

PRODUCT MONOGRAPH

EXTRANEAL

7.5% w/v Icodextrin Peritoneal Dialysis Solution

Icodextrin, Sodium Chloride, Sodium Lactate, Calcium Chloride, Magnesium Chloride

75 g/L Icodextrin
5.35 g/L Sodium Chloride
4.48 g/L Sodium Lactate
257 mg/L Calcium Chloride
51 mg/L Magnesium Chloride

Peritoneal Dialysis Solution

VANTIVE ULC
6675 Millcreek Drive, Unit 2
Mississauga, Ontario L5N 5M4

Date of Preparation:
APR 12, 2024

Control Number: 284131

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EXTRANEAL

7.5% w/v Icodextrin Peritoneal Dialysis Solution

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PART I: HEALTH PROFESSIONAL INFORMATION

SUMMARY PRODUCT INFORMATION

Route of Administration	Dosage Form / Strength	All Nonmedicinal Ingredients
Intraperitoneal	75 g/L icodextrin 5.35 g/L sodium chloride 4.48 g/L sodium lactate 257 mg/L calcium chloride 51 mg/L magnesium chloride	Hydrochloric acid (For pH adjustment) Sodium Hydroxide (For pH adjustment) Water for Injection

INDICATIONS AND CLINICAL USE

EXTRANEAL (icodextrin, sodium chloride, sodium lactate, calcium chloride, magnesium chloride) is indicated for use as an osmotic agent for long dwell, up to 12 hours, in continuous ambulatory peritoneal dialysis (CAPD) or automated peritoneal dialysis (APD), where it can be used for 14 and up to 16 hours.

CONTRAINDICATIONS

- EXTRANEAL is contraindicated for use in patients with:
 - acute renal failure
 - an allergy to starch-based polymers (e.g., corn starch) and/or icodextrin
 - maltose or isomaltose intolerance.
 - glycogen storage disease
 - pre-existing severe lactic acidosis
 - uncorrectable mechanical defects that prevent effective PD or increase the risk of infection
 - documented loss of peritoneal function or extensive adhesions that compromise peritoneal function

- The product is also contra-indicated in patients with a history of abdominal surgery in the month preceding commencement of therapy, patients with abdominal fistulae,

tumors, open wounds, herniae or other conditions which compromise the integrity of the abdominal wall, abdominal surface or intra-abdominal cavity - in common with other peritoneal dialysis fluids until healing is complete. In patients with impaired respiratory function or potassium deficiency, peritoneal dialysis may also be contraindicated.

- EXTRANEAL is not recommended for use in children.

Use in Pregnancy & Lactation

- No data from animal studies on the effects of EXTRANEAL on reproduction or lactation are available and therefore, EXTRANEAL solution should not be used during pregnancy or lactation. Women of childbearing potential should be treated with EXTRANEAL solution only when adequate contraceptive precautions have been taken. Potential effects on male and female fertility are unknown.

WARNINGS AND PRECAUTIONS

Warnings

General

Blood glucose measurement in patients receiving EXTRANEAL must be done with a glucose-specific method (monitor and test strips) to avoid interference by maltose or other metabolites of EXTRANEAL¹. Maltose interference results in inaccurate blood glucose measurement which could lead to errors in the administration of insulin to any Extraneal patient, and also in the overall management of diabetes in diabetic Extraneal patients. Glucose dehydrogenase pyrroloquinolinequinone (GDH-PQQ) or glucose-dye-oxidoreductase (GDO)-based methods must not be used. Also, the use of some glucose monitors and test strips using glucose dehydrogenase flavin-adenine dinucleotide (GDH-FAD) methodology has resulted in falsely elevated glucose readings due to the presence of maltose. The manufacturer(s) of the monitor and test strips should be contacted to determine if icodextrin or maltose causes interference or falsely elevated glucose results.

If GDH-PQQ, GDO, or GDH-FAD-based methods are used, using EXTRANEAL may cause a falsely high glucose reading which could result in the administration of more insulin than needed. Administration of more insulin than needed has caused hypoglycemia, which has resulted in loss of consciousness, coma, neurological damage and death. Additionally, falsely elevated blood glucose measurements due to maltose interference may mask true hypoglycemia and allow it to go untreated with similar consequences.

Falsely elevated glucose levels may be measured up to two weeks following cessation of EXTRANEAL(icodextrin) therapy when GDH-PQQ, GDO, or GDH-FAD-based blood glucose monitors and test strips are used.

Because GDH-PQQ, GDO, and GDH-FAD-based blood glucose monitors may be used in hospital settings, it is important that the health care providers of all peritoneal dialysis patients using EXTRANEAL(icodextrin) carefully review the product information of the blood glucose testing system, including that of test strips, to determine if the system is appropriate for use with EXTRANEAL(icodextrin).

To avoid improper insulin administration, educate all patients on EXTRANEAL therapy to alert health care providers of this interaction whenever they are admitted to the hospital.

Encapsulating peritoneal sclerosis (EPS) is considered to be a known, rare complication of peritoneal dialysis therapy. EPS has been reported in patients using peritoneal dialysis solutions including EXTRANEAL. Fatal outcomes of EPS have been reported with EXTRANEAL.

If peritonitis occurs, the choice and dosage of antibiotics should be based upon the results of identification and sensitivity studies of the isolated organism(s) when possible. Prior to identification of the involved organism(s), broad-spectrum antibiotics may be indicated.

Rarely, serious hypersensitivity reactions to EXTRANEAL have been reported such as toxic epidermal necrolysis, angioedema, serum sickness, erythema multiforme and vasculitis. Anaphylactic/anaphylactoid reactions may occur. Stop the infusion immediately and drain the solution from the peritoneal cavity if any signs or symptoms of a suspected hypersensitivity reaction develop. Appropriate therapeutic countermeasures must be instituted as clinically indicated.

Patients with severe lactic acidosis should not be treated with lactate-based peritoneal dialysis solutions. It is recommended that patients with conditions known to increase the risk of lactic acidosis [e.g. severe hypotension or sepsis, hepatic failure and/or renal failure, inborn errors of metabolism, treatment with drugs such as metformin² and nucleoside/nucleotide reverse transcriptase inhibitors (NRTIs)³] must be monitored for occurrence of lactic acidosis before the start of treatment and during treatment with lactate-based peritoneal dialysis solutions.

When prescribing the solution to be used for an individual patient, consideration should be given to the potential interaction between the dialysis treatment and therapy directed at other existing illnesses. Serum potassium levels should be monitored carefully in patients treated with cardiac glycosides. For example, rapid potassium removal may create arrhythmias in cardiac patients using digitalis or similar drugs; digitalis toxicity may be masked by hyperkalemia, hypermagnesemia, or hypocalcemia. Correction of electrolytes by dialysis may precipitate signs and symptoms of digitalis excess. Conversely, toxicity may occur at suboptimal dosages of digitalis if potassium is low or calcium high.

Precautions

General

EXTRANEAL is intended for intraperitoneal administration only. Not for intravenous administration.

Do not administer if the solution is discoloured, cloudy, contains particulate matter or shows evidence of leakage or if seals are not intact.

The drained fluid should be inspected for the presence of fibrin or cloudiness which may indicate the presence of peritonitis.

Safety and effectiveness in pediatric patients have not been established.

Protein, amino acids, water-soluble vitamins and other medicines may be lost during peritoneal dialysis and may require replacement.

Peritoneal dialysis should be done with caution in patients with: 1) fecal fistula, colostomy, large polycystic kidneys, or other conditions that compromise the integrity of the abdominal wall, abdominal surface, or intra-abdominal cavity; and 2) other conditions including aortic graft placement.

Patients should be carefully monitored to avoid over- and under hydration. An accurate fluid balance record should be kept and the patient's body weight monitored.

Overinfusion of an EXTRANEAL volume into the peritoneal cavity may be characterized by abdominal distension, feeling of fullness and/or shortness of breath.

Treatment of EXTRANEAL overinfusion is to drain the EXTRANEAL from the peritoneal cavity.

Potassium is omitted from EXTRANEAL solutions due to the risk of hyperkalemia.

- In situations in which there is a normal serum potassium level or hypokalemia, the addition of potassium chloride (up to a concentration of 4 mEq/L) may be indicated to prevent severe hypokalemia and should be made after careful evaluation of serum and total body potassium, only under the direction of a physician. (**See Monitoring and Laboratory Tests**).

In diabetic patients, blood glucose levels should be regularly monitored and the dosage insulin or other treatment for hyperglycemia should be adjusted following initiation of treatment with EXTRANEAL. Appropriate monitoring of blood glucose should be performed and insulin dosage adjusted if necessary.

Because the use of EXTRANEAL interferes with glucose dehydrogenase pyrroloquinolinequinone (GDH-PQQ) or glucose-dye-oxidoreductase based blood glucose measurements, diabetic patients should be instructed to use only glucose-specific glucose

monitors and test strips. (See **Monitoring and Laboratory Tests**).

Fluid, haematology, blood chemistry and electrolyte concentrations should be monitored periodically, including, magnesium and bicarbonate. If serum magnesium levels are low, oral magnesium supplements or peritoneal dialysis solutions containing higher magnesium concentrations may be used. Decreases in serum sodium and chloride have been observed in patients using EXTRANEAL.

Monitoring and Laboratory Tests

Blood glucose measurement must be done with a glucose-specific method to prevent maltose interference. Glucose dehydrogenase pyrroloquinolinequinone (GDH-PQQ) or glucose-dye-oxidoreductase (GDO)-based methods must not be used². Also, the use of some glucose monitors and test strips using glucose dehydrogenase flavin-adenine dinucleotide (GDH-FAD) methodology has resulted in falsely elevated glucose readings due to the presence of maltose (See **WARNINGS AND PRECAUTIONS**).

An apparent decrease in serum amylase activity has been observed in patients administered EXTRANEAL⁴.

ADVERSE REACTIONS

Clinical Trial Adverse Drug Reactions

Because clinical trials are conducted under very specific conditions the adverse reaction rates observed in the clinical trials may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse drug reaction information from clinical trials is useful for identifying drug-related adverse events and for approximating rates.

Clinical Trial Adverse Reactions[†]			
System Organ Class (SOC)	Preferred MedDRA Term	Frequency*	Frequency Percentage or Ratio N=493
INFECTIONS AND INFESTATIONS	Influenza	Uncommon	0.6
	Furuncle	Uncommon	0.2
	Infection	Uncommon	0.2
BLOOD AND LYMPHATIC SYSTEM DISORDERS	Anemia	Uncommon	0.4
	Leukocytosis	Uncommon	0.6
	Eosinophilia	Uncommon	0.2
ENDOCRINE DISORDERS	Parathyroid disorder (Increased intact-PTH)	**	**
METABOLISM AND NUTRITION DISORDERS	Dehydration	Common	2.0
	Hypovolemia	Common	1.0
	Hypoglycemia	Uncommon	0.4
	Hyponatremia	Uncommon	0.4
	Hyperglycemia	Uncommon	0.2
	Hypervolemia	Uncommon	0.8
	Anorexia	Uncommon	0.8
	Hypochloremia	Uncommon	0.8
	Hypomagnesemia	Uncommon	0.4
	Hypoproteinemia	Uncommon	0.4
PSYCHIATRIC DISORDERS	Thinking abnormal	Uncommon	0.2
	Anxiety	Uncommon	0.2
	Nervousness	Uncommon	0.2

NERVOUS SYSTEM DISORDERS	Dizziness	Common	1.8
	Headache	Common	1.4
	Hyperkinesia	Uncommon	0.2
	Parathesia	Uncommon	0.6
	Ageusia	Uncommon	0.2
EAR AND LABYRINTH DISORDERS	Tinnitus	Common	3.6
CARDIAC DISORDERS	Cardiovascular disorder	Uncommon	0.2
	Tachycardia	Uncommon	0.2
VASCULAR DISORDERS	Hypotension	Common	3.2
	Hypertension	Common	2.6
	Orthostatic hypotension	Uncommon	0.2
RESPIRATORY, THORACIC, AND MEDIASTINAL DISORDERS	Pulmonary edema	Uncommon	0.2
	Dyspnea	Uncommon	0.4
	Cough	Uncommon	0.2
	Hiccups	Uncommon	0.2
	Lung disorder	Uncommon	0.4
GASTROINTESTINAL DISORDERS	Abdominal pain	Common	1.6
	Abdominal distension	**	**
	Intestinal obstruction	Uncommon	0.2
	Peritonitis	Uncommon	0.6
	Bloody peritoneal effluent	Uncommon	0.2
	Diarrhea	Uncommon	0.6
	Gastric ulcer	Uncommon	0.2
	Gastritis	Uncommon	0.2
	Gastrointestinal disorder	Uncommon	0.4
	Vomiting	Uncommon	0.2
	Constipation	Uncommon	0.4
	Dyspepsia	Uncommon	0.6
	Nausea	Uncommon	0.2
	Dry mouth	Uncommon	0.4
	Flatulence	Uncommon	0.2
SKIN AND SUBCUTANEOUS DISORDERS	Dermatitis exfoliative	Common	1.6
	Rash	Common	5.5
	Pruritus	Common	1.4
	Urticaria	Uncommon	0.2
	Dermatitis bullous	Uncommon	0.2
	Psoriasis	Uncommon	0.4
	Rash, maculo-papular	Uncommon	0.2
	Skin ulcer	Uncommon	0.2
	Eczema	Uncommon	0.2

	Nail disorder	Uncommon	0.6
	Skin disorder	Uncommon	0.2
	Dry skin	Uncommon	0.2
	Skin discolouration	Uncommon	0.2
MUSCULOSKLETAL, CONNECTIVE TISSUE DISORDERS	Bone pain	Uncommon	0.1
	Muscle spasms	Uncommon	0.4
	Myalgia	Uncommon	0.4
	Neck Pain	Uncommon	0.4
RENAL AND URINARY DISORDERS	Renal pain	Uncommon	0.2
GENERAL DISORDERS AND ADMINISTRATIVE SITE CONDITIONS	Edema peripheral	Common	1.4
	Asthenia	Common	1.2
	Chest pain	Uncommon	0.4
	Catheter-related complication	Uncommon	0.2
	Face edema	Uncommon	0.2
	Edema	Uncommon	0.6
	Pain	Uncommon	0.2
INVESTIGATIONS	Urine output decreased	**	**
	Laboratory test abnormal	Common	2.6
	Alanine aminotransferase increased	Uncommon	0.4
	Aspartate aminotransferase increased	Uncommon	0.4
	Blood alkaline phosphatase increased	Uncommon	0.6
	Liver function test abnormal	Uncommon	0.6
	Weight decreased	Uncommon	0.2
	Weight increased	Uncommon	0.6
INJURY, POISONING, AND PROCEDURAL COMPLICATIONS	Injury	Uncommon	0.2

*Frequency has been evaluated using the following criteria: very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1,000$ to $< 1/100$), rare ($\geq 1/10,000$ to $< 1/1,000$), very rare ($< 1/10,000$). Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness.

†This table represents an integration of safety data from the following clinical trials of 493 patients: RD-97-CA-130, RD-97-CA-131, ML/IB/001, PRO-Renal-Reg-035, ML/IB/020 (DELIA), ML/IB/011 (DIANA), ML/IB/004

(Midas-2), RD-99-CA-060, and ML/IB/014. The table also includes adverse events from clinical study BLR-PG21. Additionally, safety data from studies BLR-PG22, RD-00-CA-050 and RD-00-CA-022 were reviewed and did not require additions to the clinical trial data presented.

**Reported in 1 of 18 patients who were exposed to EXTRANEAL in clinical trial BLR-PG21. Therefore, estimation of frequency not presented due to limited patient population in clinical trial BLR-PG21.

Post-Market Adverse Drug Reactions

In addition to the adverse reactions noted in clinical trials, the following adverse reactions have been reported in the post marketing experience. These reactions are listed by MedDRA System Organ Class (SOC), then by Preferred Term in order of severity.

INFECTIONS AND INFESTATIONS: Fungal peritonitis, Peritonitis bacterial, Catheter site infection, Catheter related infection

BLOOD AND LYMPHATIC SYSTEM DISORDERS: Thrombocytopenia, Leukopenia

IMMUNE SYSTEM DISORDERS: Vasculitis, Serum sickness, Hypersensitivity

METABOLISM AND NUTRITION DISORDERS: Shock hypoglycemia, Fluid overload, Fluid imbalance

NERVOUS SYSTEM DISORDERS: Hypoglycemic coma, Burning sensation

EYE DISORDERS: Vision blurred

RESPIRATORY, THORACIC AND MEDIASTINAL DISORDERS: Bronchospasm, Stridor

GASTROINTESTINAL DISORDERS: Encapsulating peritoneal sclerosis, Aseptic peritonitis*, Peritoneal cloudy effluent, Ileus, Ascites, Inguinal hernia, Abdominal discomfort

SKIN AND SUBCUTANEOUS DISORDERS: Toxic epidermal necrolysis, Erythema multiforme, Angioedema, Urticaria generalized, Toxic skin eruption, Swelling face, Periorbital edema, Exfoliative rash, Skin exfoliation, Prurigo, Rash (including macular, papular, erythematous), Dermatitis (including allergic and contact), Drug eruption, Erythema, Onychomadesis, Skin chapped, Blister

MUSCULOSKELETAL, CONNECTIVE TISSUE DISORDERS: Arthralgia, Back pain, Musculoskeletal pain

REPRODUCTIVE SYSTEM AND BREAST DISORDERS: Penile edema, Scrotal edema

GENERAL DISORDERS AND ADMINISTRATION SITE CONDITIONS: Discomfort, Pyrexia, Chills, Malaise, Drug effect decreased, Drug ineffective, Catheter site erythema, Catheter site inflammation, Infusion related reaction (including Infusion site pain, Instillation site pain)

INJURY, POISONING AND PROCEDURAL COMPLICATIONS: Device interaction

*Lower level term

DRUG INTERACTIONS

Overview

No interaction studies have been conducted with EXTRANEAL. The blood concentration of dialyzable drugs may be reduced by peritoneal dialysis.

Drug-Drug Interactions

Some drug additives may be incompatible with EXTRANEAL.

Addition of Potassium

Potassium is omitted from EXTRANEAL solutions because dialysis may be performed to correct hyperkalemia. In situations where there is a normal serum potassium level or hypokalemia, the addition of potassium chloride (up to a concentration of 4 mEq/L) may be indicated to prevent severe hypokalemia. The decision to add potassium chloride should be made by the physician after careful evaluation of serum potassium.

Addition of Insulin

Addition of insulin to EXTRANEAL was evaluated in 6 insulin-dependent diabetic patients undergoing CAPD for end stage renal disease. No interference of EXTRANEAL with insulin absorption from the peritoneal cavity or with insulin's ability to control blood glucose was observed (SEE WARNINGS AND PRECAUTIONS: Monitoring and Laboratory Tests). Appropriate monitoring of blood glucose should be performed when initiating EXTRANEAL in diabetic patients and insulin dosage adjusted if needed⁵ (SEE **WARNINGS AND PRECAUTIONS**: Monitoring and Laboratory Tests).

Addition of Heparin

No human drug interaction studies with heparin were conducted. *In vitro* studies demonstrated no evidence of incompatibility of heparin with EXTRANEAL.

Addition of Antibiotics

Compatibility has been demonstrated with vancomycin⁶, cefazolin⁷, ceftazidime⁷, gentamicin⁶, and netilmicin⁸. However, aminoglycosides should not be mixed with penicillins due to chemical incompatibility^{9, 10}.

Minimum Inhibitory Concentration (MIC)

No formal clinical data interaction studies have been performed. *In vitro* studies with EXTRANEAL and the following antibiotics have demonstrated no effects with regard to minimum inhibitory concentration (MIC): vancomycin, cefazolin, ampicillin, ampicillin/flucoxacillin, ceftazidime, gentamicin, and amphotericin.

Drug-Laboratory Interactions

Blood glucose measurement must be done with a glucose-specific method to prevent maltose interference. Glucose dehydrogenase pyrroloquinolinequinone (GDH-PQQ)- or glucose-dye-oxidoreductase (GDO)-based methods must not be used¹. Also, the use of some glucose monitors and test strips using glucose dehydrogenase flavin-adenine dinucleotide (GDH-FAD) methodology has resulted in falsely elevated glucose readings due to the presence of maltose (See **WARNINGS AND PRECAUTIONS**).

An apparent decrease in serum amylase activity has been observed in patients administered EXTRANEAL⁴.

DOSAGE AND ADMINISTRATION

Dosing Considerations

EXTRANEAL is intended for intraperitoneal administration only. Not for intravenous administration.

Treatment should be initiated under the supervision of a physician. The mode of therapy, frequency of treatment, exchange volume, duration of dwell and length of dialysis should be initiated and supervised by the physician.

Do not administer if the solution is discoloured, cloudy, contains particulate matter or shows evidence of leakage, or if seals are not intact.

EXTRANEAL is recommended for single use only. Discard any unused remaining solution.

Recommended Dose and Dosage Adjustment

EXTRANEAL is available in either a 2000 mL or a 2500 mL bag. The volume administered is based on the patient's need for adequate dialysis, as determined by the prescribing physician.

Adults: By intraperitoneal administration as a single daily exchange for the long dwell, up to 12 hours, in CAPD or 14 and up to 16 hours in APD. Aseptic technique should be employed throughout the peritoneal dialysis procedure.

The contents of a 2000 mL or 2500 mL bag (as appropriate for the patient's dialysis needs) should be instilled over a period of approximately 10 to 20 minutes at a rate which the patient finds comfortable. The recommended dwell time is between 6 and 12 hours in CAPD and 14-16 hours in APD. Drainage of CAPD fluid is by gravity and APD fluid is by a process which simulates gravity. Both should be at a rate comfortable for the patient.

The drained fluid should be inspected for the presence of fibrin or cloudiness, which may indicate the presence of infection.

Elderly: As for adults.

Children: Not recommended for use in children (less than 18 years of age).

Administration

EXTRANEAL is intended for intraperitoneal administration only.

Aseptic technique should be employed throughout the peritoneal dialysis procedure.

To reduce discomfort on administration, the solution may be warmed to a temperature of 37°C (98.6°F) prior to use. This should be done using dry heat ideally using a warming plate or heating pad specially designed for the purpose. **The bag should not be immersed in water to warm it to avoid contamination of connectors. Do not microwave.**

OVERDOSAGE

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

No data is available on the effects of overdose. However, continuous administration of more than one bag of EXTRANEAL in 24 hours would increase plasma levels of carbohydrate metabolites and maltose. The effects of such an increase are unknown but an increase in plasma osmolality may occur. Treatment could be managed by icodextrin free peritoneal dialysis or haemodialysis.

ACTION AND CLINICAL PHARMACOLOGY

Mechanism of Action

EXTRANEAL is a water-soluble α -1,4 and α -1,6 linked glucofuranose (cyclic form of glucose) polymer with an average molecular weight range of 12,000 to 20,000 daltons. When administered intraperitoneally icodextrin acts as a colloid osmotic agent, leading to net fluid movement from blood to dialysate. Icodextrin is approximately iso-osmolar (284 mOsmol/L) to serum. As an osmotic agent it is 5.5 times more effective than glucose 1.36% solution and as effective as glucose 3.86% solution.

Icodextrin does not appear to be metabolized within the peritoneal cavity and is only slowly absorbed from the peritoneal cavity, mostly by the lymphatic system⁶. The extent of absorption depends on the dwell time of the solution; about 20% of the total carbohydrate is absorbed in 8 hours, and this rises to 34% in 12 hours. This translates into mean

carbohydrate absorption for the icodextrin $29.5 \pm 5g$ vs $62 \pm 5g$ for glucose 4.25% solution per 12 hour dwell. The reduced absorption of glucose leads to reduced potential for hyperglycemia, hyperinsulemia and caloric load¹².

Absorbed icodextrin has been shown to be degraded to smaller oligosaccharides (principally maltose and maltotriose) by serum α -amylase¹³. In subjects with normal renal function, these metabolites are further degraded by kidney enzymes¹⁴. In dialysis patients, the clearance of the icodextrin and its metabolites is slower and the levels of the metabolites increase, however there is no effect on serum osmolality^{12, 13, 15}. With daily use of icodextrin solution, steady state concentrations of total icodextrin, maltose and metabolites of higher molecular weight are achieved within 7-10 days. In the MIDAS study, steady-state levels were 4.6 mg/mL for total icodextrin derived material, 1.2 mg/mL for maltose, 1.8 mg/mL for oligosaccharides between 3 and 9 glucose units (G3-G9), and 1.8 mg/ml for metabolites larger than G9. Plasma levels return to baseline values within approximately two weeks following cessation of icodextrin administration⁴. The long-term effects of raised plasma levels of maltose and glucose polymer are unknown, but there is no reason to suspect these to be harmful.

In APD (automated peritoneal dialysis), EXTRANEAL solution used for the long daytime dwell allows greater flexibility in fluid intake compared to glucose solutions.

Toxicity studies show no evidence of local damage or irritation of the peritoneum, nor any evidence of storage of the polymer.

STORAGE AND STABILITY

Store at room temperature (15-25°C). Do not store below 4°C. Do not use unless the solution is clear and the container undamaged. Any unused portion of the solution should be discarded.

SPECIAL HANDLING INSTRUCTIONS

SEE STORAGE AND STABILITY

DOSAGE FORMS, COMPOSITION AND PACKAGING

Dosage Forms

EXTRANEAL is available in Viaflex® Single or TwinBag containers holding 2000 mL or 2500 mL.

Composition

EXTRANEAL is a sterile, peritoneal dialysis fluid containing icodextrin at a concentration of 7.5% w/v in an electrolyte solution containing the following:

	<u>mmol/litre (approx)</u>	<u>mEq/litre (approx)</u>
Sodium	132	132
Calcium	1.75	3.5
Magnesium	0.25	0.5
Chloride	96	96
Lactate	40	40

Each one litre contains

Icodextrin	75 g
Sodium Chloride, PhEur or USP	5.35 g
Sodium Lactate, DAB or USP	4.48 g
Calcium Chloride Dihydrate, PhEur or USP	257 mg
Magnesium Chloride Hexahydrate, PhEur or USP	51 mg
Water for Injection, PhEur or USP	q.s.
Theoretical osmolarity	284 milliosmoles per litre
pH	5.2

Packaging

See Dosage Forms.

PART II: SCIENTIFIC INFORMATION

PHARMACEUTICAL INFORMATION

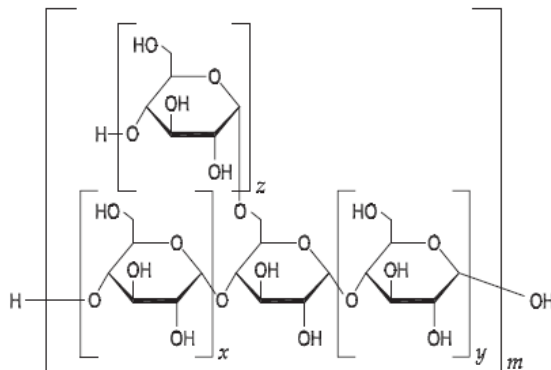
Drug Substance

Proper name: Icodextrin

Chemical name: α -1,4, poly glucopyranose

Molecular formula and molecular mass: $[C_6H_{10}O_5]_n$
 n = number of glucose units in polydisperse glucose polymer

Structural formula:



Physicochemical properties: Icodextrin is a glucopyranose (cyclic form of glucose) polymer (linked by α -1,4 and α -1,6 bonds, but predominantly α -1,4) produced by the hydrolysis of starch and fractionated by membrane separation technology to produce material with the desired molecular weight distribution. Icodextrin has a weight average molecular weight between 12,000 and 20,000 Daltons and a number average molecular weight between 5,000 and 6,500 Daltons. It bears a close structural relationship to glycogen, the natural storage polymer in the human body¹⁵.

DETAILED PHARMACOLOGY

Colloid osmosis is the predominant basis of action of icodextrin^{16, 17}. In biological systems, a transport mechanism similar to that elicited by that of icodextrin in CAPD exists naturally across the permeable membranes of capillaries. Albumin (68,000 daltons) is an effective osmotic agent whose passage across the capillary wall is restricted. It exerts a colloid osmotic pressure, even though its molar concentration (0.66 mmol/L) is a fraction of the total plasma osmolarity (295

mmol/L). Icodextrin is a glucose polymer composed of glucose residues joined largely through 1-4 links with a small degree of branching through 1,6 links with an average molecular weight at the range of 12,000 to 20,000 daltons.

Carbohydrates with structures like icodextrin are substrates for α -amylase which is found in pancreatic juice, saliva and plasma. Alpha-amylase hydrolyses these carbohydrates to oligosaccharides, maltose, isomaltose and maltotriose. These are hydrolyzed to glucose by maltase and isomaltase found in the small intestine, kidney and a variety of other tissues¹³. An assay was developed to separate and detect icodextrin and its hydrolysis products (G1-glucose to G10 and high molecular weight structure >G10) in body fluids¹⁸. The fate of intraperitoneally administered icodextrin is determined by its stability in the peritoneal cavity, the degree of absorption into systemic circulation and renal and metabolic elimination. The results of pharmacokinetic studies in animals are limited by the fact that most animal models have normal kidney function. The kidney is a major site for further metabolism of oligosaccharides by maltase. The animal studies can provide information on the absorption from the peritoneal cavity and on rates of non-renal clearance, but may not give all the desired information on metabolism and distribution. In addition, rats and dogs metabolize (due to higher levels of maltase) and excrete the product much faster than humans, as demonstrated in a 28-day study where icodextrin was not detected in the plasma of rats or dogs and was rapidly eliminated.

Table 1: Comparative Pharmacokinetic data for Icodextrin

Species	Dose Details	Sample Time (n)	Mean Plasma Levels (mg/mL)		
			G2	G3-G10	G>10
Rat	4.0 & 6.0 g/kg IP twice daily for 28 days		None detected		
Dog	6.0 g/kg IP twice daily for 28 days (12g/kg/day)	Pre-dose (8)	0.02	0.02	0.10
		Day 1:5h (8)	0.11	0.52	0.17
		Day 1:24h (8)	0.02	0.22	0.13
		Day 21:5h (8)	0.05	0.33	0.18
		Day 21:24h (8)	0.02	0.24	0.16
		Day 28:5h (8)	0.03	0.28	0.14
		Day 28:24h (8)	0.02	0.26	0.16
Man	150 g once daily IP for 6 months (2.14g/kg/day)	Pre-dose (91)	0.04	0.02	0.29
		1 month (80)	1.20	1.84	1.83
		3 months (72)	1.00	1.67	1.73
		6 months (53)	1.06	1.76	1.84

Pharmacokinetics: There is evidence of slow constant absorption of icodextrin from the peritoneal cavity via the lymphatic system^{16, 17}. In the systemic circulation it is metabolized by amylase to smaller oligosaccharides (principally maltose and maltotriose) which are detectable in serum and are cleared by metabolism and peritoneal dialysis. Following the use of icodextrin on a daily basis for overnight exchange, maltose levels reach steady-state (1.2 mg/mL) after 7-10

days. Plasma levels of icodextrin and maltose were measured in 12 patients who stopped once a day treatment with icodextrin after approximately two years. Icodextrin related material (4.8 mg/mL) and maltose (1.1 mg/mL) fell to pretreatment levels in 7-10 days¹⁹.

Clinical trials: The MIDAS¹⁵ 6 month clinical trial was set up to compare and evaluate the efficacy and safety of icodextrin with glucose (weak 1.36%/1.5% and strong 3.86%/4.25%) in 8 hours of CAPD. On weeks 4, 13 and 21, the hours were extended for 12 hours. The results indicate that icodextrin was well-tolerated and produced up to 5.5 times more ultrafiltration than 1.36% glucose and the same ultrafiltration as a 3.86% glucose solution.

Table 2: Mean Volume (mL) of Net Ultrafiltration for 8 Hour Dwell by Glucose Concentration*

Week	Control Mean SD (N)	Icodextrin Mean SD (N)
Weak (1.36%)		
Week 3	150.6 ± 328.7 (50)	497.4 ± 228.3 (42)*
Week 12	141.8 ± 309.6 (40)	480.7 ± 208.3 (42)*
Week 20	153.2 ± 313.0 (38)	516.9 ± 234.7 (37)*
Medium (2.27%) or Strong (3.86%)		
Week 3	615.4 ± 288.8 (30)	528.1 ± 241.0 (28)
Week 12	553.0 ± 357.2 (29)	515.2 ± 211.7 (23)
Week 20	464.6 ± 379.2 (24)	461.8 ± 198.5 (19)
*p<0.0001		

Table 3: Mean Volume (mL) of Ultrafiltrate for Special Weeks (12 hr Dwell) by Glucose Concentration

Special Week	Control Mean SD (N)	Icodextrin Mean SD (N)
1.5% Dextrose		
4	72.7 339.0 (51)	529.6 290.2 (42)*
13	49.3 302.0 (41)	496.9 288.9 (40)*
21	125.9 324.3 (38)	552.1 309.3 (36)*
4.25% Dextrose		
4	498.4 418.5 (31)	610.4 238.8 (28)
13	458.3 434.1 (29)	593.5 223.8 (23)
21	427.0 461.4 (25)	509.5 205.5 (21)
*p<0.0001		

In the icodextrin group, 7% of the patients experienced negative ultrafiltration (UF), while in the control group, up to 41% of the patients experienced negative UF. Over the 12-hour dwell, net ultrafiltration was similar in patients receiving icodextrin solution and the controls who were using 4.25% dextrose solution for the long dwell.

Safety: The side effects in this study were reported by half of the patients and were equally distributed between the two groups. They were mainly related to preexisting cardiovascular disease. Excluding peritonitis, the most common reported were respiratory, musculoskeletal and gastrointestinal events. There was no difference in severity of the side effects between the two groups. The icodextrin patients experienced symptomatic improvement in abdominal fullness, fatigue and shortness of breath. There were no differences in the insulin dose for diabetic patients (n=26) in both groups. The mean carbohydrate absorption for the icodextrin group (29 ± 5g) was lower than with 4.25% dextrose (62 ± 5g). The icodextrin group mean serum maltose and metabolite levels (total GHO-G1) rose to a steady-state level.

Table 4: Serum Levels of Maltose and Total Icodextrin and Metabolites

		Visit 2 Baseline	Visit 6	Visit 9	Visit 12
Maltose (mg/mL)	Control	0.0300.02 (91)			0.030.01 (64)
	Icodextrin	0.040.04 (91)	1.200.38 (91)	1.010.35 (80)	1.090.39 (67)
Total CHO-G1 (mg/mL)	Control	0.320.10 (98)			0.350.09 (64)
	Icodextrin	0.350.15 (91)	4.871.55 (80)	4.411.36 (73)	4.621.46 (67)

The elevated levels of maltose did not appear to have any clinical side effects. Some patients in the UK who elected to continue using icodextrin have been doing so for more than 5 years without any adverse effects related to icodextrin accumulation.

TOXICOLOGY

Recommended human dose 2-3 g/kg/day.

Animal toxicology testing was limited by several factors, notably by restrictions on the volume/viscosity of icodextrin which could be administered intraperitoneally, lack of renal failure animal models and by differences in the degree and speed of metabolism and excretion of icodextrin, especially in the rat and in the dog. The chronic toxicity studies were not done for the same reasons. Therefore, the results of animal toxicology studies are mostly useful for their information on the local effects of icodextrin.

Acute toxicity: Single i.v. and i.p. dose of icodextrin had no systemic or local effect in the mouse or the rat. No effect on the CNS was observed. Subacute 28-day toxicity testing in the rat (12 g/kg/day) and the dog (12 g/kg/day) revealed rapid elimination and limited exposure by icodextrin in the rat and similarly, rapid metabolism and excretion in the dog (blood levels 10-20% lower than humans), with exposure to icodextrin metabolites similar to humans despite a much higher dose.

There was no apparent effect on the peritoneum in the rat or the dog and only small changes in electrolytes, BUN and MCV, consistent with the anticipated physiological effect of peritoneal dialysis even in the presence of normal renal function. A sharp decline in the production of urine and production of more concentrated urine in the dog was consistent with the effect of peritoneal

dialysis. Plasma glucose has shown dose-related increases of up to 25-30%, which is attributed to the hydrolysis of icodextrin as it is released from the peritoneal “reservoir”. The dog has also high levels of circulating maltose and maltotriose. All changes had largely or completely disappeared after the 14-day recovery period. Mutagenicity: Using the Ames test, no effect was found at up to (icodextrin) 10,000g/plate.

In a very full test, (icodextrin) had no clastogenic effect in concentrations up to 200 mg/mL, in the presence and absence of S9 microsomes.

This concentration did not affect the osmolality of the culture medium. It had no cytotoxic action.

In a mouse micronucleus test, mice of both sexes were given (icodextrin) up to 6 g/kg i.p. In samples of bone marrow taken at several times, no micronuclei were found.

Icodextrin does not possess chemical structures known to be capable of being metabolized to mutagenic electrophilic groups. No further experiments have been done *in vitro* or *in vivo* because of the chemical nature of icodextrin, the lack of activity even in very high concentrations in the *in vitro* studies, and because it is metabolized *in vivo* to compounds normally present in the body.

Local Toxicity Studies: In terms of irritancy, clinical and necropsy observations in the acute toxicity tests did not show any features of local irritation. In a 28-day experiment in the dog, residual peritoneal fluid was sometimes obtained *in vivo* and at autopsy. It did show a variable, low leukocyte count and protein content in most instances, often exceeded by the values in fluid from animals receiving 5% glucose i.p. The latter might have been anticipated in view of the known irritancy (in man) of 5% glucose.

REFERENCES

1. Janssen W, Harf G, Caers M, Schellekens A. Positive interference of icodextrin metabolites in some enzymatic glucose methods. *Clin Chem* 44:2379-2380, 1998.
2. Silvestre J, Carvalho S, Mendes V, Coelho L, Tapadinhas C, Ferreira P, Pova P, and Ceia F. Metformin-induced lactic acidosis: a case series. *J of Med Case Rpts.* 2007;1:126.
3. Geddes R, Knight S, Moosa MYS, Reddi A, Uebel K, and Sunpath R. A high incidence of nucleoside reverse transcriptase inhibitor (NRTI)-induced lactic acidosis in HIV-infected patients in a South African context. *SAMJ.* 2006;22:722-724.
4. Plum J, Gentile S, Verger C, et al. Efficacy and safety of a 7.5% icodextrin peritoneal dialysis solution in patients treated with automated peritoneal dialysis. *Am J Kidney Dis.* 2002;39:862-871.
5. Data on file, Baxter Healthcare Corporation. ML/IB/002, Dextrin 20 Insulin Study
6. Choo, C. G., et al. Compatibility of 7.5% polyglucose peritoneal dialysis solution with gentamicin, vancomycin, heparin and insulin. *Perit. Dial. Int* 17 (1997): S94.
7. Baxter. Compatibility of Extraneal Peritoneal Dialysis Solution (PDS) with Cefazolin and Ceftazidime. Study Report RD-98-PD038.
8. Baxter. Compatibility of Netilmicin with Physioneal and Extraneal Peritoneal Dialysis Solution (PDS). Study Report RD-96-PD-135,A.
9. Henderson JL, Polk RE, Kline BJ. In vitro inactivation of gentamicin, tobramycin, and netilmicin by carbenicillin, azlocillin, or mezlocillin. *Am J Hosp Pharm.* 1981 Aug;38(8):1167-70.
10. Navarro AS, Lanao JM, Dominguez-Gil Hurlé A. In-vitro interaction between dibekacin and penicillins. *J Antimicrob Chemother.* 1986 Jan;17(1):83-9.
11. Hatano Research Institute Food and Drug Safety Center (Japan) Final Report. Protocol #Q-98-003; Distribution Study of Icodextrin in Rats.
12. Alsop RM. History, chemical and pharmaceutical development of icodextrin. *Perit Dial Int* 1994; 14 (Suppl 2): S5-S12.
13. Mistry CD. Glucose polymer as an osmotic agent in continuous peritoneal dialysis. MD Thesis, University of London, 1989.
14. Silverman M. Brush border disaccharidases in dog kidney and their spatial relationship to

- glucose transport receptors. *J. Clin Invest* 1973; 52:2486-2494.
15. Mistry CD, Gokal R, Peers E, MIDAS Study Group. A randomized multicenter clinical trial comparing isosmolar icodextrin with hyperosmolar glucose solutions in CAPD. *Kidney Int* 1994; 46:496-503.
 16. Mistry CD, Mallick NP, Gokal R. Ultrafiltration with isosmotic solution during long peritoneal dialysis exchanges. *Lancet* 1987; ii:178-182.
 17. Pannekeet MM, Stegeman G, Struijk DG, Krediet RT. Peritoneal permeability characteristics using glucose polymer based dialysate. *Perit Dial Int* 1995; 15 (suppl1):536.
 18. Johnson DW, Arndt M, O'Shea A, et al. Icodextrin as salvage therapy in peritoneal dialysis patients with refractory fluid overload. *BMC Nephrology* 2001; 2:2.
 19. Davies DS. Kinetics of icodextrin. *Peritoneal Dialysis International* 1994; 14(2):S45-S50.
 20. Evaluation of the Efficacy and Safety of a 12-Hour Night Time Dwell of BLPG in Patients Receiving Continuous Ambulatory Peritoneal Dialysis (CAPD). Protocol: BLR-PG21. Baxter Japan Limited. March 28, 2001.
 21. Arkray 510(k) Substantial Equivalence Determination Decision Summary Assay and Instrument Combination Template. 510(k) number: k063771. Section M.1.e.
 22. Baxter. Determination of Potential Interference of Icodextrin and Its Metabolites on Human Blood Glucose Measurement Using Chosen Glucometer – Glucocard X-Meter (Arkray). Study Report 33541.

READ THIS FOR SAFE AND EFFECTIVE USE OF YOUR MEDICATION

PART III: PATIENT MEDICATION INFORMATION

EXTRANEAL

7.5% w/v Icodextrin Peritoneal Dialysis Solution

(icodextrin, sodium chloride, sodium lactate, calcium chloride, magnesium chloride)

This leaflet is part III of a three-part "Product Monograph" published when EXTRANEAL was approved for sale in Canada and is designed specifically for Consumers. This leaflet is a summary and will not tell you everything about EXTRANEAL. Contact your doctor or pharmacist if you have any questions about the drug.

ABOUT THIS MEDICATION

What the medication is used for:

- EXTRANEAL is a sterile peritoneal dialysis solution used in patients whose kidneys are not working properly. It removes waste products and water from the blood. EXTRANEAL can be used up to 12 hours for continuous peritoneal dialysis in mobile patients or 14 and up to 16 hours for automated peritoneal dialysis procedures.

What it does:

EXTRANEAL contains icodextrin, which is made from cornstarch. It draws fluid and wastes from your blood stream into your peritoneal cavity (the space inside your abdomen). The fluids and wastes are removed from your body when the EXTRANEAL solution is drained.

When it should not be used:

Do not use EXTRANEAL:

- If you have been treated for acute renal failure
- If a doctor has ever told you that you have a glycogen storage disease
- If you are allergic to cornstarch or have had an allergic reaction to icodextrin
- If you have maltose or isomaltose intolerance
- If a doctor has told you that you have pre-existing severe lactic acidosis
- If you have had abdominal surgery within the last month
- If you are allergic to any of the nonmedicinal ingredients (see What the nonmedicinal ingredients are:)
- If you have impaired respiratory function or potassium deficiency
- If you are told having a surgically uncorrectable problem affecting your abdominal wall or cavity or uncorrectable

problem that increases risk of abdominal infections such as abdominal fistulae, tumors, open wounds, herniae or other conditions until healing is complete

- If you have documented loss of peritoneal function due to severe peritoneal scarring
- If you are pregnant or plan to become pregnant
- If you are breastfeeding

What the medicinal ingredients are:

Icodextrin
Sodium Chloride
Sodium Lactate
Calcium Chloride
Magnesium Chloride

What the nonmedicinal ingredients are:

Hydrochloric acid (For pH adjustment)
Sodium Hydroxide (For pH adjustment)
Water for Injection

What dosage forms it comes in:

EXTRANEAL is available in Viaflex® Single or TwinBag containers holding 2000 mL or 2500 mL.

WARNINGS AND PRECAUTIONS

If you monitor your blood glucose, you must use a glucose specific monitor and test strips. If your glucose monitor or test strips use a GDH-PQQ*GDOor GDH-FAD***-based method, using EXTRANEAL may cause a falsely high glucose reading or may mask a very low actual glucose reading. A false high blood glucose reading could cause you to give more insulin than you need. Getting more insulin than you need can cause serious reaction including loss of consciousness, coma, neurological damage and death. If you have true low blood sugar but are using a monitor that is not specific, you may inadvertently delay taking appropriate measure to correct the low blood sugar. A false elevated reading may be measured up to two weeks following the discontinuance of EXTRANEAL .**

***GDH-PQQ: glucose dehydrogenase pyrroloquinolinequinone**

****GDO: glucose-dye-oxidoreductase**

*****GDH-FAD: glucose dehydrogenase flavin-adenine dinucleotide**

If you are ever hospitalized or admitted to the emergency room, notify the hospital staff that you are using EXTRANEAL and that icodextrin and maltose may give a false high glucose reading with some types of glucose monitors or test strips.

Tell your doctor if you:

- Use cardiac glycosides, such as digoxin. Your doctor may need to monitor your blood levels of calcium, potassium and magnesium
- Have recently had surgery to repair a weakness in an abdominal artery
- Suspect you are having an allergic reaction to EXTRANEAL or any ingredient in EXTRANEAL

Patients on EXTRANEAL may experience high or low levels of potassium, calcium, or magnesium in their blood. Your doctor will monitor your blood test results.

Tell your doctor about any other conditions you have that may affect the inside, outside or the wall of your abdomen.

If you are allergic to corn or corn products, undesirable allergic reactions, including development of rash, hives, throat and/or facial swelling, wheezing, shortness of breath, low blood pressure, and other anaphylactic/anaphylactoid reactions, may occur. Stop the infusion immediately and drain the solution from the peritoneal cavity if any signs or symptoms of a suspected allergic reaction develop and contact your doctor immediately.

INTERACTIONS WITH THIS MEDICATION

Tell your doctor or pharmacist all the medications you are taking including all prescription, non-prescription and natural health products.

The blood concentration of drugs that can be removed from the body using dialysis may be reduced by peritoneal dialysis.

Talk with your doctor about any drugs prescribed as an additive to EXTRANEAL .

Tell your doctor about all the medicines you take, including insulin and blood pressure medicines. Your dose of these medicines may need to be changed when you use EXTRANEAL .

PROPER USE OF THIS MEDICATION

Usual dose

SIDE EFFECTS AND WHAT TO DO ABOUT THEM

- EXTRANEAL is used for the long dwell exchange, up to 12 hours, in CAPD. EXTRANEAL is used for the long dwell exchange (14 to 16 hours) in APD. Do not perform more than one exchange in 24 hours.
- To do your EXTRANEAL exchange, it is very important that you follow the steps shown to you in your peritoneal dialysis training. All surfaces and connecting parts must be clean to avoid serious infection. If you need more help

or have any questions you should contact your dialysis center or doctor.

- Before use, always check to make sure the bags are not leaking and the date for using the solution (expiration date) has not passed. Do not use EXTRANEAL after the expiration date shown on the carton and product label.
- Make sure the solution is clear and does not contain particles. Do not use bags that are cloudy, leaking or that contain particles.
- EXTRANEAL is for single use only. Discard any unused remaining solution.
- EXTRANEAL is only for intraperitoneal administration.
- Sometimes, too much EXTRANEAL can get into your peritoneal cavity. If you experience abdominal distention, feeling of fullness and, or shortness of breath, contact your doctor or peritoneal dialysis unit.
- To make using EXTRANEAL more comfortable, you can warm it to 37°C (98.6°F) before use. This should only be done using dry heat, such as a heating pad.
- To avoid increased risk of infection, do not place EXTRANEAL in water to heat the bags.
- Do not microwave EXTRANEAL.
- EXTRANEAL should be infused based on your need for adequate dialysis, as determined by your doctor. When draining the fluid after the dwell, always check your drained fluid for cloudiness or fibrin. Fibrin looks like clumps or stringy material in the drained solution. Cloudy drained fluid or fibrin may mean you have an infection. Call your doctor if your drained fluid is cloudy or contains fibrin.
- Carefully monitor your fluid balance. Keep an accurate fluid record. Carefully monitor your body weight to avoid too much or too little fluid in your body (over or under hydration) which may have serious effects.
- Talk to your doctor before adding any other medicines to EXTRANEAL.

Overdose

There is no information available on the effects of overdose. Only one exchange is recommended in a 24-hour period. Contact your doctor if a suspected overdose has been administered.

In case of a suspected drug overdose, contact a health care practitioner, hospital emergency department or regional Poison Control Centre immediately, even if there are no symptoms.

Rash is the most common side effect of EXTRANEAL. It usually appears during the first 3 weeks of treatment and goes away when treatment stops.

SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM

Symptom / effect	Talk with your doctor or pharmacist		Stop taking drug and seek immediate emergency medical attention	
	Only if severe	In all cases		
Common	<ul style="list-style-type: none"> Allergic Reactions: swelling of the face, throat, lips, difficulty swallowing or breathing, skin peeling, itching, hives or rash 		✓	✓
	<ul style="list-style-type: none"> Dehydration: dizziness, weakness or fainting, low or drop in blood pressure, thirst, dry mouth, constipation 	✓		
	<ul style="list-style-type: none"> Ringing in your ears 	✓		
	<ul style="list-style-type: none"> Headache 	✓		
	<ul style="list-style-type: none"> Swelling in different parts of the body such as the hands, feet, face and abdomen 	✓		
	<ul style="list-style-type: none"> Decreased urine production 		✓	
	<ul style="list-style-type: none"> High blood pressure 	✓		
Uncommon	<ul style="list-style-type: none"> Peritonitis (an infection in the peritoneal cavity): cloudy or bloody drained fluid, abdominal pain, fever, redness, nausea, upset stomach, vomiting, lack of appetite, weight loss, constipation) 		✓	
	<ul style="list-style-type: none"> High / low blood sugar 	✓		
	<ul style="list-style-type: none"> Shortness of breath, chest pain 		✓	

SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM

Symptom / effect	Talk with your doctor or pharmacist		Stop taking drug and seek immediate emergency medical attention
	Only if severe	In all cases	
<ul style="list-style-type: none"> Flu-like symptoms, cold, cough 	✓		

This is not a complete list of side effects. For any unexpected effects while taking EXTRANEAL, contact your doctor or pharmacist.

HOW TO STORE IT

Store at room temperature (15 - 25°C). Do not store below 4°C. Do not use unless the solution is clear and the container undamaged. Any unused portion of the solution should be discarded.

Keep out of reach and sight of children.

REPORTING SUSPECTED SIDE EFFECTS

You can help improve the safe use of health products for Canadians by reporting serious and unexpected side effects to Health Canada. Your report may help to identify new side effects and change the product safety information.

3 ways to report:

- Online at MedEffect (<http://hc-sc.gc.ca/dhp-mps/medeff/index-eng.php>);
- By calling 1-866-234-2345 (toll-free);
- By completing a Consumer Side Effect Reporting Form and sending it by:
 - Fax to 1-866-678-6789 (toll-free), or
 - Mail to: Canada Vigilance Program
 - Health Canada, Postal Locator 0701E
 - Ottawa, ON
 - K1A 0K9

Postage paid labels and the Consumer Side Effect Reporting Form are available at MedEffect (<http://hc-sc.gc.ca/dhp-mps/medeff/index-eng.php>).

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.

MORE INFORMATION

If you want more information about EXTRANEAL :

- 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 (<http://hc-sc-gc.ca/index-eng.php>); or by contacting the sponsor, Vantive ULC, at:1-800-387-8399

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