PRODUCT MONOGRAPH

INCLUDING PATIENT MEDICATION INFORMATION

Pr SULFATRIM

Sulfamethoxazole and Trimethoprim Tablets USP

400 mg sulfamethoxazole and 80 mg trimethoprim

Pr SULFATRIM DS

Sulfamethoxazole and Trimethoprim Tablets USP

800 mg sulfamethoxazole and 160 mg trimethoprim

Pr SULFATRIM PEDIATRIC

Sulfamethoxazole and Trimethoprim Tablets USP

100 mg sulfamethoxazole and 20 mg trimethoprim

Antibacterial Agent
ATC J01EE01

AA PHARMA INC.
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Road, Unit #1
Vaughan, Ontario
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Date of Initial Authorization:
December 31, 1979

Date of Revision:
July 28, 2023

Control No.: 273861

RECENT MAJOR LABEL CHANGES

Indications (1)	03/2020
Contraindications (2)	03/2020
Serious Warnings and Precautions Box (3)	11/2021
Dosage and Administration (4)	03/2020
Warnings and Precautions (7)	07/2023

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PART I: HEALTH PROFESSIONAL INFORMATION

1 INDICATIONS

SULFATRIM (sulfamethoxazole and trimethoprim) has been effective in the treatment of infections associated with the following gram-positive and gram-negative organisms:

Gram-Negative Organisms
Haemophilus influenzae
Neisseria gonorrhoeae
Escherichia coli
Klebsiella species
Enterobacter (Aerobacter) aerogenes
Proteus mirabilis
Proteus vulgaris
Salmonella species
Shigella species
Vibrio cholerae

Gram-Positive Organisms
Streptococcus pyogenes
Streptococcus viridans
Staphylococcus albus
Staphylococcus aureus
Diplococcus pneumoniae

Other Organisms
Brucella melitensis
Nocardia asteroides
Nocardia brasiliensis
Paracoccidioides brasiliensis
Pneumocystis jiroveci
Streptomyces somaliensis

Sensitivity tests should be performed wherever possible to determine choice of therapy. These tests should be repeated if there is a failure to respond, relapse or early recurrence.

SULFATRIM may be indicated for the following infections when caused by susceptible strains of the above organisms.

Urinary Tract Infections:
Treatment of acute uncomplicated urinary tract infections*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.

Upper and Lower Respiratory Tract Infections:
Treatment of acute exacerbations of chronic bronchitis.

Treatment of *Pneumocystis jiroveci* pneumonia*. SULFATRIM is also indicated in the treatment of infants and children with a diagnosis of *Pneumocystis jiroveci* pneumonitis, especially if they are immunosuppressed.

Gastrointestinal Tract Infections:
Treatment of cholera, as an adjunct to fluid and electrolyte replacement, when the organism has been shown to be sensitive *in vitro*.
Treatment of bacilliary dysentry*.

Other Infections:
Treatment of nocardiosis*. - Brucellosis (second line therapy), when used in combination with gentamicin or rifampicin.

SULFATRIM is not indicated in infections associated with Pseudomonas, Mycoplasma, nor when the infection is caused by a virus.

This drug has not yet been fully evaluated in streptococcal infections.

Sulfamethoxazole and trimethoprim has been investigated clinically in these indications.

To reduce the development of drug-resistant bacteria and maintain the effectiveness of SULFATRIM and other antibacterial drugs, SULFATRIM should be used only to treat infections that are proven or strongly suspected to be caused by susceptible bacteria. When culture and susceptibility information are available, they should be considered in selecting or modifying antibacterial therapy. In the absence of such data, local epidemiology and susceptibility patterns may contribute to the empiric selection of therapy.

1.1 Pediatrics

Pediatrics: SULFATRIM is not recommended for pediatric patients younger than 2 months of age (see Contraindications).

1.2 Geriatrics

Geriatrics: SULFATRIM is approved for use in geriatrics population, however, there may be an increased risk of severe adverse reactions in elderly patients, particularly when complicating conditions exist (see Warnings and Precautions and Adverse Reactions). Appropriate dosage adjustments should be made (see Dosage and Administration).

2 CONTRAINDICATIONS

SULFATRIM is contraindicated in patients who are hypersensitive to this drug or to any ingredient in the formulation, including any non-medicinal ingredient, or component of the container. For a complete listing, see Dosage Forms, Strengths, Composition and Packaging.

SULFATRIM is contraindicated in patients with a history of drug-induced immune thrombocytopenia, with use of trimethoprim and/or sulfonamides, and in patients with documented megaloblastic anemia due to folate deficiency, evidence of marked parenchymal damage, or blood dyscrasias.

SULFATRIM is contraindicated in patients with marked renal impairment where repeated measurements monitoring plasma drug concentrations cannot be performed (see also Warnings and Precautions).

SULFATRIM is contraindicated in pregnant patients and in nursing mothers, because sulfonamides pass the placenta and are excreted in the milk and may cause kernicterus.

SULFATRIM is contraindicated in premature babies and full term infants less than two months of age.

SULFATRIM should not be given to patients with acute porphyria.

3 SERIOUS WARNINGS AND PRECAUTIONS BOX

Serious Warnings and Precautions

- SULFATRIM can cause severe skin reactions that may be life threatening. These include Steven-Johnson syndrome and toxic epidermal necrolysis or drug reaction with eosinophilia and systemic symptoms (DRESS). Symptoms include: flat red rash, blisters, peeling skin, fever, body aches. They also include blisters and sores or ulcers on your mucous membranes (mouth, nose and genitals). Eyes may get red and swollen. If patients experience any of these symptoms, the treatment with SULFATRIM should be immediately stopped.
- SULFATRIM can cause a liver disease called fulminant hepatic necrosis that may be life-threatening. Symptoms include yellowing of the skin and whites of the eyes (jaundice), pain in your upper right abdomen, swelling of the abdomen, nausea (feeling sick) and vomiting (being sick). If patients experience any of these symptoms, the treatment with SULFATRIM should be immediately stopped.
- SULFATRIM can cause a blood condition called agranulocytosis, where the number of white cells in the blood becomes dangerously low. Symptoms of this can include sudden fever, chills, a sore throat, feeling weak. Patients can also experience fast heart rate or fast breathing. If patients experience any of these symptoms, the treatment with SULFATRIM should be immediately stopped.
- SULFATRIM can cause aplastic anemia, where the bone marrow is unable to make enough blood cells from being damaged. Symptoms of this can include feeling tired, feeling short of breath, pale skin, unexplained or easy bruising, fever, chills, sore throat, and a general feeling of being unwell. If patients experience any of these symptoms, the treatment with SULFATRIM should be immediately stopped.
- SULFATRIM can cause immune thrombocytopenia, which can be life-threatening. Symptoms of this include being easily bruised, a rash on the skin that appears tiny pinpoint-sized reddish or purple spots, usually on the lower legs, bleeding from the gums or nose, and blood in the urine or stool. If patients experience any of these symptoms, the treatment with SULFATRIM should be immediately stopped.
- SULFATRIM can cause an allergic reaction in the lungs and in the airways, where the airways can close up and make breathing difficult, and can be life-threatening if the person does not get medical help. Symptoms include difficulty breathing, coughing, wheezing, and a feeling of tightness in the chest. If patients experience any of these symptoms, the treatment with SULFATRIM should be immediately stopped.

4 DOSAGE AND ADMINISTRATION

4.2 Recommended Dose and Dosage Adjustment

INDICATION	DOSAGE*		DURATION OF THERAPY
	Adults & Children over 12 years # of tablets	Children under 12 years mg/kg	
Bacterial Infections	2 SULFATRIM tablets or 1 SULFATRIM DS tablet b.i.d.	15 mg SMZ/kg & 3 mg TMP/kg b.i.d.	At least 5 days or until patient is asymptomatic for 48 hours.
Severe Bacterial Infections	3 SULFATRIM tablet s or 1 1/2 SULFATRIM DS tablet b.i.d.		Urinary infections until the urine becomes sterile.
Prophylaxis and Salmonella Carriers	1 SULFATRIM and tablet or 1/2 SULFATRIM DS tablet b.i.d.		Acute Salmonellosis: at least 7 days after defervescence. Salmonella Carriers: until repeated stool cultures are negative
Uncomplicated Gonorrhea	2 SULFATRIM tablets or 1 SULFATRIM DS tablet q.i.d.		Two days.
Pneumocystis Carinii Pneumonitis	25 mg SMZ/kg & 5 mg TMP/kg q.i.d.		At least 14 days.
* SMZ = sulfamethoxazole TMP = trimethoprim			

For Patients with Impaired Renal Function:

When renal function is impaired, a reduced dosage should be employed using the following table:

Creatinine Clearance (mL/s)	**Recommended Dose Regimen**
Above 0.5 (30 mL/min.) 0.25-0.5 (15-30 mL/min.) Below 0.25 (15 mL/min.)	Usual standard regimen 1/2 the usual regimen Use not recommended

When only serum creatinine levels are known, the following formulae may be used to estimate creatinine clearance. The serum creatinine must represent a steady state of renal function:

Males: Creatinine clearance (mL/s) = or Creatinine clearance (mL/min.) =	 $\frac{\text{Weight (kg) x (140 – age)}}{\text{49 x serum creatinine (mcmol/L)}}$ $\frac{\text{Weight (kg) x (140 – age)}}{\text{72 x serum creatinine (mg/dL)}}$
Females:	85 x above value.

Serious Systemic Infections

Children:

The recommended daily dosage for children is 5 to 10 mg trimethoprim/kg body weight/day and 25 to 50 mg sulfamethoxazole/kg body weight/day.

Treatment should be continued until the patient has been symptom free for two days; the majority will require treatment for at least five days.

Other diseases, including certain tropical diseases rarely seen in Canada have also been successfully treated with sulfamethoxazole and trimethoprim. The duration of treatment is as follows:

Disease	**Duration**
Cholera	7 days
Nocardiosis	12 weeks
Brucellosis	2 weeks to 3 months

Pneumocystis jiroveci Pneumonitis

Children and Adults

Therapy should be continued for a total treatment period of at least two weeks. The aim is to obtain peak plasma or serum levels of trimethoprim of greater than or equal to 5 micrograms/mL (see Adverse Reactions)

5 OVERDOSAGE

Symptoms and Treatment

Acute

The amount of a single dose of sulfamethoxazole and trimethoprim that is either associated with symptoms of overdosage or is likely to be life-threatening has not been reported. Signs and symptoms of overdosage reported with sulfonamides include anorexia, colic, nausea, vomiting,

dizziness, headache, drowsiness, and unconsciousness. Pyrexia, hematuria, and crystalluria may be noted. Blood dyscrasias and jaundice are potential late manifestations of overdosage. Signs of acute overdosage with trimethoprim include nausea, vomiting, dizziness, headache, mental depression, confusion, and bone marrow depression.

General principles of treatment include the forcing oral fluids; and the administration of intravenous fluids if urine output is low and renal function is normal. Acidification of the urine will increase renal elimination of trimethoprim. Inducing diuresis plus alkalinisation of urine will enhance the elimination of sulfamethoxazole. Alkalinisation will reduce the rate of elimination of trimethoprim. The patient should be monitored with blood counts and appropriate blood chemistries, including electrolytes. If a significant blood dyscrasia or jaundice occurs, specific therapy should be instituted for these complications. Peritoneal dialysis is not effective and hemodialysis is only moderately effective in eliminating trimethoprim and sulfamethoxazole.

There is no known antidote for sulfonamide poisoning; however, calcium folinate (leucovorin), 3 to 6 mg I.M. for 5 to 7 days, is an effective antidote for adverse effects in the hemopoietic system caused by trimethoprim.

Chronic

Use of SULFATRIM at high doses and/or for extended periods of time may cause confusion and bone marrow depression manifested as thrombocytopenia, leukopenia, and/or megaloblastic anemia. If signs of bone marrow depression occur, the patient should be given leucovorin; 5 to 15 mg leucovorin daily has been recommended by some investigators.

For management of a suspected drug overdose, contact your regional poison control centre.

6 DOSAGE FORMS, STRENGTHS, COMPOSITION AND PACKAGING

Table – Dosage Forms, Strengths, Composition and Packaging.

SULFATRIM Tablets: Each white, round tablet, one side convex, other side FFBE, scored and engraved APO over 400-80 on the convex side, and other side plain contains 400 mg sulfamethoxazole USP and 80 mg trimethoprim USP. Available in bottles of 100.

SULFATRIM DS Tablets: Each white, capsule-shaped, biconvex tablet, partially bisected and engraved APO-DS on one side, and other side plain contains 800 mg sulfamethoxazole USP and 160 mg trimethoprim USP. Available in bottles of 500.

SULFATRIM Pediatric Tablets: Each white, round, flat-faced beveled edge tablet scored and engraved APO over PED one side, other side plain, contains 100 mg sulfamethoxazole USP and 20 mg trimethoprim USP. Available in bottles of 100.

Composition

Each SULFATRIM Tablet contains sulfamethoxazole, trimethoprim, and the following non-medicinal ingredients: colloidal silicon dioxide, croscarmellose sodium, magnesium stearate and methylcellulose.

7 WARNINGS AND PRECAUTIONS

General

SULFATRIM should only be used where, in the judgement of the physician, the benefit of treatment outweighs any possible risks; consideration should be given to the use of a single effective antibacterial agent.

Life threatening adverse reaction

Fatalities associated with the administration of sulfonamides and sulfamethoxazole and trimethoprim although rare, have occurred due to severe reactions, including Stevens-Johnson syndrome, toxic epidermal necrolysis, fulminant hepatic necrosis, agranulocytosis, immune thrombocytopenia, aplastic anemia, other blood dyscrasias, and hypersensitivity of the respiratory tract.

- Life-threatening cutaneous reactions Stevens-Johnson Syndrome (SJS), and toxic epidermal necrolysis (TEN) and drug reaction with eosinophilia and systemic symptoms (DRESS) have been reported with the use of trimethoprim-sulfamethoxazole.
- Patients should be advised of the signs and symptoms and monitored closely for skin reactions. The highest risk for occurrence of SJS or TEN is within the first weeks of treatment and of DRESS is within the first two to eight weeks after drug administration.
- If symptoms or signs of SJS TEN (e.g., progressive skin rash often with blisters or mucosal lesions) or DRESS (e.g., fever, eosinophilia) are present, trimethoprim-sulfamethoxazole treatment should be discontinued.
- The best results in managing SJS, TEN or DRESS come from early diagnosis and immediate discontinuation of any suspect drug. Early withdrawal is associated with a better prognosis.
- If the patient has developed SJS, TEN or DRESS with the use of trimethoprim-sulfamethoxazole, trimethoprim-sulfamethoxazole must not be re-started in this patient at any time.

Folate

Regular monthly blood counts are advisable when trimethoprim-sulfamethoxazole is given for long periods, or to folate deficient patients or to the elderly, since there exists a possibility of asymptomatic changes in haematological laboratory indices due to lack of available folate. Supplementation with folinic acid may be considered during treatment but this should be initiated with caution due to possible interference with antimicrobial efficacy (see *Interactions*). Changes indicative of folic acid impairment have, in certain specific situations, been reversed by folinic acid therapy.

Treatment of streptococcal pharyngitis due to Group A beta-haemolytic streptococci

SULFATRIM should not be used in the treatment of streptococcal pharyngitis. Clinical studies have documented that patients with group A β-hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with sulfamethoxazole and trimethoprim than to those patients treated with penicillin, as evidenced by failure to eradicate this organism from the tonsillopharyngeal area.

SULFATRIM should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency (e.g., the elderly, chronic alcoholics, rheumatoid arthritics, patients receiving anticonvulsant therapy, patients with malabsorption syndrome, and patients in malnutrition states), and to those with severe allergy or bronchial asthma.

Patients with glucose-6-phosphate dehydrogenase deficiency

In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related.

Patients with or at risk of acute porphyria

The administration of SULFATRIM to patients known or suspected to be at risk of acute porphyria should be avoided. Both trimethoprim and sulfonamides (although not specifically sulfamethoxazole) have been associated with clinical exacerbation of acute porphyria.

Patients with gastrointestinal tract infection

Clinicians should be aware that first line therapy in the management of all patients with diarrheal disease is the maintenance of adequate hydration.

Patients with hyperkalaemia and hyponatraemia

Caution should be exercised in administering trimethoprim to patients at risk of hyperkalemia and hyponatremia. Serum potassium and sodium and renal function should be closely monitored, and dosage should be adjusted for renal function (see Warnings and Precautions, Renal and Dosage and Administration).

The risk factors for hyperkalemia are high trimethoprim dosage (20 mg/kg/day), renal insufficiency (serum creatinine ≥ 1.2 mg/dl), hypoaldosteronism, older age, dietary potassium and other drugs that impair potassium excretion. The likely mechanism is via trimethoprim inhibition of sodium channels in the distal nephron, similar to that of the potassium-sparing diuretic amiloride.

Hyperkalemia is generally reversible on discontinuation of trimethoprim. In patients presented with hyperkalemia due to SULFATRIM, SULFATRIM can be discontinued and appropriate standard potassium-lowering therapy instituted.

Patients with serious haematological disorders

Except under careful supervision trimethoprim-sulfamethoxazole should not be given to patients with serious hematological disorders (see Adverse Reactions).

Functional inhibition of the renal tubular secretion of creatinine may produce a spurious fall in the estimated rate of creatinine clearance.

SULFATRIM may affect the results of thyroid function tests.

The possibility of superinfection with a non-sensitive organism should be borne in mind.

Fluid overload

Fluid Overload is possible, especially when very high doses are being administered to patients with underlying cardio-pulmonary disease.

Urinary output

An adequate urinary output should be maintained at all times. Evidence of crystalluria in vivo is rare, although sulfonamide crystals have been noted in cooled urine from treated patients. In patients suffering from hypoalbuminaemia the risk may be increased.

Driving and Operating Machinery

Due caution should be exercised when driving or operating a vehicle or potentially dangerous machinery.

Endocrine and Metabolism

Metabolic acidosis

Trimethoprim-sulfamethoxazole has been associated with metabolic acidosis when other possible underlying causes have been excluded. Close monitoring is always advisable when metabolic acidosis is suspected.

Gastrointestinal

Clostridium difficile – Associated Disease (CDAD)
Clostridium difficile-associated disease (CDAD) has been reported with use of many antibacterial agents, including sulfamethoxazole and trimethoprim. 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 *C. 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 the 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 *C. 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 *C. difficile*. Surgical evaluation should be instituted as clinically indicated, as surgical intervention may be required in certain severe cases (see Adverse Reactions).

Immune

Use in the Treatment of and Prophylaxis for Pneumocystis jiroveci Pneumonia in Patients with Acquired Immunodeficiency Syndrome (AIDS):

The incidence of side effects, particularly rash, severe hypersensitivity reactions, fever, leukopenia, neutropenia, thrombocytopenia and elevated aminotransferase (transaminase) values in AIDS patients who are being treated with sulfamethoxazole and trimethoprim for Pneumocystis jiroveci pneumonia (PJP) has been reported to be greatly increased compared with the incidence normally associated with the use of sulfamethoxazole and trimethoprim in non-AIDS patients. If signs of bone marrow depression occur, the patient should be given calcium folinate supplementation (5-10 mg/day). The incidence of hyperkalemia and hyponatremia appears to be increased in AIDS patients receiving sulfamethoxazole and trimethoprim. Adverse effects are generally less severe in patients receiving sulfamethoxazole and trimethoprim for prophylaxis. A history of mild intolerance to sulfamethoxazole and trimethoprim in AIDS patients does not appear to predict intolerance of subsequent secondary prophylaxis. However, if a patient develops skin rash or any sign of adverse reaction, therapy with SULFATRIM should be re-evaluated (see Warnings and Precautions). Rhabdomyolysis has been reported in HIV positive patients receiving trimethoprim-sulfamethoxazole for prophylaxis or treatment of PJP. In some cases, rhabdomyolysis led to acute renal failure requiring emergency dialysis.

Severe hypersensitivity reactions have also been reported in HIV-infected patients on re-exposure to sulfamethoxazole and trimethoprim, sometimes after a dosage interval of a few days. Concomitant administration of intravenous diphenhydramine may permit continued infusion.

The concomitant use of leucovorin with sulfamethoxazole and trimethoprim for the acute treatment of Pneumocystis jiroveci pneumonia in patients with HIV infection was associated with increased rates of treatment failure and morbidity in a placebo-controlled study.

Phenylketonuric Patients
Trimethoprim has been noted to impair phenylalanine metabolism but this is of no significance in phenylketonuric patients on appropriate dietary restriction.

Haemophagocytic lymphohistiocytosis

Cases of haemophagocytic lymphohistiocytosis (HLH) have been reported very rarely in patients treated with sulfamethoxazole-trimethoprim (see 8.5 Post-Market Adverse Reactions). HLH is a life-threatening syndrome of pathologic immune activation characterized by clinical signs and symptoms of extreme systemic inflammation (e.g. fever, hepatosplenomegaly, hypertriglyceridaemia, hypofibrinogenaemia, high serum ferritin, cytopenias and haemophagocytosis) and is associated with high mortality rates if not recognized early and treated.

- Immediately evaluate patients who develop early manifestations of pathologic immune activation.
- If HLH is diagnosed, discontinue sulfamethoxazole-trimethoprim treatment.

Renal
In patients with renal impairment, a reduced or less frequent dosage is recommended in order to avoid accumulation of trimethoprim in the blood (see Dosage and Administration). Non-ionic diffusion is the main factor in the renal handling of trimethoprim, and as renal failure advances, trimethoprim excretion decreases. For such patients, serum assays are necessary. SULFATRIM

should not be used when the serum creatinine level is above 2 mg per 100 mL, in order to avoid possible permanent impairment of renal function.

Susceptibility/Resistance

Development of Drug Resistant Bacteria

Prescribing SULFATRIM in the absence of a proven or strongly suspected bacterial infection is unlikely to provide benefit to the patient and risks the development of drug-resistant bacteria.

7.1 Special Populations

7.1.1 Pregnant Women

Trimethoprim and sulfamethoxazole cross the placenta and their safety in human pregnancy has not been established. Trimethoprim is a folate antagonist and, in animal studies, both agents have been shown to cause fetal abnormalities. At doses in excess of the recommended human therapeutic dose, trimethoprim and sulfamethoxazole have been reported to cause cleft palate and other fetal abnormalities in rats, findings typical of a folate antagonist. Effects with trimethoprim were preventable by administration of dietary folate. In rabbits, fetal loss was seen at doses of trimethoprim in excess of human therapeutic doses. Case-control studies have shown that there may be an association between exposure to folate antagonists and birth defects in humans. Therefore, SULFATRIM should be avoided in pregnancy, particularly in the first trimester, unless the potential benefit to the mother outweighs the potential risk to the fetus; folate supplementation should be considered if SULFATRIM is used in pregnancy.

Sulfamethoxazole competes with bilirubin for binding to plasma albumin. As significant maternally derived drug levels persist for several days in the newborn, there may be a risk of precipitating or exacerbating neonatal hyperbilirubinaemia, with an associated theoretical risk of kernicterus, when SULFATRIM is administered to the mother near the time of delivery. This theoretical risk is particularly relevant in infants at increased risk of hyperbilirubinaemia, such as those who are preterm and those with glucose-6-phosphate dehydrogenase deficiency.

7.1.2 Breast-feeding

Trimethoprim and sulfamethoxazole are excreted in breast milk. Administration of SULFATRIM should be avoided in late pregnancy and in lactating mothers where the mother or infant has, or is at particular risk of developing hyperbilirubinaemia. Additionally, administration of SULFATRIM should be avoided in infants younger than eight weeks in view of predisposition of young infants to hyperbilirubinaemia.

7.1.3 Pediatrics

SULFATRIM is not recommended for pediatric patients younger than 2 months of age (see Contraindications).

7.1.4 Geriatrics

There may be an increased risk of severe adverse reactions in elderly patients, particularly when complicating conditions exist, e.g., impaired kidney and/or liver function, or concomitant use of other drugs. Severe skin reactions, or generalized bone marrow suppression (see

Warnings and Precautions and Adverse Reactions), or a specific decrease in platelets (with or without purpura) are the most frequently reported severe adverse reactions in elderly patients. In those concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with or without purpura has been reported. Appropriate dosage adjustments should be made for patients with impaired kidney function (see Dosage and Administration).

Close supervision is recommended when SULFATRIM is used in elderly patients or in patients taking high doses of SULFATRIM as these patients may be more susceptible to hyperkalemia and hyponatremia.

Special care should be exercised when treating the elderly or suspected folate-deficient patients; folate supplementation should be considered.

8 ADVERSE REACTIONS

8.1 Adverse Reaction Overview

The most common adverse effects are hyperkalemia, anorexia, monilial overgrowth, headache, gastrointestinal disturbances (nausea, vomiting, diarrhea), and allergic skin reactions (such as rash and urticaria). FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES AND SULFAMETHOXAZOLE AND TRIMETHOPRIM ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, DRUG REACTION WITH EOSINOPHILIA AND SYSTEMIC SYMPTOMS (DRESS),TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA, OTHER BLOOD DYSCRASIAS, AND HYPERSENSITIVITY OF THE RESPIRATORY TRACT (See Warnings and Precautions).

General
Weakness, fatigue, insomnia, vision troubles, alopecia, epistaxis, edema. Monilial overgrowth is common.

Allergic
Stevens-Johnson syndrome, toxic epidermal necrolysis, and drug reaction with eosinophilia and systemic symptoms (DRESS) (Frequency Not Known) have been reported to be life-threatening (see Section Warnings and Precautions). Anaphylactic reaction, allergic myocarditis, erythema multiforme, toxicoderma, exfoliative dermatitis, angioedema, pyrexia, chills, hypersensitivity, vasculitis resembling Henoch-Schönlein purpura, serum sickness, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, fixed drug eruption, photosensitivity, conjunctival and scleral injection, pruritus, urticaria, and rash. In addition, periarteritis nodosa and systemic lupus erythematosus and anaphylactoid reactions (sweating and collapse) have been reported.

Severe hypersensitivity reactions associated with PJP including rash, pyrexia, neutropenia, thrombocytopenia, hepatic enzyme increased, rhabdomyolysis, hyperkalaemia, hyponatraemia have been reported at the high dosages used for PJP management, necessitating cessation of therapy.

Rhabdomyolysis has been reported in HIV positive patients receiving trimethoprim-sulfamethoxazole for prophylaxis or treatment of PJP.

Cardiovascular

QT prolongation

Endocrine and Metabolism
The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides), and oral hypoglycemic agents. Cross-sensitivity may exist with these agents. Diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides.

Decreased appetite, metabolic acidosis, renal tubular acidosis, hyperkalemia, hyponatremia, hypoglycemia (see also Warnings and Precautions).

Gastrointestinal
Pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, dry mouth, nausea, vomiting, pyrosis, gastric intolerance, gastritis or gastroenteritis, dyspepsia emesis, abdominal pain, constipation, flatulence, diarrhea, tooth and/or tongue discoloration.

Genitourinary
Impaired renal function (sometimes reported as renal failure), interstitial nephritis, kidney changes (as indicated by abnormal elevations in blood urea nitrogen, blood non-protein nitrogen, serum creatinine and urine protein levels), toxic nephrosis with oliguria and anuria, crystalluria, hematuria, urgency, and dysuria.

Hematologic
Leukopenia, neutropenia, thrombocytopenia, megaloblastic anaemia, aplastic and hemolytic anemia, methemoglobinemia, purpura, agranulocytosis, hypoprothrombinemia, eosinophilia, haemolysis in certain susceptible G-6-PD deficient patients and bone marrow depression.

Hepatic/Biliary/Pancreatic
Hepatitis, including cholestatic jaundice and hepatic necrosis, jaundice, elevation of serum transaminase, alkaline phosphatase and bilirubin.

Hepatic changes including fatalities have been recorded in at-risk patients. Cholestatic jaundice and hepatic necrosis may be fatal.

Musculoskeletal
Arthralgia, rhabdomyolysis and myalgia.

Neurologic
Aseptic meningitis, convulsions, peripheral neuritis, ataxia, tremor, vertigo, tinnitus, headache.

Aseptic meningitis was rapidly reversible on withdrawal of the drug, but recurred in a number of cases on re-exposure to either sulfamethoxazole and trimethoprim or to trimethoprim alone.

Ophthalmologic
Uveitis

Psychiatric
Hallucinations, depression, apathy, nervousness, dizziness, psychotic disorder.

Respiratory
Lung infiltration, cough, dyspnea.

Skin and subcutaneous tissue disorders
Severe cutaneous adverse reactions (SCARs)

8.5 Post-Market Adverse Reactions

Hematologic: haemophagocytic lymphohistiocytosis

9 DRUG INTERACTIONS

9.1 Drug-Drug Interactions

Diuretics (thiazides): In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with or without purpura has been reported.

Pyrimethamine: Occasional reports suggest that patients receiving pyrimethamine at doses in excess of 25 mg weekly may develop megaloblastic anemia should sulfamethoxazole and trimethoprim be prescribed concurrently.

Zidovudine: In some situations, concomitant treatment with zidovudine may increase risk of hematological adverse reactions to SULFATRIM. If concomitant treatment is necessary, consideration should be given to monitoring of hematological parameters.

Lamivudine: Administration of sulfamethoxazole and trimethoprim 800 mg/160 mg causes a 40% increase in lamivudine exposure because of the trimethoprim component. Lamivudine has no effect on the pharmacokinetics of trimethoprim or sulfamethoxazole.

Warfarin: It has been reported that sulfamethoxazole and trimethoprim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. This interaction should be kept in mind when SULFATRIM is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

Phenytoin: SULFATRIM may inhibit the hepatic metabolism of phenytoin. Sulfamethoxazole and trimethoprim, given at a common clinical dosage, increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When administering these drugs concurrently, one should be alert for possible excessive phenytoin effect. Close monitoring of the patient’s condition and serum phenytoin levels is advisable.

Methotrexate: Sulfonamides can also displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations. Folate supplementation should be considered. If SULFATRIM is considered appropriate therapy in patients receiving other anti-folate drugs, a folate supplementation should be considered.

Digoxin: Concomitant use of trimethoprim with digoxin has been shown to increase plasma digoxin levels in a proportion of elderly patients.

Hyperkalaemia: Caution should be exercised in patients taking any other drugs that can cause hyperkalemia, for example ACE inhibitors, angiotensin receptor blockers and potassium-sparing diuretics such as spironolactone. Concomitant use of trimethoprim-sulfamethoxazole (cotrimoxazole) may result in clinically relevant hyperkalaemia.

Cyclosporin: Reversible deterioration in renal function has been observed in patients treated with sulfamethoxazole and trimethoprim and cyclosporin following renal transplantation.

When trimethoprim is administered simultaneously with drugs that form cations at physiological pH, and are also partly excreted by active renal secretion (e.g., procainamide, amantadine), there is the possibility of competitive inhibition of this process which may lead to an increase in plasma concentration of one or both of the drugs.

Interaction with sulphonylurea hypoglycemic agents is uncommon but potentiation has been reported.

Rifampicin: Concurrent use of rifampicin, sulfamethoxazole and trimethoprim results in a shortening of the plasma half-life of trimethoprim after a period of about one week. This is not thought to be of clinical significance.

Trimethoprim is an inhibitor of cytochrome P450 2C8 enzyme and may interact with other drugs that are primarily metabolized by the 2C8 isoform. Sulfamethoxazole is an inhibitor of cytochrome P450 2C9 and may interact with other drugs that are primarily metabolized by the 2C9 isoform.

Repaglinide: trimethoprim may increase the exposure of repaglinide which may result in hypoglycaemia.

Folinic acid: folinic acid supplementation has been shown to interfere with the antimicrobial efficacy of trimethoprim-sulfamethoxazole. This has been observed in Pneumocystis jiroveci pneumonia prophylaxis and treatment.

Azathioprine: There are conflicting clinical reports of interactions between azathioprine and trimethoprim-sulfamethoxazole, resulting in serious haematological abnormalities.

9.2 Drug-Food Interactions

Caution should be exercised in patients following potassium enriched dietary regimens.

9.3 Drug-Laboratory Test Interactions

SULFATRIM, specifically the trimethoprim component, can interfere with a serum methotrexate assay as determined by the competitive binding protein technique (CBPA) when a bacterial dihydrofolate reductase is used as the binding protein. No interference occurs, however, if methotrexate is measured by a radioimmunoassay (RIA).

The presence of trimethoprim and sulfamethoxazole may also interfere with the Jaffé alkaline picrate reaction assay for creatinine, resulting in overestimations of about 10% in the range of normal values.

9.4 Drug-Lifestyle Interactions

Patients should be instructed to maintain an adequate fluid intake in order to prevent crystalluria and stone formation.

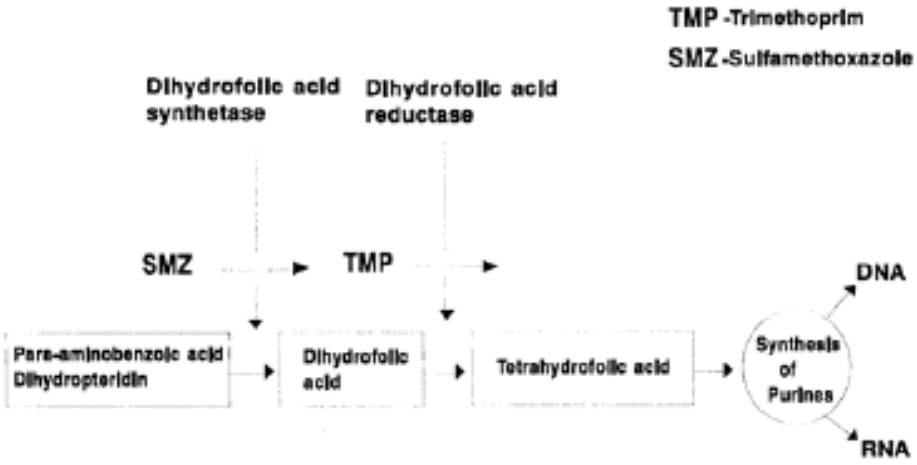
Patients should tell their physician of all dietary regimens and supplements.

10 ACTION AND CLINICAL PHARMACOLOGY

10.1 Mechanism of Action

SULFATRIM (sulfamethoxazole and trimethoprim) is an antibacterial agent with a wide spectrum of activity. It contains two active antibacterial components, sulfamethoxazole and trimethoprim, which act synergistically on many species of bacteria.

Figure 1



Sulfamethoxazole and trimethoprim act sequentially in two successive steps in the biosynthesis of nucleic acids. Trimethoprim is an inhibitor of dihydrofolate reductase, the enzyme which reduces dihydrofolic acid to its tetrahydro form. This biochemical step is essential in the production of the folate coenzymes which are involved in the biosynthesis of thymine, purine, serine and methionine. Sulfamethoxazole exerts its antibacterial activity by competing with para-aminobenzoic acid.

Most pathogenic bacteria meet their need for dihydrofolic acid by synthesizing it from para-aminobenzoic acid, pteridine and glutamic acid. Animals, in contrast, depend on exogenous sources for their needs of folic acid and do not rely upon intracellular synthesis.

Under usual circumstances, sulfamethoxazole or trimethoprim acting alone do not produce complete block in this biosynthesis of nucleic acids. Instead, they cause sufficient reduction in the synthesis of folate coenzymes to produce bacteriostasis. When the two agents act together, the superimposition of their effects produces a complete block in the synthesis, leading to death of the organism. Thus the effect of the dual action is to reduce the minimum inhibitory concentrations (MIC) of each agent (synergism) and to convert a bacteriostatic action to a bactericidal action.

The activity of SULFATRIM therefore depends upon the ability of both sulfamethoxazole and trimethoprim to affect the folate metabolism of the bacterium; however, for SULFATRIM to be therapeutic it must not affect the folate metabolism of the host. Since sulfamethoxazole affects only the de *novo* synthesis of dihydrofolic acid by bacteria, it does not affect folate metabolism of animals. Since in animals, as in bacteria, the folates have to be recycled to the active form by

dihydrofolate reductase, trimethoprim could be expected to affect mammalian folate metabolism. Trimethoprim, however, was especially selected from similar folate inhibitors because of its low toxicity for animals and high toxicity for bacteria. This difference has since been shown to be due to the fact that the affinity of trimethoprim for the dihydrofolate reductase of bacteria is some 40,000 times greater than for the corresponding mammalian enzyme.

10.2 Pharmacokinetics

The pharmacokinetic profiles of sulfamethoxazole and trimethoprim remain the same whether they are administered in combination or alone. Peak blood levels for both compounds occur one to four hours after oral administration. Detectable amounts are still present after 24 hours. The biological half-lives reported are 9 to 11 hours for sulfamethoxazole and 10 to 14 hours for trimethoprim.

Serum binding: In serum, the degree of protein-binding by trimethoprim varies with the concentration, but it normally is about 44% bound to plasma protein. Sulfamethoxazole was found to be about 70% bound to plasma protein. Addition of sulfamethoxazole reduced the binding of trimethoprim by 3 to 4%, but there was no change in the protein- binding of sulfamethoxazole at therapeutically attain able concentrations of the two drugs.

Absorption: Both trimethoprim and sulfamethoxazole are rapidly absorbed following oral administration. Detectable levels of both drugs appear in the blood in about five minutes with significant levels being reached within an hour. Peak blood levels for both compounds are attained usually in two to four hours, are maintained for about seven hours, and detectable amounts are still present after 24 hours. When the two drugs are administered together, the individual blood levels are similar to those achieved when the drugs are administered separately, thus indicating no effect in absorption of one drug by the other.

Distribution: The ratio of one part trimethoprim to five parts sulfamethoxazole achieves drug concentrations in the blood in the ratio of approximately 1:20, a ratio considered to be optimal against a wide range of bacteria. Unlike sulfamethoxazole, trimethoprim concentrates in tissues; biopsy material from a small number of patients taking trimethoprim preoperatively indicated that the concentration of trimethoprim in the tissues exceeded that of the plasma sampled at the same time - most significant in the lung (by 10 times). A similar pattern occurs in animals. Levels of trimethoprim in the sputum were also found to be higher than in the plasma following oral administration of trimethoprim-sulfamethoxazole. The concentrations of both drugs have also been found to be well-maintained in lymph and tissue fluids.

In serum, the degree of protein-binding by trimethoprim varies with the concentration, but it normally is about 44% bound to plasma protein. Sulfamethoxazole was found to be about 70% bound to plasma protein. Addition of sulfamethoxazole reduced the binding of trimethoprim by 3 to 4%, but there was no change in the protein-binding of sulfamethoxazole (about 66%) at therapeutically attainable concentrations of the two drugs.

Metabolism and Elimination: Studies conducted on the individual components administered separately, indicate that in the presence of a high fluid intake, approximately 50%, and in the presence of a low fluid intake, approximately 40% of the orally ingested trimethoprim is excreted unchanged in the urine within 24 hours. Sulfamethoxazole is more extensively metabolised than TMP, via acetylation, oxidation or glucuronidation. Over a 72 hour period, approximately 85% of the dose can be accounted for in the urine as unchanged drug plus the major (N4- acetylated) metabolite. Approximately 10% of the excreted drug is in the form of metabolites with little or no

antibacterial activity. Some trimethoprim is excreted in the bile, where concentrations twice those of plasma are obtained, but as it is almost completely reabsorbed; very little appears in the feces. Studies with radio-labelled trimethoprim indicated that it is almost completely absorbed following oral administration in man; less than 4% of the radioactivity appeared in the feces over a period of six days. Radioactivity was eliminated from the plasma and urine at almost identical rates; almost all of an oral dose being excreted in the urine within 48 hours. The biological half-life of trimethoprim was calculated to be 10 hours (range of 6.2 to 12 hours in four patients), which corresponds well to the half-life of 9 to 11 hours determined in man for sulfamethoxazole.

From 25% to 50% of the orally ingested sulfamethoxazole is excreted in the urine within 24 hours. Of the excreted drug, approximately half is the N4 acetylated derivative, a fifth is the N4 conjugate, a sixth is the unchanged parent compound, and about a tenth is another N4 free compound.

Although the amount of each drug excreted is similar when given separately or in combination, the method of excretion by the kidney is quite different. Sharpstone demonstrated that there is net tubular reabsorption of filtered sulfamethoxazole, at least in patients with normal renal function, whereas with trimethoprim there is a tubular secretory mechanism of excretion in patients with normal or impaired renal function.

Renal clearance of sulfamethoxazole increased with rising urine flow-rate, was independent of urine pH when this was less than 7, but increased with alkalinization of the urine above a pH of 7. The clearance of trimethoprim was unaffected by alteration in urine flow-rate but increased sharply with falling urine pH.

Special Patient Populations

Renal impairment
In patients with impaired renal function, sulfamethoxazole excretion was only slightly decreased, whereas trimethoprim excretion decreased markedly in severe renal impairment.

Hepatic impairment
Caution should be exercised when treating patients with severe hepatic impairment as there may decrease the absorption and biotransformation of trimethoprim and sulfamethoxazole.

Older patients
In older patients, a slight reduction in renal clearance of sulfamethoxazole but not trimethoprim has been observed.

Paediatric population
See Recommended Dose and Dosage Adjustment.

11 STORAGE, STABILITY AND DISPOSAL

SULFATRIM tablets should be stored at room temperature between 15°C to 30°C and protected from light.

Keep out of reach and sight of children.

PART II: SCIENTIFIC INFORMATION

12 PHARMACEUTICAL INFORMATION

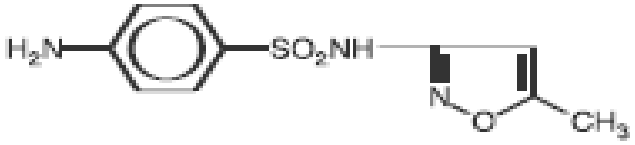
Drug Substance

The active ingredients of SULFATRIM are a combination of trimethoprim and sulfamethoxazole which has been established in a ratio of 1:5.

Proper Name: Sulfamethoxazole

Chemical Name: N1-(5 - methyl - 3 - isoxazolyl) sulfanilamide

Structural Formula:



Molecular Formula: $C_{10}H_{11}N_3O_3S$

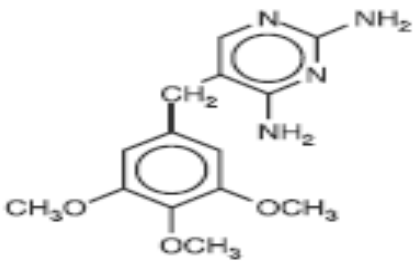
Molecular Weight: 253.31 g/mol

Description: Sulfamethoxazole is a white to off-white, practically odourless, crystalline compound. It has a melting point of 167°C.

Proper Name: Trimethoprim

Chemical Name: 2,4 - diamino - 5 - (3,4,5 - trimethoxabenzyl) pimidine

Structural Formula:



Molecular Formula: $C_{14}H_{18}N_4O_3$

Molecular Weight: 290.32 g/mol

Description: Trimethoprim is a white to cream, bitter crystalline powder. It has a melting point of 199 to 203°C and a solubility in water of 0.4 mg/mL.

13 CLINICAL TRIALS

Comparative Bioavailability Studies

A single dose, two-way crossover comparative bioavailability study of SULFATRIM DS 800 mg sulfamethoxazole/160 mg trimethoprim tablets (AA Pharma Inc.) and Bactrim® DS 800 mg sulfamethoxazole/160 mg trimethoprim tablets (Hoffmann-La Roche Limited) was conducted under fasting conditions in healthy male volunteers. The results obtained from 18 volunteers who completed the study are summarized in the following table.

SUMMARY TABLE OF THE COMPARATIVE BIOAVAILABILITY DATA

Sulfamethoxazole (1 x 800 mg sulfamethoxazole/160 mg trimethoprim) Geometric Mean Arithmetic Mean (CV %)				
Parameter	Test[1]	Reference[2]	% Ratio of Geometric Means	90% Confidence Interval
AUC_T (mcg·h/mL)	530.42 534.22 (12.27)	555.27 559.86 (13.39)	95.5	92.3 - 98.9
AUC_I (mcg·h/mL)	580.94 585.94 (13.46)	609.99 615.59 (14.12)	95.2	92.0 - 98.6
C_{max} (mcg /mL)	42.15 42.35 (9.92)	46.86 47.36 (14.64)	89.9	84.0 - 96.3
T_{max}[3] (h)	2.00 (1.00 - 6.00)	1.50 (0.50 - 4.00)		
$T_{1/2}$[4] (h)	8.78 (9.43)	9.11 (7.13)		

[1] SULFATRIM DS (sulfamethoxazole and trimethoprim) tablets, 800 mg/160 mg (AA Pharma Inc.)
[2] Bactrim® DS (sulfamethoxazole and trimethoprim) tablets, 800 mg/160 mg (Hoffmann-La Roche Limited, Canada)
[3] Expressed as the median (range) only
[4] Expressed as the arithmetic mean (CV%) only

SUMMARY TABLE OF THE COMPARATIVE BIOAVAILABILITY DATA

Trimethoprim (1 x 800 mg sulfamethoxazole/160 mg trimethoprim) Geometric Mean Arithmetic Mean (CV %)				
Parameter	Test[1]	Reference[2]	% Ratio of Geometric Means	90% Confidence Interval
AUC_T (mcg·h/mL)	20.57 20.90 (16.82)	20.66 21.01 (18.47)	99.6	92.3 - 107.4
AUC_I (mcg·h/mL)	23.36 23.81 (18.89)	23.59 24.09 (21.00)	99.0	91.1 - 107.6
C_{max} (mcg /mL)	1.48 1.49 (11.56)	1.44 1.46 (16.6)	102.8	94.4 - 111.9
T_{max}[3] (h)	1.50 (0.50 - 6.00)	1.50 (0.50 - 4.00)		
$T_{1/2}$[4] (h)	10.1 (16.62)	10.34 (15.76)		

[1] SULFATRIM DS (sulfamethoxazole and trimethoprim) tablets, 800 mg/160 mg (AA Pharma Inc.)
[2] Bactrim® DS (sulfamethoxazole and trimethoprim) tablets, 800 mg/160 mg (Hoffmann-La Roche Limited, Canada)
[3] Expressed as the median (range) only
[4] Expressed as the arithmetic mean (CV%) only

14 MICROBIOLOGY

SULFATRIM (sulfamethoxazole and trimethoprim) is bactericidal *in vitro* against the gram-negative and gram-positive organisms listed in Table 3.

In vitro Activity: Trimethoprim is, in general, more active than sulfamethoxazole against most bacterial species (see Table 1). Notable exceptions to this include *Neisseria gonorrhoeae* and *Pseudomonas aeruginosa* (which is, in general, insensitive to these drugs).

Table 1

COMPARISON OF ACTIVITY OF TRIMETHOPRIM AND SULFAMETHOXAZOLE *IN VITRO*

	MIC (mcg/mL)	
	Trimethoprim	Sulfamethoxazole
Streptococcus pyogenes	0.4	100 (± 25)
Diplococcus pneumoniae Type II	1	32 (± 16)
Viridans streptococci	0.25	8

	MIC (mcg/mL)	
	Trimethoprim	Sulfamethoxazole
Streptococcus faecalis	0.5	100
Streptococcus agalactiae	4	50
Staphylococcus aureus	0.2	4
Erysipelothrix rhusiopathiae	8	>100
Corynebacterium pyogenes	0.4	>100
Corynebacterium diphtheriae	0.4	>100
Clostridium perfringens	50	16 (± 8)
Mycobacterium tuberculosis	250	>1000
Nocardia asteroides	10	5
Escherichia coli	0.2	8
Citrobacter freundii	0.1	3
Klebsiella pneumoniae	0.5	16
Klebsiella rhinoscleromatis	0.5	10
Enterobacter aerogenes	3	>100
Salmonella typhi	0.4	4
Salmonella typhimurium	0.3	10
Shigella spp.	0.4	4
Vibrio comma	0.8	32
Pasteurella septica	0.1	8
Haemophilus influenzae	0.12	>50
Bordetella pertussis	3	100
Moraxella lacunata	4	8 (± 2)
Proteus spp.	1	8
Providence B	1	30

	MIC (mcg/mL)	
	Trimethoprim	Sulfamethoxazole
Pseudomonas aeruginosa	>100	25
Pseudomonas pseudomallei	4	10
Neisseria gonorrhoeae	12	1.6
Neisseria meningitidis	8	1.5

The activities were compared in the Wellcome Nutrient Agar containing 5% lysed horse blood. For *Neisseria* and *Haemophilus* spp., the medium was heated at 80°C for 5 minutes and in the case of *Mycobacterium tuberculosis*, Peizer and Schacter medium was used.

Demonstration of Synergy

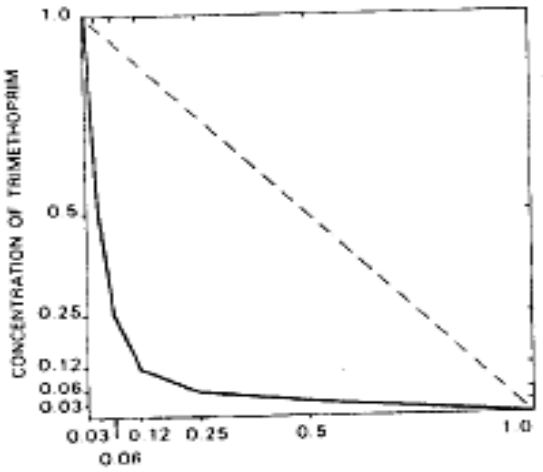
By testing trimethoprim and sulfamethoxazole, both separately and in combination, synergy can be demonstrated *in vitro*. Synergy is indicated by one or all of the following:

1. by a reduction in the MIC of each drug when the drugs are used in combination
2. by an increase in the size of the zone of inhibition around the combination disc; and
3. by an increase in bactericidal activity when the drugs are used in combination

The reduction in the MIC varies with the ratio of the drugs present and it has been demonstrated that the optimum ratio, as measured by maximum reduction in the MIC's of both drugs, is that in which the drugs are present in proportions corresponding to their respective MIC when acting singly. It should be emphasized, however, that potentiation occurs over a wide range of ratios. With an excess of one of the drugs, the proportion of the other drug may be markedly reduced below that of the optimum ratio, yet still produce a synergistic effect.

Figure 2

CONCENTRATION OF SULFAMETHOXAZOLE



CONCENTRATION OF SULFAMETHOXAZOLE: Isobologram showing the synergy existing between trimethoprim and sulfamethoxazole. Concentrations required to produce 50% inhibition of bacterial growth.

Because of the wide variation in sensitivities of organisms to trimethoprim and sulfamethoxazole, the optimum ratio is also variable and could be different for each organism. Since, in general, trimethoprim is about 20 to 100 times more active than sulfamethoxazole, when examining strains for enhanced susceptibility to the combination investigators have generally preferred to use a fixed ratio, choosing one near the modal optimum. The 1:20 ratio is used most frequently, and examples of the increase in activity are shown in Table 2.

Table 2
EFFECT ON MIC OF COMBINING 1 PART OF TRIMETHOPRIM WITH 20 PARTS OF SULFAMETHOXAZOLE

Organism	MIC mcg/mL			
	Sulfamethoxazole		Trimethoprim	
	Alone	Mixture	Alone	Mixture
Streptococcus pyogenes	>100	1.0	1.0	0.050
Diplococcus pneumoniae	30	2.0	2.0	0.100
Staphylococcus aureus	3	0.3	1.0	0.015
Haemophilus influenzae	10	0.3	1.0	0.015
Bordetella pertussis	50	4.0	3.0	0.200
Klebsiella pneumoniae	>100	4.0	1.0	0.200
Klebsiella aerogenes	>100	4.0	1.0	0.200
Escherichia coli	3	1.0	0.3	0.050
Salmonella typhimurium	10	1.0	0.3	0.050
Shigella sonnei	10	1.0	0.3	0.050
Proteus vulgaris	30	3.0	3.0	0.150
Neisseria gonorrhoeae	27	1.0	14.4	0.540

Table 3 shows the consolidated reported incidence of sensitivity of 49 165 strains of 40 species to trimethoprim plus sulfamethoxazole from 28 studies. A standard sensitivity disc containing 1.25 mcg trimethoprim and 23.75 mcg sulfamethoxazole was used in each study, but the medium varied.

Effect of Sulfamethoxazole Resistance:

A group of 449 clinical isolates were arbitrarily divided into two groups based on their respective sensitivities to sulfamethoxazole: resistant, MIC ≥ 100 mcg/mL, and sensitive, MIC < 100 mcg/mL. These organisms were then tested against various concentrations of a fixed ratio of sulfamethoxazole trimethoprim (16:1). Table 3 shows that the addition of trimethoprim significantly reduced the concentration of sulfamethoxazole required to inhibit most of the resistant organisms tested (except for Pseudomonas).

Table 3: INCIDENCE OF SENSITIVITY TO TRIMETHOPRIM + SULFAMETHOXAZOLE

Species	Total No. of Strains	Sensitive Strains	
		Total	%
S. aureus	4 929	4 280	86.8
S. epidermidis	99	83	83.8
D. pneumoniae	140	140	100.0
St. Pyogenes	757	699	92.3
St. viridans	873	803	91.9
Streptococci	191	102	53.4
St. agalactiae	20	20	100.0
Enterococci	7 394	3 798	51.4
Escherichia coli	18 903	16 851	89.1
Klebsiella	1 365	1 109	81.2
K. pneumoniae	12	12	100.0
Proteus spp.	3 142	2 436	77.5
Pr. vulgaris	610	402	65.9
Pr. mirabilis	2 730	2 337	85.6
Pr. morganii	183	160	87.4
Pr. rettgeri	498	431	86.5
Providence A	133	104	78.2
Klebs.-Enterobacter	670	458	68.4
Kl. edwardsii	2	2	100.0

Species	Total No. of Strains	Sensitive Strains	
		Total	%
Enterobacter	1 344	1 169	86.9
Ent. cloacae	193	187	96.9
Salmonella	594	586	98.6
Hafnia	92	82	89.1
Shigella	226	222	98.2
Sh. dysenteriae	12	8	66.7
Ps. aeruginosa	3 081	600	19.5
Ps. pseudomallei	12	6	50.0
Citrobacter	202	184	91.1
Serratia	28	26	92.9
Paracolobactrum	84	59	70.2
Haemophilus influenzae	284	218	76.8
Flavobacterium	2	2	100.0
Achromobacter	160	124	77.5
Arizona sp.	18	10	55.6
Alcaligenes sp.	150	127	84.7
AD group	4	4	100.0
Cory. diphtheriae	2	2	100.0
Acinetobacter	16	15	93.7
Aeromonas	4	4	100.0
Neisseria Meningitidis	6	6	100.0
Neisseria gonorrhoeae	32	31	97.0

The resistance of *Bacteroides* spp. and *Lactobacilli* is of special interest, for they comprise the major portion of the flora of the gut. Trimethoprim plus sulfamethoxazole given daily for 10 days to 12 adult volunteers, eliminated all members of the *Enterobacteriaceae* family from the feces but did not affect either of the former bacterial groups. This lack of effect of these major groups probably accounts for the infrequent occurrence of intestinal upsets during therapy with sulfamethoxazole and trimethoprim.

Trimethoprim and Sulfonamide-Resistant Strains
The theoretical basis for the synergistic effect of SULFATRIM is that sulfamethoxazole reduces the amount of dihydrofolate synthesized by the infecting organism (usually causing bacteriostasis), and an additional small amount of trimethoprim produces a complete block in the conversion of the folate to its active form (usually causing bacterial death).

When examined by conventional susceptibility methods, an organism is regarded as resistant to sulfonamides when its macroscopic growth is not affected. "Resistance" by this definition does not necessarily mean that the sulfonamide has not reduced the folate biosynthesis of the organism. There is indirect enzymatic evidence that the dihydrofolate content of such sulfonamide-resistant strains is, in fact, reduced in the presence of sulfonamides, although not to the same extent as that of sulfonamide-sensitive strains. Therefore, in the presence of sulfamethoxazole, the effect of trimethoprim on these sulfonamide-resistant strains should be increased because the amount of substrate against which the trimethoprim competes is reduced. *Streptococcus faecalis* is often regarded as being indifferent to the presence of sulfonamides, yet the susceptibility of this organism (and of sulfonamide-resistant strains of *Escherichia coli*) can be shown to be enhanced markedly with the addition of trimethoprim. Perhaps even more convincing evidence can be obtained by the diffusion method.

Although sulfonamide sensitivity discs produce no zones of inhibition with *Streptococcus faecalis*, discs containing 23.75 mcg sulfamethoxazole plus 1.25 mcg trimethoprim produce larger zones of inhibited growth of *Streptococcus faecalis* than do discs containing 1.25 mcg trimethoprim. The difference in size is abolished when para-aminobenzoic acid is present.

Reversal of Trimethoprim Activity
Trimethoprim acts by interfering with the conversion of dihydrofolic acid to tetrahydrofolic acid. Therefore, the presence of an exogenous source of the latter should, theoretically, diminish or even abolish the antibacterial activity of SULFATRIM in the host.

In vitro, 1 mcg/mL folinic acid affects only the sensitivities of *Streptococcus faecalis*, an organism known to utilize exogenous folates. *In vivo*, when administered subcutaneously to mice infected with *Diplococcus pneumoniae, Streptococcus pyogenes, Escherichia coli, Proteus vulgaris, Salmonella schottmuelleri* and *Salmonella typhimurium,* folinic acid does not affect the ability of trimethoprim to potentiate the antibacterial activity of sulfamethoxazole.

The *in vitro* interference with the action of trimethoprim and the sulfonamides by thymidine also raises the question of whether thymidine could affect *in vivo* activity. Experimental studies in the hamster indicate that thymidine is degraded rapidly *in vivo*. In experiments in mice where large doses of the nucleoside were given intraperitoneally, it did not interfere with the protection afforded by trimethoprim and sulfamethoxazole against *Proteus vulgaris*.

Resistance Development
During the serial passage in the presence of trimethoprim, little change in sensitivity occurs with light inocula; however, resistance develops rapidly with heavy inocula. With sulfonamide-

sensitive strains, the emergence of these mutants is markedly delayed by the presence of sulfamethoxazole. The delaying effect of the sulfonamide depends, however, on the degree of sulfonamide resistance and is minimal with highly resistant strains.

Recently, R factors conferring high degrees of trimethoprim resistance have been identified in members of the *Enterobacteriaceae* family isolated from man and animals. A factor conferring high trimethoprim and sulfonamide resistance was detected in a strain of *Escherichia coli* and in a strain of *Klebsiella aerogenes*. Both strains were isolated from infected urine of human patients.

15 NON-CLINICAL TOXICOLOGY

ACUTE STUDIES

Acute toxicity studies in rats of the separate components and of trimethoprim and sulfamethoxazole combined in a ratio of 1:5 demonstrated the following LD50 values:

	Sulfamethoxazole	Trimethoprim	1:5
Rats (Adult) oral	2000 mg/kg	1500 mg/kg	6500 mg/kg
Rats (Neonates) oral	1360 mg/kg	195 mg/kg	1160 mg/kg

SUBACUTE STUDIES

Daily dosages of 33, 100, and 300 mg/kg of trimethoprim and 133, 400, and 1200 mg/kg of sulfamethoxazole were given to young, sexually immature rhesus monkeys for one month. The compounds were also given in combination; the lower doses of each being combined, and similarly the higher ones. Effects on weight gain were seen. Loss in weight was noted with high and medium dosage groups with the combined drugs. Changes were induced in hemopoiesis which were consistent with trimethoprim action in interfering with dihydrofolate reductase activity. Also high doses of the sulfonamide produce hypoplastic hemopoietic changes. Half the animals on high dose levels showed increased blood urea concentrations.

A similar study in rats produced similar results. In addition, some changes associated with the sulfonamide were noted in the thyroid and in the pituitary, such as increased weight and epithelial changes. Fatty changes were also seen in the liver of monkeys and rats on the medium and high dose levels.

Chronic Studies

Six Months

Toxicity studies of six months duration were conducted in rats and monkeys with a combination of trimethoprim and sulfamethoxazole (1:2 ratio) with total daily oral doses ranging between 99 and 900 mg/kg.

Doses of 99 mg/kg daily for six months were well-tolerated in both species with minimal signs of toxicity; 300 mg/kg was well-tolerated by monkeys, but in rats impaired growth was seen and 2

of the 10 animals in this dosage group died. With 900 mg/kg, marked effects on growth and on survival occurred in both species.

Histopathological examinations were made on more than 20 different tissues from each species; these showed depression of hematopoiesis in both species in the 300 and 900 mg/kg dosage groups and minor changes with 99 mg/kg. These bone marrow changes were related to trimethoprim's interference with dihydrofolate reductase activity. Other tissue changes attributed to drug action seen in the rat, but not in the monkey, were thyroid hyperplasia and pituitary cytological effects, both associated with the sulfonamide moiety.

12 to 14 Months

Oral toxicity studies with trimethoprim and sulfamethoxazole, singly or in a 1:5 combination, were conducted in the monkey and in the rat. For the monkey, dose levels ranging from 10 + 50 to 60 + 300 mg/kg six days per week were employed for a period of 52 weeks; for the rat, dose levels ranging from 5 + 25 to 120 + 600 mg/kg per day were employed for a duration of 60 weeks.

In the monkey, the 1:5 combination did not produce any significant compound-related effects, except for a slight reduction in weight gain in the 60 + 300 mg/kg dose group.

In the rat study, thyroid hyperplasia of a dose-related severity was seen after 13 weeks in all animals receiving sulfamethoxazole. This hyperplasia progressed to nodularity or adenoma formation in some rats after 52 weeks at doses as low as 50 mg/kg per day, and to local vascular invasion and lung metastases after 60 weeks at doses as low as 150 mg/kg per day. Pituitary changes (large pale cells, often vacuolated), considered to be secondary to the thyroid change, were found in a few rats in all the sulfamethoxazole treated groups.

The phenomenon of thyroid hyperplasia in rats has been produced in this species by a number of sulfonamides and antithyroid drugs. The thyroid hyperplasia which occurs under the influence of these drugs is considered to be compensatory to the failure of thyroid hormone synthesis; it has been stated that this hyperplasia can be prevented or reversed by thyroid hormone. The progression of thyroid hyperplasia to nodule or adenoma formation is an observation in rats which has been reported previously in the literature on the antithyroid drugs, thiouracil and thiourea. It is considered that in these studies the production of thyroid tumours was due, not to any direct carcinogenic action of the drugs, but rather to the excessive and prolonged stimulation of the thyroid epithelium by the thyrotropic secretion of the pituitary.

Other changes associated with sulfamethoxazole treatment in our animal studies were: a dose-related increased alkaline phosphatase, a dose-related reduction in mean body weight gain, slight depression of hematopoiesis, testicular atrophy, focal renal calcification, and slightly increased fat vacuolation of the liver and kidney.

Human Tolerance Studies

Chronic Tolerance and Toxicity Study

A double-blind, placebo-controlled trial designed to study human tolerance and possible toxic effects of an orally administered 1:5 trimethoprim/sulfamethoxazole combination, was completed in 36 normal healthy men for 13 weeks. At the two dose levels investigated (80 + 400 and 160 + 800 mg/kg three times daily) the drug appeared to be well-tolerated, with only a few

minor, easily reversible side-effects occurring. The trial had to be stopped in two subjects due to recurrent black tongue.

Thyroid Function Study

Thyroid function tests (protein-bound iodine and serum cholesterol determinations) were conducted in 25 patients who received two to four sulfamethoxazole and trimethoprim Tablets daily for a duration of 35 to 760 days. In none of these patients was there evidence of depression of thyroid function. One patient showed a diffused stroma of the thyroid and an increased ^{131}I uptake, and another patient had a small diffused goiter after 120 days of treatment.

Reproduction and Teratology

A three-phase investigation, comprised of a fertility and general reproductive performance study and a perinatal and postnatal study in the rat, and teratology studies in the rat and rabbit, were conducted with an orally administered 1:5 combination of trimethoprim to sulfamethoxazole. The dose levels investigated, singly or combined, were 70 + 350, 30 + 150, 15 + 75, 0 + 350, 0 + 150, 0 + 75, and 14 + 0 or 70 + 0 mg/kg.

Some drug-related effects noted in the investigation were: a reduced body weight gain by eight weeks in males in the Fertility and General Reproductive Performance Study at dose levels of 150 or 350 mg/kg of sulfamethoxazole, alone or in combination, and an increased incidence of maternal mortality in the rabbit teratology study at the same dose levels. In one of the 18 litters of the high combination group, four of the eight pups were abnormal. Two had bone malformations and two had curled tails, missing or small kidneys, absence of eyelid and one also had misshapen lateral ventricles of the brain. The instances of small, underdeveloped kidneys were such as to raise a question of dose relationships. In the teratogenicity study in rats, instances of small, underdeveloped kidneys were seen: in control group - 0; in combination groups (420 mg/kg dose) - 6 (8.5%), (180 mg/kg dose) - 3 (4.7%), (90 mg/kg dose) - 2 (3.2%). Other malformations noted in a group receiving 420 mg/kg, were one instance of incomplete nasal septum and two fetuses with abnormally large openings in the lateral ventricles. Fertility and general reproductive performance, and early and late fetal development were not affected by the dose regimen employed.

Fertility

In these studies, the animals were dosed per os with a 1:5 mixture of trimethoprim to sulfamethoxazole daily from 60 days before mating until the end of weaning.

In the rat, at 600 mg/kg there was a slight, non-significant lowering of the pregnancy rate when compared with controls. The number of live progeny per litter at birth and at weaning was less than in controls. A slight treatment-related disturbance of estrus and of sperm count was also noted.

With 200 mg/kg the pregnancy rate was slightly lower than in controls, but the other effects seen with the higher dose were not noted.

In the rabbit, daily oral doses of 600 mg/kg produced vomiting, even with divided doses, and was therefore abandoned. Two hundred mg/kg did not have a significant effect on the pregnancy rate, on the number of live births per litter, or on the mean weight of progeny at birth or at weaning.

Teratogenicity
In these studies, rats and rabbits were dosed by stomach tube daily from days 8 to 16 of pregnancy, or on a single day of pregnancy (rat only). Trimethoprim and sulfamethoxazole were used alone, in a 1:4 combination, and in a 1:2 combination.

For the rat, dosing with 500 mg/kg of trimethoprim on any single day of gestation between days 8 to 16 had no effect on the dams or their fetuses. A single dose of 2000 mg/kg of trimethoprim was lethal to most fetuses when given on the eighth or ninth day, and it produced a very high incidence of malformations when given on days 10, 11 or 12. However, the incidence of these malformations dropped off precipitately when dosing was on the 13th day or later.

The most common abnormality seen with either compound in the rat, when dosing was daily on days 8 to 16 of pregnancy, was cleft palate which occurred with 200 mg/kg of trimethoprim alone and with 640 mg/kg of sulfamethoxazole alone. Higher doses of trimethoprim produced bony defects and exencephaly, related to its action in interfering with dihydrofolate reductase activity. The abnormalities could be prevented by the administration of folinic acid subcutaneously. No fetal abnormalities were found at daily doses of 160 mg/kg or less of trimethoprim, or 512 mg/kg or less of sulfamethoxazole. Using compounds in a 1:4 trimethoprim/ sulfamethoxazole combination, fetal malformations appeared at between 128 mg/kg and 160 mg/kg of trimethoprim and 512 mg/kg and 640 mg/kg of sulfamethoxazole. There appeared to be a distinct synergism with the 1 to 2 mixture.

In rabbits given the drug daily during organogenesis (days 8 to 16), no teratogenic effect was revealed with the 1:4 mixture or its components. While no important effect on the incidence of dead fetuses was noted with daily doses of 125 mg/kg of trimethoprim, 500 mg/kg or less of sulfamethoxazole, or with 312.5 mg/kg of the combination, the incidence of fetuses dying before full term was higher than for controls in the groups given trimethoprim except at the 62.5 mg/kg dose. Pregnant does tolerated the combination better than sulfamethoxazole alone.

16 SUPPORTING PRODUCT MONOGRAPHS

1. Bactrim, Product Monograph, Hoffmann-La Roche Limited. 1987.

2. Septra® Injection (solution, 80 mg sulfamethoxazole and 16 mg trimethoprim per mL), submission control 245929, Product Monograph, Aspen Pharmacare Canada Inc. Date of Revision: March 29, 2021.

READ THIS FOR SAFE AND EFFECTIVE USE OF YOUR MEDICINE

PATIENT MEDICATION INFORMATION

[Pr] SULFATRIM
Sulfamethoxazole and Trimethoprim Tablets USP

[Pr] SULFATRIM DS
Sulfamethoxazole and Trimethoprim Tablets USP

[Pr] SULFATRIM PEDIATRIC
Sulfamethoxazole and Trimethoprim Tablets USP

Read this carefully before you start taking **SULFATRIM** and each time you get a refill. This leaflet is a summary and will not tell you everything about this drug. Talk to your healthcare professional about your medical condition and treatment and ask if there is any new information about **SULFATRIM / SULFATRIM DS / SULFATRIM PEDIATRIC**.

Serious Warnings and Precautions

SULFATRIM can cause serious side effects. If you get any of these side effects, stop taking SULFATRIM and get immediate medical help:

- Severe skin reactions that may be life threatening. These include Steven-Johnson syndrome, toxic epidermal necrolysis and drug reaction with eosinophilia and systemic symptoms (DRESS).
- A liver disease called fulminant hepatic necrosis that may be life-threatening. .
- Blood problems including:
    - Agranulocytosis, where the number of white cells in the blood becomes dangerously low.
    - A blood disease called aplastic anemia, where the bone marrow is unable to make enough blood cells from being damaged.
    - A blood disease called immune thrombocytopenia, which can be life-threatening.

Allergic reaction in the lungs and in the airways, where the airways can close up and make breathing difficult, and can be life-threatening if the person does not get medical help.
For further information and symptoms see:

- the "**To help avoid side effects and ensure proper use …**" section
- the "**What are possible side effects from using SULFATRIM?**" section

What is SULFATRIM used for?

SULFATRIM is used to treat:

- urinary tract infections;
- lung infections such as bronchitis or pneumonia (a lung infection caused by fungi);
- gastrointestinal (stomach and bowel) infections such as cholera or dysentery;
- nocardiosis, an infection of the lungs or other parts of the body;
- brucellosis which is a disease spread from animals to humans. When used to treat brucellosis it is used along with another medicine, gentamicin or rifampicin.

Antibacterial drugs like SULFATRIM treat only bacterial infections. They do not treat viral infections. Although you may feel better early in treatment, SULFATRIM should be used exactly as directed. Misuse or overuse of SULFATRIM could lead to the growth of bacteria that will not be killed by SULFATRIM (resistance). This means that SULFATRIM may not work for you in the future.

How does SULFATRIM work?

SULFATRIM contains two different antibiotics called sulfamethoxazole and trimethoprim. They work together to kill or to slow or stop the growth of bacteria, or fungi that cause disease. This means that SULFATRIM can be given to prevent or to treat certain kinds of infectious diseases.

What are the ingredients in SULFATRIM / SULFATRIM DS / SULFATRIM PEDIATRIC?

Medicinal ingredients: sulfamethoxazole and trimethoprim.

Non-medicinal ingredients: colloidal silicon dioxide, croscarmellose sodium, magnesium stearate and methylcellulose.

SULFATRIM / SULFATRIM DS / SULFATRIM PEDIATRIC comes in the following dosage forms:

SULFATRIM: Tablets; 400 mg sulfamethoxazole / 80 mg trimethoprim

SULFATRIM DS: Tablets; 800 mg sulfamethoxazole / 160 mg trimethoprim

SULFATRIM PEDIATRIC: Tablets; 100 mg sulfamethoxazole / 20 mg trimethoprim

Do not use SULFATRIM if:

- you are allergic to sulfamethoxazole, trimethoprim or any of the other ingredients in SULFATRIM;
- you are allergic to sulphonamide medicines. Examples include diabetes medicines (such as gliclazide and glibenclamide). Talk to your healthcare professional if you are allergic to a medicine and you are not sure if it is a sulphonamide medicine causing bruises or bleeding (thrombocytopenia);
- you have liver problems;
- you have kidney problems;
- you have blood problems;
- you are pregnant;
- you are breastfeeding;
- you have been told that you have a rare blood problem called porphyria, which can affect your skin or nervous system.

Children
If it is for your child, SULFATRIM should not be given if they are less than 2 months old.

If you are not sure if any of the above apply to you, talk to your healthcare professional before being given SULFATRIM.

To help avoid side effects and ensure proper use, talk to your healthcare professional before you take SULFATRIM. Talk about any health conditions or problems you may have, including if you:

- have severe allergies or asthma.
- you don't have enough folic acid (a vitamin) in your body called folate deficiency;
- you are underweight or malnourished;
- you have a disease called glucose-6-phosphate dehydrogenase deficiency;
- you are at risk for a rare blood disorders called porphyria, which can affect your skin or nervous system;
- you have been told by your healthcare professional that you have a high level of potassium in your blood;
- you have been told by your healthcare professional that you have a low level of sodium or albumin in your blood;
- you have been told by your healthcare professional that you have any serious disorder of the blood or blood forming tissues such as low blood cell counts;
- you have existing heart or lung disease, which may lead to a build-up of fluid in your body;
- you have hereditary disorder called phenylketonuria and are not on a special diet to help your condition;
- you are human immunodeficiency virus (HIV) positive or have a condition called Acquired Immunodeficiency Syndrome (AIDS);
- If you have kidney problems.

Other warnings you should know about:

Use in Elderly Patients
Elderly patients are more likely to get serious side effects when receiving SULFATRIM. This is increased if you have kidney or liver disease or are taking some types of other medicines, such as diuretics.

Pregnancy and Breastfeeding
Talk to your healthcare professional before taking this medicine if you are planning to get pregnant or planning to breastfeed. You should not receive SULFATRIM if you are pregnant or are breastfeeding.

Use in Patients with Acquired Immunodeficiency Syndrome (AIDS)
If you have AIDS, you may be more likely to get side effects when receiving SULFATRIM. These may include rash, severe allergic reactions, fever or low blood cell counts.

Gastrointestinal - C. difficile colitis
SULFATRIM may increase your risk of being infected with a bacteria called *C. difficile*. Symptoms include watery diarrhea that happens three or more times per day or diarrhea associated with abdominal cramping.

Driving and using machines
After you are given SULFATRIM you may feel weak, tired, dizzy, or confused. Before driving a vehicle or using machinery wait to see how you feel after being given SULFATRIM.

Tell your healthcare professional about all the medicines you take, including any drugs, vitamins, minerals, natural supplements or alternative medicines.

The following may interact with SULFATRIM:

- medicines to remove excess water from the body knows as diuretics (water pills) such as spironolactone;
- medicines to treat malaria such as pyrimethamine;
- medicines to treat Human Immunodeficiency Virus (HIV) such as zidovudine or lamivudine;
- medicines to thin the blood such as warfarin;
- medicines to treat epilepsy (fits) and seizures such as phenytoin;
- medicines to treat cancer or arthritis such as methotrexate;
- medicines to treat heart conditions such as digoxin or procainamide;
- medicines that can increase the amount of potassium in your blood, such as steroids (like prednisolone) and heart and high blood pressure medicines;
- medicines used after organ transplantation such as cyclosporin;
- medicines to treat Parkinson's disease, multiple sclerosis, the flu or shingles such as amantadine;
- medicines to treat diabetes, such as glibenclamide, glipizide or tolbutamide (sulphonylureas) and repaglinide;
- medicines to treat bacterial infections such as rifampicin
- medicines used after cancer treatment or to help with low levels of folate such as folinic acid;
- medicines to help prevent pregnancy such as contraceptives.

Drug-Food Interactions

- Tell your healthcare professional if you have special dietary needs, especially if you are following a potassium rich diet. Potassium rich foods include beans, dark leafy greens, potatoes, squash, yogurt, fish, avocados, mushrooms and bananas.

How to take SULFATRIM

- Be sure to drink lots of fluids while taking SULFATRIM.
- Swallow tablets whole with water.
- Your healthcare professional will decide how much SULFATRIM you should take and for how long you should take it.

- Although you may feel better early in treatment, SULFATRIM should be used exactly as directed.
- Misuse or overuse of SULFATRIM could lead to the growth of bacteria that will not be killed by SULFATRIM (resistance). This means that SULFATRIM may not work for you in the future.
- Do not share your medicine.

Usual dose:

Adults and children over 12 years old:
SULFATRIM:
- The usual dose of SULFATRIM is two tablets twice a day for 5 days.

SULFATRIM DS:
- The usual dose of SULFATRIM DS is one tablet twice a day for 5 days.

Children under 12 years old:
SULFATRIM PEDIATRIC:
- Your doctor will tell you how much SULFATRIM PEDIATRIC to give your child. This dose will be based on your child's weight.

OVERDOSE:

If you have been given too much SULFATRIM, you may have the following signs or symptoms:
- anorexia (extreme fear of gaining weight);
- colic (severe pain in the abdomen caused by gas);
- nausea and vomiting;
- dizziness, drowsiness or confusion;
- fainting;
- headache;
- pyrexia (fever);
- hematuria (blood in urine);
- crystalluria (cloudy urine);
- jaundice (yellowing of the skin or whites of the eye);
- feeling depressed.

If you think you, or a person you are caring for, have taken too much SULFATRIM, contact a healthcare professional, hospital emergency department or regional poison control centre immediately, even if there are no symptoms.

Missed Dose:

- If you miss a dose, take it as soon as you remember.
- If it is almost time for your next dose, skip the missed dose and resume your usual dosing schedule.
- Never take two doses to make up for a missed dose.

What are possible side effects from using SULFATRIM?

These are not all the possible side effects you may feel when taking SULFATRIM. If you experience any side effects not listed here, contact your healthcare professional.

Side effects may include:

- Feeling weak or tired;
- Trouble sleeping;
- Vision problems;
- Hair loss;
- Nose bleed;
- Swelling of body tissues with fluid;
- Chills;
- Sensitivity to sunlight;
- Palpitations (heart beat that feels too fast, strong or irregular);
- Cold sores, ulcers, or soreness of your tongue or inside of your mouth;
- Dry mouth;
- Heartburn;
- Abdominal pain or gas;
- Constipation;
- Nausea, vomiting and diarrhea;
- Loss of appetite;
- Passing more or less urine than usual; difficulty reaching bathroom in time;
- Muscle and joint pain or muscle weakness;
- Tingling or numbness in your hands and feet;
- Problems controlling your movements;
- Uncontrollable shaking;
- Vertigo (sensation of movement or feeling off balance);
- Ringing or other unusual sounds in your ears;
- Headache;
- Inflammation of your eye that causes pain and redness;
- Depression;
- Apathy (indifference and a lack of motivation);
- Feeling unsteady or dizzy;
- Anorexia (extreme fear of gaining weight).

SULFATRIM can cause abnormal blood test results.

Serious side effects and what to do about them			
Symptom / effect	**Talk to your healthcare professional**		**Stop taking drug and get immediate medical help**
	Only if severe	**In all cases**	
Allergic reactions: swelling of face, mouth, tongue or throat which may be red and painful and/or cause difficulty in swallowing; red patches on the skin; rash; hives; fever (high temperature); joint pain; feeling sick (nausea); being sick (vomiting); chest pain.			√
Steven-Johnson syndrome (**severe skin rash**); redness, blistering and/or peeling of the skin and/or inside of the lips, eyes, mouth, nasal passages or genitals, accompanied by fever, chills, headache, cough, body aches or swollen glands.			√
Toxic Epidermal Necrolysis (severe skin reaction): redness, blistering and/or peeling of large areas of the skin			√
Drug reaction with eosinophilia and systemic symptoms (DRESS) (serious skin reaction that may affect more than one organ): fever, severe skin rash, peeling skin, and abnormal blood and liver function tests			√
Difficulty breathing, cough, wheezing, shortness of breath, tightness of the chest.			√
Aseptic meningitis (inflammation of the protective lining of the brain that is not caused by infection): including sudden headache or stiffness of your neck, accompanied by fever, nausea, vomiting, sensitivity to light.			√
Acute inflammation of the small and large intestine *Pseudomembranous colitis*; including watery or bloody diarrhea, abdominal cramps, pain or tenderness, fever, nausea, dehydration.			√
Fits (convulsions or seizures)			√
Heart problems: Increased heart rate, chest pain, shortness of breath).			√
Pancreatitis (Acute inflammation of the pancreas): including upper abdominal pain that spreads to the back, swollen and tender abdomen, nausea, vomiting, fever.			√
Hypoglycaemia (an abnormally low level of sugar in the blood): including dizziness or light-headedness, shakiness, nervousness or anxiety, feeling confused, sweating, chills			√

Serious side effects and what to do about them			
Symptom / effect	**Talk to your healthcare professional**		**Stop taking drug and get immediate medical help**
	Only if severe	**In all cases**	
Problems with your urine; pain or difficulty passing urine, blood or cloudiness in your urine.			√
Hepatitis (inflammation of the liver): fatigue, fever, body ache, abdominal pain, dark urine or pale stools, difficulty to urinate.			√
Jaundice (yellowing of the skin and whites of the eyes).			√
An infection called thrush or candidiasis which can affect your mouth or vagina.			√
Hallucinations: Seeing, hearing, smelling, tasting or feeling things that don't exist outside your mind.			√
Immune thrombocytopenia: including being easily bruised, a rash on the skin that appears tiny pinpoint-sized reddish or purple spots, usually on the lower legs, bleeding from the gums or nose, and blood in the urine or stool.			√
Aplastic anemia: including feeling tired, feeling short of breath, pale skin, unexplained or easy bruising, fever, chills, sore throat, and a general feeling of being unwell.			√
Severe Cutaneous Adverse Reactions (SCAR) (severe skin reactions that may also affect other organs): • Skin peeling, scaling, or blistering (with or without pus) which may also affect your eyes, mouth, nose or genitals, itching, severe rash, bumps under the skin, skin pain, skin color changes (redness, yellowing, purplish) • Swelling and redness of eyes or face • Flu-like feeling, fever, chills, body aches, swollen glands, cough Shortness of breath, chest pain or discomfort			√
Angioedema: swelling of the face, hands, feet, genitals, tongue or throat, difficulty swallowing or breathing; swelling of the digestive tract which may cause diarrhea, nausea or vomiting			√
Erythema multiforme (an allergic skin reaction): raised red or purple skin patches, possibly with blister or crust in the center;			√

Serious side effects and what to do about them			
Symptom / effect	**Talk to your healthcare professional**		**Stop taking drug and get immediate medical help**
	Only if severe	**In all cases**	
possibly swollen lips, mild itching or burning			
Haemophagocytic lymphohistiocytosis (condition where your white blood cells attack your organs and other blood cells): fever, enlarged liver and spleen, swollen lymph nodes, skin rashes, yellowing of your skin and eyes, breathing problems, stomach ache, vomiting and diarrhea, headache, trouble walking, feeling weak and bruising easily. **This can be serious and lead to death.**			√

If you have a troublesome symptom or side effect that is not listed here or becomes bad enough to interfere with your daily activities, talk to your healthcare professional.

Reporting Side Effects

You can report any suspected side effects associated with the use of health products to Health Canada by:

- Visiting the Web page on Adverse Reaction Reporting (https://www.canada.ca/en/health-canada/services/drugs-health-products/medeffect-canada/adverse-reaction-reporting.html) for information on how to report online, by mail or by fax; or

- Calling toll-free at 1-866-234-2345.

NOTE: Contact your health professional if you need information about how to manage your side effects. The Canada Vigilance Program does not provide medical advice.

Storage:

SULFATRIM should be stored at room temperature between 15°C to 30°C. Protect from light.

Keep out of reach and sight of children.

If you want more information about SULFATRIM:

- Talk to your healthcare professional
- Find the full Product Monograph that is prepared for healthcare professionals and includes this Patient Medication Information by visiting the Health Canada website: (https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/drug-product-database.html); the manufacturer's website (https://www.aapharma.ca/en/), or by calling 1-877-998-9097.

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Last revised: July 28, 2023