

PRODUCT MONOGRAPH

^{Pr}**Cefotaxime Sodium for Injection BP**

250 mg, 500 mg, 1 g or 2 g cefotaxime (as cefotaxime sodium) per vial

β- Lactam Antibiotic

Hospira Healthcare Corporation
1111 Dr. Frederik-Philips, Suite 600
Saint-Laurent, QC
H4M 2X6

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ACTION AND CLINICAL PHARMACOLOGY

Cefotaxime Sodium for Injection BP is a semi-synthetic, 2-aminothiazolyl cephalosporin antibiotic for parenteral use. *In vitro* studies indicate that the antibacterial action of Cefotaxime Sodium results from inhibition of cell wall synthesis. It is stable against the action of most β-lactamases.

INDICATIONS AND CLINICAL USE

TREATMENT

Cefotaxime Sodium for Injection BP may be indicated for the treatment of infections caused by susceptible strains of the designated micro-organisms in the diseases listed below.

Lower Respiratory Tract Infections:

Pneumonia and lung abscess caused by *Streptococcus pneumoniae* (formerly *Diplococcus pneumoniae*), other streptococci (excluding enterococci, e.g. *S. faecalis*), *Staphylococcus aureus* (penicillinase and non-penicillinase producing), *Escherichia coli*, *Hemophilus influenzae*, (including ampicillin-resistant strains) and unspecified *Klebsiella* species.

Urinary Tract Infections:

Caused by *Escherichia coli*, unspecified *Klebsiella* species (including *K. pneumoniae*), *Proteus mirabilis*, indole positive *Proteus*, *Serratia marcescens* and *Staphylococcus epidermidis*. Also, uncomplicated gonorrhoea caused by *N. gonorrhoeae*, including penicillin-resistant strains.

Bacteremia/Septicemia:

Caused by *Escherichia coli*, unspecified *Klebsiella* strains and *Serratia marcescens*.

Skin Infections:

Caused by *Staphylococcus aureus* (penicillinase and non-penicillinase producing), *S. epidermidis*, group A streptococci, *Escherichia coli*, *Proteus mirabilis* and indole positive *Proteus*.

Intra-abdominal Infections:

Caused by *Escherichia coli*, and unspecified *Klebsiella* species.

Gynecological Infections:

Including pelvic inflammatory disease, endometritis and pelvic cellulitis caused by *E. coli*, Group A streptococci and *Staphylococcus epidermidis*; anaerobic bacteria including unspecified *Peptococcus* and *Peptostreptococcus* strains and some strains of *Bacteroides fragilis*. In several cases, although clinical cures were achieved, bacteriological follow-up was not available.

Cefotaxime Sodium, like other cephalosporins, has no activity against *Chlamydia trachomatis*. Therefore, when cephalosporins are used in the treatment of patients with pelvic inflammatory disease and *C. trachomatis* is one of the suspected pathogens, appropriate anti-chlamydial coverage should be added.

Central Nervous System Infections:

Meningitis and ventriculitis caused by *Haemophilus influenzae*, *Neisseria meningitidis*, *Streptococcus pneumoniae*, *Klebsiella pneumoniae* and *Escherichia coli*. Cefotaxime Sodium is not active against *Listeria monocytogenes*.

Clinical experience with Cefotaxime Sodium in anaerobic infections is limited. Cefotaxime Sodium has been used with some success in wound and intra-abdominal infections against some

strains of unidentified *Bacteroides* and anaerobic cocci.

Cefotaxime Sodium has been shown to be active against some strains of *Pseudomonas*.

In the treatment of infections encountered in immunosuppressed and granulocytopenic patients, results of therapy with Cefotaxime Sodium have not been impressive.

Cefotaxime Sodium should not be considered in the treatment of enterococcal infections, i.e. *Streptococcus faecalis*.

Specimens for bacteriologic culture should be obtained prior to therapy in order to isolate and identify the causative organisms and to determine their susceptibilities to Cefotaxime Sodium. Therapy may be instituted before results of susceptibility studies are known; antibiotic treatment should be re-evaluated once these results become available.

PROPHYLACTIC USE

The administration of Cefotaxime Sodium for Injection BP perioperatively (preoperatively, intraoperatively and postoperatively) may reduce the incidence of certain infections in patients undergoing elective surgical procedures (e.g. abdominal or vaginal hysterectomy, gastrointestinal and genitourinary tract surgery) that may be classified as contaminated or potentially contaminated.

In patients undergoing cesarian section who are considered to be at increased risk of infection, intraoperative (after clamping the umbilical cord) and postoperative use of Cefotaxime Sodium for Injection BP may also reduce the incidence of certain postoperative infections.

Effective use for elective surgery depends on the time of administration (see **DOSAGE AND ADMINISTRATION**).

For patients undergoing gastrointestinal surgery, preoperative bowel preparation by mechanical cleansing as well as with a non-absorbable antibiotic (e.g. neomycin) is recommended.

If there are signs of infection, specimens for culture should be obtained for identification of the causative organism so that appropriate therapy may be instituted.

CONTRAINDICATIONS

Cefotaxime Sodium for Injection BP is contraindicated in patients who have shown hypersensitivity to cefotaxime sodium, the cephalosporin or the penicillin groups of antibiotics.

WARNINGS

Anaphylactic Reactions:

BEFORE THERAPY WITH CEFOTAXIME SODIUM FOR INJECTION BP IS INSTITUTED, IT MUST BE CAREFULLY DETERMINED WHETHER THE PATIENT HAS HAD PREVIOUS HYPERSENSITIVITY REACTIONS TO CEFOTAXIME, CEPHALOSPORINS, PENICILLINS OR OTHER DRUGS. SINCE CROSS ALLERGY EXISTS BETWEEN PENICILLINS AND CEPHALOSPORINS IN 5 TO 10% OF CASES, CEFOTAXIME SODIUM FOR INJECTION BP SHOULD BE GIVEN WITH EXTREME CAUTION TO PATIENTS WITH TYPE 1 HYPERSENSITIVITY REACTIONS TO PENICILLIN. ANTIBIOTICS, INCLUDING CEFOTAXIME SODIUM FOR INJECTION BP SHOULD BE ADMINISTERED WITH CAUTION TO ANY PATIENT WHO HAS DEMONSTRATED SOME FORM OF ALLERGY, PARTICULARLY TO DRUGS. IF AN ALLERGIC REACTION TO CEFOTAXIME SODIUM FOR INJECTION BP OCCURS, THE DRUG SHOULD BE DISCONTINUED AND THE PATIENT TREATED WITH THE USUAL AGENTS (E.G. EPINEPHRINE, ANTIHISTAMINES, PRESSOR AMINES OR CORTICOSTEROIDS).

Speed of Intravenous Injection

During post-marketing surveillance, a potentially life-threatening arrhythmia was reported in very few patients who received a rapid bolus injection of cefotaxime through a central venous catheter. Therefore, cefotaxime should only be administered as instructed in the **DOSAGE AND ADMINISTRATION** section.

Gastrointestinal

***Clostridium difficile*-associated disease:**

Clostridium difficile-associated disease (CDAD) has been reported with use of many antibacterial agents, including Cefotaxime Sodium for Injection BP. CDAD may range in severity from mild diarrhea to fatal colitis. It is important to consider this diagnosis in patients who present with diarrhea, or symptoms of colitis, pseudomembranous colitis, toxic megacolon, or perforation of colon subsequent to the administration of any antibacterial agent. CDAD has been reported to occur over 2 months after the administration of antibacterial agents.

Treatment with antibacterial agents may alter the normal flora of the colon and may permit overgrowth of *Clostridium difficile*. *Clostridium difficile* produces toxins A and B, which contribute to the development of CDAD. CDAD may cause significant morbidity and mortality. CDAD can be refractory to antimicrobial therapy.

If diagnosis of CDAD is suspected or confirmed, appropriate therapeutic measures should be initiated. Mild cases of CDAD usually respond to discontinuation of antibacterial agents not directed against *Clostridium difficile*. In moderate to severe cases, consideration should be given to management with fluids and electrolytes, protein supplementation, and treatment with an antibacterial agent clinically effective against *Clostridium difficile*. Surgical evaluation should be instituted as clinically indicated, as surgical intervention may be required in certain severe cases (see **ADVERSE REACTIONS**).

Hemolytic anemia

CEFOTAXIME SODIUM FOR INJECTION BP SHOULD NOT BE USED IN PATIENTS WITH A HISTORY OF CEPHALOSPORIN-ASSOCIATED HEMOLYTIC ANEMIA SINCE THE RECURRENCE OF HEMOLYSIS IS MUCH MORE SEVERE.

An immune mediated hemolytic anemia has been observed in patients receiving cephalosporin class antibacterials, including Cefotaxime Sodium for Injection BP. Severe cases of hemolytic anemia, including fatalities, have been reported in both adults and children. If a patient develops anemia anytime during, or within 2-3 weeks subsequent to the administration of Cefotaxime Sodium for Injection BP, the diagnosis of a cephalosporin-associated anemia should be considered and the drug discontinued until the etiology is determined.

Patients may benefit from periodic monitoring for signs and symptoms of hemolytic anemia, including measurement of hematological parameters or drug-induced antibody testing, where appropriate (see **ADVERSE REACTIONS**).

PRECAUTIONS

Cefotaxime Sodium for Injection BP should be prescribed with caution in individuals with a history of lower gastrointestinal disease, particularly colitis.

General

Prolonged use of Cefotaxime Sodium for Injection BP may result in the overgrowth of nonsusceptible organisms. Constant evaluation of the patient's condition is essential. If superinfection occurs, therapy should be discontinued and appropriate measures taken.

Cefotaxime Sodium for Injection BP, like other parenteral anti-infective drugs, may be locally irritating to tissues. In most cases, perivascular extravasation of Cefotaxime Sodium for Injection BP responds to changing of the infusion site. In rare instances, extensive perivascular

extravasation of Cefotaxime Sodium for Injection BP may result in tissue damage and require surgical treatment. To minimize the potential for tissue inflammation, infusion sites should be monitored regularly and changed when appropriate.

Driving a vehicle or performing other hazardous tasks

In the case of side effects such as dizziness, the patient's ability to concentrate and to react properly may be impaired. In such cases, patients should refrain from driving cars and using machines.

Blood disorders

As with other β -lactam antibiotics, granulocytopenia, leukopenia, neutropenia, and more rarely, bone marrow failure, pancytopenia, or agranulocytosis may develop during treatment with cefotaxime. For courses of treatment lasting longer than 10 days, blood counts should therefore be monitored and treatment discontinuation should be considered in case of abnormal results.

Use in Obstetrics

Cefotaxime crosses the placental barrier. However, the safety of Cefotaxime Sodium for Injection BP in pregnancy has not been established and it should not be used during pregnancy.

Use of Cefotaxime Sodium for Injection BP in women of child-bearing potential requires that the anticipated benefits be weighed against the possible risks.

Nursing Mothers

Since cefotaxime is excreted in human milk in low concentrations, either breast-feeding or treatment of the mother should be discontinued as necessary.

Patients with Special Diseases and Conditions

Although Cefotaxime Sodium rarely produces alterations in kidney function, evaluation of renal status is recommended, especially in severely ill patients receiving high doses.

Patients with markedly impaired renal function should be placed on the special dosage schedule recommended under **DOSAGE AND ADMINISTRATION**, because normal dosage in these individuals is likely to produce excessive and prolonged serum antibiotic concentrations. If Cefotaxime Sodium for Injection BP and aminoglycosides are to be administered to the same patient, these antibiotics should be administered separately and not as a mixed injection (see **RECONSTITUTION: Incompatibilities**). Renal function must be monitored in all such cases.

The sodium content of cefotaxime sodium (48.2 mg/g) should be taken into account in patients necessitating sodium restriction.

Drug Interactions

Probenecid interferes with the renal tubular transfer of cephalosporins, thereby delaying their excretion and increasing their plasma concentrations.

As with other cephalosporins, cefotaxime sodium may potentiate the nephrotoxic effects of nephrotoxic drugs (such as furosemide, aminoglycosides).

Drug - Laboratory Tests Interactions

Positive direct Coombs' test is known to develop in individuals during treatment with the cephalosporin group of antibiotics, including cefotaxime sodium.

In laboratory tests, a false positive reaction to glucose may occur with reducing substances but not with the use of specific glucose oxidase methods.

ADVERSE REACTIONS

Clinical Trials Adverse Drug Reactions

The most frequent adverse reactions with their frequency of occurrence are:

Central Nervous System (0.2%):

Headache.

Gastrointestinal (1.7%):

Colitis, diarrhea, nausea and vomiting. Symptoms of pseudomembranous colitis can appear during or after Cefotaxime Sodium treatment.

Genitourinary System (<1%):

Moniliasis, vaginitis.

Hematologic System (<1%):

As with other β -lactam antibiotics, neutropenia and, more rarely, agranulocytosis may develop during treatment with Cefotaxime Sodium, particularly if given over long periods. Furthermore, transient leukopenia, eosinophilia and thrombocytopenia have also been reported.

Some individuals have developed positive direct Coombs' test during treatment with Cefotaxime Sodium and other cephalosporin antibiotics (see **PRECAUTIONS: Laboratory tests**). Rare cases of hemolytic anemia have been reported.

Hypersensitivity (1.8%):

Rash, pruritus, fever.

Kidney (<1%):

Increased BUN has occasionally been observed.

Liver (<1%):

Transient elevations in SGOT, SGPT, serum LDH, and serum alkaline phosphatase levels have been reported.

Local (5%):

Injection site inflammation with intravenous administration. Pain, induration and tenderness after intramuscular injection.

Other Adverse Events including Post-Marketing Surveillance Data

Anaphylactic reactions:

Angioedema, bronchospasm, malaise possibly culminating in shock, may rarely occur. (see **WARNINGS: Anaphylactic reactions**).

Cardiovascular:

Potentially life-threatening arrhythmia following rapid bolus infusion has been reported in very few patients who received rapid intravenous administration of Cefotaxime Sodium through a central venous catheter (see **WARNINGS: Speed of Intravenous Injection**).

Central Nervous System:

Administration of high doses of β -lactam antibiotics, including Cefotaxime Sodium, particularly in patients with renal insufficiency may result in encephalopathy (e.g. impairment of consciousness, abnormal movements and convulsions). Headache and dizziness have been reported.

Cutaneous:

Rash, pruritus and less frequently urticaria. As with other cephalosporins, isolated cases of bullous eruptions (erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis) have been reported.

Cases of acute generalized exanthematous pustulosis (AGEP) have been reported.

Gastrointestinal:

During treatment with Cefotaxime Sodium, abdominal pain may occur. As with all other broad spectrum antibiotics, diarrhea may sometimes be a symptom of enterocolitis, which may, in

some cases, be accompanied by blood in stools. A particular form of enterocolitis that can occur with antibiotics is pseudomembranous colitis which is in most cases due to *Clostridium difficile*-associated disease (see **WARNINGS: Gastrointestinal, *Clostridium difficile*-associated disease**).

General disorders and administration site conditions:

Cases of pain at the injection site (for intramuscular formulation); inflammatory reactions at the injection site (including phlebitis/thrombophlebitis) have been reported.

Hematologic System:

Cases of immune hemolytic anemia have been observed (see **WARNINGS: Hemolytic Anemia**). Cases of bone marrow failure, pancytopenia, neutropenia and agranulocytosis have been reported (see **PRECAUTIONS, Blood disorders**).

Renal:

Decreases in renal function (increase of creatinine) have been observed with cephalosporins, including Cefotaxime Sodium, particularly when co-prescribed with aminoglycosides.

As with some other cephalosporins, rare cases of interstitial nephritis have been reported in patients treated with Cefotaxime Sodium.

Cases of acute renal failure have been reported.

Liver:

Increase in liver enzymes (ALT, AST, LDH, gamma-GT and/or alkaline phosphatase) and/or bilirubin have been reported. These laboratory abnormalities, which may also be explained by the infection, may rarely exceed twice the upper limit of the normal range and elicit a pattern of liver injury, usually cholestatic and most often asymptomatic. Hepatitis (sometimes with jaundice) has been reported.

Other:

Superinfection: as with other antibiotics, the use of Cefotaxime Sodium, especially if prolonged, may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition is essential. If superinfection occurs during therapy, appropriate measures should be taken.

As reported with other antibiotics for the treatment of borreliosis, a Jarisch-Herxheimer reaction may develop during the first days of treatment.

The occurrence of one or more of the following symptoms has been reported after several weeks treatment of borreliosis: skin rash, itching, fever, leucopenia, increase in liver enzymes, difficulty of breathing, joint discomfort. To some extent, these manifestations are consistent with the symptoms of the underlying disease for which the patient is being treated.

SYMPTOMS AND TREATMENT OF OVERDOSAGE

For management of a suspected drug overdose, contact your regional Poison Control Centre.

There is a risk of reversible encephalopathy in cases of administration of high doses of β -lactam antibiotics including Cefotaxime Sodium for Injection BP.

DOSAGE AND ADMINISTRATION

Cefotaxime Sodium for Injection BP may be administered intramuscularly or intravenously after reconstitution (see **Tables 3 and 4** with recommended mode of reconstitution according to route of administration).

DOSAGE

Treatment for adults and children with body weight of 50 kg or more:

The dosage of Cefotaxime Sodium for Injection BP should be determined by susceptibility of the

causative organisms, severity of the infection and condition of the patient.

Table 1: Guidelines for dosage of Cefotaxime Sodium for Injection BP for adults and children with body weight of 50 kg or more.

<i>Type of Infection</i>	<i>Daily Dose (g)</i>	<i>Frequency and Route</i>
Uncomplicated gonorrhea	1	1 g I.M. single dose
Uncomplicated infections	2	1 g every 12 hours I.M. or I.V.
Moderately severe to severe infections	3 to 6	1 to 2 g every 8 hours I.M. or I.V.
Very severe infections (e.g., septicemia, CNS)	6 to 8	2 g every 6 to 8 hours I.V.
Life-threatening infections	up to 12	2 g every 4 hours I.V.

THE MAXIMUM DAILY DOSAGE SHOULD NOT EXCEED 12 GRAMS.

Treatment for Neonates, Infants, and Children:

The following dosage schedule is recommended:

Neonates (birth to 1 month)

0-1 week of age: 50 mg/kg per dose I.V. every 12 hours

1-4 weeks of age: 50 mg/kg per dose I.V. every 8 hours

Infants and children (1 month to 12 years)

For body weights less than 50 kg, the recommended daily dose is 50 to 100 mg/kg intramuscular or intravenous of body weight divided into 4 to 6 equal doses, or up to 180 mg/kg/day for severe infections (including central nervous system infections).

For body weights 50 kg or more, the usual adult dosage should be used. THE MAXIMUM DAILY DOSAGE SHOULD NOT EXCEED 12 GRAMS.

**Table 2: Guidelines for dosage of Cefotaxime Sodium for Injection BP
for neonates, infants, and children**

Patients	Age or Weight	Dose	Route	Dose Interval
Neonates	0 to 1 week	50 mg/kg/ dose	I.V.	Every 12 hours
Neonates	1 to 4 weeks	50 mg/kg/ dose	I.V.	Every 8 hours
Infants and Children	< 50 kg	50 to 100 mg/kg/ day (up to 180 mg/kg/day for severe infections, including meningitis)	I.V. or I.M.	Divided into 4 to 6 equal doses
Children	≥ 50 kg	adult dosage		

Duration of Treatment:

Administration of Cefotaxime Sodium for Injection BP should be continued for a minimum of 48 to 72 hours after the patient defervesces or after evidence of bacterial eradication has been obtained; a minimum of 10 days of treatment is recommended for infections caused by Group A beta-hemolytic streptococci in order to guard against the risk of rheumatic fever or glomerulonephritis; frequent bacteriologic and clinical appraisal is necessary during therapy of chronic urinary tract infections and may be required for several months after therapy has been completed; persistent infections may require prolonged treatment. Doses less than those recommended should not be employed.

Prophylactic use:

Surgery patients

To prevent postoperative infection in contaminated or potentially contaminated surgery, recommended doses are as follows:

- 1 g intramuscular or intravenous administered ½ to 1½ hours prior to the initial surgical incision to ensure that adequate antibiotic levels are present in the serum and tissues at the start of surgery.
- 1 g intramuscular or intravenous administered 1½ to 2 hours following the first dose; for lengthy operative procedures, additional intraoperative doses may be administered, if

necessary, at appropriate intervals (1½ to 2 hours) during surgery.

- 1 g intramuscular or intravenous administered within 2 hours following completion of surgery

The total cumulative prophylactic dose should not exceed 6 g in a 12-hour period.

Cesarian Section Patients:

The first dose of 1 g is administered intravenously as soon as the umbilical cord is clamped. The second and third doses should be given as 1 g intramuscularly or intravenously at 6 and 12 hours after the first dose.

Dosage for Patients with Impaired Renal Function:

In patients with estimated creatinine clearance of less than 20 mL/min/1.73m², the dose of Cefotaxime Sodium for Injection BP should be halved (see **PRECAUTIONS, Patients with Special Disease and Conditions**).

If serum creatinine values alone are available, the following formula (based on sex, weight, and age of the patient) may be used to convert these values into creatinine clearance.

$$\text{Males: Clcr (ml/min)} = \frac{\text{Weight (kg)} \times (140 - \text{age in years})}{72 \times \text{serum creatinine (mg/dl)}}$$

$$\text{Females: Clcr (ml/min)} = 0.85 \times \text{above value}$$

In hemodialyzed patients

1 to 2 g daily, depending on the severity of the infection; on the day of hemodialysis, Cefotaxime Sodium for Injection BP must be administered after the dialysis session.

ADMINISTRATION

Intramuscular:

Cefotaxime Sodium for Injection BP should be injected well within the body of a relatively large

muscle such as the upper outer quadrant of the buttock (i.e. gluteus maximus); aspiration is necessary to avoid inadvertent injection into a blood vessel.

Intravenous:

The intravenous route is preferable for patients with bacteremia, bacterial septicemia, or other severe or life-threatening infections, or for patients who may be poor risks because of lowered resistance resulting from such debilitating conditions as malnutrition, trauma, surgery, diabetes, heart failure, or malignancy, particularly if shock is present or impending.

For bolus administration, the solution containing Cefotaxime Sodium for Injection BP must be injected over a period of 3 to 5 minutes (see **WARNINGS, Speed of Intravenous Injection**).

Using an infusion system, it may also be given over a longer period of time through the tubing system by which the patient may be receiving other intravenous solutions. Butterfly^{1*} or scalp vein type needles are preferred for this type of infusion. However, during infusion of the solution containing Cefotaxime Sodium for Injection BP, it is advisable to discontinue temporarily the administration of other solutions at the same site (see **DOSAGE AND ADMINISTRATION, Reconstitution, Incompatibilities**).

Reconstitution

For Intramuscular Use:

Cefotaxime Sodium for Injection BP should be reconstituted with Sterile Water for Injection in accordance with the volumes recommended in the following table.

^{1*} Reg'd TM of Abbott Laboratories

Table 3: Reconstitution table for intramuscular use

	Volume to be Added to Vial (mL)*	Approximate Available volume (mL)	Approx. Average Concentration (mg/mL)
250 mg vial	2	2.15	116
500 mg vial	2	2.2	230
1 g vial	3	3.4	300
2 g vial	5	6.0	330

* shake to dissolve

For Intravenous Use:

For intravenous bolus use

The 500 mg, 1 and 2 g vials should be reconstituted with at least 10 mL of Sterile Water for Injection.

For intravenous infusion use

Reconstituted solution may be further diluted with 50 to 1000 mL of the fluids recommended for intravenous infusion.

Table 4: Reconstitution table for intravenous use

	Volume to be added to Vial (mL)*	Approximate Available Vol. (mL)	Approx. Average Concentration (mg/mL)
500 mg vial	10	10.2	50
1 g vial	10	10.4	95
2 g vial	10	11.0	180

* shake to dissolve

Solutions for intravenous Infusion:

Further dilution may be undertaken only in glass bottles.

Cefotaxime Sodium for Injection BP is compatible with the following infusion fluids:

- Water for Injection
- 0.9% NaCl Injection
- 5% Dextrose Injection
- 0.9% NaCl and 5% Dextrose Injection

Incompatibilities:

Solutions of Cefotaxime Sodium for Injection BP must not be admixed with aminoglycoside solutions. If Cefotaxime Sodium for Injection BP and aminoglycosides are to be administered to the same patient, they must be administered separately and not as a mixed injection.

Solutions of Cefotaxime Sodium for Injection BP should not be prepared with diluents having a pH above 7.5 such as Sodium Bicarbonate Injection.

STABILITY AND STORAGE RECOMMENDATIONS

Solutions of Cefotaxime Sodium for Injection BP range from light yellow to amber, depending on concentration and the diluent used. Store at controlled room temperature (15 to 30°C) protected from light. Single dose vials. Discard unused portion.

Cefotaxime Sodium for Injection BP reconstituted in the original vial as described under **Reconstitution** maintains satisfactory potency for 12 hours at room temperature (25°C) and for 24 hours under refrigeration (2 to 8°C). Only freshly prepared reconstituted solutions may be further diluted with 50 to 1000 mL of the recommended infusion fluids in glass bottles. Such solutions maintain satisfactory potency for 12 hours at room temperature (25°C) and for 24 hours under refrigeration (2 to 8°C). Any unused solutions should be discarded.

Cefotaxime Sodium for Injection BP solutions exhibit maximum stability in the pH 5 to 7 range.

Special Instructions:

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration. Solutions of Cefotaxime Sodium for Injection BP range from light yellow to amber, depending on concentration and diluent used. The dry powder as well as solutions tend to darken, depending on storage conditions.

AVAILABILITY OF DOSAGE FORMS

Cefotaxime Sodium for Injection BP is supplied as a sterile, creamy white powder, in a box of 10 vials containing 250 mg, 500 mg, 1.0 and 2.0 g of cefotaxime (as cefotaxime sodium). Single dose vials.

Composition

Cefotaxime Sodium for Injection BP does not contain any additives or other inactive ingredients.

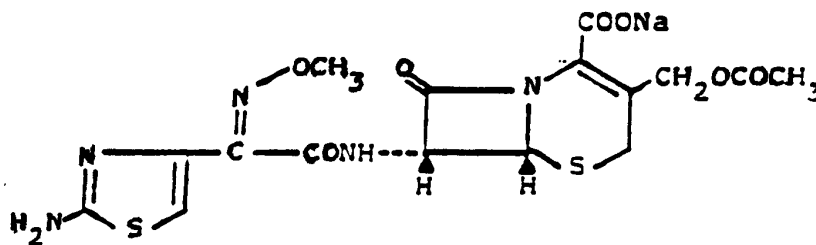
PHARMACEUTICAL INFORMATION

DRUG SUBSTANCE

Proper Name: Cefotaxime sodium

Chemical Name: sodium (6*R*,7*R*)-3-[(acetyloxy)methyl]-7-[[[(2*Z*)-2-(2-aminothiazol-4-yl)-2-(methoxyimino)acetyl]amino]-8-oxo-5-thia-1-azabicyclo[4.2.0]oct-2-ene-2-carboxylate

Structural Formula:



Molecular Formula: C₁₆H₁₆N₅NaO₇S₂

Molecular Weight: 477.5

Description: Creamy white crystalline powder. It is soluble in water at about 20%, but poorly soluble in common organic solvents including ethanol.

MICROBIOLOGY

Cefotaxime has *in vitro* activity against a wide range of Gram-positive and Gram-negative organisms as observed in the following table.

Table 5: Summary for sensitivity of aerobic and anaerobic bacteria to cefotaxime

MICROORGANISMS	No. of Strains	CUMULATIVE PERCENTAGE OF STRAINS INHIBITED AT INDICATED CONCENTRATIONS ^a (mcg/mL)									
		≤0.1	0.5	1.0	2.0	4.0	8.0	16	32	64	≥128
AEROBES: GRAM-NEGATIVE											
<i>Acinetobacter spp.</i>	39	5	10	18	28	38	62	72	87	90	100
<i>Acinetobacter anitratum</i>	154				6	13	43	71	83	87	100
<i>Acinetobacter lwoffii</i>	15			50	90		100				
<i>Citrobacter spp.</i>	47	60	74	74	77	79	85	89	94	98	100
<i>Citrobacter diversus</i>	25	100									
<i>Citrobacter freundii</i>	28	79	93	96				100			
<i>Enterobacteriaceae spp.</i>	6083		91	95	99	100					
<i>Enterobacter spp.</i>	61	79	90	95	98					100	
<i>Enterobacter aerogenes</i>	57	88	89	91		95		98		100	
<i>Enterobacter cloacae</i>	80	63	69	74	84	88				94	100
<i>Escherichia coli</i> ^b	657	95	98	99						100	
<i>Haemophilus spp.</i> ^b	294	97	99	100							
<i>Haemophilus influenzae</i> ^b	113	96	98	99						100	
<i>Klebsiella spp.</i>	101	91	97	100							
<i>Klebsiella oxytoca</i>	10			20	50	60	70	80	90	100	
<i>Klebsiella pneumoniae</i> ^b	226	88	98	99	100						
<i>Neisseria spp.</i>	12	75	100								
<i>Neisseria gonorrhoeae</i> ^b	472	100									
<i>Neisseria meningitidis</i>	150				50	90					
<i>Proteus indole</i> (+)	102	64	75	85	94	96		97		100	
<i>Proteus indole</i> (-)	20	90				95				100	
<i>Proteus mirabilis</i> (-)	186	98	99		100						
<i>Providencia spp.</i>	37	35	54	78	86	95		100			

<i>Pseudomonas spp.</i>	136		1		3	9	28	57	72	85	100
<i>Pseudomonas aeruginosa</i>	1412				1	6	30	69	85	97	100
<i>Pseudomonas maltophilia</i>	12								50	90	100
<i>Pseudomonas putida</i>	10							50		90	100
<i>Salmonella spp.</i>	33	79	97		100						
<i>Salmonella typhi</i>	30	100									
<i>Serratia spp.</i>	93	29	43	47	52	54	58	63	78	95	100
<i>Serratia marcescens</i> ^b	86	35	41	44	50	65	81	97	100		
<i>Shigella spp.</i>	19	74	84	95	100						
AEROBES: GRAM-POSITIVE											
<i>Staphylococcus aureus</i>	1686		5	16	89	95	100				
<i>Staphylococcus epidermidis</i>	175	20	45	57	73	89	99			100	
<i>Streptococcus group A</i>	12	100									
<i>Streptococcus group B</i>	20	90	100								
<i>Streptococcus enterococcus</i>	146		1	5	10	14	17	20	21	25	100
<i>Streptococcus Group D non-enterococcus</i>	23	70	87	98	100						
<i>Streptococcus pneumoniae</i>	67	91									
ANAEROBES: GRAM-NEGATIVE											
<i>Bacteroides spp.</i>	51		4		20	26	38	60	82	94	100
<i>Bacteroides fragilis</i>	28						50	90			
<i>Bacteroides thetaiotaomicron</i>	13							50		90	
ANAEROBES: GRAM-POSITIVE											
<i>Clostridium spp. (Other than C. difficile)</i>	13	15			61	84	100				
<i>Clostridium perfringens</i>	19		50			90					
<i>Cocci</i>	11	50	90								
<i>Propionibacterium</i>	11	90									

- a Serial dilutions (broth and agar methods)
b Includes producers and non-producers of β -lactamases.

The sensitivity to β -lactamases was determined by a cell-free *in vitro* test system using characteristic β -lactamases of various Richmond classes. Evidence was found of the stability of cefotaxime against the inactivating effect of cephalosporinases from *Enterobacter cloacae* P 99 (class Ia) and *Pseudomonas* HS 18 (Id), as well as against that of the β -lactamase from *Escherichia coli* TEM (IIIa). The test compound was mildly sensitive to the effects of the enzyme formed by *Klebsiella aerogenes* 1082 E (Ivc).

Table 6: Effect of β -lactamase on cefotaxime

	E.cloacae P99		Ps. Aeruginosa HS 18		Kl. Aerogenes 1082E		E. coli TEM	
	Relative β -lactamase sensitivity	MIC	Relative β -lactamase sensitivity	MIC	Relative β -lactamase sensitivity	MIC	Relative β -lactamase sensitivity	MIC
Cefotaxime	0%	125 mcg	0%	1.0 mcg	2.5%	12.5 mcg	0%	0.078 mcg

Initial count for each organism about 5×10^4 CFU per mL in each tube. There is *in vitro* evidence of synergy between cefotaxime and aminoglycoside antibiotics (gentamicin and tobramycin) against some strains of *Pseudomonas*.

A broth dilution checkerboard synergy assay was used to assess the activity of cefoperazone, cefotaxime, moxalactam, and carbenicillin, in combination with tobramycin, against 38 strains of *Pseudomonas aeruginosa*. Synergy occurred significantly more often ($p < 0.001$) when tobramycin was combined with cefotaxime (63%) than when it was combined with carbenicillin (26%), cefoperazone (21%), or moxalactam (18%). Of the 25 synergistically inhibited strains, the combination cefotaxime-tobramycin was synergistic against 24 and was the only synergistic combination against 10. Of six strains initially resistant to cefotaxime, five were susceptible to this agent (minimum inhibitory concentration, 32 mcg/mL) when it was combined with tobramycin.

Table 7: Results of synergy testing against 38 strains of *Pseudomonas aeruginosa*

Antibiotic combination ^a			No. (%) synergistic
T	+	CT ^b	24 (63.2)
T	+	CB	10 (26.3)
T	+	CP	8 (21.1)
T	+	ML	7 (18.4)

^a T (Tobramycin)
CT (Cefotaxime)
CB (Carbenicillin)
CP (Cefoperazone)
ML (Moxalactam)

^b $p < 0.001$ for T+CT vs each of the other combinations (McNemar test). Differences among the other antibiotic combinations were not statistically significant.

In another study the combination cefotaxime/gentamicin was tested against 111 clinical isolates of *Pseudomonas aeruginosa* and was found to have a synergistic effect against 73.9% of the strains tested.

Susceptibility Tests:

With the Bauer-Kirby-Sherris-Turck method of disc susceptibility testing, a disc containing 30 mcg of cefotaxime should give a zone of at least 20 mm for microorganisms to be considered susceptible to cefotaxime sodium, 15-19 mm for organisms of intermediate susceptibility and a zone of 14 mm or less for cefotaxime resistant organisms.

Because certain strains of enterobacteriaceae have been shown to be resistant to the cephalosporin class disc, only the cefotaxime discs must be used for testing the susceptibility of cefotaxime sodium.

PHARMACOLOGY

Animal Pharmacology

Animal pharmacology studies demonstrate that cefotaxime has no significant effect on the central nervous system, cardiovascular system, respiratory system, kidneys, blood clotting mechanisms and blood glucose levels.

Human Pharmacology and Kinetics

Intramuscular administration:

Single dose

Following intramuscular administration of a single 500 mg or 1 g dose of cefotaxime sodium to normal volunteers, mean peak serum concentrations of 11.7 and 20.5 mcg/mL respectively, are attained within 30 minutes and decline with an elimination half-life of approximately 1 hour.

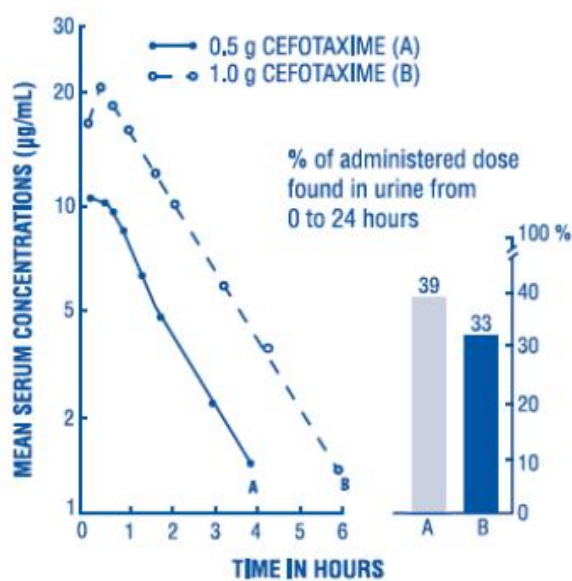


Figure 1: Mean serum concentrations and urinary excretion data of cefotaxime administered intramuscularly as a single dose of 0.5 g and 1.0 g in 14 healthy male volunteers.

Table 8: Pharmacokinetic parameters of cefotaxime after single intramuscular administration in 14 healthy male volunteers (mean)

Kinetic Parameters	Cefotaxime	
	500 mg	1000 mg
Peak serum level (mcg/mL)	11.7	20.5
Time to peak (h)	0.4	0.5
AUC _(0-∞) (mcg/mL/h)	24.1	48.4
t _{1/2 β} (h)	1.2	1.3
Cl _s (mL/min/1.73m ²)	315.6	318.5
% unchanged drug in urine/0-24 h	38.8	33.3
Cl _r (mL/min/1.73m ²)	122.4	103.8

Multiple doses

Following multiple intramuscular injections, serum levels at 30 minutes after a dose of 500 mg every 8 hours, ranged from 9.2 to 11.9 mcg/mL. There was no difference between the half-life (h) at Day 1 and Day 11, but differences were noted in the AUC_{0-8 h}, fractional serum clearance and renal clearance; the latter probably being related to significantly lower recovery of the drug on Day 11.

Drug administration time

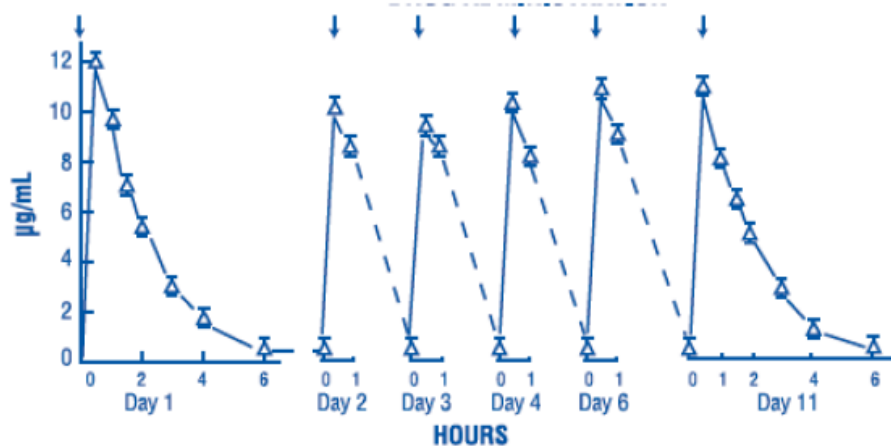


Figure 2: Mean serum levels ± SE of cefotaxime administered intramuscularly after multiple doses of 500 mg every 8 hours in 30 healthy male volunteers.

Table 9: Pharmacokinetic parameters of cefotaxime after multiple intramuscular injections of 500 mg (mean ± SE) in 30 healthy male volunteers.

	Day 1	Day 11
Elimination rate constant (β) (h^{-1})	0.778 ± 0.04	0.784 ± 0.04
$t_{1/2}$ (h)	0.93 ± 0.05	0.92 ± 0.05
$\text{AUC}_{(0-8 \text{ h})}$ (mcg/mL/h)	24.28 ± 1.18	19.9 ± 1.25
Serum clearance ($\text{mL}/\text{min}/1.73\text{m}^2$)	304.8 ± 13.49	377.3 ± 23.61
Volume of distribution ($\text{L}/1.73\text{m}^2$)	23.96 ± 1.07	29.68 ± 2.58
Renal clearance ($\text{mL}/\text{min}/1.73\text{m}^2$)	194.4 ± 18.35	146.6 ± 13.86
Drug excreted (0-6 h) (%)	62.6 ± 5.09	39.1 ± 3.77

Intravenous administration

Single dose (bolus over 5 minutes)

Following intravenous administration (bolus) of a single 500 mg, 1 g and 2 g dose of cefotaxime sodium to healthy adult male volunteers, the serum levels were 38.9, 101.7, and 214.4 mcg/mL respectively, without alteration in the elimination half-life.

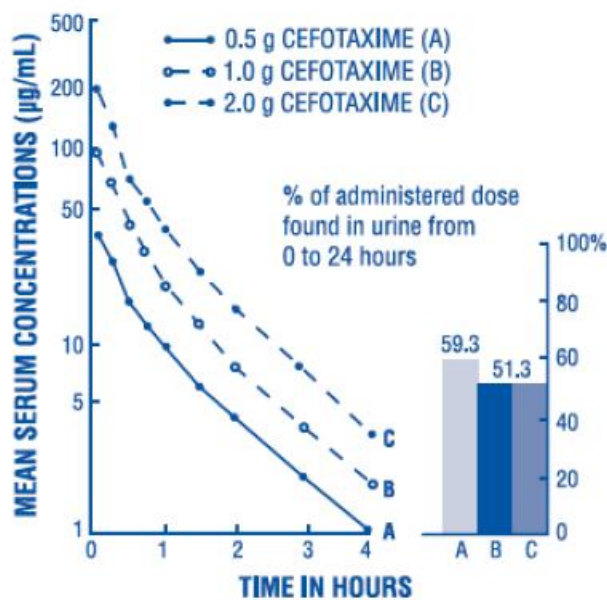


Figure 3: Mean serum concentrations and urinary excretion data of cefotaxime administered intravenously (over a 5 min. period) as a single dose of 0.5g, 1 g, and 2 g in 15 healthy male volunteers.

Table 10: Pharmacokinetic parameters of cefotaxime after intravenous administration of a single dose of 0.5g, 1g and 2g in 15 healthy male volunteers (mean)

KINETIC PARAMETERS	Cefotaxime		
	500 mg	1000 mg	2000 mg
Peak serum level (mcg/mL)	38.9	101.7	214.4
AUC _(0-∞) (mcg/mL/h)	30.6	70.4	134.1
t _{1/2 β} (h)	1.04	1.05	0.86
Cl _s (mL/min/1.73m ²)	245.3	206.8	215.1
% unchanged drug in urine/0-24 h	59.3	51.3	51.3
Cl _r (mL/min/1.73m ²)	146.8	104.0	110.4

Single dose (infusion over 30 minutes)

Administration of 1 g of cefotaxime sodium infused intravenously over 30 minutes gave mean peak serum concentrations at the end of the 30 minutes of 41.1 mcg/mL with an elimination half-life of 1.13h.

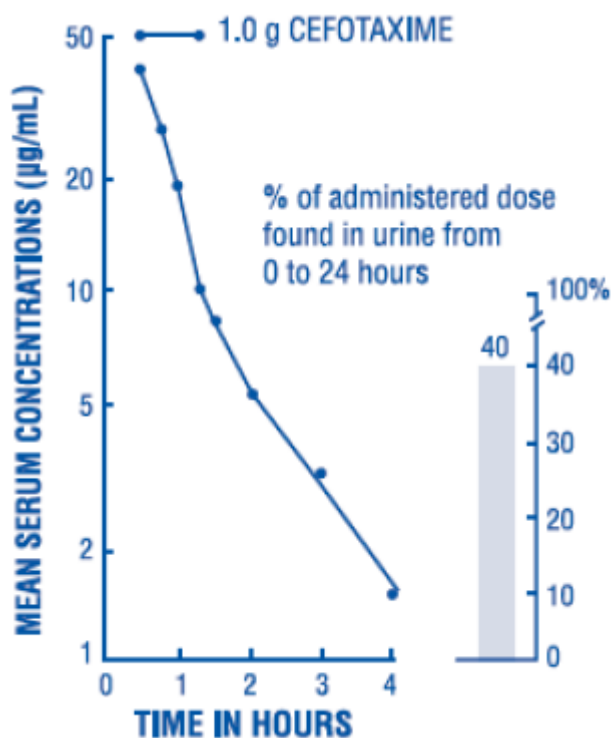


Figure 4: Mean serum concentrations and urinary excretion data of cefotaxime infused intravenously over 30 minutes as a single dose of 1.0 g in 10 healthy male volunteers.

Table 11: Pharmacokinetic parameters after single intravenous infusion over 30 min. of 1g cefotaxime in 10 healthy male volunteers (mean)

KINETIC PARAMETERS	Cefotaxime 1000 mg
Peak serum level at the end of 30 min. infusion (mcg/mL)	41.1
AUC _(0-∞) (mcg/mL/h)	44.3
t _{1/2 β} (h)	1.13
Cl _s (mL/min/1.73m ²)	341.6
% unchanged drug in urine/0-24 h	40.0
Cl _r (mL/min/1.73m ²)	130.1

Multiple dose (repetitive intravenous infusion over 30 minutes)

There was no evidence of drug accumulation following repetitive intravenous infusions over 30 minutes of 1g doses every 6 hours for 14 days.

The biological half-life was approximately 1.0 hour and the 24 hours urinary excretion of unchanged drug amounted to 62.6% of the administered dose (almost all of it in the first 6 hours).

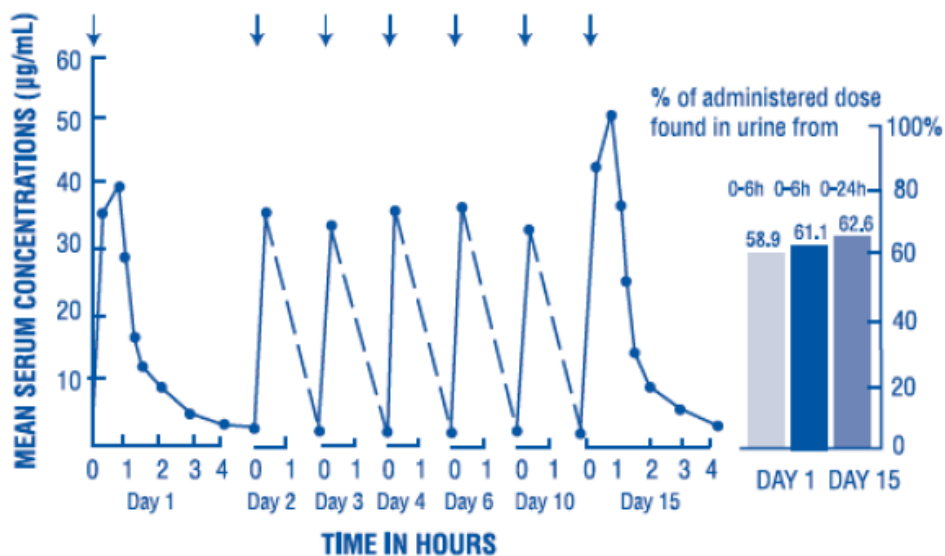


Figure 5: Mean serum concentration and urinary excretion data of cefotaxime infused intravenously over 30 minutes as a single dose of 1.0 g and every 6 hours for 14 days in 16 healthy male volunteers.

Table 12: Pharmacokinetic parameters of cefotaxime after repetitive intravenous infusion (over 30 minutes) of 1.0g doses every 6 hours, for 14 days in 16 healthy male volunteers (mean).

KINETIC PARAMETERS	1000 mg Cefotaxime	
	Day 1	Day 15
AUC _(0-∞) (mcg/mL/h)	57.4	68.9
t _{1/2 β} (h)	1.2	1.0
Cl _s (mL/min/1.73m ²)	259.3	219.5
% unchanged drug in urine/0-6 h	58.9	61.1
Cl _r (mL/min/1.73m ²)	154.5	132.9

Cerebrospinal Fluid Penetration:

Children

In 13 children (9 days to 5 years) successfully treated for bacterial meningitis with a dose of 40 mg/kg, intravenous, every 6 hours for 14 days, cefotaxime diffused consistently and in therapeutic levels into the cerebrospinal fluid. Cerebrospinal fluid levels of 6.0 mcg/mL (after 36-48 h) and 1.2 mcg/mL (after 14 days) in treatment were 17 to 275 - fold the MBCs for the infecting organisms. After a single 40 mg/kg dose to each of 5 infants (1 to 19 months) with ventriculostomies, mean cerebrospinal fluid levels of cefotaxime were 6.4, 5.7 and 4.5 mcg/mL at 2, 4 and 6 hours, respectively. Cefotaxime mean half-life in 4 infants was 1.15 ± 0.58 h in plasma and 4.3 ± 3.1 h in cerebrospinal fluid.

Table 13: Cefotaxime and desacetyl cefotaxime plasma and CSF levels after intravenous injection in 13 children with bacterial meningitis

Drug	Drug Level (µg/mL)*					
	Early (36 to 48 h)			Late (14 days)		
	Plasma	CSF	Diffusion ratio (%)	Plasma	CSF	Diffusion ratio (%)
Cefotaxime	5.1-55.7 (16.7±14.7)	0.74-38.8 (6.0±10.2)	7.0-69.7 (27.7±16.2)	1.7-13.6 (6.6±4.3)	0.6-3.1 (1.2±0.9)	4.5-64.7 (25.7±21)
Desacetyl cefotaxime	2.5-20.1 (8.1±4.2)	0.89-27.4 (4.6±7.0)	12.2-219 (51.9±54.5)	1.5-9.5 (5.4±1.9)	0.5-2.1 (1.1±0.8)	8.9-40.0 (20.8±9.3)

* values in parentheses represent the mean ± standard deviation

Adult

Thirty-two (32) cases of adult meningitis received cefotaxime, 2 g every 8 hours by bolus injection (3-5 minutes). Mean concentration of cefotaxime in cerebrospinal fluid ranged from 0.8 mcg/mL (aseptic meningitis), to 6.4 mcg/mL (Gram-negative and *Listeria monocytogenes*), and from 0.5 to 5.4 mcg/mL for the metabolite.

Paediatric Pharmacokinetics:

A single 50 mg/kg dose of cefotaxime was administered as an intravenous infusion over a 10 to 15 minute period to 29 newborn infants grouped according to birth weight and age. The mean half-life of cefotaxime in infants with lower birth weight (less than or equal to 1500 g), regardless of age, was longer (4.6 hours) than the mean half-life (3.4 hours) in infants whose birth weight was greater than 1500 g. Mean serum clearance was also smaller in the lower birth weight infants. Although the differences in mean half-life values are statistically significant for weight, they are not clinically important. Therefore, dosage should be based solely on age (see **DOSAGE AND ADMINISTRATION, Treatment for Neonates, Infants and Children**).

Table 14: Pharmacokinetic parameters in 29 newborns receiving single intravenous dose of 50 mg/kg cefotaxime (mean)

	Group I (≤ 1500 g at birth and < 5 days old)	Group II (> 1500 g at birth and < 5 days old)	Group III (varying birth weight and ≥ 5 days old)	Group A (≤ 1500 g)	Group B (> 1500 g)
Peak serum concentration (µg/ml)	116	127	122	133	117
AUC _{0-6h} (µg/ml/h)	394	418	375	400	392
AUC _{0-∞} (µg/ml/h)	683	620	551	675	561
				(1)	
Half-life (h)	4.9	3.7	3.5	4.6	3.4
	(1)			(2)	
	(2)			(2)	
Vd (L/kg)	0.53	0.44	0.45	0.51	0.44
	(2)			(2)	
	(1)			(2)	
Cl _s (mL/min/1.73m ²)	22.5	38.8	39.1	23.0	43.9
	(1)			(3)	
	(1)			(3)	

(1) p ≤ 0.05; (2) p ≤ 0.01; (3) p ≤ 0.001

Renal insufficiency:

1 g of cefotaxime was injected intravenously b.i.d. for 4 to 7 days in 9 patients with renal insufficiency whose creatinine clearances ranged from 5.0 to 25.5 mL/min/1.73m².

Table 15: Pharmacokinetic parameters of cefotaxime and its metabolites in 9 patients with renal insufficiency after repeated intravenous administration (mean)

	CEFOTAXIME		DACM		UP1		UP2	
	first dose	last dose	first dose	last dose	first dose	last dose	first dose	last dose
Peak plasma level (mcg/mL)			19.3	37.3	5.0	17.2	4.5	14.7
$\frac{C_{\max} \text{ last dose}}{C_{\max} \text{ first dose}}$	1.2		2.0		4.2		3.9	
Time-to-peak (h)			5.1	3.7	6.5	6.0	6.2	6.0
Distribution half-life (h)	0.5	0.7						
Biological half-life (h)	2.9	3.1	10.4	11.5	6.2	16.6	8.1	21.1
AUC _{0-∞} (mcg/mL/h)	280	351	331	722	106	605	115	538
$\frac{\text{AUC (0-12h) last dose}}{\text{AUC (0-12h) first dose}}$	1.3		1.7		3.1		3.0	
Renal clearance (mL/min)	13.0		14.8		30.2		30.9	
Cumulative urinary excretion (mg)	171.4	137.7	127.8	154.4	84.5	142.0	75.3	133.7

The half-lives of cefotaxime, desacetyl (DACM), and UP1 and UP2 were longer and renal clearances were decreased in these patients. The biological half-life of cefotaxime was 2.9 hours after the first dose and 3.1 hours after the 5th dose. Neither the drug nor its metabolites accumulated even when clearances were as low as 20 mL/min/1.73m².

However, in patients with creatinine clearances approaching 5 mL/min/1.73m², accumulation of the metabolites becomes apparent.

Consequently, until further clinical experience is obtained in such patients, it is recommended that the dose of cefotaxime be halved when creatinine clearance is lower than 20 mL/min/1.73m² (see **DOSAGE AND ADMINISTRATION, Dosage for Patients with Impaired Renal function**).

Metabolism and Excretion

Cefotaxime is partially metabolized in humans by non-specific esterases which desacetylate the acetoxymethyl side chain to form the desacetyl cefotaxime (DACM). Desacetylation is followed by formation of the lactone and subsequent conversion to open β-lactam ring structures (UP1 and

UP2).

Approximately 20-36% of an intravenous dose of ¹⁴C cefotaxime is excreted by the kidney as unchanged cefotaxime and 15-25% as the DACM derivative, the major metabolite. Two other urinary metabolites (UP1 and UP2) account together for about 20-25%. Faecal recovery accounts for approximately 10% of the administered dose.

The DACM has been shown to contribute to 10-15% of the bactericidal activity of the parent compound. It has no activity against *Pseudomonas*. UP1 and UP2 lack antibacterial activity.

In a study conducted on 22 healthy volunteers administered cefotaxime sodium and alcohol, there was no disulfiram-like reaction.

Protein binding:

In an *in vitro* study using the dialysis chambers method, it was found that about 51% (range 35-64%) of cefotaxime was bound to human serum proteins when concentrations ranged from 6.25 to 50 mcg/mL. The bound percentage of the desacetyl metabolite was 16% to 32% which is approximately half of the parent compound. At a concentration of 100 mcg/mL in serum, only a small percentage of both the parent compound and its metabolite was bound; most probably the portion of the protein molecules which bind them is saturated at this concentration.

TOXICOLOGY

Acute Toxicity

The acute toxicity of cefotaxime was determined in mice, rats, rabbits and dogs. The order of toxicity by various routes was IV >IP> SC. No LD₅₀s were found for per os or intramuscular administration.

Common signs of toxicity were clonic and tonic convulsions, dyspnea, hypothermia and cyanosis. There were almost no differences in sex or species. Cefotaxime was found to be twice as toxic for newborns as it was for adults. The LD₅₀ of the desacetyl derivative of cefotaxime was determined in mice and found to be similar to cefotaxime with similar signs of intoxication.

Short-term Toxicity

In a 6-day acute toxicity study, cefotaxime was given intravenously to 3 groups of beagle dogs, each consisting of 2 males and 2 females at doses of 500 mg/kg for 2 days followed by 100 mg/kg for 4 days; and in a second group, 1000 mg/kg for 2 days followed by 250 mg/kg for 4 days. A third group of 4 dogs receiving physiological saline under the same conditions served as control. The results of biochemical tests were unremarkable although there were transient increases in urea and SGPT in a few treated males and in SGPT and alkaline phosphatase in 2 treated females.

At autopsy, microscopic examinations revealed superficial hemorrhages in the urethra of one high dose male and a similar finding in the bladder of a female of the same group. The hemorrhages were the apparent result of catheterization. The other high dose male had a scar on the kidney and two scars on the bladder. Histological examination of the livers showed a few areas of Kupffer cell hyperplasia in all treated males. A male and a female of the high dose group had an abundance of glycogen in the hepatic parenchyma. Microscopic examination of the kidneys showed slightly dilated proximal convoluted tubules without epithelial changes in one male from each of the treated groups. Inflammatory and histocytic cells were noted in the kidneys of one male from both treated groups.

Long-term Toxicity (30 days and 13 weeks)

The long-term toxicity of cefotaxime was investigated in 3 groups of 17 rats each of both sexes receiving single daily subcutaneous doses of 300, 1000 and 3000 mg/kg for 1 month. At the lowest dose, cefotaxime caused slight dilation of the cecum and very slight inflammatory changes in the subcutaneous tissue at the sites of injection. In the 1000 mg/kg/day group, dilation of the cecum, inflammatory changes at the injection sites accompanied by histopathological change of the spleen and bone marrow, and tubular changes of the kidneys were observed. These changes were seen infrequently and had a slight degree of severity. In rats treated with the highest concentration of 3000 mg/kg/day, there was dilation of the cecum and extensive subcutaneous hemorrhage at the injection sites. Secondary to the hemorrhagic and inflammatory changes were an increase in neutrophils and a decrease in RBC count, hematocrit and hemoglobin values, lymphoid hyperplasia of the spleen and increased erythropoiesis in the bone marrow. Correspondingly, spleen weights were increased. After 2 weeks of reversal of treatment, these changes were reduced. Fragments of epithelial cells and amorphous salts were observed in urine sediment. Kidney weights were increased in all females. The kidneys had dilated tubules and eosinophilic granular material in the proximal tubule epithelial cells.

In another study, cefotaxime was given under the same conditions to 3 groups of 15 rats each of both sexes at dose levels of 400, 800 and 1600 mg/kg/day for 13 weeks. Different parameters such as urinalysis, hematology, clinical chemistry and postmortem examination of macroscopic and microscopic examination of lesions showed similar results as observed above.

The intravenous toxicity of cefotaxime was studied in 4 groups of 15 male and 15 female rats who received 0 to 1000 mg/kg/day in the caudal tail vein for 1 month. Except for some of the animals given the highest dose of 1000 mg/kg who squeaked, tried to escape from the drug injection and developed inflammatory changes at the sites of injection, cefotaxime administration caused neither remarkable changes in behavior nor fatal cases in any of the drug treated groups. In the hematological tests, plasma recalcification time and prothrombin time were slightly shorter and the platelet count was decreased to a slight degree in the high dose rats in both sexes

although not statistically significant. Autopsies of both males and females exhibited dose-dependent dilation of the cecum with retention of contents.

In some of these cases, hemorrhage, inflammatory changes and attenuation of the wall of the cecum were observed microscopically. There were no spleen abnormalities except that lymphoid hyperplasia was observed in all of the drug-treated and control groups. However, in another study done under the same conditions dose-related increases in spleen weights were reported. Histologically, the spleens of some of the animals treated with 100 or 300 mg/kg for 30 days were observed to have a moderate degree of white pulp activation.

The long-term intravenous and intramuscular toxicity of cefotaxime was further investigated in groups of 3 male and 3 female beagle dogs treated with doses ranging from 0 to 300 mg/kg/day for 30 consecutive days. When injected intravenously at 300 mg/kg/day, all dogs salivated profusely and showed a clear nasal discharge. In dogs, the weight of the kidneys was increased. One male and all 3 females of the high dose group had hyperemia with slight edema in the cortical areas of the kidneys. Hemorrhage and hemorrhagic residues were seen at the site of injection. Cefotaxime, when given intramuscularly at doses of 72 or 179 mg/kg/day, caused pain at the site of injection in a few animals. The intensity of the lesions at the site of injection and the frequency of their occurrences appear to be dose-related. Diarrhea was also noted in several dogs treated with cefotaxime at these two doses.

In another study, cefotaxime was injected intravenously to beagle dogs – 3 animals/sex/group – at doses of 500, 1000 and 1500 mg/kg/day for 13 weeks. As observed earlier, the mid- and high-dose dogs salivated during the injection of the compound and had occasionally soft stools. At week 11, one female treated with 1500 mg/kg/day showed signs of anemia; palpation suggested a hemorrhagic disorder in the area of the spleen. The hemograms were consistent with an acute hemorrhage. Renal lesions graded minimal to slight were reported to occur in all drug groups but not in all dogs. Some dogs treated with 1000 and 1500 mg/kg/day showed a slight increase of extra medullary hematopoiesis in the spleens. In prescapular lymph nodes, an increase of focal

lymphadenitis and erythrophagocytosis were seen in treated dogs. In male dogs, the lymph nodes showed increased activity of the germinal centers and hyperplasia of medullary plasmacytes.

Groups of 4 male and 4 female beagle pups further received subcutaneous injections of cefotaxime at doses of 0 to 1500 mg/kg/day for 30 consecutive days. A dose-related response to pain, both in intensity and duration was observed. Postmortem examinations revealed hemorrhage and edema at the injection site.

The long-term toxicity of cefotaxime was compared with that of cephaloridine and cephalothin in 6 groups of 3 male and 3 female rabbits treated intravenously, daily for 30 days.

Cefotaxime doses ranged from 0 to 120 mg/kg/day while cephaloridine and cephalothin were given at the daily dose of 120 mg/kg/day. In the cefotaxime group, one rabbit died at 30 mg/kg, three at 60 mg/kg and two at 120 mg/kg. Two rabbits died in the cephaloridine and one in the cephalothin group. Diarrhea was observed in all treated groups. Neither cefotaxime nor cephalothin produced microscopic lesions. Two rabbits given cephaloridine had myocardial necrosis.

Chronic Toxicity

The chronic toxicity of cefotaxime was investigated in rats and dogs over a period of 6 months.

Groups of 25 male and 25 female rats received subcutaneous injections of cefotaxime at doses of 0, 40, 100 and 250 mg/kg/day 7 days a week for 26 weeks. On the whole, chronic administration of cefotaxime for 6 months was well tolerated. Rats treated with 250 mg/kg/day showed a slight and transient depression of body weight gain in both males and females. Local tolerance reactions were noted in animals treated with 100 or 250 mg/kg from the third week to the end of the study. Microscopic examination of these tissues taken from the high dose animals showed marked inflammatory subcutaneous sclerosis often accompanied by the presence of hematomas and muscular atrophy.

One male treated with 250 mg/kg had to be killed after 4 months of treatment because of sudden deterioration of its general condition. Histopathological examination revealed ulceration of the stomach mucosa, congestion of the liver and a subcapsular interstitial scar in the kidney. Otherwise, there was no mortality in any of the groups.

The chronic toxicity of cefotaxime was further examined in dogs (4 animals/sex/group) when given intramuscularly at doses of 0, 40, 100 or 250 mg/kg/day, 7 days a week for 26 weeks.

Reaction of pain was observed in all dogs in the highest dosage groups immediately following the injection. Histopathologic lesions at the injection sites showed a dose-related inflammatory response. No dogs died during the treatment. Numerous variations in hematology, coagulation and biochemical values were observed in individual animals. The variations were, however, within normal limits and the distribution in the two groups did not suggest an effect of the compound.

Fertility and Reproduction

Cefotaxime was administered intravenously at doses of 0, 100, 400 and 2000 mg/kg/day to groups of 22-24 male mice for 9 weeks prior to and including mating and to groups of 23-24 females for 2 weeks before mating and through Day 6 of gestation. Under these conditions the copulation and conception rate in the treated groups were comparable to those in the control.

Treated groups did not differ from controls in the number of corpora lutea, resorptions and live and dead fetuses. Body and placental weights, crown-rump lengths and sex ratio of the live fetuses from treated females corresponded with those found in the control group. The live fetuses at each dosage level showed no external, visceral or skeletal abnormalities considered to be related to the administration of the compound.

In a similar study done in rats with 20-25 animals/ sex/ group, cefotaxime at doses of 0, 40, 100 or 250 mg/kg/day did not alter the sexual behavior and reproductive function of the parents (F₀) or of the F1 offspring.

Peri and Postnatal Behavior

Two perinatal and postnatal studies were conducted with cefotaxime in 104 mated rats. In the first study, dosage levels of 150, 300 and 600 mg/kg were administered by intravenous injection twice daily at a minimum of 6 hours apart beginning on the 15th day of gestation and continuing throughout gestation and lactation.

No effects attributable to treatment with cefotaxime were observed on maternal appearance, behavior, survival, fertility, length of gestation or number of live and non-viable pups. Maternal body weights were comparable during the gestation and lactation periods for cefotaxime-treated groups and the control groups with the exception of slightly reduced body weight gains in the 1200 mg/kg/day treated rats during the first 5 days of treatment and Days 12 through 21 of lactation. Reduced mean pup body weights were noted in this group at birth through weaning. No other biologically meaningful effects were noted from intravenous injections of cefotaxime at 1200 mg/kg/day or less during the later portion of gestation through weaning.

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Under a similar protocol, cefotaxime was given intramuscularly at doses of 0, 40, 100 or 250 mg/kg/day. At these doses, no effects of cefotaxime were observed on the peri and postnatal behaviour of the mothers and the general condition and viability of the offspring.

Teratology

Cefotaxime was given intravenously at doses of 300, 600 and 1200 mg/kg/day to groups of 20-23 pregnant mice, and to pregnant rats intravenously (300, 600 and 1200 mg/kg/day) or intramuscularly (40, 95 or 210 mg/kg/day) from Day 6 through Day 15 or 18 of gestation. No findings indicative of a compound-related teratogenic effect were noted in any of the fetuses at necropsy or during the visceral and skeletal examinations. On the basis of these studies, cefotaxime was not considered embryotoxic or teratogenic when administered parenterally in

mice and rats at levels up to 1200 mg/kg/day.

The teratogenic effect of cefotaxime was further studied in pregnant rabbits treated intramuscularly with daily doses of 25, 50 and 90 mg/kg for sequential periods of 4-7 days throughout the phase of embryogenesis. Maternal toxicity and embryotoxicity were recorded in groups dosed with 50 mg/kg and higher. Lower fetal weights were recorded in the groups dosed with 90 mg/kg/day and a few malformations or simple abnormalities appeared in all groups, including the controls. Rabbits are particularly sensitive to cephalosporins in general and are therefore inappropriate to test the reproductive and teratogenic effects of these compounds.

Mutagenicity

Possible mutagenic effects of cefotaxime were investigated using the micronucleus test in mice and the Ames test in bacterial strains. No mutagenicity could be attributed to cefotaxime using these two standard methods.

Carcinogenicity

Long-term studies in animals have not been performed to evaluate the carcinogenic potential of cefotaxime.

Nephrotoxicity

The potential nephrotoxicity of cefotaxime was compared with that of cephaloridine and cephalothin in rabbits (2 males and 2 females per group) when given daily intramuscular doses of 220, 200 and 190 mg/kg, respectively for 7 consecutive days. The 3 antibiotics induced emaciation in some animals and death of one rabbit in each treated group. Only in the animals treated with cephaloridine did the histological examination reveal tubular necrosis. No morphological substance-induced organ changes were detected in the rabbits treated with cefotaxime or cephalothin.

A potent diuretic agent, furosemide, has been shown to enhance the nephrotoxicity of

cephaloridine in animals. Studies were conducted in mice and rats to evaluate the effect of a single parenteral dose of 20 mg/kg furosemide given 15 minutes before the injection of cefotaxime on renal function and renal histology. Cefotaxime concentrations were 2000 and 4000 mg/kg in mice and 2500 and 5000 mg/kg in rats. Microscopic examination of the kidneys revealed some dilated tubules in the cortex and the medulla and some hyalin casts in control and all treated groups regardless of furosemide administration.

The nephrotoxicity of the combined administration of cefotaxime (1000 mg/kg/day IV) with gentamicin (30 mg/kg/day IM) or furosemide (100 mg/kg/day PO) was studied in groups of 16 female rats for 28 consecutive days. Single treatments with each drug, alone or in combination with cefotaxime produced neither death nor abnormalities in behavior or appearance, nor did they affect body weight gain and food consumption. Main histopathological findings were: occurrence of eosin-positive material (slight degeneration) in the epithelial cells of the proximal convoluted tubules, considered to be due to a change in the lysosomes, in the group given cefotaxime alone; interstitial inflammation and slight focal necrosis in the proximal tubules in rats injected only with gentamicin; and calcification of the distal convoluted tubules in animals administered furosemide alone. The concurrent administration of cefotaxime with gentamicin or furosemide produced combinations of the above described changes, each of which was not enhanced either in incidence or in extent.

Tolerance studies

The local intravenous tolerance of cefotaxime was investigated in rats and dogs. Rats (15 animals/sex/group) injected intravenously in the caudal vein daily for 30 days with cefotaxime at doses of 125, 500 and 1000 mg/kg in physiological saline and those being used as controls showed a slight but dose-related degeneration of the epidermis, hemorrhage, perifollicular edema and inflammatory cell infiltration of the dermis and subcutaneous tissues. In dogs, however, the intravenous tolerance was not dose-related and did not differ from that of controls. The minimal lesions observed at the injection sites following a 13 week administration of 0 to 1500 mg/kg/day were interpreted as being caused by the trauma of repeated intravenous

injections rather than by cefotaxime itself.

The local intramuscular tolerance of cefotaxime was compared with that of cephaloridine in 2 groups of 10 male rats given a single injection of 100 mcg per rat. Cefotaxime caused only minor and transient local tissue damage - necrotic areas, fragmentation of muscle fibers and inflammation - while similar doses of cephaloridine produced more severe and persistent damage.

The local intramuscular tolerance of 1000 mg/kg cefotaxime was further investigated in groups of 3 male and 3 female rabbits when given in a single injection with or without 1% lidocaine. One rabbit of each group died of diarrhea and no substance-induced organ lesions were observed at the end of a 3 week follow-up period. This study showed that the tolerance to 1000 mg/kg cefotaxime in rabbits was not affected by administration in a 1% lidocaine solution.

The sub-occipital tolerance of cefotaxime was also compared with that of cephaloridine when given as a single sub-occipital injection to groups of 10 rats at doses ranging from 2.5 to 19 mg/kg. Doses of 2.5 and 5 mg/kg cephaloridine and 19 mg/kg cefotaxime caused prostration, respiratory impairment, hyperventilation, tremors, and convulsions. At each of these dosage levels, 40-60% of animals per group died a few minutes following the injections. Doses of 2.5, 5 and 9.5 mg/kg cefotaxime and 1.25 mg/kg cephaloridine were satisfactorily tolerated.

To investigate the intrathecal tolerance, 50 mg cefotaxime was administered as a single dose through the foramen magnum to 2 male and 2 female beagles. All dogs treated with cefotaxime showed slight tetanoid convulsions for about 1 hour towards the end of anesthesia. Histological examinations did not reveal any compound-related impairment of the CNS, the spinal cord and meninges.

The renal tolerance of cefotaxime was further compared with that of cephaloridine in groups of 2 male and 2 female beagle dogs when given as a single 1000 mg/kg intravenous injection. In

contrast to cephaloridine, cefotaxime caused only a slight and transient reduction of PAH clearance. Creatinine clearance remained unchanged and the urinary output was not disturbed at any time.

Combination LD₅₀ Study

The toxicity of combinations of cefotaxime and gentamicin when studied in rats did not appear very different from the toxicities exhibited by the individual components.

BIBLIOGRAPHY

1. Acar JF, Husson JM, Guibert J, et al. HR756 pharmacokinetics. Preliminary therapeutic results in severe human infections. Presented at the 18th Interscience Conference on Antimicrobial Agents and Chemotherapy: Atlanta, Ga. Oct. 1-4, 1978.
2. Adam D, Schlakhauser. The diffusion of cefotaxime in different tissues of the urogenital tract. *Infection* 1980; 8 (suppl 3): S327-28.
3. Asmar BI, Thirumoorthi MC, Buckley JA, Kobos DM, Dajani AS. Cefotaxime diffusion into cerebrospinal fluid of children with meningitis. *Antimicrobial Agents and Chemotherapy* 1985; 28: 138-40.
4. Bauer AW, Kirby WMM, Sherris JC, Turck M. Antibiotic susceptibility testing by a standardized single disc method. *Am J Clin Pathol* 1966; 45: 493. Standardized Disc Susceptibility Test, Federal Register, 39:198182-84. Approved Standard: ASM-2, Performance Standards for Antimicrobial Disc Susceptibility Tests, July 1975.
5. Bax R, White L, Reeves D, et al. Pharmacokinetics of cefotaxime and its desacetyl metabolite. In: *Curr Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy, 1980; I:155-7.*
6. Belohradsky BH, Geiss D, Marget W, et al. Intravenous cefotaxime in children with bacterial meningitis. *Lancet* 1980; 1(8159): 61-3.
7. Bernard C, Coppens L, Mombelli G, et al. Bactericidal activity of serum in volunteers receiving cefotaxime (HR756) with or without amikacin. In: *Curr Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy, 1980 I:140-1.*
8. Brisou B, Duvallon PP, Lepers JP, et al. Clinical study and in vitro activity on *Neisseria gonorrhoeae* on a new cephalosporin. RU24756. *Med Mal Infect* 1979; 4:256-61.
9. Brown W. Cefotaxime for bacterial meningitis. *Lancet* 1979; 1(June 9):1246.
10. Chabbert YA, Lutz AJ. HR756 the syn isomer of a new methoxyimino cephalosporin with unusual antibacterial activity. *Antimicrobial Agents and Chemotherapy* 1978; 14:749-54.
11. Childs SJ. Antibiotic prophylaxis in genitourinary surgery. *Clinical Therapeutics*. 1981; (suppl A):111-23.
12. Clumeck N, Van Hoof R, Van Laethem Y, et al. Therapeutic effectiveness and

- pharmacokinetic results of cefotaxime (HR756) in human infections due to multiresistant bacteria. In: *Curr Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy*, 1980; I:122.
13. Clumeck N, Van Hoof R, Van Laethem Y, et al. Cefotaxime and nephrotoxicity. *Lancet* 1979;1(8120):835.
 14. Daikos GK, Kosmidis J, Giamerellou H et al. Clinical bacteriological and pharmacokinetic results with HR756, a new b-lactamase resistant cephalosporin. Presented at the 18th Interscience Conference on Antimicrobial Agents and Chemotherapy. Atlanta, Ga. Oct.1-4, 1978.
 15. Esmieu F, Guibert J, Rosenkilke HC, Ho I, LeGo A. Pharmacokinetics of cefotaxime in normal human volunteers. *Journal of Antimicrobial Chemotherapy* 1980 (suppl A); 6:83-92.
 16. Feldstein TJ, Uden DL, Larson TA. Cefotaxime for treatment of Gram-negative bacterial meningitis in infants and children. *Pediatr Infect Dis J* 1987; 6:471-5.
 17. Fu KP, Aswapokee P, Ho I, et al.: Pharmacokinetics of cefotaxime. *Antimicrobial Agents and Chemotherapy* 1979; 16:592-7.
 18. Geyer J, Höffler D, Demers HG et al. Cephalosporin induced encephalopathy in uremic patients. *Nephron*. 1988 ;48:237.
 19. Grassi GG, Dionigi R, Ferrara A, et al. Penetration of HR756 (cefotaxime) in lung tissue and bronchial secretions. In: *Curr Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy*, 1980; 1:120-1.
 20. Hanninen P, Toivanen P. HR756. A new cephalosporin derivative. A clinical trial. Presented at the 18th Interscience Conference on Antimicrobial Agents and Chemotherapy. Atlanta, Ga. Oct. 1-4, 1978.
 21. Hargreave TB, Hindmarsh JR, Elton R, et al. Short-term prophylaxis with cefotaxime for prostatic surgery. *Br Med J* 1982; 284:1008-10.
 22. Helwig HF. Cefotaxime in pediatrics. In: *Curr Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy*, 1980; 1:128-9.

23. Ho I, Aswapokee P, Fu KP, et al: Pharmacokinetic parameters of cefotaxime after intravenous and intramuscular administration of single and multiple doses. In: Curr Chemo and Infect Dis Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy, 1980;I :116-8.
24. Hubrechts JM, Van Hoof R, Denolf R, et al. Treatment of uncomplicated gonorrhea with cefotaxime. In: Curr Chemo and Infect Dis. Proceedings of the 11th International congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy, 1980; 11:1269-70.
25. Jacobs RF, Wells TG, Steele RW, Yamauchi T. A prospective randomized comparison of cefotaxime vs ampicillin and chloramphenicol for bacterial meningitis in children. Pediatrics 1985; 107:129-33.
26. Just M, Langmack H, Steffens A, et al. Synergy studies of piperacillin, HR756 and cefsulodin in combination with aminoglycosides against nosocomial non-fermenting organisms. Presented at the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy. Boston, Mass. Oct. 1-5, 1979.
27. Kafetzis DA, Kanarios J, Sinaniotis CA, et al. Clinical and pharmacokinetic study of cefotaxime (HR756) in infants and children. In: Curr Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy, 1980; I:134-7.
28. Kemmerich B, Lode H, Gruhlke G, et al. Clinical pharmacology of cefotaxime in bronchopulmonary infections. In: Curr Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy, 1980; I:130-2.
29. Leroy A, Esmieu A, Fillastre JP, et al. The cephalosporin HR756: pharmacokinetics in healthy adult volunteers and in patients with chronic renal failure. Drugs Exptl Clin Res 1979; 5 (2- 3):3743.
30. Lode H, Gruhlke G, Hallermann W, et al. Significance of pleural and sputum concentrations for antibiotic therapy of bronchopulmonary infections. Infections 1980; 8 (suppl 1):849-53.
31. Louie TJ, Binns BAO, Baskett TF, Ross J and Koss J. Cefotaxime, cefazolin, or ampicillin prophylaxis of febrile morbidity in emergency caesarian sections. Clinical Therapeutics 1982; 5 (suppl A):83-96.

32. Luthy R, Munch R, Blaser J, et al. Human pharmacology of cefotaxime (HR756). *Antimicrobial Agents and Chemotherapy* 1979; 16:127-33.
33. Marget W, Belohradsky B, Roos R. Effect of revised drug schedules with the cephalosporin HR756 on the treatment of severe infections. Presented at the 18th Interscience Conference on Antimicrobial Agents with Chemotherapy. Atlanta, Ga. Oct. 1-4, 1978.
34. McKendrick MW, Geddes AM, Wise R. Clinical experience with cefotaxime (HR756). In: *Curr Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy*, 1980; I:123-5.
35. Mintz L, and Drew WL: Comparative synergistic activity of cefoperazone, cefotaxime, moxalactam and carbenicillin, combined with tobramycin, against *Pseudomonas aeruginosa*. *Antimicrobial Agents and Chemotherapy* 1981; 19:332-4.
36. Mondorf AW. Nephrotoxicity of cefotaxime. *Lancet* 1979; 2(8146):799.
37. Neu HC, Aswapokee P, Fu KP, Ho I, Matthijssen C. Cefotaxime kinetics after intravenous and intramuscular injection of single and multiple doses. *Clin Pharmacol Ther* 1980; 27:677-85.
38. Neu HC, Aswapokee N, Aswapokee P, et al. HR756, a new cephalosporin active against Gram-positive and Gram-negative aerobic and anaerobic bacteria. *Antimicrobial Agents and Chemotherapy* 1979; 15:273-81.
39. Neu HC, Aswapokee N, Fu KP, Aswapokee P. Antibacterial activity of a new 1-oxa cephalosporin compared with that of other b-lactam compounds. *Antimicrobial Agents and Chemotherapy* 1979; 16:141-9.
40. Newsom SWB, Mathews J, Connellan SJ, et al. Clinical studies with cefotaxime. In: *Curr Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy*, 1980; I:125-6.
41. Ninane G: Cefotaxime (HR756) and nephrotoxicity. *Lancet* 1979; 1 (8111):332.
42. Papathanassiou B, Kosmidis J, Stathakis C, et al. Penetration of two new cephalosporins, cefuroxime and cefotaxime in bone. In: *Curr Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy*, 1980; I: 666-7.

43. Pils P, Schmidt P, Zazgornik J, et al. Azlocillin and HR756 in urosepsis and urinary tract infection with multiresistant *Pseudomonas* and *Proteus morganii*. *Dtsch Med Wochenschr* 1979; 104:6-7.
44. Regamey C, Lavanchy A. In vitro pharmacokinetic and clinical evaluation of cefotaxime. In: *Curr. Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and 9th Interscience Conference on Antimicrobial Agents and Chemotherapy*, 1980; I:126-8.
45. Reynolds V, Oates JK, Newsom SWB. Pre-pubertal gonococcal vulvovaginitis: a penicillin-resistant infection treated with cefotaxime. *Lancet* 1979; 2(8135):206-7.
46. Rimmer DMD. Cefotaxime in the treatment of septicemia. In: *Curr Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy*, 1980; I:132-3.
47. Rosin H, Uphaus W. Evaluation of so-called bone levels for instance for cefotaxime (HR756) concentrations in bone under critical conditions. *Curr Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy*, 1980; I:148-50.
48. Shah PM, Helm EB, Stille W. Clinical experience with cefotaxime, a new cephalosporin derivative. *Med Welt* 1979; 20 (8):298-301.
49. Slack RCB, Bittiner JB, Finch R. Treatment of gonorrhoea caused by b-lactamase producing strain of *Neisseria gonorrhoea* with cefotaxime. *Lancet* 1980; I(8165): 431-2.
50. Spitzky KH, Graninger W, Pichler H, et al. Cephalosporin HR756 in clinical multiresistant isolates and its use in chronic infections. Presented at the 18th Interscience Conference on Antimicrobial Agents and Chemotherapy. Atlanta, Ga. Oct. 1-4, 1978.
51. Spyridis P, Sinaniotis CA, Kafetis DA, et al. Urinary N-acetyl-b-D-glucosaminidase activity in children receiving aminoglycosides, cephalosporins and methicillin. Presented at the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy. Boston, Mass. Oct. 1- 5, 1979.
52. Usuda Y, Sekine O, Aoki N, et al. Serum and urine levels of cefotaxime (HR756) and desacetylcefotaxime in patients with various degrees of renal function. In: *Curr Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference of Antimicrobial Agents and Chemotherapy*, 1980; I:137-40.

53. Weise M, Jacques G, Keller M, et al: Urinary excretion of b2-microglobulin and other proteins after application of cephalosporins, aminoglycosides and their combination. In: Curr Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy, 1980; I:618-20.
54. Wittmann DH, Schassan HH, Freitag V. Pharmacokinetic studies and results of a clinical trial with cefotaxime (HR756) In: Curr Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy, 1980; I:114-6
55. Wittmann DH, Schassan HH, Welter J, et al. Availability of cefotaxime. Pharmacokinetic studies on the distribution in central and various peripheral compartments. Much Med Wochenschrift 1980; 122:637.
56. Wright N, Wise R. Cefotaxime elimination in patients with renal and liver dysfunction. In: Curr Chemo and Infect Dis. Proceedings of the 11th International Congress of Chemotherapy and the 19th Interscience Conference on Antimicrobial Agents and Chemotherapy, 1980; I:133-4.
57. Claforan® Product Monograph. Sanofi-aventis Canada Inc., Control Number: 176886 November 12, 2014.