Summary of Product Characteristics

1. Name of the Medicinal Product

Ciprofloxacin injection USP 0.2% w/v. (CIFIN)

2. Qualitative and Quantitative Composition

Each 1ml of solution contains2mg ciprofloxacin USP.
For full list of excipients see section 6.1

3. Pharmaceutical Form

Solution for Infusion

Description: A clear colourless solution

4. Clinical Particulars

4.1 Therapeutic Indications

Ciprofloxacin injection USP 2mg/lm is indicated for the treatment of susceptible strains of designated microorganisms in the conditions and patients populations listed below

Adult patients:

- Lower respiratory tract infections due to Gram- negative bacteria
- Pneumonia
- Chronic suppurative otitis media.
- Acute exacerbation of chronic sinusitis especially if these is caused by gram-negative bacteria.
- Urinary tract infections.
- Genital Tract Infections
- Epididymo-orchitis including cases due by neisseria gonorrhoeae
- Pelvic inflammatory diseases including cases due by neisseriagonnorrhoeae.
- Chronic bacterial prostatitis.
- Infections of the gastro-intestinal tract.
- Intra-abdominal infection.
- Infections of the skin and soft tissue caused by gram-negative bacteria.
- Malignant external otitis
- Infections of the bones and joints.
- Treatment of patients in neutropenic patients
- Prophylaxis of infections in neutropenic patients.

- Inhalation anthrax (post-exposure prophylaxis and curative treatment)
- Nosocomial pneumonia

Children and Adolescents

- Broncho-plumonary infections in cystic fibrosis caused by pseudomonas aeruginosa.
- Complicated urinary tract infections and pyelonephritis
- Inhalation anthrax (post-exposure prophylaxis and curative treatment)

Ciprofloxacin may also be used to treat severe infections in children and adolescents when this is considered to be necessary.

4.2 Posology And Method Of Administration

Posology

The dosage is determined by the indication, the severity and the site of the infection, the susceptibility to ciprofloxacin of the causative organism(s), the renal function of the patient and, in children and adolescents the body weight.

The duration of treatment depends on the severity of the illness and on the clinical and bacteriological course.

After intravenous initiation of treatment, the treatment can be switched to oral treatment with tablet or suspension if clinically indicated at the discretion of the physician. IV treatment should be followed by oral route as soon as possible.

In severe cases or if the patient is unable to take tablets (e.g. patients on enteral nutrition), it is recommended to commence therapy with intravenous ciprofloxacin until a switch to oral administration is possible.

Treatment of infections due to certain bacteria (e.g. *Pseudomonas aeruginosa*, *Acinetobacter* or *Staphylococci*) may require higher ciprofloxacin doses and co-administration with other appropriate antibacterial agents.

Treatment of some infections (e.g. pelvic inflammatory disease, intra-abdominal infections, infections in neutropenic patients and infections of bones and joints) may require co-administration with other appropriate antibacterial agents depending on the pathogens involved

Adults

Indications	**Daily dose in mg**	**Total duration of treatment (including switch to oral therapy as soon as possible)**

Infections of the lower respiratory tract		400 mg twice daily to 400 mg three times a day	7 to 14 days
Infections of the upper respiratory tract	Acute exacerbation of chronic sinusitis	400 mg twice daily to 400 mg three times a day	7 to 14 days
	Chronic suppurative otitis media	400 mg twice daily to 400 mg three times a day	7 to 14 days
	Malignant external otitis	400 mg three times a day	28 days up to 3 months
Urinary tract infections (see section 4.4)	Complicated and uncomplicated pyelonephritis	400 mg twice daily to 400 mg three times a day	7 to 21 days, it can be continued for longer than 21 days in some specific circumstances (such as abscesses)
	Prostatitis	400 mg twice daily to 400 mg three times a day	2 to 4 weeks (acute)
Genital tract infections	Epididymo-orchitis and pelvic inflammatory diseases	400 mg twice daily to 400 mg three times a day	at least 14 days
Infections of the gastro-intestinal tract and intra-abdominal infections	Diarrhoea caused by bacterial pathogens including *Shigella* spp. other than *Shigella dysenteriae* type 1 and empirical treatment of severe travellers'diarrhoea	400 mg twice daily	1 day
	Diarrhoea caused by *Shigella dysenteriae* type 1	400 mg twice daily	5 days
	Diarrhoea caused by *Vibrio cholerae*	400 mg twice daily	3 days
	Typhoid fever	400 mg twice daily	7 days
	Intra-abdominal infections due to Gram-negative bacteria	400 mg twice daily to 400 mg three times a day	5 to 14 days
Infections of the skin and soft tissue		400 mg twice daily to 400 mg three times a day	7 to 14 days
Bone and joint infections		400 mg twice daily to 400 mg three times a day	max. of 3 months
Neutropenic patients with fever that is suspected to be due to a bacterial infection. Ciprofloxacin should be co-administered with appropriate antibacterial agent(s) in accordance to official guidance.		400 mg twice daily to 400 mg three times a day	Therapy should be continued over the entire period of neutropenia
Inhalation anthrax post-exposure prophylaxis and curative treatment for persons requiring parenteral treatment Drug administration should begin as soon as possible after suspected or confirmed exposure.		400 mg twice daily	60 days from the confirmation of *Bacillus anthracis* exposure

Paediatric population

Indication	**Daily dose in mg**	**Total duration of treatment (including switch to oral therapy as soon as possible)**
Cystic fibrosis	10 mg/kg body weight three times a day with a maximum of 400 mg per dose.	10 to 14 days
Complicated urinary tract infections and pyelonephritis	6 mg/kg body weight three times a day to 10 mg/kg body weight three times a day with a maximum of 400 mg per dose.	10 to 21 days
Inhalation anthrax post-exposure curative treatment for persons requiring parenteral treatment Drug administration should begin as soon as possible after suspected or confirmed exposure.	10 mg/kg body weight twice daily to 15 mg/kg body weight twice daily with a maximum of 400 mg per dose.	60 days from the confirmation of *Bacillus anthracis* exposure
Other severe infections	10 mg/kg body weight three times a day with a maximum of 400 mg per dose.	According to the type of infections

Elderly patients

Elderly patients should receive a dose selected according to the severity of the infection and the patient`s creatinine clearance.

Patients with renal and hepatic impairment

Recommended starting and maintenance doses for patients with impaired renal function:

Creatinine Clearance [mL/min/1.73 m²]	**Serum Creatinine [µmol/L]**	**Intravenous Dose [mg]**
> 60	< 124	See Usual Dosage.
30-60	124 to 168	200-400 mg every 12 h
< 30	> 169	200-400 mg every 24 h
Patients on haemodialysis	> 169	200-400 mg every 24 h (after dialysis)
Patients on peritoneal dialysis	> 169	200-400 mg every 24 h

In patients with impaired liver function no dose adjustment is required.

Dosing in children with impaired renal and/or hepatic function has not been studied.

When only the serum creatinine concentration is known, the following may be used to estimate creatinine clearance:

Men: Creatinine Clearance (ml/min) = [Weight (kg) × (140-age)] / [72 × Serum Creatinine (mg/dl)]

Women: 0.85 × the value calculated for men

The serum creatinine should represent a steady-state of renal function.

For patients with changing renal function or for patients with renal impairment and hepatic insufficiency, careful monitoring is suggested.

No information is available on dosing adjustments necessary for pediatric patients with moderate to severe renalinsufficiency (i.e., creatinine clearance of < 50 mL/min/1.73m2).

Administration:

Parenteral drug products should be inspected visually for particulate matter anddiscoloration prior to administration. It must not be used if cloudy.

Ciprofloxacin Injection, USP should be administered by intravenous infusion over a period of 60 minutes.

Ciprofloxacin should be administered by intravenous infusion. For children, the infusion duration is 60 minutes.

In adult patients, infusion time is 60 minutes for 400 mg Ciprofloxacin solution for infusion and 30 minutes for 200 mg Ciprofloxacin solution for infusion. Slow infusion into a large vein will minimise patient discomfort and reduce the risk of venous irritation.

The infusion solution can be infused either directly or in parallel with other compatible infusion solutions

Monitoring:

An increased incidence of adverse events compared to controls, including events related to joints and/or surrounding tissues, has been observed in children and adolescents. (See Adverse Reactions.)

4.3Contraindications

- Hypersensitivity to the active ingredients, to other quinolones or to any of the excipients.
- Concomitant administration of ciprofloxacin and tizanidine.

4.4 Special Warnings and Precautions For Use

Severe infections and mixed infections with Gram-positive and anaerobic pathogens

Ciprofloxacin monotherapy is not suited for treatment of severe infections and infections that might be due to Gram-positive or anaerobic pathogens. In such infections ciprofloxacin must be co-administered with other appropriate antibacterial agents.

Streptococcal infections (including Streptococcus pneumoniae)

Ciprofloxacin is not recommended for the treatment of streptococcal infections due to inadequate efficacy.

Genital tract infections

Epididymo-orchitis and pelvic inflammatory diseases may be caused by fluoroquinolone-resistant Neisseria gonorrhoeae isolates.

For epididymo-orchitis and pelvic inflammatory diseases, empirical ciprofloxacin should only be considered in combination with another appropriate antibacterial agent (e.g. a cephalosporin) unless ciprofloxacin-resistant Neisseria gonorrhoeae can be excluded. If clinical improvement is not achieved after 3 days of treatment, the therapy should be reconsidered.

Urinary tract infections

Resistance to fluoroquinolones of Escherichia coli – the most common pathogen involved in urinary tract infections – varies across the European Union. Prescribers are advised to take into account the local prevalence of resistance in Escherichia coli to fluoroquinolones.

Intra-abdominal infections

There are limited data on the efficacy of ciprofloxacin in the treatment of post-surgical intra-abdominal infections.

Travellers' diarrhoea

The choice of ciprofloxacin should take into account information on resistance to ciprofloxacin in relevant pathogens in the countries visited.

Infections of the bones and joints

Ciprofloxacin should be used in combination with other antimicrobial agents depending on the results of the microbiological documentation.

Inhalational anthrax

Use in humans is based on in-vitro susceptibility data and on animal experimental data together with limited human data. Treating physicians should refer to national and /or international consensus documents regarding the treatment of anthrax.

Paediatric population

The use of ciprofloxacin in children and adolescents should follow available official guidance. Ciprofloxacin treatment should be initiated only by physicians who are experienced in the treatment of cystic fibrosis and/or severe infections in children and adolescents.

Ciprofloxacin has been shown to cause arthropathy in weight-bearing joints of immature animals. Safety data from a randomised double-blind study on ciprofloxacin use in children (ciprofloxacin: n=335, mean age = 6.3 years; comparators: n=349, mean age = 6.2 years; age range = 1 to 17 years) revealed an incidence of suspected drug-related arthropathy (discerned from joint-related clinical signs and symptoms) by Day +42 of 7.2% and 4.6%. Respectively, an incidence of drug-related arthropathy by 1-year follow-up was 9.0% and 5.7%. The increase of suspected drug-related arthropathy cases over time was not statistically significant between groups. Treatment should be initiated only after a careful benefit/risk evaluation, due to possible adverse events related to joints and/or surrounding tissue.

Broncho-pulmonary infections in cystic fibrosis

Clinical trials have included children and adolescents aged 5-17 years. More limited experience is available in treating children between 1 and 5 years of age.

Complicated urinary tract infections and pyelonephritis

Ciprofloxacin treatment of urinary tract infections should be considered when other treatments cannot be used, and should be based on the results of the microbiological documentation.

Other specific severe infections

Other severe infections in accordance with official guidance, or after careful benefit-risk evaluation when other treatments cannot be used, or after failure to conventional therapy and when the microbiological documentation can justify a ciprofloxacin use.

The use of ciprofloxacin for specific severe infections other than those mentioned above has not been evaluated in clinical trials and the clinical experience is limited. Consequently, caution is advised when treating patients with these infections.

Hypersensitivity

Hypersensitivity and allergic reactions, including anaphylaxis and anaphylactoid reactions, may occur following a single dose (see section 4.8) and may be life-threatening. If such reaction occurs, ciprofloxacin should be discontinued and an adequate medical treatment is required.

Musculoskeletal system

Ciprofloxacin should generally not be used in patients with a history of tendon disease/disorder related to quinolone treatment. Nevertheless, in very rare instances, after microbiological documentation of the causative organism and evaluation of the risk/benefit balance, ciprofloxacin may be prescribed to these patients for the treatment of certain severe infections,

particularly in the event of failure of the standard therapy or bacterial resistance, where the microbiological data may justify the use of ciprofloxacin.

Tendinitis and tendon rupture (especially Achilles tendon), sometimes bilateral, may occur with ciprofloxacin, even within the first 48 hours of treatment. Inflammation and ruptures of tendon may occur even up to several months after discontinuation of ciprofloxacin therapy. The risk of tendinopathy may be increased in elderly patients or in patients concomitantly treated with corticosteroids.

At any sign of tendinitis (e.g. painful swelling, inflammation), ciprofloxacin treatment should be discontinued. Care should be taken to keep the affected limb at rest.

Ciprofloxacin should be used with caution in patients with myasthenia gravis, because symptoms can be exacerbated.

Vision disorders

If vision becomes impaired or any effects on the eyes are experienced, an eye specialist should be consulted immediately.

Photosensitivity

Ciprofloxacin has been shown to cause photosensitivity reactions. Patients taking ciprofloxacin should be advised to avoid direct exposure to either extensive sunlight or UV irradiation during treatment.

Central nervous system

Ciprofloxacin like other quinolones are known to trigger seizures or lower the seizure threshold. Cases of status epilepticus have been reported. Ciprofloxacin should be used with caution in patients with CNS disorders which may be predisposed to seizure. If seizures occur ciprofloxacin should be discontinued (see section 4.8). Psychiatric reactions may occur even after first administration of ciprofloxacin. In rare cases, depression or psychosis can progress to suicidal ideations/thoughts culminating in attempted suicide or completed suicide. In the occurrence of such cases, ciprofloxacin should be discontinued.

Cases of polyneuropathy (based on neurological symptoms such as pain, burning, sensory disturbances or muscle weakness, alone or in combination) have been reported in patients receiving ciprofloxacin. Ciprofloxacin should be discontinued in patients experiencing symptoms of neuropathy, including pain, burning, tingling, numbness, and/or weakness in order to prevent the development of an irreversible condition.

Cardiac disorders

Caution should be taken when using fluoroquinolones, including ciprofloxacin, in patients with known risk factors for prolongation of the QT interval such as, for example:- congenital long QT syndrome

- concomitant use of drugs that are known to prolong the QT interval (e.g. Class IA and III anti-arrhythmics, tricyclic antidepressants, macrolides, antipsychotics)
- uncorrected electrolyte imbalance (e.g. hypokalaemia, hypomagnesaemia)
- cardiac disease (e.g. heart failure, myocardial infarction, bradycardia)

Elderly patients and women may be more sensitive to QTc-prolonging medications. Therefore, caution should be taken when using fluoroquinolones, including ciprofloxacin, in these populations.

Vascular disorders

Epidemiologic studies report an increased risk of aortic aneurysm and dissection after intake of fluoroquinolones, particularly in the older population.

Therefore, fluoroquinolones should only be used after careful benefit-risk assessment and after consideration of other therapeutic options in patients with positive family history of aneurysm disease, or in patients diagnosed with pre-existing aortic aneurysm and/or aortic dissection, or in presence of other risk factors or conditions predisposing for aortic aneurysm and dissection (e.g. Marfan syndrome, vascular Ehlers-Danlos syndrome, Takayasu arteritis, giant cell arteritis, Behcet's disease, hypertension, known atherosclerosis).

In case of sudden abdominal, chest or back pain, patients should be advised to immediately consult a physician in an emergency department.

Hypoglycaemia

As with other quinolones, hypoglycaemia has been reported most often in diabetic patients, predominantly in the elderly population. In all diabetic patients, careful monitoring of blood glucose is recommended.

Gastrointestinal system

The occurrence of severe and persistent diarrhoea during or after treatment (including several weeks after treatment) may indicate an antibiotic-associated colitis (life-threatening with possible fatal outcome), requiring immediate treatment (see section 4.8). In such cases, ciprofloxacin should immediately be discontinued, and an appropriate therapy initiated. Anti-peristaltic drugs are contraindicated in this situation.

Renal and urinary system

Crystalluria related to the use of ciprofloxacin has been reported (see section 4.8). Patients receiving ciprofloxacin should be well hydrated and excessive alkalinity of the urine should be avoided.

Impaired renal function

Since ciprofloxacin is largely excreted unchanged via renal pathway dose adjustment is needed in patients with impaired renal function as described in section 4.2 to avoid an increase in adverse drug reactions due to accumulation of ciprofloxacin.

Hepatobiliary system

Cases of hepatic necrosis and life-threatening hepatic failure have been reported with ciprofloxacin (see section 4.8). In the event of any signs and symptoms of hepatic disease (such as anorexia, jaundice, dark urine, pruritus, or tender abdomen), treatment should be discontinued.

Glucose-6-phosphate dehydrogenase deficiency

Haemolytic reactions have been reported with ciprofloxacin in patients with glucose-6-phosphate dehydrogenase deficiency. Ciprofloxacin should be avoided in these patients unless the potential benefit is considered to outweigh the possible risk. In this case, potential occurrence of haemolysis should be monitored.

Resistance

During or following a course of treatment with ciprofloxacin bacteria that demonstrate resistance to ciprofloxacin may be isolated, with or without a clinically apparent superinfection. There may be a particular risk of selecting for ciprofloxacin-resistant bacteria during extended durations of treatment and when treating nosocomial infections and/or infections caused by Staphylococcus and Pseudomonas species.

Cytochrome P450

Ciprofloxacin inhibits CYP1A2 and thus may cause increased serum concentration of concomitantly administered substances metabolised by this enzyme (e.g. theophylline, clozapine, olanzapine, ropinirole, tizanidine, duloxetine, agomelatine). Therefore, patients taking these substances concomitantly with ciprofloxacin should be monitored closely for clinical signs of overdose, and determination of serum concentrations (e.g. of theophylline) may be necessary (see section 4.5). Co -administration of ciprofloxacin and tizanidine is contraindicated.

Methotrexate

The concomitant use of ciprofloxacin with methotrexate is not recommended.

Interaction with tests

The in vitro activity of ciprofloxacin against Mycobacterium tuberculosis might give false negative bacteriological test results in specimens from patients currently taking ciprofloxacin.

Injection site reaction

Local intravenous site reactions have been reported with the intravenous administration of ciprofloxacin. These reactions are more frequent if the infusion time is 30 minutes or less. These may appear as local skin reactions which resolve rapidly upon completion of the infusion. Subsequent intravenous administration is not contraindicated unless the reactions recur or worsen.

4.5Interaction with other medicinal products and other forms of interaction

Effects of other products on ciprofloxacin:

Drugs known to prolong QT interval

Ciprofloxacin, like other fluoroquinolones, should be used with caution in patients receiving drugs known to prolong QT interval (e.g. Class IA and III anti-arrhythmics, tricyclic antidepressants, macrolides, antipsychotics).

Probenecid

Probenecid interferes with renal secretion of ciprofloxacin. Co-administration of probenecid and ciprofloxacin increases ciprofloxacin serum concentrations.

Effects of ciprofloxacin on other medicinal products:

Tizanidine

Tizanidine must not be administered together with ciprofloxacin. In a clinical study with healthy subjects, there was an increase in serum tizanidine concentration when given concomitantly with ciprofloxacin. Increased serum tizanidine concentration is associated with a potentiated hypotensive and sedative effect.

Methotrexate

Renal tubular transport of methotrexate may be inhibited by concomitant administration of ciprofloxacin, potentially leading to increased plasma levels of methotrexate and increased risk of methotrexate-associated toxic reactions. The concomitant use is not recommended.

Theophylline

Concurrent administration of ciprofloxacin and theophylline can cause an undesirable increase in serum theophylline concentration. This can lead to theophylline-induced side effects that may rarely be life threatening or fatal. During the combination, serum theophylline concentrations should be checked and the theophylline dose reduced as necessary.

Other xanthine derivatives

On concurrent administration of ciprofloxacin and caffeine or pentoxifylline (oxpentifylline), raised serum concentrations of these xanthine derivatives were reported.

Phenytoin

Simultaneous administration of ciprofloxacin and phenytoin may result in increased or reduced serum levels of phenytoin such that monitoring of drug levels is recommended.

Ciclosporin

A transient rise in the concentration of serum creatinine was observed when ciprofloxacin and ciclosporin containing medicinal products were administered simultaneously. Therefore, it is frequently (twice a week) necessary to control the serum creatinine concentrations in these patients.

Vitamin K antagonists

Simultaneous administration of ciprofloxacin with a vitamin K antagonist may augment its anti-coagulant effects. The risk may vary with the underlying infection, age and general status of the patient so that the contribution of ciprofloxacin to the increase in INR (international normalised ratio) is difficult to assess. The INR should be monitored frequently during and shortly after co-administration of ciprofloxacin with a vitamin K antagonist (e.g., warfarin, acenocoumarol, phenprocoumon, or fluindione).

Duloxetine

In clinical studies, it was demonstrated that concomitant use of duloxetine with strong inhibitors of the CYP450 1A2 isozyme such as fluvoxamine, may result in an increase of AUC and C_{max} of duloxetine. Although no clinical data are available on a possible interaction with ciprofloxacin, similar effects can be expected upon concomitant administration.

Ropinirole

It was shown in a clinical study that concomitant use of ropinirole with ciprofloxacin, a moderate inhibitor of the CYP450 1A2 isozyme, results in an increase of C_{max} and AUC of ropinirole by 60% and 84%, respectively. Monitoring of ropinirole-related side effects and dose adjustment as appropriate is recommended during and shortly after co-administration with ciprofloxacin.

Lidocaine

It was demonstrated in healthy subjects that concomitant use of lidocaine containing medicinal products with ciprofloxacin, a moderate inhibitor of CYP450 1A2 isozyme, reduces clearance of intravenous lidocaine by 22%. Although lidocaine treatment was well tolerated, a possible interaction with ciprofloxacin associated with side effects may occur upon concomitant administration.

Clozapine

Following concomitant administration of 250 mg ciprofloxacin with clozapine for 7 days, serum concentrations of clozapine and N-desmethylclozapine were increased by 29% and 31%, respectively. Clinical surveillance and appropriate adjustment of clozapine dosage during and shortly after co-administration with ciprofloxacin are advised.

Sildenafil

C_{max} and AUC of sildenafil were increased approximately twofold in healthy subjects after an oral dose of 50 mg given concomitantly with 500 mg ciprofloxacin. Therefore, caution should be used prescribing ciprofloxacin concomitantly with sildenafil taking into consideration the risks and the benefits.

4.6Pregnancy and lactation

Pregnancy**:**

The data that are available on administration of ciprofloxacin to pregnant women indicates no malformative or feoto/neonatal toxicity of ciprofloxacin. Animal studies do not indicate direct or indirect harmful effects with respect to reproductive toxicity. In juvenile and prenatal animals exposed to quinolones, effects on immature cartilage have been observed, thus, it cannot be excluded that the drug could cause damage to articular cartilage in the human immature organism / foetus.

As a precautionary measure, it is preferable to avoid the use of ciprofloxacin during pregnancy.

Breast-feeding:

Ciprofloxacin is excreted in breast milk. Due to the potential risk of articular damage, ciprofloxacin should not be used during breast-feeding.

4.7Effects on ability to drive and use machines

Due to its neurological effects, ciprofloxacin may affect reaction time. Thus, the ability to drive or to operate machinery may be impaired

4.8Undesirable effects

The most commonly reported adverse drug reactions (ADRs) are nausea, diarrhoea, vomiting, transient increase in transaminases, rash, and injection and infusion site reactions.

ADRs derived from clinical studies and post-marketing surveillance with Ciprofloxacin (oral, intravenous and sequential therapy) sorted by categories of frequency are listed below. The frequency analysis takes into account data from both oral and intravenous administration of ciprofloxacin.

System OrganmClass	**Common ≥ 1/100 to**	**Uncommon ≥ 1/1,000 to < 1/100**	**Rare ≥ 1/10,000 to**	**Very Rare < 1/10,000**	**Frequency notknown**
Infections and Infestations		Mycotic superinfections			
Blood and lymphatic system disorder s		Eosinophilia	Leukopenia Anaemia Neutropenia LeukocytosisThrombocytopeni a Thrombocytaemia	Haemolytic anaemia Agranulocytosi s Pancytopenia (lifethreatening) Bone marrow depression (lifethreatening)	
Immune system disorders			Allergic reaction Allergic oedema /angioedema	Anaphylactic reaction Anaphylactic shock (lifethreatening) Serum sickness- like reaction	
Endocrin e disorder s					Syndrome of inappropriat e secretion of antidiuretic hormone (SIADH)
Metabolism and nutrition disorders		Decreas ed appetite	Hyperglycaemi a Hypoglycaemi a		Hypoglycae mic coma
Psychiatri c disorders *		Psychomot or hyperactivit y / agitation	Confusion and disorientation Anxiety reaction Abnormal dreams Depression (potentially culminating in suicidal ideations/though ts or suicide attempts and completed suicide) Hallucinations	Psychotic reactions (potentially culminating in suicidal ideations/ thoughts or suicide attempts	Mania, incl. hypomani a

				and completed suicide)	
Nervous system disorders*		Headach e Dizzines s Sleep disorder s	Par- and Dysaesthesi a HypoaesthesiaTremor	Migraine Disturbed coordination Gait disturbance	Peripheral neuropathy and polyneuropathy
		Taste disorder s	Seizures (including status epilepticus) Vertigo	Olfactory nerve disorders Intracranial hypertension and pseudotumor cerebr	
Eye disorders*			Visual disturbances (e.g.diplopia)	Visual colour distortions	
Ear and labyrinth disorders *			Tinnitus Hearing loss / Hearing impaired		
Cardiac disorders* *			Tachycardia		Ventricular arrhythmia, torsades de pointes (reported predominantl y in patients with risk factors for QT prolongation),ECG QT prolonged
Vascular disorders* *			Vasodilatatio n Hypotension Syncope	Vasculitis	
Respirator y, thoracic and mediastina l disorders			Dyspnoe a (includin g asthmati c condition)		
Gastrointestinaldisorders	Nausea Diarrhoe a	Vomiting Gastrointesti n al and abdominal pains Dyspepsia Flatulence	Antibioticassociated colitis (very rarely with possible fatal outcome)	Pancreatitis	
Hepatobiliarydisorders		Increase in transaminas es Increased bilirubin	Hepatic impairment Cholestatic icterusHepatitis	Liver necrosis (very rarely progressing to lifethreatening hepatic failure)	
Skin and subcutaneou s tissue disorders		Rash Pruritus Urticari a	Photosensitivityreactions	Petechiae Erythema multiform e Erythema nodosum	Acute Generalised Exanthemato us Pustulosis (AGEP)

				StevensJohnson syndrome (potentially lifethreatening) Toxic epidermal necrolysis (potentially lifethreatening)	Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS)
Musculoskelet al and connective tissue disorders*		Musculoskel e tal pain (e.g. extremity pain, back pain, chest pain) Arthralgia	Myalgia Arthritis Increased muscle tone and cramping	Muscular weakness Tendinitis Tendon rupture (predominantly Achilles tendon) Exacerbation of symptoms of myasthenia gravis	
Renal and urinary disorder		Renal impairmen t	Renal failure Haematuria Crystalluria Tubulointerstitialnephritis		
General disorders and administratio n site conditions*	Injection and infusion site reactions (only intravenous administrati on)	AstheniaFeve	Oedema Sweating (hyperhidrosi s)		
Investigations		Increase in blood alkaline phosphata se	Increased amylase		International normalised ratio increased (in patients treated with Vitamin K antagonists)

*Very rare cases of prolonged (up to months or years), disabling and potentially irreversible serious drug reactions affecting several, sometimes multiple, system organ classes and senses (including reactions such as tendonitis, tendon rupture, arthralgia, pain in extremities, gait disturbance, neuropathies associated with paraesthesia, depression, fatigue, memory impairment, sleep disorders, and impairment of hearing, vision, taste and smell) have been reported in association with the use of quinolones and fluoroquinolones in some cases irrespective of preexisting risk factors. **Cases of aortic aneurysm and dissection, sometimes complicated by

rupture (including fatal ones), and of regurgitation/incompetence of any of the heart valves have been reported in patients receiving fluoroquinolones

The following undesirable effects have a higher frequency category in the subgroups of patients receiving intravenous or sequential (intravenous to oral) treatment:

Common	Vomiting, Transient increase in transaminases, Rash
Uncommon	Thrombocytopenia, Thrombocytaemia, Confusion and disorientation, Hallucinations, Par-and dysaesthesia, Seizures, Vertigo, Visual disturbances, Hearing loss, Tachycardia, Vasodilatation, Hypotension, Transient hepatic impairment, Cholestatic icterus, Renal failure, Oedema
Rare	Pancytopenia, Bone marrow depression, Anaphylactic shock, Psychotic reactions, Migraine, Olfactory nerve disorders, Hearing impaired, Vasculitis, Pancreatitis, Liver necrosis, Petechiae, Tendon rupture

Paediatric population

The incidence of arthropathy (arthralgia, arthritis), mentioned above, is referring to data collected in studies with adults. In children, arthropathy is reported to occur commonly.

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 EFDA yellow Card Scheme, online at https://primaryreporting.who-umc.org/ET or toll free call 8482 to Ethiopian food and drug authority (EFDA).

4.9 Overdose

An overdose of 12 g has been reported to lead to mild symptoms of toxicity. Anacute overdose of 16 g has been reported to cause acute renal failure. Symptoms inoverdose consist ofdizziness, tremor, headache, tiredness, seizures,hallucinations, confusion, abdominal discomfort, renal and hepatic impairment aswell as crystalluria and haematuria. Reversible renal toxicity has been reported.

Apart from routine emergency measures, e.g. ventricular emptying followed bymedical carbon, it is recommended to monitor renal function, including urinary pHand acidify, if required, to

prevent crystalluria. Patients should be kept wellhydrated. Calcium or magnesium containing antacids may theoretically reduce theabsorption of ciprofloxacin in overdoses.
Only a small quantity of ciprofloxacin (<10%) is eliminated by haemodialysis orperitoneal dialysis. In the event of overdose, symptomatic treatment should beimplemented. ECG monitoring should be undertaken, because of the possibility ofQT interval prolongation.

5 Pharmacological Properties

5.1 Pharmacodynamic Properties

Pharmacotherapeutic group: Fluoroquinolones

ATC code: J01MA02

Mechanism of action

As a fluoroquinolone antibacterial agent, the bactericidal action of ciprofloxacin results from the inhibition of both type II topoisomerase (DNA-gyrase) and topoisomerase IV, required for bacterial DNA replication, transcription, repair and recombination.

Pharmacokinetic/pharmacodynamic relationship

Efficacy mainly depends on the relation between the maximum concentration in serum (Cmax) and the minimum inhibitory concentration (MIC) of ciprofloxacin for a bacterial pathogen and the relation between the area under the curve (AUC) and the MIC.

Mechanism of resistance

In-vitro resistance to ciprofloxacin can be acquired through a stepwise process by target site mutations in both DNA gyrase and topoisomerase IV. The degree of cross-resistance between ciprofloxacin and other fluoroquinolones that results is variable. Single mutations may not result in clinical resistance, but multiple mutations generally result in clinical resistance to many or all active substances within the class.

Impermeability and/or active substance efflux pump mechanisms of resistance may have a variable effect on susceptibility to fluoroquinolones, which depends on the

physiochemical properties of the various active substances within the class and the affinity of transport systems for each active substance. All *in- vitro* mechanisms of resistance are commonly observed in clinical isolates. Resistance mechanisms that inactivate other antibiotics such as permeation barriers (common in *Pseudomonas aeruginosa*) and efflux mechanisms may affect susceptibility to ciprofloxacin.

Plasmid-mediated resistance encoded by qnr-genes has been reported.

Spectrum of antibacterial activity

Breakpoints separate susceptible strains from strains with intermediate susceptibility and the later from resistant strains.

EUCAST Recommendation

Microorganism	**Susceptible**	**Resistant**
Enterobacteriaceae	S ≤ 0.25 mg/L	R > 0.5 mg/L
Salmonella spp	S ≤ 0.06 mg/L/	R > 0.06 mg/L
Pseudomonas spp.	S ≤ 0.5 mg/L	R > 0.5 mg/L
Acinetobacter spp.	S ≤ 1 mg/L	R > 1 mg/L
Staphylococcus spp.1	S ≤ 1 mg/L	R > 1 mg/L
Haemophilus influenzae	S ≤ 0.06 mg/L	R > 0.06 mg/L
Moraxella catarrhalis	S ≤ 0.125 mg/L	R > 0.125 mg/L
Neisseria gonorrhoeae	S ≤ 0.03 mg/L	R > 0.06 mg/L
Neisseria meningitidis	S ≤ 0.03 mg/L	R > 0.03 mg/L
Non-speciesrelated breakpoints*	S ≤ 0.25 mg/L	R > 0.5 mg/L
1: Staphylococcus spp. - breakpoints for ciprofloxacin relate to high dose therapy.		
*: Non-species-related breakpoints have been determined mainly onthe basis of PK/PD data and are independent of MIC distributions ofspecific species. They are for use only for species that have not been given a species-specific breakpoint and not for those species wheresusceptibility testing is notrecommended.		

As a fluoroquinolone antibacterial agent, the bactericidal action of ciprofloxacin results from the inhibition of both type II topoisomerase (DNA-gyrase) and topoisomerase IV, required for bacterial DNA replication, transcription, repair and recombination.

COMMONLY SUSCEPTIBLE SPECIES
Aerobic Gram-positive micro-organisms *Bacillus Anthracis*
Aerobic Gram-negative micro-organisms *Aeromonas* spp. *Brucella* spp. *Citrobacter koseri* *Francisella tularensis* *Haemophilusducreyi* *Haemophilus influenzae* *Legionella* spp. *Moraxella catarrhalis*

Neisseria meningitidis *Pasteurella* spp. *Salmonella* spp. *Shigella* spp. *Vibrio* spp. *Yersinia pestis*
Anaerobic micro-organisms *Mobiluncus*
Other micro-organisms *Chlamydia trachomatis* *Chlamydia pneumoniae* *Mycoplasma hominis* *Mycoplasma pneumoniae*
SPECIES FOR WHICH ACQUIRED RESISTANCE MAY BE A PROBLEM
Aerobic Gram-positive micro-organisms *Enterococcus faecalis* *Staphylococcus* spp.
Aerobic Gram-negative micro-organisms *Acinetobacter baumannii* *Burkholderiacepacia* *Campylobacter* spp. *Citrobacter freundii* *Enterobacter aerogenes* *Enterobacter cloacae* *Escherichia coli* *Klebsiella oxytoca* *Klebsiella pneumoniae* *Morganella morganii* *Neisseria gonorrhoeae* *Proteus mirabilis* *Proteus vulgaris* *Providencia* spp. *Pseudomonas aeruginosa* *Pseudomonas fluorescens* *Serratia marcescens*
Anaerobic micro-organisms *Peptostreptococcus*spp. *Propionibacterium acnes*
INHERENTLY RESISTANT ORGANISMS
Aerobic Gram-positive micro-organisms Actinomyces Enteroccus faecium Listeria monocytogenes Aerobic Gram-negativemicro organisms *Stenotrophomonas maltophilia*

Anaerobic microorganismsExcepted aslisted above Other microorganisms Mycoplasma genitalium Ureaplasmaurealitycum
*: Clinical efficacy has been demonstrated for susceptible isolates in approved clinical indications +: Resistance rate ≥ 50% in one or more EU countries ($): Natural intermediate susceptibility in the absence of acquiredmechanism of resistance (1) : Studies have been conducted in experimental animal infections dueto inhalations of *Bacillus anthracis* spores; these studies reveal thatantibiotics starting early after exposition avoid the occurrence of thedisease if the treatment is made up to the decrease of the number ofspores in the organism under the infective dose. The recommendeduse in human subjects is based primarily on *in-vitro* susceptibility and on animal experimental data together with limited human data. Twomonthtreatment duration in adults with oral ciprofloxacin given at thefollowing dose, 500 mg bid, is considered as effective to prevent anthrax infection in humans. The treating physician should refer tonational and/or international consensus documents regarding treatmentof anthrax. (2) : Methicillin-resistant *S. aureus* very commonly express coresistance to fluoroquinolones. The rate of resistance to methicillin isaround 20 to 50% among all staphylococcal species and is usually higher in nosocomial isolates.

5.2 Pharmacokinetic Properties

Absorption

Following an intravenous infusion of ciprofloxacin the mean maximum serum concentrations were achieved at the end of infusion. Pharmacokinetics of ciprofloxacin were linear over the dose range up to 400 mg administered intravenously.

Comparison of the pharmacokinetic parameters for a twice a day and three times a day intravenous dose regimen indicated no evidence of drug accumulation for ciprofloxacin and its metabolites.

A 60-minute intravenous infusion of 200 mg ciprofloxacin or the oral administration of 250 mg ciprofloxacin, both given every 12 hours, produced an equivalent area under the serum concentration time curve (AUC).

A 60-minute intravenous infusion of 400 mg ciprofloxacin every 12 hours was bioequivalent to a 500 mg oral dose every 12 hours with regard to AUC.

The 400 mg intravenous dose administered over 60 minutes every 12 hours resulted in a C_{max} similar to that observed with a 750 mg oral dose.

A 60-minute infusion of 400 mg ciprofloxacin every 8 hours is equivalent with respect to AUC to 750 mg oral regimen given every 12 hours.

Distribution

Protein binding of ciprofloxacin is low (20-30%). Ciprofloxacin is present in plasma largely in a non-ionised form and has a large steady state distribution volume of 2-3 L/kg body weight. Ciprofloxacin reaches high concentrations in a variety of tissues such as lung (epithelial fluid, alveolar macrophages, biopsy tissue), sinuses, inflamed lesions (cantharides blister fluid), and the urogenital tract (urine, prostate, endometrium) where total concentrations exceeding those of plasma concentrations are reached.

Biotransformation

Low concentrations of four metabolites have been reported, which were identified as: desethyleneciprofloxacin (M 1), sulphociprofloxacin (M 2), oxociprofloxacin (M 3) and formylciprofloxacin (M 4). The metabolites display *in-vitro* antimicrobial activity but to a lower degree than the parent compound.

Ciprofloxacin is known to be a moderate inhibitor of the CYP 450 1A2 iso-enzymes.

Elimination

Ciprofloxacin is largely excreted unchanged both renally and, to a smaller extent, faecally.

Excretion of ciprofloxacin (% of dose)		
	Intravenous Administration	
	Urine	**Faeces**
Ciprofloxacin	61.5	15.2
Metabolites (M_1-M_4)	9.5	2.6

Renal clearance is between 180-300 mL/kg/h and the total body clearance is between 480-600 mL/kg/h. Ciprofloxacin undergoes both glomerular filtration and tubular secretion. Severely impaired renal function leads to increased half lives of ciprofloxacin of up to 12 h.

Non-renal clearance of ciprofloxacin is mainly due to active trans-intestinal secretion and metabolism. 1% of the dose is excreted via the biliary route. Ciprofloxacin is present in the bile in high concentrations.

Paediatric patients

The pharmacokinetic data in paediatric patients are limited.

In a study in children C_{max} and AUC were not age-dependent (above one year of age). No notable increase in C_{max} and AUC upon multiple dosing (10 mg/kg three times daily) was observed.

In 10 children with severe sepsis C_{max} was 6.1 mg/L (range 4.6-8.3 mg/L) after a 1-hour intravenous infusion of 10 mg/kg in children aged less than 1 year compared to 7.2 mg/L (range 4.7-11.8 mg/L) for children between 1 and 5 years of age. The AUC values were 17.4 mg*h/L

(range 11.8-32.0 mg*h/L) and 16.5 mg*h/L (range 11.0-23.8 mg*h/L) in the respective age groups.

These values are within the range reported for adults at therapeutic doses. Based on population pharmacokinetic analysis of paediatric patients with various infections, the predicted mean half-life in children is approx. 4-5 hours and the bioavailability of the oral suspension ranges from 50 to 80%.

5.3 Pre clinical safety data

Non-clinical data reveal no special hazards for humans based on conventionalstudies of single dose toxicity, repeated dose toxicity, carcinogenic potential, ortoxicity to reproduction.

Like a number of other quinolones, ciprofloxacin is phototoxic in animals atclinically relevant exposure levels. Data on photomutagenicity/photocarcinogenicity show a weak photomutagenic or phototumorigenic effect ofciprofloxacin *in-vitro* and in animal experiments. This effect was comparable to thatof other gyrase inhibitors.

Articular tolerability

As reported for other gyrase inhibitors, ciprofloxacin causes damage to the largeweight-bearing joints in immature animals. The extent of the cartilage damagevaries according to age, species and dose; the damage can be reduced by takingthe weight off the joints. Studies with mature animals (rat, dog) revealed noevidence of cartilage lesions. In a study in young beagle dogs, ciprofloxacincaused severe articular changes at therapeutic doses after two weeks oftreatment, which were still observed after 5 months.

6 Pharmaceutical particulars

6.1 List of excipients

Water for Injections B.P.

Lactic acid B.P

Edetate disodium B.P

Hydrochloric acid B.P

Sodium Hydroxide B.P

Sodium Chloride B.P

6.2 Incompatibilities

Ciprofloxacin 2mg/ml solution for infusion is incompartible with injection solutions (e.gpenicillins, heparin solutions), which are chemically or physically unstable at its pH of 3.9-4.3. Unless stability has been proven, the infusion should always be administered separately.

However ciprofloxacin 2mg/ml solution has been shown to be compatible with the following administration fluids:

Ringer's solution

Glucose solutions 5% and 10%.

Sodium Chloride solution 0.9%.

Glucose/Saline solution 5%/0.9%

Fructose solution 10%

6.3Shelf life

24 months when unopened

The infusion solution must be used immediately after opening,.

6.4 Special precautions for storage

Store below 30°C, but do not freeze.

Keep bottle within the outer carton before use, in order to protect from light.

6.5 Nature and contents of container

pack sizes: 100 mL

The bottles are made from Low Density Polyethylene plastic; the bottles are thenflow wrapped in a protective plastic pouch and packed in baby cartons.

6.6 Special Precautions for Disposal And Other Handling

Ciprofloxacin solution for infusion should be administered without mixing with any other substances or infusion fluids.

Ciprofloxacin infusion has been shown to be compatible with Ringer's solution, Sodium chloride 9 mg/ml (0.9%) solution for infusion, Glucose 50 mg/ml (5%) and 100 mg/ml (10%) solution for infusion and Fructose 100 mg/ml (10%) solution for infusion when infused in parallel.

Unless compatibility is proven, the infusion solution should always be administered separately.

When ciprofloxacin infusion solutions are mixed with compatible infusion solutions, for microbial reasons and light sensitivity these solutions must be administered shortly after admixture.

For single use only.

At cool temperatures precipitation may occur, which will re-dissolve at room temperature (15°C – 25°C).

The solution should be visually inspected for particulate matter and discoloration prior to administration. Only clear and colourless or slightly yellow solution should be used.

Any unused solution and the bags should be adequately disposed off, in accordance with local requirements.

Use as directed by the physician.

Keep out of reach of children.

7.Marketing Authorisation Holder

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8.Marketing Authorisation Number(s)

N/A

9.Date of First Authorisation/Renewal of Authorisation

Oct 2019

10.Date of revision of the text

July 2023