

## SUMMARY OF PRODUCT CHARACTERISTICS

### 1 NAME OF THE MEDICINAL PRODUCT

Clarithromycin 250mg Film-coated Tablets

### 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains clarithromycin, 250 mg

For excipients, see 6.1.

### 3 PHARMACEUTICAL FORM

Film coated Tablet

Yellow, oval, film-coated, biconvex tablets, “250” on one side and “CL” on the other side.

### 4 CLINICAL PARTICULARS

#### 4.1 Therapeutic indications

Clarithromycin 250 mg Film-coated Tablets are indicated in adults and children 12 years and older.

Clarithromycin 250 mg Film-coated Tablets are indicated for treatment of infections caused by susceptible micro-organisms. Indications include:

Lower respiratory tract infections, for example; acute and chronic bronchitis, and pneumonia. Upper respiratory tract infections, for example; sinusitis and pharyngitis.

Clarithromycin is appropriate for initial therapy in community acquired respiratory infections and has been shown to be active in vitro against common and atypical respiratory pathogens.

Clarithromycin is also indicated in skin and soft tissue infections of mild to moderate severity.

Clarithromycin in the presence of acid suppression effected by omeprazole or lansoprazole is also indicated for the eradication of *H. pylori* in patients with duodenal ulcers. See section 4.2 Posology and method of administration

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

#### 4.2 Posology and method of administration

Children younger than 12 years: Use of clarithromycin tablets is not recommended for children younger than 12 years. Use clarithromycin paediatric suspension.

Children older than 12 years: As for adults.

The usual duration of treatment is 6 to 14 days.

*Patients with respiratory tract/skin and soft tissue infections:*

Adults and children over 12 years: The usual dose is 250 mg twice daily for 7 days although this may be increased to 500mg twice daily for up to 14 days in severe infections.

*Eradication of H. pylori in patients with duodenal ulcers (Adults):*

Triple Therapy (7 - 14 days): Clarithromycin 500 mg twice daily and lansoprazole 30 mg twice daily should be given with amoxicillin 1000 mg twice daily for 7 - 14 days.

Triple Therapy (7 days): Clarithromycin 500 mg twice daily and lansoprazole 30 mg twice daily should be given with metronidazole 400 mg twice daily for 7 days.

Triple Therapy (7 days): Clarithromycin 500 mg twice daily and omeprazole 40 mg daily should be given with amoxicillin 1000 mg twice daily or metronidazole 400 mg twice daily for 7 days.

Triple Therapy (10 days): Clarithromycin 500mg twice daily should be given with amoxicillin 1000mg twice daily and omeprazole 20mg daily for 10 days.

Dual Therapy (14 days): Clarithromycin can be dosed 500 mg three times daily for 14 days. Clarithromycin should be administered with oral omeprazole 40 mg once daily. The fundamental study was conducted with omeprazole 40 mg once daily for 28 days. Supportive studies have been conducted with omeprazole 40 mg once daily for 14 days.

Dosage adjustment is not required for the elderly.

Renal impairment:

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.

Clarithromycin Film-coated Tablets may be given irrespective of food as it does not affect the extent of bioavailability.

### **4.3 Contraindications**

Clarithromycin is contraindicated in patients with known hypersensitivity to clarithromycin, to any other macrolide antibiotic drug, or any other ingredient of the tablets.

Concomitant administration of clarithromycin and any of the following drugs is contraindicated: astemizole, cisapride, pimozone, terfenadine as this may result in QT prolongation and cardiac arrhythmias, including ventricular tachycardia, ventricular fibrillation, and torsades de pointe (see section 4.5). Concomitant administration of clarithromycin and ergotamine or dihydroergotamine is contraindicated, as this may result in ergot toxicity.

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 the 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 diarrhea (CDAD) has been reported with use of nearly all antibacterial agents including clarithromycin, and may range in severity from mild diarrhea 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 diarrhea 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, hypomagnesemia, 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 hypoglycemic agents/Insulin: The concomitant use of clarithromycin and oral hypoglycemic agents and/or insulin can result in significant hypoglycemia. With certain hypoglycemic drugs such as nateglinide, pioglitazone, repaglinide and rosiglitazone, inhibition of CYP3A enzyme by clarithromycin may be involved and could cause hypoglycemia when used concomitantly. Careful monitoring of glucose is recommended.

Oral anticoagulants: There is a risk of serious hemorrhage 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 colonization 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

#### **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, pimozide, 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 pimozide 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 a two to three 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

Postmarketing reports indicate that co-administration of clarithromycin with ergotamine or dihydroergotamine has been associated with acute ergot toxicity characterized by vasospasm, and ischemia 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<sub>min</sub>) 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<sub>max</sub> increased by 31%, C<sub>min</sub> 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<sub>CR</sub> 30 to 60 mL/min the dose of clarithromycin should be reduced by 50%. For patients with CL<sub>CR</sub> <30 mL/min the dose of clarithromycin should be decreased by 75%. Doses of clarithromycin greater than 1 gm/day should not be coadministered 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 metabolized 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 metabolized by this enzyme.

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

The following drugs or drug classes are known or suspected to be metabolized by the same CYP3A isozyme: alprazolam, astemizole, carbamazepine, cilostazol, cisapride, cyclosporine, 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 postmarketing reports of torsades de pointes occurring with concurrent use of clarithromycin and quinidine or disopyramide. Electrocardiograms should be monitored for QT 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<sub>max</sub>, AUC<sub>0-24</sub>, and t<sub>1/2</sub> 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 metabolized, 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 there was a modest but statistically significant ( $p \geq 0.05$ ) 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 metabolizer 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 metabolized 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 metabolized 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<sub>max</sub> values of saquinavir which were 177% and 187% higher than those seen with saquinavir alone. Clarithromycin AUC and C<sub>max</sub> 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.

#### Indications with other *H.pylori* regimes

Although the plasma concentrations of clarithromycin and omeprazole may be increased when they are administered concurrently, no adjustment to the dosage is necessary. At the dosages recommended, there is no clinically significant interaction between clarithromycin and lansoprazole. Increased plasma concentrations of clarithromycin may also occur when it is co-administered with Maalox or ranitidine. No amendment to the dosage is necessary.

#### Oral Contraceptives

Clarithromycin has been shown not to interact with oral contraceptives.

### **4.6 Fertility, pregnancy and lactation**

The safety of clarithromycin for use 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 pediatric populations are abdominal pain, diarrhea, 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.

<b>System Organ Class</b>	<b>Very common ≥1/10</b>	<b>Common ≥ 1/100 to &lt; 1/10</b>	<b>Uncommon ≥1/1,000 to &lt; 1/100</b>	<b>Not Known (cannot be estimated from the available data)</b>
Infections and infestations			Cellulitis <sup>1</sup> , candidiasis, gastroenteritis <sup>2</sup> , infection <sup>3</sup> , vaginal infection	Pseudomembranous colitis, erysipelas, erythrasma
Blood and lymphatic system			Leukopenia, neutropenia <sup>4</sup> , thrombocythemia <sup>3</sup> , eosinophilia <sup>4</sup>	Agranulocytosis, thrombocytopenia
Immune system disorders <sup>5</sup>			Anaphylactoid reaction <sup>1</sup> , hypersensitivity	Anaphylactic reaction
Metabolism and nutrition disorders			Anorexia, decreased appetite	Hypoglycaemia <sup>6</sup>
Psychiatric disorders		Insomnia	Anxiety, nervousness <sup>3</sup> , screaming <sup>3</sup>	Psychotic disorder, confusional state, depersonalisation, depression, disorientation, hallucination, abnormal dreams
Nervous system disorders		Dysgeusia, headache, taste perversion	Loss of consciousness <sup>1</sup> , dyskinesia <sup>1</sup> , dizziness, somnolence <sup>7</sup> , tremor	Convulsion, ageusia, parosmia, anosmia
Ear and labyrinth disorders			Vertigo, hearing impaired, tinnitus	Deafness
Cardiac disorders			Cardiac arrest <sup>1</sup> , atrial fibrillation <sup>1</sup> , electrocardiogram QT prolonged <sup>8</sup> , extrasystoles <sup>1</sup> , palpitations	Torsade de pointes <sup>8</sup> , ventricular tachycardia <sup>8</sup>
Vascular disorders		Vasodilation <sup>1</sup>		Hemorrhage <sup>9</sup>
Respiratory, thoracic and mediastinal disorder			Asthma <sup>1</sup> , epistaxis <sup>2</sup> , pulmonary embolism <sup>1</sup>	
Gastrointestinal		Diarrhea <sup>10</sup> ,	Esophagitis <sup>1</sup> ,	Pancreatitis acute,

disorders		vomiting, dyspepsia, nausea, abdominal pain	gastro-oesophageal reflux disease <sup>2</sup> , gastritis, proctalgia <sup>2</sup> , stomatitis, glossitis, abdominal distension <sup>4</sup> , constipation, dry mouth, eructation, flatulence,	tongue discolouration, tooth discoloration
Hepatobiliary disorders		Liver function test abnormal	Cholestasis <sup>4</sup> , hepatitis <sup>4</sup> , alanine aminotransferase increased, aspartate aminotransferase increased, gamma-glutamyltransferase increased <sup>4</sup>	Hepatic failure <sup>11</sup> , jaundice hepatocellular
Skin and subcutaneous tissue disorders		Rash, hyperhidrosis	Dermatitis bullous <sup>1</sup> , pruritus, urticaria, rash maculopapular <sup>3</sup>	Stevens-Johnson syndrome <sup>5</sup> , toxic epidermal necrolysis <sup>5</sup> , drug rash with eosinophilia and systemic symptoms (DRESS), acne
Musculoskeletal and connective tissue disorders			Muscle spasms <sup>3</sup> , musculoskeletal stiffness <sup>1</sup> , myalgia <sup>2</sup>	Rhabdomyolysis <sup>2,12</sup> , myopathy
Renal and urinary disorders			Blood creatinine increased <sup>1</sup> , blood urea increased <sup>1</sup>	Renal failure, nephritis interstitial
General disorders and administration site conditions	Injection site phlebitis <sup>1</sup>	Injection site pain <sup>1</sup> , injection site inflammation <sup>1</sup>	Malaise <sup>4</sup> , pyrexia <sup>3</sup> , asthenia, chest pain <sup>4</sup> , chills <sup>4</sup> , fatigue <sup>4</sup>	
Investigations			Albumin globulin ratio abnormal <sup>1</sup> , blood alkaline phosphatase increased <sup>4</sup> , blood lactate dehydrogenase increased <sup>4</sup>	International normalised ratio increased <sup>9</sup> , prothrombin time prolonged <sup>9</sup> , urine color abnormal

<sup>1</sup> ADRs reported only for the Powder for Solution for Injection formulation

<sup>2</sup> ADRs reported only for the Extended-Release Tablets formulation

<sup>3</sup> ADRs reported only for the Granules for Oral Suspension formulation

<sup>4</sup> ADRs reported only for the Immediate-Release Tablets formulation

<sup>5,8,10,11,12</sup>See section a)

<sup>6,7,9</sup>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 diarrhea should be paid as *Clostridium difficile*-associated diarrhea (CDAD) has been reported with use of nearly all antibacterial agents including clarithromycin, and may range in severity from mild diarrhea 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 diarrhea 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 hypoglycemia, some of which have occurred in patients on concomitant oral hypoglycemic 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 hemorrhage 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 diarrhea. 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, diarrhea, 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.

#### **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](http://www.mhra.gov.uk/yellowcard).

## **4.9 Overdose**

Reports indicate the ingestion of large amounts of clarithromycin can be expected to produce gastrointestinal symptoms. One patient who had a history of bipolar disorder ingested eight grams of clarithromycin and showed altered mental status, paranoid behavior, hypokalemia, and hypoxemia.

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 hemodialysis or peritoneal dialysis.

## 5 PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antibacterials for systemic use, Macrolides ATC code J01F A09

#### Mechanism of Action

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.

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.

#### Breakpoints

BSAC  $R \geq 1$   $S \leq 0.5$  mg/L, except *H. influenzae*  $R \geq 32$   $S \leq 0.5$  mg/L and *H.pylori*  $R \geq 2$   $S \leq 1$  mg/L

#### Susceptibility

The prevalence of resistance may vary geographically and with time selected species and local information on resistance is desirable, particularly when treating severe infections. This information gives only an approximate guidance on probabilities whether microorganisms will be susceptible to clarithromycin or not.

The susceptibility pattern of various micro-organisms to clarithromycin is presented below:

<b>Commonly susceptible species</b>
Gram-negative bacteria <i>Moraxella catarrhalis</i>
Anaerobic Bacteria <i>Peptococcus species</i> <i>Peptostreptococcus species</i> <i>Propionibacterium acnes</i> <i>Clostridium perfringens</i>
Others <i>Chlamydia pneumoniae</i> <i>Legionella pneumophila</i> <i>Mycoplasma pneumoniae</i>
<b>Species for which acquired resistance may be a problem</b>

Gram-positive bacteria <i>Staphylococcus aureus</i> (methicillin-susceptible) <i>Staphylococcus aureus</i> (methicillin-resistant)* <i>Streptococcus agalactiae</i> <i>Streptococcus pneumoniae</i> <i>Streptococcus pyogenes</i>
Gram-negative bacteria <i>Haemophilus influenzae</i>
<i>Staphylococcus aureus</i> (methicillin-resistant)

\*Resistance to macrolides among MRSA is commonly more than 50% in the EU and affects nearly all strains in some areas.

### Mechanisms of Resistance

Resistance of gram-positive organisms to the macrolides usually involves an alteration of the antimicrobial binding site. The MLSB type resistance, which may be constitutive or induced by exposure to certain macrolides in staphylococci and which is inducible in streptococci, is mediated by a variety of acquired genes (erm family) encoding methylases targeted at the peptidyl transferase centre of 23S ribosomal RNA. Methylation impedes binding of antibacterials to the ribosome and gives rise to cross resistance to macrolides (all macrolides when constitutive), lincosamides and type B streptogramins but not to type A streptogramins. Less frequent mechanisms of resistance include antimicrobial degradation by inactivating enzymes such as esterase and active efflux of the antimicrobial from the bacteria.

Gram negative organisms may be intrinsically resistant to the macrolides because of the inability of the macrolide to effectively penetrate the outer cell membrane; macrolides having a better penetration may have activity against some gram-negative organisms.

Gram-negative organisms may also produce ribosomal methylase or macrolide inactivating enzymes.

## **5.2 Pharmacokinetic properties**

*H. pylori* is associated with acid peptic disease including duodenal ulcer and gastric ulcer in which about 95% and 80% of patients respectively are infected with the agent. *H. pylori* is also viewed as a major contribution factor in the development of gastric and ulcer recurrence in such individuals.

Clarithromycin has been used in small numbers of patients in other treatment regimens. Possible kinetic interactions have not been fully investigated. These regimens include:

Clarithromycin plus tinidazole and omeprazole; clarithromycin plus tetracycline, bismuth subsalicylate and ranitidine; clarithromycin plus ranitidine alone.

Clinical studies using various different *H. pylori* eradication regimens have shown that eradication of *H. pylori* prevents ulcers returning.

Clarithromycin is rapidly and well absorbed from the gastro-intestinal tract after oral administration of Clarithromycin Film coated Tablets. The microbiologically active metabolite 14-hydroxyclearithromycin is formed by first pass metabolism.

Clarithromycin Film coated Tablets may be given without regard to meals as food does not affect the extent of bioavailability of the medicinal product. Food does slightly delay the onset of absorption of clarithromycin and formation of the 14-hydroxymetabolite. The pharmacokinetics of clarithromycin are non linear; however, steady-state is attained within 2 days of dosing. At 250 mg b.i.d. 15-20% of unchanged drug is excreted in the urine. With 500 mg b.i.d. daily dosing urinary excretion is greater (approximately 36%). The 14-hydroxyclarithromycin is the major urinary metabolite and accounts for 10-15% of the dose. Most of the remnants of the dose are removed in the faeces, primarily via the bile. 5-10% of the parent drug is recovered from the faeces.

When clarithromycin 500 mg is given three times daily, the clarithromycin plasma concentrations are increased with respect to the 500 mg twice daily dosage. Clarithromycin Film-coated Tablets provides tissue concentrations that are several times higher than the circulating drug levels. Elevated levels have been found in both tonsillar and lung tissue. Clarithromycin is 80% bound to plasma proteins at therapeutic levels.

Clarithromycin also penetrates the gastric mucus. Levels of clarithromycin in gastric mucus and gastric tissue are higher when clarithromycin is co-administered with omeprazole than when clarithromycin is administered alone.

### **5.3 Preclinical safety data**

In acute mouse and rat studies, the median lethal dose was greater than the highest feasible dose for administration (5g/kg).

In repeated dose studies, toxicity was related to dose, duration of treatment and species. Dogs were more sensitive than primates or rats. The major clinical signs at toxic doses included emesis, weakness, reduced food consumption and weight gain, salivation, dehydration and hyperactivity. In all species the liver was the primary target organ at toxic doses. Hepatotoxicity was detectable by early elevations of liver function tests. Discontinuation of the drug generally resulted in a return to or toward normal results. Other tissues less commonly affected included the stomach, thymus and other lymphoid tissues and the kidneys. At near therapeutic doses, conjunctival injection and lacrimation occurred only in dogs. At a massive dose of 400mg/kg/day, some dogs and monkeys developed corneal opacities and/or oedema.

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 show any teratogenicity from clarithromycin. However, a further study in Sprague-Dawley rats indicated a low (6%) incidence of cardiovascular abnormalities which seemed to be due to spontaneous expression of genetic changes. Two mouse studies revealed a variable incidence (3-30%) of cleft palate and embryonic loss was seen in monkeys but only at dose levels which were clearly toxic to the mothers.

## **6 PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

Microcrystalline cellulose

Croscarmellose sodium

Pregelatinised maize starch

Colloidal anhydrous silica

Povidone

Talc

Magnesium stearate

Titanium dioxide

Polydextrose (E1200)

Hypromellose

Triacetin

Macrogol

Quinoline yellow (E104)

## **6.2 Incompatibilities**

Not applicable.

## **6.3 Shelf life**

36 months

## **6.4 Special precautions for storage**

Do not store above 30° C

## **6.5 Nature and contents of container**

- a) AL/PVDC Blister packs Pack size 12 & 14 tablets
- b) HDPE container with PP cap. Pack size 100 tablets

## **6.6 Special precautions for disposal**

No special requirements

## **7 MARKETING AUTHORISATION HOLDER**

Aptil Pharma Limited

Unit 4, Charlwood Court,

County Oak Way

Crawley

West Sussex

RH11 7XA

United Kingdom

## **8 MARKETING AUTHORISATION NUMBER(S)**

PL 40378/0009

**9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE  
AUTHORISATION**

04/10/2005

**10 DATE OF REVISION OF THE TEXT**

[to be inserted]

## **SUMMARY OF PRODUCT CHARACTERISTICS**

### **1 NAME OF THE MEDICINAL PRODUCT**

Clarithromycin 500mg Film-coated Tablets

### **2 QUALITATIVE AND QUANTITATIVE COMPOSITION**

Each tablet contains clarithromycin, 500 mg

For excipients, see 6.1.

### **3 PHARMACEUTICAL FORM**

Film coated Tablet

Yellow, oval, film-coated, biconvex tablets, “500” on one side and “CL” on the other side.

### **4 CLINICAL PARTICULARS**

#### **4.1 Therapeutic indications**

Clarithromycin 500 mg Film-coated Tablets are indicated in adults and children 12 years and older.

Clarithromycin 500 mg Film-coated Tablets are indicated for treatment of infections caused by susceptible micro-organisms. Indications include:

Lower respiratory tract infections, for example; acute and chronic bronchitis, and pneumonia. Upper respiratory tract infections, for example; sinusitis and pharyngitis.

Clarithromycin is appropriate for initial therapy in community acquired respiratory infections and has been shown to be active *in vitro* against common and atypical respiratory pathogens.

Clarithromycin is also indicated in skin and soft tissue infections of mild to moderate severity.

Clarithromycin in the presence of acid suppression effected by omeprazole or lansoprazole is also indicated for the eradication of *H. pylori* in patients with duodenal ulcers. See section 4.2 Posology and method of administration.

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

#### **4.2 Posology and method of administration**

Children younger than 12 years: Use of clarithromycin tablets is not recommended for children younger than 12 years. Use clarithromycin paediatric suspension.  
Children older than 12 years: As for adults.

The usual duration of treatment is 6 to 14 days.

*Patients with respiratory tract/skin and soft tissue infections:*

Adults and children over 12 years: The usual dose is 250 mg twice daily for 7 days although this may be increased to 500mg twice daily for up to 14 days in severe infections.

*Eradication of H. pylori in patients with duodenal ulcers (Adults):*

Triple Therapy (7 - 14 days) : Clarithromycin 500 mg twice daily and lansoprazole 30 mg twice daily should be given with amoxicillin 1000 mg twice daily for 7 - 14 days.

Triple Therapy (7 days) : Clarithromycin 500 mg twice daily and lansoprazole 30 mg twice daily should be given with metronidazole 400 mg twice daily for 7 days.

Triple Therapy (7 days) : Clarithromycin 500 mg twice daily and omeprazole 40 mg daily should be given with amoxicillin 1000 mg twice daily or metronidazole 400 mg twice daily for 7 days.

Triple Therapy (10 days) : Clarithromycin 500mg twice daily should be given with amoxicillin 1000mg twice daily and omeprazole 20mg daily for 10 days.

Dual Therapy (14 days) : Clarithromycin can be dosed 500 mg three times daily for 14 days. Clarithromycin should be administered with oral omeprazole 40 mg once daily. The fundamental study was conducted with omeprazole 40 mg once daily for 28 days. Supportive studies have been conducted with omeprazole 40 mg once daily for 14 days.

Dosage adjustment is not required for the elderly.

**Renal impairment:**

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.

Clarithromycin Film-coated Tablets may be given irrespective of food as it does not affect the extent of bioavailability.

### **4.3 Contraindications**

Clarithromycin is contraindicated in patients with known hypersensitivity to clarithromycin, to any other macrolide antibiotic drug, or any other ingredient of the tablets.

Concomitant administration of clarithromycin and any of the following drugs is contraindicated: astemizole, cisapride, pimozide, terfenadine as this may result in QT prolongation and cardiac arrhythmias, including ventricular tachycardia, ventricular fibrillation, and torsades de pointe (see section 4.5). Concomitant administration of clarithromycin and ergotamine or dihydroergotamine is contraindicated, as this may result in ergot toxicity.

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 the 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 diarrhea (CDAD) has been reported with use of nearly all antibacterial agents including clarithromycin, and may range in severity from mild diarrhea 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 diarrhea 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, hypomagnesemia, 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 hypoglycemic agents/Insulin: The concomitant use of clarithromycin and oral hypoglycemic agents and/or insulin can result in significant hypoglycemia. With certain hypoglycemic drugs such as nateglinide, pioglitazone, repaglinide and rosiglitazone, inhibition of CYP3A enzyme by clarithromycin may be involved and could cause hypoglycemia when used concomitantly. Careful monitoring of glucose is recommended.

Oral anticoagulants: There is a risk of serious hemorrhage 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 colonization 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.

#### **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 a two to three 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

Postmarketing reports indicate that co-administration of clarithromycin with ergotamine or dihydroergotamine has been associated with acute ergot toxicity characterized by vasospasm, and ischemia 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 coadministered 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 metabolized 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 metabolized by this enzyme.

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

The following drugs or drug classes are known or suspected to be metabolized by the same CYP3A isozyme: alprazolam, astemizole, carbamazepine, cilostazol, cisapride, cyclosporine, 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 postmarketing reports of torsades de pointes occurring with concurrent use of clarithromycin and quinidine or disopyramide. Electrocardiograms should be monitored for QT 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 metabolized, 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 there was a modest but statistically significant ( $p \geq 0.05$ ) 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 metabolizer 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 metabolized 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 metabolized 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.

#### Indications with other *H.pylori* regimes

Although the plasma concentrations of clarithromycin and omeprazole may be increased when they are administered concurrently, no adjustment to the dosage is necessary. At the dosages recommended, there is no clinically significant interaction between clarithromycin and lansoprazole. Increased plasma concentrations of clarithromycin may also occur when it is co-administered with Maalox or ranitidine. No amendment to the dosage is necessary.

#### Oral Contraceptives

Clarithromycin has been shown not to interact with oral contraceptives.

### **4.6 Fertility, pregnancy and lactation**

The safety of clarithromycin for use 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 embryofoetal 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 pediatric populations are abdominal pain, diarrhea, 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 preexisting 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 <sup>1</sup> , candidiasis, gastroenteritis <sup>2</sup> , infection <sup>3</sup> , vaginal infection	Pseudomembranous colitis, erysipelas, erythrasma
Blood and lymphatic system			Leukopenia, neutropenia <sup>4</sup> , thrombocytopenia <sup>3</sup> , eosinophilia <sup>4</sup>	Agranulocytosis, thrombocytopenia
Immune system disorders <sup>5</sup>			Anaphylactoid reaction <sup>1</sup> , hypersensitivity	Anaphylactic reaction
Metabolism and nutrition disorders			Anorexia, decreased appetite	Hypoglycaemia <sup>6</sup>
Psychiatric disorders		Insomnia	Anxiety, nervousness <sup>3</sup> , screaming <sup>3</sup>	Psychotic disorder, confusional state, depersonalisation, depression, disorientation, hallucination, abnormal dreams
Nervous system disorders		Dysgeusia, headache, taste perversion	Loss of consciousness <sup>1</sup> , dyskinesia <sup>1</sup> , dizziness, somnolence <sup>7</sup> , tremor	Convulsion, ageusia, parosmia, anosmia
Ear and labyrinth disorders			Vertigo, hearing impaired, tinnitus	Deafness
Cardiac disorders			Cardiac arrest <sup>1</sup> , atrial	Torsade de pointes <sup>8</sup> ,

			fibrillation <sup>1</sup> , electrocardiogram QT prolonged <sup>8</sup> , extrasystoles <sup>1</sup> , palpitations	ventricular tachycardia <sup>8</sup>
Vascular disorders		Vasodilation <sup>1</sup>		Hemorrhage <sup>9</sup>
Respiratory, thoracic and mediastinal disorder			Asthma <sup>1</sup> , epistaxis <sup>2</sup> , pulmonary embolism <sup>1</sup>	
Gastrointestinal disorders		Diarrhea <sup>10</sup> , vomiting, dyspepsia, nausea, abdominal pain	Esophagitis <sup>1</sup> , gastroesophageal reflux disease <sup>2</sup> , gastritis, proctalgia <sup>2</sup> , stomatitis, glossitis, abdominal distension <sup>4</sup> , constipation, dry mouth, eructation, flatulence,	Pancreatitis acute, tongue discolouration, tooth discoloration
Hepatobiliary disorders		Liver function test abnormal	Cholestasis <sup>4</sup> , hepatitis <sup>4</sup> , alanine aminotransferase increased, aspartate aminotransferase increased, gamma- glutamyltransferase increased <sup>4</sup>	Hepatic failure <sup>11</sup> , jaundice hepatocellular
Skin and subcutaneous tissue disorders		Rash, hyperhidrosis	Dermatitis bullous <sup>1</sup> , pruritus, urticaria, rash maculo-papular <sup>3</sup>	Stevens-Johnson syndrome <sup>5</sup> , toxic epidermal necrolysis <sup>5</sup> , drug rash with eosinophilia and systemic symptoms (DRESS), acne
Musculoskeletal and connective tissue disorders			Muscle spasms <sup>3</sup> , musculoskeletal stiffness <sup>1</sup> , myalgia <sup>2</sup>	Rhabdomyolysis <sup>2,12</sup> , myopathy
Renal and urinary disorders			Blood creatinine increased <sup>1</sup> , blood urea increased <sup>1</sup>	Renal failure, nephritis interstitial
General disorders and administration site conditions	Injection site phlebitis <sup>1</sup>	Injection site pain <sup>1</sup> , injection site inflammation <sup>1</sup>	Malaise <sup>4</sup> , pyrexia <sup>3</sup> , asthenia, chest pain <sup>4</sup> , chills <sup>4</sup> , fatigue <sup>4</sup>	
Investigations			Albumin globulin ratio abnormal <sup>1</sup> , blood alkaline phosphatase increased <sup>4</sup> , blood lactate dehydrogenase increased <sup>4</sup>	International normalised ratio increased <sup>9</sup> , prothrombin time prolonged <sup>9</sup> , urine color abnormal

<sup>1</sup> ADRs reported only for the Powder for Solution for Injection formulation

<sup>2</sup> ADRs reported only for the Extended-Release Tablets formulation

<sup>3</sup> ADRs reported only for the Granules for Oral Suspension formulation

<sup>4</sup> ADRs reported only for the Immediate-Release Tablets formulation

<sup>5,8,10,11,12</sup> See section a)

<sup>6,7,9</sup> 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 diarrhea should be paid as *Clostridium difficile*-associated diarrhea (CDAD) has been reported with use of nearly all antibacterial agents including clarithromycin, and may range in severity from mild diarrhea 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 diarrhea 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 hypoglycemia, some of which have occurred in patients on concomitant oral hypoglycemic 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 hemorrhage 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 diarrhea. 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, diarrhea, 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.

### **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](http://www.mhra.gov.uk/yellowcard).

### **4.9 Overdose**

Reports indicate the ingestion of large amounts of clarithromycin can be expected to produce gastrointestinal symptoms. One patient who had a history of bipolar disorder ingested eight grams of clarithromycin and showed altered mental status, paranoid behavior, hypokalemia, and hypoxemia.

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 hemodialysis or peritoneal dialysis.

## **5 PHARMACOLOGICAL PROPERTIES**

### **5.1 Pharmacodynamic properties**

Pharmacotherapeutic group: Antibacterials for systemic use, Macrolides ATC code J01F A09

#### Mechanism of Action

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.

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.

#### Breakpoints

BSAC  $R \geq 1$   $S \leq 0.5$  mg/L except *H. influenzae*  $R \geq 32$   $S \leq 0.5$  mg/L, *H.pylori*  $R \geq 2$   $S \leq 1$  mg/L

#### Susceptibility

The prevalence of resistance may vary geographically and with time selected species and local information on resistance is desirable, particularly when treating severe infections. This information gives only an approximate guidance on probabilities whether microorganisms will be susceptible to clarithromycin or not.

The susceptibility pattern of various micro-organisms to clarithromycin is presented below:

<b>Commonly susceptible species</b>
Gram-negative bacteria <i>Moraxella catarrhalis</i>
Anaerobic Bacteria <i>Peptococcus species</i> <i>Peptostreptococcus species</i> <i>Propionibacterium acnes</i> <i>Clostridium perfringens</i>
Others <i>Chlamydia pneumoniae</i> <i>Legionella pneumophila</i> <i>Mycoplasma pneumoniae</i>

<b>Species for which acquired resistance may be a problem</b>
Gram-positive bacteria <i>Staphylococcus aureus (methicillin-susceptible)</i> <i>Staphylococcus aureus (methicillin-resistant)*</i> <i>Streptococcus agalactiae</i> <i>Streptococcus pneumoniae</i> <i>Streptococcus pyogenes</i>
Gram-negative bacteria <i>Haemophilus influenzae</i> <i>Staphylococcus aureus (methicillin-resistant)</i>

\*Resistance to macrolides among MRSA is commonly more than 50% in the EU and affects nearly all strains in some areas.

### Mechanisms of Resistance

Resistance of gram-positive organisms to the macrolides usually involves an alteration of the antimicrobial binding site. The MLSB type resistance, which may be constitutive or induced by exposure to certain macrolides in staphylococci and which is inducible in streptococci, is mediated by a variety of acquired genes (erm family) encoding methylases targeted at the peptidyl transferase centre of 23S ribosomal RNA. Methylation impedes binding of antibacterials to the ribosome and gives rise to cross resistance to macrolides (all macrolides when constitutive), lincosamides and type B streptogramins but not to type A streptogramins. Less frequent mechanisms of resistance include antimicrobial degradation by inactivating enzymes such as esterase and active efflux of the antimicrobial from the bacteria.

Gram negative organisms may be intrinsically resistant to the macrolides because of the inability of the macrolide to effectively penetrate the outer cell membrane; macrolides having a better penetration may have activity against some gram-negative organisms.

Gram-negative organisms may also produce ribosomal methylase or macrolide inactivating enzymes.

## 5.2 Pharmacokinetic properties

*H. pylori* is associated with acid peptic disease including duodenal ulcer and gastric ulcer in which about 95% and 80% of patients respectively are infected with the agent. *H. pylori* is also viewed as a major contribution factor in the development of gastric and ulcer recurrence in such individuals.

Clarithromycin has been used in small numbers of patients in other treatment regimens. Possible kinetic interactions have not been fully investigated. These regimens include:

Clarithromycin plus tinidazole and omeprazole; clarithromycin plus tetracycline, bismuth subsalicylate and ranitidine; clarithromycin plus ranitidine alone.

Clinical studies using various different *H. pylori* eradication regimens have shown that eradication of *H. pylori* prevents ulcers returning.

Clarithromycin is rapidly and well absorbed from the gastro-intestinal tract after oral administration of Clarithromycin Film coated Tablets. The microbiologically active metabolite 14-hydroxyclearithromycin is formed by first pass metabolism.

Clarithromycin Film coated Tablets may be given without regard to meals as food does not affect the extent of bioavailability of the medicinal product. Food does slightly delay the onset of absorption of clarithromycin and formation of the 14-hydroxymetabolite. The pharmacokinetics of clarithromycin are non linear; however, steady-state is attained within 2 days of dosing. At 250 mg b.i.d. 15-20% of unchanged drug is excreted in the urine. With 500 mg b.i.d. daily dosing urinary excretion is greater (approximately 36%). The 14-hydroxyclearithromycin is the major urinary metabolite and accounts for 10-15% of the dose. Most of the remnants of the dose are removed in the faeces, primarily via the bile. 5-10% of the parent drug is recovered from the faeces.

When clarithromycin 500 mg is given three times daily, the clarithromycin plasma concentrations are increased with respect to the 500 mg twice daily dosage.

Clarithromycin Film-coated Tablets provides tissue concentrations that are several times higher than the circulating drug levels. Elevated levels have been found in both tonsillar and lung tissue. Clarithromycin is 80% bound to plasma proteins at therapeutic levels.

Clarithromycin also penetrates the gastric mucus. Levels of clarithromycin in gastric mucus and gastric tissue are higher when clarithromycin is co-administered with omeprazole than when clarithromycin is administered alone.

## 5.3 Preclinical safety data

In acute mouse and rat studies, the median lethal dose was greater than the highest feasible dose for administration (5g/kg).

In repeated dose studies, toxicity was related to dose, duration of treatment and species. Dogs were more sensitive than primates or rats. The major clinical signs at toxic doses included emesis, weakness, reduced food consumption and weight gain, salivation, dehydration and hyperactivity. In all species the liver was the primary target organ at toxic doses. Hepatotoxicity was detectable by early elevations of liver function tests. Discontinuation of the drug generally resulted in a return to or toward normal results. Other tissues less commonly affected included the stomach, thymus and other lymphoid tissues and the kidneys. At near therapeutic doses, conjunctival injection and lacrimation occurred only in dogs. At a massive dose of 400mg/kg/day, some dogs and monkeys developed corneal opacities and/or oedema.

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 show any teratogenicity from clarithromycin. However, a further study in Sprague-Dawley rats indicated a low (6%) incidence of cardiovascular abnormalities which seemed to be due to spontaneous expression of genetic changes. Two mouse studies revealed a variable incidence (3-30%) of cleft palate and embryonic loss was seen in monkeys but only at dose levels which were clearly toxic to the mothers.

## **6 PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

Microcrystalline cellulose  
Croscarmellose sodium  
Pregelatinised maize starch  
Colloidal anhydrous silica  
Povidone  
Talc  
Magnesium stearate.  
Titanium dioxide  
Polydextrose (E1200)  
Hypromellose  
Triacetin  
Macrogol  
Quinoline yellow (E104).

### **6.2 Incompatibilities**

Not applicable.

### **6.3 Shelf life**

36 months

### **6.4 Special precautions for storage**

Do not store above 30°C

## **6.5 Nature and contents of container**

- a) AL/PVDC Blister packs. Pack size 14, 20 tablets
- b) HDPE container with PP cap. Pack size 100 tablets.

## **6.6 Special precautions for disposal**

No special requirements.

## **7 MARKETING AUTHORISATION HOLDER**

Aptil Pharma Limited  
Unit 4, Charlwood Court,  
County Oak Way  
Crawley  
West Sussex  
RH11 7XA  
United Kingdom

## **8 MARKETING AUTHORISATION NUMBER(S)**

PL 40378/0010

## **9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION**

04/10/2005

## **10 DATE OF REVISION OF THE TEXT**

[to be inserted]