1. Name of the medicinal product
KADNAT Suspension 125mg/5ml
2. Qualitative and quantitative composition
Cefuroxime 125mg/5ml (as 300 mg Cefuroxime axetil)
3. Pharmaceutical form
Granules for constitution with water to form a suspension for oral administration.
4. Clinical particulars
4.1 Therapeutic indications
KADNAT is indicated for the treatment of the infections listed below in adults and children from the age of 3 months (see sections 4.4 and 5.).
• Acute streptococcal tonsillitis and pharyngitis.
• Acute bacterial sinusitis.
• Acute otitis media.
• Acute exacerbations of chronic bronchitis.
• Cystitis.
• Pyelonephritis.
• Uncomplicated skin and soft tissue infections.
• Treatment of early Lyme disease.
Consideration should be given to official guidance on the appropriate use of antibacterial agents.
4.2 Posology and method of administration
Posology
The usual course of therapy is seven days (may range from five to ten days).
Table 1. Adults and children (≥40 kg)
Indication Dosage
Acute tonsillitis and pharyngitis, acute bacterial sinusitis 250 mg twice daily
Acute otitis media 500 mg twice daily
Acute exacerbations of chronic bronchitis 500 mg twice daily
Cystitis 250 mg twice daily
Pyelonephritis 250 mg twice daily
Uncomplicated skin and soft tissue infections 250 mg twice daily
Lyme disease 500 mg twice daily for 14 days (range of 10 to 21 days)
Table 2. Children (<40 kg)
Indication Dosage
Acute tonsillitis and pharyngitis, acute bacterial sinusitis 10 mg/kg twice daily to a maximum of 125 mg twice daily
Children aged two years or older with otitis media or, where appropriate, with more severe infections 15 mg/kg twice daily to a maximum of 250 mg twice daily
Cystitis 15 mg/kg twice daily to a maximum of 250 mg twice daily
Pyelonephritis 15 mg/kg twice daily to a maximum of 250 mg twice daily for 10 to 14 days
Uncomplicated skin and soft tissue infections 15 mg/kg twice daily to a maximum of 250 mg twice daily
Lyme disease 15 mg/kg twice daily to a maximum of 250 mg twice daily for 14 days (10 to 21 days)
There is no experience of using KADNAT in children under the age of 3 months.
Cefuroxime axetil tablets and cefuroxime axetil granules for oral suspension are not bioequivalent and are not substitutable on a milligram-per milligram basis (see section 5.2).
In infants (from the age of 3 months) and children with a body mass of less than 40 kg, it may be preferable to adjust dosage according to weight or age. The dose in infants and children 3 months to 18 years is 10 mg/kg twice daily for most infections, to a maximum of 250 mg daily. In otitis media or more severe infections the recommended dose is 15 mg/kg twice daily to a maximum of 500 mg daily.

The following two tables, divided by age group, serve as a guideline for simplified administration, e.g measuring spoon (5 ml), for the 125 mg/5 ml or the 250 mg/5 ml suspension if provided.

Table 3. 10 mg/kg dosage for most infections

Age	Dose (mg) twice daily		Volume per dose (ml) No. of sachets per dose	
	125 mg	250 mg	125 mg	250 mg
3 to 6 months	40 to 60		2.5	- - -
6 months to 2 years	60 to 120		2.5 to 5	- - -
2 to 18 years	125	5	2.5	1 -

Table 4. 15 mg/kg dosage for otitis media and more serious infections

Age	Dose (mg) twice daily		Volume per dose (ml) No. of sachets per dose	
	125 mg	250 mg	125 mg	250 mg
3 to 6 months	60 to 90		2.5	- - -
6 months to 2 years	90 to 180	5 to 7.5	2.5	1 (125 mg) -
2 to 18 years	180 to 250	7.5 to 10	2.5 to 5	2 (250 mg) 1 (250 mg)

Renal impairment

The safety and efficacy of cefuroxime axetil in patients with renal failure have not been established. Cefuroxime is primarily excreted by the kidneys. In patients with markedly impaired renal function it is recommended that the dosage of cefuroxime should be reduced to compensate for its slower excretion. Cefuroxime is effectively removed by dialysis.

Table 5. Recommended doses for KADNAT in renal impairment

Creatinine clearance	$T_{1/2}$ (hrs)	Recommended dosage
≥30 ml/min/1.73 m_2	1.4–2.4	no dose adjustment necessary standard dose of 125 mg to 500 mg given twice daily
10-29 ml/min/1.73 m_2	4.6	standard individual dose given every 24 hours
<10 ml/min/1.73 m_2	16.8	standard individual dose given every 48 hours
During haemodialysis	2–4	a single additional standard individual dose should be given at the end of each dialysis

Hepatic impairment

There are no data available for patients with hepatic impairment. Since cefuroxime is primarily eliminated by the kidney, the presence of hepatic dysfunction is expected to have no effect on the pharmacokinetics of cefuroxime.

Method of administration

Oral use

For optimal absorption cefuroxime axetil suspension should be taken with food.

For instructions on reconstitution of the medicinal product before administration, see section 6.6.

Depending on the dosage, there are other presentations available.

4.3 Contraindications

Hypersensitivity to cefuroxime or to any of the excipients listed in section 6.1.

Patients with known hypersensitivity to cephalosporin antibiotics.

History of severe hypersensitivity (e.g. anaphylactic reaction) to any other type of betalactam antibacterial agent (penicillins, monobactams and carbapenems).

4.4 Special warnings and precautions for use

Hypersensitivity reactions

Special care is indicated in patients who have experienced an allergic reaction to penicillins or other beta-lactam antibiotics because there is a risk of cross-sensitivity. As with all beta-lactam antibacterial agents, serious and occasionally fatal hypersensitivity reactions have been reported. In case of severe hypersensitivity reactions, treatment with cefuroxime must be discontinued immediately and adequate emergency measures must be initiated.

Before beginning treatment, it should be established whether the patient has a history of severe

hypersensitivity reactions to cefuroxime, to other cephalosporins or to any other type of beta-lactam agent. Caution should be used if cefuroxime is given to patients with a history of non-severe hypersensitivity to other beta-lactam agents.

Jarisch-Herxheimer reaction

The Jarisch-Herxheimer reaction has been seen following cefuroxime axetil treatment of Lyme disease. It results directly from the bactericidal activity of cefuroxime axetil on the causative bacteria of Lyme disease, the spirochaete Borrelia burgdorferi. Patients should be reassured that this is a common and usually self-limiting consequence of antibiotic treatment of Lyme disease (see section 4.8).

Overgrowth of non-susceptible microorganisms

As with other antibiotics, use of cefuroxime axetil may result in the overgrowth of Candida. Prolonged use may also result in the overgrowth of other non-susceptible microorganisms (e.g. enterococci and Clostridium difficile), which may require interruption of treatment (see section 4.8).

Antibacterial agent–associated pseudomembranous colitis have been reported with nearly all antibacterial agents, including cefuroxime and may range in severity from mild to life threatening. This diagnosis should be considered in patients with diarrhoea during or subsequent to the administration of cefuroxime (see section 4.8). Discontinuation of therapy with cefuroxime and the administration of specific treatment for Clostridium difficile should be considered. Medicinal products that inhibit peristalsis should not be given (see section 4.8).

Interference with diagnostic tests

The development of a positive Coomb's Test associated with the use of cefuroxime may interfere with cross matching of blood (see section 4.8).

As a false negative result may occur in the ferricyanide test, it is recommended that either the glucose oxidase or hexokinase methods are used to determine blood/plasma glucose levels in patients receiving cefuroxime axetil.

Important information about excipients

The sucrose content of cefuroxime axetil suspension and granules should be taken into account when treating diabetic patients and appropriate advice provided.

125mg/5ml granules for oral suspension:

Contains 1.2 g of sucrose per 5 ml dose

Cefuroxime axetil suspension contains aspartame, which is a source of phenylalanine and so should be used with caution in patients with phenylketonuria.

4.5 Interaction with other medicinal products and other forms of interaction

Drugs which reduce gastric acidity may result in a lower bioavailability of cefuroxime axetil compared with that of the fasting state and tend to cancel the effect of enhanced absorption after food.

Cefuroxime axetil may affect the gut flora, leading to lower oestrogen reabsorption and reduced efficacy of combined oral contraceptives.

Cefuroxime is excreted by glomerular filtration and tubular secretion. Concomitant use of probenicid is not recommended. Concurrent administration of probenecid significantly increases the peak concentration, area under the serum concentration time curve and elimination half-life of cefuroxime.

Concomitant use with oral anticoagulants may give rise to increased INR.

4.6 Fertility, pregnancy and lactation

Pregnancy

There are limited data from the use of cefuroxime in pregnant women. Studies in animals have shown no harmful effects on pregnancy, embryonal or foetal development, parturition or postnatal development. KADNAT should be prescribed to pregnant women only if the benefit outweighs the risk.

Breastfeeding

Cefuroxime is excreted in human milk in small quantities. Adverse effects at therapeutic doses are not expected, although a risk of diarrhoea and fungus infection of the mucous membranes cannot be excluded. Breastfeeding might have to be discontinued due to these effects. The possibility of sensitisation should be taken into account. Cefuroxime should only be used during breastfeeding after benefit/risk assessment by the physician in charge.

Fertility

There are no data on the effects of cefuroxime axetil on fertility in humans. Reproductive studies in animals have shown no effects on fertility.

4.7 Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been performed. However, as this medicine may cause dizziness, patients should be warned to be cautious when driving or operating machinery.

4.8 Undesirable effects

The most common adverse reactions are Candida overgrowth, eosinophilia, headache, dizziness, gastrointestinal disturbances and transient rise in liver enzymes.

The frequency categories assigned to the adverse reactions below are estimates, as for most reactions suitable data (for example from placebo controlled studies) for calculating incidence were not available. In addition the incidence of adverse reactions associated with cefuroxime axetil may vary according to the indication.

Data from large clinical studies were used to determine the frequency of very common to rare undesirable effects. The frequencies assigned to all other undesirable effects (i.e. those occurring at <1/10,000) were mainly determined using post-marketing data and refer to a reporting rate rather than true frequency. Placebo-controlled trial data were not available. Where incidences have been calculated from clinical trial data, these were based on drug related (investigator assessed) data. Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness.

Treatment related adverse reactions, all grades, are listed below by MedDRA body system organ class, frequency and grade of severity. The following convention has been utilised for the classification of frequency: very common ≥ 1/10; common ≥ 1/100 to < 1/10, uncommon ≥ 1/1,000 to < 1/100; rare ≥ 1/10,000 to < 1/1,000; very rare < 1/10,000 and not known (cannot be estimated from the available data).

System organ class	Common	Uncommon	Not known
Infections and infestations	Candida overgrowth	Clostridium difficile overgrowth	
Blood and lymphatic system disorders	eosinophilia positive Coomb's test,	thrombocytopenia, leukopenia (sometimes profound)	haemolytic anaemia
Immune system disorders		drug fever, serum sickness, anaphylaxis, Jarisch-Herxheimer reaction	
Nervous system disorders	headache, dizziness		
Gastrointestinal disorders	diarrhoea, nausea, abdominal pain	vomiting pseudomembranous colitis (see section 4.4)	

Hepatobiliary disorders
transient increases of hepatic enzyme levels
jaundice (predominantly cholestatic), hepatitis
Skin and subcutaneous tissue disorders
skin rashes urticaria, pruritus, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis (exanthematic necrolysis) (see Immune system disorders), angioneurotic oedema

Description of selected adverse reactions

Cephalosporins as a class tend to be absorbed onto the surface of red cells membranes and react with antibodies directed against the drug to produce a positive Coombs' test (which can interfere with cross-matching of blood) and very rarely haemolytic anaemia.

Transient rises in serum liver enzymes have been observed which are usually reversible.

Paediatric population

The safety profile for cefuroxime axetil in children is consistent with the profile in adults.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product.

4.9 Overdose

Overdose can lead to neurological sequelae including encephalopathy, convulsions and coma.

Symptoms of overdose can occur if the dose is not reduced appropriately in patients with renal impairment (see sections 4.2 and 4.4).

Serum levels of cefuroxime can be reduced by haemodialysis and peritoneal dialysis.

5. Pharmacological properties

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: antibacterials for systemic use, second-generation cephalosporins, ATC code: J01DC02

Mechanism of action

Cefuroxime axetil undergoes hydrolysis by esterase enzymes to the active antibiotic, cefuroxime.

Cefuroxime inhibits bacterial cell wall synthesis following attachment to penicillin binding proteins (PBPs). This results in the interruption of cell wall (peptidoglycan) biosynthesis, which leads to bacterial cell lysis and death.

Mechanism of resistance

Bacterial resistance to cefuroxime may be due to one or more of the following mechanisms:

• hydrolysis by beta-lactamases; including (but not limited to) by extended-spectrum beta-lactamases (ESBLs), and AmpC enzymes that may be induced or stably derepressed in certain aerobic Gram-negative bacteria species;

• reduced affinity of penicillin-binding proteins for cefuroxime;

• outer membrane impermeability, which restricts access of cefuroxime to penicillin binding proteins in Gram-negative bacteria;

• bacterial efflux pumps.

Organisms that have acquired resistance to other injectable cephalosporins are expected to be resistant to cefuroxime.

Depending on the mechanism of resistance, organisms with acquired resistance to penicillins may demonstrate reduced susceptibility or resistance to cefuroxime.

Cefuroxime axetil breakpoints

Minimum inhibitory concentration (MIC) breakpoints established by the European Committee on Antimicrobial Susceptibility Testing (EUCAST) are as follows:

Microorganism	Breakpoints (mg/L)	
	S	R
Enterobacteriaceae [1, 2]	≤8	>8
Staphylococcus spp.	Note[3]	Note[3]
Streptococcus A, B, C and G	Note[4]	Note[4]
Streptococcus pneumoniae	≤0.25	>0.5
Moraxella catarrhalis	≤0.125	>4
Haemophilus influenzae	≤0.125	>1
Non-species related breakpoints[1]	IE[5]	IE[5]

[1] The cephalosporin breakpoints for Enterobacteriaceae will detect all clinically important resistance mechanisms (including ESBL and plasmid mediated AmpC). Some strains that produce beta-lactamases are susceptible or intermediate to 3rd or 4th generation cephalosporins with these breakpoints and should be reported as found, i.e. the presence or absence of an ESBL does not in itself influence the categorization of susceptibility. In many areas, ESBL detection and characterization is recommended or mandatory for infection control purposes.

[2] Uncomplicated UTI (cystitis) only (see section 4.1).

[3] Susceptibility of staphylococci to cephalosporins is inferred from the methicillin susceptibility except for ceftazidme and cefixime and ceftibuten, which do not have breakpoints and should not be used for staphylococcal infections.

[4] The beta-lactam susceptability of beta-haemolytic streptococci groups A, B, C and G is inferred from the penicillin susceptibility.

[5] insufficient evidence that the species in question is a good target for therapy with the drug. An MIC with a comment but without an accompanying S or R-categorization may be reported.

S=susceptible, R=resistant

Microbiological susceptibility

The prevalence of acquired resistance may vary geographically and with time for selected species and local information on resistance is desirable, particularly when treating severe infections. As necessary, expert advice should be sought when the local prevalence of resistance is such that the utility of cefuroxime axetil in at least some types of infections is questionable.

Cefuroxime is usually active against the following microorganisms in vitro.

Gram-positive aerobes:
Staphylococcus aureus (methicillin susceptible)*
Coagulase negative staphylococcus (methicillin susceptible)
Streptococcus pyogenes
Streptococcus agalactiae
Commonly susceptible species
Gram-negative aerobes:
Haemophilus influenzae
Haemophilus parainfluenzae
Moraxella catarrhalis
Spirochaetes:
Borrelia burgdorferi
Microorganisms for which acquired resistance may be a problem
Gram-positive aerobes:
Streptococcus pneumoniae
Gram-negative aerobes: Citrobacter freundii Enterobacter aerogenes Enterobacter

cloacae Escherichia coli
Klebsiella pneumoniae
Proteus mirabilis
Proteus spp.(other than P. vulgaris)
Providencia spp.
Gram-positive anaerobes:
Peptostreptococcus spp.
Propionibacterium spp.
Gram-negative anaerobes:
Fusobacterium spp.
Bacteroides spp.
Inherently resistant microorganisms
Gram-positive aerobes:
Enterococcus faecalis Enterococcus
faecium
Gram-negative aerobes:
Acinetobacter spp.
Campylobacter spp.
Morganella morganii
Proteus vulgaris
Pseudomonas aeruginosa
Serratia marcescens
Gram-negative anaerobes:
Bacteroides fragilis
Others:
Chlamydia spp.
Mycoplasma
spp.
Legionella spp.

*All methicillin-resistant S. aureus are resistant to cefuroxime.

5.2 Pharmacokinetic properties

Absorption

After oral administration cefuroxime axetil is absorbed from the gastrointestinal tract and rapidly hydrolysed in the intestinal mucosa and blood to release cefuroxime into the circulation. Optimum absorption occurs when it is administered shortly after a meal.

Following administration of cefuroxime axetil tablets peak serum levels (2.1 mcg/ml for a 125 mg dose, 4.1 mcg/ml for a 250 mg dose, 7.0 mcg/ml for a 500 mg dose and 13.6 mcg/ml for a 1000 mg dose) occur approximately 2 to 3 hours after dosing when taken with food. The rate of absorption of cefuroxime from the suspension is reduced compared with the tablets, leading to later, lower peak serum levels and reduced systemic bioavailability (4 to 17% less). Cefuroxime axetil oral suspension was not bioequivalent to cefuroxime axetil tablets when tested in healthy adults and therefore is not substitutable on a milligram-per-milligram basis (see section 4.2).The pharmacokinetics of cefuroxime is linear over the oral dosage range of 125 to 1000 mg. No accumulation of cefuroxime occurred following repeat oral doses of 250 to 500 mg.

Distribution

Protein binding has been stated as 33 to 50% depending on the methodology used. Following a single dose of cefuroxime axetil 500 mg tablet to 12 healthy volunteers, the apparent volume of distribution was 50 L (CV%=28%). Concentrations of cefuroxime in excess of the minimum inhibitory levels for common pathogens can be achieved in the tonsilla, sinus tissues, bronchial mucosa, bone, pleural fluid, joint fluid, synovial fluid, interstitial fluid, bile, sputum and aqueous humor. Cefuroxime passes the blood-brain barrier when the meninges are inflamed.

Biotransformation

Cefuroxime is not metabolised.

Elimination

The serum half-life is between 1 and 1.5 hours. Cefuroxime is excreted by glomerular filtration and tubular secretion. The renal clearance is in the region of 125 to 148 ml/min/1.73 m .

Special patient populations

Gender

No differences in the pharmacokinetics of cefuroxime were observed between males and females.
Elderly
No special precaution is necessary in the elderly patients with normal renal function at dosages up to the normal maximum of 1 g per day. Elderly patients are more likely to have decreased renal function; therefore, the dose should be adjusted in accordance with the renal function in the elderly (see section 4.2).
Paediatrics
In older infants (aged >3 months) and in children, the pharmacokinetics of cefuroxime are similar to that observed in adults.
There is no clinical trial data available on the use of cefuroxime axetil in children under the age of 3 months.
Renal impairment
The safety and efficacy of cefuroxime axetil in patients with renal failure have not been established. Cefuroxime is primarily excreted by the kidneys. Therefore, as with all such antibiotics, in patients with markedly impaired renal function (i.e. C1cr <30 ml/minute) it is recommended that the dosage of cefuroxime should be reduced to compensate for its slower excretion (see section 4.2). Cefuroxime is effectively removed by dialysis.
Hepatic impairment
There are no data available for patients with hepatic impairment. Since cefuroxime is primarily eliminated by the kidney, the presence of hepatic dysfunction is expected to have no effect on the pharmacokinetics of cefuroxime.
Pharmacokinetic/pharmacodynamic relationship
For cephalosporins, the most important pharmacokinetic-pharmacodynamic index correlating with in vivo efficacy has been shown to be the percentage of the dosing interval (%T) that the unbound concentration remains above the minimum inhibitory concentration (MIC) of cefuroxime for individual target species (i.e. %T>MIC).
5.3 Preclinical safety data
Non-clinical data reveal no special hazard for humans based on studies of safety pharmacology, repeated dose toxicity, genotoxicity and toxicity to reproduction and development. No carcinogenicity studies have been performed; however, there is no evidence to suggest carcinogenic potential.
Gamma glutamyl transpeptidase activity in rat urine is inhibited by various cephalosporins, however the level of inhibition is less with cefuroxime. This may have significance in the interference in clinical laboratory tests in humans.
6. Pharmaceutical particulars
6.1 List of excipients
Aspartame
Sodium carboxymethyl cellulose
Tutti Frutti Flavour
Colloidal Silicon dioxide
Allura red
Sodium benzoate
Sucrose
Purified Water
Sucrose Quantities:
125 mg/5ml Suspension
1.159 g/5ml
6.2 Incompatibilities
None.
6.3 Shelf life
The shelf life of unconstituted KADNAT Suspension from date of manufacture is 24 months stored below 30°C. The reconstituted suspension, when refrigerated between 2 and 8°C can be kept for up to 10 days.

6.4 Special precautions for storage
KADNAT Suspension granules should be stored below 30°C.
PET Bottles: The reconstituted suspension must be refrigerated as soon as possible at between 2 and 8°C.
6.5 Nature and contents of container
KADNAT Suspension 125mg/5ml, granules for oral suspension are supplied in amber PET bottles of 100ml.
6.6 Special precautions for disposal and other handling
Any unused medicinal product or waste material should be disposed of in accordance with local requirements.
Constitution/Administration instructions
The bottle should be shaken vigorously before the medication is taken.
The reconstituted suspension when refrigerated between 2 and 8°C can be kept for up to 10 days.
If desired, KADNAT suspension from PET bottles can be further diluted in cold fruit juices, or milk drinks and should be taken immediately.
Directions for reconstituting suspension in PET bottles
1. Shake the bottle to loosen the content. All the granules should be free-flowing in the bottle.
2. Add the total amount of cold water as stated on the label or up to the volume line on the cup provided (if supplied). If the water was previously boiled it must be allowed to cool to room temperature before adding. Do not mix KADNAT granules for oral suspension with hot or warm liquids. Cold water must be used to prevent the suspension becoming too thick.
3. Replace the cap. Allow the bottle to stand to allow the water to fully soak through the granules; this should take about one minute.
4. Invert the bottle and shake well (for at least 15 seconds) until all the granules have mixed with the water.
5. Turn the bottle into an upright position and shake well for one minute until all the granules have blended with the water.
Store the KADNAT suspension immediately at between 2 and 8°C (do not freeze) and let it rest for at least one hour before taking the first dose.
The reconstituted suspension when refrigerated between 2 and 8°C can be kept for up to 10 days.
Always shake the bottle well before taking the medication.
The reconstituted suspension or granules should not be mixed with hot liquids.
7. Manufacturer
MIRAFLASH NIGERIA LIMITED
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