Recombinant human erythropoietin (epoetin alfa) has been used in clinical settings for more than a decade. Its indications have expanded considerably from its original use as hormone therapy in the treatment of anemia in adults with chronic kidney disease. Since the introduction of epoetin alfa, a greater understanding of anemia pathophysiology and the interactions of erythropoietin, iron, and erythropoiesis has been elucidated. Anemia is now independently associated with increased mortality and disease progression. Potential survival benefits associated with correction of anemia in various patient populations are leading to consideration of earlier, more aggressive treatment of mild to moderate anemia with epoetin alfa. Moreover, this agent’s therapeutic use may extend beyond currently accepted roles. Epoetin alfa is undergoing evaluation with promising results in a variety of new clinical settings, including anemia associated with congestive heart failure, ribavirin–interferon alfa treatment of hepatitis C virus infection, and critical illness. Preclinical studies also have established erythropoietin and its recombinant equivalent to be a pleiotropic cytokine with antiapoptotic activity and neuroprotective actions in the central nervous system. The therapeutic potential of epoetin alfa appears yet to be fully realized.
Table 1. Timeline of Approved Indications for Epoetin Alfa (Varies by Country and Formulation)

<table>
<thead>
<tr>
<th>Year</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>Anemia associated with chronic renal failure in patients undergoing hemodialysis†‡</td>
</tr>
<tr>
<td>1990</td>
<td>Anemia in zidovudine-treated human immunodeficiency virus–infected patients‡</td>
</tr>
<tr>
<td>1992</td>
<td>Anemia of chronic renal failure in adult patients undergoing peritoneal dialysis and in those not requiring dialysis†‡</td>
</tr>
<tr>
<td>1993</td>
<td>Anemia in patients with nonmyeloid malignancies receiving chemotherapy†‡</td>
</tr>
<tr>
<td>1994</td>
<td>Anemia of chronic renal failure in pediatric patients undergoing hemodialysis†</td>
</tr>
<tr>
<td>1995</td>
<td>To increase yield of autologous blood from patients in predonation programs†</td>
</tr>
<tr>
<td>1996</td>
<td>Reduction of allogeneic blood transfusion in anemic patients undergoing elective noncardiac, nonvascular surgery‡</td>
</tr>
<tr>
<td>1998</td>
<td>Reduction of allogeneic blood transfusion in adult patients prior to major elective orthopedic surgery†</td>
</tr>
<tr>
<td>1999</td>
<td>Anemia in pediatric patients (≥1 month old) with chronic renal failure requiring dialysis‡</td>
</tr>
<tr>
<td>2000</td>
<td>Reduction of anemia-related sequelae (eg, fatigue, decreased energy, and activity reduction) in adult chemotherapy patients†‡</td>
</tr>
</tbody>
</table>

*In the United States, Epogen (epoetin alfa) is manufactured and marketed by Amgen Inc, Thousand Oaks, Calif. †Outside of the United States, epoetin alfa is manufactured by Ortho Biologics, LLC, and distributed and marketed as EPREX or ERYPO by Ortho Biotech, Toronto, Ontario, and Janssen-Cilag, Issy-les-Moulineaux, France. ‡In the United States, PROCRIT (epoetin alfa) is manufactured by Amgen Inc and distributed and marketed by Ortho Biotech Products, LP, Bridgewater, NJ.

antiapoptotic activity,14-16 as well as potential neuroprotective effects against central nervous system (CNS) injury. This review summarizes the developments and insights gained regarding the biology and clinical use of epoetin alfa since its initial introduction, focusing on clinical uses other than anemia in patients with advanced stages of CKD (ie, end-stage renal disease), as well as important areas of ongoing and new research that are anticipated to widen its therapeutic potential.

**BIOLOGY OF ERYTHROPOIETIN**

Erythropoietin is a glycoprotein produced primarily in the kidneys that stimulates the division and differentiation of committed erythroid progenitors in the bone marrow.17-19 Plasma erythropoietin levels remain relatively constant when Hb levels remain at or above 12 g/dL but begin to rise rapidly and markedly when the Hb level decreases below 12 g/dL. (Figure 1.)20 It takes 3 to 4 days following erythropoietin stimulation for circulating reticulocytes to increase.21 Depending on the degree of anemia, maturation of circulating reticulocytes into mature red blood cells (RBCs) may take an additional 1 to 3 days.22 Thus, any clinically significant increase in Hb levels is usually not observed in less than 2 weeks following erythropoietin stimulation and may require up to 6 weeks in some patients.

Epoetin alfa is the recombinant equivalent of the endogenous cytokine, with an identical amino acid structure and indistinguishable biologic activity both in vitro and in vivo.1,2,22 Over the last decade, greater efforts to more completely describe the biology of erythropoietin in humans have been undertaken, particularly to identify roles and actions of the cytokine in hematopoiesis and other biologic processes.

Erythropoietin has high affinity for the erythropoietin receptor expressed on the surface of erythroid cells. This receptor belongs to the cytokine receptor family that includes growth hormone, prolactin, various colony-stimulating factors, leptin, and several interleukins.15,23 In addition to its essential role in erythropoiesis, the erythropoietin receptor also is expressed in mast cells and megakaryocytes, as well as in nonhematopoietic tissues (eg, gastric mucosa, vascular smooth muscle, and brain neurons).16,24-27 In brain neurons, a role for erythropoietin receptor signaling during ischemia-associated neuronal angiogenesis has been suggested.28,29 In addition, erythropoietin acts to inhibit programmed cell death (apoptosis) of erythroid progenitor cells,30 as well as in neurons following cerebral ischemia and metabolic stress.14 Other proposed neuroprotective mechanisms for erythropoietin include antioxidation31 and a direct neurotrophic effect.32

**DOsing of Epoetin Alfa**

Epoetin alfa was initially administered intravenously 3 times weekly (TIW) to patients with CKD who were undergoing dialysis to mimic the normal physiologic environment and to allow the patient to receive the drug simultaneously with dialysis.3-5 Additional experience demonstrated that the drug could also be administered subcutaneously (SC) at the same or a somewhat reduced dose and schedule.33 The TIW dosing regimen was used in clinical trials evaluating epoetin alfa for subsequent indications, but investigation of alternative, more convenient dosing schedules followed.34-36 Pharmacokinetic and pharmacodynamic studies in healthy subjects established that epoetin alfa administered SC at intervals of 7 to 10 days resulted in significant increases in reticulocyte counts34,36 and Hb levels.34 A subsequent random-
ized, parallel-design study in healthy adults demonstrated that epoetin alfa, 150 U/kg SC TIW, and 40 000 U SC once weekly for 4 weeks were clinically equivalent regimens, producing similar increases in percentage of reticulocytes, Hb, and total RBCs.37 Once-weekly epoetin alfa dosing has been shown to significantly increase Hb levels in anemic patients with CKD,38 patients scheduled for major orthopedic surgery,33 anemic patients with cancer receiving chemotherapy40 or sequential or concurrent radiation plus chemotherapy,40,41 anemic HIV-positive patients (including patients receiving highly active antiretroviral therapy [HAART] with or without zidovudine),42,43 and hepatitis C virus (HCV)-infected patients who develop anemia while receiving ribavirin–interferon alfa therapy.49 The efficacy and safety profiles of once-weekly epoetin alfa dosing in these populations were similar to those observed with TIW dosing. The once-weekly dosing regimen is now widely used in these patient populations (Table 2). Studies also are in progress in anemic patients with cancer receiving chemotherapy,45,46 patients with CKD not undergoing dialysis,45 and HIV-positive patients to evaluate alternative epoetin alfa dosing regimens, including higher starting doses (eg, 60 000 U SC once weekly)45,46 and extended maintenance dosing intervals (eg, every 2-4 weeks).45,47 Traditionally, patients with anemia were not treated until Hb levels dropped below 10 g/dL, at which time RBC transfusions often were administered empirically. Concerns about potential HIV and other infections in the 1980s influenced the treatment of mild to moderate anemia because no alternative was available. Transfusions were generally withheld until Hb levels declined to 7 to 8 g/dL or the patient manifested symptoms of severe anemia. Normal physiologic stimulation of endogenous erythropoietin begins when Hb level falls below 12 g/dL. Based on this standard and data from anemic patients with cancer who demonstrate a significant relationship between QOL and Hb levels from 8 to 14 g/dL—with the greatest improvements in QOL occurring as Hb levels increased from 11 to 12 g/dL—it may be more appropriate to consider treating anemic patients at Hb levels lower than 12 g/dL rather than waiting until more severe anemia develops.48,49 This strategy would more closely mimic the body’s normal response to inadequate tissue oxygenation and low Hb levels.20

**IRON REQUIREMENTS WITH EPOETIN ALFA USE**

Transferrin saturation and serum ferritin should be monitored both prior to and during epoetin alfa therapy. In addition, patients who fail to respond or to maintain a response to recommended epoetin alfa doses should be evaluated for the presence of an underlying infectious, inflammatory, or malignant process; occult blood loss; underlying hematologic disease (eg, thalassemia and refractory anemia); vitamin deficiencies (folic and vitamin B12); hemolysis; aluminum intoxication; and osteitis fibrosa cystica. In contrast to absolute iron deficiency, which results from inadequate iron stores, functional iron deficiency describes the failure to provide iron quickly enough to meet the demands of erythropoiesis.50 Inflammatory cytokines associated with the anemia of chronic disease are believed to inhibit the release of iron in storage, limiting the rate of RBC production. In particular, in clinical settings such as cancer and HIV and in patients with CKD undergoing dialysis, epoetin alfa stimulation of RBC production may surpass the rate of iron mobilization from iron stores to the labile iron pool, despite the existence of adequate iron in storage form.51 This results in a rapidly depleted labile iron pool, delaying a response to epoetin alfa and requiring iron supplementation to achieve or to maintain the effectiveness of epoetin alfa. Oral iron formulations cannot always provide iron quickly enough to support the accelerated erythropoiesis that occurs with epoetin alfa, and intravenous iron supplementation may be required.51,54

**CLINICAL EVOLUTION**

**Chronic Kidney Disease**

As defined by the National Kidney Foundation (NKF), CKD describes patients with chronically reduced renal function, including those with chronic allograft dysfunction and those with end-stage renal disease.52 Normochromic, normocytic anemia occurs in most patients with CKD and is associated with physiologic abnormalities including cardiac dysfunction, impaired cognitive function, impaired immune response, growth retardation in ped...
diantic patients, reduced QOL, and decreased patient survival. In use since 1986, epoetin alfa has proven safe and effective for management of anemia in adult and pediatric patients with CKD, both prior to and during dialysis. Effective treatment of the anemia of CKD may improve survival (in predialysis patients and patients undergoing dialysis). Decrease the risk of hospitalization, decrease morbidity, slow disease progression, and improve QOL. The NKF guidelines now recommend target Hb levels of 11 to 12 g/dL and hematocrit (HCT) values ranging from 33% to 36%, which are associated with marked improvement in oxygen utilization; muscle strength and function; cognitive and brain function; cardiac function; sexual function; and QOL.

Early CKD
A novel approach to managing anemia and its complications in CKD is to start epoetin alfa therapy in patients with early CKD at the first indication that Hb levels are falling below normal. Because cardiovascular disease is common in patients with CKD and anemia is an independent risk factor for left ventricular hypertrophy in predialysis patients with CKD, early treatment of anemic patients with CKD may prevent the cardiovascular dysfunction (eg, left ventricular hypertrophy, cardiac failure, and stroke) or its progression commonly observed in anemic patients with end-stage renal disease. As in diabetic patients with microalbuminuria who are treated for maximum blood pressure control and with angiotensin-converting enzyme inhibitors to prevent progression to macroalbuminuria or deteriorating renal function, treatment of anemia in patients with early CKD may have the potential to alter the disease course. An additional goal in early CKD is to maintain exercise capacity and QOL. Patients also would likely be in better overall health when dialysis becomes necessary.

For an early treatment strategy to be optimally used, a clearer understanding of the scope of anemia in early CKD is needed. In a recent preliminary analysis, 48% of 1716 patients with early CKD (serum creatinine concentration: women, ≥1.5 mg/dL [≥132.6 µmol/L], or men, ≥2.0 mg/dL [≥176.8 µmol/L], but ≤6 mg/dL [≤530.4 µmol/L] within the past 12 months) had an Hb level of 12 g/dL or lower, including 9% with an Hb level of 10 g/dL or lower. As might be anticipated, a relationship between anemia severity and worsening renal function also was observed; approximately 52% of patients with a creatinine clearance of 30 mL/min or less also had an Hb level of 12 g/dL or lower. These initial findings suggest a high prevalence of anemia in patients with earlier stages of CKD. In this context, Provenzano et al recently conducted a large, prospective, multicenter study in patients with early CKD (serum creatinine concentration: women, ≥1.5 mg/dL [≥132.6 µmol/L], men, ≥2.0 mg/dL [≥176.8 µmol/L], but ≤6 mg/dL [≤530.4 µmol/L] over 16 weeks) and showed that once-weekly epoetin alfa treatment improved Hb and HCT values from a baseline of 9.2 g/dL and 27.5%, respectively, to 11.9 g/dL and 36.2%, respectively, over 16 weeks. Transfusion rates were reduced from 11.1% to 0.5% in these patients, and QOL measures also showed improvement throughout the 16-week treatment period.

Treatment with epoetin alfa prior to initiation of dialysis also may improve survival in patients with CKD. A retrospective analysis performed on data from 4866 patients with end-stage renal disease, of whom 1107 (23%) were treated with epoetin alfa prior to initiation of dialysis, showed that patients treated with epoetin alfa before starting dialysis had a lower mortality risk compared with patients who did not receive epoetin alfa treatment before dialysis (adjusted relative risk, 0.80). The greatest survival benefit was observed in patients with HCT values greater than 31.8% prior to dialysis (adjusted relative risk, 0.67; P < .001). Patients also received the most benefit during the first 19 months of dialysis (adjusted relative risk, 0.81), with no sustained survival advantage among patients undergoing dialysis for more than 31 months relative to patients who did not receive epoetin alfa prior to dialysis.

Early detection and intervention are key to the overall management strategy of patients with CKD. This includes managing primary comorbidities (eg, diabetes and hypertension), preventing uremic complications (eg, anemia, acidosis, and malnutrition), and instituting appropriate measures to delay disease progression (eg, treatment with angiotensin-converting enzyme inhibitors, lipid management, and protein restriction). Correction of anemia plays a principal role in effectively managing many of these issues.

HIV/AIDS
Anemia is the most common hematologic abnormality of HIV infection, and its frequency and severity usually increase as infection progresses to immunologic and clinical AIDS. The first antiretroviral agent, zidovudine, was a well-recognized cause of bone marrow suppression and anemia, especially with the higher dosages used prior to the introduction of HAART. The evaluation of epoetin alfa as a potential therapy for anemia in patients with HIV or AIDS who were receiving zidovudine was prompted by the growing HIV/AIDS epidemic; the anticipated increase in transfusion requirements; concerns over the immunosuppressive effect of transfusions in this population; and the fact that, although elevated above normal, plasma erythropoietin levels in patients with HIV or AIDS were usually inadequate for the degree of anemia. Four placebo-controlled clinical trials including 255 evaluable patients demonstrated that epoetin alfa administered TIW significantly increased HCT (P < .001) and decreased transfusion requirements (P = .003) in patients with HIV or AIDS receiving zidovudine. These results were confirmed in an analysis of data from 1943 anemic patients with AIDS who participated in an open-label, multicenter, epoetin alfa treatment investigational new drug protocol. The increase in HCT values and reduction in transfu-
Anemia is a frequent, often debilitating complication of cancer and its treatment. Fatigue, the most common symptom associated with anemia, affects most patients with cancer during the course of their disease and treatment, with many of these patients experiencing fatigue daily or reporting that fatigue significantly affects their daily routines. Historically, reporting of anemia as a toxic effect in chemotherapy studies was mainly focused on the more severe grades. Mild to moderate anemia, however, occurs in 50% to 75% of adults receiving the most common single agents and combination regimens used to treat major nonmyeloid malignancies. A recent systematic, quantitative review of available literature suggests that anemia may be an independent prognostic factor for survival in patients with cancer. The overall estimated increased relative risk of death, after adjusting for other factors, was 65%; anemia was associated with significantly shorter survival times in patients with lung cancer, head and neck cancer, prostate cancer, or lymphoma. The anemia of cancer most closely resembles the anemia associated with chronic disease, with patients demonstrating serum erythropoietin levels that are elevated above normal but not as high as levels observed in patients with similar decreases in Hb level caused by iron deficiency or hemolytic anemia. It appears that patients with cancer experience a blunted erythropoietin response to anemia, as well as inadequate erythropoietin production, making higher doses of epoetin alfa necessary to correct anemia in this setting.

Epoetin alfa (150-300 U/kg TIW) has been shown in randomized, double-blind, placebo-controlled clinical trials to effectively increase Hb levels and reduce transfusion requirements in anemic patients with cancer treated with cisplatin-containing or non-cisplatin-containing chemotherapy. Three additional large, prospective, community-based trials further established the efficacy of epoetin alfa (150-300 U/kg TIW...
Epoetin alfa also is undergoing active investigation for the treatment of anemia in pediatric patients with Hodgkin disease, acute lymphocytic leukemia, and non-Hodgkin lymphoma who are receiving chemotherapy, as well as in patients with cancer who receive radiotherapy only. Randomized controlled trials show that epoetin alfa treatment can significantly reduce transfusion incidence, increase mean Hb level, and improve QOL in patients with multiple myeloma. Epoetin alfa also may allow disease downstaging in B-cell chronic lymphoproliferative disorders with long-term use. Epoetin alfa administration in mice bearing multiple myeloma tumors has been shown to markedly prolong survival and reduce mortality, suggesting that epoetin alfa may act as an antitumor therapeutic agent in addition to its role in erythropoiesis. Results of several clinical studies also suggest that use of epoetin alfa as an adjunct to radiotherapy can increase and maintain Hb levels and improve QOL during radiotherapy administered alone or either sequentially or concomitantly with chemotherapy. Preliminary results in patients with head and neck cancer further suggest that epoetin alfa therapy may improve locoregional control and survival rates to levels observed in patients with normal pretreatment Hb levels. Additional clinical trials designed specifically to assess the potential impact of epoetin alfa on survival of patients with cancer are ongoing.

To confirm early clinical studies suggesting that epoetin alfa can effectively correct anemia in patients with advanced cancer without regard to chemotherapy use, Quirt et al recently demonstrated that epoetin alfa administration to patients with non-myeloid malignancies, including a large cohort of anemic patients (n=183) not receiving chemotherapy, significantly improved Hb levels and decreased transfusion use, with increases in Hb levels positively correlating with significant improvements in QOL and changes in Eastern Cooperative Oncology Group performance scores. These results indicate that patients with cancer-related anemia who are not receiving chemotherapy can achieve substantial clinical benefits with epoetin alfa treatment.

Surgery

Despite significant improvements in the safety of the blood supply in recent years, efforts continue to refine existing blood conservation programs and develop new ways to minimize perioperative allogeneic blood exposure. Epoetin alfa has been shown in placebo-controlled trials to significantly decrease allogeneic transfusion requirements and increase preoperative Hb levels in mildly anemic (Hb level >10 g/dL to ≤13 g/dL) patients undergoing major elective orthopedic procedures. In addition, epoetin alfa therapy resulted in comparable or significantly higher mean Hb levels preoperatively, postoperatively, and at discharge compared with preoperative autologous donation patients undergoing total joint arthroplasty surgery (P<.001). These results suggest that epoetin alfa may effectively allow bloodless orthopedic surgery in many patients. Epoetin alfa also has been shown to reduce perioperative exposure to allogeneic blood in patients undergoing radical retropubic prostatectomy. The results of these trials indicate that perioperative epoetin alfa administration is a safe, well-tolerated, effective, and cost-equivalent alternative to preoperative autologous donation.

Quality of Life

From the patient’s perspective, QOL has become an increasingly important consideration in health care management and therapeutic decisions for individual patients. Numerous studies have now demonstrated a correlation between a positive response to epoetin alfa therapy and improved QOL (overall QOL, energy level, and activity level) in anemic patients with CKD, cancer, and HIV infection. Clinically relevant insights are emerging regarding the relationship between Hb levels and patient well-being and functional outcomes. In anemic patients with cancer treated with chemotherapy, significant improvements in self-reported QOL parameters and functional status have been reported by patients demonstrating a hematologic response to epoetin alfa with improvements occurring independent of tumor response. An incremental analysis of the clinical and outcomes data from the combined results of the 2 community-based trials using TIW epoetin alfa dosing demonstrated a significant (P<.01), nonlinear relationship between Hb level and QOL over the Hb level range of 8 to 14 g/dL, with the greatest improvement in QOL occurring when the Hb level increased from 11 to 12 g/dL (range, 11-13 g/dL). These studies in anemic patients with cancer indicate that Hb levels lower than 12 g/dL are associated with suboptimal degrees of overall QOL and functional abilities and are consistent with a large body of evidence in anemic patients with renal dysfunction that functional status is optimized at a Hb level of 12 g/dL. Collectively, these results have had a significant impact on the understanding of anemia and its relationship to patient well-being, sug-
Association. 

Figure 2. Quality of life parameters (Functional Assessment of Cancer Therapy–Anemia [FACT-An]) analyzed based on changes in hemoglobin levels and tumor response from baseline to final assessment. Asterisk indicates significantly (P<.01) different from baseline; dagger, significantly (P<.01) different from adjacent hemoglobin change group; and double dagger, significantly (P<.05) different from adjacent hemoglobin change group. Adapted with permission from Demetri et al.103

<p>| Table 3: Hematologic and Clinical Findings in 26 Patients With Heart Failure at Baseline and Following Epoetin Alfa Therapy*144 |
|---------------------------------|------------------|------------------|</p>
<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>End of Study†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin, g/dL</td>
<td>10.16 ± 3.12</td>
<td>12.10 ± 1.21†‡</td>
</tr>
<tr>
<td>LVEF, %</td>
<td>27.7 ± 4.8</td>
<td>35.4 ± 7.6‡</td>
</tr>
<tr>
<td>NYHA class (I-IV)</td>
<td>3.66 ± 0.47</td>
<td>2.66 ± 0.70§</td>
</tr>
<tr>
<td>No. of hospitalizations per patient</td>
<td>2.72 ± 1.21</td>
<td>0.22 ± 0.65§</td>
</tr>
<tr>
<td>Oral furosemide, mg/d</td>
<td>200.9 ± 120.4</td>
<td>78.3 ± 41.3§</td>
</tr>
<tr>
<td>IV furosemide, mg/mo</td>
<td>164.7 ± 178.9</td>
<td>19.8 ± 47.0§</td>
</tr>
</tbody>
</table>

Abbreviations: IV, intravenous; LVEF, left ventricular ejection fraction; NYHA, New York Heart Association.

*Data are mean ± SD value.
†Mean study duration, 7.2 ± 5.5 months (range, 4-15 months).
‡P<.001 vs baseline, paired t test.
§P<.05 vs baseline, paired t test.

Figure 2. Quality of life parameters (Functional Assessment of Cancer Therapy–Anemia [FACT-An]) analyzed based on changes in hemoglobin levels and tumor response from baseline to final assessment. Asterisk indicates significantly (P<.01) different from baseline; dagger, significantly (P<.01) different from adjacent hemoglobin change group; and double dagger, significantly (P<.05) different from adjacent hemoglobin change group. Adapted with permission from Demetri et al.103

Table 3. Hematologic and Clinical Findings in 26 Patients With Heart Failure at Baseline and Following Epoetin Alfa Therapy*144

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>End of Study†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin, g/dL</td>
<td>10.16 ± 3.12</td>
<td>12.10 ± 1.21†‡</td>
</tr>
<tr>
<td>LVEF, %</td>
<td>27.7 ± 4.8</td>
<td>35.4 ± 7.6‡</td>
</tr>
<tr>
<td>NYHA class (I-IV)</td>
<td>3.66 ± 0.47</td>
<td>2.66 ± 0.70§</td>
</tr>
<tr>
<td>No. of hospitalizations per patient</td>
<td>2.72 ± 1.21</td>
<td>0.22 ± 0.65§</td>
</tr>
<tr>
<td>Oral furosemide, mg/d</td>
<td>200.9 ± 120.4</td>
<td>78.3 ± 41.3§</td>
</tr>
<tr>
<td>IV furosemide, mg/mo</td>
<td>164.7 ± 178.9</td>
<td>19.8 ± 47.0§</td>
</tr>
</tbody>
</table>

Abbreviations: IV, intravenous; LVEF, left ventricular ejection fraction; NYHA, New York Heart Association.

*Data are mean ± SD value.
†Mean study duration, 7.2 ± 5.5 months (range, 4-15 months).
‡P<.001 vs baseline, paired t test.
§P<.05 vs baseline, paired t test.

**NEW AREAS OF RESEARCH**

Congestive Heart Failure

Patients with congestive heart failure often develop anemia, which generally worsens with increasing heart failure severity.131-135 The anemia appears to occur despite plasma erythropoietin levels that increase progressively with increasing New York Heart Association (NYHA) severity.135 Based on animal and human studies, the ischemic or hypertrophied heart seems to be more sensitive than healthy myocardium to anemia, including very small changes in Hb level, which result in a marked worsening of ischemia and impairment in cardiac function in the diseased heart.136,137 Conversely, chronic severe anemia results in salt and fluid retention that appears to improve when the anemia is corrected.138 In anemic patients with CKD, treatment with epoetin alfa has resulted in reductions in left ventricular hypertrophy, prevention of left ventricular dilatation, and improvement in left ventricular ejection fraction, stroke volume, and cardiac output.139-143 Thus, correction of anemia in patients with congestive heart failure may improve myocardial function.

In a recent retrospective analysis, the prevalence and significance of mild anemia (Hb level <12 g/dL) in 142 patients with heart failure were shown to increase with heart failure severity, ranging from 9% in patients with NYHA class I heart failure to 79% of patients with NYHA class IV disease.144 Of note, 19% of patients with mild heart failure (NYHA class II) and 53% of patients with moderate disease (NYHA class III) were anemic and had concomitant serum creatinine levels ranging from 1.9 to 2.4 mg/dL (168-212 µmol/L), indicating some degree of renal insufficiency even in patients with relatively mild cardiac impairment. A subset of 26 patients with NYHA class IV heart failure, despite maximally tolerated therapy for at least 6 months and Hb levels lower than 12 g/dL, were enrolled in an intervention trial and received epoetin alfa (mean ± SD dosage, 5227 ± 455 U SC once weekly) and intravenous iron supplementation for a mean ± SD of 7.2 ± 5.5 (range, 4-15) months. In this subset, epoetin alfa therapy was associated with significant improvements in Hb levels and functional status and a 28% increase in left ventricular ejection fraction compared with baseline (Table 3). These improvements correlated with a significant reduction in oral and intravenous furosemide administration from baseline, a 92% decrease in hospitalizations compared with a similar period prior to initiation of epoetin alfa therapy, and a decrease in the rate of renal failure progression. No adverse events associated with epoetin alfa therapy were reported. Thus, treatment of anemia in patients with even mild to moderate heart failure may ameliorate progression of CKD and congestive cardiomyopathy. If successful treatment of anemia can improve car-
diac function and reduce hospitalizations in patients with congestive heart failure who have or develop anemia. Epoetin alfa therapy may have an important role in the overall management of major cardiovascular disease. Further evaluation is warranted, and a randomized, controlled trial is ongoing.

**CNS Disorders**

There is considerable interest in agents that might have neuroprotective effects associated with various CNS insults such as head trauma, anoxic injury, and stroke. Epoetin alfa administered via intracerebrovascular injection appears to have such neuroprotective properties in animal models of hypoxic and/or ischemic stress. In studies using various in vitro and animal models of human CNS disorders, epoetin alfa had a protective effect against several forms of neuronal damage occurring in stroke, head trauma, epilepsy, and autoimmune encephalitis. Astrocytes and neurons also can produce erythropoietin under hypoxic or ischemic conditions. However, physiologic erythropoietin production alone cannot meet the oxygen demand needed to adequately respond to acute and severe hypoxic and/or ischemic neuronal stress, such as that which occurs following cerebrovascular accident, blunt head trauma, or status epilepticus. Thus, it is possible that exogenous epoetin alfa administration following neuronal stress may augment the activity of endogenous erythropoietin in the CNS.

Intracerebrovascular injection is clearly not practical in the clinical setting and, until recently, systemically administered epoetin alfa had not been seriously evaluated in animal models because conventional wisdom suggested that large glycosylated molecules (eg, epoetin alfa) were not capable of crossing the blood-brain barrier. However, certain large proteins are transported into the CNS via binding to receptors on the capillary endothelium. Using immunocytochemistry techniques, the expression of erythropoietin receptors on human brain capillaries was recently reported. In addition, evidence suggesting a specific, saturable, receptor-mediated transport mechanism for epoetin alfa across the blood-brain barrier that was not dependent on the existence of injury or inflammation was reported. Collectively, the preclinical data suggest that epoetin alfa possesses immunomodulatory, antiapoptotic, and anti-inflammatory properties in addition to the ability to stimulate erythropoiesis. The neuroprotective effects may be conferred by erythropoietin receptors that have been shown to exist throughout the CNS. Further investigation of epoetin alfa in these and related CNS models is warranted to more specifically define its therapeutic potential in human CNS disorders.

**Cognition**

It is increasingly recognized that therapeutic interventions, such as coronary artery bypass surgery or adjuvant chemotherapy in patients with breast cancer, are associated with a relatively high prevalence of cognitive impairment and a decline in cognitive functioning. The exact cause(s) of these cognitive deficits in the various affected patient populations has not been established, but reduced oxygen delivery to CNS tissues may be involved. Because of the neuroprotective effect of epoetin alfa in preclinical studies and its ability to improve QOL in anemic patients with cancer, clinical studies are ongoing to explore the potential relationship between decreases in Hb levels and cognitive function in patients with cancer receiving chemotherapy and a possible role for epoetin alfa in ameliorating cognitive deficits in anemic patients with cancer receiving chemotherapy. Jacobsen et al recently reported that declines in Hb levels during the course of chemotherapy in patients with cancer were associated with increases in cognitive complaints (eg, problems with memory and concentration) and declines in cognitive abilities. In a randomized, double-blind, placebo-controlled pilot trial enrolling 100 patients with breast cancer receiving anthracycline-based adjuvant chemotherapy, O’Shaughnessy et al found that patients receiving epoetin alfa, 40000 U SC once weekly, experienced improvements in mood, attenuations in the decline in QOL, and improvements in executive control cognitive function compared with patients receiving placebo. Based on these novel results, a larger follow-up, placebo-controlled clinical trial is under way.

**Critical Care**

Anemia occurs almost universally among critically ill patients and is associated with considerable RBC transfusion use and potentially increased risk of mortality in the intensive care unit (ICU) setting. Two recent observational studies conducted in Europe and the United States described transfusion rates of 37% and 44%, respectively, in the ICU setting, with transfusions occurring more frequently in older patients and those with extended (≥7 days) ICU stays. In critically ill patients, the characteristic compensatory endogenous erythropoietin response to anemia is diminished and iron metabolism abnormalities are present, suggesting that the anemia is an underproduction anemia similar, if not identical, to anemia of chronic inflammatory disease. Typically, critically ill patients with anemia receive transfusions despite well-recognized potential adverse effects of allogeneic blood and an association between transfusion and increased risk of morbidity and mortality. However, allowing critically ill patients to maintain a low but apparently tolerable Hb level (typically 7-10 g/dL) also may not be an acceptable option for positive clinical outcomes, particularly in patients with underlying or apparent comorbidities.

Critically ill patients with anemia still demonstrate a bone marrow response to epoetin alfa. Its potential role in the management of anemia in critically ill patients was initially assessed in a randomized, double-blind, placebo-controlled trial. Patients were randomized to receive either epoetin alfa, 300 U/kg...
verse events between the 2 treatment groups. The notable response to epoetin alfa in this setting provided further evidence that these patients have an impaired erythropoietin response to physiologic stimuli, as well as a limited ability to respond to endogenous erythropoietin. In this setting, epoetin alfa therapy may allow critically ill patients to achieve higher Hb levels while decreasing their need for RBC transfusions. Further research is needed to determine whether the reduction in RBC transfusion will result in improved clinical outcomes in some critically ill patients. Given the extent of transfusion in the critically ill, particularly in those with longer than 1-week length of stay in the ICU, the potential impact of epoetin alfa therapy on transfusion use in this setting could be substantial.

**HCV Infection: Treatment-Related Anemia**

Chronic HCV infection is now recognized as the leading cause of liver disease in North America, resulting in cirrhosis, end-stage liver disease, and hepatocellular carcinoma. Combination therapy with conventional interferon alfa or pegylated interferon alfa plus ribavirin, a guanosine analogue with activity against a range of viruses, is now considered standard reference therapy for HCV infection. However, a common and predictable adverse effect of ribavirin is a dose-dependent, reversible anemia, resulting in a drop in Hb levels to below 11 g/dL in 25% to 35% of patients and to below 10 g/dL in 8% to 9% of patients, requiring ribavirin dosage reduction or treatment discontinuation. In addition, data suggest that interferon alfa administration causes bone marrow suppression and a blunted reticulocytosis.

Concomitant treatment with epoetin alfa may ameliorate this anemia and allow HCV-infected patients to continue therapy with interferon alfa-2b plus ribavirin. In an open-label, randomized, multicenter, parallel-group study, 36 anemic HCV-infected patients (mean baseline Hb level, 11.0 g/dL) received epoetin alfa, 40000 U once weekly, along with combination ribavirin–interferon alfa-2b therapy, while 28 patients (mean baseline Hb level, 11.0 g/dL) received ribavirin–interferon alfa-2b and standard of care treatment for Hb level decreases. At weeks 2, 4, 8, 12, and 16, patients receiving epoetin alfa had significantly (P < .01) higher Hb levels than at baseline, as well as significantly (P < .05) higher levels than those patients receiving the standard of care. In addition, mean ribavirin daily doses remained constant throughout the 16-week treatment period in patients receiving epoetin alfa but decreased in patients receiving the standard of care. In the on-treatment analysis, the mean ribavirin daily dose in patients receiving the standard of care was lower than that in patients receiving epoetin alfa throughout the study (P < .05 at week 16), with 83% of patients receiving epoetin alfa maintaining ribavirin daily doses of 800 mg or greater compared with 54% of patients receiving the standard of care (P = .02). These results suggest that epoetin alfa may be a valuable addition to the standard treatment regimen of HCV-infected patients who develop anemia with combination ribavirin–interferon alfa-2b therapy. By allowing maintenance of therapeutic doses of ribavirin, epoetin alfa may increase the likelihood of patients achieving sustained virologic responses to HCV treatment.
Use in Pediatric Patients

Several clinical trials have confirmed the benefit of early epoetin alfa treatment (300-600 U/kg per week for 4-6 weeks) to decrease the need for blood transfusion in infants (weight from under 1000 g to 1750 g; gestational age ≤33 weeks; baseline Hb level <10 g/dL; baseline HCT ≤35%) with the anemia of prematurity.184-187 In these trials, infants receiving epoetin alfa received significantly fewer transfusions and experienced higher reticulocyte counts and serum erythropoietin levels compared with infants receiving transfusions alone or placebo.

Epoetin alfa is indicated for the treatment of pediatric patients aged 1 month to 16 years with anemia associated with CKD requiring dialysis.188-192 The drug also has been used successfully to treat pediatric patients with anemia associated with CKD not requiring dialysis,193,194 HIV-infected pediatric patients,194,195 and those with cancer-associated anemia currently receiving chemotherapy.196,197 In each of these settings, epoetin alfa administration was associated with dose-dependent increases in Hb and HCT values and decreases in transfusion requirements.191,193,197 Ongoing studies are investigating the once-weekly administration of epoetin alfa to anemic pediatric patients with cancer.198

Safety of Epoetin Alfa

Epoetin alfa is generally well tolerated and has demonstrated proven safety. The adverse effects reported in patients receiving epoetin alfa for its approved indications are generally consistent with the underlying disease (eg, CKD, cancer, and HIV) and its progression or with commonly reported sequelae following surgery. Rapid increases in HCT in patients with CKD may be associated with hypertension. The use of epoetin alfa is contraindicated in patients with uncontrolled hypertension.

In a randomized, prospective study of 1265 hemodialysis patients with clinically evident cardiac disease in which patients were assigned to epoetin alfa treatment targeted to maintain an HCT of either 42%±3% or 30%±3%, increased mortality (35%) was observed in the 634 patients randomized to the higher HCT compared with the 631 patients randomized to the lower target (29% mortality). The reason for the increased mortality is not known. The incidence of nonfatal myocardial infarctions (3.1% vs 2.3%), vascular access thrombosis (39% vs 29%), and all other thrombotic events (22% vs 18%) was also higher in the group randomized to 42% HCT.192 In cancer patients undergoing chemotherapy, the only adverse events that occurred with a statistically greater incidence in patients receiving epoetin alfa than in placebo-treated patients were diarrhea and edema. The most commonly reported adverse effects were pyrexia, vomiting, shortness of breath, paresthesia, and upper respiratory tract infection. The safety of perioperative use of epoetin alfa has been evaluated only in patients who received anticoagulant prophylaxis. Thus, the risk of postoperative thrombotic and/or vascular events cannot be excluded. The occurrence of pure RBC aplasia associated with the presence of anterythropoietin antibodies has been reported with recombinant human erythropoietin administered SC in a small number of patients with chronic renal failure.199,200 To date, no definitive causative factors have been identified.201

CONCLUSIONS

Over the last decade, epoetin alfa has been used in over 1 million patients in the United States and in over 3 million patients worldwide. As one of the original recombinant DNA technology products made available for clinical use, epoetin alfa has proven to have a significant therapeutic role in treating anemia in many conditions beyond its initial use as hormone therapy in patients with anemia of CKD. Epoetin alfa is an accepted treatment for patients with HIV- and cancer-associated anemia, with the value of anemia therapy in these settings supported by the established relationship of anemia to QOL and functional outcomes. This relationship also has led to a reevaluation of traditional approaches to diagnosing and treating anemia, prompting more aggressive and earlier treatment of mild to moderate anemia in the disease course to minimize or avoid the adverse effect of anemia on patient well-being and functional status in established indications. The independent association between anemia and an increased risk of mortality in HIV infection, cancer, and CKD, along with the finding that correction of anemia with epoetin

Costs

The expansion of clinical uses of epoetin alfa has prompted further examination of the costs of therapy relative to traditional treatment options for anemia (primarily transfusions). Recent cost analysis studies have demonstrated that the costs of outpatient blood transfusions in patients with cancer have been underestimated.202,203 These findings imply that previous estimates of the cost-effectiveness of alternatives to transfusions, including epoetin alfa, were understated because the cost of transfusions was only partially captured.202 Crémieux et al204 showed that epoetin alfa can be used cost-effectively to treat anemic patients with cancer and that epoetin alfa is a cost-effective alternative to blood transfusions. Cost of erythropoietic treatment is an important issue, and additional pharmacoeconomic analysis on the use of erythropoietic agents across clinical uses could provide better perspective on their relative cost-effectiveness. Limited pharmacoeconomic data are available for use in most clinical settings, and direct comparisons of the various agents are not yet available. The issue is complicated in part because the cost of the agents and their reimbursement rates vary by institution, state, and country. In the United States, the average wholesale price as of February 2003 for available agents was $13.35 per 1000 U for epoetin alfa (Procrit; Ortho Biotech Products, LP, Bridgewater, NJ) and $124.69 per 25 µg for darbepoetin alfa (Aranesp; Amgen, Thousand Oaks, Calif).205

©2004 American Medical Association. All rights reserved.
alma may be associated with improved survival in these settings, warrants continued research of the potential survival benefit of epoetin alfa therapy. Epoetin alfa also is undergoing evaluation in a variety of new clinical settings, including CHF, CNS disorders, critical care, HCV infection, and the anemia of prematurity, with promising results. It will be important to more fully evaluate the clinical effects of epoetin alfa on neuroprotection and cognition, since these avenues might provide new treatment approaches for a variety of conditions with inadequate therapies. Greater insight into the biology of erythropoietin and its recombinant equivalent, including antiapoptotic and neuroprotective actions, have led to its more accurate characterization as a pleiotropic cytokine. Epoetin alfa provides an important therapeutic option for anemia or its prevention in a variety of settings in which correction may have significant clinical and patient benefits. The potential uses and value of epoetin alfa therapy appear yet to be fulfilled.

Accepted for publication February 28, 2003.

Corresponding author and reprints: David H. Henry, MD, Joan Karnell Cancer Center, Pennsylvania Hospital, 230 W Washington Sq, Philadelphia, PA 19104 (e-mail: dhhenry@juno.com).

REFERENCES


79. Levine AM, Berhane K, Masri-Lavine L, et al. Prevalence and correlates of anemia in a large...
cohort of HIV-infected women: Women’s inter-

90. Leveden C, Legort C, Cuzin L, et al, for the A
APROCDO Study Group. Prognostic factors of
mortality in the APROCO-ANRS EP11 cohort of
HIV-1 infected adults started on a protease in-
hibitor-containing therapy [abstract]. In: Pro-
ceedings of the 40th International Conference on
Antimicrobial Agents and Chemotherapy; Sep-
tember 17-20, 2000; Toronto, Ontario. Abstract
1909.

91. Creagh T, Mildvan D, Moore R, Bohn H, Yarrish
R, Ray L. A case-control study examining the as-
sociation of disease prognosis with the devel-
opment and treatment of anemia in patients in-
fected with HIV-1, interim results [abstract]. In: 12th
National HIV/AIDS Update Conference: HIV/
AIDS at the crossroads: confronting critical is-
sues; March 14-17, 2000; San Francisco, Calif.
Abstract 304.

92. Lundgren JD, Mocroft A, Gatell JM, et al. A cli-
nically prognostic scoring system for patients re-
ceiving highly active antiretroviral therapy: re-
results from the EuroSIDA study. J Infect Dis.

93. Moore RD. Anemia and human immunodefi-
cency virus disease in the era of highly active
antiretroviral therapy. Semin Hematol.

94. Vogelzang NJ, Breitbart W, Cella D, et al, for the
A PROCO Study Group. Impact of therapy with epoetin alfa
for the treatment of the anemia of multiple
myeloma: a prospective, randomized, placebo-
controlled, double-blind trial. Arch Intern Med.
1995;155:2069-2074.

95. Österborg A, Boogaerts MA, Cimino R, et al, for the
European Study Group of the Erythropoi-
eitin (Epoetin Beta) Treatment in Multiple
Myeloma and Non-Hodgkin’s Lymphoma. Re-

combinant human erythropoietin in transfusion-
dependent anemic patients with multiple my-
eloma and non-Hodgkin’s lymphoma—a
randomized multicenter study. Blood. 1996;87:
2675-2682.

96. Dammacco F, Castoldi G, Rödjer S. Efficacy of
epoetin alfa in the treatment of anemia of mul-

97. Siakantaris MP, Angelopoulou MK, Vassilakoi-
poulos TP, Dimopoulou MN, Kontopodi FN, Pan-
galis GA. Correction of disease related anemia
of B-chronic lymphoproliferative disorders by re-
combinant human erythropoietin: maintenance
is necessary to sustain response. Leuk Lym-

98. Mittelman M, Neumann D, Peled A, Kanter P, Ha-
ran-Ghara N. Erythropoietin induces tumor re-
gression and antitumor immune responses in
murine myeloma models. Proc Natl Acad Sci U

99. Lavey RS, Dampsy WH. Erythropoietin in-
creases hemoglobin in cancer patients during ra-
1993;27:1147-1152.

100. Dusenbery KE, McGuire WA, Holt PJ, et al, Eryth-
ropoietin increases hemoglobin during radia-
tion therapy for cervical cancer. Int J Radiat On-

of subcutaneous recombinant human erythro-
poietin in cancer patients receiving radio-
therapy: final report of a randomized, open-
labelled, phase II trial. Br J Cancer. 1996;77:

sequential chemo-radiotherapy with vs without
erythropoietin in high-risk patients with carci-
noma of the cervix—first results of a phase III

103. Glaser C, Millesi W, Gössweiner S, Leitha T,
Dobrowsky W, Kornek GV. +H+EpoErythropoietin
supply increases efficacy of neoadjuvant radio-
chemotherapy in patients with oral squamous cell
carcinoma [abstract 1532]. Proc Am Soc Clin On-

104. Glaser CM, Millesi W, Kornek GV, et al, Impact of
hemoglobin (Hgb) level and use of recombi-
nant human erythropoietin (r-HUPO) on re-
sponse to neoadjuvant chemoradiation therapy,
tumor control, and survival in patients with oral
or oropharyngeal squamous cell carcinoma
(SSCA) [abstract 10]. Int J Radiat Oncol Biol Phys.
1999;45(suppl 1):149-150.

105. Ludwig H, Fritz E, Kotzmann H, Höcker P,
Gisslinger H, Barnas U. Erythropoietin treat-
ment of anemia associated with multiple my-

106. Öster W, Haas R, Gansauge H, et al, Eryth-
ropoietin for the treatment of anemia of malign-
ancy associated with neoplastic bone marrow

107. Henry DH, Abels RI. Recombinant human eryth-
ropoietin in the treatment of cancer and chemo-
therapy-induced anemia: results of double-
blind and open-label follow-up studies. Semin

108. Caro JJ, Salas M, Ward A, Goss G. Anemia as
impact on quality of life. Int J STD AIDS. 2000;11:
659-665.

109. Haber HL, Leavy JA, Kessler PD, Kuikin ML, Got-
tlieb SS, Packer M. The erythrocyte sedimenta-

110. Rich MW, Beckham V, Wittenberg C, Leven CL,
Freedland KE, Canev MY. A multidisciplinary in-
tervention to prevent the readmission of elderly

111. Rich MW, Shah AS, Vinson JM, Freedland KE,
Kuru T, Sperry JC. Iatrogenic congestive heart
(RePRINTED) ARCH INTERN MED/VOL 164, FEB 9, 2004 WWW.ARCHINTERNMED.COM

©2004 American Medical Association. All rights reserved.

Downloaded From: by a Non-Human Traffic (NHT) User  on 01/18/2019
failure in older adults: clinical course and prog-

134. Maeda K, Tanaka Y, Tsukano Y, et al. Multivar-

136. Carson JL. Morbidity risk assessment in the sur-

143. Linde T, Wikstrom B, Andersson LG, Danielson

142. Foley RN, Parfrey PS, Morgan J, et al. A ran-

1060.

W. Echocardiographic findings in patients on

1993;70:357-362.

1997;17:1359-1363.

159. Brezden CB, Phillips K-A, Abdolell M, Bunston

152. Marti HH, Wenger RH, Rivas LA, et al. Impairment of cognitive function in women re-

153. Marti HH, Gassmann M, Wenger RH, et al. De-


145. Goldberg N, Lundin AP, Delano B, Friedman EA, Small changes in left ventricular size, wall

thickness, and function in anemic patients treated

with recombinant human erythropoietin. Am J


154. Foley RN, Parfrey PS, Morgan J, et al. A ran-

domized controlled trial of complete vs partial

correction of anemia in hemodialysis patients with


9:208.

155. Linde T, Wilksrom B, Andersson LG, Danielson

BG. Renal anaemia treatment with recombinant

erthropoietin crosses the blood–brain barrier to pro-

tection of erythropoietin in human liquor: Intrin-

sic erythropoietin production in the brain. Kid-

ney Int. 1997;51:416-418.

156. Golden PL, Maccagnan TJ, Partridge WM. Hu-

man blood brain barrier receptor: binding and

endocytosis in isolated human brain micro-


tion after coronary-artery bypass surgery. N Engl


159. van Dam FSAM, Schagen SB, Muller MJ, Boog-

erd W, Lindeboom J, Bruning PF. Cognitive defi-

cits after postoperative adjuvant chemotherapy for


T, Tannock IF. Cognitive function in breast can-

cer patients receiving adjuvant chemotherapy. J


161. Jacobsen PB, Thors CL, Cawley M, Ax E, Gren-

dys EC. Relation of decline in hemoglobin to cog-

nitive functioning and fatigue during chemo-

therapy treatment [abstract 1542]. Proc Am Soc


tritional deficiencies and blunted erythropoietin

response as causes of the anemia of critical ill-


163. Corvin HL, Parsonnet KC, Gettigner A. RBC trans-

fusion in ICU: Is there a reason? Chest 1995;


164. Groeger JS, Guntupalli KK, Strobs MG, et al. De-

scriptive analysis of critical care units in the United States: patient characteristics and inten-

sive care unit utilization. Crit Care Med. 1993;


165. Vincent JL. Anemia and blood transfusion in criti-


166. Corvin HL, Abraham E, Fink MP, et al. Anemia and

blood transfusion in the critically ill: current cli-


167. Hébert PC, Wells G, Blajchman MA, et al. For the

Transfusion Requirements in Critical Care In-

vestigators for the Canadian Critical Care Trials

Group. A multicenter, randomized, controlled clinical trial of transfusion requirements in criti-


168. Krabbe-Jacobs B, Levettow ML, Bray GL, Rutt-

mann E, Pollack MM. Erythropoietin response to


169. van Iperen CE, Gaillard CAJM, Kraaijenhagen RJ, et al. Response of erythropoiesis and iron me-

tabolism to recombinant human erythropoietin in intensive care unit patients. Crit Care Med.


170. Corvin HL, Krantz SB. Anemia of the critically ill

cell anemia: acute anemia of chronic disease [edito-


171. Corwin HL, Gettigner A, Rodriguez RM, et al. Ef-

ficacy of recombinant human erythropoietin in the critically ill patient: a randomized, double-

blind, placebo-controlled trial. Crit Care Med.

1999;27:2246-2350.

172. Bodenheimer HC Jr, Lindsay KL, Davis GL, Lewis

JH, Thung SN, Seiff LB. Tolerance and efficacy of

oral rbciniram treatment of chronic hepatitis C in a mul-


173. Davis GL, Esteban-Mur R, Rustig V, et al. Inter-

feron alfa-2b alone or in combination with raba-

virin for the treatment of relapse of chronic hepa-

titis C patients [abstract]. In: Proceedings of the


the Hepatitis Interventional Therapy Group. In-

terferon alfa-2b alone or in combination with raba-

virin as initial treatment for chronic hepatitis C.


175. Centers for Disease Control and Prevention. Rec-

ommendations for prevention and control of hepatitis C virus (HCV) infection and HCV-

related chronic disease. MMWR Recomm Rep.


176. Bodenheimer HC Jr, Lindsay KL, Davis GL, Lewis

JH, Thung SN, Seiff LB. Tolerance and efficacy of

oral rbciniram treatment of chronic hepatitis C in a mul-


177. Davis GL, Esteban-Mur R, Rustig V, et al. Inter-

feron alfa-2b alone or in combination with raba-

virin for the treatment of relapse of chronic hepa-

titis C patients [abstract]. In: Proceedings of the


the Hepatitis Interventional Therapy Group. In-

terferon alfa-2b alone or in combination with raba-

virin as initial treatment for chronic hepatitis C.


179. Rebtoron prescribing information. Kenilworth, NJ:


tients with chronic hepatitis C treated with raba-

virin and interferon [abstract C181]. Antivir Ther.

2000;5(suppl 1):C96.

181. De Franceschi L, Fattovich G, Turriini F, et al. He-

molytic anemia induced by ribavirin therapy in patients with chronic hepatitis C virus infection: role of membrane oxidative damage. Hepatol-


182. Weisz KB, Braun JF, Dieterich DT, et al, and the Hepatitis Resource Network. Erythropoietin use for ribavirin/interferon-induced anemia in hepato-


183. Dieterich D, Weisz K, Goldman D, Talal A, Malic-

dem L, Markatou M. Interferon (IFN) and raba-

virin (RBV) therapy for hepatitis C (HCV) in HIV-

184. Trakad T, Frager MB, Schubert J, et al. Multivar-

iante analysis using a linear discriminant func-

tion for predicting the prognosis of congestive


185. Volpe M, Tratto C, Tasta U, et al. Blood levels of

erythropoietin in congestive heart failure and cor-

relation with clinical, hemodynamic, and hor-


186. Carson JL. Morbidity risk assessment in the sur-

01/18/2019

https://www.archinternmed.com

©2004 American Medical Association. All rights reserved.


---

**Call for Photographs**

*Archives of Internal Medicine* Covers

With the January 13, 2003 issue, the *Archives of Internal Medicine* introduced photographs as cover art for the journal. Do you have a scenic photograph you have taken that you think would make a great cover shot? Submissions should be from our readers, reviewers, and authors, and must be formatted horizontally. They should be in color and at least 3.5 x 5 in but no larger than 8 x 10 in. Due to legal concerns, no recognizable people should appear in the picture. Please include your name and address and where the picture was taken. Send submissions to *Archives of Internal Medicine*, 680 N Lake Shore Dr, Suite 1102, Chicago, IL 60611. Cover photos will be chosen at the discretion of the *Archives* editorial staff. We look forward to seeing your photo on the cover of a future issue of the *Archives!*