

1. NAME OF THE MEDICINAL PRODUCT
Klacid SR Tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Active: Clarithromycin 500 mg/tablet

3. PHARMACEUTICAL FORM

Tablets slow release

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

For treatment of infections caused by susceptible organisms.
For lower respiratory tract infections,

upper respiratory tract infections, skin and soft tissue infections.

4.2 Posology and method of administration

Adults: The usual recommended dosage of Klacid SR Tablets in adults is one 500mg modified-release tablet daily to be taken with food . In more severe infections, the dosage can be increased to two 500mg modified-release tablets daily. The usual duration of treatment is 6 to 14 days.

Children older than 12 years: As for adults.

Children younger than 12 years: Use of Klacid SR are not recommended for children younger than 12 years. Clinical trials have been conducted using clarithromycin paediatric suspension in children 6 months to 12 years of age. Therefore, children under 12 years of age should use clarithromycin paediatric suspension (granules for oral suspension).

In patients with renal impairment with creatinine clearance less than 30 mL/min, the dosage of clarithromycin should be reduced by one-half, *i.e.* 250 mg once daily, or 250 mg twice daily in more severe infections. Treatment should not be continued beyond 14 days in these patients. Because the tablet cannot be split, the dose cannot be reduced from 500 mg daily, Klacid SR Tablets should not be used in this patient population (see section 4.3).

4.3 Contraindications

Klacid SR Tablets are contra-indicated in patients with known hypersensitivity to macrolide antibiotic drugs or to any of its excipients.

As the dose cannot be reduced from 500mg daily, Klacid SR Tablets are contraindicated in patients with creatinine clearance less than 30 mL/min. All other formulations may be used in this patient population.

Concomitant administration of clarithromycin and ergotamine or dihydroergotamine is contraindicated, as this may result in ergot toxicity.

Concomitant administration of clarithromycin and any of the following drugs is contraindicated: astemizole, cisapride, pimozone and terfenadine this may result in QT prolongation and cardiac arrhythmias, including ventricular tachycardia, ventricular fibrillation, and torsades de pointe (see section 4.5). Clarithromycin should not be given to patients with history of QT prolongation or ventricular cardiac arrhythmia, including torsades de pointe (see sections 4.4 and 4.5).

Clarithromycin should not be used concomitantly with HMG-CoA reductase inhibitors (statins), lovastatin or simvastatin, due to the risk of rhabdomyolysis. Treatment with these agents should be discontinued during clarithromycin treatment (see section 4.4).

Clarithromycin should not be given to patients with hypokalaemia (risk of prolongation of QT-time).

Clarithromycin should not be used in patients who suffer from severe hepatic failure in combination with renal impairment.

4.4 Special warnings and precautions for use

The physician should not prescribe clarithromycin to pregnant women without carefully weighing the benefits against risk, particularly during the first three months of pregnancy (see section 4.6).

Caution is advised in patients with severe renal insufficiency (see section 4.2).

Clarithromycin is principally excreted by the liver. Therefore caution should be exercised in administering this antibiotic to patients with impaired hepatic function. Caution should also be exercised when administering clarithromycin to patients with moderate to severe renal impairment.

Cases of fatal hepatic failure (see section 4.8) have been reported. Some patients may have had pre-existing hepatic disease or may have been taking other hepatotoxic medicinal products. 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.

Pseudomembranous colitis has been reported with nearly all antibacterial agents, including macrolides, and may range in severity from mild to life-threatening. *Clostridium difficile*- associated diarrhoea (CDAD) has been reported with use of nearly all antibacterial agents including clarithromycin, and may range in severity from mild diarrhoea to fatal colitis. Treatment with antibacterial agents alters the normal flora of the colon, which may lead to overgrowth of *C. difficile*. CDAD must be considered in all patients who present with diarrhoea following antibiotic use. Careful medical history is necessary since CDAD has been reported to occur over two months after the administration of antibacterial agents. Therefore, discontinuation of clarithromycin therapy should be considered regardless of the indication. Microbial testing should be performed and adequate treatment initiated. Drugs inhibiting peristalsis should be avoided.

Exacerbation of symptoms of myasthenia gravis has been reported in patients receiving clarithromycin therapy.

There have been post-marketing reports of colchicine toxicity with concomitant use of clarithromycin and colchicine, especially in the elderly, some of which occurred in patients with renal insufficiency. Deaths have been reported in some such patients (see section 4.5). If concomitant administration of colchicine and clarithromycin is necessary, patients should be monitored for clinical symptoms of colchicine toxicity.

Caution is advised regarding concomitant administration of clarithromycin and triazolobenzodiazepines, such as triazolam, and midazolam (see section 4.5).

Caution is advised regarding concomitant administration of clarithromycin with other ototoxic drugs, especially with aminoglycosides. Monitoring of vestibular and auditory function should be carried out during and after treatment.

Due to the risk for QT prolongation, clarithromycin should be used with caution in patients with coronary artery disease, severe cardiac insufficiency, hypomagnesaemia, bradycardia (<50 bpm), or when co-administered with other medicinal products associated with QT prolongation (see section 4.5). Clarithromycin must not be used in patients with congenital or documented acquired QT prolongation or history of ventricular arrhythmia (see section 4.3).

Pneumonia: In view of the emerging resistance of *Streptococcus pneumoniae* to macrolides, it is important that sensitivity testing be performed when prescribing clarithromycin for community-acquired pneumonia. In hospital-acquired pneumonia, clarithromycin should be used in combination with additional appropriate antibiotics.

Skin and soft tissue infections of mild to moderate severity: These infections are most often caused by *Staphylococcus aureus* and *Streptococcus pyogenes*, both of which may be resistant to macrolides. Therefore, it is important that sensitivity testing be performed. In cases where *beta*-lactam antibiotics cannot be used (e.g. allergy), other antibiotics, such as clindamycin, may be the drug of first choice. Currently, macrolides are only considered to play a role in some skin and soft tissue infections, such as those caused by *Corynebacterium minutissimum* (erythrasma), acne vulgaris, and erysipelas and in situations where penicillin treatment cannot be used.

In the event of severe acute hypersensitivity reactions, such as anaphylaxis, Stevens-Johnson Syndrome, and toxic epidermal necrolysis, clarithromycin therapy should be discontinued immediately and appropriate treatment should be urgently initiated.

Clarithromycin should be used with caution when administered concurrently with medications that induce the cytochrome CYP3A4 enzyme (see section 4.5).

HMG-CoA reductase inhibitors: Concomitant use of clarithromycin with lovastatin or simvastatin is contraindicated (see section 4.3). As with other macrolides, clarithromycin has been reported to increase concentrations of HMG-CoA reductase inhibitors (see section 4.5). Rare reports of rhabdomyolysis have been reported in patients taking these drugs concomitantly. Patients should be monitored for signs and symptoms of myopathy. Rare reports of rhabdomyolysis have also been reported in patients taking atorvastatin or rosuvastatin concomitantly with clarithromycin. When used with clarithromycin, atorvastatin or rosuvastatin should be administered in the lowest possible doses. Adjustment of the statin dose or use of a statin that is not dependent on CYP3A metabolism (e.g. fluvastatin or pravastatin) should be considered.

Oral hypoglycaemic agents/Insulin: The concomitant use of clarithromycin and oral hypoglycaemic agents and/or insulin can result in significant hypoglycaemia. With certain hypoglycaemic drugs such as nateglinide, pioglitazone, repaglinide and rosiglitazone, inhibition of CYP3A enzyme by clarithromycin may be involved and could cause hypoglycaemia when used concomitantly. Careful monitoring of glucose is recommended.

Oral anticoagulants: There is a risk of serious haemorrhage and significant elevations in International Normalized Ratio (INR) and prothrombin time when clarithromycin is co-administered with warfarin (see section 4.5). INR and prothrombin times should be frequently monitored while patients are receiving clarithromycin and oral anticoagulants concurrently.

Use of any antimicrobial therapy, such as clarithromycin, to treat *H. pylori* infection may select for drug-resistant organisms.

Long-term use may, as with other antibiotics, result in colonisation with increased numbers of non-susceptible bacteria and fungi. If superinfections occur, appropriate therapy should be instituted.

Attention should also be paid to the possibility of cross resistance between clarithromycin and other macrolide drugs, as well as lincomycin and clindamycin.

Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine.

4.5 Interaction with other medicinal products and other forms of interaction

The use of the following drugs is strictly contraindicated due to the potential for severe drug interaction effects:

Cisapride, pimozone, astemizole and terfenadine:

Elevated cisapride levels have been reported in patients receiving clarithromycin and cisapride concomitantly. This may result in QT prolongation and cardiac arrhythmias including ventricular tachycardia, ventricular fibrillation and torsades de pointes. Similar effects have been observed in patients taking clarithromycin and pimozone concomitantly (see section 4.3).

Macrolides have been reported to alter the metabolism of terfenadine resulting in increased levels of terfenadine which has occasionally been associated with cardiac arrhythmias, such as QT prolongation, ventricular tachycardia, ventricular fibrillation and torsades de pointes (see section 4.3). In one study in 14 healthy volunteers, the concomitant administration of clarithromycin and terfenadine resulted in 2- to 3-fold increase in the serum level of the acid metabolite of terfenadine and in prolongation of the QT interval which did not lead to any clinically detectable effect. Similar effects have been observed with concomitant administration of astemizole and other macrolides.

Ergotamine/dihydroergotamine:

Post-marketing reports indicate that co-administration of clarithromycin with ergotamine or dihydroergotamine has been associated with acute ergot toxicity characterized by vasospasm, and ischaemia of the extremities and other tissues including the central nervous system. Concomitant administration of clarithromycin and these medicinal products is contraindicated (see section 4.3).

Effects of Other Medicinal Products on Clarithromycin

Drugs that are inducers of CYP3A (e.g. rifampicin, phenytoin, carbamazepine, phenobarbital, St John's wort) may induce the metabolism of clarithromycin. This may result in sub-therapeutic levels of clarithromycin leading to reduced efficacy. Furthermore, it might be necessary to monitor the plasma levels of the CYP3A inducer, which could be increased owing to the inhibition of CYP3A by clarithromycin (see also the relevant product information for the CYP3A4 inhibitor administered). Concomitant administration of rifabutin and clarithromycin resulted in an increase in rifabutin, and decrease in clarithromycin serum levels together with an increased risk of uveitis.

The following drugs are known or suspected to affect circulating concentrations of clarithromycin; clarithromycin dosage adjustment or consideration of alternative treatments may be required.

Efavirenz, nevirapine, rifampicin, rifabutin and rifapentine

Strong inducers of the cytochrome P450 metabolism system such as efavirenz, nevirapine, rifampicin, rifabutin, and rifapentine may accelerate the metabolism of clarithromycin and thus lower the plasma levels of clarithromycin, while increasing those of 14-OH-clarithromycin, a metabolite that is also microbiologically active. Since the microbiological activities of clarithromycin and 14-OH-clarithromycin are different for different bacteria, the intended therapeutic effect could be impaired during concomitant administration of clarithromycin and enzyme inducers.

Fluconazole

Concomitant administration of fluconazole 200 mg daily and clarithromycin 500 mg twice daily to 21 healthy volunteers led to increases in the mean steady-state minimum clarithromycin concentration (C_{min}) and area under the curve (AUC) of 33% and 18% respectively. Steady state concentrations of the active metabolite 14-OH-clarithromycin were not significantly affected by concomitant administration of fluconazole. No clarithromycin dose adjustment is necessary.

Ritonavir

A pharmacokinetic study demonstrated that the concomitant administration of ritonavir 200 mg every eight hours and clarithromycin 500 mg every 12 hours resulted in a marked inhibition of the metabolism of clarithromycin. The clarithromycin C_{max} increased by 31%, C_{min} increased 182% and AUC increased by 77% with concomitant administration of ritonavir. An essentially complete inhibition of the formation of 14-OH-clarithromycin was noted. Because of the large therapeutic window for clarithromycin, no dosage reduction should be necessary in patients with normal renal function. However, for patients with renal impairment, the following dosage adjustments should be considered: For patients with CL_{CR} 30 to 60 mL/min the dose of clarithromycin should be reduced by 50%. For patients with CL_{CR} <30 mL/min the dose of clarithromycin should be decreased by 75%. Doses of

clarithromycin greater than 1 gm/day should not be co-administered with ritonavir.

Similar dose adjustments should be considered in patients with reduced renal function when ritonavir is used as a pharmacokinetic enhancer with other HIV protease inhibitors including atazanavir and saquinavir (see section below, Bi-directional drug interactions).

Effect of Clarithromycin on Other Medicinal Products

CYP3A-based interactions

Co-administration of clarithromycin, known to inhibit CYP3A, and a drug primarily metabolised by CYP3A may be associated with elevations in drug concentrations that could increase or prolong both therapeutic and adverse effects of the concomitant drug. Clarithromycin should be used with caution in patients receiving treatment with other drugs known to be CYP3A enzyme substrates, especially if the CYP3A substrate has a narrow safety margin (e.g. carbamazepine) and/or the substrate is extensively metabolised by this enzyme.

Dosage adjustments may be considered, and when possible, serum concentrations of drugs primarily metabolised by CYP3A should be monitored closely in patients concurrently receiving clarithromycin.

The following drugs or drug classes are known or suspected to be metabolised by the same CYP3A isozyme: alprazolam, astemizole, carbamazepine, cilostazol, cisapride, ciclosporin, disopyramide, ergot alkaloids, lovastatin, methylprednisolone, midazolam, omeprazole, oral anticoagulants (e.g. warfarin), pimozone, quinidine, rifabutin, sildenafil, simvastatin, sirolimus, tacrolimus, terfenadine, triazolam and vinblastine. Drugs interacting by similar mechanisms through other isozymes within the cytochrome P450 system include phenytoin, theophylline and valproate.

Antiarrhythmics

There have been post-marketed reports of torsade de points occurring with the concurrent use of clarithromycin and quinidine or disopyramide. Electrocardiograms should be monitored for QTc prolongation during co-administration of clarithromycin with these drugs. Serum levels of quinidine and disopyramide should be monitored during clarithromycin therapy.

Omeprazole

Clarithromycin (500 mg every 8 hours) was given in combination with omeprazole (40 mg daily) to healthy adult subjects. The steady-state plasma concentrations of omeprazole were increased (C_{max} , AUC_{0-24} , and $t_{1/2}$ increased by 30%, 89%, and 34%, respectively), by the concomitant administration of clarithromycin. The mean 24-hour gastric pH value was 5.2 when omeprazole was administered alone and 5.7 when omeprazole was co-administered with clarithromycin.

Sildenafil, tadalafil and vardenafil

Each of these phosphodiesterase inhibitors is metabolised, at least in part, by CYP3A, and CYP3A may be inhibited by concomitantly administered clarithromycin. Co-administration of clarithromycin with sildenafil, tadalafil or vardenafil would likely result in increased phosphodiesterase inhibitor exposure. Reduction of sildenafil, tadalafil and vardenafil dosages should be considered when these drugs are co-administered with clarithromycin.

Theophylline, carbamazepine

Results of clinical studies indicate that there was a modest but statistically significant ($p \leq 0.05$) increase of circulating theophylline or carbamazepine levels when either of these drugs were administered concomitantly with clarithromycin. Dose reduction may need to be considered.

Tolterodine

The primary route of metabolism for tolterodine is via the 2D6 isoform of cytochrome P450 (CYP2D6). However, in a subset of the population devoid of CYP2D6, the identified pathway of metabolism is via CYP3A. In this population subset, inhibition of CYP3A results in significantly higher serum concentrations of tolterodine. A reduction in tolterodine dosage may be necessary in the presence of CYP3A inhibitors, such as clarithromycin in the CYP2D6 poor metaboliser population.

Triazolobenzodiazepines (e.g., alprazolam, midazolam, triazolam)

When midazolam was co-administered with clarithromycin tablets (500 mg twice daily), midazolam AUC was increased 2.7-fold after intravenous administration of midazolam and 7-fold after oral administration. Concomitant administration of oral midazolam and clarithromycin should be avoided. If intravenous midazolam is co-administered with clarithromycin, the patient must be closely monitored to allow dose adjustment. The same precautions should also apply to other benzodiazepines that are metabolised by CYP3A, including triazolam and alprazolam. For benzodiazepines which are not dependent on CYP3A for their elimination (temazepam, nitrazepam, lorazepam), a clinically important interaction with clarithromycin is unlikely.

There have been post-marketing reports of drug interactions and central nervous system (CNS) effects (e.g., somnolence and confusion) with the concomitant use of clarithromycin and triazolam. Monitoring the patient for increased CNS pharmacological effects is suggested.

Other drug interactions

Colchicine

Colchicine is a substrate for both CYP3A and the efflux transporter, P-glycoprotein (Pgp). Clarithromycin and other macrolides are known to inhibit CYP3A and Pgp. When clarithromycin and colchicine are administered together, inhibition of Pgp and/or CYP3A by clarithromycin may lead to increased exposure to colchicine. Patients should be monitored for clinical symptoms of colchicine toxicity (see section 4.4).

Digoxin

Digoxin is thought to be a substrate for the efflux transporter, P-glycoprotein (Pgp). Clarithromycin is known to inhibit Pgp. When clarithromycin and digoxin are administered together, inhibition of Pgp by clarithromycin may lead to increased exposure to digoxin. Elevated digoxin serum concentrations in patients receiving clarithromycin and digoxin concomitantly have also been reported in post marketing surveillance. Some patients have shown clinical signs consistent with digoxin toxicity, including potentially fatal arrhythmias. Serum digoxin concentrations should be carefully monitored while patients are receiving digoxin and clarithromycin simultaneously.

Zidovudine

Simultaneous oral administration of clarithromycin tablets and zidovudine to HIV-infected adult patients may result in decreased steady-state zidovudine concentrations. Because clarithromycin appears to interfere with the absorption of simultaneously administered oral zidovudine, this interaction can be largely avoided by staggering the doses of clarithromycin and zidovudine to allow for a 4-hour interval between each medication. This interaction does not appear to occur in paediatric HIV-infected patients taking clarithromycin suspension with zidovudine or dideoxyinosine. This interaction is unlikely when clarithromycin is administered via intravenous infusion.

Phenytoin and Valproate

There have been spontaneous or published reports of interactions of CYP3A inhibitors, including clarithromycin with drugs not thought to be metabolised by CYP3A (e.g. phenytoin and valproate). Serum level determinations are recommended for these drugs when administered concomitantly with clarithromycin. Increased serum levels have been reported.

Bi-directional drug interactions

Atazanavir

Both clarithromycin and atazanavir are substrates and inhibitors of CYP3A, and there is evidence of a bi-directional drug interaction. Co-administration of clarithromycin (500 mg twice daily) with atazanavir (400 mg once daily) resulted in a 2-fold increase in exposure to clarithromycin and a 70% decrease in exposure to 14-OH-clarithromycin, with a 28% increase in the AUC of

atazanavir. Because of the large therapeutic window for clarithromycin, no dosage reduction should be necessary in patients with normal renal function. For patients with moderate renal function (creatinine clearance 30 to 60 mL/min), the dose of clarithromycin should be decreased by 50%. For patients with creatinine clearance <30 mL/min, the dose of clarithromycin should be decreased by 75% using an appropriate clarithromycin formulation. Doses of clarithromycin greater than 1000 mg per day should not be co-administered with protease inhibitors.

Itraconazole

Both clarithromycin and itraconazole are substrates and inhibitors of CYP3A, leading to a bidirectional drug interaction. Clarithromycin may increase the plasma levels of itraconazole, while itraconazole may increase the plasma levels of clarithromycin. Patients taking itraconazole and clarithromycin concomitantly should be monitored closely for signs or symptoms of increased or prolonged pharmacologic effect.

Saquinavir

Both clarithromycin and saquinavir are substrates and inhibitors of CYP3A, and there is evidence of a bi-directional drug interaction. Concomitant administration of clarithromycin (500 mg twice daily) and saquinavir (soft gelatin capsules, 1200 mg three times daily) to 12 healthy volunteers resulted in steady-state AUC and C_{max} values of saquinavir which were 177% and 187% higher than those seen with saquinavir alone. Clarithromycin AUC and C_{max} values were approximately 40% higher than those seen with clarithromycin alone. No dose adjustment is required when the two drugs are co-administered for a limited time at the doses/formulations studied. Observations from drug interaction studies using the soft gelatin capsule formulation may not be representative of the effects seen using the saquinavir hard gelatin capsule. Observations from drug interaction studies performed with saquinavir alone may not be representative of the effects seen with saquinavir/ritonavir therapy. When saquinavir is co-administered with ritonavir, consideration should be given to the potential effects of ritonavir on clarithromycin.

Verapamil

Hypotension, bradyarrhythmias and lactic acidosis have been observed in patients taking clarithromycin and verapamil concomitantly.

Clarithromycin has been shown not to interact with oral contraceptives.

4.6 Pregnancy and lactation

The safety of clarithromycin during pregnancy and breast feeding of infants has not been established. Based on variable results obtained from studies in mice, rats, rabbits and monkeys, the possibility of adverse effects on embryofetal development cannot be excluded. Therefore, use during

pregnancy is not advised without carefully weighing the benefits against risk. Clarithromycin is excreted into human breast milk.

4.7 Effects on ability to drive and use machines

There are no data on the effect of clarithromycin on the ability to drive or use machines. The potential for dizziness, vertigo, confusion and disorientation, which may occur with the medication, should be taken into account before patients drive or use machines.

4.8 Undesirable effects

a. Summary of the safety profile

The most frequent and common adverse reactions related to clarithromycin therapy for both adult and paediatric populations are abdominal pain, diarrhoea, nausea, vomiting and taste perversion. These adverse reactions are usually mild in intensity and are consistent with the known safety profile of macrolide antibiotics (see section b of section 4.8).

There was no significant difference in the incidence of these gastrointestinal adverse reactions during clinical trials between the patient population with or without pre-existing mycobacterial infections.

b. Tabulated summary of adverse reactions

The following table displays adverse reactions reported in clinical trials and from post-marketing experience with clarithromycin immediate-release tablets, granules for oral suspension, powder for solution for injection, extended-release tablets and modified-release tablets.

The reactions considered at least possibly related to clarithromycin are displayed by system organ class and frequency using the following convention: very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1,000$ to $< 1/100$) and not known (adverse reactions from post-marketing experience; cannot be estimated from the available data). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness when the seriousness could be assessed.

System Organ Class	Very common $\geq 1/10$	Common $\geq 1/100$ to $< 1/10$	Uncommon $\geq 1/1,000$ to $< 1/100$	Not Known (cannot be estimated from the available data)
Infections and infestations			Cellulitis ¹ , candidiasis, gastroenteritis ² , infection ³ , vaginal infection	Pseudomembranous colitis, erysipelas, erythrasma
Blood and lymphatic			Leukopenia, neutropenia ⁴ ,	Agranulocytosis, thrombocytopenia

system			thrombocythaemia ³ , eosinophilia ⁴	
Immune system disorders ⁵			Anaphylactoid reaction ¹ , hypersensitivity	Anaphylactic reaction
Metabolism and nutrition disorders			Anorexia, decreased appetite	Hypoglycaemia ⁶
Psychiatric disorders		Insomnia	Anxiety, nervousness ³ , screaming ³	Psychotic disorder, confusional state, depersonalisation, depression, disorientation, hallucination, abnormal dreams
Nervous system disorders		Dysgeusia, headache, taste perversion	Loss of consciousness ¹ , dyskinesia ¹ , dizziness, somnia ⁷ , tremor	Convulsion, ageusia, parosmia, anosmia
Ear and labyrinth disorders			Vertigo, hearing impaired, tinnitus	Deafness
Cardiac disorders			Cardiac arrest ¹ , atrial fibrillation ¹ , electrocardiogram QT prolonged ⁸ , extrasystoles ¹ , palpitations	Torsade de pointes ⁸ , ventricular tachycardia ⁸
Vascular disorders		Vasodilation ¹		Haemorrhage ⁹
Respiratory, thoracic and mediastinal disorder			Asthma ¹ , epistaxis ² , pulmonary embolism ¹	
Gastrointestinal disorders		Diarrhoea ¹⁰ , vomiting, dyspepsia, nausea, abdominal pain	Esophagitis ¹ , gastroesophageal reflux disease ² , gastritis, proctalgia ² , stomatitis, glossitis, abdominal distension ⁴ , constipation, dry mouth, eructation, flatulence,	Pancreatitis acute, tongue discolouration, tooth discoloration
Hepatobiliary disorders		Liver function test abnormal	Cholestasis ⁴ , hepatitis ⁴ , alanine aminotransferase increased, aspartate aminotransferase increased, gamma- glutamyltransferase increased ⁴	Hepatic failure ¹¹ , jaundice hepatocellular
Skin and subcutaneous tissue disorders		Rash, hyperhidrosis	Dermatitis bullous ¹ , pruritus, urticaria, rash maculo-papular ³	Stevens-Johnson syndrome ⁵ , toxic epidermal necrolysis ⁵ , drug rash with eosinophilia and systemic symptoms (DRESS), acne
Musculoskeletal and connective tissue disorders			Muscle spasms ³ , musculoskeletal stiffness ¹ , myalgia ²	Rhabdomyolysis ^{2,12**} , myopathy
Renal and urinary			Blood creatinine increased ¹ , blood urea	Renal failure, nephritis interstitial

disorders			increased ¹	
General disorders and administration site conditions	Injection site phlebitis ¹	Injection site pain ¹ , injection site inflammation ¹	Malaise ⁴ , pyrexia ³ , asthenia, chest pain ⁴ , chills ⁴ , fatigue ⁴	
Investigations			Albumin globulin ratio abnormal ¹ , blood alkaline phosphatase increased ⁴ , blood lactate dehydrogenase increased ⁴	International normalised ratio increased ⁹ , prothrombin time prolonged ⁹ , urine color abnormal

¹ ADRs reported only for the Powder for Solution for Injection formulation

² ADRs reported only for the Extended-Release Tablets formulation

³ ADRs reported only for the Granules for Oral Suspension formulation

⁴ ADRs reported only for the Immediate-Release Tablets formulation

^{5,8,10,11,12} See section a)

^{6,7,9} See section c)

c. Description of selected adverse reactions

Injection site phlebitis, injection site pain, vessel puncture site pain, and injection site inflammation are specific to the clarithromycin intravenous formulation.

In very rare instances, hepatic failure with fatal outcome has been reported and generally has been associated with serious underlying diseases and/or concomitant medications (see section 4.4).

A special attention to diarrhoea should be paid as *Clostridium difficile*-associated diarrhoea (CDAD) has been reported with use of nearly all antibacterial agents including clarithromycin, and may range in severity from mild diarrhoea to fatal colitis. (see section 4.4)

In the event of severe acute hypersensitivity reactions, such as anaphylaxis, Stevens-Johnson Syndrome and toxic epidermal necrolysis, clarithromycin therapy should be discontinued immediately and appropriate treatment should be urgently initiated (see section 4.4).

As with other macrolides, QT prolongation, ventricular tachycardia, and *torsade de pointes* have rarely been reported with clarithromycin (see section 4.4 and 4.5).

Pseudomembranous colitis has been reported with nearly all antibacterial agents, including clarithromycin, and may range in severity from mild to life threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhoea subsequent to the administration of antibacterial agents (see section 4.4).

In some of the reports of rhabdomyolysis, clarithromycin was administered concomitantly with statins, fibrates, colchicine or allopurinol (see section 4.3 and 4.4).

There have been post-marketing reports of colchicine toxicity with concomitant use of clarithromycin and colchicine, especially in elderly and/or patients with renal insufficiency, some with a fatal outcome. (see sections 4.4 and 4.5).

There have been rare reports of hypoglycaemia, some of which have occurred in patients on concomitant oral hypoglycaemic agents or insulin (see section 4.4 and 4.5).

There have been post-marketing reports of drug interactions and central nervous system (CNS) effects (e.g. somnolence and confusion) with the concomitant use of clarithromycin and triazolam. Monitoring the patient for increased CNS pharmacological effects is suggested (see section 4.5).

There is a risk of serious haemorrhage and significant elevations in INR and prothrombin time when clarithromycin is co-administered with warfarin. INR and prothrombin times should be frequently monitored while patients are receiving clarithromycin and oral anticoagulants concurrently (see section 4.4 and 4.5).

There have been rare reports of clarithromycin ER tablets in the stool, many of which have occurred in patients with anatomic (including ileostomy or colostomy) or functional gastrointestinal disorders with shortened GI transit times. In several reports, tablet residues have occurred in the context of diarrhoea. It is recommended that patients who experience tablet residue in the stool and no improvement in their condition should be switched to a different clarithromycin formulation (e.g. suspension) or another antibiotic.

Special population: Adverse Reactions in Immunocompromised Patients (see section e)

d. Paediatric populations

Clinical trials have been conducted using clarithromycin paediatric suspension in children 6 months to 12 years of age. Therefore, children under 12 years of age should use clarithromycin paediatric suspension. There are insufficient data to recommend a dosage regimen for use of the clarithromycin IV formulation in patients less than 18 years of age.

Frequency, type and severity of adverse reactions in children are expected to be the same as in adults.

e. Other special populations

Immunocompromised patients

In AIDS and other immunocompromised patients treated with the higher doses of clarithromycin over long periods of time for mycobacterial infections, it was

often difficult to distinguish adverse events possibly associated with clarithromycin administration from underlying signs of Human Immunodeficiency Virus (HIV) disease or intercurrent illness.

In adult patients, the most frequently reported adverse reactions by patients treated with total daily doses of 1000 mg and 2000mg of clarithromycin were: nausea, vomiting, taste perversion, abdominal pain, diarrhoea, rash, flatulence, headache, constipation, hearing disturbance, Serum Glutamic Oxaloacetic Transaminase (SGOT) and Serum Glutamic Pyruvate Transaminase (SGPT) elevations. Additional low-frequency events included dyspnoea, insomnia and dry mouth. The incidences were comparable for patients treated with 1000mg and 2000mg, but were generally about 3 to 4 times as frequent for those patients who received total daily doses of 4000mg of clarithromycin.

In these immunocompromised patients, evaluations of laboratory values were made by analysing those values outside the seriously abnormal level (i.e. the extreme high or low limit) for the specified test. On the basis of these criteria, about 2% to 3% of those patients who received 1000mg or 2000mg of clarithromycin daily had seriously abnormal elevated levels of SGOT and SGPT, and abnormally low white blood cell and platelet counts. A lower percentage of patients in these two dosage groups also had elevated Blood Urea Nitrogen levels. Slightly higher incidences of abnormal values were noted for patients who received 4000mg daily for all parameters except White Blood Cell.

4.9 Overdose

Reports indicate that the ingestion of large amounts of clarithromycin can be expected to produce gastro-intestinal symptoms. One patient who had a history of bipolar disorder ingested 8 grams of clarithromycin and showed altered mental status, paranoid behaviour, hypokalaemia and hypoxaemia.

Adverse reactions accompanying overdosage should be treated by the prompt elimination of unabsorbed drug and supportive measures. As with other macrolides, clarithromycin serum levels are not expected to be appreciably affected by haemodialysis or peritoneal dialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Clarithromycin is a semi-synthetic derivative of erythromycin A. It exerts its antibacterial action by binding to the 50s ribosomal sub-unit of susceptible bacteria and suppresses protein synthesis. It is highly potent against a wide variety of aerobic and anaerobic gram-positive and gram-negative organisms. The minimum inhibitory concentrations (MICs) of clarithromycin are generally two-fold lower than the MICs of erythromycin.

The 14-hydroxy metabolite of clarithromycin also has antimicrobial activity. The MICs of this metabolite are equal or two-fold higher than the MICs of the parent compound, except for *H. influenzae* where the 14-hydroxy metabolite is two-fold more active than the parent compound.

Clarithromycin is usually active against the following organisms *in vitro*:

Gram-positive Bacteria: *Staphylococcus aureus* (methicillin susceptible); *Streptococcus pyogenes* (Group A beta-hemolytic streptococci); alpha-hemolytic streptococci (viridans group); *Streptococcus (Diplococcus) pneumoniae*; *Streptococcus agalactiae*; *Listeria monocytogenes*.

Gram-negative Bacteria: *Haemophilus influenzae*; *Haemophilus parainfluenzae*; *Moraxella (Branhamella) catarrhalis*; *Neisseria gonorrhoeae*; *Legionella pneumophila*; *Bordetella pertussis*; *Campylobacter jejuni*.

Mycoplasma: *Mycoplasma pneumoniae*; *Ureaplasma urealyticum*.

Other Organisms: *Chlamydia trachomatis*; *Mycobacterium avium*; *Mycobacterium leprae*; *Mycobacterium kansasii*; *Mycobacterium chelonae*; *Mycobacterium fortuitum*; *Mycobacterium intracellulare*; *Chlamydia pneumoniae*.

Anaerobes: *Clostridium perfringens*; Peptococcus species; Peptostreptococcus species; *Propionibacterium acnes*.

Clarithromycin has bactericidal activity against several bacterial strains. The organisms include *Haemophilus influenzae*; *Streptococcus pneumoniae*; *Streptococcus pyogenes*; *Streptococcus agalactiae*; *Moraxella (Branhamella) catarrhalis*; *Neisseria gonorrhoeae* and *Campylobacter* spp.

5.2 Pharmacokinetic properties

The kinetics of orally administered modified-release clarithromycin have been studied in adult humans and compared with clarithromycin 250mg and 500mg immediate release tablets. The extent of absorption was found to be equivalent when equal total daily doses were administered. The absolute bioavailability is approximately 50%. Little or no unexplained accumulation was found and the metabolic disposition did not change in any species following multiple dosing. Based upon the finding of equivalent absorption the following *in vitro* and *in vivo* data are applicable to the modified-release formulation.

In vitro: Results of *in vitro* studies showed that the protein binding of clarithromycin in human plasma averaged about 70 % at concentrations of 0.45 - 4.5µg/mL. A decrease in binding to 41% at 45.0µg/mL suggested that the binding sites might become saturated, but this only occurred at concentrations far in excess of therapeutic drug levels.

In vivo: Clarithromycin levels in all tissues, except the central nervous system, were several times higher than the circulating drug levels. The highest concentrations were found in the liver and lung tissue, where the tissue to plasma ratios reached 10 to 20.

The pharmacokinetic behaviour of clarithromycin is non-linear. In fed patients given 500mg clarithromycin modified-release daily, the peak steady state plasma concentration of clarithromycin and 14 hydroxy clarithromycin were 1.3 and 0.48µg/mL, respectively. When the dosage was increased to 1000mg daily, these steady-state values were 2.4µg/mL and 0.67µg/mL respectively. Elimination half-lives of the parent drug and metabolite were approximately 5.3 and 7.7 hours respectively. The apparent half-lives of both clarithromycin and its hydroxylated metabolite tended to be longer at higher doses.

Urinary excretion accounted for approximately 40% of the clarithromycin dose. Faecal elimination accounts for approximately 30%.

5.3 Preclinical safety data

In repeated dose studies, clarithromycin toxicity was related to dose and duration of treatment. The primary target organ was the liver in all species, with hepatic lesions seen after 14 days in dogs and monkeys. Systemic exposure levels associated with this toxicity are not known but toxic mg/kg doses were higher than the dose recommended for patient treatment.

No evidence of mutagenic potential of clarithromycin was seen during a range of in vitro and in vivo tests.

Fertility and reproduction studies in rats have shown no adverse effects. Teratogenicity studies in rats (Wistar (p.o.) and Sprague-Dawley (p.o. and i.v.)), New Zealand White rabbits and cynomolgous monkeys failed to demonstrate any teratogenicity from clarithromycin. However, a further similar study in Sprague-Dawley rats indicated a low (6%) incidence of cardiovascular abnormalities which appeared to be due to spontaneous expression of genetic changes. Two mouse studies revealed a variable incidence (3-30%) of cleft palate and in monkeys embryonic loss was seen but only at dose levels which were clearly toxic to the mothers.

No other toxicological findings considered to be of relevance to the dose level recommended for patient treatment have been reported.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Citric acid anhydrous, sodium alginate, sodium calcium alginate, lactose¹, povidone K30, talc, water purified¹, ethanol¹, stearic acid, magnesium stearate, methylhydroxypropyl cellulose (hypromellose) 6cps, polyethylene glycol

(macrogol) 400, polyethylene glycol (macrogol) 8000, titanium dioxide (E171), sorbic acid, quinoline yellow (dye) aluminium lake (E104).

1. not present in the finished drug product

6.2 Incompatibilities

None known.

6.3 Shelf-life

36 months

6.4 Special precautions for storage

Below 30°C

6.5 Nature and contents of container

Blister. 1, 2, 4, 5, 6, 7, 8, 10, 12, 14, 16, 20 tablets in package.

6.6 Special precautions for disposal of a used medicinal product or waste materials derived from such medicinal products and other handling of the product _

Not applicable.

7. MANUFACTURER

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QUEENBOROUGH, KENT ME11 5EL, ENGLAND

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