Ketoconazole: a reappraisal

The recent letter from the chairman of the Committee on the Safety of Medicines to doctors in Britain about oral ketoconazole and hepatotoxicity has aroused widespread concern. This imidazole antifungal drug is available for both oral and topical use and so has wide potential clinical applications. Serious adverse effects have been rare, though symptoms such as gynaecomasia related to androgen blocking activity1 and anaphylaxis have been reported in addition to hepatotoxicity.2 The effect of ketoconazole on the liver ranges from asymptomatic transient abnormalities of the enzyme activities to potentially fatal acute hepatic necrosis.3 In view of these findings clearly the risks of using the drug need to be weighed against the likely benefits to the patient. Fortunately, considerably more information is now available on the clinical uses of ketoconazole than when it was first reviewed in the BMJ.4

Many superficial fungal infections are best treated with topically applied antifungal agents. In dermatophytosis (ringworm) oral treatment should be reserved for infections of the scalp or nails and for widespread disease. Though ketoconazole is effective in dermatophytosis, comparative studies have shown that it has no real clinical advantages over griseofulvin5 except in some specific or resistant cases such as intractable tinea corporis.6 In particular, both drugs produce similar responses in nail infections (which are notoriously difficult to treat).7 Ketoconazole may be effective in some fingernail infections which have failed to respond to adequate treatment with griseofulvin.

In the second main group of superficial infections, candidiasis, topical antifungals are also generally effective. In vaginal candidiasis, for instance, one large study found no difference in response rates to topical clotrimazole and oral ketoconazole, though patients preferred the latter.8 In persistent and distressing superficial candidal infections, however, and in particular in chronic mucocutaneous candidiasis9 ketoconazole appears to offer the best chance of clinical recovery. Generally the alternative drugs are satisfactory for the superficial fungal infections, and ketoconazole may be reserved for specific indications.

Deep fungal infections present different problems in view of the risk of severe incapacity or even death in untreated patients. Ketoconazole is effective in the tropical sub-


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Risk of leukaemia associated with cancer chemotherapy

The objectives of the treatment of cancer must be to restore a good quality of life and when possible cure. The experienced clinician should be able to weigh the risks of temporary morbidity associated with a particular treatment against the prospect of achieving these objectives. As the results of treatment improve and survival is prolonged new clinical events may become manifest in association either with the disease or with its treatment. When this happens the late effects of treatment must be distinguished from those of the disease itself.

Potentially one of the most serious late events is the induction of a second cancer. An association between the administration of arsenic and the development of squamous cell carcinoma was recognised a century ago, and in the late 1940s an antineoplastic drug was shown to have carcinogenic properties. Of the various classes of antitumor drugs the alkylating agents, which so effectively damage DNA, might be expected to induce malignant change in a predictable fashion. Proving this suspicion conclusively and in a way that might usefully modify clinical practice has been a difficult and lengthy exercise. Plainly the problem is not substantial, for despite the widespread use of chemotherapy second cancers are rare (though this may partly reflect the limited survival of many of those treated). When second malignancies do occur the epidemiologist might reasonably argue that these may be spontaneous in patients with an increased tendency to malignant change. Both features might be expected to be more apparent in patients whose survival is increased. At present measurement of the risk of malignancy induced by treatment depends on the relation between the observed number of cases and those which might be expected for the population studied. Identifying this denominator is a weak link in the calculation but one that may be strengthened by comparing different types of populations theoretically at risk.

Exposure to radiation might be regarded as the benchmark for comparison. The Japanese populations exposed to whole body irradiation from the atomic bombs showed an increase in acute non-lymphoblastic leukaemia after some years and in solid tumours after a much longer latent period. For this type of exposure a dose relation may be identified, whereas that resulting from high dose fractionated irradiation is much more haphazard. The relation between exposure to radiation and the induction of cancer is highly complex, so that comparisons with exposure to radiation may not be appropriate or helpful in understanding the risks of leukaemia induced by chemotherapy. The mechanism of induction of malignant change is almost certainly unrelated to immunosuppression even though the incidence of some types of malignant tumours does increase in patients who are immunosuppressed (by whatever means).

Acute non-lymphoblastic leukaemia features only rarely among the resulting tumours. Retrospective analyses of patients with cancer who have received different permutations of treatments indicate that in some groups the incidence of acute non-lymphoblastic leukaemia seems to be increased above that expected. The problems of relating this to treatment should not be underestimated, but a certain consistency in outcome is apparent among the surveys from different centres. An increased incidence (observed over expected) has been seen in patients...