1.3.1 Summary of Product Characteristics (SmPC)

1. NAME OF THE MEDICINAL PRODUCT

DEEKIN'S OFLOXACIN TABLETS
(OFLOXACIN TABLETS USP 200 mg)

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Sr. No.	Name of Ingredient	Category	Specification	Quantity Per Unit Dose (mg)	Required Quantity (KG)
	Active Material				
1.	Ofloxacin	API	USP	200.000	140.000*
2.	Maize Starch	Binder	BP	140.000	107.800**
	Dry Mixing				
3.	Sodium Benzoate	Preservative	BP	1.000	0.700
4.	Maize Starch	Binder	BP	24.000	16.800
5.	PVP K-30	Diluent	BP	2.000	1.400
6.	Purified water	Solvent	BP	q.s.	120.000
	Lubricants				
7.	Talcum	Lubricant	BP	7.000	4.900
8.	Sodium Starch Glycolate	Disintegrate	BP	4.000	2.800
9.	Magnesium Stearate	Lubricant	BP	4.000	2.800
	Total weight of tablet			**382.0 mg**	**267.400 kg**
	Coating				
10.	Insta Coat Universal (IC-U-1308) (white)*	Film Former	IH	8.000	6.160***
11.	Purified water	Solvent	BP	q. s.	60.000
	Total weight of tablet			**390.00**	**273.000**

3. PHARMACEUTICAL FORM

Oral Tablets
Description: White, Caplet shape, Film coated tablets, de-bossed "SMILE" logo on one side & "BREAKLINE" on other side.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

The following indications are restricted to adults.

Ofloxacin is suitable for treatment of the following bacterial infections if these are caused by pathogens sensitive to ofloxacin:

• Lower respiratory tract infections including pneumonia, bronchitits and acute exacerbations of chronic bronchitis caused by gram negative aerobic bacteria. (Ofloxacin tablets are not the drug of first choice in pneumonia caused by Streptococcus pneumoniae, Mycoplasma pneumoniae or Chlamydia

pneumoniae).

• Upper and lower urinary tract infections, including uncomplicated (cystitis) and complicated urinary tract infections.

• Uncomplicated urethral and cervical gonorrhoea, non-gonococcal urethritis and cervicitis.

Consideration should be given to official guidance on the appropriate use of anti-bacterial agents.

4.2 Posology and method of administration

Posology

The dose of ofloxacin is determined by the type and severity of the infection. The dosage range for adults is 200 mg to 800 mg daily.

Up to 400 mg may be given as a single dose, preferably in the morning. Generally, individual doses should be given at approximately equal intervals.

In individual cases it may be necessary to increase the dose to a maximum total dose of 800 mg daily, which should be given as 400 mg twice daily, at approximately equal intervals. This may be appropriate in infections due to pathogens known to have reduced or variable susceptibility to ofloxacin, in severe and/or complicated infections (e.g. of the respiratory or urinary tracts) or if the patient does not respond adequately.

The following doses are recommended

Indications	**Single and Daily Doses**
Uncomplicated urethral/ cervical gonorrhoea	400 mg
Uncomplicated lower urinary tract infections	200 mg-400 mg daily
Complicated infections of the upper urinary tract	400 mg daily, increasing if necessary, to 400 mg twice a day
Lower respiratory tract infections	400 mg daily, increasing, if necessary, to 400 mg twice a day
No gonococcal urethritis and cervicitis	400 mg daily

A single dose of 400 mg of ofloxacin is sufficient for the treatment of uncomplicated gonorrhoea.

Special patient populations

Impaired renal function

Following a normal initial dose, dosage should be reduced in patients with impairment of renal function as determined by creatinine clearance or plasma creatinine level.

Creatinine Clearance	*Plasma Creatinine*	*Maintenance Dose**
20 to 50 ml/min*	1.5 to 5 mg/dl	100 mg - 200 mg ofloxacin per day)
<20ml/min**	>5 mg/dl	100 mg ofloxacin per day

* According to indication or dose interval

** The serum concentration of ofloxacin should be monitored in patients with severe renal impairment and dialysis patients.

Patients undergoing haemodialysis or peritoneal dialysis should be given 100 mg ofloxacin per day. When creatinine clearance cannot be measured, it can be estimated with reference to the serum creatinine level using the following Cockcroft's formula for adults:

Men: $ClCr\ (ml/min) = \frac{weight(kg) \times (140 - age\ in\ years)}{72 \times serum\ creatinine\ (mg/dl)}$

or

$ClCr\ (ml/min) = \frac{weight(kg) \times (140 - age\ in\ years)}{0.814 \times serum\ creatinine\ (\mu mol/l)}$

Women: $ClCr\ (ml/min) = 0.85 \times (above\ value)$

Impaired liver function:
The excretion of ofloxacin may be reduced in patients with severe hepatic dysfunction.
(E.g. cirrhosis of the liver with ascites). In such cases, it is recommended that the dose should not exceed 400 mg ofloxacin daily, because of possible reduction of excretion.

Elderly:

No adjustment of dosage is required in the elderly other than that imposed by consideration of renal or hepatic function see section 4.4 QT interval prolongation).

Paediatric population:
Ofloxacin is contraindicated for use in children or growing adolescents (see section 4.3). Elderly No adjustment of dosage is required in the elderly, other than that imposed by consideration of renal or hepatic function. (See section 4.4 QT interval prolongation).

Duration:
Treatment should not exceed 2 months duration.
A daily dose of up to 400 mg ofloxacin may be given as a single dose. In this case, it is preferable to administer ofloxacin in the morning.
Daily doses of more than 400 mg must be divided into two separate doses and be given at approximately equal intervals.

Method of administration for oral use.
Ofloxacin tablets should be swallowed whole with sufficient liquid before or during meal times. They should not be taken within two hours of mineral antacids, sucralfate or metal ion preparations (aluminium, iron, magnesium or zinc), didanosine chewable or buffered tablets (for HIV), since reduction of absorption of ofloxacin can occur.

4.3 Contraindications
The use of ofloxacin is contraindicated as follows:
- Hypersensitivity to the active substance, to any other fluoroquinolone antibacterial, or to any of the excipients listed in section 6.1.
- In patients with a history of epilepsy or an existing central nervous system disorder with a lowered seizure threshold.
- In patients with a history of tendon disorders related to fluoroquinolone administration
- In children or growing adolescents, and in pregnant or breastfeeding women, since animal experiments do not entirely exclude the risk of damage to the growth plate cartilage in the growing organism cannot be entirely excluded.
- In patients with latent or actual defects in glucose-6-phosphate dehydrogenase activity because they may be prone to haemolytic reactions when treated with quinolone antibacterial agents.

4.4 Special warnings and precautions for use

The use of ofloxacin should be avoided in patients who have experienced serious adverse reactions in the past when using quinolone or fluoroquinolone containing products (see section 4.8). Treatment of these patients with ofloxacin should only be initiated in the absence of alternative treatment options and after careful benefit/risk assessment (see also section 4.3).

Ofloxacin tablets are not the drug of first choice in pneumonia caused by Streptococcus pneumoniae or Chlamydia pneumoniae.

Methicillin resistant S. aureus
Are very likely to possess co-resistance to fluoroquinolones, including ofloxacin. Therefore ofloxacin is not recommended for the treatment of known or suspected MRSA infections unless laboratory results have confirmed susceptibility of the organism to ofloxacin (and commonly recommended antibacterial agents for the treatment of MRSA-infections are considered inappropriate).

Resistance to fluoroquinolones of E. coli
The most common pathogen involved in urinary tract infections – varies across the European Union. Prescribers are advised to take into account the local prevalence of resistance in E. coli to fluoroquinolones.

Streptococcus pneumoniae, β-haemolytic Streptococci and Mycoplasma
Ofloxacin is not the drug of first choice for pneumonia caused by Pneumococci or Mycoplasma or infection caused by β-haemolytic Streptococci.

Neisseria gonorhoeae infections

Due to increase in resistance to N. gonorrhoeae, ofloxacin should not be used as empirical treatment option in suspected gonococcal infection unless the pathogen has been identified and confirmed as susceptible to ofloxacin. If clinical improvement is not achieved after 3 days of treatment, the therapy should be reconsidered.

Hypersensitivity and allergic reactions

Hypersensitivity and allergic reactions have been reported for fluoroquinolones after first administration. Anaphylactic and anaphylactoid reactions can progress to life-threatening shock, even after the first administration. In these cases ofloxacin should be discontinued and suitable treatment (e.g. treatment for shock) should be initiated.

Prolonged, disabling and potentially irreversible serious adverse drug reactions

Very rare cases of prolonged (continuing months or years), disabling and potentially irreversible serious adverse drug reactions affecting different, sometimes multiple, body systems (musculoskeletal, nervous, psychiatric and senses) have been reported in patients receiving quinolones and fluoroquinolones irrespective of their age and pre-existing risk factors. Ofloxacin should be discontinued immediately at the first signs or symptoms of any serious adverse reaction and patients should be advised to contact their prescriber for advice.

Aortic aneurysm and dissection

Epidemiologic studies report an increased risk of aortic aneurysm and dissection after intake of fluoroquinolones, particularly in the older population.

Therefore, fluoroquinolones should only be used after careful benefit-risk assessment and after consideration of other therapeutic options in patients with positive family history of aneurysm disease, or in patients diagnosed with pre-existing aortic aneurysm and/or aortic dissection, or in presence of other risk factors or conditions predisposing for aortic aneurysm and dissection (e.g. Marfan syndrome,

vascular Ehlers-Danlos syndrome, Takayasu arteritis, giant cell arteritis, Behcet's disease, hypertension, known atherosclerosis).

In case of sudden abdominal, chest or back pain, patients should be advised to immediately consult a physician in an emergency department.

Severe bullous reactions

Cases of severe bullous skin reactions such as Stevens-Johnson syndrome or toxic epidermal necrolysis have been reported with ofloxacin (see section 4.8). Patients should be advised to contact their doctor immediately prior to continuing treatment if skin and/or mucosal reactions occur.

Diseases caused by Clostridioides difficile

Diarrhoea, especially if severe, persistent and/or bloody, occurring during or after treatment with ofloxacin (including several weeks after treatment), may indicate a condition caused by Clostridioides difficile, the most severe form of which is pseudomembranous colitis (CDAD). CDAD may range in severity from mild to life threatening, the most severe form of which is pseudomembranous colitis (see section 4.8). It is therefore important to consider this diagnosis in patients who develop serious diarrhoea during or after treatment with ofloxacin. If pseudomembranous colitis is suspected, treatment should be discontinued immediately.

Appropriate specific antibiotic therapy must be started without delay (e.g. oral vancomycin, oral teicoplanin or metronidazole). Medicinal products that inhibit peristalsis are contraindicated in such cases.

Patients predisposed to seizures

Quinolones may lower the seizure threshold and may trigger seizures. Ofloxacin is contraindicated in patients with a history of epilepsy or with a known predisposition to seizures (see section 4.3) and, as with other quinolones, ofloxacin should be used with extreme caution in patients predisposed to seizures.

Patients with a known predisposition to seizures may include those with pre-existing central nervous system lesions, concomitant treatment with fenbufen and similar non-steroidal anti-inflammatory drugs (NSAIDs), or with drugs which lower the cerebral seizure threshold, such as theophylline (see section 4.5 interactions).

In case of convulsive seizures, treatment with ofloxacin should be discontinued (see section 4.5).

Tendinitis and tendon rupture

Tendinitis and tendon rupture (especially but not limited to Achilles tendon), sometimes bilateral, may occur as early as within 48 hours of starting treatment with quinolones and fluoroquinolones and have been reported to occur even up to several months after discontinuation of treatment. The risk of tendinitis and tendon rupture is increased in older patients, patients with renal impairment, patients with solid organ transplants, and those treated concurrently with corticosteroids. Therefore, concomitant use of corticosteroids should be avoided. The daily dose should be adjusted in elderly patients based on creatinine clearance (see section 4.2). Close monitoring of these patients is therefore necessary if they are prescribed ofloxacin.

All patients should consult their physician if they experience symptoms of tendinitis. At the first sign of tendinitis (e.g. painful swelling, inflammation) the treatment with ofloxacin should be discontinued and alternative treatment should be considered. The affected limb(s) should be appropriately treated (e.g. immobilisation). Corticosteroids should not be used if signs of tendinopathy occur.

Patients with impaired renal function

Since ofloxacin is eliminated primarily via the kidneys, the dose should be adjusted in patients with impaired renal function (see section 4.2).

Patients with history of psychotic disorder

Psychotic reactions have been reported in patients receiving fluoroquinolones. In some cases these have progressed to suicidal thoughts or self-endangering behavior including suicide attempt, sometimes after a single dose of ofloxacin (see section 4.8). In the event that a patient develops these reactions, ofloxacin should be discontinued and appropriate measures instituted.

Ofloxacin should be used with caution in patients with a history of psychotic disorder or in patients with psychiatric disease.

Patients with impaired liver function

Ofloxacin should be used with caution in patients with impaired liver function, as liver damage may occur. Cases of fulminant hepatitis potentially leading to liver failure (including fatal cases) have been reported with fluoroquinolones. Patients should be advised to stop treatment and contact their doctor if signs and symptoms of hepatic disease develop such as anorexia, jaundice, dark urine, pruritus or tender abdomen (see section 4.8).

Patients treated with vitamin K antagonists

Due to possible increase in coagulation tests (PT/INR) and/or bleeding in patients treated with fluoroquinolones, including ofloxacin, in combination with a vitamin K antagonist (e.g. warfarin), coagulation tests should be monitored when these drugs are given concomitantly (see section 4.5).

Myasthenia gravis

Fluoroquinolones, including ofloxacin, have neuromuscular blocking activity and may exacerbate muscle weakness in patients with myasthenia gravis. Post marketing serious adverse reactions, including deaths and the requirement for respiratory support, have been associated with fluoroquinolone use in patients with myasthenia gravis. Ofloxacin is not recommended in patients with a known history of myasthenia gravis.

Superinfection

As with other antibiotics, the use of ofloxacin, especially if prolonged, may result in overgrowth of non-susceptible organisms, especially Enterococci, resistant strains of some organisms or Candida. Repeated evaluation of the patient's condition is essential and periodic in vitro susceptibility tests may be useful. If secondary infection occurs during therapy, appropriate measures should be taken.

Prevention of photosensitisation

Photosensitisation has been reported with ofloxacin (see section 4.8). It is recommended that patients should not expose themselves unnecessarily to strong sunlight or to artificial UV rays (e.g. sunray lamp, solarium), during treatment and for 48 hours following treatment discontinuation in order to prevent photosensitisation.

QT interval prolongation

Very rare cases of QT interval prolongation have been reported in patients taking fluoroquinolones.

Caution should be taken when using fluoroquinolones, including ofloxacin, in patients with known risk factors for prolongation of the QT interval such as, for example:

- Elderly patients and women may be more sensitive to QTc-prolonging medications. Therefore, caution should be taken when using fluoroquinolones, including ofloxacin, in these populations.

- Uncorrected electrolyte imbalance (e.g. hypokalaemia, hypomagnesaemia)

- Congenital long QT syndrome

- Concomitant use of drugs that are known to prolong the QT interval (e.g. Class IA and III anti-arrhythmics, tricyclic antidepressants, macrolides, antipsychotics)

- Cardiac disease (e.g. heart failure, myocardial infarction, bradycardia)

(See section 4.2 Elderly, section 4.5, section 4.8, and section 4.9).

Dysglycaemia

As with all quinolones, disturbances in blood glucose, including both hypoglycaemia and hyperglycaemia have been reported (see section 4.8), usually in diabetic patients receiving concomitant treatment with an oral hypoglycaemic agent (e.g., glibenclamide) or with insulin. Cases of hypoglycaemic coma have been reported. In these diabetic patients, careful monitoring of blood glucose is recommended.

Peripheral neuropathy

Cases of sensory or sensorimotor polyneuropathy resulting in paraesthesia, hypaesthesia, dysesthesia, or weakness have been reported in patients receiving quinolones and fluoroquinolones. Patients under treatment with ofloxacin should be advised to inform their doctor prior to continuing treatment if symptoms of neuropathy such as pain, burning, tingling, numbness, or weakness develop in order to prevent the development of potentially irreversible condition (see section 4.8).

Patients with glucose-6-phosphate-dehydrogenase deficiency

Patients with latent or diagnosed glucose-6-phosphate-dehydrogenase deficiency may be predisposed to haemolytic reactions if they are treated with quinolones. Therefore if ofloxacin has to be used in these patients, potential occurrence of haemolysis should be monitored.

Interference with laboratory tests

In patients treated with ofloxacin, determination of opiates or porphyrin levels in urine may give false-positive results. It may be necessary to confirm positive opiate or porphyrin screens by more specific methods.

Vision disorders

If vision becomes impaired or any effects on the eyes are experienced, an eye specialist should be consulted immediately (see sections 4.7 and 4.8).

Excipient with known effect

Ofloxacin contains lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency, or glucose-galactose malabsorption should not take this medicine.

Ofloxacin contains less than 1 mmol sodium (23 mg) per tablet, that is to say essentially 'sodium-free'.

4.5 Interaction with other medicinal products and other forms of interaction

Antacids, Sucralfate, Metal Cations

Co-administered magnesium/aluminum antacids, sucralfate, zinc or iron preparations and didanosine chewable/buffered tablets can reduce absorption of ofloxacin. Therefore, ofloxacin should be taken 2 hours before such preparations.

Theophylline, fenbufen or similar non-steroidal anti-inflammatory drugs

No pharmacokinetic interactions of ofloxacin were found with theophylline in a clinical study. However, a pronounced lowering of the cerebral seizure threshold may occur when quinolones are given concurrently with theophylline, nonsteroidal anti-inflammatory drugs, or other agents, which lower the seizure threshold.

In case of convulsive seizures, treatment with ofloxacin should be discontinued.

Probenecid, cimetidine, furosemide, and methotrexate

Probenecid decreased the total clearance of ofloxacin by 24%, and increased AUC by 16%. The proposed mechanism is a competition or inhibition for active transport at the renal tubular excretion. Caution should be exercised when ofloxacin is co-administered with drugs that affect the tubular renal secretion such as probenecid, cimetidine, furosemide and methotrexate.

Drugs known to prolong QT interval

Ofloxacin, like other fluoroquinolones, should be used with caution in patients receiving drugs known to prolong the QT interval (e.g. Class IA and III antiarrhythmics, tricyclic antidepressants, macrolides, and antipsychotics) (see section 4.4 QT interval prolongation).

Vitamin K antagonists

Increased coagulation tests (PT/INR) and/or bleeding, which may be severe, have been reported in patients treated with ofloxacin in combination with a vitamin K antagonist (e.g. warfarin). Coagulation tests should, therefore, be monitored in patients treated with vitamin K antagonists because of a possible increase in the effect of coumarin derivatives (see section 4.4).

Glibenclamide

Ofloxacin may cause a slight increase in plasma glibenclamide levels when administered concurrently, it is therefore recommended that patients treated concomitantly with ofloxacin and glibenclamide be monitored particularly closely. Since hypoglycaemia is then more likely to occur, close monitoring of blood sugar levels is recommended in such cases.

4.6 Fertility, pregnancy and lactation

Pregnancy

Based on a limited amount of human data, the use of fluoroquinolones in the first trimester of pregnancy has not been associated with an increased risk of major malformations or other adverse effects on pregnancy outcome. Animal studies have shown damage to the joint cartilage in immature animals but no teratogenic effects (see section 5.3). Therefore ofloxacin must not be used during pregnancy (see section 4.3).

Breast-feeding

Ofloxacin is excreted into human breast milk in small amounts. Because of the potential for arthropathy and other serious toxicity in the nursing infant, breast-feeding should be discontinued during treatment with ofloxacin (see section 4.3).

4.7 Effects on ability to drive and use machines

Since there have been occasional reports of drowsiness/somnolence, impairment of skills, dizziness/vertigo and visual disturbances, which may impair the patient's ability to concentrate and react, and therefore may constitute a risk in situations where these abilities are of special importance (e.g. driving a car or operating machinery), patients should know how they react to ofloxacin before they drive or operate machinery. These effects may be enhanced by alcohol.

4.8 Undesirable effects

The information given below is based on data from clinical studies and on extensive post marketing experience.

System organ class	Uncommon (≥1/1,000 to <1/100)	Rare (≥1/10,000 to <1/1,000)	Very rare (< 1/10,000)	Not known (cannot be estimated from available data)*
Infections and Infestations	Fungal infection, Pathogen resistance			
Blood and lymphatic system disorders			Anaemia, Haemolytic anaemia, Leucopenia, Eosinophilia, Thrombocytopenia	Agranulocytosis, Bone marrow failure, Pancytopenia
Immune system disorders		Anaphylactic reaction*, Anaphylactoid reaction*, Angioedema*	Anaphylactic shock*, Anaphylactoid shock*	
Metabolism and Nutrition disorders		Anorexia		Hypoglycaemia in diabetics treated with hypoglycaemic agents (see section 4.4), Hyperglycaemia, Hypoglycaemic coma
Psychiatric disorders	Agitation, Sleep disorder, Insomnia	Psychotic disorder (for e.g. hallucination), Anxiety, Confusional state, Nightmares, Depression		Psychotic disorder and depression with self-endangering behaviour including suicidal ideation or suicide attempt (see Section 4.4), Nervousness
Nervous system Disorders	Dizziness, Headache	Somnolence, Paraesthesia, Dysgeusia, Parosmia	Peripheral sensory neuropathy*, Peripheral sensory motor neuropathy*, Convulsion*, Extra-pyramidal symptoms or other disorders of muscular coordination	Tremor, Dykinesia, Ageusia, Syncope
Eye disorders	Eye irritation	Visual disturbance		Uveitis
Ear and labyrinth Disorders	Vertigo		Tinnitus, Hearing loss	Hearing impaired
Cardiac disorders		Tachycardia		Ventricular arrhythmias and torsades de pointes (reported predominantly in
				patients with risk factors for QT prolongation), ECG QT prolonged (see section 4.4 and 4.9)
Vascular disorders		Hypotension		

Respiratory, thoracic and mediastinal Disorders	Cough, Nasopharyngitis	Dyspnoea, Bronchospasm		Allergic pneumonitis, Severe dyspnoea
Gastrointestinal disorders	Abdominal pain, Diarrhoea, Nausea, Vomiting	Enterocolitis, sometimes haemorrhagic	Pseudomembranous colitis*	Dyspepsia, Flatulence, Constipation, Pancreatitis
Hepatobiliary disorders		Hepatic enzymes increased (ALAT, ASAT, LDH, gamma-GT and/or alkaline phosphatase), Blood bilirubin increased	Jaundice cholestatic	Hepatitis, which may be severe* Severe liver injury, including cases with acute liver failure, sometimes fatal, have been reported with ofloxacin, primarily in patients with underlying liver disorders (see section 4.4).
Skin and subcutaneous tissue disorders	Pruritus, Rash	Urticaria, Hot flushes, Hyperhidrosis Pustular rash	Erythema multiforme, Toxic epidermal necrolysis, Photo-sensitivity reaction*, Drug eruption , Vascular purpura, Vasculitis, which can lead in exceptional cases to skin necrosis	Stevens-Johnson syndrome, Acute generalised exanthemous pustulosis, Drug rash, Stomatitis Exfoliative dermatitis
Musculoskeletal and connective tissue disorders		Tendonitis	Arthralgia, Myalgia, Tendon rupture (e.g. Achilles tendon) which may occur within 48 hours of treatment start and may be bilateral	Rhabdomyolysis and/or Myopathy, Muscular weakness, Muscle tear, Muscle rupture, Ligament rupture, Arthritis
Renal and urinary Disorders Congenital, familial and genetic disorders		Serum creatinine increased	Acute renal failure	Acute interstitial nephritis Attacks of porphyria in patients with porphyria
General disorders and administration site conditions				Asthenia, Pyrexia, Pain (including pain in back, chest and extremities)

4.9 Overdose

Symptoms

The most important signs to be expected following acute overdose are CNS symptoms such as confusion, dizziness, impairment of consciousness and convulsive seizures increases in QT interval as well as gastrointestinal reactions such as nausea and mucosal erosions.

CNS effects including confusional state, convulsion, hallucination, and tremor have been observed in post marketing experience.

Management

In the case of overdose steps to remove any unabsorbed ofloxacin e.g. gastric lavage, administration of adsorbants and sodium sulphate, if possible during the first 30 minutes, are recommended; antacids are recommended for protection of the gastric mucosa.

In the event of overdose, symptomatic treatment should be implemented. ECG monitoring should be undertaken, because of the possibility of QT interval prolongation. Antacids may be used for protection of gastric mucosa. A fraction of ofloxacin may be removed from the body with haemodialysis. Peritoneal dialysis and CAPD are not effective in removing ofloxacin from the body. No specific antidote exists.

Elimination of ofloxacin may be increased by forced diuresis.

5. Pharmacological properties

5.1 Pharmacodynamic properties

Pharmacotherapeutic Group: Quinolone Antibacterials, Fluoroquinolones; ATC code: J01MA01
Mechanism of action
Ofloxacin inhibits bacterial DNA replication by inhibiting bacterial topoisomerases, particularly DNA gyrase and topoisomerase IV. It is active after oral administration.
Therapeutic doses of ofloxacin are devoid of pharmacological effects on the voluntary or autonomic nervous system. The NCCLS MIC breakpoint recommendations are as follows:
S ≤ 2 mg/l and R ≥ 1 mg/L

Haemophilus influenzae and Neisseria gonorrhoea are exceptions with breakpoints at S ≤ 0.25 mg/l and R ≥ 1 mg/l The BSAC general recommendations are S ≤ 2 mg/l and R ≥ 4 mg/l
According to DIN 58 940, the following limits apply for ofloxacin: S ≤ 1 mg/L, I = 2 mg/L, R ≥ 4 mg/L.
The prevalence of resistance may vary geographically and with time for selected species and local information on resistance is desirable, particularly when treating severe infections. This information gives only an approximate guidance on probabilities whether micro-organisms will be susceptible to ofloxacin or not.
Only those pathogens relevant to the indications are listed.

	European range of acquired bacterial resistance to ofloxacin
Normally susceptible	
Aerobic Gram-positive micro organisms	
S. aureus - methicillin-sensitive	0.3-12.6%
S. pyogenes	2-5%
Aerobic Gram-negative micro organisms	
Acinetobacter spp	0.3-7.3%
Citrobacter spp.	3-15%
Enterobacter spp.	2-13%
E. coli	1-8%
H. influenzae	1%
Klebsiella spp.	1-10%
Moraxella spp.	0-0.2%
Morganella morganii	0-6.9%
N. gonorrhoeae	25%
Proteus spp.	1-15%

Serratia marcescens	2-2.4%
Others	
Chlamydia spp	
L. pneumophila	
Intermediately susceptible	
Aerobic Gram-positive micro organisms	
S. pneumoniae	70%
Providentia	17.1%
Aerobic Gram-negative micro organisms	
E. faecalis	50%
P. aeruginosa	20-30%
Serratia spp.	20-40%
Stenotrophomonas maltophilia	5.1-11%
Others	
Mycoplasma spp.	0-5.3%
Ureaplasma spp.	0-2.1%
Resistant	
Anaerobic bacteria	
S. aureus - methicillin-resistant	69.2-85.7%
T. pallidum	

Resistance

The main mechanism of bacterial resistance to ofloxacin involves one or more mutations in the target enzymes, which generally confer resistance to other active substances in the class. Efflux pump and impermeability mechanisms of resistance have also been described and may confer variable resistance to active substances in other classes.

5.2 Pharmacokinetic properties

Absorption
The administration of oral doses to fasting volunteers was followed by a rapid and almost complete absorption of ofloxacin. The peak plasma concentration after a single oral dose of 200mg averaged 2.6 µg/ml and was reached within one hour. The plasma elimination half-life was 5.7 to 7.0 hours and was not dose related.

Distribution
The apparent distribution volume was 120 litres. The plasma concentration did not materially rise with repeat doses (accumulation factor for twice daily dosage: 1.5). The plasma protein binding was approx. 25%.

Biotransformation
The biotransformation of ofloxacin was below 5%. The two main metabolites found in the urine were N-desmethyl- ofloxacin and ofloxacin-N-oxide.

Elimination
Excretion is primarily renal. Between 80 and 90% of the dose were recovered from the urine as unchanged substance.
Ofloxacin was present in the bile in glucuronidised form. The pharmacokinetics of ofloxacin after

intravenous infusion are very similar to those after oral doses. The plasma half-life is prolonged in persons with renal insufficiency; Total and renal clearance decrease in accordance with the creatinine clearance. In renal insufficiency the dose should be reduced.
No clinically relevant interactions were seen with food and no interaction was found between ofloxacin and theophylline.

5.3 Preclinical safety data
Preclinical effects in conventional studies of safety pharmacology, acute toxicity, repeated dose toxicity, reproductive studies were observed only at exposures considered sufficiently in excess of the maximum human exposure indicating little relevance to clinical use. Joint toxicity was observed at exposure in the human therapeutic range in juvenile rats and dogs. Ofloxacin exhibits a neurotoxic potential and causes reversible testicular alterations at high doses.

Mutagenicity studies showed no evidence for mutagenicity of ofloxacin. However, like some other quinolones Ofloxacin is phototoxic in animals at exposure in the human therapeutic range. The phototoxic, photomutagenic and photocarcinogenic potential of ofloxacin is comparable with that of other gyrase inhibitors.

Preclinical data from conventional genotoxicity studies reveal no special hazard to humans, carcinogen potential has not been investigated.

Reproduction toxicity

Ofloxacin has no effect on fertility, peri- or postnatal development, and therapeutic doses did not lead to any teratogenic or other embryotoxic effects in animals. Ofloxacin crosses the placenta and levels reached in the amniotic fluid are about 30% of the maximal concentrations measured in maternal serum.

6. Pharmaceutical Particulars

6.1. List of excipients

Raw Materials	**Pharmacopoeia Reference**
Sodium Benzoate	BP
Maize Starch	BP
PVP K-30	BP
Purified water	BP
Talcum	BP
Sodium Starch Glycolate	BP
Magnesium Stearate	BP
Insta Coat Universal (IC-U-1308) (White)*	IH

6.2. Incompatibilities
None

6.3. Shelf life
36 Months.

6.4 Special precautions for storage
Store below above 30 ^{o}C.
Store in the original package, in order to protect from moisture.

6.5. Nature and contents of container
Pack 1:
Aluminium-Aluminium Blister
10Tablets packed in 1 Aluminium -Aluminium blister.
1 X 10 (10 Tablets) blisters are packed in one carton with package insert.

Pack 2:
Aluminium-Aluminium Blister
10 Tablets packed in 1 Aluminium -Aluminium blister
(1X10) 1 blisters are packed in one carton with package insert

6.6. Special Precaution for Disposal
No special requirement

7. APPLICANT/MANUFACTURER

NAFDAC REG. NO: B4-5392
DIVINE KINGS
PHARMA LIMITED

ZOTA HEALTHCARE
LIMITED
PLOT 169, SURAT
SPECIAL ECONOMIC
ZONE, NEAR SACHIN
RAILWAY STATION,
SACHIN SURAT, INDIA