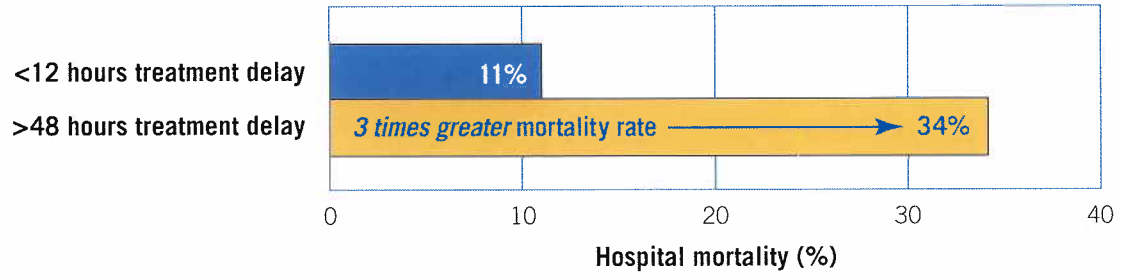
In the treatment of invasive fungal infections...

Big Threat

Delaying Appropriate Treatment Beyond 48 Hours Increases Mortality 3-Fold

Mortality rate was 3 times higher when antifungal therapy began >48 hours compared to <12 hours after first positive blood sample was taken*[1]

Treatment Delay† Increases Mortality Among Patients With Invasive Candidiasis[1]



Adapted with permission from Morrell et al, 2005.

†Time from collection of first positive blood culture to start of antifungal treatment.

- A higher APACHE II score and prior antibiotic therapy were also identified as independent risk factors for mortality‡
- **Conclusion: initiate the most appropriate empiric therapy as early as possible to minimize mortality[1]**

Fungal growth is dramatic over a 72-hour period

Mold Showed Minimal Change In Vitro After 3 Hours and Considerable Growth After 72 Hours

Aspergillus fumigatus baseline (24 hours post-innoculation)§ | Baseline +3 hours | Baseline +72 hours

*A retrospective cohort analysis of 157 patients with *Candida* bloodstream infection.

‡Other variables that were evaluated but were not independent risk factors for mortality included age, gender, presence of underlying malignancy, neutropenia, seropositivity for HIV antibody, diabetes mellitus, bone marrow or solid organ transplant, abdominal or cardiothoracic surgery, hypotension, white blood cell count, body temperature, serum creatinine level, mechanical ventilation for respiratory failure, administration of vasopressors for circulatory shock, presence of a central venous catheter and duration of use, administration of parenteral nutrition, prior antifungal therapy, number of ventilator days and intensive care unit days, variables describing fungal bloodstream infections and their treatment (with the exception of delay in antifungal therapy).

§Grown at 36°C

References: 1. Morrell M, Fraser VJ, Kollef MH. Delaying the empiric treatment of *Candida* bloodstream infection until positive blood culture results are obtained: a potential risk factor for hospital mortality. *Antimicrob Agents Chemother.* 2005;49(9):3640-3645. **2.** Taraschi TF, Beggs JM. [Letter]. *J Liposome Res.* 2000;10:96-98. **3.** Legrand P, Chéron M, Leroy L, Bolard J. Release of amphotericin B from delivery systems and its action against fungal and mammalian cells. *J Drug Target.* 1997;4(5):311-319. **4.** Bekersky I, Fielding RM, Dressler DE, Lee JW, Buell DN, Walsh TJ. Plasma protein binding of amphotericin B and pharmacokinetics of bound versus unbound amphotericin B after administration of intravenous liposomal amphotericin B (AmBisome) and amphotericin B deoxycholate. *Antimicrob Agents Chemother.* 2002;46(3):834-840. **5.** van Burik J-AH, Bowden RA. Standard antifungal treatment, including role of alternative modalities to administer amphotericin B. *Baillieres Clin Infect Dis.* 1995;2:89-109. **6.** Hiemenz JW, Walsh TJ. Lipid formulations of amphotericin B: recent progress and future directions. *Clin Infect Dis.* 1996;22(suppl 2):S133-S144.

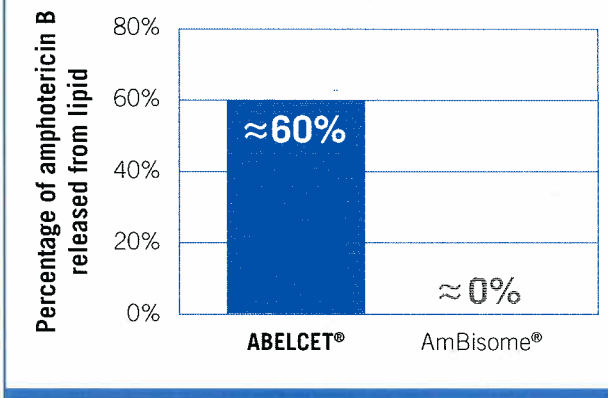
In the treatment of invasive fungal infections...

Rapid Activity.

3-Hour Drug Mobilization With ABELCET®

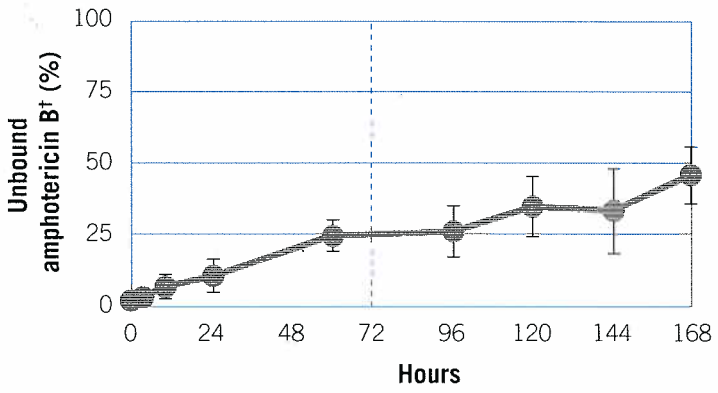
Amphotericin B is released from the lipid more rapidly after administration of ABELCET® than with AmBisome®*[2-4]

ABELCET® vs AmBisome® After 3 Hours[2]



60% to 75% of the amphotericin B in ABELCET® was released within 3 hours, as compared to ≈0% of the amphotericin B in AmBisome® in one in vitro study[2,3]

Percentage of AmBisome® Released Over Time[4]



Only ≈25% of amphotericin B was released from the AmBisome® lipid after 72 hours in another single-dose study†[4]

*Results from in vitro data do not necessarily predict clinical efficacy.

Adapted with permission from Bekersky et al, 2002.

†As measured in plasma.

ABELCET®: faster delivery to the site of infection than AmBisome®[2,5,6]

- More rapid uptake by macrophages
- More rapid concentration in tissues at common sites of infection

ABELCET® is indicated for the treatment of invasive fungal infections in patients who are refractory to or intolerant of conventional amphotericin B therapy. This is based on open-label treatment of patients judged by their physicians to be intolerant to or failing conventional amphotericin B therapy.

The adverse events most commonly reported with ABELCET® are transient chills and/or fever during infusion of the drug. ABELCET® is contraindicated in patients who have shown hypersensitivity to amphotericin B or any component in the formulation. Anaphylaxis has been reported with amphotericin B desoxycholate and other amphotericin B–containing drugs (0.1% incidence rate with ABELCET®).

Despite generally less nephrotoxicity of ABELCET® observed at a dose of 5 mg/kg/day compared with conventional amphotericin B therapy at a dose of 0.6 to 1 mg/kg/day, dose-limiting renal toxicity may still be observed with ABELCET®. Renal toxicity of doses greater than 5 mg/kg/day of ABELCET has not been formally studied.

Please see full Prescribing Information for ABELCET®.

Not intended to be left behind without full Prescribing Information. Full Prescribing Information available through your Enzon representative. Additional information available through Enzon Medical Information at 866-792-5172.

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AmBisome® is a registered trademark of Gilead Sciences, Inc.

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ABELCET®
(Amphotericin B Lipid Complex Injection)

Right Choice. Right Now.

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