

Summary of product Characteristics

1. Name of the medicinal product

Emmox 500 mg Capsules

2. Qualitative and quantitative composition

Emmox trihydrate equivalent to 500mg Amoxicillin per capsule.

For a full list of excipients, see section 6.1.

3. Pharmaceutical form

Hard Capsules.

4. Clinical particulars

4.1 Therapeutic indications

Emmox is indicated for the treatment of the following infections in adults and children (see sections 4.2, 4.4 and 5.1):

- Acute bacterial sinusitis
- Acute streptococcal tonsillitis and pharyngitis
- Acute exacerbations of chronic bronchitis (AECB)/acute exacerbation of chronic obstructive pulmonary disease (AECOPD)
- Community acquired pneumonia
- Acute otitis media
- Acute cystitis
- Acute pyelonephritis
- Asymptomatic bacteriuria in pregnancy
- Typhoid and paratyphoid fevers
- Dental abscess with spreading cellulitis
- Prosthetic joint infections
- *Helicobacter pylori* eradication
- Lyme disease

Emmox is also indicated for the prophylaxis of endocarditis. Consideration should be given to official guidance on the appropriate use of antibacterial agents.

4.2 Posology and method of administration

Posology

The dose of Emmox that is selected to treat an individual infection should take into account:

- The expected pathogens and their likely susceptibility to antibacterial agents (see section 4.4)
- The severity and the site of the infection
- The age, weight and renal function of the patient; as shown below

The duration of therapy should be determined by the type of infection and the response of the patient, and should generally be as short as possible. Some infections require longer periods of treatment (see section 4.4 regarding prolonged therapy).

Adults and children \geq 40 kg

Indication*	Dose*
Acute bacterial sinusitis	250 mg to 500 mg every 8 hours or 750 mg to 1 g every 12 hours For severe infections 750 mg to 1 g every 8 hours Acute cystitis may be treated with 3g twice daily for one day
Asymptomatic bacteriuria in pregnancy	
Acute pyelonephritis	
Dental abscess with spreading cellulitis	
Acute cystitis	
Acute otitis media	500 mg every 8 hours, 750 mg to 1 g every 12 hours For severe infections 750 mg to 1 g every 8 hours for 10 days
Acute streptococcal tonsillitis and pharyngitis	
Acute exacerbations of chronic bronchitis	
Community acquired pneumonia	500 mg to 1 g every 8 hours
Typhoid and paratyphoid fever	500 mg to 2 g every 8 hours
Prosthetic joint infections	500 mg to 1 g every 8 hours
Prophylaxis of endocarditis	2 g orally, single dose 30 to 60 minutes before procedure
<i>Helicobacter pylori</i> eradication	750 mg to 1 g twice daily in combination with a proton pump inhibitor (e.g. omeprazole, lansoprazole) and another antibiotic (e.g. clarithromycin, metronidazole) for 7 days
Lyme disease (see section 4.4)	Early stage: 500 mg to 1 g every 8 hours up to a maximum of 4 g/day in divided doses for 14 days (10 to 21 days) Late stage (systemic involvement): 500 mg to 2 g every 8 hours up to a maximum of 6 g/day in divided doses for 10 to 30 days
*Consideration should be given to the official treatment guidelines for each indication	

Children <40 kg

Indication*	Dose*
Acute bacterial sinusitis	20 to 90 mg/kg/day in divided doses*
Acute otitis media	
Community acquired pneumonia	
Acute cystitis	
Acute pyelonephritis	
Dental abscess with spreading cellulitis	
Acute streptococcal tonsillitis and pharyngitis	40 to 90 mg/kg/day in divided doses*
Typhoid and paratyphoid fever	100 mg/kg/day in three divided doses
Prophylaxis of endocarditis	50 mg/kg orally, single dose 30 to 60 minutes before procedure
Lyme disease (see section 4.4)	Early stage: 25 to 50 mg/kg/day in three divided doses for 10 to 21 days Late stage (systemic involvement): 100 mg/kg/day in three divided doses for 10 to 30 days
+ Consideration should be given to the official treatment guidelines for each indication.	
*Twice daily dosing regimens should only be considered when the dose is in the upper range.	

Elderly

No dose adjustment is considered necessary.

Renal impairment

GFR (ml/min)	Adults and children \geq 40 kg	Children < 40 kg [#]
greater than 30	No adjustment necessary	No adjustment necessary
10 to 30	Maximum 500 mg twice daily	15 mg/kg given twice daily (maximum 500 mg twice daily)
less than 10	Maximum 500 mg/day	15 mg/kg given as a single dose (maximum 500 mg)

[#] In the majority of cases, parenteral therapy is preferred.

In patients receiving haemodialysis

Emmox may be removed from the circulation by haemodialysis.

	Haemodialysis
Adults and children over 40 kg	500 mg every 24 h Prior to haemodialysis one additional dose of 500 mg should be administered. In order to restore circulating drug levels, another dose of 500 mg should be administered after haemodialysis.
Children under 40 kg	15 mg/kg/day given as a single daily dose (maximum 500 mg). Prior to haemodialysis one additional dose of 15 mg/kg should be administered. In order to restore circulating drug levels, another dose of 15 mg/kg should be administered after haemodialysis.

In patients receiving peritoneal dialysis

Emmox maximum 500 mg/day.

Hepatic impairment

Dose with caution and monitor hepatic function at regular intervals (see sections 4.4 and 4.8).

Method of administration

Emmox is for oral use.

Absorption of Emmox is unimpaired by food.

Therapy can be started parenterally according to the dosing recommendations of the intravenous formulation and continued with an oral preparation.

Swallow with water without opening capsule.

Capsules are not suitable for the treatment of patients who cannot swallow capsules due to the risk of going down the wrong way.

Other presentations are available, depending on the dosage, including oral presentations that can be used especially in patients who cannot swallow capsules.

4.3 Contraindications

Hypersensitivity to the active substance, to any of the penicillins or to any of the excipients listed in section 6.1.

History of a severe immediate hypersensitivity reaction (e.g. anaphylaxis) to another beta-lactam agent (e.g. a cephalosporin, carbapenem or monobactam).

4.4 Special warnings and precautions for use

Hypersensitivity reactions

Before initiating therapy with Emmox, careful enquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins or other beta-lactam agents (see sections 4.3 and 4.8).

Serious and occasionally fatal hypersensitivity reactions (including anaphylactoid and severe cutaneous adverse reactions) have been reported in patients receiving beta-lactam antibiotics (see section 4.3). These reactions are more likely to occur in individuals with a history of penicillin hypersensitivity and in atopic individuals. Hypersensitivity reactions can also progress to Kounis syndrome, a serious allergic reaction that can result in myocardial infarction (see section 4.8). Presenting symptoms of such reactions can include chest pain occurring in association with an allergic reaction to Emmox (see section 4.8). If an allergic reaction occurs, Emmox therapy must be discontinued and appropriate alternative therapy instituted.

Drug-induced enterocolitis syndrome (DIES) has been reported mainly in children receiving Emmox (see section 4.8). DIES is an allergic reaction with the leading symptom of protracted vomiting (1-4 hours after drug intake) in the absence of allergic skin or respiratory symptoms. Further symptoms could comprise abdominal pain, diarrhoea, hypotension or leucocytosis with neutrophilia. There have been severe cases including progression to shock.

Non-susceptible microorganisms

Emmox is not suitable for the treatment of some types of infection unless the pathogen is already documented and known to be susceptible or there is a very high likelihood that the pathogen would be suitable for treatment with Emmox (see section 5.1). This particularly applies when considering the treatment of patients with urinary tract infections and severe infections of the ear, nose and throat.

Convulsions

Convulsions may occur in patients with impaired renal function or in those receiving high doses or in patients with predisposing factors (e.g. history of seizures, treated epilepsy or meningeal disorders (see section 4.8).

Renal impairment

In patients with renal impairment, the dose should be adjusted according to the degree of impairment (see section 4.2).

Skin reactions

The occurrence at the treatment initiation of a feverish generalised erythema associated with pustula may be a symptom of acute generalised exanthemous pustulosis (AGEP, see section 4.8). This reaction requires Emmox discontinuation and contra-indicates any subsequent administration.

Emmox should be avoided if infectious mononucleosis is suspected since the occurrence of a morbilliform rash has been associated with this condition following the use of Emmox.

Jarisch-Herxheimer reaction

The Jarisch-Herxheimer reaction has been seen following Emmox treatment of Lyme disease (see section 4.8). It results directly from the bactericidal activity of Emmox 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.

Overgrowth of non-susceptible microorganisms

Prolonged use may occasionally result in overgrowth of non-susceptible organisms.

Antibiotic-associated colitis has been reported with nearly all antibacterial agents and may range in severity from mild to life threatening (see section 4.8). Therefore, it is important to consider this diagnosis in patients who present with diarrhoea during, or subsequent to, the administration of any antibiotics. Should antibiotic-associated colitis occur, Emmox should immediately be discontinued, a physician consulted and an appropriate therapy initiated. Anti-peristaltic medicinal products are contra-indicated in this situation.

Prolonged therapy

Periodic assessment of organ system functions; including renal, hepatic and haematopoietic function is advisable during prolonged therapy. Elevated liver enzymes and changes in blood counts have been reported (see section 4.8).

Crystalluria

In patients with reduced urine output, crystalluria (including acute renal injury) has been observed very rarely, predominantly with parenteral therapy. During the administration of high doses of Emmox, it is advisable to maintain adequate fluid intake and urinary output in order to reduce the possibility of Emmox crystalluria. In patients with bladder catheters, a regular check of patency should be maintained (see sections 4.8 and 4.9).

Anticoagulants

Prolongation of prothrombin time has been reported rarely in patients receiving Emmox. Appropriate monitoring should be undertaken when anticoagulants are prescribed concomitantly. Adjustments in the dose of oral anticoagulants may be necessary to maintain the desired level of anticoagulation (see sections 4.5 and 4.8).

Interference with diagnostic tests

Elevated serum and urinary levels of Emmox are likely to affect certain laboratory tests. Due to the high urinary concentrations of Emmox, false positive readings are common with chemical methods.

It is recommended that when testing for the presence of glucose in urine during Emmox treatment, enzymatic glucose oxidase methods should be used.

The presence of Emmox may distort assay results for oestriol in pregnant women.

4.5 Interaction with other medicinal products and other forms of interaction

Oral anticoagulants

Oral anticoagulants and penicillin antibiotics have been widely used in practice without reports of interaction. However, in the literature there are cases of increased international normalised ratio in patients maintained on acenocoumarol or warfarin and prescribed a course of Emmox. If co-administration is necessary, the prothrombin time or international normalised ratio should be carefully monitored with the addition or withdrawal of Emmox. Moreover, adjustments in the dose of oral anticoagulants may be necessary (see sections 4.4 and 4.8).

Probenecid

Concomitant use of probenecid is not recommended. Probenecid decreases the renal tubular secretion of Emmox. Concomitant use of probenecid may result in increased and prolonged blood levels of Emmox

Allopurinol

Concurrent administration of allopurinol during treatment with Emmox can increase the likelihood of allergic skin reactions.

Tetracyclines

Tetracyclines and other bacteriostatic drugs may interfere with the bactericidal effects of Emmox.

Methotrexate

Penicillins may reduce the excretion of methotrexate causing a potential increase in toxicity.

4.6 Fertility, pregnancy and lactation

Pregnancy:

Animal studies do not indicate direct or indirect harmful effects with respect to reproductive toxicity. Limited data on the use of Emmox during pregnancy in humans do not indicate an increased risk of congenital malformations. Emmox may be used in pregnancy when the potential benefits outweigh the potential risks associated with treatment.

Breast-feeding:

Emmox is excreted into breast milk in small quantities with the possible risk of sensitisation. Consequently, diarrhoea and fungus infection of the mucous membranes are possible in the breast-fed infant, so that breast-feeding might have to be discontinued. Emmox should only be used during breast-feeding after benefit/risk assessment by the physician in charge.

Fertility:

There are no data on the effects of Emmox 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, undesirable effects may occur (e.g. allergic reactions, dizziness, convulsions), which may influence the ability to drive and use machines (see section 4.8).

4.8 Undesirable effects

The most commonly reported adverse drug reactions (ADRs) are diarrhoea, nausea and skin rash.

The ADRs derived from clinical studies and post-marketing surveillance with Emmox, presented by MedDRA System Organ Class are listed below.

The following terminologies have been used in order to classify the occurrence of undesirable effects:

Very common ($\geq 1/10$),

Common ($\geq 1/100$ to $<1/10$),

Uncommon ($\geq 1/1000$ 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)

Infections and infestations	
Very rare	Mucocutaneous candidiasis
Blood and lymphatic system disorders	
Very rare	Reversible leucopenia (including severe neutropenia or agranulocytosis), reversible thrombocytopenia and haemolytic anaemia. Prolongation of bleeding time and prothrombin time (see section 4.4).
Immune system disorders	
Very rare	Severe allergic reactions, including angioneurotic oedema, anaphylaxis, serum sickness and hypersensitivity vasculitis (see section 4.4).
Not known	Jarisch-Herxheimer reaction (see section 4.4).
Nervous system disorders	
Very rare	Hyperkinesia, dizziness, convulsions (see section 4.4).
Not known	Aseptic meningitis
Gastrointestinal disorders	
<i>Clinical Trial Data</i>	
*Common	Diarrhoea and nausea
*Uncommon	Vomiting
<i>Post-marketing Data</i>	
Very rare	Antibiotic associated colitis (including pseudomembraneous colitis and haemorrhagic colitis see section 4.4). Black hairy tongue
Not known	Drug-induced enterocolitis syndrome
Hepatobiliary disorders	
Very rare	Hepatitis and cholestatic jaundice. A moderate rise in AST and/or ALT.
Skin and subcutaneous tissue disorders	
<i>Clinical Trial Data</i>	
*Common	Skin rash
*Uncommon	Urticaria and pruritus
<i>Post-marketing Data</i>	
Very rare	Skin reactions such as erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis, bullous and exfoliative dermatitis, acute generalised exanthematous pustulosis (AGEP) (see section 4.4), and drug reaction with eosinophilia and systemic symptoms (DRESS).
Not known	Linear IgA disease
Renal and urinary tract disorders	
Very rare	Interstitial nephritis
Not known	Crystalluria (including acute renal injury)
Cardiac disorders	

Not known	Kounis syndrome
* The incidence of these AEs was derived from clinical studies involving a total of approximately 6,000 adult and paediatric patients taking Emmox.	

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. Healthcare professionals are asked to report any suspected adverse reactions via the Yellow Card Scheme at: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

4.9 Overdose

Symptoms and signs of overdose

Gastrointestinal symptoms (such as nausea, vomiting and diarrhoea) and disturbances of the fluid and electrolyte balances may be evident. Emmox crystalluria, in some cases leading to renal failure, has been observed. Convulsions may occur in patients with impaired renal function or in those receiving high doses (see sections 4.4 and 4.8).

Treatment of intoxication

Gastrointestinal symptoms may be treated symptomatically, with attention to the water/electrolyte balance.

Emmox can be removed from the circulation by haemodialysis.

Emmox crystalluria, in some cases leading to renal failure, has been observed (see section 4.4).

5. Pharmacological properties

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: penicillins with extended spectrum; ATC code: J01CA04

Mechanism of action

Emmox is a semisynthetic penicillin (beta-lactam antibiotic) that inhibits one or more enzymes (often referred to as penicillin-binding proteins, PBPs) in the biosynthetic pathway of bacterial peptidoglycan, which is an integral structural component of the bacterial cell wall. Inhibition of peptidoglycan synthesis leads to weakening of the cell wall, which is usually followed by cell lysis and death.

Emmox is susceptible to degradation by beta-lactamases produced by resistant bacteria and therefore the spectrum of activity of Emmox alone does not include organisms which produce these enzymes.

Pharmacokinetic/pharmacodynamic relationship

The time above the minimum inhibitory concentration ($T > MIC$) is considered to be the major determinant of efficacy for Emmox.

Mechanisms of resistance

The main mechanisms of resistance to Emmox are:

- Inactivation by bacterial beta-lactamases
- Alteration of PBPs, which reduce the affinity of the antibacterial agent for the target.

Impermeability of bacteria or efflux pump mechanisms may cause or contribute to bacterial resistance, particularly in Gram-negative bacteria.

Breakpoints

MIC breakpoints for Emmox are those of the European Committee on Antimicrobial Susceptibility Testing (EUCAST) version 11.0.

Organism	Susceptibility Breakpoints (μ g/ml)	
	Susceptible	Resistant
<i>Haemophilus influenzae</i> ¹	≤ 0.001	> 2
<i>Moraxella catarrhalis</i>	Note ²	Note ²
<i>Staphylococcus spp.</i>	Note ^{3, 4, 5}	Note ^{3, 4, 5}
<i>Enterococcus spp.</i> ⁶	≤ 4 ⁷	> 8 ⁷
Streptococcus groups A, B, C, G (indications other than meningitis)	Note ⁸	Note ⁸
<i>Streptococcus pneumoniae</i> ⁹	≤ 0.5	> 1
Enterobacterales ¹⁰	≤ 8	> 8
Gram-negative Anaerobes ¹¹	≤ 0.5	> 2
Gram-positive Anaerobes ¹¹ (except <i>Clostridioides difficile</i>)	≤ 4	> 8
Non-species related breakpoints	≤ 2	> 8
Viridans group streptococci	≤ 0.5	>2
<i>Pasteurella multocida</i>	≤ 1	>1
<i>Helicobacter pylori</i>	≤ 0.125	>0.125
<i>Neisseria meningitidis</i> (indications other than meningitis)	≤ 0.125	>1

¹ Beta-lactamase positive isolates can be reported resistant to ampicillin, Emmox and piperacillin without inhibitors. Tests based on a chromogenic cephalosporin can be used to detect the beta-lactamase.

² Most *M. catarrhalis* produce beta-lactamase, although beta-lactamase production is slow and may give weak results with *in vitro* tests. Beta-lactamase producers should be reported resistant to penicillins and aminopenicillins without inhibitors.

³ Most *S. aureus* are penicillinase producers and some are methicillin resistant. Either mechanism renders them resistant to benzylpenicillin, phenoxymethylpenicillin, ampicillin, Emmox, piperacillin and ticarcillin. Isolates that test susceptible to benzylpenicillin and cefoxitin can be reported susceptible to all penicillins. Isolates that test resistant to benzylpenicillin but susceptible to cefoxitin are susceptible to β -lactam β -lactamase inhibitor combinations, the isoxazolympenicillins (oxacillin, cloxacillin, dicloxacillin and flucloxacillin) and nafcillin. For agents given orally, care to achieve sufficient exposure at the site of the infection should be exercised. Isolates that test resistant to cefoxitin are resistant to all penicillins.

⁴ Most coagulase-negative staphylococci are penicillinase producers and some are methicillin resistant. Either mechanism renders them resistant to benzylpenicillin, phenoxymethylpenicillin, ampicillin, Emmox, piperacillin and ticarcillin. No currently available method can reliably detect penicillinase production in coagulase-negative staphylococci but methicillin resistance can be detected with cefoxitin as described.

⁵ Ampicillin susceptible *S. saprophyticus* are *mecA*-negative and susceptible to ampicillin, Emmox and piperacillin (without or with a beta-lactamase inhibitor).

⁶ Aminopenicillin breakpoints in enterococci are based on intravenous administration. For oral administration the breakpoints are relevant for urinary tract infections only.

⁷ Susceptibility to ampicillin, Emmox and piperacillin (with and without beta-lactamase inhibitor) can be inferred from ampicillin. Ampicillin resistance is uncommon in *E. faecalis* (confirm with MIC) but common in *E. faecium*.

⁸ The susceptibility of streptococcus groups A, B, C and G to penicillins is inferred from the benzylpenicillin susceptibility (indications other than meningitis) with the exception of phenoxymethylpenicillin and isoxazolympenicillins for streptococcus group B.

⁹ The oxacillin 1 μ g disk screen test or a benzylpenicillin MIC test shall be used to exclude beta-lactam resistance mechanisms. When the screen is negative (oxacillin inhibition zone ≥ 20 mm, or benzylpenicillin MIC ≤ 0.06 mg/l) all beta-lactam agents for which clinical breakpoints are available, can be reported susceptible without further testing,

except for cefaclor, which if reported, should be reported as “susceptible, increased exposure” (I). When the screen is positive (inhibition zone <20 mm, or benzylpenicillin MIC >0.06 mg/l), refer to EUCAST flow chart.

¹⁰ Aminopenicillin breakpoints in Enterobacterales are based on intravenous administration. For oral administration the breakpoints are relevant for urinary tract infections only. Breakpoints for other infections are under review.

¹¹ Susceptibility to ampicillin, Emmox, piperacillin and ticarcillin can be inferred from susceptibility to benzylpenicillin.

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. 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.

In vitro susceptibility of micro-organisms to Emmox
Commonly Susceptible Species
Gram-positive aerobes: <i>Enterococcus faecalis</i> Beta-hemolytic streptococci (Groups A, B, C and G) <i>Listeria monocytogenes</i>
Species for which acquired resistance may be a problem
Gram-negative aerobes: <i>Escherichia coli</i> <i>Haemophilus influenzae</i> <i>Helicobacter pylori</i> <i>Proteus mirabilis</i> <i>Salmonella typhi</i> <i>Salmonella paratyphi</i> <i>Pasteurella multocida</i>
Gram-positive aerobes: Coagulase negative staphylococcus <i>Staphylococcus aureus</i> [‡] <i>Streptococcus pneumoniae</i> Viridans group streptococcus
Gram-positive anaerobes: <i>Clostridium</i> spp.
Gram-negative anaerobes: <i>Fusobacterium</i> spp.
Other: <i>Borrelia burgdorferi</i>
Inherently resistant organisms[†]
Gram-positive aerobes: <i>Enterococcus faecium</i> [†]
Gram-negative aerobes: <i>Acinetobacter</i> spp. <i>Enterobacter</i> spp. <i>Klebsiella</i> spp. <i>Pseudomonas</i> spp.
Gram-negative anaerobes: <i>Bacteroides</i> spp. (many strains of <i>Bacteroides fragilis</i> are resistant).
Others: <i>Chlamydia</i> spp. <i>Mycoplasma</i> spp. <i>Legionella</i> spp.
[†] Natural intermediate susceptibility in the absence of acquired mechanism of resistance. [‡] Almost all <i>S.aureus</i> are resistant to Emmox due to production of penicillinase. In addition, all methicillin-resistant strains are resistant to Emmox.

5.2 Pharmacokinetic properties

Absorption

Emmox fully dissociates in aqueous solution at physiological pH. It is rapidly and well absorbed by the oral route of administration. Following oral administration, Emmox is approximately 70% bioavailable. The time to peak plasma concentration (T_{max}) is approximately one hour.

The pharmacokinetic results for a study, in which an Emmox dose of 250 mg three times daily was administered in the fasting state to groups of healthy volunteers are presented below.

C_{max} (μ g/ml)	T_{max}^* (h)	AUC _(0-24h) (μ g.h/ml)	$T_{1/2}$ (h)
3.3 \pm 1.12	1.5 (1.0-2.0)	26.7 \pm 4.56	1.36 \pm 0.56
*Median (range)			

In the range 250 to 3000 mg the bioavailability is linear in proportion to dose (measured as C_{max} and AUC). The absorption is not influenced by simultaneous food intake.

Haemodialysis can be used for elimination of Emmox.

Distribution

About 18% of total plasma Emmox is bound to protein and the apparent volume of distribution is around 0.3 to 0.4 l/kg.

Following intravenous administration, Emmox has been found in gall bladder, abdominal tissues, skin, fat, muscle tissue, synovial and peritoneal fluids, bile and pus. Emmox does not adequately distribute into the cerebrospinal fluid.

From animal studies there is no evidence for significant tissue retention of drug-derived material. Emmox, like most penicillins, can be detected in breast milk (see section 4.6).

Emmox has been shown to cross the placental barrier (see section 4.6).

Biotransformation

Emmox is partly excreted in the urine as the inactive penicilloic acid in quantities equivalent to up to 10 to 25% of the initial dose.

Elimination

The major route of elimination for Emmox is via the kidney.

Emmox has a mean elimination half-life of approximately one hour and a mean total clearance of approximately 25 l/hour in healthy subjects. Approximately 60 to 70% of the Emmox is excreted unchanged in urine during the first 6 hours after administration of a single 250 mg or 500 mg dose of Emmox. Various studies have found the urinary excretion to be 50-85% for Emmox over a 24 hour period.

Concomitant use of probenecid delays Emmox excretion (see section 4.5).

Age

The elimination half-life of Emmox is similar for children aged around 3 months to 2 years and older children and adults. For very young children (including preterm newborns) in the first week of life the interval of administration should not exceed twice daily administration due to immaturity of the renal pathway of elimination. Because elderly patients are more

likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function.

Gender

Following oral administration of Emmox to healthy males and female subjects, gender has no significant impact on the pharmacokinetics of Emmox.

Renal impairment

The total serum clearance of Emmox decreases proportionately with decreasing renal function (see sections 4.2 and 4.4).

Hepatic impairment

Hepatically impaired patients should be dosed with caution and hepatic function monitored at regular intervals.

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.

Carcinogenicity studies have not been conducted with Emmox.

6. Pharmaceutical particulars

6.1 List of excipients

Magnesium Stearate (E572)

Silica Colloidal Anhydrous

Capsule shell components:

Body:

Iron Oxide Red (E172)

Iron Oxide Yellow (E172)

Titanium Dioxide (E171)

To 100% Gelatin

Cap:

Indigo Carmine (E132)

Erythrosine (E127)

Titanium Dioxide (E171)

To 100% Gelatin

Composition of Ink

Shellac

Dehydrated Alcohol

Isopropyl Alcohol

Butyl Alcohol

Propylene Glycol

Strong Ammonia Solution

Potassium Hydroxide

Black Iron Oxide (E172)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

3 years: Polypropylene/polyethylene containers.

2 years: Blister strips

6.4 Special precautions for storage

Do not store above 25° C. Store in the original package and keep containers tightly closed.

6.5 Nature and contents of container

Polypropylene/polyethylene containers and tamper evident closures/ 1000, 500, 100, 21, 20 and 15 capsules.

Blister strips: 15 and 21 capsules.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

Not applicable.

7. Marketing authorisation holder

Emzor pharmaceutical Industries, Plot 3c Block A aswani market road,

Isolo-oshodi expressway Lagos

8. Marketing authorisation number(s)

NA

9. Date of first authorisation/renewal of the authorisation

NA

10. Date of revision of the text

NA