Rx Ceftriaxone Injection IP

WIAXONE®

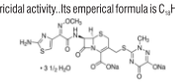
विएक्सोन

For I.M./I.V. use only

Composition :
Each vial contains:
Ceftriaxone Sodium (Sterile) IP
Eq. to Anhydrous Ceftriaxone 1000 mg

This pack also contains one FFS ampoule of Sterile Water for Injections I.P. 10 ml.

PROPERTIES:
Ceftriaxone Sodium is the sodium salt form of ceftriaxone, a beta-lactam, third-generation cephalosporin antibiotic with bactericidal activity. Its emperical formula is $C_{18}H_{16}N_8Na_2O_7S_2.3½H_2O$ and molecular weight is 662. Structural formula is as shown:



CLINICAL PHARMACOLOGY:
Pharmacodynamics
Pharmacotherapeutic group: Antibacterials for systemic use, Third-generation cephalosporins
ATC code: J01DD04
Mechanism of action
Ceftriaxone 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.
Pharmacokinetics
Absorption
Intramuscular administration
Following intramuscular injection, mean peak plasma ceftriaxone levels are approximately half those observed after intravenous administration of an equivalent dose. The maximum plasma concentration after a single intramuscular dose of 1 g is about 81 mg/l and is reached in 2 - 3 hours after administration. The area under the plasma concentration-time curve after intramuscular administration is equivalent to that after intravenous administration of an equivalent dose.
Intravenous administration
After intravenous bolus administration of ceftriaxone 500 mg and 1 g, mean peak plasma ceftriaxone levels are approximately 120 and 200 mg/l respectively. After intravenous infusion of ceftriaxone 500 mg, 1 g and 2 g, the plasma ceftriaxone levels are approximately 80, 150 and 250 mg/l respectively.
Distribution
The volume of distribution of ceftriaxone is 7 – 12. Concentrations well above the minimal inhibitory concentrations of most relevant pathogens are detectable in tissue including lung, heart, biliary tract/liver, tonsil, middle ear and nasal mucosa, bone, and in cerebrospinal, pleural, prostatic and synovial fluids. An 8 - 15 % increase in mean peak plasma concentration (Cmax) is seen on repeated administration; steady state is reached in most cases within 48 - 72 hours depending on the route of administration. Penetration into particular tissues Ceftriaxone penetrates the meninges. Penetration is greatest when the meninges are inflamed. Mean peak ceftriaxone concentrations in CSF in patients with bacterial meningitis are reported to be up to 25 % of plasma levels compared to 2 % of plasma levels in patients with uninflamed meninges. Peak ceftriaxone concentrations in CSF are reached approximately 4-6 hours after intravenous injection. Ceftriaxone crosses the placental barrier and is excreted in the breast milk at low concentrations. Protein binding. Ceftriaxone is reversibly bound to albumin. Plasma protein binding is about 95 % at plasma concentrations below 100 mg/l. Binding is saturable and the bound portion decreases with rising concentration (up to 85 % at a plasma concentration of 300 mg/l).
Biotransformation
Ceftriaxone is not metabolised systemically; but is converted to inactive metabolites by the gut flora.
Elimination
Plasma clearance of total ceftriaxone (bound and unbound) is 10 - 22 ml/min. Renal clearance is 5 - 12 ml/min. 50 - 60 % of ceftriaxone is excreted unchanged in the urine, primarily by glomerular filtration, while 40 - 50 % is excreted unchanged in the bile. The elimination half-life of total ceftriaxone in adults is about 8 hours.
Patients with renal or hepatic impairment In patients with renal or hepatic dysfunction, the pharmacokinetics of ceftriaxone are only minimally altered with the half-life slightly increased (less than two fold), even in patients with severely impaired renal function. The relatively modest increase in half-life in renal impairment is explained by a compensatory increase in non-renal clearance, resulting from a decrease in protein binding and corresponding increase in non-renal clearance of total ceftriaxone. In patients with hepatic impairment, the elimination half-life of ceftriaxone is not increased, due to a compensatory increase in renal clearance. This is also due to an increase in plasma free fraction of ceftriaxone contributing to the observed paradoxical increase in total drug clearance, with an increase in volume of distribution paralleling that of total clearance. Older people In older people aged over 75 years the average elimination half-life is usually two to three times that of young adults. Paediatric population The half-life of ceftriaxone is prolonged in neonates. From birth to 14 days of age, the levels of free ceftriaxone may be further increased by factors such as reduced glomerular filtration and altered protein binding. During childhood, the half-life is lower than in neonates or adults. The plasma clearance and volume of distribution of total ceftriaxone are greater in neonates, infants and children than in adults. Linearity/non-linearity The pharmacokinetics of ceftriaxone are non-linear and all basic pharmacokinetic parameters, except the elimination half-life, are dose dependent if based on total drug concentrations, increasing less than proportionally with dose. Non-linearity is due to saturation of plasma protein binding and is therefore observed for total plasma ceftriaxone but not for free (unbound) ceftriaxone. Pharmacokinetic/pharmacodynamic relationship As with other beta-lactams, the pharmacokinetic-pharmacodynamic index demonstrating the best correlation with in vivo efficacy is the percentage of the dosing interval that the unbound concentration remains above the minimum inhibitory concentration (MIC) of ceftriaxone for individual target species (i.e. %T > MIC).
INDICATIONS:
Ceftriaxone is indicated in the treatment of the following infections in adults and children including term neonates (from birth): Bacterial Meningitis, Community acquired pneumonia, Hospital acquired pneumonia, Acute otitis media, Intra-abdominal infections, Complicated urinary tract infections (including pyelonephritis), Infections of bones and joints, Complicated skin and soft tissue infections, Gonorrhoea, Syphilis, Bacterial endocarditis, Ceftriaxone may be used: For treatment of acute exacerbations of chronic obstructive pulmonary disease in adults For treatment of disseminated Lyme borreliosis (early (stage II) and late (stage III)) in adults and children including neonates from 15 days of age. For Pre-operative prophylaxis of surgical site infections In the management of neutropenic patients with fever that is suspected to be due to a bacterial infection In the treatment of patients with bacteraemia that occurs in association with, or is suspected to be associated with, any of the infections listed above Ceftriaxone should be co-administered with other antibacterial agents whenever the possible range of causative bacteria would not fall within its spectrum.Consideration should be given to official guidance on the appropriate use of antibacterial agents.
DOSAGE AND ADMINISTRATION:
Posology The dose depends on the severity, susceptibility, site and type of infection and on the age and hepato-renal function of the patient. The doses recommended in the tables below are the generally recommended doses in these indications. In particularly severe cases, doses at the higher end of the recommended range should be considered.
Adults and children over 12 years of age (≥ 50 kg)

Ceftriaxone Dosage*	Treatment frequency**	Indications
1-2 g	Once daily	Community acquired pneumonia
		Acute exacerbations of chronic obstructive pulmonary disease
		Intra-abdominal infections
		Complicated urinary tract infections (including pyelonephritis)
2 g	Once daily	Hospital acquired pneumonia
		Complicated skin and soft tissue infections
		Infections of bones and joints
2-4 g	Once daily	Management of neutropenic patients with fever that is suspected to be due to a bacterial infection
		Bacterial endocarditis
		Bacterial meningitis

* In documented bacteraemia, the higher end of the recommended dose range should be considered.
** Twice daily (12 hourly) administration may be considered where doses greater than 2 g daily are administered. Indications for adults and children over 12 years of age (≥ 50 kg) that require specific dosage schedules: Acute otitis media
A single intramuscular dose of Ceftriaxone 1-2 g can be given. Limited data suggest that in cases where the patient is severely ill or previous therapy has failed, Ceftriaxone may be effective when given as an intramuscular dose of 1-2 g daily for 3 days.
Pre-operative prophylaxis of surgical site infections
2 g as a single pre-operative dose.
Gonorrhoea
500 mg as a single intramuscular dose.
Syphilis
The generally recommended doses are 500 mg-1 g once daily increased to 2 g once daily for neurosyphilis for 10-14 days. The dose recommendations in syphilis, including neurosyphilis, are based on limited data. National or local guidance should be taken into consideration.
Disseminated Lyme borreliosis (early [Stage II] and late [Stage III]) 2 g once daily for 14-21 days. The recommended treatment durations vary and national or local guidelines should be taken into consideration.
Paediatric population Neonates, infants and children 15 days to 12 years of age (< 50 kg) For children with bodyweight of 50 kg or more, the usual adult dosage should be given.

Ceftriaxone dosage*	Treatment frequency**	Indications
50-80 mg/kg	Once daily	Intra-abdominal infections
		Complicated urinary tract infections (including pyelonephritis)
		Community acquired pneumonia
		Hospital acquired pneumonia
50-100 mg/kg (Max 4 g)	Once daily	Complicated skin and soft tissue infections
		Infections of bones and joints
		Management of neutropenic patients with fever that is suspected to be due to a bacterial infection
80-100 mg/kg (max 4 g)	Once daily	Bacterial meningitis
100 mg/kg (max 4 g)	Once daily	Bacterial endocarditis

* In documented bacteraemia, the higher end of the recommended dose range should be considered.
** Twice daily (12 hourly) administration may be considered where doses greater than 2 g daily are administered.
Indications for neonates, infants and children 15 days to 12 years (< 50 kg) that require specific dosage schedules:
Acute otitis media
For initial treatment of acute otitis media, a single intramuscular dose of Ceftriaxone 50 mg/kg can be given. Limited data suggest that in cases where the child is severely ill or initial therapy has failed, Ceftriaxone may be effective when given as an intramuscular dose of 50 mg/kg daily for 3 days.
Pre-operative prophylaxis of surgical site infections
50-80 mg/kg as a single pre-operative dose.
Syphilis
The generally recommended doses are 75-100 mg/kg (max 4 g) once daily for 10-14 days. The dose recommendations in syphilis, including neurosyphilis, are based on very limited data. National or local guidance should be taken into consideration.
Disseminated Lyme borreliosis (early [Stage II] and late [Stage III]) 50–80 mg/kg once daily for 14-21 days. The recommended treatment durations vary and national or local guidelines should be taken into consideration.
Neonates 0-14 days
Ceftriaxone is contraindicated in premature neonates up to a postmenstrual age of 41 weeks (gestational age + chronological age).

Ceftriaxone dosage*	Treatment frequency	Indications
20-50 mg/kg	Once daily	Intra-abdominal infections
		Complicated skin and soft tissue infections
		Complicated urinary tract infections (including pyelonephritis)
		Community acquired pneumonia
		Hospital acquired pneumonia
		Infections of bones and joints
		Management of neutropenic patients with fever that is suspected to be due to a bacterial infection
50 mg/kg	Once daily	Bacterial meningitis
		Bacterial endocarditis

* In documented bacteraemia, the higher end of the recommended dose range should be considered. A maximum daily dose of 50 mg/kg should not be exceeded. Indications for neonates 0-14 days that require specific dosage schedules:
Acute otitis media
For initial treatment of acute otitis media, a single intramuscular dose of Ceftriaxone 50 mg/kg can be given. Pre-operative prophylaxis of surgical site infections 20-50 mg/kg as a single pre-operative dose. Syphilis The generally recommended dose is 50 mg/kg once daily for 10-14 days. The dose recommendations in syphilis, including neurosyphilis, are based on very limited data. National or local guidance should be taken into consideration. Duration of therapy The duration of therapy varies according to the course of the disease. As with antibiotic therapy in general, administration of ceftriaxone should be continued for 48 - 72 hours after the patient has become afebrile or evidence of bacterial eradication has been achieved. Older people The dosages recommended for adults require no modification in older people provided that renal and hepatic function is satisfactory. Patients with hepatic impairment Available data do not indicate the need for dose adjustment in mild or moderate liver function impairment provided renal function is not impaired. There are no study data in patients with severe hepatic impairment. Patients with renal impairment: In patients with impaired renal function, there is no need to reduce the dosage of ceftriaxone provided hepatic function is not impaired. Only in cases of preterminal renal failure (creatinine clearance < 10 ml/min) should the ceftriaxone dosage not exceed 2 g daily. In patients undergoing dialysis no additional supplementary dosing is required following the dialysis. Ceftriaxone is not removed by peritoneal- or haemodialysis. Close clinical monitoring for safety and efficacy is advised. Patients with severe hepatic and renal impairment In patients with both severe renal and hepatic dysfunction, close clinical monitoring for safety and efficacy is advised.
Method of administration
Intramuscular administration
1g ceftriaxone should be dissolved in 3.5ml of 1% Lidocaine Injection BP. The solution should be administered by deep intramuscular injection. Intramuscular injections should be injected well within the bulk of a relatively large muscle and not more than 1 g should be injected at one site.
Dosages greater than 1g should be divided and injected at more than one site. As the solvent used is lidocaine, the resulting solution should never be administered intravenously.
Intravenous administration For IV injection 1 g ceftriaxone is dissolved in 10 ml of water for injections PhEur. The injection should be administered over 5 minutes, directly into the vein or via the tubing of an intravenous infusion. Ceftriaxone can be administered by intravenous infusion over at least 30 minutes (preferred route) or by slow intravenous injection over 5 minutes. Intravenous intermittent injection should be given over 5 minutes preferably in larger veins. Intravenous doses of 50 mg/kg or more in infants and children up to 12 years of age should be given by infusion. In neonates, intravenous doses should be given over 60 minutes to reduce the potential risk of bilirubin encephalopathy. Intramuscular administration should be considered when the intravenous route is not possible or less appropriate for the patient. For doses greater than 2 g intravenous administration should be used. Ceftriaxone is contraindicated in neonates (≤ 28 days) if they require (or are expected to require) treatment with calcium-containing intravenous solutions, including continuous calcium-containing infusions such as parenteral nutrition, because of the risk of precipitation of ceftriaxone-calcium. Diluents containing calcium, (e.g. Ringer's solution or Hartmann's solution), should not be used to reconstitute ceftriaxone vials or to further dilute a reconstituted vial for IV administration because a precipitate can form. Precipitation of ceftriaxone-calcium can also occur when ceftriaxone is mixed with calcium-containing solutions in the same IV administration line. Therefore, ceftriaxone and calcium-containing solutions must not be mixed or administered simultaneously. For pre-operative prophylaxis of surgical site infections, ceftriaxone should be administered 30-90 minutes prior to surgery.
CONTRAINDICATIONS: Hypersensitivity to the active substance, to any other cephalosporin or to any of the excipients History of severe hypersensitivity (e.g. anaphylactic reaction) to any other type of beta-lactam antibacterial agent (penicillins, monobactams and carbapenems). Ceftriaxone is contraindicated in: Premature neonates up to a postmenstrual age of 41 weeks (gestational age + chronological age)* Full-term neonates (up to 28 days of age): - withhyperbilirubinaemia, jaundice, or who are hypoalbuminaemic or acidotic because these are conditions in which bilirubin binding is likely to be impaired* - if they require (or are expected to require) intravenous calcium treatment, or calcium-containing infusions due to the risk of precipitation of a ceftriaxone-calcium salt. * In vitro studies have shown that ceftriaxone can displace bilirubin from its serum albumin binding sites leading to a possible risk of bilirubin encephalopathy in these patients. Contraindications to lidocaine must be excluded before intramuscular injection of ceftriaxone when lidocaine solution is used as a solvent. Ceftriaxone solutions containing lidocaine should never be administered intravenously.
WARNING AND PRECAUTIONS:
Hypersensitivity reactions As with all beta-lactam antibacterial agents, serious and occasionally fatal hypersensitivity reactions have been reported. In case of severe hypersensitivity reactions, treatment with ceftriaxone 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 ceftriaxone, to other cephalosporins or to any other type of beta-lactam agent. Caution should be used if ceftriaxone is given to patients with a history of non-severe hypersensitivity to other beta-lactam agents. Severe cutaneous adverse reactions (Stevens Johnson syndrome or Lyell's syndrome/toxic epidermal necrolysis) and drug reaction with eosinophilia and systemic symptoms (DRESS)) which can be life-threatening or fatal, have been reported in association with ceftriaxone treatment; however, the frequency of these events is not known.
Jarisch-Herxheimer reaction (JHR) Some patients with spirochete infections may experience a Jarisch-Herxheimer reaction (JHR) shortly after ceftriaxone treatment is started. JHR is usually a self - limiting condition or can be managed by symptomatic treatment. The antibiotic treatment should not be discontinued if such reaction occurs. Interaction with calcium containing products Cases of fatal reactions with calcium-ceftriaxone precipitates in lungs and kidneys in premature and full-term neonates aged less than 1 month have been described. At least one of them had received ceftriaxone and calcium at different times and through different intravenous lines. In the available scientific data, there are no reports of confirmed intravascular precipitations in patients, other than neonates, treated with ceftriaxone and calcium-containing solutions or any other calcium-containing products. In vitro studies demonstrated that neonates have an increased risk of precipitation of ceftriaxone-calcium compared to other age groups. In patients of any age ceftriaxone must not be mixed or administered simultaneously with any calcium-containing intravenous solutions, even via different infusion lines or at different infusion sites. However, in patients older than 28 days of age ceftriaxone and calcium-containing solutions may be administered sequentially one after another if infusion lines at different sites are used or if the infusion lines are replaced or thoroughly flushed between infusions with physiological salt-solution to avoid precipitation. In patients requiring continuous infusion with calcium-containing total parenteral nutrition (TPN) solutions, healthcare professionals may wish to consider the use of alternative antibacterial treatments which do not carry a similar risk of precipitation. If the use of ceftriaxone is considered necessary in patients requiring continuous nutrition, TPN solutions and ceftriaxone can be administered simultaneously, albeit via different infusion lines at different sites. Alternatively, infusion of TPN solution could be stopped for the period of ceftriaxone infusion and the infusion lines flushed between solutions.
Paediatric population Safety and effectiveness of Ceftriaxone in neonates, infants and children have been established for the dosages described under Posology and Method of Administration. Studies have shown that ceftriaxone, like some other cephalosporins, can displace bilirubin from serum albumin. Ceftriaxone is contraindicated in premature and full-term neonates at risk of developing bilirubin encephalopathy.
Immune mediated haemolytic anaemia An immune mediated haemolytic anaemia has been observed in patients receiving cephalosporin class antibacterials including Ceftriaxone. Severe cases of haemolytic anaemia, including fatalities, have been reported during Ceftriaxone treatment in both adults and children. If a patient develops anaemia while on ceftriaxone, the diagnosis of a cephalosporin-associated anaemia should be considered and ceftriaxone discontinued until the aetiology is determined. Long term treatment During prolonged treatment complete blood count should be performed at regular intervals.
Colitis/Overgrowth of non-susceptible microorganisms Antibacterial agent-associated colitis and pseudo-membranous colitis have been reported with nearly all antibacterial agents, including ceftriaxone, and may range in severity from mild to life-threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhoea during or subsequent to the administration of ceftriaxone. Discontinuation of therapy with ceftriaxone and the administration of specific treatment for Clostridium difficile should be considered. Medicinal products that inhibit peristalsis should not be given. Superinfections with non-susceptible micro-organisms may occur as with other antibacterial agents.
Severe renal and hepatic insufficiency
In severe renal and hepatic insufficiency, close clinical monitoring for safety and efficacy is advised.
Interference with serological testing
Interference with Coombs tests may occur, as Ceftriaxone may lead to false-positive test results. Ceftriaxone can also lead to false-positive test results forgalactosaemia. Non-enzymatic methods for the glucose determination in urine may give false-positive results. Urine glucose determination during therapy with Ceftriaxone should be done enzymatically. The presence of ceftriaxone may falsely lower estimated blood glucose values obtained with some blood glucose monitoring systems. Please refer to instructions for use for each system. Alternative testing methods should be used if necessary.
Sodium This medicinal product contains 82mg sodium per 1g vial, equivalent to 4.1% of the WHO recommended maximum daily intake of 2 g sodium for an adult.
Antibacterial spectrum Ceftriaxone has a limited spectrum of antibacterial activity and may not be suitable for use as a single agent for the treatment of some types of infections unless the pathogen has already been confirmed. In polymicrobial infections, where suspected pathogens include organisms resistant to ceftriaxone, administration of an additional antibiotic should be considered.
Use of lidocaine In case a lidocaine solution is used as a solvent, ceftriaxone solutions must only be used for intramuscular injection. The lidocaine solution should never be administered intravenously.
Biliary lithiasis When shadows are observed on sonograms, consideration should be given to the possibility of precipitates of calcium ceftriaxone. Shadows, which have been mistaken for gallstones, have been detected on sonograms of the gallbladder and have been observed more frequently at ceftriaxone doses of 1 g per day and above. Caution should be particularly considered in the paediatric population. Such precipitates disappear after discontinuation of ceftriaxone therapy. Rarely precipitates of calcium ceftriaxone have been associated with symptoms. In symptomatic cases, conservative nonsurgical management is recommended and discontinuation of ceftriaxone treatment should be considered by the physician based on specific benefit risk assessment.
Biliary stasis Cases of pancreatitis, possibly of biliary obstruction aetiology, have been reported in patients treated with Ceftriaxone. Most patients presented with risk factors for biliary stasis and biliary sludge e.g. preceding major therapy, severe illness and total parenteral nutrition. A trigger or cofactor of Ceftriaxone-related biliary precipitation cannot be ruled out.
Renal lithiasis Cases of renal lithiasis have been reported, which is reversible upon discontinuation of ceftriaxone. In symptomatic cases, sonography should be performed. Use in patients with history of renal lithiasis or with hypercalciuria should be considered by the physician based on specific benefit risk assessment.
Encephalopathy Encephalopathy has been reported with the use of ceftriaxone, particularly in elderly patients with severe renal impairment or central nervous system disorders. If ceftriaxone-associated encephalopathy is suspected (e.g. decreased level of consciousness, altered mental state, myoclonus, convulsions), discontinuation of ceftriaxone should be considered.
DRUG INTERACTIONS: Calcium-containing diluents, such as Ringer's solution or Hartmann's solution, should not be used to reconstitute Ceftriaxone vials or to further dilute a reconstituted vial for intravenous administration because a precipitate can form. Precipitation of ceftriaxone-calcium can also occur when ceftriaxone is mixed with calcium-containing solutions in the same intravenous administration line. Ceftriaxone must not be administered simultaneously with calcium-containing intravenous solutions, including continuous calcium-containing infusions such as parenteral nutrition via a Y-site. However, in patients other than neonates, ceftriaxone and calcium-containing solutions may be administered sequentially of one another if the infusion lines are thoroughly flushed between infusions with a compatible fluid. In vitro studies using adult and neonatal plasma from umbilical cord blood demonstrated that neonates have an increased risk of precipitation of ceftriaxone-calcium. Concomitant use with oral anticoagulants may increase the anti-vitamin K effect and the risk of bleeding. It is recommended that the International Normalised Ratio (INR) is monitored frequently and the posology of the anti-vitamin K drug adjusted accordingly, both during and after treatment with ceftriaxone. There is conflicting evidence regarding a potential increase in renal toxicity of aminoglycosides when used with cephalosporins. The recommended monitoring of aminoglycoside levels (and renal function) in clinical practice should be closely adhered to in such cases. In an in-vitro study antagonistic effects have been observed with the combination of chloramphenicol and ceftriaxone. The clinical relevance of this finding is unknown. There have been no reports of an interaction between ceftriaxone and oral calcium-containing products or interaction between intramuscular ceftriaxone and calcium-containing products (intravenous or oral). In patients treated with ceftriaxone, the Coombs' test may lead to false-positive test results. Ceftriaxone, like other antibiotics, may result in false-positive tests for galactosaemia. Likewise, non-enzymatic methods for glucose determination in urine may yield false-positive results. For this reason, glucose level determination in urine during therapy with ceftriaxone should be carried out enzymatically. No impairment of renal function has been observed after concurrent administration of large doses of ceftriaxone and potent diuretics (e.g. furosemide). Simultaneous administration of probenecid does not reduce the elimination of ceftriaxone.
PREGNANCY AND LACTATION: Pregnancy Ceftriaxone crosses the placental barrier. There are limited amounts of data from the use of ceftriaxone in pregnant women. Animal studies do not indicate direct or indirect harmful effects with respect to embryonal/foetal, perinatal and postnatal development. Ceftriaxone should only be administered during pregnancy and in particular in the first trimester of pregnancy if the benefit outweighs the risk.
Breastfeeding Ceftriaxone is excreted into human milk in low concentrations but at therapeutic doses of ceftriaxone no effects on the breastfed infants are anticipated. However, a risk of diarrhoea and fungal infection of the mucous membranes cannot be excluded. The possibility of sensitisation should be taken into account. A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from ceftriaxone therapy, taking into account the benefit of breast feeding for the child and the benefit of therapy for the woman.
Fertility
Reproductive studies have shown no evidence of adverse effects on male or female fertility.
SIDE EFFECTS: The most frequently reported adverse reactions for ceftriaxone are eosinophilia, leucopenia, thrombocytopenia, diarrhoea, rash, and hepatic enzymes increased. Data to determine the frequency of ceftriaxone ADRs was derived from clinical trials. The following convention has been used for the classification of frequency: Very common (≥ 1/10) Common (≥ 1/100 - < 1/10) Uncommon (≥ 1/1000 - < 1/100) Rare (≥ 1/10000 - < 1/1000) Not known (cannot be estimated from the available data)
Infections and infestations
Uncommon: Genital fungal infection
Rare: Pseudomembranous colitis
Not known: Superinfection
Blood and lymphatic system disorders
Common: Eosinophilia, Leucopenia, Thrombocytopenia
Uncommon: Granulocytopenia, Anaemia, Coagulopathy
Not known: Haemolytic anaemia, Agranulocytosis
Immune system disorders
Not known: Anaphylactic shock, Anaphylactic reaction, Anaphylactoid reaction, Hypersensitivity, Jarisch-Herxheimerreactionb
Nervous system disorders
Uncommon: Headache, Dizziness
Rare: Encephalopathy
Not known: Convulsion
Ear and labyrinth disorders
Not known: Vertigo
Respiratory, thoracic and mediastinal disorders
Rare: Bronchospasm
Gastrointestinal disorders
Common: Diarrhoea, Loose stools
Uncommon: Nausea, Vomiting
Not known: Pancreatitis, Stomatitis, Glossitis
Hepatobiliary disorders
Common: Hepatic enzyme increased
Not known: Gall bladder precipitation, Kernicterus, Hepatitis, Hepatitis cholestatic
Skin and subcutaneous tissue disorders
Common: Rash
Uncommon: Pruritus
Rare: Urticaria
Not known: Stevens Johnson Syndrome, Toxic epidermal necrolysis, Erythema multiforme, Acute generalised exanthematouspustulosis, drug reaction with eosinophilia and systemic symptoms (DRESS)
Renal and urinary disorders
Rare: Haematuria, Glycosuria
Not known: Oliguria, Renal precipitation (reversible)
General disorders and administration site conditions
Uncommon: Phlebitis, Injection site pain, Pyrexia
Rare: Oedema, Chills
Investigations
Uncommon: Blood creatinine increased
Not known: Coombs test false positive, Galactosaemia test false positive, Non enzymatic methods for glucose determination false positive
OVERDOSE: In overdose, the symptoms of nausea, vomiting and diarrhoea can occur. Ceftriaxone concentrations cannot be reduced by haemodialysis or peritoneal dialysis. There is no specific antidote. Treatment is symptomatic.

STORAGE CONDITIONS: Store in a cool & dry place, protected from light.

SHELF LIFE:
2 years.

For reconstituted solution, chemical and physical in-use stability has been demonstrated for 24 hours at 25°C and for four days at 2-8°C. From a microbiological point of view, once opened, the product should be used immediately. If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours at 2-8°C, unless reconstitution has taken place in controlled and validated aseptic conditions.
DOSAGE FORM AND PACKAGING AVAILABLE:
Ceftriaxone sodium for Injection IP 1000mg is supplied in 10ml clear colorless vial with grey bromobutyl rubber stopper and aluminium flip off seal.Such 1 vial is packed in a mono carton along with one 10ml FFS ampoule of sterile water for Injection IP with insert.

MANUFACTURED BY:
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windlas

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