

1. NAME OF THE MEDICINAL PRODUCT

KADCEP® 200mg Hard Gelatin Capsules

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each capsule contains: Cefpodoxime Proxetil equivalent to Cefpodoxime 200 mg

Excipients with known effect: None

For a full list of excipients, see section 6.1

3. PHARMACEUTICAL FORM

Hard gelatin capsules with yellow body with “KADCEP 200” marked in black and maroon cap with “MIRAFLASH” marked in black. Each capsule contains Cefpodoxime 200mg as trihydrate USP

4. Clinical particulars

4.1 Therapeutic indications

Cefpodoxime is indicated for the treatment of the following infections when caused by susceptible pathogens (see sections 4.4 and 5.1) in adults:

Upper respiratory tract infections

Acute bacterial sinusitis

Lower respiratory tract infections

Acute exacerbation of chronic bronchitis

Bacterial pneumonia - Cefpodoxime might not be suitable option depending on the pathogen involved, please see section 4.4.

Consideration should be given to the official guidance on the appropriate use of antibacterial agents.

4.2 Posology and method of administration

Posology

Route of administration: oral.

The tablets should be taken with food for optimum absorption. Adults and adolescents with normal renal function:

Upper respiratory tract infections: Acute bacterial sinusitis: 200 mg twice daily.

Lower respiratory tract infections:

Acute exacerbation of chronic bronchitis: 200mg twice daily Bacterial pneumonia: 200mg twice daily

Elderly:

It is not necessary to modify the dose in elderly patients with normal renal function. Children:

Pediatric formulation of cefpodoxime is available for infants and children. Hepatic

Impairment: The dosage does not require modification in cases of hepatic impairment. Renal

Impairment:

The dosage of cefpodoxime does not require modification if creatinine clearance exceeds 40 ml/min. Below this value, pharmacokinetic studies indicate an increase in plasma elimination half-life and the maximum plasma concentrations, and hence the dosage should be adjusted appropriately.

CREATININE CLEARANCE (ml/min)	
39-10	Single dose ¹ administered every 24 hours instead of twice a day (i.e half of the usual adult dose).
<10	Single dose ¹ administered every 48 hours (i.e quarter of the usual adult dose).
Haemodialysis Patients	Single dose ¹ administered after each dialysis session.

NOTE¹: The Single dose is either 100 mg or 200 mg, depending on the type of infection.

4.3 Contraindications

Hypersensitivity to cefpodoxime, any other cephalosporins or to any of the excipients.

Previous history of immediate and / or severe hypersensitivity reaction (anaphylaxis) to penicillin or other beta-lactam antibiotic.

4.4 Special warnings and precautions for use

Cefpodoxime is not a preferred antibiotic for the treatment of staphylococcal pneumonia and should not be used in the treatment of atypical pneumonia caused by organisms such as Legionella, Mycoplasma and Chlamydia. Cefpodoxime is not recommended for the treatment of pneumonia due to S. pneumoniae (see section 5.1).

As with all beta-lactam antibacterial agents, serious and occasionally fatal hypersensitivity reactions have been reported. In case of severe hypersensitivity reactions, treatment with cefpodoxime 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 cefpodoxime, to other cephalosporins or to any other type of beta-lactam

agent. Caution should be used if cefpodoxime is given to patients with a history of non-severe hypersensitivity to other beta-lactam agents.

In cases of severe renal insufficiency, it may be necessary to reduce the dosage regimen dependent on the creatinine clearance (see section 4.2).

Antibacterial agent-associated colitis and pseudo-membranous colitis have been reported with nearly all anti-bacterial agents, including cefpodoxime, and may range in severity from mild to life-threatening.

Therefore, it is important to consider this diagnosis in patients who present with diarrhoea during or subsequent to the administration of cefpodoxime (see section 4.8). Discontinuation of therapy with cefpodoxime and the administration of specific treatment for *Clostridium difficile* should be considered. Medicinal products that inhibit peristalsis should not be given.

Cefpodoxime should always be prescribed with caution in patients with a history of gastrointestinal disease, particularly colitis.

As with all beta-lactam antibiotics, neutropenia and more rarely agranulocytosis may develop particularly during extended treatment. For cases of treatment lasting longer than 10 days, the blood count should be monitored and treatment discontinued if neutropenia is found.

Cephalosporins may be absorbed onto the surface of red cell membranes and react with antibodies directed against the drug. This can produce a positive Coomb's test and very rarely, haemolytic anaemia. Cross-reactivity may occur with penicillin for this reaction.

Changes in renal function have been observed with cephalosporin antibiotics, particularly when given concurrently with potentially nephrotoxic drugs such as aminoglycosides and/or potential diuretics. In such cases, renal function should be monitored.

As with other antibiotics, prolonged use of cefpodoxime may result in the overgrowth of non-susceptible organisms (*Candida* and *Clostridium difficile*), which may require interruption of treatment.

Interaction with laboratory tests:

A false positive reaction for glucose in the urine may occur with Benedict's or Fehling's solutions or with copper sulphate test tablets, but not with tests based on enzymatic glucose oxidase reactions. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine.

4.5 Interaction with other medicinal products and other forms of interaction

No clinically significant drug interactions have been reported during the course of clinical studies.

Histamine H₂-antagonists and antacids reduce the bioavailability of cefpodoxime. Probenecid reduces the excretion of cephalosporins. Cephalosporins potentially enhance the anticoagulant effect of coumarins and reduce the contraceptive effect of oestrogens.

Oral anticoagulants:

Simultaneous administration of cefpodoxime with warfarin may augment its anti-coagulant effects. There have been many reports of increases in oral anti-coagulant activity in patients receiving antibacterial agents, including cephalosporins. The risk may vary with the underlying infection, age and general status of the patient so that the contribution of the cephalosporins to the increase in INR (international normalised ratio) is difficult to assess. It is recommended that the INR should be monitored frequently during and shortly after co-administration of cefpodoxime with an oral anti-coagulant agent.

Studies have shown that bioavailability is decreased by approximately 30% when cefpodoxime is administered with drugs which neutralise gastric pH or inhibit acid secretions. Therefore, such drugs as antacids of the mineral type and H₂ blockers such as ranitidine, which can cause an increase in gastric pH, should be taken 2 to 3 hours after Cefpodoxime administration.

4.6 Pregnancy and Lactation

Pregnancy:

There are no or limited amount of data from the use of cefpodoxime in pregnant women. Animal studies do not indicate direct or indirect harmful effects with respect to reproductive toxicity (see section 5.3). Due to the benefit of antibiotic treatment, the use of cefpodoxime may be considered during pregnancy if necessary.

Caution should be exercised when prescribing to pregnant women. Lactation:

Cefpodoxime is excreted in breast milk in small amounts. Cefpodoxime may be used during breast-feeding. Continuation of breast-feeding should be questioned in case of diarrhoea or mucosal fungus infection in the breastfed infant. The possibility of sensitisation should be borne in mind.

4.7 Effects on ability to drive and use machines

Dizziness has been reported during treatment with cefpodoxime and may affect the ability to drive and use machines.

4.8 Undesirable effects

Adverse drug reactions are listed below by system organ class and frequency. Frequencies are defined as: Very common ($\geq 1/10$)

Common ($\geq 1/100$ to $< 1/10$) Uncommon ($\geq 1/1,000$ to $< 1/100$) Rare ($\geq 1/10,000$ to $< 1/1,000$) Very rare ($< 1/10,000$), not known (cannot be estimated from the available data)

Blood and lymphatic system disorders

Rare:

Haematological disorders such as reduction in haemoglobin, thrombocytosis, thrombocytopenia, leucopenia and eosinophilia

Very rare:

Haemolytic anaemia. Nervous system disorders Uncommon:

Headache, paraesthesia, dizziness Ear and labyrinth disorders
Uncommon: Tinnitus

Gastrointestinal disorders

Common:

Gastric pressure, nausea, vomiting, abdominal pain, flatulence, diarrhoea. Bloody diarrhoea can occur as a symptom of enterocolitis.

The possibility of pseudomembranous enterocolitis should be considered if severe or persistent diarrhoea occurs during or after treatment (see section 4.4).

Metabolism and nutrition disorders

Common:

Loss of appetite

Immune system disorders

Hypersensitivity reactions of all degrees of severity have been observed (see section 4.4). Very rare:

anaphylactic reactions, bronchospasm, purpura and angioedema.

Renal and urinary disorders

Very rare:

Slight increases in blood urea and creatinine

Hepato-biliary disorders

Rare:

Transient moderate elevations of ASAT, ALAT and alkaline phosphatase and/or bilirubin. These laboratory abnormalities which may be explained by the infection, may rarely exceed twice the upper limit of the named range and elicit a pattern of liver injury, usually cholestatic and most often asymptomatic.

Very rare:

liver damage

Skin and subcutaneous tissue disorders

Uncommon:

Hypersensitivity mucocutaneous reactions, rash, urticaria, pruritus

Very rare:

Stevens- Johnson syndrome, toxic epidermal necrolysis and erythema multiforme

Infections and infestations

There can be multiplication of non-sensitive micro-organisms (see section 4.4)

General disorders and administration site conditions

Uncommon:

Asthenia or malaise

4.9 Overdose

In the event of overdosage with cefpodoxime, supportive and symptomatic therapy is indicated.

In cases of overdosage, particularly in patients with renal insufficiency, encephalopathy may occur. The encephalopathy is usually reversible once cefpodoxime plasma levels have fallen.

PHARMACOLOGICAL PROPERTIES

Pharmacodynamics properties

Pharmacotherapeutic group: Beta-lactam antibacterial, a 3rd generation cephalosporin. ATC Code: J01DD13

Mode of Action:

Cefpodoxime 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.

PK/PD 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 that the unbound concentration remains above the minimum inhibitory concentration (MIC) of cefpodoxime for individual target species (i.e. %T>MIC).

Mechanism(s) of resistance:

Resistance to cephalosporins results from a variety of mechanisms: alteration of the cell-wall permeability of gram-negative bacteria. alteration of the penicillin binding proteins (PBPs)

β -lactamase
production bacterial
efflux pumps

Break points:

European Committee on Antimicrobial Susceptibility Testing (EUCAST) clinical breakpoints for MIC testing are presented below. EUCAST clinical MIC breakpoints for cefpodoxime (2011-01-05, v 1.3)

Organism	Susceptible (S) (mg/l)	Resistant (R) (mg/l)
Enterobacteriaceae (uncomplicated UTI only)	≤ 1	>1
Staphylococcus spp.	Note1	Note1
Streptococcus groups A, B, C	Note2	Note2
Streptococcus pneumoniae	≤ 0.25	>0.5
Haemophilus influenzae	≤ 0.25 Note3	>0.5
Moraxella catarrhalis	≤ 0.25 Note3	>0.5
Neisseria gonorrhoeae	IE	IE
Non-species related breakpoint	IE	IE

Susceptibility of staphylococci to cephalosporins is inferred from the ceftazidime susceptibility.

The beta-lactam susceptibility of beta-haemolytic streptococcus groups A, B, C and G is inferred from the penicillin susceptibility.

Strains with MIC values above the susceptible breakpoint are very rare or not yet reported. The identification and antimicrobial susceptibility tests on any such isolate must be repeated and if the result is confirmed the isolate must be sent to a reference laboratory.

*Insufficient evidence

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 the agent in at least some types of infections is questionable.

Antibacterial spectrum

Commonly Susceptible species
Aerobic Gram positive organisms:
Staphylococcus aureus (Methicillin-susceptible)
Streptococcus pyogenes
Aerobic Gram negative organisms:
Haemophilus influenzae

Moraxella catarrhalis
Proteus mirabilis%
Species for which acquired resistance may be a problem
Aerobic Gram positive organisms
Streptococcus pneumoniae
Aerobic Gram negative organisms
Citrobacter freundii\$
Enterobacter cloacae\$
Escherichia coli%
Klebsiella pneumoniae%
Serratia marcescens\$
Inherently resistant organisms
Aerobic Gram positive organisms
Enterococcus spp.
Staphylococcus aureus (methicillin resistant)
Aerobic Gram negative organisms
Morganella morganii
Pseudomonas aeruginosa.
Others
Chlamydia spp.
Chlamydophilaspp.
Legionella pneumophila
Mycoplasma spp.

\$ natural intermediate susceptibility

+Resistance rates >50% in at least 1 region

% ESBL producing species are always resistant

Pharmacokinetic properties

Cefpodoxime is taken up in the intestine and is hydrolysed to the active metabolite cefpodoxime. When cefpodoxime proxetil is administered orally to fasting subjects as a tablet corresponding to 100 mg of cefpodoxime, 51.5% is absorbed and absorption is increased by food intake. The volume of distribution is

32.3 L and peak levels of cefpodoxime occur 2 to 3 hrs after dosing. The maximum plasma concentration is

1.2 mg/L and 2.5 mg/L after doses of 100 mg and 200 mg respectively. Following administration of 100 mg and 200 mg twice daily over 14.5 days, the plasma pharmacokinetic parameters of

cefpodoxime remain unchanged.

Serum protein binding of cefpodoxime, 40% principally to albumin. This binding is non saturable in type. Concentrations of cefpodoxime in excess of the minimum inhibitory levels (MIC) for common pathogens can be achieved in lung parenchyma, bronchial mucosa, pleural fluid, tonsils, interstitial fluid and prostate tissue.

As the majority of cefpodoxime is eliminated in the urine, the concentration is high. (Concentrations in 0-4, 4-8, 8-12 hr fractions after a single dose exceed MIC90 of common urinary pathogens). Good diffusion of cefpodoxime is also seen into renal tissue, with concentrations above MIC90 of the common urinary pathogens, 3-12 hrs after an administration of a single 200 mg dose (1.6-3.1µg/g). Concentrations of cefpodoxime in the medullary and cortical tissues is similar.

Studies in healthy volunteers show median concentrations of cefpodoxime in the total ejaculate 6-12 hrs following administration of a single 200 mg dose to be above the MIC90 of N.gonorrhoeae.

The main route of excretion is renal, 80% is excreted unchanged in the urine, with an elimination half- life of approx 2.4 hours.

5.3 Preclinical safety data

Preclinical data based on conventional studies on acute toxicity, repeated dose toxicity, reproduction toxicity and genotoxicity reveal no special hazard for humans not already considered in other sections of the SPC.

PHARMACEUTICAL PARTICULARS List of

excipients

Maize starch
Purified talc
Sodium benzoate

Incompatibilities

Not applicable.

Shelf life

3 years

Special precautions for storage

Store below 25°C.

Cefpodoxime 200mg capsules are available in PVC blister packs, containing 10 hard gelatine capsules.

Any unused product or waste material should be disposed off in accordance with local requirements

MANUFACTURER-MIRAFLASH NIGERIA LIMITED

2-8 Success Estate, Off Brenthfield Avenue,
Oke-Afa, Magboro, Ogun State