SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Septrin 800 mg/160 mg Forte Tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each Septrin Forte tablet contains 800 mg Sulfamethoxazole and 160 mg of Trimethoprim.

Excipients:
For full list of excipients, see section 6.1

3 PHARMACEUTICAL FORM

Tablet.
White, elongated tablet marked “GX O2C” on one side and a scoreline on the other side.
The scoreline is only to facilitate breaking for ease of swallowing and not to divide into equal doses.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Co-Trimoxazole Forte tablets are indicated for the treatment of the following infections when owing to sensitive organisms (see section 5.1):
Treatment and prevention of Pneumocystis jiroveci (P. carinii) pneumonitis.
Treatment and prophylaxis of toxoplasmosis
Treatment of nocardiosis.
The following infections may be treated with Co-Trimoxazole where there is bacterial evidence of sensitivity to Co-Trimoxazole and good reason to prefer the combination of antibiotics in Co-Trimoxazole to a single antibiotic:
Acute uncomplicated urinary tract infection
Acute otitis media
Acute exacerbation of chronic bronchitis
Consideration should be given to official guidance on the appropriate use of antibacterial agents.

4.2 Posology and method of administration

Posology

Standard dosage recommendations for acute infections

Adults and paediatric patients over 12 years:

Forte Tablets Standard Dose
1 every 12 hours

This dosage approximates to 6 mg trimethoprim and 30 mg sulfamethoxazole per kilogram body weight per 24 hours.

Treatment should be continued until the patient has been symptom free for two days; the majority will require treatment for at least 5 days. If clinical improvement is not evident after 7 days’ therapy, the patient should be reassessed.

As an alternative to Standard Dosage for acute uncomplicated lower urinary tract infections, short-term therapy of 1 to 3 days’ duration has been shown to be effective.

The elderly:
See Special Warnings and Precautions for Use. Unless otherwise specified standard dosage applies.

Impaired hepatic function:

No data are available relating to dosage in patients with impaired hepatic function.

Special Dosage Recommendations

(Standard dosage applies unless otherwise specified).

Where dosage is expressed as "tablets" this refers to the adult tablet, i.e 80 mg Trimethoprim BP and 400 mg Sulfamethoxazole BP. If other formulations are to be used appropriate adjustment should be made.

Impaired renal function:

Adults and paediatric patients over 12 years: (no information is available for paediatric patients under 12 years of age).

<table>
<thead>
<tr>
<th>Creatinine Clearance (ml/min)</th>
<th>Recommended Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 30</td>
<td>STANDARD DOSAGE</td>
</tr>
<tr>
<td>15 to 30</td>
<td>Half the STANDARD DOSAGE</td>
</tr>
<tr>
<td>&lt;15</td>
<td>Not recommended</td>
</tr>
</tbody>
</table>

Measurements of plasma concentration of sulfamethoxazole at intervals of 2 to 3 days are recommended in samples obtained 12 hours after administration of Septrin. If the concentration of total sulfamethoxazole exceeds 150 microgram/ml then treatment should be interrupted until the value falls below 120 microgram/ml.
**Pneumocystis jiroveci pneumonitis:**

*Treatment:* A higher dosage is recommended using 20 mg trimethoprim and 100 mg sulfamethoxazole per kg of body weight per day in two or more divided doses for two weeks. The aim is to obtain peak plasma or serum levels of trimethoprim of greater than or equal to 5 microgram/ml (verified in patients receiving 1-hour infusions of intravenous Septrin). (see section 4.8).

*Prevention: Adults:* The following dose schedules may be used:
- 160 mg trimethoprim/800 mg sulfamethoxazole daily 7 days per week.
- 160 mg trimethoprim/800 mg sulfamethoxazole three times per week on alternative days.
- 320 mg trimethoprim/1600 mg sulfamethoxazole per day in two divided doses three times per week on alternative days.

*Paediatric patients:* The following dose schedules may be used for the duration of the period at risk (see Standard dosage recommendations for acute infections subsection of 4.2):
- Standard dosage taken in two divided doses, seven days per week.
- Standard dosage taken in two divided doses, three times per week on alternate days.
- Standard dosage taken in two divided doses, three times per week on consecutive days.
- Standard dosage taken as a single dose, three times per week on consecutive days.

The daily dose given on a treatment day approximates to 150 mg trimethoprim/m^2/day and 750 mg sulfamethoxazole/m^2/day. The total daily dose should not exceed 320 mg trimethoprim and 1600 mg sulfamethoxazole.

*Nocardiosis:* There is no consensus on the most appropriate dosage. Adult doses of 6 to 8 tablets daily for up to 3 months have been used (one tablet contains 400 mg sulfamethoxazole and 80 mg trimethoprim).

*Toxoplasmosis:* There is no consensus on the most appropriate dosage for the treatment or prophylaxis of this condition. The decision should be based on clinical experience. For prophylaxis, however, the dosages suggested for prevention of *Pneumocystis jiroveci* pneumonitis may be appropriate.

**Method of administration**

Oral.

It may be preferable to take Septrin with some food or drink to minimise the possibility of gastrointestinal disturbances.

**4.3 Contraindications**

- Septrin should not be given to patients with a history of hypersensitivity to sulphonamides, trimethoprim, co-trimoxazole or any excipients of Septrin.
- Severe hepatic parenchymal damage.
- Contra-indicated in severe renal insufficiency where repeated measurements of the plasma concentration cannot be performed.
- Septrin should not be given to patients with a history of drug-induced immune thrombocytopenia with use of trimethoprim and/or sulphonamides.
- Septrin should not be given to patients with acute porphyria.
- Septrin should not be given to premature babies nor to full-term infants during the first 6 weeks of life except for the treatment/prophylaxis of PJP in infants 4 weeks of age or greater.

4.4 Special warnings and precautions for use

Fatalities, although very rare, have occurred due to severe reactions including Stevens-Johnson syndrome, toxic epidermal necrolysis, fulminant hepatic necrosis, agranulocytosis, aplastic anaemia, other blood dyscrasias and hypersensitivity of the respiratory tract.

- Life-threatening cutaneous reactions Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) have been reported with the use of Septrin.
- Patients should be advised of the signs and symptoms and monitored closely for skin reactions. The highest risk for occurrence of SJS or TEN is within the first weeks of treatment.
- If symptoms or signs of SJS or TEN (e.g. progressive skin rash often with blisters or mucosal lesions) are present, Septrin treatment should be discontinued (see section 4.8).
- The best results in managing SJS and TEN come from early diagnosis and immediate discontinuation of any suspect drug. Early withdrawal is associated with a better prognosis.
- If the patient has developed SJS or TEN with the use of Septrin, Septrin must not be re-started in this patient at any time.

Particular care is always advisable when treating elderly patients because, as a group, they are more susceptible to adverse reactions and more likely to suffer serious effects as a result particularly when complicating conditions exist, e.g. impaired kidney and/or liver function and/or concomitant use of other drugs.

For patients with known renal impairment special measures should be adopted (see section 4.2).

An adequate urinary output should be maintained at all times. Evidence of crystalluria in vivo is rare, although sulphonamide crystals have been noted in cooled urine from treated patients. In patients suffering from malnutrition the risk may be increased.

Regular monthly blood counts are advisable when Septrin is given for long periods, or to folate deficient patients or to the elderly, since there exists a possibility of asymptomatic changes in haematological laboratory indices due to lack of available folate. Supplementation with folinic acid may be considered during treatment but this should be initiated with caution due to possible interference with antimicrobial efficacy (see section 4.5).

In glucose-6-phosphate dehydrogenase (G-6-PD) deficient patients haemolysis may occur.

Septrin should be given with caution to patients with severe atopy or bronchial asthma.
Septrin should not be used in the treatment of streptococcal pharyngitis due to Group A beta-haemolytic streptococci; eradication of these organisms from the oropharynx is less effective than with penicillin.

Trimethoprim has been noted to impair phenylalanine metabolism but this is of no significance in phenylketonuric patients on appropriate dietary restriction.

The administration of Septrin to patients known or suspected to be at risk of porphyria should be avoided. Both trimethoprim and sulphonamides (although not specifically sulfamethoxazole) have been associated with clinical exacerbation of porphyria.

Close monitoring of serum potassium and sodium is warranted in patients at risk of hyperkalaemia and hyponatraemia.

Septrin has been associated with metabolic acidosis when other possible underlying causes have been excluded. Close monitoring is always advisable when metabolic acidosis is suspected.

Except under careful supervision Septrin should not be given to patients with serious haematological disorders (see section 4.8). Septrin has been given to patients receiving cytotoxic therapy with little or no additional effect on the bone marrow or peripheral blood.

The combination of antibiotics in Septrin should only be used where, in the judgement of the physician, the benefits of treatment outweigh any possible risks; consideration should be given to the use of a single effective antibacterial agent.

4.5 Interaction with other medicinal products and other forms of interaction

Interaction with laboratory tests: trimethoprim may interfere with the estimation of serum/plasma creatinine when the alkaline picrate reaction is used. This may result in overestimation of serum/plasma creatinine of the order of 10%. The creatinine clearance is reduced: the renal tubular secretion of creatinine is decreased from 23% to 9% whilst the glomerular filtration remains unchanged.

Zidovudine: in some situations, concomitant treatment with zidovudine may increase the risk of haematological adverse reactions to co-trimoxazole. If concomitant treatment is necessary, consideration should be given to monitoring of haematological parameters.

Cyclosporin: reversible deterioration in renal function has been observed in patients treated with co-trimoxazole and cyclosporin following renal transplantation.

Rifampicin: concurrent use of rifampicin and Septrin results in a shortening of the plasma half-life of trimethoprim after a period of about one week. This is not thought to be of clinical significance.

When trimethoprim is administered simultaneously with drugs that form cations at physiological pH, and are also partly excreted by active renal secretion (e.g. procainamide, amantadine), there is the possibility of competitive inhibition of this process which may lead to an increase in plasma concentration of one or both of the drugs.

Diuretics (thiazides): in elderly patients concurrently receiving diuretics, mainly thiazides, there appears to be an increased risk of thrombocytopenia with or without purpura.
**Pyrimethamine:** occasional reports suggest that patients receiving pyrimethamine at doses in excess of 25 mg weekly may develop megaloblastic anaemia should co-trimoxazole be prescribed concurrently.

**Warfarin:** co-trimoxazole has been shown to potentiate the anticoagulant activity of warfarin via stereo-selective inhibition of its metabolism. Sulfamethoxazole may displace warfarin from plasma-albumin protein-binding sites in vitro. Careful control of the anticoagulant therapy during treatment with Septrin is advisable.

**Phenytoin:** co-trimoxazole prolongs the half-life of phenytoin and if co-administered could result in excessive phenytoin effect. Close monitoring of the patient's condition and serum phenytoin levels are advisable.

**Digoxin:** concomitant use of trimethoprim with digoxin has been shown to increase plasma digoxin levels in a proportion of elderly patients.

**Methotrexate:** co-trimoxazole may increase the free plasma levels of methotrexate. If Septrin is considered appropriate therapy in patients receiving other anti-folate drugs such as methotrexate, a folate supplement should be considered (see section 4.4).

Trimethoprim interferes with assays for serum methotrexate when dihydrofolate reductase from *Lactobacillus casei* is used in the assay. No interference occurs if methotrexate is measured by radioimmuno assay.

**Lamivudine:** administration of trimethoprim/sulfamethoxazole 160 mg/800 mg (co-trimoxazole) causes a 40% increase in lamivudine exposure because of the trimethoprim component. Lamivudine has no effect on the pharmacokinetics of trimethoprim or sulfamethoxazole.

Interaction with *sulphonylurea hypoglycaemic agents* is uncommon but potentiation has been reported.

**Hyperkalaemia:** caution should be exercised in patients taking any other drugs that can cause hyperkalaemia.

**Repaglinide:** trimethoprim may increase the exposure of repaglinide which may result in hypoglycaemia.

**Folinic acid:** folinic acid supplementation has been shown to interfere with the antimicrobial efficacy of trimethoprim-sulfamethoxazole. This has been observed in *Pneumocystis jiroveci* pneumonia prophylaxis and treatment.

**Contraceptives:** oral contraceptive failures have been reported with antibiotics. The mechanism of this effect has not been elucidated. Women on treatment with antibiotics should temporarily use a barrier method in addition to the oral contraceptive, or choose another method of contraception.

### 4.6 Fertility, pregnancy and lactation

**Pregnancy**

Trimethoprim and sulfamethoxazole cross the placenta and their safety in pregnant women has not been established. Case-control studies have shown that there may be an association between exposure to folate antagonists and birth defects in humans.
Trimethoprim is a folate antagonist and, in animal studies, both agents have been shown to cause foetal abnormalities (see section 5.3). Septrin should not be used in pregnancy, particularly in the first trimester, unless clearly necessary. Folate supplementation should be considered if Septrin is used in pregnancy.

Sulfamethoxazole competes with bilirubin for binding to plasma albumin. As significantly maternally derived drug levels persist for several days in the newborn, there may be a risk of precipitating or exacerbating neonatal hyperbilirubinaemia, with an associated theoretical risk of kernicterus, when Septrin is administered to the mother near the time of delivery. This theoretical risk is particularly relevant in infants at increased risk of hyperbilirubinaemia, such as those who are preterm and those with glucose-6-phosphate dehydrogenase deficiency.

**Breast-feeding**

The components of Septrin (trimethoprim and sulfamethoxazole) are excreted in breast milk. Administration of Septrin should be avoided in late pregnancy and in lactating mothers where the mother or infant has, or is at particular risk of developing, hyperbilirubinaemia. Additionally, administration of Septrin should be avoided in infants younger than eight weeks in view of the predisposition of young infants to hyperbilirubinaemia.

### 4.7 Effects on ability to drive and use machines

There have been no studies to investigate the effect of Co-Ttrimoxazole on driving performance or the ability to operate machinery. Further a detrimental effect on such activities cannot be predicted from the pharmacology of the drug. Nevertheless the clinical status of the patient and the adverse events profile of Co-Ttrimoxazole should be borne in mind when considering the patients ability to operate machinery.

### 4.8 Undesirable effects

As co-ttrimoxazole contains trimethoprim and a sulphonamide the type and frequency of adverse reactions associated with such compounds are expected to be consistent with extensive historical experience.

Data from large published clinical trials were used to determine the frequency of very common to rare adverse events. Very rare adverse events were primarily determined from post-marketing experience data and therefore refer to reporting rate rather than a “true” frequency. In addition, adverse events may vary in their incidence depending on the indication.

The following convention has been used for the classification of adverse events in terms of frequency: Very common $\geq 1/10$, common $\geq 1/100$ and $<1/10$, uncommon $\geq 1/1000$ and $<1/100$, rare $\geq 1/10,000$ and $<1/1000$, very rare $<1/10,000$.

<table>
<thead>
<tr>
<th>System Organ Class</th>
<th>Frequency</th>
<th>Side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infections and infestations</td>
<td>Common</td>
<td>Monilial overgrowth.</td>
</tr>
<tr>
<td>Blood and lymphatic system disorders</td>
<td>Very rare</td>
<td>Leucopenia, neutropenia, thrombocytopenia, agranulocytosis, megaloblastic anaemia, aplastic anaemia, haemolytic anaemia, methaemoglobinemia, eosinophilia,</td>
</tr>
<tr>
<td>System</td>
<td>Frequency</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------</td>
<td>---------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Immune system disorders</td>
<td>Very rare</td>
<td>Serum sickness, anaphylactic reactions, allergic myocarditis, angioedema, pyrexia, hypersensitivity vasculitis resembling Henoch-Schoenlein purpura, periarteritis nodosa, systemic lupus erythematosus.</td>
</tr>
<tr>
<td>Metabolism and nutrition</td>
<td>Very common</td>
<td>Hyperkalaemia.</td>
</tr>
<tr>
<td>disorders</td>
<td></td>
<td>Hypoglycaemia, hyponatraemia, decreased appetite, metabolic acidosis, renal tubular acidosis.</td>
</tr>
<tr>
<td>Psychiatric disorders</td>
<td>Very rare</td>
<td>Depression, hallucination.</td>
</tr>
<tr>
<td>Nervous system disorders</td>
<td></td>
<td>Headache.</td>
</tr>
<tr>
<td></td>
<td>Very rare</td>
<td>Aseptic meningitis*, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, dizziness.</td>
</tr>
<tr>
<td>Eye disorders</td>
<td>Very rare</td>
<td>Uveitis.</td>
</tr>
<tr>
<td>Respiratory, thoracic and</td>
<td>Very rare</td>
<td>Cough, dyspnoea, lung infiltration*.</td>
</tr>
<tr>
<td>mediastinal disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal disorders</td>
<td>Common</td>
<td>Nausea, diarrhoea.</td>
</tr>
<tr>
<td></td>
<td>Uncommon</td>
<td>Vomiting.</td>
</tr>
<tr>
<td></td>
<td>Very rare</td>
<td>Glossitis, stomatitis, pseudomembranous colitis, acute pancreatitis.</td>
</tr>
<tr>
<td>Hepatobiliary disorders</td>
<td>Very rare</td>
<td>Cholestatic jaundice, hepatic necrosis. ¹ Elevation of serum transaminases, elevation of bilirubin levels.</td>
</tr>
<tr>
<td>Skin and subcutaneous tissue</td>
<td>Common</td>
<td>Rash.</td>
</tr>
<tr>
<td>disorders*</td>
<td></td>
<td>Photosensitivity, exfoliative dermatitis, fixed drug eruption, erythema multiforme, Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN)*.</td>
</tr>
<tr>
<td>Musculoskeletal and connective</td>
<td>Very rare</td>
<td>Arthralgia, myalgia.</td>
</tr>
<tr>
<td>tissue disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal and urinary disorders</td>
<td>Very rare</td>
<td>Renal impairment (sometimes reported as renal failure), tubulointerstitial nephritis.</td>
</tr>
</tbody>
</table>

* see description of selected adverse reactions
¹ Cholestatic jaundice and hepatic necrosis may be fatal.

Description of selected adverse reactions

Aseptic meningitis

Aseptic meningitis was rapidly reversible on withdrawal of the drug, but recurred in a number of cases on re-exposure to either co-trimoxazole or to trimethoprim alone.

Pulmonary hypersensitivity reactions

Cough, dyspnoea and lung infiltration may be early indicators of respiratory hypersensitivity which, while very rare, has been fatal.
Skin and subcutaneous tissue disorders

Common: Skin rashes

Very rare: Photosensitivity, exfoliative dermatitis, fixed drug eruption, erythema multiforme.

Severe cutaneous adverse reactions (SCARs)

Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) have been reported (see section 4.4)

Effects associated with Pneumocystis jiroveci (P.carinii) Pneumonitis (PJP) management

Very rare: Severe hypersensitivity reactions, rash, pyrexia, neutropenia, thrombocytopenia, hepatic enzyme increased, hyperkalaemia, hyponatraemia, rhabdomyolysis.

At the high dosages used for PJP management severe hypersensitivity reactions have been reported, necessitating cessation of therapy. Severe hypersensitivity reactions have been reported in PJP patients on re-exposure to co-trimoxazole, sometimes after a dosage interval of a few days. Rhabdomyolysis has been reported in HIV positive patients receiving co-tromixazole for prophylaxis or treatment of PJP.

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.

4.9 Overdose

Symptoms:

Nausea, vomiting, dizziness and confusion are likely signs/symptoms of overdosage. Bone marrow depression has been reported in acute trimethoprim overdosage.

Treatment:

If vomiting has not occurred, induction of vomiting may be desirable. Gastric lavage may be useful, though absorption from the gastrointestinal tract is normally very rapid and complete within approximately two hours. This may not be the case in gross overdosage. Dependant on the status of renal function administration of fluids is recommended if urine output is low.

Both trimethoprim and active sulfamethoxazole are moderately dialysable by haemodialysis. Peritoneal dialysis is not effective.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties
Pharmacotherapeutic group: Combinations of sulphonamides and trimethoprim, incl. derivatives, ATC code: J01EE01.

**Mechanism of Action**

Sulfamethoxazole competitively inhibits the utilisation of para-aminobenzoic acid in the synthesis of dihydrofolate by the bacterial cell resulting in bacteriostasis. Trimethoprim reversibly inhibits bacterial dihydrofolate reductase (DHFR), an enzyme active in the folate metabolic pathway converting dihydrofolate to tetrahydrofolate. Depending on the conditions the effect may be bactericidal. Thus trimethoprim and sulfamethoxazole block two consecutive steps in the biosynthesis of purines and therefore nucleic acids essential to many bacteria. This action produces marked potentiation of activity in vitro between the two agents. Trimethoprim binds to plasmodial DHFR but less tightly than to the bacterial enzyme. Its affinity for mammalian DHFR is some 50,000 times less than for the corresponding bacterial enzyme.

**Mechanism of resistance**

In vitro studies have shown that bacterial resistance can develop more slowly with both sulfamethoxazole and trimethoprim in combination that with either sulfamethoxazole or trimethoprim alone.

Resistance to sulfamethoxazole may occur by different mechanisms. Bacterial mutations cause an increase the concentration of PABA and thereby out-compete with sulfamethoxazole resulting in a reduction of the inhibitory effect on dihydropteroate synthetase enzyme. Another resistance mechanism is plasmid-mediated and results from production of an altered dihydropteroate synthetase enzyme, with reduced affinity for sulfamethoxazole compared to the wild-type enzyme.

Resistance to trimethoprim occurs through a plasmid-mediated mutation which results in production of an altered dihydrofolate reductase enzyme having a reduced affinity for trimethoprim compared to the wild-type enzyme.

Trimethoprim binds to plasmodial DHFR but less tightly than to bacterial enzyme. Its affinity for mammalian DHFR is some 50,000 times less than for the corresponding bacterial enzyme.

Many common pathogenic bacteria are susceptible in vitro to trimethoprim and sulfamethoxazole at concentrations well below those reached in blood, tissue fluids and urine after the administration of recommended doses. In common with other antibiotics, however, in vitro activity does not necessarily imply that clinical efficacy has been demonstrated and it must be noted that satisfactory susceptibility testing is achieved only with recommended media free from inhibitory substances, especially thymidine and thymine.

**Susceptibility testing breakpoints**

**EUCAST**

*Enterobacteriaceae*: S ≤ 2 R > 4  
*S. maltophilia*: S ≤ 4 R > 4  
*Acinetobacter*: S ≤ 2 R > 4  
*Staphylococcus*: S ≤ 2 R > 4  
*Enterococcus*: S ≤ 0.032 R > 1  
*Streptococcus ABCG*: S ≤ 1 R > 2  
*Streptococcus pneumoniae*: S ≤ 1 R > 2  
*Hemophilus influenzae*: S ≤ 0.5 R > 1
**Moraxella catarrhalis:** \( S \leq 0.5 \ R > 1 \)

*Psuedomonas aeruginosa* and other non-enterobacteriaceae: \( S \leq 2 \ R > 4 \)

\( S = \) susceptible, \( R = \) resistant. *These are CLSI breakpoints since no EUCAST breakpoints are currently available for these organisms.

Trimethoprim: sulfamethoxazole in the ratio 1:19. Breakpoints are expressed as trimethoprim concentration.

**Antibacterial Spectrum**

The prevalence of resistance may vary geographically and with time for selected species and local information on resistance is desirable, particularly when treating severe infections. As necessary, expert advice should be sought when the local prevalence of resistance is such that the utility of the agent in at least some types of infections is questionable. This information gives only an approximate guidance on probabilities whether microorganisms will be susceptible to trimethoprim/sulfamethoxazole or not.

Trimethoprim/sulfamethoxazole susceptibility against a number of bacteria are shown in the table below:

<table>
<thead>
<tr>
<th>Commonly susceptible species:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gram-positive aerobes:</strong></td>
</tr>
<tr>
<td><em>Staphylococcus aureus</em></td>
</tr>
<tr>
<td><em>Streptococcus pyogenes</em></td>
</tr>
<tr>
<td><strong>Gram-negative aerobes:</strong></td>
</tr>
<tr>
<td><em>Enterobacter cloacae</em></td>
</tr>
<tr>
<td><em>Haemophilus influenzae</em></td>
</tr>
<tr>
<td><em>Moraxella catarrhalis</em></td>
</tr>
<tr>
<td><em>Salmonella</em> spp.</td>
</tr>
<tr>
<td><em>Stenotrophomonas maltophilia</em></td>
</tr>
<tr>
<td><em>Yersinia</em> spp.</td>
</tr>
<tr>
<td><strong>Species for which acquired resistance may be a problem:</strong></td>
</tr>
<tr>
<td><strong>Gram-positive aerobes:</strong></td>
</tr>
<tr>
<td><em>Enterococcus faecalis</em></td>
</tr>
<tr>
<td><em>Nocardia</em> spp.</td>
</tr>
<tr>
<td><em>Staphylococcus epidermidis</em></td>
</tr>
<tr>
<td><em>Streptococcus pneumoniae</em></td>
</tr>
<tr>
<td><strong>Gram-negative aerobes:</strong></td>
</tr>
<tr>
<td><em>Citrobacter</em> spp.</td>
</tr>
<tr>
<td><em>Escherichia coli</em></td>
</tr>
<tr>
<td><em>Klebsiella pneumoniae</em></td>
</tr>
<tr>
<td><em>Proteus mirabilis</em></td>
</tr>
<tr>
<td><em>Proteus vulgaris</em></td>
</tr>
<tr>
<td><em>Serratia marcesans</em></td>
</tr>
<tr>
<td><strong>Inherently resistant organisms:</strong></td>
</tr>
<tr>
<td><strong>Gram-negative aerobes:</strong></td>
</tr>
</tbody>
</table>
5.2 Pharmacokinetic properties

Absorption

After oral administration trimethoprim and sulfamethoxazole are rapidly and nearly completely absorbed. The presence of food does not appear to delay absorption. Peak levels in the blood occur between one and four hours after ingestion and the level attained is dose related. Effective levels persist in the blood for up to 24 hours after a therapeutic dose. Steady state levels in adults are reached after dosing for 2-3 days. Neither component has an appreciable effect on the concentrations achieved in the blood by the other.

Distribution

Approximately 50% of trimethoprim in the plasma is protein bound. Tissue levels of trimethoprim are generally higher than corresponding plasma levels, the lungs and kidneys showing especially high concentrations. Trimethoprim concentrations exceed those in plasma in the case of bile, prostatic fluid and tissue, saliva, sputum and vaginal secretions. Levels in the aqueous humor, breast milk, cerebrospinal fluid, middle ear fluid, synovial fluid and tissue (intestinal) fluid are adequate for antibacterial activity. Trimethoprim passes into amniotic fluid and foetal tissues reaching concentrations approximating those of maternal serum.

Approximately 66% of sulfamethoxazole in the plasma is protein bound. The concentration of active sulfamethoxazole in amniotic fluid, aqueous humour, bile, cerebrospinal fluid, middle ear fluid, sputum, synovial fluid and tissue (interstitial) fluids is of the order of 20 to 50% of the plasma concentration.

Biotransformation

Renal excretion of intact sulfamethoxazole accounts for 15-30% of the dose. This drug is more extensively metabolised than trimethoprim, via acetylation, oxidation or glucuronidation. Over a 72 hour period, approximately 85% of the dose can be accounted for in the urine as unchanged drug plus the major (N4-acetylated) metabolite.

Elimination

The half-life of trimethoprim in man is in the range 8.6 to 17 hours in the presence of normal renal function. It is increased by a factor of 1.5 to 3.0 when the creatinine clearance is less than 10 ml/minute. There appears to be no significant difference in elderly patients compared with young patients.

The principal route of excretion of trimethoprim is renal and approximately 50% of the dose is excreted in the urine within 24 hours as unchanged drug. Several metabolites have been identified in the urine. Urinary concentrations of trimethoprim vary widely.

The half-life of sulfamethoxazole in man is approximately 9 to 11 hours in the presence of normal renal function.
There is no change in the half-life of active sulfamethoxazole with a reduction in renal function but there is prolongation of the half-life of the major, acetylated metabolite when the creatinine clearance is below 25 ml/minute.

The principal route of excretion of sulfamethoxazole is renal; between 15% and 30% of the dose recovered in the urine is in the active form. In elderly patients there is a reduced renal clearance of sulfamethoxazole.

**Special patient population**

*Renal impairment*

The elimination half-life of trimethoprim is increased by a factor of 1.5-3.0 when the creatinine clearance is less than 10 mL/minute. When the creatinine clearance falls below 30 mL/min the dosage of Septrin should be reduced (see section 4.2).

*Hepatic impairment*

Caution should be exercised when treating patients with severe hepatic parenchymal damage as there may be changes in the absorption and biotransformation of trimethoprim and sulfamethoxazole.

*Elderly patients*

In elderly patients, a slight reduction in renal clearance of sulfamethoxazole but not trimethoprim has been observed.

*Paediatric population*

See special dosage regimen (see section 4.2).

### 5.3 Preclinical safety data

At doses in excess of recommended human therapeutic dose, trimethoprim and sulfamethoxazole have been reported to cause cleft palate and other foetal abnormalities in rats, findings typical of a folate antagonist. Effects with trimethoprim were preventable by administration of dietary folate. In rabbits, foetal loss was seen at doses of trimethoprim in excess of human therapeutic doses.

### 6 PHARMACEUTICAL PARTICULARS

#### 6.1 List of excipients

Povidone  
Sodium Starch Glycollate  
Magnesium Stearate  
Docusate Sodium

#### 6.2 Incompatibilities

None Known
6.3 Shelf life
60 months

6.4 Special precautions for storage
Do not store above 25°C
Keep container in the outer carton

6.5 Nature and contents of container
Polypropylene containers with polyethylene snap-fit closure or PVC/Al foil blister packs.
Pack size: 100
Round enamelled tin
Pack size: 2000
PVC/Aluminium foil blister pack (sample pack)
Pack size: 5

6.6 Special precautions for disposal and other handling
Trimethoprim interferes with assays for serum methotrexate when dihydrofolate reductase from *Lactobacillus casei* is used in the assay. No interference occurs if methotrexate is measured by radioimmune assay.

Trimethoprim may interfere with the estimation of serum/plasma creatinine when the alkaline picrate reaction is used. This may result in overestimation of serum/plasma creatinine of the order of 10%. Functional inhibition of the renal tubular secretion of creatinine may produce a spurious fall in the estimated rate of creatinine clearance.

7. MARKETING AUTHORISATION HOLDER
Aspen Pharma Trading Limited
3016 Lake Drive
Citywest Business Campus
Dublin 24
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8 MARKETING AUTHORISATION NUMBER(S)
PL 39699/0035
9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

07/05/2012

10 DATE OF REVISION OF THE TEXT

03/01/2017