients in the 3 treatment groups. A number of patients had complete reepithelialization of their lesions but cultures either on the last day of treatment or at the 9-week examination were still positive. In order to show both clinical response rates as well as clinical plus parasitological response rate, in Figures 1, 2, and 3, each treatment group is represented by 2 lines. The lower, bold, line represents the percentage of patients that had complete reepithelialization of their lesions and negative cultures at the end of treatment and at 9 weeks. The upper, narrow, line represents the percentage of patients that had a complete clinical response, irrespective of the results of cultures.

Figure 2 shows response rates for the 52 patients infected with L. b. braziliensis. Patients who received sodium stibogluconate usually responded rapidly, and by the end of 20 days of treatment all patients were parasitologically negative and 30% had completely closed their lesions. By 13 weeks only 1 patient (7%) had not responded both clinically and parasitologically. This patient had 3 large ulcers; 2 had closed completely by the 13th week, but 1 was only 70% reepithelialized. Cultures of all 3 lesions were negative. He may have continued to improve without further treatment, but in compliance with the study protocol he was dropped from the study and treated successfully with meglumine antimonate.

At the time of this report, only 14 of the 18 patients infected with <u>L. b. braziliensis</u> and treated with sodium stibogluconate have

returned for their follow-up examinations at 26 and 52 weeks. Of this group, none has had reactivations of their lesions.

Patients infected with <u>L. b. braziliensis</u> and treated with ketoconazole did not respond as well as those treated with sodium stibogluconate but responded better than those treated with placebo. At the 13-week examination, the clinical response rate for the ketoconazole group was significantly less than that for the sodium stibogluconate group (p<0.01; Fisher's exact test) but was significantly greater than that for the placebo group (p<0.03). The rates for ketoconazole clinical plus parasitological responses were also significantly less than that for sodium stibogluconate (p<0.01) but not significantly greater than that for placebo (p<0.09).

Patients who received placebo treatment and who were infected with <u>L. b. braziliensis</u> did not do well. At 13 weeks only 3 were clinically cured, but 2 of these had positive cultures. By 26 weeks 2 of the 3 had reactivations of their lesions.

Figure 3 shows the response rates for the 34 patients infected with  $\underline{L}.$   $\underline{m}.$   $\underline{m}.$ 

Of the 99 patients who have returned for their 52-week follow-up examination, the vast majority have returned to a <a href="leishmania">leishmania</a>-endemic area. Despite this only 2 have developed new lesions of

leis maniasis. One had received sodium stibogluconate and had a new lesion due to  $\underline{L}$ .  $\underline{b}$ .  $\underline{b}$  raziliensis, and the other was treated with ketoconazole and was infected with  $\underline{L}$ .  $\underline{m}$ .  $\underline{m}$  mexicana.

Thirteen (11%) of the patients developed small papules at the edge of healed lesions after treatment was completed. In 4 cases the papules grew rapidly, ulcerated within 4 weeks, and provided positive cultures. In the remaining 9 cases the papules remained stable for the duration of our follow-up, and all cultures were negative. Since stable papules did not appear to be a bad prognostic sign, for the purposes of this study we have not considered them to signify reactivation of lesions.

Figures 4 and 5 show the mean change in lesion size from 2 weeks before to 13 weeks after starting treatment. Figure 4 depicts data for patients infected with  $\underline{L}$ .  $\underline{b}$ .  $\underline{b}$  raziliensis and Figure 5 shows data for patients infected with  $\underline{L}$ .  $\underline{m}$ .  $\underline{m}$  rexicana.

Laboratory test and adverse effects

Table 2 lists the laboratory values before, at the end of, and 9 weeks after treatment.

Note that results for alkaline phosphatase are not included in the summary, although they are given in annex 2, which lists all laboratory values. The laboratory that ran our specimens changed analytic procedures for alkaline phosphatase several times, making it impossible to compare results from patient to patient or even for the same patient from 1 time period to another.

Six (15%) of the 40 patients who received sodium stibogluconate developed elevated transaminases. Aspartate aminotransferase and

alanine aminotransferase values were equally elevated, but neither direct nor indirect bilirubin values were ever elevated, no patients developed jaundice, and no patients complained of right upper quadrant pain. The highest aspartate aminotransferase value was 358 IU (upper limit of normal = 55 IU). The course of elevated transaminase values was irregular. Often the highest values were not on the last day of treatment, and in several cases, the values dropped despite continued therapy. We believe that a number of instances of elevated values were due to the concurrent ingestion of alcohol.

One patient in the sodium stibogluconate group and 2 patients in the ketoconazole group developed anemia during treatment. In all 3 cases the patients developed fever and chills and blood smears were positive for <u>Plasmodium vivax</u>. Treatment of the malaria resolved the anemia.

Note that the 600 electrocardiograms taken during this study are still being analyzed. The results will be ready within the next 2 months. Preliminary analysis shows that t-wave suppression was very common in the sodium stibogluconate group, but no cases occurred of t-wave inversion or concave st-segments.

Table 3 shows the adverse reactions reported by patients.

Adverse reactions were reported by 21 patients who received sodium stibogluconate, 7 patients who received ketoconazole, and 4 patients who received placebo. The majority of the adverse reactions were minor and did not require medical attention, and none were severe enough to pose a threat the patient.

For the sodium stibogluconate group, 5 patients had 7 adverse reactions significant enough to warrant medical intervention. For

the ketoconazole group, 3 patients reported 4 moderate adverse reactions, and for the placebo group, 1 patient reported moderately severe epigastric pain. In only 2 patients, both of whom received ketoconazole, were the adverse reactions severe enough to lead to the premature termination of treatment.

The first patient developed a generalized pruritic papular erythematous rash on the 17th day of treatment with ketoconazole. The patient had no urticaria or wheezing, and his blood pressure remained normal. Although in the opinion of the treating physician the rash did not require the termination of ketoconazole, the patient decided to withdraw from the study. The rash spontaneously resolved 3 days after cessation of ketoconazole. The patient was successfully treated with meglumine antimonate.

The second patient developed epigastric pain and nausea 2 hours after the second dose of ketoconazole. Two hours after the onset of these symptoms the patient vomited several times and had diarrhea. Ketoconazole was stopped for 2 days, during which the patient had no gastrointestinal symptoms. Ketoconazole and antacids were restarted and the patient again developed moderately severe epigastric pain, but this time did not vomit or have diarrhea. The patient was able to continue ketoconazole until the 16th dose when the epigastric pain increased substantially and he again vomited once. The patient was withdrawn from the study and treated successfully with meglumine antimonate. One day after ketoconazole was stopped the gastrointestinal symptoms resolved.

#### DISCUSSION

Treatment with high dose (20 mg/kg/day for 20 days) sodium stibogluconate in this clinical trial proved very effective against infections due to <u>L. b. braziliensis</u> but not more effective than placebo against infections caused by <u>L. m. mexicana</u>. In our clinical trial of 1990, we reported that only 64% of patients infected with <u>L. b. braziliensis</u> had clinical and parasitological responses to 850 mg antimony/day for 15 days (225 mg/kg total dose). \1/

The higher dose of sodium stibogluconate used in this study is apparently more effective than the lower dose used in the 1990 study for infections caused by <u>L. b. braziliensis</u>. Adverse effects such as arthralgias, nausea, headaches, and phlebitis were more common with the higher dose, but these were never more than moderately severe and did not require the premature termination of antimony.

Dosages of antimony of 20 mg/kg, which for an adult is equivalent to 12 to 15 ml/dose, require that the drug be given by intravenous infusion. Dosages of 850 mg, equivalent to 8.5 to 10 ml/dose, can be given by injection into the muscle. Although intravenous infusions can be less painful than intramuscular injections, they require special equipment and training. For clinics that are properly equipped, intravenous infusions pose no special problems. Cutaneous leishmaniasis, however, usually occurs in remote areas far from well equipped clinics. To the extent that it is advantageous to decentralize the treatment of cutaneous leishmaniasis in developing countries, higher dosage regimens of antimony are a drawback.

In contrast to our impressive results with sodium stibogluconate for infections caused by <u>L. b. braziliensis</u>, this drug was not significantly better than placebo for infections caused by the other major species of <u>Leishmania</u> in Guatemala, <u>L. m. mexicana</u>. Although infections by <u>L. m. mexicana</u> are traditionally considered benign, in our experience in Guatemala, they can cause significant morbidity if treatment is not available or is restricted to antimonials. Of 18 patients who we have treated with at least 2 courses of antimonials, 16 were infected with <u>L. m. mexicana</u>, and of 5 patients who have required at least 3 courses of antimonials, all 5 were infected with <u>L. m. mexicana</u>.

The tradition belief that <u>L. m. mexicana</u> infections, once healed, never reactivate also does not apply to Guatemalan infections. In our experience untreated or undertreated <u>L. m.</u> mexicana infections often run a cyclical course. They will ulcerate and stay open for several months, then reepithelialize and stay closed for several months, and then ulcerate again. Such cycles can continue for at least 7 years in our experience. Of the 12 patients in the present study infected with <u>L. m. mexicana</u> who received placebo treatment and did not respond, 5 (42%) at some point in their follow-up healed their lesions before developing reactivations.

Given the cyclical nature of  $\underline{L}$ .  $\underline{m}$ .  $\underline{m}$  mexicana infections and their poor response to antimonials, it is encouraging that ketoconazole appears to be effective.

Table 1. Characteristics of patients by treatment group

	Treatment group						
Characteristic		Ketoconazole (n=38)					
Age (years)	19.1 <u>+</u> 0.6	20.2 <u>+</u> 1.2	21.3 ± 1.4				
Number lesions/patient	1.6 <u>+</u> 0.2	$1.5 \pm 0.1$	1.5 <u>+</u> 0.2				
Mean area of ulceration (cm <sup>2</sup> )	1.5 <u>+</u> 0.3	$2.2 \pm 0.4$	$2.0 \pm 0.4$				
Mean age of lesions (days)	73.7 <u>+</u> 34	68.3 <u>+</u> 10	59.1 <u>+</u> 7				
Infecting species 1							
L. m. mexicana	8	10	16				
L. b. braziliensis	18	19	15				
Unknown	12	9	9				

<sup>1.</sup> Provisional

Table 2. Laboratory values before, during, and after treatment

	Treatment group						
Laboratory test	Pentostam (n=40)	Ketoconazole (n=38)	Placebo (n=40)				
Serum creatinine (mg/100ml)	0.75	0.75	0.05				
Before treatment	0.75	0.75	0.85				
Last day of treatment	0.79	0.81	0.79				
9 weeks	0.76	0.83	0.82				
# with abnormalities on .							
last day of treatment *	0	0	0				
Aspartate aminotransferase (IU)							
Before treatment	20	17	15				
Last day of treatment	35	14	15				
9 weeks	20	15	18				
# with abnormalities on *			_				
last day of treatment *	3	0	0				
Alanine aminotransferase (IU)							
Before treatment	20	16	14				
Last day of treatment	34	14	15				
9 weeks	19	17	17				
# with abnormalities on *							
last day of treatment ^	3	0	0				
Indirect Bilirubin (mg/100ml)							
Before treatment	0.27	0.23	0.29				
Last day of treatment	0.24	0.26	0.30				
9 weeks	0.25	0.28	0.26				
# with abnormalities on .							
last day of treatment *	0	0	0				

Table 2. Continued

	Treatment group						
Laboratory test	Pentostam (n=40)	Ketoconazole (n=38)	Placebo (n=40)				
Direct Bilirubin (mg/100ml)							
Before treatment	0.29	0.28	0.33				
Last day of treatment	0.24	0.36	0.30				
9 weeks	0.31	0.31	0.26				
# with abnormalities on .							
last day of treatment *	0	0	0				
Platelets (#/mm <sup>3</sup> X 1000)							
Before treatment	227	228	228				
Last day of treatment	207	224	222				
9 weeks	216	206	218				
9 weeks	216	200	210				
<pre># with abnormalities on _</pre>							
last day of treatment *	0	0	0				
Hemoglobin (gm/100 ml)							
Before treatment	14.9	14.4	14.4				
Last day of treatment	14.2	13.9	14.7				
9 weeks	14.8	14.1	14.8				
<pre># with abnormalities on .</pre>							
last day of treatment *	0	0	0				
Hematocrit (%)	<b>4</b> ⊆	4.3	43				
Before treatment	45	= =	43 44				
Last day of treatment	43	42					
9 weeks	4 4	42	45				
# with abnormalities on *	2	2	0				
last day of treatment ^	1	2	0				

Table 2. Continued

	Т	reatment group	
Laboratory test	Pentostam (n=40)	Ketoconazole (n=38)	Placebo (n=40)
White blood cells (#/mm <sup>3</sup> )			
Before treatment	7070	6992	7491
Last day of treatment	6795	7540	7823
9 weeks	6831	7808	7609
<pre># with abnormalities on   last day of treatment *</pre>	0	0	0

<sup>\*</sup> Number of patients with values at the last day of treatment outside of the normal range for the testing laboratory.

Table 3. Adverse Reactions Reported by Patients

Treatment group/ Adverse reaction	Mild	Moderate	Severe	Total
Pentostam				
Nausea	3	2	0	5
Anorexia	4	0	0	4
Headache	1	2	0	3
Rash	1	0	0	3 1 5
Arthralgias	5	1	0	
Phlebitis	8	2	0	10
Ketoconazole		. <b>*</b> *	_	_
Nausea	1	1	0	2 2 2 1
Abdominal pain	1	1	0 0	2
Headache Dizziness	1 1	7	0	1
Rash	0	1 1 0 1 **	0	1
Placebo				
Abdominal pain	2	1	0	3
Nausea	1	0	0	1
Anorexia	1	0	0	1

Moderate: Required medical attention, but posed no danger to

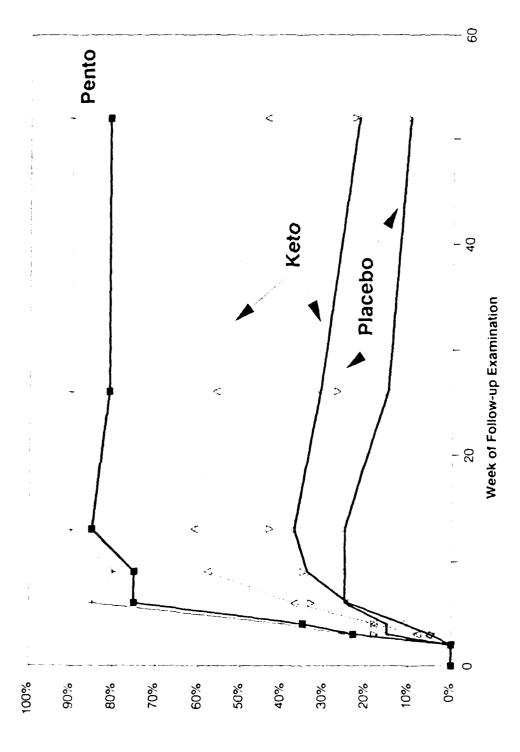
patient

Severe: Required immediate medical attention to prevent danger

to patient

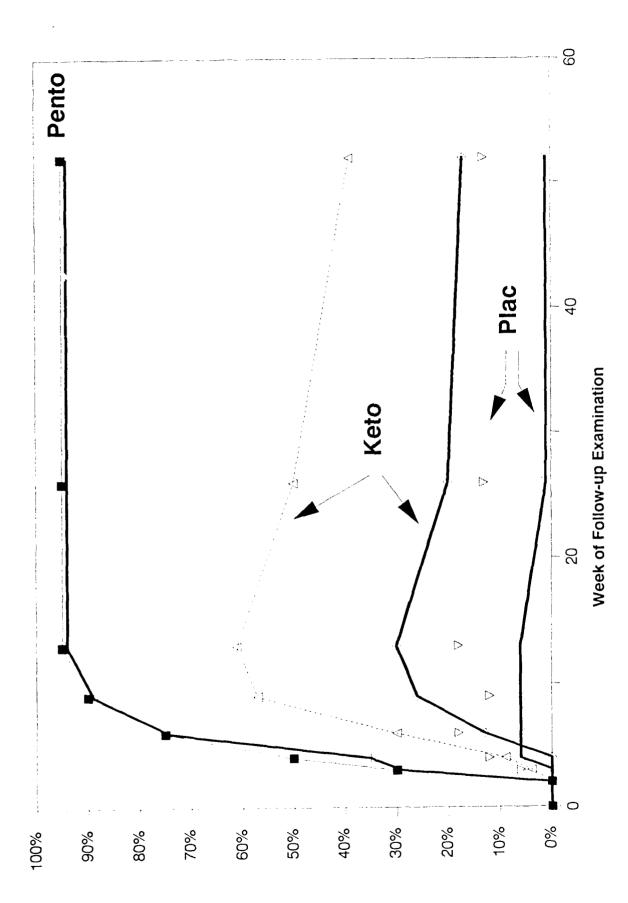
<sup>\*</sup> Mild: No need for medical attention

<sup>\*\*</sup> Adverse reaction led to the premature termination of the study drug



Bold line = clinical and parasitological response
Narrow line = clinical response (cultures may have been positive)

Patients who did not respond by the 13-week examination were removed from the The lower bold line represents the percentage of patients that had complete reepithelialization of their lesions and negative The upper narrow line represents the percentage of patients that had a complete clinical response, irrespective of the results of cultures. Pa stibogluconate, ketoconazole, or placebo by week of follow-up examination. Each of the 3 treatment groups is represented by Percent of patients who responded to treatment with sodium cultures at the end of treatment and at 9 weeks. analysis and treated with meglumine antimonate. 2 lines. Figure 1.

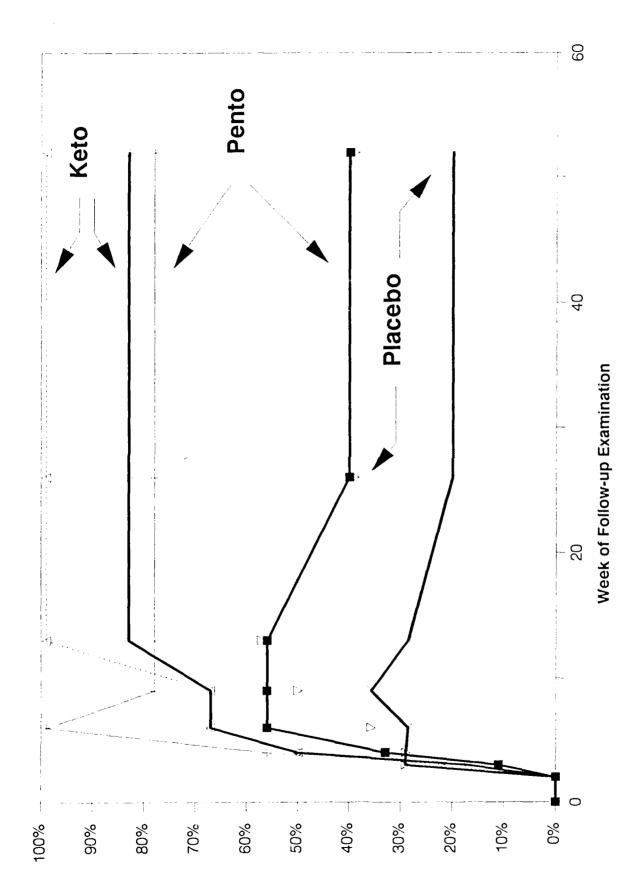


Percent of patients infected with L. b. braziliensis who responded to treatment. See Figure 1 for explanation. Figure 2.

Narrow line = clinical response (cultures may have been positive)

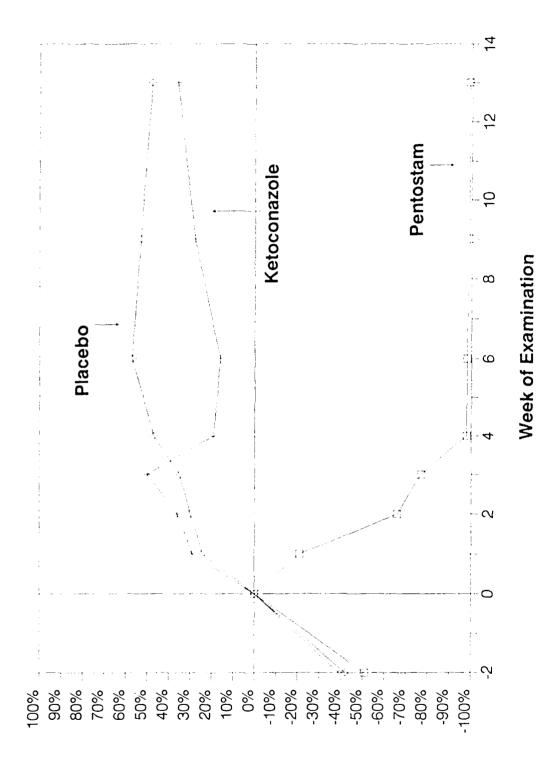
= clinical and parasitological response

**Bold line** 

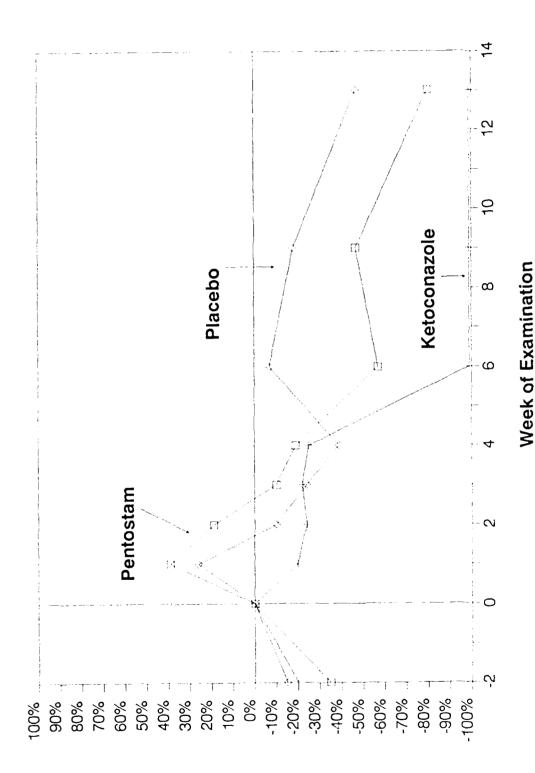


clinical and parasitological responseclinical response (cultures may have been positive) Narrow line **Bold line** 

Percent of patients infected with L. m. mexicana who responded to treatment. See Figure 1 for explanation. Figure 3.



Change in lesion size from 2 weeks before to 13 weeks after starting therapy for patients infected with L. b. braziliensis. Figure 4.



Change in lesion size from 2 weeks before to 23 weeks after starting therapy for patients infected with  $\overline{L}$ .  $\underline{m}$ .  $\underline{mexicana}$ . Figure 5.

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ANNEX 1: LIST OF ADVERSE REACTIONS BY TREATMENT GROUP

# ADVERSE REACTIONS SUMMARY SHEET STUDY OF PENTOSTAM/KETOCONAZOLE/PLACEBO DEC 2, 1989

# Pentostam

ID	Severity <sup>1</sup>	Adverse Reaction
GA-225	Moderate	Pain and edema after Pentostam injection extravasated. Resolved in 48 hours with application of cold packs. Treatment not interrupted.
GA-245	Moderate	Headache. Approximately 9 hours after the 7th dose the patient developed a moderately severe headache that lasted 2 to 4 hours. Aspirin alleviated most of the pain, but the headache returned for the next 5 days, always about 9 hours after a dose. Treatment was not interrupted.
GA-246	Mild	Local pain at the site of injection. Treatment was not interrupted
GA-270	Mild	Local pain at the site of injection. Treatment was not interrupted
GA-290	Mild	Arthralgias. Began 18th day of treatment and involved the shoulder and knee joints. Resolved 2 days after stopping treatment.
GC-256	Mild	Nausea, anorexia, and headache. Began on day 15 of treatment and continued for the remaining 5 days of treatment and for 1 day more. No specific medication prescribed, and treatment was not interrupted.
GC-257	Mild	Rash. Began on the 3rd day of treatment and lasted for 12 days. Papular, pruritic rash of the upper arms and trunk. Treatment was not interrupted.
GC-275	Mild	Local pain at the site of injection. Began on day 12 of treatment and lasted for 4 days. Treatment was not interrupted.
GC-323	Mild	Local pain at the site of injection. Began on day 5 of treatment and lasted 20 days. Treatment was not interrupted.
GC-330	· Mild	Local pain at the site of injection. Began on day 20 of treatment and lasted for 10 days. Treatment was not interrupted.
GC-334	Mild	Fever. Began on 9th day of treatment and lasted for 6 days. Blood smear positive for P. vivax and patient improved with chloroquine.
GC-348	Mild	Arthralgias. Began on day 11 of treatment in the shoulders. On day 16 the pain spread to include the knees. Resolved 3 days after stopping treatment
GC-353	Mild	Arthralgias. Began on 12th day of treatment and involved the shoulders. Resolved 2 days after stopping treatment.
GC-355	Moderate	Nausea, anorexia, and fainting spell. Five days after starting medicine, patient lost his appetite and felt nausea. On the 6th day of treatment, he fainted and was unconscious for a few minutes several hours after his injection. He recovered without problems and continued with his treatment.

## Pentostam (page 2)

GC-360	Mild	Nausea and anorexia. Ten days into treatment, the patient developed mild nausea and anorexia that lasted for 15 days (10 days of treatment and for 5 days more).
GC-368	Mild	Local pain at the site of injection. The pain was mild and resolved without further problems.
GC-370	Mild	Arthralgias. After 14 days of treatment, the patient developed joint pain of the wrist and elbow of the right arm. The pain lasted for 10 days and resolved 5 days after stopping therapy.
GC-373	Moderate	Headache, nausea, anorexia, and arthralgias. After 5 days of treatment, the patient developed moderately severe headaches that required aspirin. He also complained of mild nausea and anorexia. The three symptoms lasted for a total of 20 days, and resolved 5 days after stopping treatment. This patient also developed athralgias after the 15th day of treatment and lasted for 10 days.
GC-379	Moderate	Extravasation of drug. Six hours after the 7th dose, the patient developed edema, pain, and erythema of the hand where the intravenous injection had been placed. The reaction resolved over 3 days with application of cold packs.
GG-001	Mild	Local pain at site of injection. Began on day 15 of treatment and lasted 5 days.  Required treatment with hot packs and aspirin. Treatment was not interrupted. Note: this was described as moderate in severity on the original case report forms, but on review, we now believe that this represented a mild adverse reaction.
GG-007	Mild	Local pain at the site of injection. Began on dat 5 of treatment and lasted for 4 days. Treatment was not interrupted.

<sup>1.</sup> Mild: No medical attention necessary

Moderate: Medical attention necessary, but condition not dangerous

Severe: Dangerous if no medical attention available

# ADVERSE REACTIONS SUMMARY SHEET STUDY OF PENTOSTAM/KETOCONAZOLE/PLACEBO DEC 2, 1989

## Ketoconazole

ID	Severity <sup>1</sup>	Adverse Reaction
GA-219	Mild	Nausea/vomiting. Approximately 2 hours after the 16th dose, the patient developed a headache with nausea and vomited 2 times. The nausea continued for 24 hours and the headache lasted for 48 hours. The symptoms resolved without any medications. Treatment was not interrupted.
GA-286	Mild	Abdominal pain. Two hours after the 21st dose the patient developed mild abdominal pain that lasted for 2 days. The symptom resolved with no medical intervention. Treatment was not interrupted.
GE-023	Mild	Headache. One hour after the 2nd dose the patient felt a moderately severe headache that lasted about 3 hours. These headaches came back after the 3rd and 4th dose, but then resolved spontaneously.
GE - 030	Moderate	Rash. On the 17th day of treatment, patient noted a generalized pruritic rash over his whole body that began 1 hour after taking the pills. There was no urticaria or wheezing and the blood pressure remained normal. Although in the opinion of the treating physician the rash could have been managed with antihistiminics, the patient insisted on terminating treatment with ketoconazole. The rash resolved spontaneously 3 days after it began.
GG-010	Mild	Dizzyness. About 3 hours after the 18th dose, the patient felt light-headed. The symptoms lasted for about 1 hour and resolved spontaneously. Treatment was not interrupted.
GG-014	Moderate	Headache. On the second day of treatment the patient began to complain of moderately severe headaches that began just after taking ketoconazole and lasted for 4 to 8 hours. The headaches continued for 26 days and resolved the day after the medication was stopped.
GG-018	Moderate	Nausea and abdominal pain. After the second dose the patient developed epigastric pain, vomited, and had diarrhea. The patient stopped treatment for 2 days during which he had no symptoms. When treatment was restarted, the patient again developed moderately severe epigastric pain, but this time did not vomit or have diarrhea. After the 16th dose the epigastric pain increased and the patient vomited once. Treatment was terminated prematurely because of these adverse reactions, and the symptoms resolved.

Mild = No medical attention necessary
 Moderate = Medical attention necessary, but not dangerous
 Severe = Dangerous if no medical attention available

# ADVERSE REACTIONS SUMMARY SHEET STUDY OF PENTOSTAM/KETOCONAZOLE/PLACEBO DEC 2, 1989

## Placebo

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ID	Severity <sup>1</sup>	Adverse Reaction
GA-248	Mild	Abdominal pain. Six hours after the 4th dose of placebo tablets the patient complained of mild stomach pain. No medical treatment was required, and the symptoms resolved in 48 hours.
GE-031	Moderate	Abdominal pain. The patient had chronic abdominal pain, but 11 days after starting treatment the patient developed worsening epigastric pain that lasted 7 days.
GC-290	Mild	Abdominal pain. Began on day 19 of treatment and lasted for 12 days (for the rest of treatment and then 3 days more). Resolved without specific medication and treatment was not interrupted.

## INJECTIONS

GC-359	Mild	Nausea and anorexia. One day after stopping his medication, patient complained of
		nausea and loss of appetite. This resolved without treatment in 6 days.

Mild = No medical attention necessary
 Moderate = Medical attention necessary, but not dangerous
 Severe = Dangerous if no medical attention available

ANNEX 2: LIST OF LABORATORY VALUES BY TREATMENT GROUP

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01	872.JJ		04-40 04-40	66-355	00-360	66-373	GC-383		GA-290	GA-246	GA-287	GA-298	GA-283	GA-258	GA-263	GA-274	66-353	CC-379	CC-348	GA-270	CC-30 <b>9</b>	CC-334	66-001	CC-257	66-011	GC-353	CC-282	CC-256	GC-310	500-55	GA-245	GC-329	65-275	282-25	6A - 225	/00-99	GC- 521	GC-338	GC-281	CC-330	PENTOSTA	max	e i e	mean

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290 CREAT	09.0	0.48	0.50	0.50	1.20	0.80		0.80	0.75	0.80	0.70	1.10	09.0	0.41	1.20	0.00	0.00	0.74	1.20	0.95	0.87	1.00	1.20	0.64	0.86	79.0	0.70	0.81	0.60	1.00	0.72	0.70	0.69	00.	0.70	0.93	0.74	1.20	0.80	0.82		1.20	0.41	ا8.0
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0 CREAT	0.70	0.40	0.70	0.6	0.8	0.80	0.60	0.6	0.50	0.6	0.9	0.6	0.50	0.75	0.74	1.00	0.80	0.90	0.5	0.9	0.8	0.83	1.03	0.6	0.6	1.00	0.8	0.7	0.7	0.6	0.6	Σ Σ	Σ ·	76.0		0.6	0.7	0.8	0	1.05		1.05	7.0	.; n
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2% 81L1	NO IN	0.10	0.18	0.50	0.20	0.30	0.40		0.20	0.30	0.10	0.10	0.20	0.10	0.14	0.30	0.14	0.30	0.2	0.20	0.33	0.15	0.08	0.20	0.40	0.50	0.40	0.20	0.50	0.16	0.50	0.30	0.50	0.35	0.04	0.30	0.50	0.60	0.30	0.30	0.20		040	3 6	0.26
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86	BILI	0.02		0.30	0.10	0.16	0.20		0.50	0.20	0.30				0.20	0.60		0.20	0.14	0.20	0.10	0.10	0.50	0.30	0.20	0.70	0.40	0.28			0.30	0.17	0.30	0.00	0.19	0.40	0.30	0.20		0.90	0.36		0.00	0.02	0.31
8	BIL1 DIREC	07.50	0.12	07.50	30	.50	30		0.10	06.0	09.	7.0	0.80	.12	. 14	.90	9.16	.30	7.0	09.0	.25	3.35	0.50	0.30	.50	0.70	.53	09.0	3.30	.34	0.40	.30	0.20	0.10	7.55	0.10	30	.25	.50	07.50	02.0		06.0	0.10	0.36
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8	BILI B DIREC D	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0 (	۰.	0	0	0	0	0	0	0		0	0	0
0	BIL1 DIREC	0.36	0.20	0.40	0.60	0.30	0.20	0.30	0.08	0.30	0.20	0.25	0.18	0.12	0.30	0.20	0.20	0.08	0.02	0.20	0.56	0.38	0.30	0.28	0.36	0.80	0.30	0.40	0.20	0.26	0.36	0.28	0.50	0.10	0.32	0.10	0.28	0.30	0.28	0.21	0.30	_	0.80	0.02	0.28
	0	GE-021	CC-343	CA-256	66-030	66-019	66-027	66-018	CG-025	210-99	66-023	GE-022	66-014	66-015	GE-036	66-016	020-050	66-024	GC-341	56-015	GE-002	CC-280	692-29	CC-285	GC-319	GC-314	900-99	GC-333	GC-316	GE-030	962-25 0C-588	GE-023	64-288 64-288	500-55	60-274	66-555	66-010	GC - 308	262-35		GA-219	Ketocoba	max	e i e	mean

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95 B1L1	5	0,40	0.10	0.19	0.10	0.24		0.10	0.80	0.10					0.30	0.20	0.40	0.51			0.10		0.90	0.16	0.30	07.0	0.20	;	0.50	0.10	21.0	10	•	0.20	0.50		0.30	0.40	07.0		0		0.26
290 811.1 1ND1R	0 20	0.50	0.20	0.20	0.20	0.20	0.21	0.30	0.30	0.30	0.23	0.20	0.40	0.30	0.20	0.16	0.30	0.30	0.75	0.17																					75	25.0	0.28
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140 811.1 1ND 1R	0.30	0.30	07.0	0.30		0.20	0.25	0.20	09.0	0.40	0.16	0.10	0.20	0.50	0.20	0.40	0.20	0.20	0.08	0.30	0.20	0.60	0.30	0.10	0.12	0.30	0.20	0.22	0.50	0.20	2 6	0.10	0.10	0.30	0.40	0.50	0.16	0.40	0.20		040	200	0.27
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0 811.1 IND 1R	0.60	0.10	0.20	0.08	0.81	0.16	0.30	0.10	0.20	0.50	07.0	0.08	0.40	0.51	0.36	0.10	0.20	0.10	0.12	0.50	0.20	0.50	0.32	90.0	0.16	0.20	0.20	0.60	0.50	9 6	0.70	0.50	0.15	0.50	0.50	0.30	0.12	0.20	0.30		06	200	0.29
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140 BIL1 DIREC		0.20				0.50	.30	0.20	0.10	09.0	51.0	0.20	0.50	3.25	0.20	0.30	9.18	0.30	3.52	0.30	0.30	0.10	0.30	0.30	0.36	0.30	0.20	0.20	0.20	0.10	0.35	0.58	0.10	0.32	0.50	0.20	0.10	0.20	0.20	0.10		0.60	01.0	0.27	
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0 811.1 DIREC	0.20	0.90	07.0	0.28	0.89	0.20	0.50	0.50	0.10	0.30	0.10	0.20	0.30	0.30	0.39	0.20	0.70	0.40	0.24	0.10	0.20	0.20	0.15	0.56	0.14	0.60	0.20	0.30	0.20	0.20	0.61	0.30	0.10	0.56	0.30	0.40	0.50	0.36	0.40	0.20		0.0	0.10	0.33	
01	GC- 365	66-028	620-99	CA-248	CG-022	GE-031	GE-041	920-99	66-021	66-012	90-95	CC-238	GE-C05	062-39	600-55	GA-221	800-99	GA-236	CC-279	200-00	GA-276	CC-377	656-35	275-39	GA-264	GA-293	GA-281	CC-345	cc-366			CC-295								GE-017	DI ACERO	max		mean	

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