among patients treated with deferasirox. Of note, the study population included primarily patients with active malignancy, and few patients in the study had diabetes mellitus as their only risk factor. Deferasirox is therefore contraindicated as therapy in patients with active malignancy, but its role in patients who have diabetes mellitus without malignancy (the setting in which its preclinical efficacy was optimal) remains uncertain.

Posaconazole and isavuconazole are the only FDA-approved azoles with reliable in vitro activity against the Mucorales. However, there are limited data regarding the efficacy of posaconazole monotherapy for mucormycosis, and in contrast to polyene-echinocandin therapy, there are no data to support the use of combination posaconazole-polyene regimens. Although the minimal inhibitory concentrations of isavuconazole against the Mucorales are four- to eightfold higher than those of posaconazole, blood levels may be higher with standard isavuconazole dosing than with posaconazole. Isavuconazole is FDA approved for the treatment of mucormycosis on the basis of a small, historically controlled study. Given this limited data set, many experts continue to think that lipid polyenes are first-line options and that isavuconazole, like posaconazole, is best reserved for oral stepdown therapy in patients whose condition has substantially improved on polyene-based therapy or for salvage therapy in patients who are intolerant of polyene-based regimens or whose infection is refractory to these regimens. As with posaconazole, no data support the use of combination isavuconazole-polyene regimens in lieu of polyene monotherapy or polyene-echinocandin combination regimens. Some experts use triple therapy with a polyene, echinocandin, and either posaconazole or isavuconazole for patients who have extensive disease or whose disease has progressed on prior therapy. Empirical, dual lipid polyene–azole therapy is a rational choice in a patient with likely invasive mold infections when septate molds and mucormycosis are both in the differential diagnosis and the etiologic agent has not yet been confirmed. Alternatively, initial therapy with isavuconazole monotherapy may be reasonable for a brief period of time in a stable patient if mucormycosis is felt to be possible, but less likely than a septated mold infection.