



Listen To Your Heart

Although cardiovascular disease is the nation's No. 1 killer, you don't have to be a statistic. There are new drugs and treatments that can save your life.



If you want a good scare, no need to visit your local cineplex to see a horror flick—just read the latest update from the American Heart Association. It reports that more than 71 million American adults are suffering from one or more types of cardiovascular disease. It also reminds us that CVD claims more lives each year than the next four diseases combined, killing an average of one person every 35 seconds.

But there's good news too. Although heart disease remains the No. 1 killer, the U.S. death rate from heart disease has actually been declining. According to Wayne Rosamond, an epidemiologist who chairs the American Heart Association's statistics committee, the decline has averaged 2% or 3% a year over the past 20 years. New drugs and advanced treatments are responsible for a big part of the improvement. Prevention has played an important role too: The public has become better educated about diet, weight control, exercise, the danger of smoking, and the need to respond quickly to heart attack symptoms.

Cholesterol Guidelines

New attention has also been focused on the key role played by cholesterol, a soft, fat-like waxy substance produced naturally by the body and augmented by the foods we eat. It's one of three proven causes of damage to the arterial wall, the other two being high blood pressure and tobacco smoke. Elevated levels of LDL, the so-called bad cholesterol, can build up plaque along the walls of arteries that feed the heart and brain. On the other hand, HDL, the good cholesterol, slows the growth of plaque. Following a series of multidisciplinary studies, new guidelines were recently released that concluded that LDL levels should be lower and HDL levels higher than previously recommended.

The overall cholesterol recommendation remains the same at 200, but the optimal level of LDL was cut to 100 from the previous 130, and HDL was increased

from 35 to 40. The new guidelines call for more aggressive management of cholesterol levels by individuals who have major heart disease risk factors. They also stress intensified use of nutrition, exercise, and weight control to treat high cholesterol, and recommend paying special attention to patients with diabetes.

In addition to the emphasis on lowering blood cholesterol, new evidence has surfaced suggesting that the buildup of plaque in the coronary arteries not only can be reduced but actually reversed. A study presented at the American College of Cardiology's 55th annual scientific session in March demonstrated for the first time that a very intensive effort to lower cholesterol levels with a statin drug can partly reverse the development of plaque.

The two-year study, known by the acronym ASTEROID, used high doses of rosuvastatin, a statin produced by AstraZeneca and sold under the brand name Crestor. The study, of patients in the U.S. and eight other countries, found that the use of Crestor produced a 53% drop in LDL cholesterol and a 15% hike in HDL. Researchers also found "a highly significant and unprecedented reversal of coronary artery disease in all patient groups," said Dr. Steven Nissen, interim chairman of the Cleveland Clinic's Department of Cardiovascular Medicine and president of the American College of Cardiology.

"These findings suggest that maximizing the use of statins to lower cholesterol levels in patients with heart disease can substantially reduce plaque burden, an outcome previously thought unattainable," said Nissen, who headed the study.

"These results also imply that the goal of statin treatment in coronary disease patients should be the maximum cholesterol reduction that can be achieved safely rather than an arbitrary target level."

The ASTEROID study is part of AstraZeneca's long-term statin-research program designed to address important unanswered questions in statin research and to investigate the impact of Crestor on cardiovascular risk reduction and patient outcomes. The study program has



When it comes to bad cholesterol— Ask your doctor if lower is better.

Getting high cholesterol down is important.

Doctors know lowering high cholesterol is important for everyone. But for some people, it's even more important. In fact, a panel of medical experts recently proposed updated guidelines suggesting many patients aim for an even lower cholesterol goal than before.*

Working with your doctor is key to helping you reach your cholesterol goal.

If, after all you've tried—including diet and exercise—your doctor believes you need to get your bad cholesterol even lower, ask whether CRESTOR might help.

Aim lower.

CRESTOR may make the difference you need. In fact, the 10-mg dose of CRESTOR, along with diet, can lower bad cholesterol by as much as 52% (vs 7% with placebo). That means your LDL-C—the bad cholesterol—could go down about half. Your results may vary.

Is CRESTOR right for you?

That's another conversation you need to have with your doctor. Your doctor will decide the best course of treatment for you after assessing your particular needs.

Get more information about CRESTOR.

To learn more about CRESTOR, or if you are without prescription coverage and can't afford your medication, AstraZeneca may be able to help. Call 800-CRESTOR or visit CRESTOR.com.

Here is important safety information about CRESTOR you need to know.

CRESTOR is prescribed along with diet for lowering high cholesterol and has not been determined to prevent heart disease, heart attacks, or strokes. CRESTOR is not right for everyone, including women who are nursing, pregnant, or who may become pregnant, or anyone with liver problems. Your doctor will do blood tests before and during treatment with CRESTOR to monitor your liver function. Unexplained muscle pain and weakness could be a sign of a rare but serious side effect and should be reported to your doctor right away. The 40-mg dose of CRESTOR is only for patients who do not reach goal on 20 mg. Be sure to tell your doctor if you are taking any medications. Side effects occur infrequently and include muscle aches, constipation, weakness, abdominal pain, and nausea. They are usually mild and tend to go away.


If your doctor says,
"lower is better," aim lower with CRESTOR.



CRESTOR is a registered trademark of the AstraZeneca group of companies. © 2005 AstraZeneca Pharmaceuticals LP. All rights reserved. 229304 06/05

*Adult Treatment Panel (ATP) III, Update, 2004

Please read the important Product Information about CRESTOR on the adjacent page and discuss it with your doctor.

AstraZeneca 

Please read this summary carefully and then ask your doctor about CRESTOR. No advertisement can provide all the information needed to determine if a drug is right for you. This advertisement does not take the place of careful discussions with your doctor. Only your doctor has the training to weigh the risks and benefits of a prescription drug.

BRIEF SUMMARY: For full Prescribing Information, see package insert. **INDICATIONS AND USAGE:** CRESTOR is indicated: 1. as an adjunct to diet to reduce elevated total-C, LDL-C, ApoB, nonHDL-C, and TG levels and to increase HDL-C in patients with primary hypercholesterolemia (heterozygous familial and nonfamilial) and mixed dyslipidemia (Fredrickson Type IIa and IIb); 2. as an adjunct to diet for the treatment of patients with elevated serum TG levels (Fredrickson Type IV); 3. to reduce LDL-C, total-C, and ApoB in patients with homozygous familial hypercholesterolemia as an adjunct to other lipid-lowering treatments (e.g., LDL apheresis) or if such treatments are unavailable. **CONTRAINDICATIONS:** CRESTOR is contraindicated in patients with a known hypersensitivity to any component of this product. Rosuvastatin is contraindicated in patients with active liver disease or with unexplained persistent elevations of serum transaminases (see WARNINGS, Liver Enzymes). **Pregnancy and Lactation:** Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. ROSUVASTATIN SHOULD BE ADMINISTERED TO WOMEN OF CHILDBEARING AGE ONLY WHEN SUCH PATIENTS ARE HIGHLY UNLIKELY TO CONCEIVE AND HAVE BEEN INFORMED OF THE POTENTIAL HAZARDS. If the patient becomes pregnant while taking this drug, therapy should be discontinued immediately and the patient apprised of the potential hazard to the fetus. **WARNINGS:** **Liver Enzymes:** HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. The incidence of persistent elevations (>3 times the upper limit of normal [ULN]) occurring on 2 or more consecutive occasions) in serum transaminases in fixed dose studies was 0.4, 0.0, and 0.1% in patients who received rosuvastatin 5, 10, 20, and 40 mg, respectively. In most cases, the elevations were transient and resolved or improved on continued therapy or after a brief interruption in therapy. There were two cases of jaundice, for which a relationship to rosuvastatin therapy could not be determined, which resolved after discontinuation of therapy. There were no cases of liver failure or irreversible liver disease in these trials. It is recommended that liver function tests be performed before and at 12 weeks following both the initiation of therapy and any elevation of dose, and periodically (e.g., semiannually) thereafter. Liver enzyme changes generally occur in the first 3 months of treatment with rosuvastatin. Patients who develop increased transaminase levels should be monitored until the abnormalities have resolved. Should an increase in ALT or AST of >3 times ULN persist, reduction of dose or withdrawal of rosuvastatin is recommended. Rosuvastatin should be used with caution in patients who consume substantial quantities of alcohol and/or have a history of liver disease (see CLINICAL PHARMACOLOGY, Special Populations, Hepatic Insufficiency). Active liver disease or unexplained persistent transaminase elevations are contraindications to the use of rosuvastatin (see CONTRAINDICATIONS). **Myopathy/Rhabdomyolysis:** Rare cases of rhabdomyolysis with acute renal failure secondary to myoglobinuria have been reported with rosuvastatin and with other drugs in this class. Uncomplicated myalgia has been reported in rosuvastatin-treated patients (see ADVERSE REACTIONS). Creatine kinase (CK) elevations (>10 times upper limit of normal) occurred in 0.2% to 0.4% of patients taking rosuvastatin at doses up to 40 mg in clinical studies. Treatment-related myopathy, defined as muscle aches or muscle weakness in conjunction with increases in CK values >10 times upper limit of normal, was reported in up to 0.1% of patients taking rosuvastatin doses of up to 40 mg in clinical studies. In clinical trials, the incidence of myopathy and rhabdomyolysis increased at doses of rosuvastatin above the recommended dosage range (5 to 40 mg). In post-marketing experience, effects on skeletal muscle, e.g., uncomplicated myalgia, myopathy and, rarely, rhabdomyolysis have been reported in patients treated with HMG-CoA reductase inhibitors including rosuvastatin. As with other HMG-CoA reductase inhibitors, reports of rhabdomyolysis with rosuvastatin are rare, but higher at the highest marketed dose (40 mg). Factors that may predispose patients to myopathy with HMG-CoA reductase inhibitors include advanced age (>65 years), hypothyroidism, and renal insufficiency. Consequently, 1. Rosuvastatin should be prescribed with caution in patients with predisposing factors for myopathy, such as, renal impairment (see DOSAGE AND ADMINISTRATION), advanced age, and inadequately treated hypothyroidism. 2. Patients should be advised to promptly report unexplained muscle pain, tenderness, or weakness, particularly if accompanied by malaise or fever. Rosuvastatin therapy should be discontinued if markedly elevated CK levels occur or myopathy is diagnosed or suspected. 3. The 40 mg dose of rosuvastatin is reserved only for those patients who have not achieved their LDL-C goal utilizing the 20 mg dose of rosuvastatin once daily (see DOSAGE AND ADMINISTRATION). 4. The risk of myopathy during treatment with rosuvastatin may be increased with concurrent administration of other lipid-lowering therapies or cyclosporine, (see CLINICAL PHARMACOLOGY, Drug Interactions, PRECAUTIONS, Drug Interactions, and DOSAGE AND ADMINISTRATION). **The benefit of further alterations in lipid levels by the combined use of rosuvastatin with fibrates or niacin should be carefully weighed against the potential risks of this combination. Combination therapy with rosuvastatin and gemfibrozil should generally be avoided. (See DOSAGE AND ADMINISTRATION and PRECAUTIONS, Drug Interactions).** 5. The risk of myopathy during treatment with rosuvastatin may be increased in circumstances which increase rosuvastatin drug levels (see CLINICAL PHARMACOLOGY, Special Populations, Race and Renal Insufficiency, and PRECAUTIONS, General). 6. Rosuvastatin therapy should also be temporarily withheld in any patient with an acute, serious condition suggestive of myopathy or predisposing to the development of renal failure secondary to rhabdomyolysis (e.g., sepsis, hypotension, dehydration, major surgery, trauma, severe metabolic, endocrine, and electrolyte disorders, or uncontrolled seizures). **PRECAUTIONS:** **General:** Before instituting therapy with rosuvastatin, an attempt should be made to control hypercholesterolemia with appropriate diet and exercise, weight reduction in obese patients, and treatment of underlying medical problems (see INDICATIONS AND USAGE). Administration of rosuvastatin 20 mg to patients with severe renal impairment ($Cl_{CR} < 30$ mL/min/1.73 m²) resulted in a 3-fold increase in plasma concentrations of rosuvastatin compared with healthy volunteers (see WARNINGS, Myopathy/Rhabdomyolysis and DOSAGE AND ADMINISTRATION). The result of a large pharmacokinetic study conducted in the US demonstrated an approximate 2-fold elevation in median exposure in Asian subjects (having either Filipino, Chinese, Japanese, Korean, Vietnamese or Asian-Indian origin) compared with a Caucasian control group. This increase should be considered when making rosuvastatin dosing decisions for Asian patients. (See WARNINGS, Myopathy/Rhabdomyolysis; CLINICAL PHARMACOLOGY, Special Populations, Race, and DOSAGE AND ADMINISTRATION.) **Information for Patients:** Patients should be advised to report promptly unexplained muscle pain, tenderness, or weakness, particularly if accompanied by malaise or fever. When taking rosuvastatin with an aluminum and magnesium hydroxide combination antacid, the antacid should be taken at least 2 hours after rosuvastatin administration (see CLINICAL PHARMACOLOGY, Drug Interactions). **Laboratory Tests:** In the rosuvastatin clinical trial program, dipstick-positive proteinuria and microscopic hematuria were observed among rosuvastatin-treated patients, predominantly in patients dosed above the recommended dose range (i.e., 80 mg). However, this finding was more frequent in patients taking rosuvastatin 40 mg, when compared to lower doses of rosuvastatin or comparator statins, though it was generally transient and was not associated with worsening renal function. Although the clinical significance of this finding is unknown, a dose reduction should be considered for patients on rosuvastatin 40 mg therapy with unexplained persistent proteinuria during routine urinalysis testing. **Drug Interactions:** **Cyclosporine:** When rosuvastatin 10 mg was coadministered with cyclosporine in cardiac transplant patients, rosuvastatin mean C_{max} and mean AUC were increased 11-fold and 7-fold, respectively, compared with healthy volunteers. These increases are considered to be clinically significant and require special consideration in the dosing of rosuvastatin to patients taking

concomitant cyclosporine (see WARNINGS, Myopathy/Rhabdomyolysis, and DOSAGE AND ADMINISTRATION). **Warfarin:** Coadministration of rosuvastatin to patients on stable warfarin therapy resulted in clinically significant rises in INR (>4, baseline 2-3). In patients taking coumarin anticoagulants and rosuvastatin concomitantly, INR should be determined before starting rosuvastatin and frequently enough during early therapy to ensure that no significant alteration of INR occurs. Once a stable INR time has been documented, INR can be monitored at the intervals usually recommended for patients on coumarin anticoagulants. If the dose of rosuvastatin is changed, the same procedure should be repeated. Rosuvastatin therapy has not been associated with bleeding or with changes in INR in patients not taking anticoagulants. **Gemfibrozil:** Coadministration of a single rosuvastatin dose to healthy volunteers on gemfibrozil (600 mg twice daily) resulted in a 2.2- and 1.9-fold, respectively, increase in mean C_{max} and mean AUC of rosuvastatin (see DOSAGE AND ADMINISTRATION). **Endocrine Function:** Although clinical studies have shown that rosuvastatin alone does not reduce basal plasma cortisol concentration or impair adrenal reserve, caution should be exercised if any HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered concomitantly with drugs that may decrease the levels or activity of endogenous steroid hormones such as ketconazole, spironolactone, and cimetidine. **CNS Toxicity:** CNS vascular lesions, characterized by perivascular hemorrhages, edema, and mononuclear cell infiltration of perivascular spaces, have been observed in dogs treated with several other members of this drug class. A chemically similar drug in this class produced dose-dependent optic nerve degeneration (Wallenian degeneration of retinogeniculate fibers) in dogs, at a dose that produced plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose. Edema, hemorrhage, and partial necrosis in the interstitium of the choroid plexus was observed in a female dog sacrificed moribund at day 24 at 90 mg/kg/day by oral gavage (systemic exposures 100 times the human exposure at 40 mg/day based on AUC comparisons). Corneal opacity was seen in dogs treated for 52 weeks at 6 mg/kg/day by oral gavage (systemic exposures 20 times the human exposure at 40 mg/day based on AUC comparisons). Cataracts were seen in dogs treated for 12 weeks by oral gavage at 30 mg/kg/day (systemic exposures 60 times the human exposure at 40 mg/day based on AUC comparisons). Retinal dysplasia and retinal loss were seen in dogs treated for 4 weeks by oral gavage at 90 mg/kg/day (systemic exposures 100 times the human exposure at 40 mg/day based on AUC). Doses ≤ 30 mg/kg/day (systemic exposures ≤ 60 times the human exposure at 40 mg/day based on AUC comparisons) following treatment up to one year, did not reveal retinal findings. **Carcinogenesis, Mutagenesis, Impairment of Fertility:** In a 104-week carcinogenicity study in rats at dose levels of 2, 20, 60, or 80 mg/kg/day by oral gavage, the incidence of uterine stromal polyps was significantly increased in females at 80 mg/kg/day at

Adverse Experiences: Adverse experiences, regardless of causality assessment, reported in $\geq 2\%$ of patients in placebo-controlled clinical studies of rosuvastatin are shown in Table 1; discontinuations due to adverse events in these studies of up to 12 weeks duration occurred in 3% of patients on rosuvastatin and 5% on placebo.

Table 1. Adverse Events in Placebo-Controlled Studies

Adverse event	Rosuvastatin N=744	Placebo N=382
Pharyngitis	9.0	7.6
Headache	5.5	5.0
Diarrhea	3.4	2.9
Dyspepsia	3.4	3.1
Nausea	3.4	3.1
Myalgia	2.8	1.3
Asthenia	2.7	2.6
Back pain	2.6	2.4
Flu syndrome	2.3	1.8
Urinary tract infection	2.3	1.6
Rhinitis	2.2	2.1
Sinusitis	2.0	1.8

In addition, the following adverse events were reported, regardless of causality assessment, in $\geq 1\%$ of 10,275 patients treated with rosuvastatin in clinical studies. The events in *italics* occurred in $\geq 2\%$ of these patients. **Body as a Whole:** Abdominal pain, accidental injury, chest pain, infection, pain, pelvic pain, and neck pain. **Cardiovascular System:** Hypertension, angina pectoris, vasodilatation, and palpitation. **Digestive System:** Constipation, gastroenteritis, vomiting, flatulence, periodontal abscess, and gastritis. **Endocrine:** Diabetes mellitus. **Hemic and Lymphatic System:** Anemia and ecchymosis. **Metabolic and Nutritional Disorders:** Peripheral edema. **Musculoskeletal System:** Arthritis, arthralgia, and pathological fracture. **Nervous System:** Dizziness, insomnia, hypertonia, paresthesia, depression, anxiety, vertigo, and neuralgia. **Respiratory System:** Bronchitis, cough increased, dyspnea, pneumonia, and asthma. **Skin and Appendages:** Rash and pruritus. **Laboratory Abnormalities:** In the rosuvastatin clinical trial program, dipstick-positive proteinuria and microscopic hematuria were observed among rosuvastatin-treated patients, predominantly in patients dosed above the recommended dose range (i.e., 80 mg). However, this finding was more frequent in patients taking rosuvastatin 40 mg, when compared to lower doses of rosuvastatin or comparator statins, though it was generally transient and was not associated with worsening renal function. (See PRECAUTIONS, Laboratory Tests.) Other abnormal laboratory values reported were elevated creatinine phosphokinase, transaminases, hyperglycemia, glutamyl transpeptidase, alkaline phosphatase, bilirubin, and thyroid function abnormalities. Other adverse events reported less frequently than 1% in the rosuvastatin clinical study program, regardless of causality assessment, included arrhythmia, hepatitis, hypersensitivity reactions (i.e., face edema, thrombocytopenia, leukopenia, vesiculobullous rash, urticaria, and angioedema), kidney failure, syncope, myasthenia, myositis, pancreatitis, photosensitivity reaction, myopathy, and rhabdomyolysis. **Postmarketing Experience:** In addition to the events reported above, as with other drugs in this class, the following event has been reported during post-marketing experience with CRESTOR, regardless of causality assessment: very rare cases of jaundice. **OVERDOSAGE:** There is no specific treatment in the event of overdose. In the event of overdose, the patient should be treated symptomatically and supportive measures instituted as required. Hemodialysis does not significantly enhance clearance of rosuvastatin. **DOSAGE AND ADMINISTRATION:** The patient should be placed on a standard cholesterol-lowering diet before receiving CRESTOR and should continue on this diet during treatment. CRESTOR can be administered as a single dose at any time of day, with or without food. **Hypercholesterolemia (Heterozygous Familial and Nonfamilial) and Mixed Dyslipidemia (Fredrickson Type IIa and IIb):** The dose range for CRESTOR is 5 to 40 mg once daily. Therapy with CRESTOR should be individualized according to goal of therapy and response. The usual recommended starting dose of CRESTOR is 10 mg once daily. However, initiation of therapy with 5 mg once daily should be considered for patients requiring less aggressive LDL-C reductions, who have predisposing factors for myopathy, and as noted below for special populations such as patients taking cyclosporine, Asian patients, and patients with severe renal insufficiency (see CLINICAL PHARMACOLOGY, Race, and Renal Insufficiency, and Drug Interactions). For patients with marked hypercholesterolemia (LDL-C >190 mg/dL) and aggressive lipid targets, a 20 mg starting dose may be considered. After initiation and/or upon titration of CRESTOR, lipid levels should be analyzed within 2 to 4 weeks and dosage adjusted accordingly. The 40-mg dose of CRESTOR is reserved only for those patients who have not achieved their LDL-C goal utilizing the 20 mg dose of CRESTOR once daily (see WARNINGS, Myopathy/Rhabdomyolysis). When initiating statin therapy or switching from another statin therapy, the appropriate CRESTOR starting dose should first be utilized, and only then titrated according to the patient's individualized goal of therapy. **Homozygous Familial Hypercholesterolemia:** The recommended starting dose of CRESTOR is 20 mg once daily in patients with homozygous FH. The maximum recommended daily dose is 40 mg. CRESTOR should be used in these patients as an adjunct to other lipid-lowering treatments (e.g., LDL apheresis) or if such treatments are unavailable. Response to therapy should be estimated from pre-apheresis LDL-C levels. **Dosage in Asian Patients:** Initiation of CRESTOR therapy with 5 mg once daily should be considered for Asian patients. The potential for increased systemic exposures relative to Caucasians is relevant when considering escalation of dose in cases where hypercholesterolemia is not adequately controlled at doses of 5, 10, or 20 mg once daily. (See WARNINGS, Myopathy/Rhabdomyolysis, CLINICAL PHARMACOLOGY, Special Populations, Race, and PRECAUTIONS, General). **Dosage in Patients Taking Cyclosporine:** In patients taking cyclosporine, therapy should be limited to CRESTOR 5 mg once daily (see WARNINGS, Myopathy/Rhabdomyolysis, and PRECAUTIONS, Drug Interactions). **Concomitant Lipid-Lowering Therapy:** The effect of CRESTOR on LDL-C and total-C may be enhanced when used in combination with a bile acid binding resin. If CRESTOR is used in combination with gemfibrozil, the dose of CRESTOR should be limited to 10 mg once daily (see WARNINGS, Myopathy/Rhabdomyolysis, and PRECAUTIONS, Drug Interactions). **Dosage in Patients With Renal Insufficiency:** No modification of dosage is necessary for patients with mild to moderate renal insufficiency. For patients with severe renal impairment ($Cl_{CR} < 30$ mL/min/1.73 m²) not on hemodialysis, dosing of CRESTOR should be started at 5 mg once daily and not to exceed 10 mg once daily (see PRECAUTIONS, General, and CLINICAL PHARMACOLOGY, Special Populations, Renal Insufficiency).

NOTE: This summary provides important information about CRESTOR. For more information, please ask your doctor or health care professional about the full Prescribing Information and discuss it with them.

Rx only
CRESTOR is a trademark of the AstraZeneca group of companies.
© AstraZeneca 2005
Licensed from SHIONOGI & CO., LTD., Osaka, Japan
Manufactured for: AstraZeneca Pharmaceuticals LP
Wilmington, DE 19850
By: IPR Pharmaceuticals, Inc.
Carolina, PR 00984
PCC 630101
30043-00 31028-00
Rev 03/05 228011



systemic exposure 20 times the human exposure at 40 mg/day based on AUC. Increased incidence of polyps was not seen at lower doses. In a 107-week carcinogenicity study in mice given 10, 60, 200 mg/kg/day by oral gavage, an increased incidence of hepatocellular adenoma/carcinoma was observed at 200 mg/kg/day at systemic exposures 20 times human exposure at 40 mg/day based on AUC. An increased incidence of hepatocellular tumors was not seen at lower doses. Rosuvastatin was not mutagenic or clastogenic with or without metabolic activation in the Ames test with *Salmonella typhimurium* and *Escherichia coli*, the mouse lymphoma assay, and the chromosomal aberration assay in Chinese hamster lung cells. Rosuvastatin was negative in the *in vivo* mouse micronucleus test. In rat fertility studies with oral gavage doses of 5, 15, 50 mg/kg/day, males were treated for 9 weeks prior to and throughout mating and females were treated 2 weeks prior to mating and throughout mating until gestation day 7. No adverse effect on fertility was observed at 50 mg/kg/day (systemic exposures up to 10 times human exposure at 40 mg/day based on AUC comparisons). In testicles of dogs treated with rosuvastatin at 30 mg/kg/day for one month, spermatid giant cells were seen. Spermatid giant cells were observed in monkeys after 6-month treatment at 30 mg/kg/day in addition to vacuolization of seminiferous tubular epithelium. Exposures in the dog were 20 times and in the monkey 10 times human exposure at 40 mg/day based on body surface area comparisons. Similar findings have been seen with other drugs in this class. **Pregnancy Pregnancy Category X:** See CONTRAINDICATIONS. Rosuvastatin may cause fetal harm when administered to a pregnant woman. Rosuvastatin is contraindicated in women who are or may become pregnant. Safety in pregnant women has not been established. There are no adequate and well-controlled studies of rosuvastatin in pregnant women. Rosuvastatin crosses the placenta and is found in fetal tissue and amniotic fluid at 3% and 20%, respectively, of the maternal plasma concentration following a single 25 mg/kg oral gavage dose on gestation day 16 in rats. A higher fetal tissue distribution (25% maternal plasma concentration) was observed in rabbits after a single oral gavage dose of 1 mg/kg on gestation day 18. If this drug is administered to a woman with reproductive potential, the patient should be apprised of the potential hazard to a fetus. In female rats given oral gavage doses of 5, 15, 50 mg/kg/day rosuvastatin before mating and continuing through day 7 postcoitus results in decreased fetal body weight (female pups) and delayed ossification at the high dose (systemic exposures 10 times human exposure at 40 mg/kg/day based on AUC comparisons). In pregnant rats given oral gavage doses of 2, 20, 50 mg/kg/day from gestation day 7 through lactation day 21 (weaning), decreased pup survival occurred in groups given 50 mg/kg/day, systemic exposures ≥ 12 times human exposure at 40 mg/kg/day based on body surface area comparisons. In pregnant rabbits given oral gavage doses of 0.3, 1, 3 mg/kg/day from gestation day 6 to lactation day 18 (weaning), exposures equivalent to human exposure at 40 mg/kg/day based on body surface area comparisons, decreased fetal viability and maternal mortality was observed. Rosuvastatin was not teratogenic in rats at ≤ 25 mg/kg/day or in rabbits ≤ 3 mg/kg/day (systemic exposures equivalent to human exposure at 40 mg/kg/day based on AUC or body surface comparison, respectively). **Nursing Mothers:** It is not known whether rosuvastatin is excreted in human milk. Studies in lactating rats have demonstrated that rosuvastatin is secreted into breast milk at levels 3 times higher than that obtained in the plasma following oral gavage dosing. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from rosuvastatin, a decision should be made whether to discontinue nursing or administration of rosuvastatin taking into account the importance of the drug to the lactating woman. **Pediatric Use:** The safety and effectiveness in pediatric patients have not been established. Treatment experience with rosuvastatin in a pediatric population is limited to 8 patients with homozygous FH. None of these patients was below 8 years of age. **Geriatric Use:** Of the 10,275 patients in clinical studies with rosuvastatin, 3,159 (31%) were 65 years and older, and 698 (6.8%) were 75 years and older. The overall frequency of adverse events and types of adverse events were similar in patients above and below 65 years of age. (See WARNINGS, Myopathy/Rhabdomyolysis.) The efficacy of rosuvastatin in the geriatric population (≥ 65 years of age) was comparable to the efficacy observed in the non-elderly. **ADVERSE REACTIONS:** Rosuvastatin is generally well tolerated. Adverse reactions have usually been mild and transient. In clinical studies of 10,275 patients, 3.7% were discontinued due to adverse experiences attributable to rosuvastatin. The most frequent adverse events thought to be related to rosuvastatin were myalgia, constipation, asthenia, abdominal pain, and nausea. **Clinical**





recruited 50,000 subjects in more than 50 countries.

Surgical Advances

Meantime, highly refined surgical techniques continue to achieve important results in the fight against heart disease. In February the Texas Heart Institute at St. Luke's Episcopal Hospital in Houston completed its 1,000th heart transplant, a milestone that took place 38 years after Dr. Denton A. Cooley, who founded the institute, performed the first successful U.S. heart transplant in 1968. The surgery this time was performed by a team headed by Dr. Bud Frazier, the institute's chief of cardiopulmonary transplantation and director of surgical research. Frazier and his team are working to refine the techniques, devices, and treatments for heart transplantation and patient care, including studying new drugs to prevent organ rejection.

Everardo Flores, the 21-year-old recipient of the new heart in February, is no stranger to surgical milestones. He came to the institute in 2003 suffering from severe heart failure and was the first patient in the U.S. to receive the HeartMate II, a high-speed rotary blood pump that supported him for two years until an infection forced its removal last November. "The HeartMate II served its purpose as a bridge to transplant," Frazier said. "Even though we had to take it out, we found his heart had recovered some function and we were able to manage his heart failure symptoms in the hospital until a donor heart could be found."

The Texas Heart Institute is also active in stem-cell research. With approval from the Food and Drug Administration, it is harvesting stem cells from the bone marrow of a patient suffering from advanced heart failure, processing them for three hours, and then injecting them directly into the patient's heart muscle through a catheter. Initial studies have been encouraging. One Brazilian patient who had difficulty walking more than ten steps without becoming breathless is now running on the beach three times a week.

Although heart disease is the leading cause of death among women over 65, accounting for more than all types of cancers combined, a large number of women are not fully aware of the

threat. Heart disease tends to develop later in women—seven or eight years later—but by age 65 men and women have about the same level of risk. Studies have found that physicians tend to be less likely to refer women for diagnostic coronary testing, and women themselves perceive their conditions to be less serious and debilitating even while they are being treated for the disease.

Regular Checkups

On the plus side, women are becoming increasingly knowledgeable about the disease. More than 55% who responded to a recent survey said they know that heart disease is the No. 1 killer of women. That was up sharply from only 30% in 1997. Health authorities are urging women to take a more active role regarding their heart health, through regular checkups, staying physically active, and watching their diets. In addition, a clinical trial conducted by the Women's Health Initiative of the National Institutes of Health confirmed the value of a low-dose aspirin regimen, revealing that it reduced the incidence of stroke by a substantial 17%.

But with all these advances in averting and treating heart disease, there's one rather old-fashioned approach that's worth keeping in mind. Research reported by the American Heart Association has found that middle-aged people who sleep five hours or less a night run an increased risk of developing high blood pressure. So one medically valuable prescription might certainly be: Get a good night's sleep. ■

To advertise in our health sections or order reprints, please contact Debbie Linehan, FORTUNE / Money Group Custom Projects, at 212-522-4362.

Staunch Supporters

We would like to thank the following underwriters for their participation in this section.

AstraZeneca 

TEXAS HEART INSTITUTE
at St. Luke's Episcopal Hospital

Resource Guide

Men's Health Network (MHN) is a non-profit educational organization comprised of physicians, researchers, public health workers, individuals, and other health professionals. MHN is committed to improving the health and wellness of men through education campaigns and workplace health programs.
<http://www.menshealthnetwork.org>