August

Better Pharmacist Knowledge

Jordan Drug Information and Toxicology Centre 2025

2025

Aspirin for stage I to III PIK3CA-mutated colorectal cancer (August 2025)

For patients with stage I to III colorectal cancer and a somatic (tumoral) phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (*PIK3CA*) mutation who have completed surgery, UpToDateguidelines suggests aspirin , **at a dose of 160 mg orally daily, to be continued for three years.**For patients with treated stage I to III colorectal cancer (CRC) and a somatic (tumoral) phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (*PIK3CA*) mutation, studies are evaluating the benefits of aspirin.

preliminary results of a placebo-controlled randomized trial revealed that **low-dose aspirin (160 mg daily) for three years reduced the recurrence rate**. For patients with stage I to III CRC who complete surgery and have a somatic *PIK3CA* mutation, we now suggest low-dose aspirin, to be continued for three years [1].

Methotrexate as initial therapy for symptomatic, moderate-to-severe pulmonary sarcoidosis (June 2025)

For most symptomatic patients with pulmonary sarcoidosis who have severe lung involvement, worsening radiographic opacities, or increasing pulmonary function impairment, UpToDate guidelines **suggests initial treatment with methotrexate rather than glucocorticoid therapy, observation alone, or other alternative therapies.**

Pulmonary sarcoidosis is usually treated initially with oral glucocorticoids, which have numerous side effects.a new open-label trial revealed that Methotrexate had a slower onset of action but was associated with less weight gain and similar patient satisfaction by the end of the trial. Based in part on this evidence, we **now suggest methotrexate as initial therapy for most patients with moderate-to-severe pulmonary sarcoidosis requiring treatment; concurrent oral glucocorticoids are appropriate for those with rapidly progressing disease [2]**.

Updated guidelines for prophylaxis after a nonoccupational exposure to HIV(July 2025)

For most people who initiate nonoccupational post-exposure prophylaxis to prevent HIV, Up To Date guidelines suggests bictegravir-emtricitabine-tenofoviralafenamide.

People who present within 72 hours of a possible nonoccupational exposure to human immunodeficiency virus (HIV) should be evaluated for post-exposure prophylaxis with antiretroviral therapy (nPEP). If indicated, updated guidelines from the United States Centers for Disease Control and Prevention suggest bictegravir-emtricitabine-tenofoviralafenamide or dolutegravir plus either tenofoviralafenamide or tenofovirdisoproxilfumarate .For most people, we suggest bictegravir-emtricitabine-tenofoviralafenamide since it is administered as a single pill once daily.

There may be additional considerations for regimen selection in those with reduced kidney function or exposure to drug-resistant HIV [3].

References:
1.Aspirin for stage I to III PIK3CA-mutated colorectal cancer, accessed online via uptodate ,cited on august 24th-2025.
2.Methotrexate as initial therapy for symptomatic, moderate-to-severe pulmonary sarcoidosisaccessed online via uptodate , cited on august 24th-2025..
3. Updated guidelines for prophylaxis after a nonoccupational exposure to HIV, accessed online via uptodate , cited on august 24th-2025.

Issue 27 JDITC

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Add-on therapy for refractory COPD in patients with peripheral eosinophilia(June 2025)

For patients with COPD and peripheral eosinophilia (≥300 cells/microL) who have recurrent exacerbations despite triple inhaled therapy, we suggest the addition of dupilumab or mepolizumab rather than other therapies.

The use of biologics targeting type 2 inflammation in chronic obstructive pulmonary disease (COPD) has demonstrated promise, with approval of dupilumab in 2024 and new approval of mepolizumab for patients with eosinophilia and exacerbations despite inhaled therapies. Mepolizumab approval followed a trial of over 800 patients with COPD, peripheral hypereosinophilia (≥300 cells/microL), and exacerbations despite triple inhaled therapy (long-acting muscarinic antagonist, long-acting beta agonist, and inhaled corticosteroid). Those randomized to treatment with the anti-interleukin 5 monoclonal antibody mepolizumab (100 mg subcutaneously monthly) had a reduction in moderate or severe exacerbations compared with placebo, but no improvements in lung function or respiratory symptoms. Similar patients treated with dupilumab have shown a somewhat larger reduction in exacerbation rates and modest improvements in lung function and symptoms. Absent comparative trials,UpToDate guidelines now suggest either dupilumab or mepolizumab for patients with COPD and peripheral eosinophilia who have persistent exacerbations despite optimized inhaled therapy [1].

تعميم صادر عن المؤسسة العامة للغذاء والدّواء:

Recommendations on the duration of contraception following the end of treatment with a genotoxic drug:

The recommended duration of contraception in ***male*** patients should beuntil the end of relevant systemic exposure to the genotoxic compound incl. potential genotoxic metabolites (i.e**. five half-lives after the last dose) plus 90 days.** The same would be true for a pure aneugenic compound.

The recommended duration of contraception in ***female*** subjects participating in clinical trials should be until the end of relevant systemic exposure incl. potential genotoxic metabolites (i.e. **five half-lives after the last dose) plus 6 months**. In the more theoretical case of treatment with a pure aneugenic pharmaceutical recommended duration of contraception should be until the end of relevant systemic exposure (i.e. five half-lives after the last dose) plus 1 month.

With regard to the recommendation of the half-life based additional time period for contraception, practical well as worst-case scenario approaches should be applied.

Genotoxicity/genetic damage at the level of the germ cells and/or conceptus may deserve particular attention due to its potential irreversible nature. This is independent of the therapeutic indication. Therefore, the recommendations should apply to any genotoxic active substance regardless of its therapeutic indication. However, these recommendations should not apply to active substances whose mechanism of genotoxicity is known to have a threshold which is not expected to be attained in patients.[2].

References:

1. Add-on therapy for refractory COPD in patients with peripheral eosinophilia .accessed online via uptodate , cited on august 24th-2025.
2. تعميم صادر عن المؤسسة العامة للغذاء والدّواءaccessed online via JFDA on August 24th -2025.

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Issue 27 JDITC

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