Sex-Dependent Differences in Cytochrome P450 3A Activity as Assessed by Midazolam Disposition in Humans: A Meta-Analysis

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Received November 20, 2009; accepted February 17, 2010

ABSTRACT:

Controversy exists concerning the sex-dependent differences in cytochrome P450 3A activity in humans. Meta-analysis of selected studies may address this question. Meta-analysis was performed on published or unpublished data in terms of sex-dependent differences in midazolam (MDZ) disposition in humans. The following pharmacokinetic parameters were included for the analysis: MDZ oral and systemic clearance, area under the concentration-time curve of oral and intravenous MDZ, oral bioavailability (F), and MDZ gastrointestinal extraction (Eg). Ten studies including 409 healthy volunteers were identified. Women exhibited 16% higher weight-corrected MDZ oral clearance (P < 0.001) and 20% higher systemic clearance (P = 0.002) than men. No significant difference in the AUC after oral dosing of MDZ was noted between sexes. Women showed lower AUC of intravenous MDZ than men (P = 0.02). No sex-dependent differences were observed in F and Eg. In conclusion, women showed significantly greater hepatic CYP3A activity than men, whereas no sex-dependent difference in intestinal CYP3A activity was observed.

The enzyme subfamily cytochrome P450 3A and its two major members—CYP3A4 and, to a lesser extent, CYP3A5—are considered the most important drug-metabolizing enzymes by virtue of their high concentration, strategic localization, and wide substrate specificity (Thummel and Wilkinson, 1998). Midazolam (MDZ) is a selective substrate of CYP3A4 and CYP3A5 and is almost exclusively metabolized by CYP3A to form the primary metabolite 1-hydroxymidazolam. Systemic or apparent oral clearance of MDZ is the most widely tested and accepted biomarker for hepatic and intestinal CYP3A activity (Streetman et al., 2000). Intravenous administration of MDZ reflects only hepatic CYP3A activity, whereas orally administered MDZ is a measure of intestinal and hepatic CYP3A activities (Thummel et al., 1996; Gorski et al., 1998; Streetman et al., 2000).

Numerous studies have examined potential sex differences in the metabolic activity of CYP3A. These studies include prospective clinical studies and retrospective analysis of data from previous studies. The findings from clinical studies have been inconsistent or inconclusive. For example, mean MDZ clearances were greater in women in several investigations, reaching statistical significance in some (Greenblatt et al., 1984; Gorski et al., 1998, 1999; Zhu et al., 2003; Chen et al., 2006b; Miao et al., 2009). Miao et al. (2009) concluded that women exhibited 19% higher weight-corrected systemic clearance and 38% higher oral clearance than men (P < 0.05). This study reviewed the data from seven clinical studies, which were previously conducted by their research team, but only included subjects whose DNA samples were available. In addition, this study included a study conducted exclusively on women (without male volunteers) (Gorski et al., 2000). The oral clearance data of this study were surprisingly higher than those of other included studies. As a result, the retrospective study by Miao et al. (2009) is at a higher risk of bias compared with that for a prospective study. In the other retrospective study, Chen et al. (2006b) found that women exhibited 11% higher mean weight-corrected MDZ systemic clearance and 28% higher oral clearance than men (P ≤ 0.01). The authors of this retrospective study concluded that women showed significantly greater mean hepatic and intestinal CYP3A activity than men. However, many studies did not find a sex-dependent difference in MDZ oral bioavailability (Thummel et al., 1996; Gorski et al., 1998, 2003; Kharasch et al., 2007). As a result, further studies are needed to address the question of whether sex-dependent differences exist in the intestine.

ABBREVIATIONS: MDZ, midazolam; OM, AIC, area under the curve; F, MDZ oral bioavailability; Eg, gastrointestinal extraction; WMD, weighted mean difference; SMD, standardized mean difference; 95% CI, 95% confidence intervals; CLpo, weight-corrected midazolam oral clearance; CLiv, weight-corrected MDZ systemic clearance; AUCpo, AUC of oral MDZ; AUCiv, area under the concentration-time curve of intravenous MDZ.
In this meta-analysis, we quantitatively summarized the sex-dependent differences in CYP3A activity as assessed by MDZ disposition in humans. We also attempted to address the question of whether sex-dependent differences exist in the intestine.

Materials and Methods

Search Strategy. The electronic databases Ovid, Medline, PubMed, Embase, and The Cochrane Library 2009 (Issue 3) were searched from 1980 until September 2009. The search terms were midazolam, CYP3A, and sex (or gender). Two reviewers (W. Jia and Y.-S.Z.) screened reference lists from all articles and reviews retrieved to identify additional studies. Studies included were hand-searched to identify those that fitted the selection criteria. We independently assessed these articles based on the inclusion criteria. Data derived from abstracts were also used. Any discrepancies about inclusion between the two researchers were resolved through consensus.

Inclusion Criteria. Studies were included if they were clinical trials from which the data of sex-dependent differences in MDZ disposition could be obtained. Studies were excluded if the study design showed different recruiting criteria for women and men, unless the difference in recruiting criterion was judged to have no influence on the outcome. Excluded subjects include patients or healthy volunteers who were taking medications known to affect CYP3A activity before study enrollment. Studies conducted on elderly volunteers were included because there was no significant difference in CYP3A activity between young and old populations (Klotz, 2009).

According to the retrospective studies by Miao et al. (2009) and Chen et al. (2006b), the sex difference in MDZ clearance ranged from 11 to 38%. Many relevant studies on this topic used a small sample size. To assure enough subjects to be included in our meta-analysis, we chose a conservative threshold (40% sex difference) for the estimation of sample size. Furthermore, this conservative threshold reduces the possibility of excluding small-sized studies of good methodology quality (potentially confounding factors were equally distributed between sexes). With use of MDZ clearance data (Sharable et al., 2005), sample sizes needed to detect a 40% difference in MDZ clearance between sexes were eight women and eight men ($\alpha = 0.05, \beta = 0.2$). As a result, we decided to exclude studies that enrolled fewer than seven women and seven men. In fact, many meta-analyses also included studies with small sample sizes. For example, Liu et al. (2009) excluded studies with fewer than 10 participants from their meta-analysis. Gilbert et al. (2004) excluded studies with fewer than 150 participants. Neither study explained why the threshold was chosen.

Retrospective analyses were also included if most of the single clinical studies included in these analyses met the inclusion criteria established above. In a retrospective study by Miao et al. (2009), three of the seven clinical studies failed to meet the inclusion criteria (insufficient sample size). In addition, as mentioned in the Introduction, this study had several drawbacks for the study of sex differences in CYP3A. As a result, the data from this study were excluded from the meta-analysis. With regard to the retrospective study by Chen et al. (2006b), most of the clinical studies included were eligible (nine studies eligible, three ineligible because of inadequate sample size, and one study unknown). Mean data from this study was used for the meta-analysis because of the difficulty in obtaining raw data from each of the clinical studies.

It should be pointed out that three eligible clinical studies did not find a significant sex-dependent difference in MDZ clearance (MDZ clearance was not weight-corrected in two of the studies). However, mean and S.D. data on MDZ clearance for women or men were not provided in the articles (Dresser et al., 2003; Floyd et al., 2003; Eap et al., 2004). Unfortunately, we failed to obtain the raw data from the original investigators, so these studies are not presented here. There was a study conducted on a large number of healthy young volunteers (104 women and 98 men) (Zhu et al., 2003). However, only the plasma 1-hydroxymidazolam (OM) versus MDZ ratio, a suboptimal index for CYP3A activity, was available. This study was not included in the meta-analysis, but we qualitatively assess the data under Results.

Data Extraction and Analysis. Meta-analysis was performed on published data and on an unpublished study by our group. Discrepancies about data extraction were resolved by consensus of all authors. The following pharmacokinetic information was gathered in duplicate using a standardized format from all relevant studies: 1) number of female and male volunteers and 2) weighted-corrected MDZ oral and systemic clearance, AUC of intravenous and oral MDZ, MDZ oral bioavailability ($F$), and MDZ gastrointestinal extraction ($E_G$) in women and men (mean ± S.D.). S.E. or confidence intervals were transformed to S.D. MDZ clearance data were converted to the units of liters per hour per kilogram. The mean and S.D. data obtained from young and elderly subjects were combined by the formula suggested in the Cochrane Handbook for Systematic Reviews of Interventions, version 5.0.2 (http://www.mrc-bsu.cam.ac.uk/cochrane/handbook/chapter_7/table_7_7_a_formulae_for_combining_groups.htm). Whenever possible, $E_G$ was calculated as $1 - F_G$ or $1 - F_{GI}$, where $F_G$ is gastrointestinal availability and $F_{GI}$ is hepatic availability. AUC values were reported as medians and ranges instead of means and S.D.s in one study (Chen et al., 2006b); we imputed the means and S.D.s as described by Hozo et al. (2005).

Statistical heterogeneity among studies was evaluated using the $\chi^2$ test, $P$ values, and $I^2$ statistics (Higgins and Thompson, 2002). We considered both the presence of significant heterogeneity at the 10% level of significance and values of $P$ exceeding 56% as an indicator of significant heterogeneity. In addition, we assessed the probability of publication bias with funnel plots and the Egger test if more than five studies were included. When we found significant heterogeneity, we calculated weighted mean difference (WMD), standardized mean difference (SMD), and 95% confidence interval (95% CI) with a random-effects model meta-analysis, which assumes that the true underlying effect varies among studies. If significant heterogeneity was not found, we used a fixed-effects model to pool data. WMD measures the absolute difference between the mean value in two groups in a clinical trial. SMD measures absolute difference between the mean value in two groups relative to the S.D. observed among participants in that study. We also conducted a sensitivity analysis in which one or two studies were removed, and the rest were analyzed to evaluate whether there was a statistically significant effect on the results. A two-sided test was used, and $P < 0.05$ was considered significant. Analyses were done with Review Manager 5.0.21 (The Cochrane Collaboration, Oxford, UK). Funnel plots and the Egger test were done with Stata (version 10.1; StataCorp, College Station, TX).

Results

Study Characteristics and Methodological Quality. Twenty-seven potentially relevant studies were evaluated (Fig. 1 shows the numbers of studies evaluated at each stage). Nine clinical trials including 291 healthy volunteers and one retrospective study including 118 healthy volunteers were identified. Table 1 shows characteristics of the studies. Two of the clinical studies included were conducted in our own laboratory (Hu et al., 2009) (Z.-Y. Hu, Q. Yu, and Z.-N. Cheng, unpublished data). The study protocol of the unpublished study conformed to the ethical guidelines of the Declaration of Helsinki of 1975 (as revised in 1983) and was approved by the ethics committee of the School of Pharmaceutical Sciences, Central South University.

Records identified through database searching (n = 27) supplementary search

Records excluded (n = 6) Volunteers were patients (n = 2)

Small sample size (n = 4)

Full-text articles (if available) assessed for eligibility (n = 21)

Full-text articles or abstract included (n = 13)

Studies presented in this report (n = 10)

Full-text articles or abstract included (n = 13)

Studies not presented (n = 3)

Means and SDs can not be obtained (n = 3)

FIG. 1. Studies evaluated at each stage of the meta-analysis. * supplementary search included reference lists and contacting authors.
University. All subjects provided written informed consent before study procedures. Details of the unpublished study are provided as supplemental data.

In one included study (Kharasch et al., 2007), subjects were CYP3A5-genotyped before enrollment in the dosing phase of the investigation to ensure that there were enough subjects carrying at least one CYP3A5*1 allele. However, this study design may not affect the outcome of sex-dependent differences in MDZ clearance because the CYP3A5 genotype had no effect on the oral or systemic clearance of MDZ (Kharasch et al., 2007). In addition, gender is balanced between CYP3A5*1 carriers and noncarriers (Kharasch et al., 2007). A few female volunteers in two of the studies were taking oral contraceptives (Gorski et al., 1998, 2003). However, the original investigators previously demonstrated that oral contraceptives did not alter oral or systemic disposition of MDZ (Belle et al., 2002).

Most of the studies included were crossover or fixed-order design (Table 1). Among these studies, seven of the studies also investigated the effect of CYP3A inhibitors (clarithromycin, ketoconazole, and fluvoxamine) or an inducer (rifampin) on MDZ disposition. The studies by Chen et al. (2006a,c) were already included in the retrospective study (Chen et al., 2006b). As a result, both studies were excluded from our meta-analysis.

There was no evidence of publication bias from either the funnel plot (refer to Supplemental Fig. S1) or Egger test (Table 2). The meta-analysis is summarized in Table 2.

**MDZ Oral Clearance.** MDZ oral clearance was provided in seven published studies (Thummel et al., 1996; Gorski et al., 1998, 1999, 2003; Chen et al., 2006b; Kharasch et al., 2007; Hu et al., 2009) and an unpublished study (Z.-Y. Hu, Q. Yu, and Z.-N. Cheng, unpublished data) that enrolled 307 healthy volunteers. The meta-analysis showed significantly higher MDZ oral clearance in women than in men [WMD 0.20 (95% CI 0.11–0.28) l/h/kg; P < 0.001] (Fig. 2). Heterogeneity was not significant among these studies (I² = 41%, P = 0.10), so a fixed-effects model was used.

There was no change in result [WMD 0.26 (95% CI 0.13–0.38) l/h/kg; P < 0.001] if we excluded the study by Chen et al. (2006b) (retrospective study, weight = 57.7%) from the meta-analysis. The heterogeneity completely disappeared after the study of Kharasch et al. (2007) was excluded from the analysis (I² = 3%, P = 0.40). In this study, 25% of the volunteers were black (African Americans), and subjects were recruited based on CYP3A5 genotype (Kharasch et al., 2007). The overall effect was constant if this study was excluded [WMD 0.18 (95% CI 0.09–0.26) l/h/kg; P < 0.001], which demonstrated the reliability of the result.

**MDZ Systemic Clearance.** Seven studies including 309 healthy volunteers were included for analysis (Greenblatt et al., 1984; Thummel et al., 1996; Gorski et al., 1998, 1999, 2003; Chen et al., 2006b; Kharasch et al., 2007). There was significant heterogeneity (I² = 72%; P = 0.002) among these studies, and they was combined using a random-effects model. Pooling data from these studies showed significantly higher MDZ systemic clearance in women than in men [WMD 0.08 (95% CI 0.03–0.13) l/h/kg; P = 0.002] (Fig. 2).

There was no change in the result when a fixed-effects model was used [WMD 0.08 (95% CI 0.05–0.10) l/h/kg; P < 0.001]. This observed heterogeneity was greatly reduced after exclusion of the studies by Kharasch et al. (2007) and Gorski et al. (1999) (I² = 40%; P = 0.16). It should be pointed out that the study by Gorski et al. (1999) was conducted on elderly volunteers (published as an abstract), and the subjects in the study by Kharasch et al. (2007) was chosen based on CYP3A genotype. Exclusion of both studies from the meta-analysis did not cause an obvious change in the result [WMD 0.05 (95% CI 0.02–0.08) l/h/kg; P = 0.001]. No significant difference in
the result was seen if we analyzed the studies using intravenous bolus and intravenous infusion separately (data not shown).

**Extent of Sex-Dependent Differences in Terms of MDZ Oral and Systemic Clearance.** In the current meta-analysis, women exhibited 0.08 l/h/kg higher MDZ systemic clearance and 0.2 l/h/kg higher oral clearance than men \( (P \leq 0.001) \). MDZ oral clearance was approximately 3-fold higher than systemic clearance \( (\text{mean } CL_{po} = 1.26 \text{ l/h/kg and mean } CL_{iv} = 0.40 \text{ l/h/kg, weighted by the sample size of each study}) \). The extent of the sex-dependent difference in MDZ oral clearance was comparable to that of MDZ systemic clearance \( (16 \text{ versus } 20\%) \). However, the studies included in the meta-analysis of MDZ oral clearance were not necessarily included in the analysis of MDZ systemic clearance and vice versa. There were six studies \( (\text{Thummel et al., } 1996; \text{Gorski et al., } 1998, 1999, 2003; \text{Chen et al., } 2006b; \text{Kharasch et al., } 2007) \) in common for the analysis of MDZ oral and systemic clearance. We did a further meta-analysis of these studies that had both oral and systemic clearance to demonstrate the reliability of the above-mentioned result. We still found that women exhibited significantly higher MDZ oral clearance \( [\text{WMD } 0.29 \text{ (95\% CI } 0.15–0.40) \text{ l/h/kg}] \) and systemic clearance \( [\text{WMD } 0.08 \text{ (95\% CI } 0.02–0.13) \text{ l/h/kg}] \). With respect to the comparison of the extent of the sex-dependent differences, no obvious change in the result was seen \( (23 \text{ versus } 20\%) \).

**AUC of Oral MDZ.** Eight studies including an unpublished study \( (\text{Z.-Y. Hu, Q. Yu, and Z.-N. Cheng}) \) with a total of 307 healthy volunteers provided AUC in women and men \( (\text{Thummel et al., } 1996; \text{Gorski et al., } 1998, 1999, 2003; \text{Chen et al., } 2006b; \text{Kharasch et al., } 2007; \text{Quinney et al., } 2008) \). Although a suboptimal index for CYP3A activity was used, the result of this study could serve as indirect evidence to support the conclusion that women exhibit higher hepatic or intestinal CYP3A activity than men.

**Discussion**

This study has several potential limitations. First, the possibility of publication and selection biases cannot be completely excluded because we were unable to obtain data from three eligible studies. To assess the influence of these three studies on our results, we attempted to include these studies in our meta-analysis with the assumed data. None of the three studies found a significant sex difference in MDZ clearance, and only combined MDZ clearance data were provided. Hence, we assumed the MDZ clearance to be the same in women and men. If weight-corrected MDZ clearance was not available, we calculated it based on the assumed weight of women and men. Inclusion of these studies did not change the result of our meta-analysis. The extent of sex-dependent differences in oral and systemic clearance was 14 and 17\%, respectively. In the present meta-analysis, there was no evidence of publication bias from either the funnel plot or the Egger test. As a caution, we also calculated the “fail-safe N” to assess the potential for publication bias to have influenced the results of our meta-analysis. Fail-safe N can be defined as the number of new, unpublished, or unretrieved nonsignificant studies that would be required to exist to lower the significance of a meta-analysis to nonsignificant \( (\text{Rosenthal, } 1979; \text{Rosenberg, } 2005) \). The fail-safe N was 58 and 89 \( (0.05 \text{ significance level}) \) for sex difference in MDZ oral clearance and systemic clearance, respectively. The existence of many unpublished studies is improbable, so the results of our meta-analysis were robust. Second, there was significant heterogeneity among the studies analyzed, probably caused by differences in study population, race/ethnicity, dose administered, dosing regimen, and dosage formulation. It should also be pointed out that detection of sex differences was not the major aim in several included studies. Third, retrospective mean data of 13 independent clinical studies were in-

### TABLE 2

<table>
<thead>
<tr>
<th>Pharmacokinetic Parameters</th>
<th>No. of Studies</th>
<th>No. of Participants (No. of Women)</th>
<th>Statistical Method</th>
<th>Effect Size</th>
<th>Test for Heterogeneity</th>
<th>Egger Test: P</th>
<th>N.E.</th>
</tr>
</thead>
<tbody>
<tr>
<td>( CL_{po} )</td>
<td>8</td>
<td>307 (148)</td>
<td>WMD (fixed), 95% CI</td>
<td>0.20 (0.11 to 0.28)</td>
<td>&lt;0.001*</td>
<td>11.89</td>
<td>0.10</td>
</tr>
<tr>
<td>( CL_{iv} )</td>
<td>7</td>
<td>309 (153)</td>
<td>WMD (random), 95% CI</td>
<td>0.08 (0.03 to 0.13)</td>
<td>0.002*</td>
<td>21.32</td>
<td>0.002</td>
</tr>
<tr>
<td>( AUC_{po} )</td>
<td>8</td>
<td>307 (148)</td>
<td>SMD (fixed), 95% CI</td>
<td>−0.05 (−0.28 to 0.17)</td>
<td>0.64</td>
<td>7.33</td>
<td>0.40</td>
</tr>
<tr>
<td>( AUC_{iv} )</td>
<td>6</td>
<td>269 (132)</td>
<td>SMD (fixed), 95% CI</td>
<td>−0.29 (−0.53 to −0.04)</td>
<td>0.02†</td>
<td>8.33</td>
<td>0.14</td>
</tr>
<tr>
<td>( F )</td>
<td>6</td>
<td>243 (116)</td>
<td>WMD (fixed), 95% CI</td>
<td>−0.01 (−0.03 to 0.02)</td>
<td>0.63</td>
<td>7.95</td>
<td>0.16</td>
</tr>
<tr>
<td>( E_{Gi} )</td>
<td>5</td>
<td>203 (95)</td>
<td>WMD (random), 95% CI</td>
<td>−0.06 (−0.15 to 0.04)</td>
<td>0.25</td>
<td>9.33</td>
<td>0.05</td>
</tr>
</tbody>
</table>

N.E.: Egger test was not done if fewer than six studies were included.
† Significantly higher in women at 0.01 level of significance.
†† Significantly higher in men at 0.05 level of significance.
included in the meta-analysis because of the difficulties in obtaining raw data for each of the clinical studies (Chen et al., 2006b).

A retrospective analysis of the 13 clinical studies showed that women exhibited 11% higher mean weight-corrected MDZ systemic clearance and 28% higher oral clearance than men ($P \leq 0.01$) (Chen et al., 2006b). More recently, results of the largest-scale clinical

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studies (41 women and 58 men) showed that systemic clearances were 30% greater in women, but there was no sex difference for oral MDZ (Kharasch et al., 2007). Both vivo studies showed that the extent of sex-dependent differences in MDZ oral clearance was much different from that in systemic clearance, suggesting that sex differences in MDZ F may exist. However, a meta-analysis of pooled data from six studies (Greenblatt et al., 1984; Thummel et al., 1996; Gorski et al., 1998, 2003; Kharasch et al., 2007; Quinney et al., 2008) showed no sex difference in either MDZ F (P = 0.63) or MDZ E (P = 0.25). As a result, the extent of sex-dependent differences in MDZ oral clearance should actually be comparable to that in MDZ systemic clearance. It was not surprising that we did observe a comparable extent of sex-dependent differences in MDZ oral and systemic clearance (COPO = 16% and CLPO = 20%). Because MDZ was not considered to be a P-glycoprotein substrate, any sex difference in oral and systemic clearances is unlikely to be explained by this transporter (Kharasch et al., 2007). Thummel et al. (1996) found that there was a significant contribution by the intestine to the overall first-pass elimination of oral MDZ. Based on this evidence, we can conclude that women have higher hepatic CYP3A activity than men, whereas no sex-dependent difference existed in intestine. This conclusion was supported by the in vitro studies conducted on a large number of samples. For example, higher hepatocyte CYP3A4 activity (Parkinson et al., 2004), higher CYP3A4 hepatic content, and CYP3A4 mRNA have been reported in white women (n = 46) compared with white men (n = 48) (Wolbold et al., 2003). In contrast, Payne et al. (2005) found a lack of a sex-dependent difference in expression levels of intestinal CYP3A (45 women and 46 men).

In the present study, no sex-dependent difference was noted in MDZ AUCpo (P = 0.85). However, AUCiv was lower in women than in men (P = 0.02). The observed difference, although statistically significant, was moderate. This suggests that sex differences in MDZ exposure may not be important.

If we stratified the included studies into subgroups representing different races, no ethnic difference was observed. For example, pooled data from Asians showed significantly higher MDZ oral clearance in women than in men [WMD 0.22 (95% CI 0.08 – 0.37) l/h/kg; P = 0.003]. Similar results were observed in whites and other races [WMD 0.18 (95% CI 0.09 – 0.28) l/h/kg; P < 0.001]. This result was reasonable because the pharmacokinetics of MDZ is similar in white subjects and East Asians after weight correction (Tateishi et al., 2001).

To assure that only the studies with good-quality data were included in our study, we excluded one retrospective study (Miao et al., 2009) and four clinical studies with small sample sizes (Lown et al., 1995; Tsunoda et al., 1999; He et al., 2005; Rocha et al., 2008). Therefore, MDZ is not adjusted based on body size or sex, with women and men receiving the same medication doses per clinical guidelines for the condition. If a fixed absolute dose were administered to men and women, the 20% higher weight-normalized clearance in women would be offset by their lower average body weight. Under this circumstance, the exposure of medications was expected to be similar in women and men. However, in clinical practice, the doses of some medications are adjusted based on body size (e.g., alfentanil). Considering the lower average body weight of women, women are often given lower doses of such medications than men. Therefore, women may be underdosed, suggesting that the dosing regimen should be adjusted accordingly (e.g., increase doses or shorten dosing interval). The goal of clinical pharmacology is to assure that the right dose of the right drug is administered to the patient. Accomplishing this goal will require that sex-specific medication-prescribing information be incorporated into clinical therapeutics.

Considering the conclusive finding of this study, we believe that there may be no need for further studies to test whether there is a sex difference in MDZ systemic clearance.
difference in CYP3A activity. However, there is a need for studies that focus on the underlying mechanism of sex difference in CYP3A and also on the effect of this sex difference on clinical outcome.

In conclusion, women showed significantly greater hepatic CYP3A activity than men, whereas no sex-dependent difference in intestinal CYP3A activity was observed. To our knowledge, this sex-based study is the most comprehensive analysis that has examined CYP3A activity by use of MDZ as a probe. Although a sex-dependent difference in CYP3A activity was statistically significant, this may or may not translate into differences in pharmacodynamics or clinical outcome (Chen, 2005).

Acknowledgments. We kindly acknowledge Wei Jia for screening relevant articles from reference lists and Dai-Li Xi for valuable comments and suggestions regarding this article.

References


