

MIMS Full Prescribing Information

Keflex

Company Aspen

Primary Section: Infections and Infestations - Cephalosporins

ARTG Registered medicine

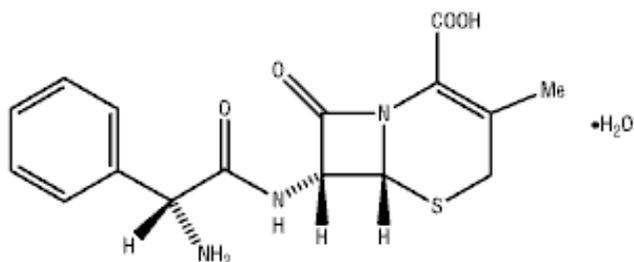
MIMS revision date: 01 Oct 2011

Composition Cephalexin monohydrate.

Excipients**Capsules.** Avicel RC 591, dimethicone 350 and magnesium stearate. The capsule shell consists of patent blue V, quinoline yellow, titanium dioxide, gelatin and colorcon S-1-8144 black ink.

Powder for oral liquid in bottles. Sodium lauryl sulphate, allura red AC, methylcellulose, dimethicone 350, xanthan gum, pregelatinised maize starch, tuttifrutti 51880 TP0551 and sucrose.

Powder for oral liquid in sachets. Erythrosine (125 mg/5 mL), sunset yellow FCF (250 mg/5 mL), tuttifrutti 51880 TP0551 and sucrose.



Cephalexin monohydrate

Description Chemical name: 7-(d-alpha-amino-alpha-phenyl-acetamido)- 3-methyl-3-cephem-4-carboxylic acid, monohydrate. Keflex (cephalexin monohydrate) is a semisynthetic cephalosporin antibiotic for oral administration. The nucleus of cephalexin is related to that of other cephalosporin antibiotics. The compound is a zwitterion; i.e. the molecule contains both a basic and an acidic group. The isoelectric point of cephalexin in water is approximately 4.5 to 5.

The crystalline form of cephalexin which is available is a monohydrate. It is a white crystalline solid having a bitter taste. Solubility in water is low at room temperature; 1 or 2 mg/mL may be dissolved readily, but higher concentrations are obtained with increasing difficulty.

The cephalosporins differ from penicillins in the structure of the bicyclic ring system. Cephalexin has a d-phenylglycyl group as substituent at the 7-amino position and an unsubstituted methyl group at the 3-position.

Actions Pharmacology.Human pharmacology. Keflex is acid stable and may be given without regard to meals. It is rapidly absorbed after oral administration. Following doses of 250 mg, 500 mg and 1 g, average peak serum levels of approximately 9, 18 and 32 microgram/mL, respectively, were obtained at one hour. Measurable levels were present six hours after administration. Cephalexin is excreted in the urine by glomerular filtration and tubular secretion. Studies showed that over 90% of the drug is excreted unchanged in the urine within eight hours. During this period, peak urine concentrations following the 250 mg, 500 mg and 1 g doses were approximately 1,000, 2,200 and 5,000 microgram/mL, respectively.

Microbiology. *In vitro* tests demonstrate that the cephalosporins are bactericidal because they inhibit cell wall synthesis. Keflex is active against the following organisms *in vitro*: beta-haemolytic Streptococci, Staphylococci, including coagulase positive, coagulase negative and penicillinase producing strains, *Streptococcus (Diplococcus) pneumoniae*, *Escherichia coli*, *Proteus mirabilis*, Klebsiella sp.

Note. Most strains of Enterococci (*Enterococcus faecalis*) and a few strains of Staphylococci are resistant to Keflex. It is not active against most strains of Enterobacter sp., *Morganella morganii* (formerly *Pr. morganii*) and *Pr. vulgaris*. It has no activity against Pseudomonas or *Acinetobacter calcoaceticus* (formerly *Mima* and *Herellea* sp.). When tested by *in vitro* methods, Staphylococci exhibit cross resistance between Keflex and methicillin type antibiotics.

Disc susceptibility. Dilution or diffusion techniques, either quantitative (MIC) or breakpoint, should be used following a regularly updated, recognised and standardised method (e.g. NCCLS). Standardised susceptibility test procedures require the use of laboratory control microorganisms to control the technical aspects of the laboratory procedures.

A report of 'susceptible' indicates that the pathogen is likely to be inhibited if the antimicrobial compound in the blood reaches the concentrations usually achievable. A report of 'intermediate' indicates that the result should be considered equivocal and, if the microorganism is not fully susceptible to alternative, clinically feasible drugs, the test should be repeated. This category implies possible clinical applicability in body sites where the drug is physiologically concentrated or in situations where high dosage of drug can be used. This category also provides a buffer zone, which prevents small uncontrolled technical factors from causing major discrepancies in interpretation. A report of 'resistant' indicates that the pathogen is not likely to be inhibited if the antimicrobial compound in the blood reaches the concentrations usually achievable; other therapy should be selected.

Note. The prevalence of resistance may vary geographically for selected species and local information on resistance is desirable, particularly when treating severe infections.

Minimal inhibitory concentration (MIC) breakpoints. Zone diameters, reported off cephalothin discs, are provided with corresponding breakpoints in Table 1.

Refer to Table 1.

Keflex	Table 1	
Organisms	Zone diameter	MIC breakpoint*
Susceptible	18 mm or greater	8 mcg/mL or less
Moderately susceptible	15-17 mm	1-16 mcg/mL
Resistant	14 mm or less	More than 16 mcg/mL

* Please note that quality control strains are needed to assure that the procedure being run is consistent with expected results.

Indications Keflex is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Respiratory tract infections caused by *S. pneumoniae* and group A beta-haemolytic Streptococci (penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. Keflex is generally effective in the eradication of Streptococci from the nasopharynx; however, substantial data establishing the efficacy of Keflex in the subsequent prevention of rheumatic fever are not available at present).

Bacterial sinusitis caused by Streptococci, *S. pneumoniae* and *S. aureus* (methicillin sensitive only).

Otitis media due to *S. pneumoniae*, Staphylococci.

Skin and soft tissue infections caused by Staphylococci and/or Streptococci.

Genitourinary tract infections, including acute prostatitis caused by *E. coli*, *P. mirabilis* and Klebsiella sp.

The effectiveness of Keflex in the treatment of bacterial infections of the brain and spinal column has not been established and Keflex is not indicated in these conditions.

Note. Appropriate culture and susceptibility tests should be initiated prior to and during therapy to determine susceptibility of the causative organism to Keflex. Renal function studies should be performed when indicated.

Contraindications Keflex is contraindicated in patients with known allergy to the cephalosporin group of antibiotics or who have previously experienced a major allergy to penicillin (see Precautions).

Precautions Before instituting therapy with cephalexin, every attempt should be made to determine if the patient has had previous hypersensitivity reactions to the cephalosporins, penicillins or other drugs. This product should be given cautiously to penicillin sensitive patients.

There is some clinical and laboratory evidence of partial cross allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

If an allergic reaction to Keflex occurs, the drug should be discontinued and the patient treated with the usual agents (e.g. adrenaline or other pressor amines, antihistamines or corticosteroids).

Antibiotic associated pseudomembranous colitis has been reported with virtually all broad spectrum antibiotics (including macrolides, semisynthetic penicillins and cephalosporins). A toxin produced with *Clostridium difficile* appears to be the primary cause. The severity of the colitis may range from mild to life threatening. It is important to consider the diagnosis in patients who develop diarrhoea or colitis in association with antibiotic use (this may occur up to several weeks after cessation of antibiotic therapy). Mild cases usually respond to drug discontinuation alone. However, in moderate to severe cases appropriate therapy with a suitable oral antibacterial agent effective against *C. difficile* should be considered. Fluids, electrolytes and protein replacement should be provided when indicated.

Drugs which delay peristalsis, e.g. opiates and diphenoxylate with atropine (Lomotil) may prolong and/or worsen the condition and should not be used.

Broad spectrum antibiotics should therefore be prescribed with caution in individuals with a history of gastrointestinal

disease, particularly colitis.

Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected.

Prolonged use of Keflex may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Keflex should be administered with caution in the presence of markedly impaired renal function. Careful clinical and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Use in pregnancy (Category A)

Use in lactation Keflex is excreted in the milk. Caution should be exercised when Keflex is administered to a breastfeeding woman. Alternative feeding arrangements for the infant should be considered.

Interactions As with other beta-lactams, the renal excretion of Keflex is inhibited by probenecid.

In healthy subjects given single 500 mg doses of cephalexin and metformin, plasma metformin C_{max} and AUC increased by an average of 34 and 24%, respectively, and metformin renal clearance decreased by an average of 14%. The interaction of cephalexin and metformin following multiple dose administration has not been studied. Administration of a cephalosporin to a metformin treated patient may result in increased metformin exposure.

Effects on laboratory tests The quantitative determination of urinary protein excretion using strong acids is misleading during Keflex therapy as precipitation of cephalexin in the urine may occur.

A false positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest. Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In haematological studies or in transfusion cross matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborn infants whose mothers have received cephalosporin antibiotics before parturition, it should be recognised that a positive Coombs' test may be due to the drug.

Adverse Reactions Adverse drug reactions reported with cephalexin are very rare (< 0.01%) and are listed below.

Blood and lymphatic system disorders. Eosinophilia, neutropenia, thrombocytopenia, haemolytic anaemia.

Gastrointestinal disorders. Nausea, vomiting, diarrhoea, dyspepsia, abdominal pain.

General disorders and administration site conditions. Fatigue.

Hepatobiliary disorders. Cholestatic jaundice, transient hepatitis, elevated ALT, elevated AST.

Immune system disorders. Allergic reactions, urticaria, angioedema.

These reactions usually subsided upon discontinuation of the drug.

Anaphylaxis has also been reported.

Infections and infestations. Pseudomembranous colitis.

Musculoskeletal and connective tissue disorders. Joint disorder, arthralgia, arthritis.

Nervous system disorders. Dizziness, headache.

Psychiatric disorders. Hallucinations, agitation, confusion.

Renal and urinary disorders. Reversible interstitial nephritis.

Reproductive and breast disorders. Genital and anal pruritus, genital moniliasis, vaginitis, vaginal discharge.

Skin and subcutaneous tissue disorders. Rash, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis.

These reactions usually subsided upon discontinuation of the drug.

Dosage and Administration Keflex is administered orally.

Adults. The adult dosage ranges from 1 to 4 g daily in divided doses. The usual adult dose is 250 mg every six hours.

For streptococcal pharyngitis or tonsillitis, mild, uncomplicated urinary tract infections and skin and soft tissue infections, a dosage of 500 mg may be administered every 12 hours.

For more severe infections or those caused by less susceptible organisms, larger doses may be needed. If daily doses of Keflex greater than 4 g are required, parenteral cephalosporins, in appropriate doses, should be considered.

Twice daily dosing is not recommended when doses larger than 1 g daily are administered.

Children. The usual recommended daily dosage for children is 25 to 50 mg/kg in divided doses. For streptococcal pharyngitis in patients over 1 year of age, tonsillitis, mild, uncomplicated urinary tract infection and skin and soft tissue infections, the total daily dose may be divided and administered every 12 hours. See Table 2.

Refer to Table 2.

Keflex**Table 2**

Keflex suspension

Child's weight	125 mg/5 mL	250 mg/5 mL
10 kg	2.5-5 mL q.i.d.	
20 kg	5-10 mL q.i.d.	2.5-5 mL q.i.d.
40 kg	10-20 mL q.i.d.	5-10 mL q.i.d.
Or		
Child's weight	125 mg/5 mL	250 mg/5 mL
10 kg	5-10 mL b.i.d.	2.5-5 mL b.i.d.
20 kg	10-20 mL b.i.d.	5-10 mL b.i.d.
40 kg	20-40 mL b.i.d.	10-20 mL b.i.d.

In severe infections, the dosage may be doubled.

In the therapy of otitis media, clinical studies have shown that a dosage of 75 to 100 mg/kg/day in four divided doses is recommended.

In the treatment of beta-haemolytic streptococcal infections, a therapeutic dosage of Keflex should be administered for at least ten days.

Impaired renal function. See Precautions.

Overdosage There is no definite experience of poisoning or severe overdosage with cephalexin. However, clinical features of overdosage may be similar to those seen with other cephalosporins and penicillins, i.e. convulsions, hallucinations, hyperreflexia, electrolyte imbalance, gastrointestinal disturbances and haematuria.

In the event of severe overdosage, general supportive care is recommended including close clinical and laboratory monitoring of haematological, renal, hepatic functions and coagulation status until the patient is stable.

Forced diuresis, peritoneal dialysis, haemodialysis or charcoal haemoperfusion have not been established as beneficial for an overdose of cephalexin.

Contact the Poisons Information Centre on 131 126 for management of overdose.

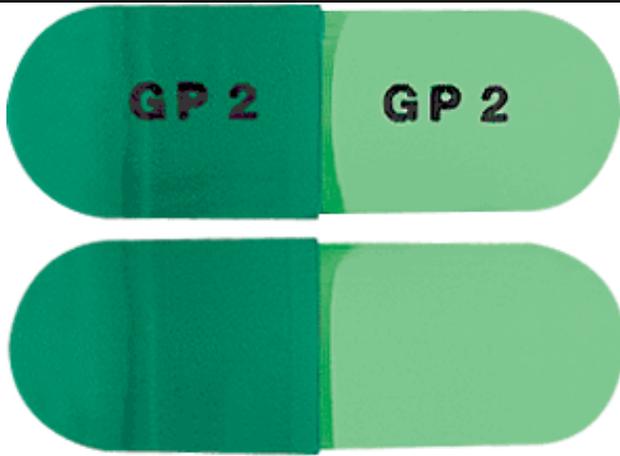
Presentation Capsules (opaque, marked on cap and body), cephalexin 250 mg (dark green/white, size 1, marked GP1), 500 mg (dark green/light green, size 0, marked GP2): 2's (sample pack), 20's.

Powder for oral liquid (white free flowing powder forming red suspension after reconstitution), cephalexin 125 mg/5 mL, 250 mg/5 mL: sample sachets* (3's), bottle (100 mL).

*Not currently marketed in Australia.



Product Image: Keflex 250 mg



Product Image: Keflex 500 mg

Storage Keflex capsules.250 mg. Store below 30deg. C.

500 mg. Store below 25deg. C.

Keflex powder for oral liquid in bottles. Store below 25deg. C and protect from light. Upon reconstitution, the suspension must be stored in a refrigerator between 2 and 8deg. C. Do not freeze. Discard unused portion 14 days after mixing.

Keflex powder for oral liquid in sachets. Store below 30deg. C. Upon reconstitution, the suspension must be stored in a refrigerator between 2 and 8deg. C. Do not freeze. Discard unused portion 14 days after mixing.

References • Bauer, A.W., Kirby, W.M.M., Sherris, J.C., and Turck, M.: Antibiotic Susceptibility Testing by a Standardized Single Disk Method, Am. J. Clin. Pathol., 45:493, 1966.

• Standardized Disc Susceptibility Test, Federal Register, 39:19182-19184, 1974.

Poisons Schedule S4.

Date of TGA approval or last amendment 14/10/2010