

PRODUCT MONOGRAPH

TAXOL^{*}

(paclitaxel)

Injection, 6 mg/mL

ANTINEOPLASTIC AGENT

Bristol-Myers Squibb Canada
Montréal, Canada

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THERAPEUTIC CLASSIFICATION

ANTINEOPLASTIC AGENT

TAXOL (PACLITAXEL) SHOULD BE ADMINISTERED UNDER THE SUPERVISION OF A PHYSICIAN EXPERIENCED IN THE USE OF CANCER CHEMOTHERAPEUTIC AGENTS.

PATIENTS RECEIVING TAXOL SHOULD BE PRETREATED WITH CORTICOSTEROIDS, ANTIHISTAMINES, AND H₂ ANTAGONISTS (SUCH AS DEXAMETHASONE, DIPHENHYDRAMINE AND CIMETIDINE OR RANITIDINE) TO MINIMIZE HYPERSENSITIVITY REACTIONS (SEE DOSAGE AND ADMINISTRATION). SEVERE HYPERSENSITIVITY REACTIONS CHARACTERIZED BY DYSPNEA AND HYPOTENSION REQUIRING TREATMENT, ANGIOEDEMA, AND GENERALIZED URTICARIA HAVE OCCURRED IN PATIENTS RECEIVING TAXOL. THESE REACTIONS ARE PROBABLY HISTAMINE MEDIATED. RARE FATAL REACTIONS HAVE OCCURRED IN PATIENTS DESPITE PRE-TREATMENT. PATIENTS WHO EXPERIENCE SEVERE HYPERSENSITIVITY REACTIONS TO TAXOL SHOULD NOT BE RECHALLENGED WITH THE DRUG.

ACTIONS AND CLINICAL PHARMACOLOGY

TAXOL (paclitaxel) is a novel antimicrotubule agent that promotes the assembly of microtubules from tubulin dimers and stabilizes microtubules by preventing depolymerization.

In vitro, TAXOL exhibits cytotoxic activity against a wide variety of both human and rodent tumor cell lines including leukemia, non-small cell lung carcinoma, small cell lung carcinoma, colon carcinoma, CNS carcinoma, melanoma, renal carcinoma, ovarian carcinoma and breast carcinoma (see PHARMACOLOGY).

The pharmacokinetics of paclitaxel have been evaluated over a wide range of doses, up to 300 mg/m², and infusion schedules ranging from 3 to 24 hours. Following intravenous administration of TAXOL, the drug exhibited a biphasic decline in plasma concentrations. The initial rapid decline represents distribution to the peripheral compartment and elimination of the drug. The later phase is due, in part, to a relatively slow efflux of paclitaxel from the peripheral compartment. In patients treated with doses of 135 and 175 mg/m² given as 3 and 24 hour infusions, mean terminal half-life has ranged from 3.0 to 52.7 hours, and total body clearance has ranged from 11.6 to 24.0 L/h/m². Mean steady state volume of distribution has ranged from 198 to 688 L/m², indicating extensive extravascular distribution and/or tissue binding. Following 3 hour infusions of 175 mg/m², mean terminal half-life was estimated to be 9.9 hours; mean total body clearance was 12.4 L/h/m².

Variability in systemic paclitaxel exposure, as measured by AUC_{0-∞} for successive treatment courses was minimal; there was no evidence of accumulation of paclitaxel with multiple treatment courses.

The pharmacokinetics of paclitaxel have been shown to be non-linear. There is a disproportionately large increase in C_{max} and AUC with increasing dose, accompanied by an apparent dose-related decrease in total body clearance. These findings are most readily observed in patients in whom high plasma concentrations of paclitaxel are achieved. Saturable processes in distribution and elimination/metabolism may account for these findings.

In vitro studies of binding to human serum proteins, using paclitaxel concentrations ranging from 0.1 to 50 µg/mL, indicated that on average 89% of drug is bound; the presence of cimetidine, ranitidine, dexamethasone, or diphenhydramine did not affect protein binding of paclitaxel.

In vitro studies with human liver microsomes and tissue slices showed that paclitaxel was metabolized primarily to 6 α -hydroxypaclitaxel by the cytochrome P450 isozyme CYP2C8; and to two minor metabolites, 3-*p*-hydroxypaclitaxel and 6 α , 3'-*p*-dihydroxypaclitaxel by CYP3A4. *In vitro*, the metabolism of paclitaxel to 6 α -hydroxypaclitaxel was inhibited by a number of agents (see PRECAUTIONS: Drug Interactions). The effect of renal or hepatic dysfunction on the disposition of paclitaxel has not been investigated.

The disposition of paclitaxel has not been fully elucidated in humans. After intravenous administration of TAXOL, mean values for cumulative urinary recovery of unchanged drug ranged from 1.3 to 12.7% of the dose, indicating extensive non-renal clearance. In five patients administered a 225 or 250 mg/m² dose of radiolabeled TAXOL as a 3-hour infusion, 14% of the radioactivity was recovered in the urine and 71% was excreted in the feces in 120 hours. Total recovery of radioactivity ranged from 56% to 101% of the dose. Paclitaxel represented a mean of 5% of the administered radioactivity recovered in the feces while metabolites, primarily 6 α -hydroxypaclitaxel, accounted for the balance.

INDICATIONS AND CLINICAL USE

TAXOL (paclitaxel) is indicated, alone or in combination, for the treatment of carcinoma of the ovary, breast, lung, or AIDS-related Kaposi's Sarcoma.

Ovarian Carcinoma

- First-line treatment in combination with other chemotherapeutic agents.
- Second-line treatment of metastatic carcinoma of the ovary after failure of standard therapy.

Breast Carcinoma

- Adjuvant treatment of node-positive breast cancer administered sequentially to standard combination therapy. In the clinical trial, there was an overall favorable effect on disease-free and overall survival in the total population of patients with receptor-positive and receptor-negative tumors, but the benefit has been specifically demonstrated by available data (median follow-up 30 months) only in the patients with estrogen and progesterone receptor-negative tumors. (See PHARMACOLOGY - Clinical Trials).
- Second-line treatment of metastatic carcinoma of the breast after failure of standard therapy.

Lung Carcinoma

- First-line treatment of advanced non-small cell lung cancer.

Kaposi's Sarcoma

- Treatment of advanced, liposomal anthracycline-refractory AIDS-related Kaposi's Sarcoma.

CONTRAINDICATIONS

TAXOL (paclitaxel) is contraindicated in patients who have a history of severe hypersensitivity reactions to paclitaxel or other drugs formulated in Cremophor[†] EL (polyethoxylated castor oil).

TAXOL should not be used in patients with severe baseline neutropenia ($<1,500$ cells/mm³) nor in patients with AIDS-related Kaposi's Sarcoma with baseline or subsequent neutrophil counts of $<1,000$ cells/mm³.

WARNINGS

TAXOL (paclitaxel) should be administered under the supervision of a physician experienced in the use of cancer chemotherapeutic agents.

TAXOL should be administered as a diluted infusion. Patients receiving TAXOL should be pretreated with corticosteroids, antihistamines, and H₂ antagonists (such as dexamethasone, diphenhydramine and cimetidine or ranitidine) to minimize hypersensitivity reactions (see DOSAGE AND ADMINISTRATION). Anaphylaxis and severe hypersensitivity reactions characterized by dyspnea and hypotension requiring treatment, angioedema, or generalized urticaria have occurred in approximately 2% of patients receiving TAXOL. These reactions are probably histamine-mediated. Rare fatal reactions have occurred in patients despite pre-treatment. In case of a severe hypersensitivity reaction, TAXOL infusion should be discontinued immediately and the patient should not be rechallenged with the drug (see ADVERSE REACTIONS).

TAXOL should not be administered to patients with baseline neutrophil counts of less than 1,500 cells/mm³ ($<1,000$ cells/mm³ for patients with Kaposi's Sarcoma). Bone marrow suppression (primarily neutropenia) is dose and schedule dependent and is the dose-limiting toxicity within a regimen. Neutrophil nadirs occurred at a median of 11 days. Frequent monitoring of blood counts should be instituted during TAXOL treatment. Patients should not be retreated with subsequent cycles of TAXOL until neutrophils recover to a level $>1,500$ cells/mm³ ($>1,000$ cells/mm³ for patients with Kaposi's Sarcoma) and platelets recover to a level $>100,000$ cells/mm³ (see DOSAGE AND ADMINISTRATION).

Severe cardiac conduction abnormalities have been reported in $< 1\%$ of patients during TAXOL therapy. If patients develop significant conduction abnormalities during administration, appropriate therapy should be administered and continuous electrocardiographic monitoring should be performed during subsequent therapy with TAXOL (see ADVERSE REACTIONS).

[†] T.M. of B.A.S.F.

Use in Pregnancy

TAXOL may cause fetal harm when administered to a pregnant woman. TAXOL has been shown to be embryotoxic and fetotoxic in rabbits and to decrease fertility in rats. There are no studies in pregnant women. Women of childbearing potential should be advised to avoid becoming pregnant during therapy with TAXOL. If TAXOL is used during pregnancy, or if the patient becomes pregnant while receiving this drug, the patient should be apprised of the potential hazard.

Nursing Mothers

It is not known whether TAXOL is excreted in human milk. Breast feeding should be discontinued for the duration of TAXOL therapy.

Use in Children

The safety and effectiveness of TAXOL in pediatric patients have not been established. There have been reports of central nervous system (CNS) toxicity (rarely associated with death) in a clinical trial in pediatric patients in which TAXOL was infused intravenously over 3 hours at doses ranging from 350 mg/m² to 420 mg/m². The toxicity is most likely attributable to the high dose of the ethanol component of the TAXOL vehicle given over a short infusion time. The use of concomitant antihistamines may intensify this effect. Although a direct effect of the paclitaxel itself cannot be discounted, the high doses used in this study (over twice the recommended adult dosage) must be considered in assessing the safety of TAXOL for use in this population.

PRECAUTIONS

Contact of the undiluted concentrate with plasticized polyvinyl chloride (PVC) equipment or devices used to prepare solutions for infusion is not recommended. In order to minimize patient exposure to the plasticizer DEHP [di-(2-ethylhexyl)phthalate], which may be leached from PVC infusion bags or sets, diluted TAXOL (paclitaxel) solutions should preferably be stored in bottles (glass, polypropylene) or plastic bags (polypropylene, polyolefin) and administered through polyethylene-lined administration sets.

Drug Interactions

Cisplatin

In a Phase I trial in which TAXOL was administered as a 24-hour infusion and cisplatin was administered as a 1 mg/min infusion, myelosuppression was more profound when TAXOL was given after cisplatin than with the alternate sequence (i.e. TAXOL before cisplatin). When TAXOL is given before cisplatin, the safety profile of TAXOL is consistent with that reported for single-agent use. Pharmacokinetic data from these patients demonstrated a decrease in paclitaxel clearance of approximately 33% when TAXOL was administered following cisplatin. Therefore, TAXOL should be given before cisplatin when used in combination. Patients treated with TAXOL and cisplatin may have an increased risk of renal failure during the combination therapy of paclitaxel and cisplatin in gynecological cancers as compared to cisplatin alone.

Cimetidine

The effect of cimetidine premedication on the metabolism of paclitaxel has been investigated; the clearance of paclitaxel was not affected by cimetidine pretreatment.

Substrates, Inducers, Inhibitors of Cytochrome P450 2C8 and 3A4

The metabolism of TAXOL is catalyzed by cytochrome P450 isoenzymes CYP2C8 and CYP3A4. Caution should be exercised when administering TAXOL concomitantly with known substrates, inducers or inhibitors of the cytochrome P450 isoenzymes CYP2C8 and CYP3A4. *In vitro*, the metabolism of paclitaxel to 6 α -hydroxypaclitaxel was inhibited by a number of agents (ketoconazole, verapamil, diazepam, quinidine, dexamethasone, cyclosporine, teniposide, etoposide, and vincristine), but the concentrations used exceeded those found *in vivo* following normal therapeutic doses. Testosterone, 17 α -ethinyl estradiol, retinoic acid, montelukast and quercetin, a specific inhibitor of CYP2C8, also inhibited the formation of 6 α -hydroxypaclitaxel *in vitro*. The pharmacokinetics of paclitaxel may also be altered *in vivo* as a result of interactions with compounds that are substrates, inducers, or inhibitors of CYP2C8 and/or CYP3A4.

Potential interactions between TAXOL, a substrate of CYP3A4, and protease inhibitors (ritonavir, saquinavir, indinavir, and nelfinavir), which are substrates and/or inhibitors of CYP3A4, have not been evaluated in clinical trials. Caution and close monitoring of liver function is required; further, no unapproved (e.g., investigational) protease inhibitor should be administered with TAXOL.

Doxorubicin

Sequence effects characterized by more profound neutropenic and stomatitis episodes, have been observed with combination use of TAXOL and doxorubicin when TAXOL was administered BEFORE doxorubicin and using longer than recommended infusion times (TAXOL administered over 24 hours; doxorubicin administered over 48 hours). Plasma levels of doxorubicin (and its active metabolite doxorubicinol) may be increased when TAXOL and doxorubicin are used in combination. However, data from a trial using bolus doxorubicin and 3-hour TAXOL infusion found no sequence effects on the pattern of toxicity.

Hematology

TAXOL should not be administered to patients with baseline neutrophil counts of less than 1,500 cells/mm³ (see WARNINGS, CONTRAINDICATIONS). In order to monitor the occurrence of myelotoxicity, it is recommended that frequent peripheral blood cell counts be performed on all patients receiving TAXOL. Patients should not be retreated with subsequent cycles of TAXOL until neutrophils recover to a level > 1,500 cells/mm³ and platelets recover to a level >100,000 cells/mm³. In the case of severe neutropenia (< 500 cells/mm³) during a course of TAXOL therapy, a 20% reduction in dose for subsequent courses of therapy is recommended. For patients with advanced HIV disease and poor-risk AIDS-related Kaposi's sarcoma, TAXOL, at the recommended dose for this disease, can be initiated and repeated if the neutrophil count is at least 1,000 cells/mm³. (See DOSAGE AND ADMINISTRATION).

Hypersensitivity Reactions

Patients with a history of severe hypersensitivity reactions to products containing Cremophor[†] EL should not be treated with TAXOL (see WARNINGS, CONTRAINDICATIONS). Minor

symptoms such as flushing, skin reactions, dyspnea, hypotension or tachycardia do not require interruption of therapy. However, severe reactions, such as hypotension requiring treatment, dyspnea requiring bronchodilators, angioedema or generalized urticaria require immediate discontinuation of TAXOL and aggressive symptomatic therapy. Patients who have developed severe hypersensitivity reactions should not be rechallenged with TAXOL.

Cardiovascular

Hypotension, hypertension and bradycardia have been observed during TAXOL administration; patients are usually asymptomatic and generally do not require treatment. In severe cases, TAXOL infusions may need to be interrupted or discontinued at the discretion of the treating physician. Frequent monitoring of vital signs, particularly during the first hour of TAXOL infusion, is recommended. Continuous cardiac monitoring is not required except for patients who develop serious conduction abnormalities (see WARNINGS, ADVERSE REACTIONS). When TAXOL is used in combination with doxorubicin for treatment of metastatic breast cancer, monitoring of cardiac function is recommended.

Nervous System

Although the occurrence of peripheral neuropathy is frequent, the development of severe symptomatology is unusual. A dose reduction of 20% is recommended for all subsequent courses of TAXOL for severe neuropathy (see ADVERSE REACTIONS, DOSAGE AND ADMINISTRATION).

TAXOL contains dehydrated ethanol, 396 mg/mL; consideration should be given to possible CNS and other effects of ethanol. Children may be more sensitive than the adults to the effects of ethanol (see WARNINGS; Use in Children).

Hepatic

There is evidence that the toxicity of TAXOL is enhanced in patients with elevated liver enzymes. Patients with hepatic impairment may be at increased risk of toxicity, particularly grade III-IV myelosuppression. Caution should be exercised when administering TAXOL to patients with moderate to severe hepatic impairment. Patients should be monitored closely for the development of profound myelosuppression. (see ADVERSE REACTIONS)

Injection Site Reaction

Injection site reactions, including reactions secondary to extravasation, were usually mild and consisted of pain, erythema, tenderness, skin discoloration, or swelling at the injection site. These reactions have been observed more frequently with the 24-hour infusion than with the 3-hour infusion. Recurrence of skin reactions at a site of previous extravasation following administration of TAXOL at a different site, i.e., "recall", has been reported rarely.

Rare reports of more severe events such as phlebitis, cellulitis, induration, skin exfoliation, necrosis and fibrosis have been received as part of the continuing surveillance of TAXOL safety. In some cases the onset of the injection site reaction either occurred during a prolonged infusion or was delayed by a week to ten days.

A specific treatment for extravasation reactions is unknown at this time. Given the possibility of extravasation, it is advisable to closely monitor the infusion site for possible infiltration during drug administration.

Driving/Operating Machinery

Since TAXOL contains ethanol, consideration should be given to the possibility of CNS and other effects.

ADVERSE REACTIONS

The frequency and severity of adverse events are generally similar between patients receiving TAXOL for the treatment of ovarian, breast non-small cell lung carcinoma, or Kaposi's Sarcoma, but patients with AIDS-related Kaposi's sarcoma may have more frequent and severe hematologic toxicity, infections, and febrile neutropenia. These patients require a lower dose intensity and supportive care. (See CLINICAL TRIALS: AIDS-Related Kaposi's Sarcoma).

The incidences of adverse reactions in the table that follows are derived from ten clinical trials in carcinoma of the ovary and of the breast involving 812 patients treated with single-agent TAXOL (paclitaxel) at doses ranging from 135-300 mg/m²/day and schedules of 3 or 24 hours. Data from a subset of 181 patients treated at the recommended dose of 175 mg/m² and a 3-hour infusion schedule is also included in the table.

	135-300 mg/m² % of Patients N=812	175 mg/m² % of Patients N=181
<u>Bone Marrow</u>		
Neutropenia < 2,000/mm ³	90	87
< 500/mm ³	52	27
Leukopenia < 4,000/mm ³	90	86
< 1,000/mm ³	17	4
Thrombocytopenia < 100,000/mm ³	20	6
< 50,000/mm ³	7	1
Anemia < 11 g/dL	78	62
< 8 g/dL	16	6
Infections	30	18
Bleeding	14	9
Red Cell Transfusions	25	13
Red Cell Transfusions (normal baseline)	12	6
Platelet Transfusions	2	0
<u>Hypersensitivity Reactions</u>		
All	41	40
Severe	2	1

	135-300 mg/m² % of Patients N=812	175 mg/m² % of Patients N=181
<u>Cardiovascular</u>		
Bradycardia (first 3 hours of infusion)	3	3
Hypotension (first 3 hours of infusion)	12	11
Severe events	1	2
<u>Abnormal ECG</u>		
All Patients	23	13
Patients with normal baseline	14	8
<u>Peripheral Neuropathy</u>		
Any symptoms	60	64
Severe symptoms	3	4
<u>Myalgia/Arthralgia</u>		
Any symptoms	60	54
Severe symptoms	8	12
<u>Gastrointestinal</u>		
Nausea and vomiting	52	44
Diarrhea	38	25
Mucositis	31	20
<u>Alopecia</u>	87	93
<u>Hepatic</u> (Patients with normal baseline)		
Bilirubin elevations	7	4
Alkaline phosphatase elevations	22	18
AST elevations	19	18
<u>Injection site reactions</u>	13	4

Safety referring to a large randomized trial of TAXOL (135 mg/m² over 24 hours) / cisplatin (75 mg/m²) versus cyclophosphamide/cisplatin, including 410 patients (196 receiving TAXOL), has been evaluated. The combination of TAXOL with platinum agents has not resulted in any clinically relevant changes to the safety profile of the drug when used at the recommended dosage.

Safety data were collected for 3,121 patients in the Phase III adjuvant breast carcinoma study. The adverse event profile for the patients who received TAXOL subsequent to cyclophosphamide and doxorubicin was consistent with that seen in the pooled analysis of data from 812 patients treated with single-agent TAXOL in 10 clinical studies.

SUMMARY OF 3-HOUR INFUSION DATA AT A DOSE OF 175 mg/m²

Unless otherwise stated, the following safety data relate to 62 patients with ovarian cancer and 119 patients with breast cancer treated at a dose of 175 mg/m² and a 3-hour infusion schedule, in phase III clinical trials. All patients were premedicated to minimize hypersensitivity reactions. Data from these clinical trials demonstrate that TAXOL given at this dose and schedule is well tolerated. Bone marrow suppression and peripheral neuropathy were the principle dose-related adverse effects associated with TAXOL. Compared to 24-hour infusion

schedules, neutropenia was less common when TAXOL was given as a 3-hour infusion. Neutropenia was generally rapidly reversible and did not worsen with cumulative exposure. The frequency of neurologic symptoms increases with repeated exposure.

None of the observed toxicities were influenced by age.

AIDS-related KAPOSI'S SARCOMA

The following table shows the frequency of important adverse events in the 85 patients with KS treated with two different single-agent TAXOL regimens.

Frequency^a of Important* Adverse Events in the AIDS-Related Kaposi's Sarcoma Studies

	Percent of Patients	
	Study CA139-174 135/3 ^b /3 wk (n = 29)	Study CA139-281 100/3 ^b /2 wk (n = 56)
<u>Bone Marrow</u>		
Neutropenia < 2,000/mm ³	100	95
< 500/mm ³	76	35
Thrombocytopenia < 100,000/mm ³	52	27
< 50,000/mm ³	17	5
Anemia < 11 g/dL	86	73
< 8 g/dL	34	25
Febrile Neutropenia	55	9
<u>Opportunistic Infections</u>		
Any	76	54
Cytomegalovirus	45	27
Herpes Simplex	38	11
<i>Pneumocystis carinii</i>	14	21
<i>M. avium intracellulare</i>	24	4
Candidiasis, esophageal	7	9
Cryptosporidiosis	7	7
Cryptococcal meningitis	3	2
Leukoencephalopathy	—	2
<u>Hypersensitivity Reaction^c</u>		
All	14	9
<u>Cardiovascular</u>		
Hypotension	17	9
Bradycardia	3	—
<u>Peripheral Neuropathy</u>		

	Percent of Patients	
	Study CA139-174 135/3 ^b /3 wk (n = 29)	Study CA139-281 100/3 ^b /2 wk (n = 56)
Any	79	46
Severe**	14	16
<u>Myalgia/Arthralgia</u>		
Any	93	48
Severe**	14	16
<u>Gastrointestinal</u>		
Nausea and vomiting	69	70
Diarrhea	90	73
Mucositis	45	20
<u>Renal</u> (Creatinine elevation)		
Any	34	18
Severe**	7	5
Discontinuation for drug toxicity	7	16

^a Based on worst course analysis.

^b TAXOL dose in mg/m²/infusion duration in hours.

^c All patients received premedication.

* Clinically relevant and/or possibly related.

** Severe events are defined as at least Grade III toxicity.

As demonstrated in the above table, toxicity was more pronounced in the study utilizing TAXOL at a dose of 135 mg/m² every 3 weeks than in the study utilizing TAXOL at a dose of 100 mg/m² every 2 weeks. Notably, severe neutropenia (76% versus 35%), febrile neutropenia (55% versus 9%), and opportunistic infections (76% versus 54%) were more common with the former dose and schedule. The differences between the two studies with respect to dose escalation and use of hematopoietic growth factors, as described below, should be taken into account. (See CLINICAL TRIALS: AIDS-Related Kaposi's Sarcoma).

Adverse Experiences by Body System

Unless otherwise noted, the following discussion refers to the overall safety database of 812 patients with solid tumors treated with single-agent TAXOL in 10 clinical studies. Toxicities that occurred with greater severity or frequency in previously untreated patients with ovarian carcinoma or NSCLC who received TAXOL in combination with cisplatin or in patients with breast cancer who received TAXOL after doxorubicin/cyclophosphamide in the adjuvant setting, or in patients with AIDS-related Kaposi's sarcoma, and that occurred with a difference that was clinically significant in these populations are also described. In addition, rare events have been reported from postmarketing experience or from other clinical studies.

The frequency and severity of adverse events have been generally similar for all patients receiving TAXOL. However, patients with AIDS-related Kaposi's sarcoma may have more frequent and severe hematologic toxicity, infections, and febrile neutropenia. These patients require a lower dose intensity and supportive care. Toxicities that were observed only in or were noted to have occurred with greater severity in the population with Kaposi's sarcoma and that occurred with a difference that was clinically significant in this population are described.

Hematologic

The most frequent significant undesirable effect of TAXOL was bone marrow suppression. Neutropenia was dose and schedule dependent and was generally rapidly reversible. Severe neutropenia (<500 cells/mm³) occurred in 27% of patients treated at a dose of 175 mg/m², but was not associated with febrile episodes. Only 1% of patients experienced severe neutropenia for 7 days or more. Neutropenia was not more frequent or severe in patients who received prior radiation therapy, nor did it appear to be affected by treatment duration or cumulative exposure.

When TAXOL was administered to patients with ovarian carcinoma at a dose of 175 mg/m²/3 hours in combination with cisplatin versus the control arm of cyclophosphamide plus cisplatin, the incidences of severe neutropenia and of febrile neutropenia were similar in the TAXOL plus cisplatin arm and in the control arm.

When TAXOL was administered in combination with cisplatin to patients with advanced NSCLC in the Eastern Cooperative Oncology Group (ECOG) study, the incidence of neutropenia (Grade IV) was 74% (TAXOL 135 mg/m²/24 hours plus cisplatin) and 65% (TAXOL 250 mg/m²/24 hours plus cisplatin and G-CSF) compared with 55% in patients who received cisplatin/etoposide. Considerably less Grade IV neutropenia was observed in the European Organization for Research and Treatment of Cancer (EORTC) (28%) and CA139-208 (45%) studies for TAXOL 175 mg/m²/3 hours plus cisplatin (without G-CSF).

Fever was frequent (12% of all treatment courses). Infectious episodes occurred in 30% of all patients and 9% of all courses; these episodes were fatal in 1% of all patients, and included sepsis, pneumonia and peritonitis. In the Phase 3 second-line ovarian study, infectious episodes were reported in 20% of the patients given 135 mg/m² and 26% of the patients given 175 mg/m² by a 3-hour infusion. Urinary tract infections and upper respiratory tract infections were the most frequently reported infectious complications. In the immunosuppressed patient population with advanced HIV disease and poor-risk AIDS-related Kaposi's sarcoma, 61% of the patients reported at least one opportunistic infection. The use of supportive therapy, including G-CSF, is recommended for patients who have experienced severe neutropenia. (See DOSAGE AND ADMINISTRATION).

Twenty percent of the patients experienced a drop in their platelet count below 100,000 cells/mm³ at least once while on treatment; 7% had a platelet count < 50,000 cells/mm³ at the time of their worst nadir. Bleeding episodes were reported in 4% of all courses and by 14% of all patients, but most of the hemorrhagic episodes were localized and the frequency of these events was unrelated to the TAXOL dose and schedule. In the Phase III second-line ovarian cancer study, bleeding episodes were reported in 10% of the patients who received study medication; however, none of the patients treated with the 3-hour infusion received platelet transfusions. In the adjuvant breast carcinoma trial, the incidence of severe thrombocytopenia and platelet transfusions increased with higher doses of doxorubicin.

Anemia (Hb<11 g/dL) was observed in 78% of all patients and was severe (Hb<8 g/dL) in 16% of the cases. No consistent relationship between dose or schedule and the frequency of anemia was observed. Among all patients with normal baseline hemoglobin, 69% became anemic on study but only 7% had severe anemia. Red cell transfusions were required in 25% of all patients and in 12% of those with normal baseline hemoglobin levels.

Hypersensitivity Reactions (HSR)

All patients received premedication prior to TAXOL (see WARNINGS section). The frequency and severity of HSR were not affected by the dose or schedule of TAXOL administration. In the Phase III second-line ovarian study, the 3-hour infusion was not associated with a greater increase in HSR when compared to the 24-hour infusion. Hypersensitivity reactions were observed in 20% of all courses and in 41% of all patients. These reactions were severe in less than 2% of the patients and 1% of the courses. No severe reactions were observed after course 3 and severe symptoms occurred generally within the first hour of TAXOL infusion. The most frequent symptoms observed during these severe reactions were dyspnea, flushing, chest pain and tachycardia. Abdominal pain, pain in the extremities, diaphoresis, and hypertension are also noted.

The minor hypersensitivity reactions consisted mostly of flushing (28%), rash (12%), hypotension (4%), dyspnea (2%), tachycardia (2%) and hypertension (1%). The frequency of hypersensitivity reactions remained relatively stable during the entire treatment period.

Rare reports of chills and reports of back pain in association with hypersensitivity reactions have been received as part of the continuing surveillance of TAXOL safety.

Cardiovascular

Hypotension, during the first 3 hours of infusion, occurred in 12% of all patients and 3% of all courses administered. Bradycardia, during the first 3 hours of infusion, occurred in 3% of all patients and 1% of all courses. In the Phase III second-line ovarian study, neither dose nor schedule had an effect on the frequency of hypotension and bradycardia. These vital sign changes most often caused no symptoms and required neither specific therapy nor treatment discontinuation. The frequency of hypotension and bradycardia were not influenced by prior anthracycline therapy.

Significant cardiovascular events possibly related to single-agent TAXOL occurred in approximately 1% of all patients. These events included syncope, rhythm abnormalities, hypertension and venous thrombosis. One of the patients with syncope treated with TAXOL at 175 mg/m² over 24 hours had progressive hypotension and died. The arrhythmias included asymptomatic ventricular tachycardia, bigeminy and complete AV block requiring pacemaker placement. The incidence of Grade III or greater cardiovascular events was 13% (TAXOL 135 mg/m²/24 hours plus cisplatin), 12% (TAXOL 250 mg/m²/24 hours plus cisplatin and G--CSF), and 6% (TAXOL 175 mg/m²/3 hours plus cisplatin) when TAXOL followed by cisplatin was administered to patients with advanced NSCLC; there was a similar incidence in the non-TAXOL control arms. The apparent increase in these cardiovascular events in patients with NSCLC compared to patients with breast or ovarian cancer is possibly related to the difference in cardiovascular risk factors among patients with lung cancer.

Electrocardiogram (ECG) abnormalities were common among patients at baseline. ECG abnormalities on study did not usually result in symptoms, were not dose-limiting, and required no intervention. ECG abnormalities were noted in 23% of all patients. Among patients with a normal ECG prior to study entry, 14% of all patients developed an abnormal tracing while on study. The most frequently reported ECG modifications were non-specific repolarization abnormalities, sinus bradycardia, sinus tachycardia and premature beats. Among patients with normal ECG at baseline, prior therapy with anthracyclines did not influence the frequency of ECG abnormalities.

Cases of myocardial infarction have been reported rarely. Congestive heart failure (cardiac dysfunction and reduction of left ventricular ejection fraction or ventricular failure) has been reported typically in patients who have received other chemotherapy, notably anthracyclines. (See PRECAUTIONS: Drug Interactions)

Rare reports of atrial fibrillation and supraventricular tachycardia have been received as part of the continuing surveillance of TAXOL safety.

Respiratory

Rare reports of interstitial pneumonia, lung fibrosis and pulmonary embolism, have been received as part of the continuing surveillance of TAXOL safety. Rare reports of radiation pneumonitis have been received in patients receiving concurrent radiotherapy.

Neurologic

The frequency and severity of neurologic manifestations were influenced by prior and concomitant therapy with cisplatin. In general, the frequency and severity of neurologic manifestations were dose-dependent in patients receiving single-agent TAXOL. Paresthesia commonly occurs in the form of hyperesthesia. Peripheral neuropathy was observed in 60% of all patients (3% severe) and in 52% (2% severe) of the patients without pre-existing neuropathy.

The frequency of peripheral neuropathy increased with cumulative dose. Neurologic symptoms were observed in 27% of the patients after the first course of treatment and in 34-51% from course 2 to 10. Peripheral neuropathy was the cause of TAXOL discontinuation in 1% of all patients. Sensory symptoms have usually improved or resolved within several months of TAXOL discontinuation. The incidence of neurologic symptoms did not increase in the subset of patients previously treated with cisplatin. Pre-existing neuropathies resulting from prior therapies are not a contraindication for TAXOL therapy. In the Intergroup first-line ovarian carcinoma study, the regimen with TAXOL 175 mg/m² by 3-hour infusion followed by cisplatin 75 mg/m² resulted in greater incidence and severity of neurotoxicity (reported as neuromotor or neurosensory events) than the regimen containing cyclophosphamide 750 mg/m² followed by cisplatin 75 mg/m², 87% (21% severe) versus 52% (2% severe), respectively. In the GOG first-line ovarian carcinoma study, the regimen with TAXOL (135 mg/m² over 24 hours) followed by cisplatin (75 mg/m²) resulted in an incidence of neurotoxicity (reported as peripheral neuropathy) that was similar to the regimen containing cyclophosphamide 750 mg/m² followed by cisplatin 75 mg/m², 25% (3% severe) versus 20% (0% severe), respectively. Cross-study comparison of neurotoxicity in Intergroup and GOG trials suggests that when TAXOL is given in combinations with cisplatin 75 mg/m², the incidence of severe neurotoxicity is more common at a TAXOL dose of 175 mg/m² given by 3-hour infusion (21%) than at a dose of 135 mg/m² given by 24-hour infusion (3%). In patients with NSCLC, administration of TAXOL followed by

cisplatin resulted in greater incidence of severe neurotoxicity compared to the incidence in patients with ovarian or breast cancer treated with single-agent TAXOL. Severe neurosensory symptoms were noted in 13% of NSCLC patients receiving TAXOL 135 mg/m² by 24-hour infusion followed by cisplatin 75 mg/m² and 8% of NSCLC patients receiving cisplatin/etoposide.

Other than peripheral neuropathy, serious neurologic events following TAXOL administration have been rare (<1%) and have included grand mal seizures, ataxia and encephalopathy.

Rare reports of autonomic neuropathy resulting in paralytic ileus and motor neuropathy with resultant minor distal weakness have been received as part of the continuing surveillance of TAXOL safety. Optic nerve and/or visual disturbances (scintillating scotoma) have also been reported, particularly in patients who have received higher doses than those recommended. These effects generally have been reversible. However, rare reports in the literature of abnormal visual evoked potentials in patients have suggested persistent optic nerve damage. Postmarketing reports of ototoxicity (hearing loss and tinnitus) have been received.

Arthralgia/myalgia

There was no consistent relationship between dose or schedule of TAXOL and the frequency or severity of arthralgia/myalgia. Sixty percent of all patients treated in single-agent trials experienced arthralgia/myalgia; 8% experienced severe symptoms. The symptoms were usually transient, occurred two or three days after TAXOL administration, and resolved within a few days. The frequency and severity of musculoskeletal symptoms remained unchanged throughout the treatment period.

Alopecia

Alopecia was observed in almost all patients.

Gastrointestinal

Nausea/vomiting, diarrhea and mucositis were reported by 52%, 38% and 31% of all patients, respectively. These manifestations were usually mild to moderate. Mucositis was schedule dependent and occurred more frequently with the 24-hour than with the 3-hour infusion.

In the first-line Phase III ovarian carcinoma study, the incidence of nausea and vomiting when TAXOL was administered in combination with cisplatin appeared to be greater compared with the database for single-agent TAXOL in ovarian and breast carcinoma. In the same study, diarrhea of any grade was reported more frequently (16%) compared to the control arm (8%) (p=0.008), but there was no difference for severe diarrhea.

Rare reports of intestinal obstruction, intestinal perforation, pancreatitis, ischemic colitis, and dehydration have been received as part of the continuing surveillance of TAXOL safety. Rare reports of neutropenic enterocolitis (typhlitis), despite the coadministration of G-CSF, were observed in patients treated with TAXOL alone and in combination with other chemotherapeutic agents.

In patients with poor-risk AIDS-related Kaposi's sarcoma, nausea/vomiting, diarrhea, and mucositis were reported by 69%, 79% and 28% of patients, respectively. One third of patients with Kaposi's sarcoma complained of diarrhea prior to study start.

Hepatic

No relationship was observed between liver function abnormalities and either dose or schedule of TAXOL administration. Among patients with normal baseline liver function 7%, 22% and 19% had elevations in bilirubin, alkaline phosphatase and AST (SGOT), respectively. There is no evidence that TAXOL when given as a 3-hour infusion to patients with mildly abnormal liver function causes exacerbation of abnormal liver function. Prolonged exposure to TAXOL was not associated with cumulative hepatic toxicity.

Rare reports of hepatic necrosis and hepatic encephalopathy leading to death have been received as part of the continuing surveillance of TAXOL safety.

Renal

Among the patients treated for Kaposi's sarcoma with TAXOL, five patients had renal toxicity of grade III or IV severity. One patient with suspected HIV nephropathy of grade IV severity had to discontinue therapy. The other four patients had renal insufficiency with reversible elevations of serum creatinine.

Injection Site Reactions

Injection site reactions, including reactions secondary to extravasation, were usually mild and consisted of pain, erythema, tenderness, skin discoloration, or swelling at the injection site. These reactions have been observed more frequently with the 24-hour infusion than with the 3-hour infusion. Recurrence of skin reactions at a site of previous extravasation following administration of TAXOL at a different site, i.e., "recall", has been reported rarely.

Rare reports of more severe events such as phlebitis, cellulitis, induration, skin exfoliation, necrosis and fibrosis have been received as part of the continuing surveillance of TAXOL safety. In some cases the onset of the injection site reaction either occurred during a prolonged infusion or was delayed by a week to ten days.

A specific treatment for extravasation reactions is unknown at this time. Given the possibility of extravasation, it is advisable to closely monitor the infusion site for possible infiltration during drug administration.

Other

Transient skin changes due to TAXOL-related hypersensitivity reactions have been observed, but no other skin toxicities were significantly associated with TAXOL administration. Nail changes (changes in pigmentation or discoloration of nail bed) were uncommon (2%). Edema was reported in 21% of all patients (17% of those without baseline edema); only 1% had severe edema and none of these patients required treatment discontinuation. Edema was most commonly focal and disease-related. Edema was observed in 5% of all courses for patients with normal baseline and did not increase with time on study.

Rare reports of skin abnormalities related to radiation recall as well as reports of maculopapular rash, pruritus, Stevens-Johnson syndrome, and toxic epidermal necrolysis have been received as part of the continuing surveillance of TAXOL safety.

Reports of asthenia and malaise have been received as part of the continuing surveillance of TAXOL safety. In the Phase III trial of TAXOL 135 mg/m² over 24 hours in combination with cisplatin as first-line therapy of ovarian cancer, asthenia was reported in 17% of the patients, significantly greater than the 10% incidence observed in the control arm of cyclophosphamide/cisplatin.

Post-Marketing Adverse Drug Events

Unless otherwise indicated, the table below lists undesirable effects regardless of severity associated with the administration of single agent TAXOL (812 patients treated in clinical trials) or as reported in the postmarketing surveillance* of TAXOL.

The frequency of undesirable effects listed below is defined using the following convention: very common ($\geq 1/10$); common ($\geq 1/100$, $< 1/10$); uncommon ($\geq 1/1,000$, $< 1/100$); rare ($\geq 1/10,000$, $< 1/1,000$); very rare ($< 1/10,000$).

Infections and infestations:	<i>Very common:</i> infection <i>Uncommon:</i> septic shock <i>Rare*:</i> pneumonia, sepsis
Blood and the lymphatic system disorders:	<i>Very common:</i> myelosuppression, neutropenia, anemia, thrombocytopenia, leukopenia, fever, bleeding <i>Rare:</i> febrile neutropenia <i>Very rare*:</i> acute myeloid leukemia, myelodysplastic syndrome
Immune system disorders:	<i>Very common:</i> minor hypersensitivity reactions (mainly flushing and rash) <i>Uncommon:</i> significant hypersensitivity reactions requiring therapy (eg, hypotension, angioneurotic edema, respiratory distress, generalised urticaria, edema, back pain, chills) <i>Rare*:</i> anaphylactic reactions (with fatal outcome) <i>Very rare*:</i> anaphylactic shock
Metabolism and nutrition disorders:	<i>Very rare*:</i> anorexia
Psychiatric disorders:	<i>Very rare*:</i> confusional state
Nervous system disorders:	<i>Very common:</i> neurotoxicity (mainly: peripheral neuropathy) <i>Rare*:</i> motor neuropathy (with resultant minor distal weakness) <i>Very rare*:</i> autonomic neuropathy (resulting in paralytic ileus and orthostatic hypotension), grand mal seizures, convulsions, encephalopathy, dizziness, headache, ataxia
Eye disorders:	<i>Very rare*:</i> reversible optic nerve and/or visual

	disturbances (scintillating scotomata), particularly in patients who have received higher doses than recommended, photopsia, visual floaters
Ear and labyrinth disorders:	<i>Very rare*</i> : hearing loss, tinnitus, vertigo, ototoxicity
Cardiac disorders:	<i>Very common</i> : abnormal ECG <i>Common</i> : bradycardia <i>Uncommon</i> : cardiomyopathy, asymptomatic ventricular tachycardia, tachycardia with bigeminy, AV block and syncope, myocardial infarction. <i>Very rare*</i> : atrial fibrillation, supraventricular tachycardia
Vascular disorders:	<i>Very common</i> : hypotension <i>Uncommon</i> : hypertension, thrombosis, thrombophlebitis <i>Very rare*</i> : shock
Respiratory, thoracic and mediastinal disorders:	<i>Rare*</i> : dyspnea, pleural effusion, respiratory failure, interstitial pneumonia, lung fibrosis, pulmonary embolism <i>Very rare*</i> : cough
Gastrointestinal disorders:	<i>Very common</i> : nausea, vomiting, diarrhea, mucosal inflammation <i>Rare*</i> : bowel obstruction, bowel perforation, ischemic colitis, pancreatitis <i>Very rare*</i> : mesenteric thrombosis, pseudomembranous colitis, esophagitis, constipation, ascites
Hepato-biliary disorders:	<i>Very rare*</i> : hepatic necrosis (with fatal outcome), hepatic encephalopathy (with fatal outcome)
Renal disorders:	<i>Unknown*</i> : renal failure
Skin and subcutaneous tissue disorders:	<i>Very common</i> : alopecia <i>Common</i> : transient and mild nail and skin changes <i>Rare*</i> : pruritus, rash, erythema, phlebitis, cellulitis, skin exfoliation, necrosis and fibrosis, radiation recall <i>Very rare*</i> : Stevens-Johnson syndrome, epidermal necrolysis, erythema multiforme, exfoliative dermatitis, urticaria, onycholysis (patients on therapy should wear sun protection on hands and feet), scleroderma-like changes preceded by chronic edema
Musculoskeletal, connective tissue and bone disorders:	<i>Very common</i> : arthralgia, myalgia

General disorders and administration site conditions:	<i>Common:</i> injection site reactions (including localised edema, pain, erythema, induration, on occasion extravasation can result in cellulitis) <i>Rare*:</i> asthenia, malaise, pyrexia, dehydration, edema
Investigations:	<i>Common:</i> severe elevation in AST (SGOT), severe elevation in alkaline phosphatase <i>Uncommon:</i> severe elevation in bilirubin <i>Rare*:</i> Increase in blood creatinine

SYMPTOMS AND TREATMENT OF OVERDOSAGE

There is no known antidote for TAXOL (paclitaxel) overdose. The primary anticipated complications of overdose would consist of bone marrow suppression, peripheral neurotoxicity and mucositis. Overdoses in pediatric patients may be associated with acute ethanol toxicity (see PRECAUTIONS, Pediatric Use section WARNINGS, Use in Children).

DOSAGE AND ADMINISTRATION

Note: Undiluted concentrate should not come in contact with plasticized PVC equipment. In order to minimize patients exposure to the plasticizer DEHP [di-(2-ethylhexyl)phthalate], which may be leached from PVC infusion bags or sets, diluted TAXOL (paclitaxel) solutions should preferably be stored in bottles (glass, polypropylene) or plastic bags (polypropylene, polyolefin) and administered through polyethylene-lined administration sets.

TAXOL should be administered through an in-line filter with a microporous membrane not greater than 0.22 microns. Use of filter devices such as IVEX-2® filters which incorporate short inlet and outlet PVC-coated tubing has not resulted in significant leaching of DEHP.

All patients should be premedicated prior to TAXOL administration in order to reduce the risk of severe hypersensitivity reactions. Such premedication may consist of dexamethasone 20 mg orally (or its equivalent) approximately 12 and 6 hours before TAXOL, diphenhydramine 50 mg I.V. (or its equivalent), 30 to 60 minutes prior to TAXOL, and cimetidine (300 mg) or ranitidine (50 mg) I.V. 30 to 60 minutes before TAXOL.

Metastatic carcinoma of the ovary

The administration of TAXOL at a dose of 175 mg/m² over 3 hours in combination with cisplatin 75 mg/m² every 3 weeks is recommended for the primary treatment of patients with advanced carcinoma of the ovary. TAXOL should be given before cisplatin when used in combination.

In patients previously treated with chemotherapy, the recommended regimen is 175 mg/m² administered intravenously over 3 hours every 3 weeks.

Carcinoma of the breast

For the adjuvant treatment of node-positive breast cancer, the recommended regimen is TAXOL, at a dose of 175 mg/m² intravenously over 3 hours every 3 weeks for four courses administered sequentially to standard combination therapy.

After failure of initial chemotherapy for metastatic disease or relapse within 6 months of adjuvant chemotherapy, TAXOL at a dose of 175 mg/m² administered intravenously over 3 hours every 3 weeks has been shown to be effective.

Non-small cell lung carcinoma

The recommended regimen, given every 3 weeks, is TAXOL administered intravenously over 3 hours at a dose of 175 mg/m² followed by cisplatin.

Single courses of TAXOL should not be repeated until the neutrophil count is at least 1,500 cells/mm³ and the platelet count is at least 100 000 cells/mm³. Patients who experience severe neutropenia (neutrophil < 500 cells/mm³) or severe peripheral neuropathy during TAXOL therapy should have the dosage reduced by 20% for subsequent courses of TAXOL.

AIDS-related Kaposi's Sarcoma

TAXOL 135 mg/m² administered intravenously over 3 hours with a 3 week interval between courses or 100 mg/m² administered intravenously over 3 hours with a 2 week interval between courses (dose intensity 45-50 mg/m²/week). In the two clinical trials evaluating these schedules (see CLINICAL TRIALS: AIDS-Related Kaposi's Sarcoma), the former schedule (135 mg/m² every 3 weeks) was more toxic than the latter. In addition, all patients with low performance status were treated with the latter schedule (100 mg/m² every 2 weeks).

Based upon the immunosuppression observed in patients with advanced HIV disease, the following modifications are recommended in these patients.

1. the dose of dexamethasone as one of the three premedication drugs should be reduced to 10 mg orally.
2. treatment with TAXOL should be initiated or repeated only if the neutrophil count is at least 1,000 cells/mm³.
3. the dose of subsequent courses of TAXOL should be reduced by 20% for those patients who experience severe neutropenia (<500 cell/mm³ for a week or longer).
4. concomitant hematopoietic growth factor (G-CSF), should be initiated as clinically indicated.

Preparation and Administration Precautions

TAXOL is a cytotoxic anticancer drug and, as with other potentially toxic compounds, caution should be exercised in handling TAXOL. The use of gloves is recommended. Following topical exposure, tingling, burning, redness have been observed. If TAXOL solution contacts the skin, wash the skin immediately and thoroughly with soap and water.

If TAXOL contacts mucous membranes, the membranes should be flushed thoroughly with water. Upon inhalation, dyspnea, chest pain, burning eyes, sore throat and nausea have been reported. Given the possibility of extravasation, it is advisable to closely monitor the infusion site for possible infiltration during drug administration (see PRECAUTIONS and ADVERSE REACTIONS; Injection Site Reaction).

Preparation for Intravenous Administration

TAXOL for Injection must be diluted prior to infusion. TAXOL should be diluted in 0.9% Sodium Chloride Injection, 5% Dextrose Injection, 5% Dextrose and 0.9% Sodium Chloride Injection, or 5% Dextrose in Ringer's Injection to a final concentration of 0.3 to 1.2 mg/mL. The solutions are physically and chemically stable for up to 27 hours at ambient temperature (15-30°C) and room lighting conditions; infusions should be completed within this timeframe. There have been rare reports of precipitation with longer than the recommended 3-hour infusion schedules. Excessive agitation, vibration or shaking may induce precipitation and should be avoided. Infusion sets should be flushed thoroughly with a compatible diluent before use.

Upon preparation, solutions may show haziness, which is attributed to the formulation vehicle. No significant loss in potency has been noted following simulated delivery of the solution through i.v. tubing containing an in-line (0.22 micron) filter.

Data collected for the presence of the extractable plasticizer DEHP [di-(2-ethylhexyl)phthalate] show that levels increase with time and concentration when dilutions are prepared in PVC containers. Consequently, the use of plasticized PVC containers and administration sets is not recommended. TAXOL solutions should be prepared and stored in glass, polypropylene, or polyolefin containers. Non-PVC containing administration sets, such as those which are polyethylene-lined, should be used.

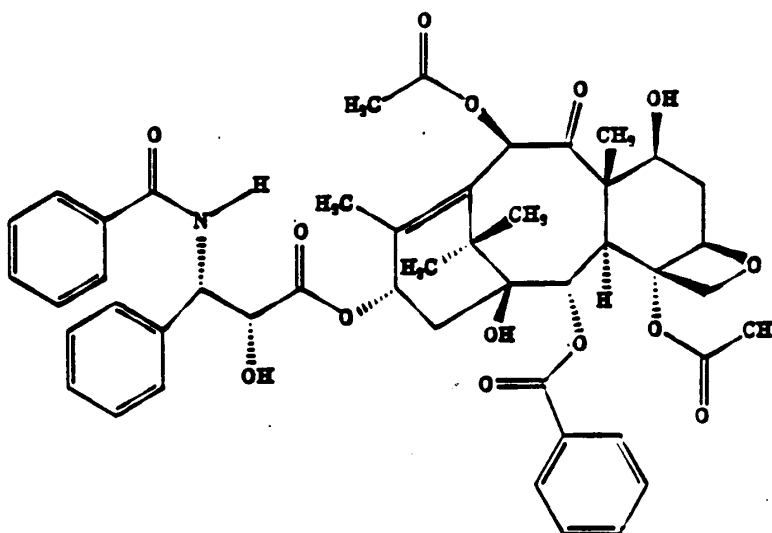
Devices with spikes should not be used with vials of TAXOL since they can cause the stopper to collapse resulting in loss of sterile integrity of TAXOL solution.

PHARMACEUTICAL INFORMATION

I. DRUG SUBSTANCE

Proper Name: Paclitaxel

Chemical Name: 5 β ,20-Epoxy-1,2 α ,4,7 β ,10 β ,13 α -hexahydroxytax-11-en-9-one
4,10-diacetate 2-benzoate 13-ester with (2R,
3S)-N-benzoyl-3-phenylisoserine



Structural Formula:

Molecular Formula: C₄₇H₅₁NO₁₄

Molecular Weight: 853.9

Description: Paclitaxel is a white to off-white crystalline powder with a melting point of 213.5-223°C. It is highly lipophilic and insoluble in water.

II. COMPOSITION

Each mL of TAXOL (paclitaxel) Injection contains paclitaxel 6 mg, purified Cremophor^{††} EL (polyethoxylated castor oil) 527 mg and dehydrated ethanol 49.7% v/v.

III. STABILITY AND STORAGE RECOMMENDATIONS

TAXOL for Injection should be stored at room temperature (15-30°C). Retain in the

^{††} T.M. of B.A.S.F.

original package and protect from light. Once punctured, the 5 and 16.7 mL vials of TAXOL are stable for 28 days at room temperature. The 50 mL pharmacy bulk vial should be used within 24 hours after initial entry.

Solutions for infusion prepared as recommended may be stored at room temperature (15-30°C) only if necessary. However, the infusion should be initiated within 24 hours of reconstitution.

If unopened vials are refrigerated, a precipitate may form which redissolves with little or no agitation upon reaching room temperature. Product quality is not affected. If the solution remains cloudy or if an insoluble precipitate is noted, the vial should be discarded.

IV. PREPARATION FOR INTRAVENOUS ADMINISTRATION

Contact of undiluted TAXOL with plasticized PVC equipment or devices used to prepare solutions for infusion is not recommended (see DOSAGE AND ADMINISTRATION).

Prior to infusion, TAXOL should be diluted in 0.9% Sodium Chloride Injection, 5% Dextrose Injection, 5% Dextrose and 0.9% Sodium Chloride Injection or 5% Dextrose in Ringer's Injection to a final concentration of 0.3 to 1.2 mg/mL.

As with all parenteral drug products, intravenous admixtures should be inspected visually for clarity, particulate matter, precipitate, discoloration and leakage prior to administration, whenever solution and container permit.

TAXOL should be administered through an in-line filter with a microporous membrane not greater than 0.22 microns.

V. SPECIAL INSTRUCTIONS

1. Preparation of TAXOL should be done in a vertical laminar flow hood (Biological Safety Cabinet - Class II).
2. Personnel preparing TAXOL should wear PVC gloves, safety glasses, disposable gowns and masks.
3. All needles, syringes, vials and other materials which have come in contact with TAXOL should be segregated and incinerated at 1000°C or more. Sealed containers may explode. Intact vials should be returned to the Manufacturer for destruction. Proper precautions should be taken in packaging these materials for transport.
4. Personnel regularly involved in the preparation and handling of TAXOL should have bi-annual blood examinations.
5. Directions for Dispensing from Pharmacy Bulk Vial
The use of Pharmacy Bulk Vial is restricted to hospitals with a recognized intravenous admixture program. The Pharmacy Bulk Vial is intended for single puncture, multiple dispensing and for intravenous use only. Dispensing from the

Pharmacy Bulk Vial should be completed within 24 hours after initial entry.

AVAILABILITY OF DOSAGE FORMS

TAXOL (paclitaxel) Injection is available in multidose vials of 5 mL and 16.7 mL and pharmacy bulk vial of 50 mL containing respectively 30 mg, 100 mg and 300 mg paclitaxel at a concentration of 6 mg/mL

PHARMACOLOGY

In vitro

TAXOL (paclitaxel) exhibits cytotoxic activity against a wide variety of both human and rodent tumor cell lines *in vitro* including leukemia, non-small cell lung carcinoma, small cell lung carcinoma, colon carcinoma, CNS carcinoma, melanoma, renal carcinoma, ovarian carcinoma and breast carcinoma at IC₅₀ concentration (defined as the concentration required to inhibit cell proliferation to 50% of that of untreated control cells) in the nM range. TAXOL blocks cell replication in the late G2 and/or M phases of the cell cycle. Additionally, TAXOL produces unusual cytoskeletons characterized by discrete bundles or microtubules and the formation of abnormal spindle asters during mitosis. As a consequence of the disruption of the microtubule cytoskeleton, TAXOL inhibits a variety of cell functions including chemotaxis, migration, cell spreading, polarization, generation of hydrogen peroxide and killing of phagocytosed microorganisms.

In addition to its ability to induce microtubule polymerization, exposure of murine macrophages to TAXOL results in the release of tumor necrosis factor- α (TNF- α) accompanied by down regulation of the receptor.

In Vivo

TAXOL has shown antitumor activity against many tumor models including leukemias and solid tumors and human solid xenografts. The table that follows summarizes TAXOL's activity.

Tumor, Site	Form	Route	Activity
MURINE LEUKEMIAS			
L1210, ip	*	ip	Borderline → modest
P388, ip	*	ip	Mild
P1534, ip	*	ip	Mild → substantial
MURINE SOLID TUMORS			
ADJ/PC 6, ip	*	ip	Mild
C26, ip	*	ip	Mild
B16, ip	*	ip	Moderate → potentially curative
M109, ip	*	ip	Moderate → potentially curative
M109, ip (staged)	**	ip	Moderate → substantial
M109, sc	**	sc	Moderate
M109 src	**	sc	Moderate
HUMAN TUMOR XENOGRAFTS			
CX-1, src	*	sc	Mild → substantial
LOX, ip	*	ip	Moderate → potentially curative
MX-1, src	*	sc	Potentially curative
A431, src	**	iv	Substantial
A2780, src	**	iv	Substantial
A2780, sc	**	iv	Moderate
H2981, src	**	iv	Substantial
HCT-116	**	iv	Moderate
L2987, src	**	iv	Moderate
LX-1, src	**	iv	Moderate

* Suspension in hydroxypropylcellulose

** TAXOL in ethanol/cremophor diluted with saline

Clinical trials

Ovarian Carcinoma

Study Design	Treatments / Doses	No. of Patients	Population	Endpoints/Conclusion
<p><i>First-Line data:</i> Phase 3 multicenter, randomized, controlled trial conducted by GOG, comparing therapy with Taxol (T) in combination with cisplatin (c) to cyclophosphamide (AC) in combination with cisplatin (c)</p>	<p>- 135 mg/m² of T over 24 hrs + 75 mg/m² of c</p> <p>- 750 mg/m² of AC + 75 mg/m² of c</p>	410	Stage III or IV disease (> 1 cm residual disease after staging laparotomy or distant metastases) with no prior chemotherapy	Patients treated with T in combination with cisplatin has significantly longer time to progression (median 16.6 vs. 13.0 months, p = 0.0008) and nearly a year longer median survival time (p = 0.0002) compared with standard therapy.
<p><i>Second-Line data:</i> Phase 3 multicenter, bifactorial, randomized trial comparing two dosage regimens of Taxol (T) irrespective of the schedules and two schedules irrespective of dose.</p>	<p>- 175 mg/m² of T over 24 hrs</p> <p>- 175 mg/m² of T over 3 hrs</p> <p>- 135 mg/m² of T over 24 hrs</p> <p>- 135 mg/m² of T over 3 hrs</p>	407	Patients (pts) who have failed initial or subsequent chemotherapy for metastatic carcinoma of the ovary.	<p>Pts receiving the 175 mg/m² dose had a response rate (RR) similar to that for those receiving the 135 mg/m² dose: 18% vs. 14% (p=0.28). No difference in RR was detected when comparing the 3-hr with the 24-hr infusion: 15% vs. 17% (p=0.50). Pts receiving the 175 mg/m² dose of T had a longer time to progression (TTP) than those receiving the 135 mg/m² dose: median 4.2 vs. 3.1 months (p=0.03). The median TTP for pts receiving the 3-hour vs. the 24-hr infusion were 4.0 months vs. 3.7 months, respectively.</p> <p>Median survival was 11.6 months in pts receiving the 175 mg/m² dose of T and 11.0 months in pts receiving the 135 mg/m² dose (p=0.92).</p> <p>Median survival was 11.7 months for pts receiving the 3-hr infusion of T and 11.2 months for pts receiving the 24-hr infusion (p=0.91).</p>

First-Line data: The adverse event profile for patients receiving TAXOL in combination with cisplatin was consistent with that seen in previous clinical studies (see ADVERSE REACTIONS).

Second-Line data: In addition to the Phase 3 trial described above, data from five Phase 1 and 2 clinical studies as well as an interim analysis of data from more than 300 patients enrolled in a treatment referral center program were used in support of the use of Taxol in patients who have failed initial or subsequent chemotherapy for metastatic carcinoma of the ovary. TAXOL remained active in patients who had developed resistance to platinum-containing therapy (defined as tumor progression while on, or tumor relapse within 6 months from completion of, a platinum containing regimen) with response rates of 14% in the Phase 3 study and 31% in the Phase 1 & 2 clinical studies. The adverse event profile in this Phase 3 study was consistent with that seen in previous clinical studies (see ADVERSE REACTIONS).

The results of this randomized study support the use of TAXOL at doses of 135 to 175 mg/m² , administered by a 3-hour intravenous infusion. The same doses administered by 24-hour infusion were more toxic.

Breast Carcinoma

Study Design	Treatments / Doses	No. of Patients	Population	Endpoints/Conclusion
<p><i>Adjuvant Breast Carcinoma Study:</i> Phase 3 multicenter, 3X2 factorial, randomized trial, conducted by CALGB, ECOG, NCCTG and SWOG, comparing adjuvant therapy with Taxol (T) to no further chemotherapy following four courses of doxorubicin (A) and cyclophosphamide (C)</p>	<p>600 mg/m² of C + A at doses of either</p> <ul style="list-style-type: none"> - 60 mg/m² (on day 1), - 75 mg/m² (in two divided doses on days 1 and 2), or - 90 mg/m² (in two divided doses on days 1 and 2 with prophylactic G-CSF support and ciprofloxacin) <p>every 3 weeks for four courses and either</p> <ul style="list-style-type: none"> - 175 mg/m² of T over 3 hrs every 3 weeks for four additional courses or - no additional chemotherapy. <p>Patients (pts) whose tumors were +ve were to receive subsequent tamoxifen (20 mg daily for 5 years); patients who received segmental mastectomies prior to study were to receive breast irradiation after recovery from treatment-related toxicities.</p>	<p>3170</p>	<p>Node-positive breast carcinoma following either mastectomy or segmental mastectomy and nodal dissections.</p>	<p>Median follow-up was 30.1 months. Of 2066 pts who were hormone receptor positive, 93% received tamoxifen. Based on a multivariate Cox model for disease-free survival, pts on AC+T had 22% risk reduction of disease recurrence compared to pts on AC (Hazard Ratio [HR] = 0.78, 95% CI 0.67-0.91, p = 0.0022) and 26% reduction in the risk of death (HR = 0.74, 95% CI 0.60-0.92, p = 0.0065). Increasing the dose of A higher than 60 mg/m² had no effect on either disease-free survival or overall survival. Subset analyses including number of positive lymph nodes, tumor size, hormone receptor status, and menopausal status showed a reduction in hazard similar to above for disease-free and overall survival in all larger subsets with one exception; pts with receptor-positive tumors had a smaller reduction in hazard (HR = 0.92) for disease-free survival with T than other groups.</p>

<p><i>After Failure of Initial Chemotherapy:</i> Phase 3 multicenter, randomized trial comparing two dosage regimens of Taxol (T).</p>	<p>- 175 mg/m² of T over 3 hrs - 135 mg/m² of T over 3 hrs</p>	<p>471</p>	<p>Patients (pts) who failed chemotherapy either in the adjuvant (30%) or metastatic (39%) setting or both (31%). At study entry, 60% had symptomatic disease with impaired performance status and 73% had visceral metastases.</p>	<p>The overall response rate was 26% (95% CI: 22 to 30%), with 17 complete and 99 partial responses. The median duration of response, measured from the first day of treatment, was 8.1 months (range: 3.4-18.1 + months). Overall, the median time to progression was 3.5 months (range: 0.03-17.1 months). Median survival was 11.7 months (range: 0-18.9 months).</p>
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Adjuvant Breast Carcinoma Study: The adverse event profile for patients receiving TAXOL subsequent to AC was consistent with that seen in previous clinical studies (see ADVERSE REACTIONS).

After Failure of Initial Chemotherapy: In addition to the Phase 3 trial described above, data from three Phase 2 clinical studies were used in support of the use of Taxol in patients with metastatic breast carcinoma. The adverse event profile for patients receiving TAXOL subsequent to AC was consistent with that seen in previous clinical studies (see ADVERSE REACTIONS).

Non-Small Cell Lung Carcinoma (NSCLC)

Study Design	Treatments / Doses	No. of Patients	Population	Endpoints/Conclusion
Phase 3 multicenter, open label, randomized trial conducted by ECOG, comparing two dosage regimens of Taxol (T) in combination with cisplatin (c) to cisplatin (c) followed by etoposide (VP)	<ul style="list-style-type: none"> - 135 mg/m² of T over 24 hrs + 75 mg/m² of c - 250 mg/m² of T over 24 hrs + 75 mg/m² of c with G-CSF support - 75 mg/m² of c on day 1 followed by 100 mg/m² of VP on days 1, 2 and 3 (control) 	599	Non-Small Cell Lung Cancer	There were statistically significant differences favoring each of the T plus c arms for response rate and time to tumor progression. There was no statistically significant difference in survival between either T plus c arm and the c plus VP arm. In this study, the Functional Assessment of Cancer Therapy-Lung (FACT-L) questionnaire had seven subscales that measured subjective assessment of treatment. Of the seven, the Lung Cancer Specific Symptoms subscale favored T at 135 mg/m ² of T as a 24-hr infusion + 75 mg/m ² of c. For all other factors, there was no difference in the treatment groups.

The adverse event profile for patients who received TAXOL in combination with cisplatin was consistent with that seen in previous clinical studies (see ADVERSE REACTIONS).

AIDS-Related Kaposi's Sarcoma

Study Design	Treatments / Doses	No. of Patients	Population	Endpoints/Conclusion
CA139-174: Phase 2 single-centre, open-label, non-randomized study to assess the activity of Taxol (T) against AIDS-related Kaposi's Sarcoma.	135 mg/m ² of T over 3 hrs every 3 weeks (intended dose intensity 45 mg/m ² /wk). If no dose-limiting toxicity was observed, subjects were to receive 155 mg/m ² and 175 mg/m ² in subsequent courses. Hematopoietic growth factors were not to be used initially.	29	AIDS-related Kaposi's sarcoma for which systemic chemotherapy was warranted	Objective response rate was 69%, including two complete responses (CR) and 18 partial responses (PR). An additional 28% of patients achieved stabilization of disease. Response rate for patients receiving prior systemic therapy was 79% (including 2 CRs and 13 Prs). Median time to response was 11.9 wks (range: 2.9 to 19.0 wks). Median duration of response was 7.0 months (range 3.5 to 29.2 months).
CA139-281: Phase 2, two-centre, open-label, non-randomized study to assess the efficacy and safety of Taxol (T) in patients with advanced AIDS-related Kaposi's Sarcoma.	100 mg/m ² of T over 3 hrs every 2 weeks (intended dose intensity 50 mg/m ² /wk). Patients could be receiving hematopoietic growth factors before the start of TAXOL therapy or this support was to be initiated as indicated; the dose of TAXOL was not increased.	56		Objective response rate was 59% (95% C.I.: 45% to 77%), including one complete response (CR) and 32 partial responses (PR). An additional 25% of patients achieved stabilization of disease. Response rate for patients receiving prior systemic therapy was 55% (22 PRs). Median time to response was 6.1 wks (range: 4.0 to 36.0 wks). Median duration of response was 10.4 months (range 2.8 to 18+ months).

All patients had widespread and poor-risk disease. Applying the ACTG staging criteria to patients with prior systemic therapy, 93% were poor risk for extent of disease (T1), 88% had a CD4 count <200 cells/mm³ (I1), and 97% had poor risk considering their systemic illness (S1).

All patients in Study CA139-174 had a Karnofsky performance status of 80 or 90 at baseline; in Study CA139-281, there were 26 (46%) patients with a Karnofsky performance status of 70 or worse at baseline.

Although the planned dose intensity in the two studies was slightly different (45 mg/m² /week in Study CA139-174 and 50 mg/m² /week in Study CA139-281), delivered dose intensity was 38-39 mg/m² /week in both studies, with a similar range (20-24 to 51-61).

Efficacy: The efficacy of TAXOL (paclitaxel) Injection was evaluated by assessing cutaneous tumor response according to the amended ACTG criteria and by seeking evidence of clinical benefit in patients in six domains of symptoms and/or conditions that are commonly related to AIDS-related Kaposi's sarcoma.

Cutaneous Tumor Response (Amended ACTG Criteria): The objective response rate was 63% (95% CI: 49% to 75%) (37 of 59 patients) in patients with prior systemic therapy. Cutaneous responses were primarily defined as flattening of more than 50% of previously raised lesions.

The median time to response was 8.1 weeks and the median duration of response measured from the first day of treatment was 9.1 months (95% CI: 6.9 - 11.0 months) for the patients who had previously received systemic therapy. The median time to progression was 6.2 months (95% CI: 4.6 to 8.7 months).

Additional Clinical Benefit: Most data on patient benefit were assessed retrospectively (plans for such analyses were not included in the study protocols). Nonetheless, clinical descriptions and photographs indicated clear benefit in some patients, including instances of improved pulmonary function in patients with pulmonary involvement, improved ambulation, resolution of ulcers, and decreased analgesic requirements in patients with KS involving the feet and resolution of facial lesions and edema in patients with KS involving the face, extremities, and genitalia.

Safety: The adverse event profile of TAXOL administered to patients with advanced HIV disease and poor-risk AIDS-related Kaposi's sarcoma was generally similar to that seen in a pooled analysis of data from 812 patients with solid tumors (See ADVERSE REACTIONS). In this immunosuppressed patient population, however, a lower dose intensity of TAXOL and supportive therapy including hematopoietic growth factors in patients with severe neutropenia are recommended. (See DOSAGE AND ADMINISTRATION). Patients with AIDS-related Kaposi's sarcoma may have more severe hematologic toxicities than patients with solid tumors. (See ADVERSE REACTIONS).

TOXICOLOGY

ACUTE TOXICITY

Species / Strain	No. / Sex / Group	Route	LD₅₀ (mg/kg)
Rat/Sprague-Dawley	5 M/F (RF) ^a 10 M/F (L) ^b	ip ip	34 (combined)
Rat/Sprague-Dawley	10 M/F	ip	M: 32 F: 36
Rat/Sprague-Dawley	5 M/F	iv	>85
Dog/Beagle	1 M/F	iv	>9

a Range-Finding phase

b Lethality phase

Signs of toxicity in rats were lethargy, rough coat, thinness, hunched posture, neck abscesses, soft stool, decreased body weight, squinted eyes, alopecia.

Signs of toxicity in dogs were decreased body weight.

SUBACUTE TOXICITY

Species/Strain	No./ Group	Sex	Dose Range mg/kg/day	Route	Duration	Drug Related Findings
Mouse/CD2F ₁	5 5	M F	0, 1-15	iv	5 Days	No drug related toxicities.
Mouse/CD2F ₁	5 5	M F	0, 1-15*	ip	5 Days	20 and 45 mg/kg/day: Decreased body weight >10% 45 mg/kg/day: Rough coat, thin/hunched posture. All died.
	15 15	M F	0, 21-43**	ip	5 Days	≥24 mg/kg/day: Dose-related decreased body weight, rough coat, thin/hunched posture, ataxia, hypothermia, squinted eyes and dyspnea, deaths (74/88 M, 56/90 F).
Rat/Sprague-Dawley	5 5	M F	0, 5-45*	ip	5 Days	≥8.66 mg/kg/day: Dose-related decreased body weight, rough coat, thin/hunched posture, stool changes, soiling, hypothermia, eye tearing and squinting, abscesses, deaths [(19/20 M, 18/20 F)*; (44/70 M at all doses, 26/40 F)**].
	10 10	M F	0, 5.3-14.2**	ip	5 Days	
Mouse/CD2F ₁	10 10	M F	Negative ^b Control	ip	5 Days	<u>1/2 LD₁₀, LD₁₀ and LD₅₀ dose groups:</u> Necrosis of developing spermatocytes. Giant cell formation.
	10 10	M F	Vehicle Control			<u>LD₁₀ and LD₅₀ dose groups:</u> Decrease in reticulocyte and neutrophil values. Lower liver and testicular weights. Moderate to severe thymic cortical lymphoid depletion. Necrosis or atrophy of small intestinal mucosa and crypt cell hypoplasia. Neurophilic hyperplasia, eosinopenia, lymphoid hypoplasia and atypical megakaryocytes, deaths (2/10 M, 8/10 F at LD ₁₀ ; 8/10 M, 9/9 F at LD ₅₀).
	10 10	M F	1/2 LD ₁₀ 10.79 13.05			
	10 10	M F	LD ₁₀ 21.57 26.09			<u>All dose groups:</u> Dose-related decreased body weight, lethargy, rapid respiration, rough coat, thin/hunched posture, hypothermia, squinted eyes with exudate.
	10 10	M F	LD ₅₀ 25.50 29.52			

Species/Strain	No./ Group	Sex	Dose Rangea mg/kg/day	Route	Duration	Drug Related Findings
Rat/Sprague-Dawley	10	M	Negative ^b	ip	5 Days	<p><u>LD₅₀ dose group</u>: Testicular necrosis, visceral peritoneum inflammation (F only), deaths (3/10 M, 3/10 F).</p> <p><u>LD₁₀ and LD₅₀ dose groups</u>: Markedly decreased leukocyte and platelet counts. Weight loss, bone marrow hypoplasia, deaths (1/10 M, 3/10 F at LD₁₀).</p> <p><u>All dose groups</u>: Dose related thymic and splenic lymphoid depletion, rough coat, thin/hunched posture, lethargy, soft stool, neck abscesses. Decreased reticulocyte counts, white foci in submandibular lymph nodes and/or salivary glands.</p>
	10	F	control			
	10	M	Vehicle			
	10	F	Control			
	10	M	1/2 LD ₁₀			
10	F	2.55				
10	F	4.29				
10	M	LD ₁₀				
10	F	5.11				
10	F	8.58				
10	M	LD ₅₀				
10	F	7.47				
10	F	9.99				
Dog/Beagle	1	M	0, 0.375,	iv	5 Days	<p><u>All doses</u>: Decreased body weight. Increased ALT, cholesterol, triglycerides and total lipids. Intestinal hemorrhage or agonal changes. Lymphoid depletion of tonsils and/or bronchial lymph node.</p> <p><u>≥1.5 mg/kg/day</u>: Marked decreases in leukocyte, reticulocyte, platelet, and erythrocyte counts.</p> <p><u>≤1.5 mg/kg/day</u>: Moderate to severe bone marrow hematopoietic hypoplasia.</p> <p><u>3.0 to 6.0 mg/kg/day</u>: Deaths (All)</p>
	1	F	0.75, 1.5, 3.0, 6.0			

* Range Finding phase

** Lethality phase

a Taxol dissolved in Cremophor[†] EL (50%): ethanol (50%) and then diluted with saline to provide dosing solutions

b Untreated

CHRONIC TOXICITY

Species/ Strain	No./ Group	Sex	Dose* (mg/kg/day)	Route	Duration	Drug Related Findings
Rat/Sprague-Dawley	10	M	Neg. Cont., saline	iv	1 Month	<p><u>3.3 mg/kg/day</u>: Slight decreases in erythrocyte, neutrophil and platelet counts and hemoglobin and hematocrit values; moderate decreases in leukocyte counts. Increased splenic extramedullary hematopoiesis and bone marrow hypoplasia. Moderate to severe decrease in reticulocyte counts. Minimal increase in lymphocyte counts.</p> <p><u>10 mg/kg/day</u>: Rough coat, alopecia, decreased body weight/weight gain and food and water intakes. Slight decreases in erythrocyte and neutrophil counts, hemoglobin and hemocrit values; moderate to severe decreases in reticulocyte count and slight increases in platelet and relative lymphocyte counts. Decreased weight of thymus, testes and seminal vesicles. Lower weights of testes and epididymides present at end of observation period.</p> <p>Microscopically, increased splenic extra medullary hematopoiesis and lymphoid depletion, thymic atrophy and lymphoid depletion, mandibular lymph node atrophy of lymph follicle, and lymphadenitis; bone marrow hypoplasia; hypospermatogenesis and atrophy of seminiferous tubules; glandular atrophy in seminal vesicle and prostate and giant cell formation in the epididymides.</p>
	10	F				
	10	M	Vehicle Control			
	10	F				
	10	M	1, 3.3, 10			
	10	F				

Species/ Strain	No./ Group	Sex	Dose* (mg/kg/day)	Route	Duration	Drug Related Findings
Dog/Beagle	5	M	Neg. Cont., saline	iv	1 Month	<p><u>0.3 and 1 mg/kg/day:</u> Reversible minimal decreases in bone marrow cellularity.</p> <p><u>3 mg/kg/day:</u> Interdigital cysts, swollen infusion sites, and transient decreased weight gain and food intake. Decreased erythrocyte numbers, hemoglobin concentration and hemocrit (M/F) and decreased leucocyte (severe neutropenia) counts in individual females. Lymphoid depletion of spleen or lymph nodes, duodenal inflammation and crypt dilation, decreased bone marrow cellularity, skin lesions and giant cell formation in the testes and epididymides. Residual drug-effects present in some lymphoid organs, duodenum, testes and skin at the end of recovery period.</p>
	5	F				
	3	M	Vehicle Control			
	3	F				
	3	M	0.3, 1			
	3	F				
	5	M	3			
	5	F				

* Taxol in Cremophor EL: ethanol (50/50) diluted with saline for dosing solutions

REPRODUCTION AND TERATOLOGY

Species/ Strain	No./ Group	Sex	Route	Dose* and Frequency	Drug Related Findings
SEGMENT I Rat/Sprague- Dawley	20	M	iv	0 (vehicle), 0 (saline) 0.1, 0.3, 1.0 mg/kg M: 63 days prior to mating and during mating F: During mating and through day 7 of gestation	<p>Body weight gain and food intake were lower in F₀ males and females Days 25-63 and Days 28-62, respectively, of pre-mating period. Body weight gain and food intake were lower in F₀ females during Days 2-20 of gestation at the high dose level. Fertility indices in the F₀ generation were lower at 1 mg/kg/day compared to saline and vehicle control groups. Copulation indices were similar to control.</p>
	20	F			

Species/ Strain	No./ Group	Sex	Route	Dose* and Frequency	Drug Related Findings
SEGMENT II Rabbit/New Zealand White	20	F	iv	O (saline), 0 (vehicle), 0.3, 1, 3 mg/kg, Days 6-18 of presumed gestation.	<p>Twelve of 20 does given the high dose died or were sacrificed as moribund. Clinical signs of toxicity in the does that died included red excreta, stool consistency changes, decreased activity, food intake decreases and body weight loss.</p> <p>Liver and kidney weights were increased and ovary weights were decreased in the does given the high dose.</p> <p>Litter group mean values for corpora lutea, litter size, live fetuses and the number of does with viable fetuses in the high dose group were reduced. Litter group mean values for resorption (total or early), percentage of dead or resorbed conceptuses and the number of does with all conceptuses dead or resorbed were increased in the high dose group.</p> <p>In summary, taxol at 3 mg/kg/day caused severe maternal toxicity (mortality, abortions, clinical signs and reduced organ weights, body weights and food consumption) and severe developmental toxicity (reduced corpora lutea, litter size and live fetuses and increased resorption). Taxol doses as high as 1 mg/kg/day did not cause any maternal or fetal toxicity.</p>

* Taxol in Cremophor[†] EL: ethanol 50/50 diluted with saline for dosing solutions.

MUTAGENECITY AND GENOTOXICITY

TAXOL (paclitaxel) was not mutagenic in the Ames/Salmonella and Escherichia Coli WP2 reverse mutation assays but was found to be clastogenic, in the *in vitro* cytogenetics assay in primary human lymphocytes.

TAXOL was genotoxic *in vivo* on the mouse erythropoietic system in the mouse bone marrow erythrocyte micronucleus assay.

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