

 **9 October 2023**

**SUMMARY OF PRODUCT CHARACTERISTICS**

**for**

**Cefudoc, film-coated tablets**

**0. D.SP.NO.**

 21238

**1. NAME OF THE MEDICINAL PRODUCT**

 Cefudoc

**2. QUALITATIVE AND QUANTITATIVE COMPOSITION**

Each tablet contains 250 mg or 500 mg cefuroxime equivalent to 300.72 mg or 601.44 mg of cefuroxime axetil.

Excipients with known effect:

The tablets Cefudoc 500 mg contains 23.61 mg sodium.

The tablets Cefudoc 250 mg / 500 mg contain castor oil.

Cefudoc 250 mg contains 15.00 mg castor oil per dose.

Cefudoc 500 mg contains 30.00 mg castor oil per dose.

For the full list of excipients, see section 6.1.

**3. PHARMACEUTICAL FORM**

Film-coated tablets

250 mg: white round film-coated tablets (tablet) with a score on one side

500 mg: white oblong film-coated tablets (tablet)

**4. CLINICAL PARTICULARS**

**4.1 Therapeutic indications**

Cefudoc is indicated for the treatment of the infections listed below in adults and children from the age of 3 months (see sections 4.4 and 5.1).

* Acute streptococcal tonsillitis and pharyngitis
* Acute bacterial sinusitis
* Acute otitis media
* Acute exacerbations of chronic bronchitis
* Cystitis
* Pyelonephritis
* Uncomplicated skin and soft tissue infections
* Treatment of early Lyme disease

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

**4.2 Posology and method of administration**

Posology

The usual course of therapy is seven days (may range from five to ten days).

*Table 1. Adults and children (≥ 40 kg)*

|  |  |
| --- | --- |
| **Indication** | **Dosage** |
| Acute tonsillitis and pharyngitis, acute bacterial sinusitis  | 250 mg twice daily |
| Acute otitis media | 500 mg twice daily |
| Acute exacerbations of chronic bronchitis | 500 mg twice daily |
| Cystitis | 250 mg twice daily |
| Pyelonephritis | 250 mg twice daily |
| Uncomplicated skin and soft tissue infections | 250 mg twice daily |
| Lyme disease | 500 mg twice daily for 14 days (range of 10 to 21 days) |

*Table 2. Children (< 40 kg)*

|  |  |
| --- | --- |
| **Indication** | **Dosage** |
| Acute tonsillitis and pharyngitis, acute bacterial sinusitis  | 10 mg/kg twice daily to a maximum of 125 mg twice daily  |
| Children aged two years or older with otitis media or, where appropriate, with more severe infections | 15 mg/kg twice daily to a maximum of 250 mg twice daily  |
| Cystitis | 15 mg/kg twice daily to a maximum of 250 mg twice daily  |
| Pyelonephritis | 15 mg/kg twice daily to a maximum of 250 mg twice daily for 10 to 14 days |
| Uncomplicated skin and soft tissue infections | 15 mg/kg twice daily to a maximum of 250 mg twice daily  |
| Lyme disease | 15 mg/kg twice daily to a maximum of 250 mg twice daily for 14 days (10 to 21 days) |

There is no experience of using cefuroxime axetil in children under the age of 3 months.

Cefuroxime axetil tablets and cefuroxime axetil granules for oral suspension are not bioequivalent and are not substitutable on a milligram-per-milligram basis (see section 5.2).

*Renal impairment*

The safety and efficacy of cefuroxime axetil in patients with renal failure have not been established. Cefuroxime is primarily excreted by the kidneys. In patients with markedly impaired renal function it is recommended that the dosage of cefuroxime should be reduced to compensate for its slower excretion. Cefuroxime is effectively removed by dialysis.

*Table 3. Recommended doses for Cefudoc in renal impairment*

|  |  |  |
| --- | --- | --- |
| **Creatinine clearance** | **T½ (hrs)** | **Recommended dosage** |
| ≥ 30 ml/min/1.73 m2 | 1.4-2.4 | no dose adjustment necessary (standard dose of 125 mg to 500 mg given twice daily) |
| 10-29 ml/min/1.73 m2 | 4.6 | standard individual dose given every 24 hours |
| < 10 ml/min/1.73 m2 | 16.8 | standard individual dose given every 48 hours |
| Patients on haemodialysis  | 2-4 | a further standard individual dose should be given at the end of each dialysis |

*Hepatic impairment*

There are no data available for patients with hepatic impairment. Since cefuroxime is primarily eliminated by the kidney, the presence of hepatic dysfunction is expected to have no effect on the pharmacokinetics of cefuroxime.

Method of administration

Oral use

Cefudoc tablets should be taken after food for optimum absorption.

Cefudoc tablets should not be crushed and are therefore unsuitable for treatment of patients who cannot swallow tablets. In children cefuroxime axetil oral suspension may be used.

Depending on the dosage, there are other presentations available.

**4.3 Contraindications**

Hypersensitivity to cefuroxime or to any of the excipients listed in section 6.1.

Patients with known hypersensitivity to cephalosporin antibiotics.

History of severe hypersensitivity (e.g. anaphylactic reaction) to any other type of betalactam antibacterial agent (penicillins, monobactams and carbapenems).

**4.4 Special warnings and precautions for use**

Hypersensitivity reactions

Special care is indicated in patients who have experienced an allergic reaction to penicillins or other beta-lactam antibiotics because there is a risk of cross-sensitivity. As with all beta-lactam antibacterial agents, serious and occasionally fatal hypersensitivity reactions have been reported. There have been reports of hypersensitivity reactions which progressed to Kounis syndrome (acute allergic coronary arteriospasm that can result in myocardial infarction, see section 4.8). In case of severe hypersensitivity reactions, treatment with cefuroxime must be discontinued immediately and adequate emergency measures must be initiated.

Before beginning treatment, it should be established whether the patient has a history of severe hypersensitivity reactions to cefuroxime, to other cephalosporins or to any other type of beta-lactam agent. Caution should be used if cefuroxime is given to patients with a history of non-severe hypersensitivity to other beta-lactam agents.

Severe cutaneous adverse reactions (SCARS)

Severe cutaneous adverse reactions including: Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN) and drug reaction with eosinophilia and systemic symptoms (DRESS), which can be life-threatening or fatal, have been reported in association with cefuroxime treatment (see section 4.8).

At the time of prescription patients should be advised of the signs and symptoms and monitored closely for skin reactions. If signs and symptoms suggestive of these reactions appear, cefuroxime should be withdrawn immediately and an alternative treatment considered. If the patient has developed a serious reaction such as SJS, TEN or DRESS with the use of cefuroxime, treatment with cefuroxime must not be restarted in this patient at any time.

Jarisch-Herxheimer reaction

The Jarisch-Herxheimer reaction has been seen following cefuroxime axetil treatment of Lyme disease. It results directly from the bactericidal activity of cefuroxime axetil on the causative bacteria of Lyme disease, the spirochaete *Borrelia burgdorferi.* Patients should be reassured that this is a common and usually self-limiting consequence of antibiotic treatment of Lyme disease (see section 4.8).

Overgrowth of non-susceptible microorganisms

As with other antibiotics, use of cefuroxime axetil may result in the overgrowth of Candida. Prolonged use may also result in the overgrowth of other non-susceptible microorganisms (e.g. enterococci and *Clostridium difficile*), which may require interruption of treatment (see section 4.8).

Antibacterial agent–associated pseudomembranous colitis have been reported with nearly all antibacterial agents, including cefuroxime and may range in severity from mild to life threatening. This diagnosis should be considered in patients with diarrhoea during or subsequent to the administration of cefuroxime (see section 4.8). Discontinuation of therapy with cefuroxime and the administration of specific treatment for *Clostridium difficile* should be considered. Medicinal products that inhibit peristalsis should not be given (see section 4.8).

Interference with diagnostic tests

The development of a positive Coomb’s Test associated with the use of cefuroxime may interfere with cross matching of blood (see section 4.8).

As a false negative result may occur in the ferricyanide test, it is recommended that either the glucose oxidase or hexokinase methods are used to determine blood/plasma glucose levels in patients receiving cefuroxime axetil.

Important information about excipients

Cefudoc 250 mg contains less than 1 mmol sodium (23 mg) per film-coated tablet, that is to say essentially “sodium-free”.

Cefudoc 500 mg contains 23.61 mg sodium per film-coated tablet, equivalent to 1.2 % of the WHO recommended maximum daily intake of 2 g sodium for an adult.

Cefudoc contains hydrogenated castor oil.

Hydrogenated castor oil may cause stomach upset and diarrhoea.

**4.5 Interaction with other medicinal products and other forms of interaction**

Drugs which reduce gastric acidity may result in a lower bioavailability of cefuroxime axetil compared with that of the fasting state and tend to cancel the effect of enhanced absorption after food.

Cefuroxime axetil may affect the gut flora, leading to lower oestrogen reabsorption and reduced efficacy of combined oral contraceptives.

Cefuroxime is excreted by glomerular filtration and tubular secretion. Concomitant use of probenecid is not recommended. Concurrent administration of probenecid significantly increases the peak concentration, area under the serum concentration time curve and elimination half-life of cefuroxime.

Concomitant use with oral anticoagulants may give rise to increased INR.

**4.6 Fertility, pregnancy and lactation**

Pregnancy

There are limited data from the use of cefuroxime in pregnant women. Studies in animals have shown no harmful effects on pregnancy, embryonal or foetal development, parturition or postnatal development. Cefudoc should be prescribed to pregnant women only if the benefit outweighs the risk.

Breastfeeding

Cefuroxime is excreted in human milk in small quantities. Adverse effects at therapeutic doses are not expected, although a risk of diarrhoea and fungus infection of the mucous membranes cannot be excluded. Breastfeeding might have to be discontinued due to these effects. The possibility of sensitisation should be taken into account. Cefuroxime should only be used during breastfeeding after benefit/risk assessment by the physician in charge.

Fertility

There are no data on the effects of cefuroxime axetil on fertility in humans. Reproductive studies in animals have shown no effects on fertility.

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

No traffic warning.

No studies on the effects on the ability to drive and use machines have been performed. However, as this medicine may cause dizziness, patients should be warned to be cautious when driving or operating machinery.

**4.8 Undesirable effects**

The most common adverse reactions are *Candida* overgrowth, eosinophilia, headache, dizziness, gastrointestinal disturbances and transient rise in liver enzymes.

The frequency categories assigned to the adverse reactions below are estimates, as for most reactions suitable data (for example from placebo-controlled studies) for calculating incidence were not available. In addition, the incidence of adverse reactions associated with cefuroxime axetil may vary according to the indication.

Data from large clinical studies were used to determine the frequency of very common to rare undesirable effects. The frequencies assigned to all other undesirable effects (i.e. those occurring at <1/10,000) were mainly determined using post-marketing data and refer to a reporting rate rather than true frequency. Placebo-controlled trial data were not available. Where incidences have been calculated from clinical trial data, these were based on drug-related (investigator assessed) data. Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness.

Treatment related adverse reactions, all grades, are listed below by MedDRA body system organ class, frequency and grade of severity. The following convention has been utilised for the classification of frequency:

Very common (≥ 1/10)

Common (≥ 1/100 to < 1/10)

Uncommon (≥ 1/1,000 to < 1/100)

Rare (≥1/10,000 to < 1/1,000)

Very rare (< 1/10,000)

Not known (cannot be estimated from the available data)

|  |  |  |  |
| --- | --- | --- | --- |
| **System organ class** | **Common** | **Uncommon** | **Not known** |
| **Infections and infestations** | *Candida*overgrowth |  | *Clostridium difficile* overgrowth |
| **Blood and lymphatic system disorders** | eosinophilia | positive Coomb’s test, thrombocytopenia, leukopenia (sometimes profound) | haemolytic anaemia |
| **Immune system disorders** |  |  | drug fever, serum sickness,anaphylaxis, Jarisch-Herxheimer reaction |
| **Nervous system disorders** | headache, dizziness |  |  |
| **Cardiac disorders** |  |  | Kounis syndrome |
| **Gastrointestinal disorders** | diarrhoea, nausea, abdominal pain | vomiting | pseudomembranous colitis(see section 4.4) |
| **Hepatobiliary disorders** | transient increases of hepatic enzyme levels |  | jaundice (predominantly cholestatic), hepatitis |
| **Skin and subcutaneous tissue disorders** |  | skin rashes | urticaria, pruritus, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis (exanthematic necrolysis) (*see* *Immune system disorders*), drug reaction with eosinophilia and systemic symptoms (DRESS), angioneurotic oedema |
| *Description of selected adverse reactions*Cephalosporins as a class tend to be absorbed onto the surface of red cells membranes and react with antibodies directed against the drug to produce a positive Coombs’ test (which can interfere with cross- matching of blood) and very rarely haemolytic anaemia.Transient rises in serum liver enzymes have been observed which are usually reversible. |

*Paediatric population*

The safety profile for cefuroxime axetil in children is consistent with the profile in adults.

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:

Lægemiddelstyrelsen

Axel Heides Gade 1

DK-2300 København S

Website: www.meldenbivirkning.dk

**4.9 Overdose**

Overdose can lead to neurological sequelae including encephalopathy, convulsions and coma. Symptoms of overdose can occur if the dose is not reduced appropriately in patients with renal impairment (see sections 4.2 and 4.4).

Serum levels of cefuroxime can be reduced by haemodialysis or peritoneal dialysis.

**4.10 Legal status**

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**5. PHARMACOLOGICAL PROPERTIES**

**5.1 Pharmacodynamic properties**

Pharmacotherapeutic group: antibacterials for systemic use, second-generation cephalosporins, ATC code: J01DC02.

Mechanism of action

Cefuroxime axetil undergoes hydrolysis by esterase enzymes to the active antibiotic, cefuroxime. Cefuroxime inhibits bacterial cell wall synthesis following attachment to penicillin binding proteins (PBPs). This results in the interruption of cell wall (peptidoglycan) biosynthesis, which leads to bacterial cell lysis and death.

Mechanism of resistance

Bacterial resistance to cefuroxime may be due to one or more of the following mechanisms:

* hydrolysis by beta-lactamases; including (but not limited to) by extended-spectrum beta-lactamases (ESBLs), and AmpC enzymes that may be induced or stably derepressed in certain aerobic Gram-negative bacteria species
* reduced affinity of penicillin-binding proteins for cefuroxime
* outer membrane impermeability, which restricts access of cefuroxime to penicillin binding proteins in Gram-negative bacteria
* bacterial efflux pumps

Organisms that have acquired resistance to other injectable cephalosporins are expected to be resistant to cefuroxime.

Depending on the mechanism of resistance, organisms with acquired resistance to penicillins may demonstrate reduced susceptibility or resistance to cefuroxime.

Cefuroxime axetil breakpoints

Minimum inhibitory concentration (MIC) breakpoints established by the European Committee on

Antimicrobial Susceptibility Testing (EUCAST) are as follows:

|  |  |
| --- | --- |
| **Microorganism** | **Breakpoints (mg/l)** |
|  | S | R |
| *Enterobacteriaceae* 1, 2 | ≤8 | >8 |
| *Staphylococcus* spp. | Note3 | Note3 |
| *Streptococcus* A, B, C and G | Note4 | Note4 |
| *Streptococcus pneumoniae* | ≤0.25 | >0.5 |
| *Moraxella catarrhalis* | ≤0.125 | >4 |
| *Haemophilus influenzae* | ≤0.125 | >1 |
| Non-species related breakpoints1 | IE5 | IE5 |
| 1 The cephalosporin breakpoints for *Enterobacteriaceae* will detect all clinically important resistance mechanisms (including ESBL and plasmid mediated AmpC). Some strains that produce beta-lactamases are susceptible or intermediate to 3rd or 4th generation cephalosporins with these breakpoints and should be reported as found, i.e. the presence or absence of an ESBL does not in itself influence the categorization of susceptibility. In many areas, ESBL detection and characterization is recommended or mandatory for infection control purposes.2 Uncomplicated UTI (cystitis) only (see section 4.1).3 Susceptibility of staphylococci to cephalosporins is inferred from the methicillin susceptibility except for ceftazidme and cefixime and ceftibuten, which do not have breakpoints and should not be used for staphylococcal infections.4 The beta-lactam susceptability of beta-haemolytic streptococci groups A, B, C and G is inferred from the penicillin susceptibility.5 Insufficient evidence that the species in question is a good target for therapy with the drug. An MIC with a comment but without an accompanying S or R-categorization may be reported. |

S=susceptible, R=resistant

Microbiological susceptibility

The prevalence of acquired 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 cefuroxime axetil in at least some types of infections is questionable.

Cefuroxime is usually active against the following microorganisms in vitro.

|  |
| --- |
| **Commonly susceptible species** |
| Gram-positive aerobes:*Staphylococcus aureus* (methicillin susceptible)*\***Coagulase negative staphylococcus* (methicillin susceptible)*Streptococcus pyogenes**Streptococcus agalactiae* |
| Gram-negative aerobes: *Haemophilus influenzae* *Haemophilus parainfluenzae* *Moraxella catarrhalis* |
| Spirochaetes:*Borrelia burgdorferi* |
| **Microorganisms for which acquired resistance may be a problem** |
| Gram-positive aerobes:*Streptococcus pneumoniae* |
| Gram-negative aerobes:*Citrobacter freundii**Enterobacter aerogenes* *Enterobacter cloacae* *Escherichia coli* *Klebsiella pneumoniae* *Proteus mirabilis**Proteus* spp. (other than *P. vulgaris*)*Providencia* spp. |
| Gram-positive anaerobes:*Peptostreptococcus* spp.*Propionibacterium* spp. |
| Gram-negative anaerobes:*Fusobacterium* spp.*Bacteroides* spp. |
| **Inherently resistant microorganisms** |
| Gram-positive aerobes:*Enterococcus faecalis**Enterococcus faecium* |
| Gram-negative aerobes: *Acinetobacter* spp. *Campylobacter* spp. *Morganella morganii* *Proteus vulgaris* *Pseudomonas aeruginosa* *Serratia marcescens* |
| Gram-negative anaerobes:*Bacteroides fragilis* |
| Others:*Chlamydia* spp. *Mycoplasma* spp. *Legionella* spp. |

\* All methicillin-resistant *S. aureus* are resistant to cefuroxime.

**5.2 Pharmacokinetic properties**

Absorption

After oral administration cefuroxime axetil is absorbed from the gastrointestinal tract and rapidly hydrolysed in the intestinal mucosa and blood to release cefuroxime into the circulation. Optimum absorption occurs when it is administered shortly after a meal.

Following administration of cefuroxime axetil tablets peak serum levels (2.1 µg/ml for a 125 mg dose, 4.1 µg/ml for a 250 mg dose, 7.7 µg/ml for a 500 mg dose and 13.6 µg/ml for a 1000 mg dose) occur approximately 2­­ to ­3 hours after dosing when taken with food. The rate of absorption of cefuroxime from the suspension is reduced compared with the tablets, leading to later, lower peak serum levels and reduced systemic bioavailability (4 to 17% less). Cefuroxime axetil oral suspension was not bioequivalent to cefuroxime axetil tablets when tested in healthy adults and therefore is not substitutable on a milligram- per-milligram basis (see section 4.2). The pharmacokinetics of cefuroxime is linear over the oral dosage range of 125 to 1000 mg. No accumulation of cefuroxime occurred following repeat oral doses of 250 to 500 mg.

Distribution

Protein binding has been stated as 33 to 50% depending on the methodology used. Following a single dose of cefuroxime axetil 500 mg tablet to 12 healthy volunteers, the apparent volume of distribution was 50 L (CV%=28%). Concentrations of cefuroxime in excess of the minimum inhibitory levels for common pathogens can be achieved in the tonsilla, sinus tissues, bronchial mucosa, bone, pleural fluid, joint fluid, synovial fluid, interstitial fluid, bile, sputum and aqueous humor. Cefuroxime passes the blood-brain barrier when the meninges are inflamed.

Biotransformation

Cefuroxime is not metabolised.

Elimination

The serum half-life is between 1 and 1.5 hours. Cefuroxime is excreted by glomerular filtration and tubular secretion. The renal clearance is in the region of 125 to 148 ml/min/1.73 m2.

***Special patient populations***

Gender

No differences in the pharmacokinetics of cefuroxime were observed between males and females.

Elderly

No special precaution is necessary in the elderly patients with normal renal function at dosages up to the normal maximum of 1 g per day. Elderly patients are more likely to have decreased renal function; therefore, the dose should be adjusted in accordance with the renal function in the elderly (see section 4.2).

Paediatrics

In older infants (aged >3 months) and in children, the pharmacokinetics of cefuroxime are similar to that observed in adults.

There is no clinical trial data available on the use of cefuroxime axetil in children under the age of 3 months.

Renal impairment

The safety and efficacy of cefuroxime axetil in patients with renal failure have not been established. Cefuroxime is primarily excreted by the kidneys. Therefore, as with all such antibiotics, in patients with markedly impaired renal function (i.e. C1cr <30 ml/minute) it is recommended that the dosage of cefuroxime should be reduced to compensate for its slower excretion (see section 4.2). Cefuroxime is effectively removed by dialysis.

Hepatic impairment

There are no data available for patients with hepatic impairment. Since cefuroxime is primarily eliminated by the kidney, the presence of hepatic dysfunction is expected to have no effect on the pharmacokinetics of cefuroxime.

Pharmacokinetic/pharmacodynamic relationship

For cephalosporins, the most important pharmacokinetic-pharmacodynamic index correlating with *in vivo* efficacy has been shown to be the percentage of the dosing interval (%T) that the unbound concentration remains above the minimum inhibitory concentration (MIC) of cefuroxime for individual target species (i.e. %T>MIC).

**5.3 Preclinical safety data**

Non-clinical data reveal no special hazard for humans based on studies of safety pharmacology, repeated dose toxicity, genotoxicity and toxicity to reproduction and development. No carcinogenicity studies have been performed; however, there is no evidence to suggest carcinogenic potential.

Gamma glutamyl transpeptidase activity in rat urine is inhibited by various cephalosporins, however the level of inhibition is less with cefuroxime. This may have significance in the interference in clinical laboratory tests in humans.

**6. PHARMACEUTICAL PARTICULARS**

**6.1 List of excipients**

Tablet core:

Croscarmellose sodium

Crospovidone

Sodium laurilsulfate

Precipitated silica

Hydrogenated castor oil

Methylcellulose

Film-coat:

Hypromellose,

Microcrystalline cellulose,

Macrogol 8 stearate

Talc

Titanium dioxide (E171)

**6.2 Incompatibilities**

A positive Coombs' test has been reported during treatment with cephalosporins - this phenomenon can interfere with cross-matching of blood.

**6.3 Shelf life**

3 years

**6.4 Special precautions for storage**

Do not store above 25 °C.

**6.5 Nature and contents of container**

The film-coated tablets are packaged in PVC/PVdC alu - blisters.

Package-size

250 mg: 6, 8, 10, 12, 14, 16, 20, 24, and 50 film-coated tablets

500 mg: 6, 8, 10, 12, 14, 16, 20, 24, and 50 film-coated tablets

Not all pack sizes may be marketed.

**6.6 Special precautions for disposal and other handling**

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

**7. MARKETING AUTHORISATION HOLDER**

Aristo Pharma GmbH

Wallenroder Strasse 8-10

13435 Berlin

Tyskland

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

250 mg: 33236

500 mg: 33237

**9. DATE OF FIRST AUTHORISATION**

 25 September 2003

**10. DATE OF REVISION OF THE TEXT**

9 October 2023