

PRODUCT MONOGRAPH
INCLUDING PATIENT MEDICATION INFORMATION

PrClindamycin Injection in 5% Dextrose

Sterile solution, clindamycin 12 mg / mL (600 mg / 50 mL) and 18 mg / mL (900 mg / 50 mL) (as clindamycin phosphate) in ready-to-use bags, for intravenous infusion

Manufacturer's Standard

Antibiotic

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L5N 0C2

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RECENT MAJOR LABEL CHANGES

4 DOSAGE AND ADMINISTRATION, 4.2 Recommended Dose and Dosage Adjustment	05/2024
7 WARNINGS AND PRECAUTIONS, Renal	05/2024

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PART I: HEALTH PROFESSIONAL INFORMATION

1 INDICATIONS

Clindamycin Injection in 5% Dextrose (clindamycin phosphate) is indicated for the treatment of serious infections due to susceptible anaerobic bacteria, such as *Bacteroides* species, *Peptostreptococcus*, anaerobic streptococci, *Clostridium* species and microaerophilic streptococci.

Clindamycin Injection in 5% Dextrose is also indicated for the treatment of serious infections due to susceptible strains of gram positive aerobic bacteria (staphylococci, including penicillinase-producing staphylococci, streptococci and pneumococci) as well as in the treatment of *Chlamydia trachomatis*, when the patient is intolerant of, or the organism is resistant to other appropriate antibiotics.

Because of the risk of *Clostridium difficile*-associated disease (CDAD) as described in [7 WARNINGS AND PRECAUTIONS](#), before selecting clindamycin the health professional should consider the nature of the infection and the suitability of alternative therapy.

Clindamycin Injection in 5% Dextrose is indicated for the treatment of the following serious infections when caused by susceptible strains of the designated organisms in the conditions listed below:

- **Lower respiratory infections** including pneumonia, empyema, and lung abscess when caused by anaerobes, *Streptococcus pneumoniae*, other streptococci (except *Enterococcus faecalis*) and *Staphylococcus aureus*.
- **Skin and skin structure infections** including cellulitis, abscesses, and wound infections when caused by *Streptococcus pyogenes*, *Staphylococcus aureus* and anaerobes.
- **Gynecological infections** including endometritis, pelvic cellulitis, vaginal cuff infections, non-gonococcal tubo-ovarian abscess, salpingitis, and pelvic inflammatory disease when caused by susceptible anaerobes or *Chlamydia trachomatis*. Clindamycin should be given in conjunction with an antibiotic of appropriate gram negative aerobic spectrum.
- **Intra-abdominal infections** including peritonitis and abdominal abscess when caused by susceptible anaerobes. Clindamycin should be given in conjunction with an antibiotic of appropriate gram negative aerobic spectrum.
- **Septicemia** caused by *Staphylococcus aureus*, streptococci (except *Enterococcus faecalis*) and susceptible anaerobes, where the bactericidal efficacy of clindamycin against the infecting organism has been determined *in vitro* at achievable serum levels.
- **Bone and joint infections** including osteomyelitis and septic arthritis when caused by sensitive strains of *Staphylococcus aureus* and anaerobes.

- ***Pneumocystis jiroveci* pneumonia** in patients with AIDS. Clindamycin in combination with primaquine may be used in patients who are intolerant to, or fail to respond to conventional therapy.

Note: Clindamycin Injection in 5% Dextrose is not indicated in the treatment of meningitis since it penetrates poorly into cerebrospinal fluid, even in the presence of inflamed meninges.

Bacteriologic studies should be performed to determine the causative organisms and their susceptibility to clindamycin.

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

To reduce the development of drug-resistant bacteria and maintain the effectiveness of Clindamycin Injection in 5% Dextrose and other antibacterial drugs, Clindamycin Injection in 5% Dextrose 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 (<18 years of age): No data are available to Health Canada; therefore, Health Canada has not authorized an indication for pediatric use of Clindamycin Injection in 5% Dextrose GALAXY plastic containers. It is not known if use of clindamycin in the pediatric population is associated with differences in safety or effectiveness compared with adult patients.

Clindamycin Injection in 5% Dextrose GALAXY plastic containers are not suitable for use in pediatric patients. Pediatric dosing requires dose adjustments which would result in partial use of the GALAXY plastic containers. Partial use of GALAXY plastic containers is not feasible in a clinical setting, therefore clindamycin injection (150 mg / mL) is more suitable for dosing in this population (See [7 WARNINGS AND PRECAUTIONS, Special Populations, 7.1.3 Pediatrics](#)).

1.2 Geriatrics

Geriatrics (>60 years of age): Insufficient data are available to Health Canada. Clinical studies of clindamycin did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently from younger patients. However, antibiotic-associated colitis

may occur more frequently and with increased severity among elderly (> 60 years) and debilitated patients (See [7 WARNINGS AND PRECAUTIONS, Special Populations, 7.1.4 Geriatrics](#)).

2 CONTRAINDICATIONS

Clindamycin Injection in 5% Dextrose (clindamycin phosphate) is contraindicated in patients with a known hypersensitivity to preparations containing clindamycin or lincomycin or to any ingredient in the formulation or component of the container. For a complete listing, see [6 DOSAGE FORMS, STRENGTHS, COMPOSITION AND PACKAGING](#).

4 DOSAGE AND ADMINISTRATION

4.1 Dosing Considerations

The partial use of clindamycin phosphate GALAXY plastic containers is not recommended.

Dosage and route of administration should be determined by the severity of the infection, the condition of the patient and the susceptibility of the causative microorganisms.

In cases of β -hemolytic streptococcal infections, treatment should be continued for at least 10 days.

Antibiotic-associated colitis may occur more frequently and with increased severity among elderly (> 60 years) and debilitated patients. These patients should be carefully monitored for the development of diarrhea.

Periodic kidney function tests should be performed in patients with pre-existing renal dysfunction or taking concomitant nephrotoxic drugs, or if therapy is prolonged.

Periodic liver function tests and blood counts should be performed during prolonged therapy or when treating patients with severe liver disease.

4.2 Recommended Dose and Dosage Adjustment

Adults (IV Administration)

The usual daily adult dosage of Clindamycin Injection in 5% Dextrose (clindamycin phosphate) for infections of the intra-abdominal area, female pelvis, and other complicated or serious infections is 2400-2700 mg given in 3 or 4 equal doses. Less complicated infections may respond to lower doses such as 1200- 1800 mg / day administered in 2 or 3 equal doses.

Pelvic Inflammatory Disease

Clindamycin Injection in 5% Dextrose 900 mg (IV) every 8 hours plus an antibiotic with appropriate gram negative aerobic spectrum administered IV. Treatment with intravenous drugs should continue for at least 48 hours after the patient demonstrates significant clinical improvement. Then continue with appropriate oral therapy to complete 10-14 days total therapy.

Pneumocystis jiroveci pneumonia in patients with AIDS

Clindamycin Injection in 5% Dextrose 600-900 mg (IV) every 6 hours or 900 mg (IV) every 8 hours in combination with oral daily dose of 15-30 mg of primaquine. Alternatively, clindamycin hydrochloride 300-450 mg may be given orally every 6 hours in combination with 15-30 mg of primaquine for 21 days. If patients should develop serious hematologic adverse effects, reducing the dosage regimen of primaquine and / or Clindamycin Injection in 5% Dextrose should be considered.

Dosage Adjustments

Pharmacokinetic studies with clindamycin have shown no clinically important differences between young and elderly subjects with normal hepatic function and normal (age-adjusted) renal function after oral or intravenous administration. Therefore, dosage adjustments are not necessary in the elderly with normal hepatic function and normal (age-adjusted) renal function.

Clindamycin Injection in 5% Dextrose dose modification may not be necessary in patients with renal disease.

Clindamycin Injection in 5% Dextrose dosage reduction in liver disease is not generally considered necessary.

4.3 Reconstitution

Infusion Rates

Infusion rates for Clindamycin Injection in 5% Dextrose should NOT EXCEED 30 MG PER MINUTE as indicated below:

Table 1 – Infusion rates

Dose	Strength	Time
600 mg / 50 mL	12 mg / mL	20 min.
900 mg / 50 mL	18 mg / mL	30 min.

Administration of more than 1200 mg in a single 1-hour infusion is not recommended.

Alternatively, the drug may be administered in the form of a single rapid infusion of the first dose followed by continuous IV infusion as follows:

Table 2 – Infusion rates per clindamycin levels

To Maintain Serum Clindamycin Levels	Rapid Infusion Rate	Maintenance Infusion Rate
Above 4 mcg / mL	10 mg / min. for 30 min.	0.75 mg / min.
Above 5 mcg / mL	15 mg / min. for 30 min.	1.00 mg / min.
Above 6 mcg / mL	20 mg / min. for 30 min.	1.25 mg / min.

Pediatrics (≤ 12 years)

Clindamycin Injection in 5% Dextrose GALAXY plastic containers are not suitable for use in pediatric patients. Pediatric dosing requires dose adjustments which would result in partial use of the GALAXY plastic containers. Partial use of GALAXY plastic containers is not feasible in a clinical setting, therefore clindamycin injection (150 mg / mL) is more suitable for dosing in this population (See [1 INDICATIONS, 1.1 Pediatrics](#)).

4.4 Administration

The intravenous mixture should be inspected visually for clarity, discolouration, particulate matter, precipitate and leakage prior to administration. Solutions showing haziness, particulate matter, precipitate, discolouration or leakage should not be used.

4.5 Missed Dose

If a dose is missed, it should be taken as soon as remembered unless it is almost time for the next dose. The dose should not be doubled to make up for a missed dose.

5 OVERDOSAGE

Reported cases of overdose with clindamycin phosphate have occurred very infrequently. The majority of these reports have involved infants and young children ranging in age from one day to three years. In this age group, doses as high as 2.4 grams have been used intravenously in 36 hours without observation of adverse reactions. Cardio-respiratory arrest and hypotension have been seen with rapid intravenous administration. Hemodialysis and peritoneal dialysis are not effective in removing clindamycin from the serum. No specific antidote is known. The serum elimination half-life of clindamycin is about 3 hours in adults and 2.5 hours in pediatric patients.

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

6 DOSAGE FORMS, STRENGTHS, COMPOSITION AND PACKAGING

Table 3 – Dosage Forms, Strengths, Composition and Packaging

Route of Administration	Dosage Form / Strength / Composition	Non-medicinal Ingredients
Intravenous (IV)	Solution; clindamycin 12 mg / mL, 18 mg / mL (as clindamycin phosphate)	Dextrose Hydrate, Edetate Disodium dihydrate, Hydrochloric Acid, Sodium Hydroxide.

Clindamycin Injection in 5% Dextrose is a ready-to-use solution for IV administration.

600 mg / 50 mL ready-to-use GALAXY plastic container

Each 50 mL of Clindamycin Injection in 5% Dextrose solution contains clindamycin phosphate equivalent to 600 mg of clindamycin, 2500 mg dextrose hydrous, 2 mg of edetate disodium dihydrate, hydrochloric acid and / or sodium hydroxide to adjust pH and water for injection.

900 mg / 50 mL ready-to-use GALAXY plastic container

Each 50 mL of Clindamycin Injection in 5% Dextrose solution contains clindamycin phosphate equivalent to 900 mg of clindamycin, 2500 mg dextrose hydrous, 2 mg of edetate disodium dihydrate, hydrochloric acid and / or sodium hydroxide to adjust pH and water for injection.

Clindamycin Injection in 5% Dextrose is available in 50 mL GALAXY plastic containers in a case of 24.

7 WARNINGS AND PRECAUTIONS

General

The partial use of clindamycin phosphate GALAXY plastic containers is not recommended.

Clindamycin Injection in 5% Dextrose does not diffuse adequately into cerebrospinal fluid and thus should not be used in the treatment of meningitis.

Care should be exercised when treating patients with multiple medications (see [9 DRUG INTERACTIONS](#)).

Gastrointestinal

Clindamycin Injection in 5% Dextrose (clindamycin phosphate) should be prescribed with caution in patients with a history of gastrointestinal disease, particularly colitis, inflammatory bowel disease (including regional enteritis and ulcerative colitis), or a history of antibiotic-associated colitis (including pseudomembranous colitis).

NOTE: If diarrhea occurs during treatment, this antibiotic should be discontinued.

***Clostridium difficile*-associated disease (CDAD)**

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

Treatment with antibacterial agents may alter the normal flora of the colon and may permit overgrowth of *Clostridium difficile*. *C. 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 *Clostridium difficile*. In moderate to severe cases, consideration should be given to management with fluids and electrolytes, protein supplementation, and treatment with an antibacterial agent clinically effective against *Clostridium difficile*. Surgical evaluation should be instituted as clinically indicated, as surgical intervention may be required in certain severe cases (see [8 ADVERSE REACTIONS](#)).

Hematologic

In patients with G-6-PD deficiency, the combination of clindamycin with primaquine may cause hemolytic reactions. Reference should also be made to the primaquine product monograph for other possible risk groups for other hematologic reactions (see [8 ADVERSE REACTIONS](#)).

If patients should develop serious hematologic adverse effects, reducing the dosage regimen of primaquine and / or Clindamycin Injection in 5% Dextrose should be considered (see [4 DOSAGE AND ADMINISTRATION](#)).

Hepatic/Biliary/Pancreatic

In patients with moderate to severe liver disease, prolongation of the half-life of clindamycin has been found. However, it was postulated from studies that when given every eight hours, accumulation of clindamycin should rarely occur. Therefore, dosage reduction in liver disease is not generally considered necessary. Periodic liver enzyme determinations should be made when treating patients with severe liver disease (see [10 CLINICAL PHARMACOLOGY](#)).

Immune

Clindamycin Injection in 5% Dextrose (clindamycin phosphate) should be prescribed with caution in atopic individuals.

The use of antibiotics occasionally results in overgrowth of non-susceptible organisms, particularly yeasts. Should superinfections occur, appropriate measures should be taken as dictated by the clinical situation.

If a hypersensitivity reaction occurs clindamycin should be discontinued and appropriate therapy should be initiated (see [2 CONTRAINDICATIONS](#); [7 WARNINGS AND PRECAUTIONS, Skin](#); [8 ADVERSE REACTIONS](#)).

Monitoring and Laboratory Tests

Periodic kidney function tests should be performed in patients with pre-existing renal dysfunction or taking concomitant nephrotoxic drugs, or if therapy is prolonged.

Periodic liver function tests and blood counts should be performed during prolonged therapy or when treating patients with severe liver disease.

Routine blood examinations should be done during therapy with primaquine to monitor potential hematologic toxicities.

Serum assays for active clindamycin require an inhibitor to prevent *in vitro* hydrolysis of clindamycin phosphate.

Renal

Clindamycin is potentially nephrotoxic. Acute kidney injury including acute renal failure has been reported. Therefore, periodic monitoring of renal function should be performed during therapy of patients with pre-existing renal dysfunction or taking concomitant nephrotoxic drugs or if therapy is prolonged.

Clindamycin Injection in 5% Dextrose dose modification may not be necessary in patients with renal disease. The serum half-life of clindamycin is increased slightly in patients with markedly reduced renal function.

Sensitivity/Resistance

Development of drug-resistant bacteria

Prescribing Clindamycin Injection in 5% Dextrose 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.

Skin

Serious hypersensitivity reactions, including anaphylactoid reactions, severe skin reactions such as drug reaction with eosinophilia and systemic symptoms (DRESS), and dermatological reactions including Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN) and acute generalized exanthematous pustulosis (AGEP) have been reported in patients on clindamycin therapy.

Maculopapular rash and urticaria have been observed during drug therapy. Generalized mild to moderate morbilliform-like skin rashes are the most frequently reported reactions.

7.1 Special Populations

7.1.1 Pregnant Women

There are no adequate and well-controlled studies in pregnant women. Safety for use in pregnancy has not been established.

Clindamycin should not be used in pregnancy unless clearly needed and unless the expected benefits to the mother outweigh any potential risks to the fetus. Clindamycin crosses the placenta in humans. After multiple doses, amniotic fluid concentrations were approximately 30% of maternal blood concentrations. Clindamycin was widely distributed in fetal tissues with the highest concentration found in liver.

Reproduction studies have been performed in rats and mice using subcutaneous and oral doses of clindamycin ranging from 20 to 600 mg / kg / day and have revealed no evidence of impaired fertility or harm to the fetus due to clindamycin except at doses that caused maternal toxicity. In one mouse strain, cleft palates were observed in treated fetuses; this response was not produced in other mouse strains or in other species, and therefore may be a strain specific effect. Oral and subcutaneous reproductive toxicity studies in rats and rabbits revealed no evidence of impaired fertility or harm to the fetus due to clindamycin, except at doses that caused maternal toxicity. Animal reproduction studies are not always predictive of human response.

7.1.2 Breast-feeding

Clindamycin should not be administered to nursing mothers. Clindamycin has been reported to appear in human breast milk in ranges from <0.5 to 3.8 mcg / mL.

Clindamycin has the potential to cause adverse effects on the breastfed infant's gastrointestinal flora such as diarrhea or blood in the stool, or rash. Because of the potential for serious adverse reactions in nursing infants, if clindamycin is required by a nursing mother, it is not a reason to discontinue breastfeeding, but an alternate drug may be preferred. If Clindamycin Injection in 5% Dextrose is used by a nursing mother, monitor the infant for possible adverse effects on the gastrointestinal flora, such as diarrhea, candidiasis (thrush, diaper rash) or blood in the stool indicating possible antibiotic-associated colitis.

The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for Clindamycin Injection in 5% Dextrose and any potential adverse effects on the breastfed child from Clindamycin Injection in 5% Dextrose or from the underlying maternal condition.

7.1.3 Pediatrics

Clindamycin Injection in 5% Dextrose GALAXY plastic containers are not suitable for use in pediatric patients. Pediatric dosing requires dose adjustments which would result in partial use of the GALAXY plastic containers. Partial use of GALAXY plastic containers is not feasible in a clinical setting, therefore clindamycin injection (150 mg / mL) is more suitable for dosing in this population.

7.1.4 Geriatrics

Geriatrics (> 60 years of age): Experience has demonstrated that antibiotic-associated colitis may occur more frequently and with increased severity among elderly (> 60 years) and debilitated patients. These patients should be carefully monitored for the development of diarrhea.

8 ADVERSE REACTIONS

8.2 Clinical Trial Adverse Reactions

Clinical trials are conducted under very specific conditions. The adverse reaction rates observed in the clinical trials; therefore, may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse reaction information from clinical trials may be useful in identifying and approximating rates of adverse drug reactions in real-world use.

Adverse drug reaction frequencies for the three clindamycin formulations (clindamycin capsules, clindamycin granules for oral solution and clindamycin injection) are based on the clinical data sources from the original drug submission and on the total number of patients enrolled in the clinical trials (N=1787).

Adverse drug reactions that were considered causally related to clindamycin and observed in \geq 1% of patients are presented below in Table 4. They are listed according to MedDRA system organ class.

Table 4 - Adverse Drug Reactions Occurring in ≥ 1% of Patients treated with clindamycin within the Original Clinical Trials

Adverse Reaction System Organ Class / Preferred Term	Clindamycin Total N=1787¹ n (%)
Gastrointestinal disorders Diarrhea	26 (1.45)
Investigations Liver function test abnormal	66 (3.7)
Skin and subcutaneous tissue disorders Rash maculopapular	21 (1.18)

¹clindamycin hydrochloride capsules N=851; clindamycin granules for oral solution N=340; clindamycin phosphate injection N=596

8.3 Less Common Clinical Trial Adverse Reactions

Less common adverse drug reactions that were considered causally related to clindamycin and observed in < 1% of patients are listed below.

Blood and lymphatic system disorders: Eosinophilia.

Gastrointestinal disorders: Nausea, abdominal pain and vomiting.

Nervous system disorders: Dysgeusia.

Skin and subcutaneous tissue disorders: Urticaria, erythema multiforme and pruritus.

8.5 Post-Market Adverse Reactions

Additional adverse events which have been reported in temporal association with clindamycin Injection phosphate formulations (clindamycin capsules, clindamycin granules for oral solution and clindamycin injection) since market introduction are listed below. Because they are reported voluntarily from a population of unknown size, estimates of frequency cannot be established.

Blood and lymphatic system disorders: Agranulocytosis, leucopenia, neutropenia and thrombocytopenia. In clindamycin / primaquine combination studies, serious hematologic toxicities (grade III, grade IV neutropenia or anemia, platelet counts < 50 x 10⁹ / L, or methemoglobin levels of 15% or greater) have been observed.

Cardiac disorders: Cardio-respiratory arrest and hypotension have been seen with rapid intravenous administration (see [4 DOSAGE AND ADMINISTRATION](#)).

Gastrointestinal disorders: Colitis and pseudomembranous colitis. *Clostridium difficile*-associated disease (CDAD) has been observed and may manifest as a range of symptoms varying from watery diarrhea to fatal colitis, the onset of which may occur during or after antibacterial treatment (see [7 WARNINGS AND PRECAUTIONS](#)). Esophagitis and esophageal ulcer have been reported with the oral formulations.

General disorders and administration site conditions: Injection site irritation, thrombophlebitis. These reactions can be minimized by deep IM injection and avoidance of indwelling intravenous catheters.

Hepatobiliary disorders: Jaundice.

Immune system disorders: Generalized mild to moderate morbilliform-like skin rashes, anaphylactic shock, anaphylactoid reactions, anaphylactic reactions, hypersensitivity, and drug reaction with eosinophilia and systemic symptoms (DRESS).

Infections and infestations: *Clostridium difficile* colitis.

Musculoskeletal: Polyarthrititis.

Renal and urinary disorders: Renal dysfunction as evidenced by azotemia, oliguria and / or proteinuria.

Acute kidney injury including acute renal failure has been reported (see [7 WARNINGS AND PRECAUTIONS](#)).

Skin and subcutaneous tissue disorders: Toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome (SJS), erythema multiforme, dermatitis exfoliative, dermatitis bullous, dermatitis vesiculobullous, rash morbilliform, vaginal infection, vaginitis, acute generalized exanthematous pustulosis (AGEP), angioedema.

Vascular disorders: Thrombophlebitis has been seen with rapid intravenous administration (see [4 DOSAGE AND ADMINISTRATION](#)).

9 DRUG INTERACTIONS

9.2 Drug Interactions Overview

Clindamycin is metabolized predominantly by CYP3A4, and to a lesser extent CYP3A5, to the major metabolite clindamycin sulfoxide and minor metabolite, N-desmethylclindamycin. Therefore, inhibitors of CYP3A4 and CYP3A5 may reduce clindamycin clearance and inducers of these isoenzymes may increase clindamycin clearance. In the presence of strong CYP3A4 inducers such as rifampin, monitor for loss of effectiveness.

In vitro studies indicate that clindamycin does not inhibit CYP1A2, CYP2C9, CYP2C19, CYP2E1, or CYP2D6 and only moderately inhibits CYP3A4. Therefore, clinically important interactions between clindamycin and co-administered drugs metabolized by these CYP enzymes are unlikely.

Clindamycin has been shown to have neuromuscular blocking properties and potential antagonism with erythromycin and aminoglycosides (see [Table 5](#)).

In a clindamycin / primaquine combination study, serious hematologic toxicity has been observed, but the contribution of clindamycin, if any, is unknown (see [8 ADVERSE REACTIONS](#)).

For other physicochemical interactions, please see to compatibility / incompatibility information in section [4 DOSAGE AND ADMINISTRATION](#).

Primaquine

In patients with G-6-PD deficiency, the combination of clindamycin with primaquine may result in hemolytic reactions (see [7 WARNINGS AND PRECAUTIONS](#)). Serious hematologic toxicities (grade III, grade IV neutropenia or anemia, platelet counts $< 50 \times 10^9 / L$, or methemoglobin levels of 15% or greater) have been observed. Routine blood examinations should be done during therapy with primaquine to monitor potential hematologic toxicities.

9.4 Drug-Drug Interactions

The drugs listed in the table below are based on either drug interaction case reports or studies, or potential interactions due to the expected magnitude and seriousness of the interaction.

Table 5 - Established or Potential Drug-Drug Interactions

Proper name	Source of Evidence	Effect	Clinical comment
Neuromuscular blocking agents Examples include: atracurium, doxacurium, pancuronium, vecuronium	CS	Clindamycin has been shown to have neuromuscular blocking properties that may enhance the action of other neuromuscular blocking agents.	Use with caution in patients receiving these agents concurrently.
aminoglycosides	T	Clindamycin is reported to antagonize bactericidal activity of aminoglycosides <i>in vitro</i> . <i>In vivo</i> antagonism has not been demonstrated.	
erythromycin	T	Antagonism has been demonstrated between clindamycin and erythromycin <i>in vitro</i> . Clindamycin and erythromycin may compete for the same protein binding site in bacteria.	Due to possible clinical significance the two drugs should not be administered concurrently.
Inhibitors of CYP3A4, CYP3A5	T	Clearance of clindamycin may be reduced.	
Inducers of CYP3A4, CYP3A5	T	Clearance of clindamycin may be increased.	Monitor for loss of effectiveness.
Strong inducers of CYP3A4 such as rifampin	CS and CT	Rifampin appears to dramatically decrease the serum clindamycin concentration.	Serum clindamycin levels and effectiveness should be carefully monitored. A clinically relevant effect of clindamycin on rifampin concentrations is not expected.

Legend: CS = Case Study; CT = Clinical Trial; T = Theoretical

9.5 Drug-Food Interactions

Interactions with food have not been established.

9.6 Drug-Herb Interactions

Efficacy of clindamycin should be closely monitored in patients using concomitant St. John's Wort, a CYP3A4 inducer.

9.7 Drug-Laboratory Test Interactions

Interactions between clindamycin and laboratory tests have not been studied.

10 CLINICAL PHARMACOLOGY

10.1 Mechanism of Action

Following parenteral administration, biologically inactive clindamycin phosphate is rapidly hydrolyzed in plasma to active clindamycin. Clindamycin is a lincosamide antibiotic that inhibits bacterial protein synthesis. It binds to the 50S ribosomal subunit and affects both ribosome assembly and the translation process. At usual doses, clindamycin exhibits bacteriostatic activity *in vitro*.

Clindamycin is primarily bacteriostatic, but may be bactericidal at high concentrations. The mechanism of action of clindamycin in combination with primaquine on *Pneumocystis jiroveci* is not known.

10.2 Pharmacodynamics

(See [15 MICROBIOLOGY](#)).

10.3 Pharmacokinetics

Absorption:

An equilibrium state is reached by the third dose. After intramuscular injection, peak serum levels of clindamycin are reached within 3 hours in adults and 1 hour in pediatric patients. Peak serum levels of clindamycin are achieved immediately after the end of a short-term (10 to 45 minutes) intravenous infusion.

Distribution:

Clindamycin binds primarily to alpha-1-acid glycoprotein. Protein binding is concentration dependent, ranging from 60% to 94% at therapeutic serum concentrations.

Clindamycin is distributed into body fluids and tissues including bone, synovial fluid, bile and pleural fluid. Significant levels of clindamycin are not reached in cerebrospinal fluid even in the presence of inflamed meninges. Clindamycin does not cross the blood-brain barrier even in the presence of inflamed meninges. Clindamycin readily crosses the placenta and is distributed into breast milk.

Table 6 records tissue and body fluid levels of clindamycin base following administration of clindamycin phosphate in adult patients undergoing surgical procedures.

Table 6 - Clindamycin concentrations in Tissues and Fluids

Specimen	Dosage of Clindamycin phosphate	Tissue or Fluid Level
Bone	IM 300 mg every 8 hours	6.4 mcg / g
Bone	IM 600 mg every 8 hours	1.44 mcg / g
Bone	IV 600 mg every 8 hours	0.75 mcg / g
Bone Marrow	IM 600 mg every 8 hours	10.83 mcg / g
Bile	IV 300 mg every 6 hours	2.70 mcg / g
Synovial Fluid	IM 300 mg every 8 hours	4.87 mcg / mL
Synovial Fluid	IM 150 mg every 12 hours	15.6 mcg / mL
Pleural Fluid	IV 450 mg every 8 hours	3.65 mcg / mL

Table 7 - Average Peak Serum Concentrations After Dosing with Clindamycin Phosphate

Clindamycin Phosphate Dosage Regimen	Clindamycin mcg / mL	Clindamycin Phosphate mcg / mL
Healthy Adult Male (Post Equilibrium)		
600 mg IV in 20 min., q8h	10	23
900 mg IV in 30 min., q12h	11	29

Metabolism:

In vitro studies in human liver and intestinal microsomes indicate clindamycin is predominantly oxidized by CYP3A4, with minor contribution from CYP3A5, to form clindamycin sulfoxide and a minor metabolite, N-desmethylclindamycin.

Elimination:

Approximately 10% of the microbiologically active form is excreted in the urine and about 4% in the feces. The remainder is excreted as biologically inactive metabolites.

Clindamycin phosphate disappears rapidly from the serum; the average elimination half-life is 6 minutes following IM or IV administration in adults. The serum elimination half-life of clindamycin is about 3 hours in adults and 2.5 hours in pediatric patients.

Special Populations and Conditions**Geriatrics:**

Pharmacokinetic studies with clindamycin have shown no clinically important differences between young and elderly subjects with normal hepatic function and normal (age-adjusted) renal function after oral or intravenous administration. Therefore, dosage adjustments are not necessary in the elderly with normal hepatic function and normal (age-adjusted) renal function.

Hepatic Impairment:

Six patients with impaired liver function had a mean serum elimination half-life of 4.5 hours (range 4.2 to 7.0 hours).

Renal Impairment:

Four patients with impaired renal function had a mean serum elimination half-life of 3.0 hours (range 1.7 to 5.6 hours).

Obese Adults Aged 18 to 20 Years: An analysis of pharmacokinetic data in obese adults aged 18 to 20 years demonstrated that clindamycin clearance and volume of distribution normalized by total body weight are comparable regardless of obesity.

11 STORAGE, STABILITY AND DISPOSAL

Exposure of pharmaceutical products to heat should be minimized. It is recommended that Clindamycin Injection in 5% Dextrose in GALAXY plastic container be stored between 15°C to 25°C. Avoid temperatures above 30°C.

12 SPECIAL HANDLING INSTRUCTIONS

All parenteral products should be visually inspected for haziness, particulate matter, discolouration and leakage prior to administration.

Premixed Clindamycin Injection in 5% Dextrose is for intravenous infusion using sterile equipment. Check for minute leaks prior to use by squeezing bag firmly. If leaks are found, discard solution as sterility may be impaired. Do **NOT** add supplementary medication.

Do **NOT** use plastic containers in series connections. Such use could result in air embolism due to residual air being drawn from the primary container before administration of the fluid from the secondary container is complete.

Preparation for Administration:

1. Suspend container from eyelet support.
2. Remove protector from outlet port at bottom of container.
3. Attach the GALAXY bag to the administration set. Refer to complete directions accompanying the administration set.

Compatibility with other products

Clindamycin has been shown to be compatible with gentamicin sulfate, tobramycin sulfate and amikacin sulfate.

Incompatibility with other products

Clindamycin is physically incompatible with ampicillin, phenytoin sodium, barbiturates, aminophyllin, calcium gluconate, magnesium sulfate, ceftriaxone sodium, and ciprofloxacin. Following treatment with Clindamycin Injection in 5% Dextrose GALAXY plastic containers, the infusion line should be flushed with saline prior to IV administration of these drugs.

PART II: SCIENTIFIC INFORMATION

13 PHARMACEUTICAL INFORMATION

Drug Substance

Proper name: Clindamycin phosphate

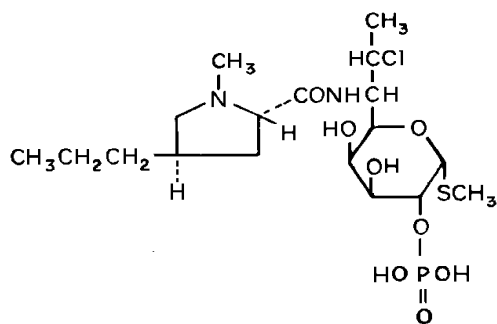
Chemical name: *L-threo-α-D-galacto*-Octopyranoside, methyl 7-chloro-6,7,8- trideoxy-6-[[[(1-methyl-4-propyl-2-pyrrolidinyl) carbonyl] amino]- 1-thio, 2-(dihydrogen phosphate), (*2S-trans*);

Methyl 7-chloro-6,7,8-trideoxy-6-(1-methyl-*trans*-4-propyl-L-2- pyrrolidinecarboxamido)-1-thio-*L-threo-α-D-galacto*- octopyranoside 2-(dihydrogen phosphate);

7-(*S*)-Chloro-7-deoxylincomycin 2-phosphate.

Molecular formula and molecular mass: $C_{18}H_{34}ClN_2O_8PS$, 505 g / mol

Structural formula:



Physicochemical properties:

Clindamycin phosphate is a water soluble ester of clindamycin and phosphoric acid. It is a white to off-white crystalline hygroscopic powder that is odourless or nearly odourless. It has a pH of 3.5 to 4.5 and melts with decomposition at about 175°C. The partition coefficient is 0.03.

14 CLINICAL TRIALS

The authorized indications were based on safety and efficacy clinical trials which were conducted with clindamycin phosphate.

15 MICROBIOLOGY

Efficacy is related to the time period over which the agent level is above the minimum inhibitory concentration (MIC) of the pathogen (%T / MIC).

Resistance

Resistance to clindamycin is most often due to mutations at the rRNA antibiotic binding site or methylation of specific nucleotides in the 23S RNA of the 50S ribosomal subunit. These alterations can determine *in vitro* cross resistance to macrolides and streptogramins B (MLSB phenotype). Resistance is occasionally due to alterations in ribosomal proteins. Resistance to clindamycin may be inducible by macrolides in macrolide-resistant bacterial isolates. Inducible resistance can be demonstrated with a disk test (D-zone test) or in broth. Less frequently encountered resistance mechanisms involve modification of the antibiotic and active efflux. There is complete cross resistance between clindamycin and lincomycin. As with many antibiotics, the incidence of resistance varies with the bacterial species and the geographical area. The incidence of resistance to clindamycin is higher among methicillin-resistant staphylococcal isolates and penicillin-resistant pneumococcal isolates than among organisms susceptible to these agents.

Breakpoints

The prevalence of acquired resistance may vary geographically and with time for selected species and local information on resistance is desirable, particularly when treating severe infections. As necessary, expert advice should be sought when the local prevalence of resistance is such that the utility of the agent in at least some types of infections is questionable. Particularly in severe infections or therapy failure microbiological diagnosis with verification of the pathogen and its susceptibility to clindamycin is recommended.

Resistance is usually defined by susceptibility interpretive criteria (breakpoints) established by Clinical and Laboratory Standards Institute (CLSI) or European Committee on Antimicrobial Susceptibility Testing (EUCAST) for systemically administered antibiotics.

In order to assess the significance of *in vitro* antibiotic activity against bacterial species, it is necessary to compare the organism's minimum inhibitory concentration (MIC) to the defined

susceptibility interpretive breakpoints for the antibiotic. Table 8 identifies the currently-accepted NCCLS (1990) MIC interpretative breakpoints for clindamycin.

Clinical and Laboratory Standards Institute (CLSI) breakpoints for relevant organisms are listed below.

Table 8 - CLSI Susceptibility Interpretive Criteria for Clindamycin

Pathogen	Susceptibility Interpretive Criteria					
	Minimal Inhibitory Concentrations (MIC in mcg / mL)			Disk Diffusion (Zone Diameters in mm) ^a		
<i>Staphylococcus</i> spp.	S ≤ 0.5	I 1-2	R ≥ 4	S ≥ 21	I 15-20	R ≤ 14
<i>Streptococcus pneumoniae</i> and other <i>Streptococcus</i> spp.	≤ 0.25	0.5	≥ 1	≥ 19	16-18	≤ 15
Anaerobic Bacteria ^b	≤ 2	4	≥ 8	NA	NA	NA

NA = not applicable

^aDisk content 2 micrograms of clindamycin .

^bMIC ranges for anaerobes are based on agar dilution methodology.

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

The reported clindamycin MIC₉₀ value (i.e., the concentration of clindamycin that inhibits 90% of test isolates) was utilized as the most descriptive measure of clindamycin activity. Where the data from more than one study are summarized, the weighted average MIC₉₀ value was calculated to account for differences in the number of strains in each study.

Standardized susceptibility test procedures require the use of laboratory controls to monitor and ensure the accuracy and precision of the supplies and reagents used in the assay, and the techniques of the individuals performing the test. Standard clindamycin powder should provide the MIC ranges in Table 9. For the disk diffusion technique using the 2 mcg clindamycin disk the criteria provided in Table 10 should be achieved.

Table 9 - CLSI Acceptable Quality Control (QC) Ranges for Clindamycin to be Used in Validation of Susceptibility Test Results

QC Strain	Minimum Inhibitory Concentration Range (mcg / mL)	Disk Diffusion Range (Zone Diameters in mm)
<i>Staphylococcus aureus</i> ATCC 29213	0.06–0.25	NA
<i>Staphylococcus aureus</i> ATCC 25923	NA	24–30
<i>Streptococcus pneumoniae</i> ATCC 49619	0.03–0.12	19–25
<i>Bacteroides fragilis</i> ATCC 25285	0.5–2 ^a	NA
<i>Bacteroides thetaiotaomicron</i> ATCC 29741	2–8 ^a	NA
<i>Eggerthella lenta</i> ATCC 43055	0.06–0.25 ^a	NA

NA=Not applicable.

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^aMIC ranges for anaerobes are based on agar dilution methodology.

The European Committee on Antimicrobial Susceptibility Testing (EUCAST) breakpoints are presented below.

Table 10 - EUCAST Susceptibility Interpretive Criteria for Clindamycin

Organism	MIC breakpoints (mg / L)		Zone diameter breakpoints (mm) ^a	
	S ≤	R >	S ≥	R <
<i>Staphylococcus</i> spp.	0.25	0.5	22	19
<i>Streptococcus</i> Groups A, B, C and G	0.5	0.5	17	17
<i>Streptococcus pneumoniae</i>	0.5	0.5	19	19
Viridans group streptococci	0.5	0.5	19	19
Gram-positive anaerobes	4	4	NA	NA

Gram-negative anaerobes	4	4	NA	NA
<i>Corynebacterium</i> spp.	0.5	0.5	20	20

^aDisk content 2 µg of clindamycin

NA=not applicable; S=susceptible; R=resistant

EUCAST QC ranges for MIC and disk zone determinations are in the table below.

Table 11 - EUCAST Acceptable Quality Control (QC) Ranges for Clindamycin to be Used in Validation of Susceptibility Test Results

QC Strain	Minimum Inhibitory Concentration Range (mcg / mL)	Disk Diffusion Range (Zone Diameters in mm)
<i>Staphylococcus aureus</i> ATCC 29213	0.06–0.25	23-29
<i>Streptococcus pneumoniae</i> ATCC 49619	0.03–0.125	22-28

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The *in vitro* susceptibility of clinical isolates to clindamycin is presented in Table 12 (gram-positive aerobic bacteria), Table 13 (gram-negative aerobic bacteria), Table 14 (gram-positive anaerobic bacteria), Table 15 (gram-negative anaerobic bacteria) and Table 16 (*Chlamydia* spp and *Mycoplasma* spp).

Table 12 - *In vitro* activity of clindamycin against gram-positive aerobic bacteria^a

Organism	N ^b	MIC ₉₀ Range ^c	MIC ₉₀ ^d
<i>Bacillus cereus</i>	46	1	1
<i>Corynebacterium diphtheriae</i>	192	0.1	0.1
<i>Listeria monocytogenes</i>	218	1-8	2.22
<i>Staphylococcus aureus</i> (methicillin-susceptible)	286	0.12-2	0.50
<i>Staphylococcus saprophyticus</i>	57	0.12 - 0.25	0.16
<i>Streptococcus agalactia</i>	59	≤0.06 - 0.50	0.15
<i>Streptococcus bovis</i>	22	0.04	0.04
<i>Streptococcus pneumoniae</i> (penicillin-susceptible)	660	0.03-0.25	0.23
<i>Streptococcus pyogenes</i>	141	0.13-0.25	0.08

<i>Streptococcus</i> spp, Group B	38	≤0.12-0.25	0.15
<i>Streptococcus</i> spp, Group C	30	≤0.12 - 0.50	0.22
<i>Streptococcus</i> spp, Group G	34	0.06-0.50	0.31
<i>Streptococcus</i> spp, viridans Group (penicillin-susceptible)	67	≤0.06-1.6	0.53

^aclinical efficacy has not been established for some of these species

^bN, total number of isolates

^cRange of reported MIC₉₀ values

^dMIC₉₀ for single study or weighted average MIC₉₀ for two or more studies

Table 13 - *In vitro* activity of clindamycin against gram-negative aerobic bacteria^a

Organism	N ^b	MIC ₉₀ Range ^c	MIC ₉₀ ^d
<i>Campylobacter jejuni</i>	449	0.39-8	1.7
<i>Campylobacter fetus</i>	41	1 - 1.6	1.2
<i>Campylobacter coli</i>	31	0.50	0.50
<i>Gardnerella vaginalis</i>	156	≤0.06 - 0.39	0.3
<i>Helicobacter pylori</i>	47	2-3.1	2.6
<i>Neisseria gonorrhoeae</i> (β-lactamase-negative)	77	4	4
<i>Neisseria gonorrhoeae</i> (β-lactamase-positive)	54	2	2

^a clinical efficacy has not been established for some of these species

^bN, total number of isolates

^cRange of reported MIC₉₀ values

^dMIC₉₀ for single study or weighted average MIC₉₀ for two or more studies

Table 14 - *In vitro* activity of clindamycin against gram-positive anaerobic bacteria^a

Organism	N ^b	MIC ₉₀ Range ^c	MIC ₉₀ ^d
<i>Actinomyces israelii</i>	46	0.12	0.12
<i>Actinomyces</i> spp	38	0.50 - 1	0.8
<i>Clostridium botulinum</i>	224	4	4
<i>Clostridium difficile</i>	191	4->256	57.7
<i>Clostridium novyi</i>	18	2	2
<i>Clostridium perfringens</i>	386	0.25-8	3.4
<i>Clostridium ramosum</i>	98	4-12.5	8.3
<i>Eubacterium</i> spp	45	0.4-2	1.1

<i>Lactobacillus</i> spp	88	0.50 - 1	0.8
<i>Peptostreptococcus anaerobes</i>	283	0.25 - 0.50	0.4
<i>Peptostreptococcus asaccharolyticus</i>	268	0.25 - 2	1.5
<i>Peptostreptococcus magnus</i>	90	2	2
<i>Peptostreptococcus prevotii</i>	87	0.12 - 4	2.9
<i>Peptostreptococcus tetradius</i>	28	0.5	0.5
Anaerobic gram-positive cocci	247	0.5 - 1	0.9
<i>Propionibacterium acnes</i>	267	0.10 - 0.25	0.2
<i>Propionibacterium</i> spp	71	0.12 - 0.20	0.16

^aclinical efficacy has not been established for some of these species.

^bN, total number of isolates

^cRange of reported MIC₉₀ values

^dMIC₉₀ for single study or weighted average MIC₉₀ for two or more studies

Table 15 - *In vitro* activity of clindamycin against gram-negative anaerobic bacteria^a

Organism	N ^b	MIC ₉₀ Range ^c	MIC ₉₀ ^d
<i>Bacteroides fragilis</i> group	4284	0.5-8	2.45
<i>Bacteroides fragilis</i>	2002	≤0.20 - 4	2.22
<i>Bacteroides melaninogenicus</i>	224	≤0.03-0.50	0.07
<i>Bacteroides</i> spp	141	≤0.06 - 0.50	0.31
<i>Bacteroides bivius</i>	155	≤0.03 - ≤0.05	≤0.11
<i>Bacteroides disiens</i>	33	≤0.03 - ≤0.06	≤0.05
<i>Fusobacterium</i> spp	330	≤0.10 - 2	0.85
<i>Mobiluncus mulieris</i>	10	0.06	0.06
<i>Mobiluncus curtisii</i>	12	0.12	0.12
<i>Veillonella</i> spp	38	0.06 - 0.25	0.20

^aclinical efficacy has not been established for some of these species.

^bN, total number of isolates

^cRange of reported MIC₉₀ values

^dMIC₉₀ for single study or weighted average MIC₉₀ for two or more studies

Clindamycin has demonstrated *in vitro* activity against *Chlamydia trachomatis* and *Mycoplasma* spp (see [Table 16](#)). For *Chlamydia trachomatis*, the MIC₉₀ for clindamycin is reached at 2.3 mcg / mL; *in vitro* synergism with gentamicin has also been demonstrated.

Table 16 - *In vitro* activity of clindamycin against *Chlamydia* spp and *Mycoplasma* spp^a

Organism	N ^b	MIC ₉₀ Range ^c	MIC ₉₀ ^d
<i>Chlamydia trachomatis</i>	84	0.5 - 5.9	2.3
<i>Mycoplasma hominis</i>	106	0.25 - 0.8	0.58
<i>Mycoplasma pneumoniae</i>	9	4	4

^aclinical efficacy has not been established for some of these species.

^bN, total number of isolates

^cRange of reported MIC₉₀ values

^dMIC₉₀ for single study or weighted average MIC₉₀ for two or more studies

The *in vitro* activity of clindamycin in combination with primaquine has not been determined.

Development of resistance to clindamycin by staphylococci is slow and stepwise rather than rapid and streptomycin-like. Clindamycin, like lincomycin, participates in the dissociated cross-resistance phenomenon with erythromycin. Clindamycin is not cross-resistant with penicillin, ampicillin, tetracycline or streptomycin. It is, however, cross-resistant with lincomycin.

Resistance to clindamycin may occur by one of several mechanisms. Resistance does not appear to be caused by reduced drug uptake but rather is generally due to alterations in the bacterial target site (50S ribosomal subunit).

Resistance can result from either changes in a ribosomal protein at the receptor site or a change in the 23S ribosomal RNA by methylation of adenine. Rare isolates of staphylococci and some veterinary isolates of streptococci may enzymatically inactivate clindamycin by adenylation.

Plasmid-mediated transferable resistance to clindamycin (and erythromycin) in *B.fragilis* was reported in 1979. Despite the existence of multiple resistance mechanisms, the reported incidence of clindamycin resistance in the *B.fragilis* group has remained relatively low (averaging 5.3% from 1970-1987 in over 7,600 isolates). Susceptibility of isolates to clindamycin should be assessed by individual MIC determinations.

16 NON-CLINICAL TOXICOLOGY

General Toxicology:

Acute Toxicity

The results of LD₅₀ studies are shown in Table 17:

Table 17- LD₅₀ Results

Species	Route	LD50 (mg / kg)
Adult Mouse	IP	1145
Adult Mouse	IV	855
Adult Rat	SC	>2000
Adult Rat	PO	1832
Newborn Rat	SC	179

Table 18 and 19 summarize toxicity and teratology studies. Table 20 summarizes human studies.

Carcinogenicity:

Long term studies in animals have not been performed with clindamycin to evaluate carcinogenic potential.

Table 18 - TOXICITY STUDIES

Type of Study	Species	Route	Dose mg / kg / d	Duration	Conclusions
Tolerance	Rabbit N = 3	IM	100, 200, 300	Single dose	Slight to moderate local irritation
Tolerance	Rat N = 10	SC	120	6 days	Local evidence of multiple epidermal breakdown with scab formation over the injection site was present in most rats. No systemic evidence of drug effect was detected at necropsy. Organ weights were not significantly different from control animals and likewise no significant deviations of hematologic data were noted among treated animals.
Tolerance	Dog N = 3	IM	60	6 days	These doses were well tolerated by the dogs. Serum transaminase values were elevated terminally with SGOT values increasing in advance of SGPT values, suggesting that the source of these changes was the injected muscles. No other evidence of treatment-related changes was noted in terminal hemograms, blood chemistry values and urinalyses. Gross pathological changes were confined to the injection sites where there were signs of slight hemorrhage and edema.

Subacute Toxicity	Rat N = 10	SC	30, 60, 90	1 month	No drug-related systemic effects were observed. Local inflammatory changes were seen at all three dose levels with focal necrosis of the subcutaneous tissues and overlying epidermis seen in the 60 and 90 mg / kg groups.
Subacute Toxicity	Dog N = 9	IM	30, 60, 90	1 month	Under the conditions of this study, clindamycin phosphate was found to be mildly to moderately irritating. Elevations of SGOT and SGPT were noted in these dogs and were thought to be due to muscle damage caused by the injections. Other blood evaluations and liver function tests were in the normal range. A slight dose-related increase in liver weight was indicated on the basis of per cent of body weight, but no morphologic evidence of drug effect on the liver was obtained.
Subacute Toxicity	Dog N = 8	IV	60, 120	1 month	No drug related effects were observed in any of the animals during or after the intravenous administrations. In particular, there was no evidence of drug-induced hemolysis or drug-related changes in the cephalic veins on both gross and microscopic examination.

Table 19 - TERATOLOGY STUDIES

Species	Route	Dose mg / kg / day	Duration	Conclusions
Rat	SC	0, 100, 180	Gestation days 6-15	Not teratogenic
Mouse	SC 2 strains	100, 180	Gestation days 6-15	A low incidence of cleft palate occurred in one strain in the initial experiment and as a result, the study was repeated twice with no abnormalities noted. The study in the second strain of mice was completely within normal limits.
Rat	PO	100, 300		No biologically significant effect on the reproductive parameters studied was noted. Pups from treated females were slightly lighter at birth and weaning but post-natal survival was not affected by this slight weight reduction. None of the pups which were dead at birth, died before weaning, or were sacrificed at weaning, exhibited significant morphologic abnormalities.

Table 20 - HUMAN TOLERANCE STUDIES

N	Route	Dose	Duration	Conclusions
8	IM	300 mg clindamycin phosphate	Single dose	Subjectively, one patient had mild pain, four had moderate pain and two had marked pain which did not occur immediately, but reached its maximum at 10 to 30 minutes after injection and subsided to a mild ache 30 to 60 minutes later. Clinical laboratory findings were all normal.
8	IM	600 mg clindamycin phosphate	Single dose	Only three patients had short-lived moderate pain 30 minutes after injection.
24	IM	Group 1 (8 patients): 300 mg clindamycin phosphate	Every 8 hr. (total 43 injections)	One volunteer in each of the clindamycin phosphate and Lincocin group was removed from the study after 41 injections due to local intolerance. One volunteer from sodium chloride group left on day 5 (after 15 injections) complaining that the injections were too painful. Three Lincocin volunteers were dropped from the study on day 8 (after 24 injections); one due to local discomfort and a suspected viral illness; one due to a rash and one because of headache and tinnitus. In general, in these small groups, clindamycin phosphate was as well tolerated as Lincocin. There was no necrosis in any case. Pain, tenderness, swelling and induration were typically mild. Two clindamycin phosphate-treated volunteers developed mild cases of loose stools, lasting two to ten days during treatment. Audiometric examinations showed no change from pre-treatment examinations. Clinical laboratory findings did not indicate any drug-induced toxicity. A marked rise in creatinine phosphokinase was seen in both the clindamycin phosphate and Lincocin groups. SGOT also rose above
		Group 2 (8 patients): 2 mL of sodium chloride injection USP		
		Group 3 (8 patients): 600 mg Lincocin sterile solution		

								normal in the clindamycin group, but not in the Lincocin group. SGPT findings remained within normal range in all groups. These changes are consistent with changes due to muscle irritation and not attributed to liver damage.	
20	IV	Dosing Schedule						Five days	Tolerance observations included blood pressure, pulse, respiratory rate and lead II electrocardiographic monitoring prior to, every 5 minutes during and at the end of each infusion. A 12 lead electrocardiographic tracing was done prior to treatment and after the 12th infusion. Audiograms were performed prior to treatment, within 48 hours after and 90 days after the 12th infusion. Subjects were watched closely for signs of local intolerance during each infusion period. Prior to the 1st, 5th, 9th and 4 hours after the 12th infusion, blood and urine samples were obtained for the following clinical laboratory determinations: complete blood count (CBC); complete urinalysis; serum glutamic oxalacetic transaminase (SGOT); serum alkaline phosphatase; serum creatinine; total, direct and indirect bilirubin; urine bilirubin; and serum haptoglobin. None of the tolerance data indicated any clinically significant side effects from the intravenous infusion of clindamycin phosphate
		Subject Nos.	Treatment Group	Dose (mg)	Infusion Regimen	Infusion Rate	Total Daily Dose (mg)		
		1-6	A	300	4 doses BID 4 doses TID 4 doses QID	30 mg / minute for 10 minutes	600 900 1200		
		7-12	B	600*	4 doses BID 4 doses TID 4 doses QID	30 mg / minute for 20 minutes	1200 1800 2400		
		13-16	C	900	4 doses BID 4 doses TID 4 doses	30 mg / minute for 30 minutes	1800 2700 3600		

					QID				
		17-20	D	1200	4 doses BID	26.7 mg / minute for 45 minutes	2400 3600 4800		
					4 doses TID				
					4 doses QID				

*Subjects 7 and 8 received 1200 mg in 20 minutes on infusion #1

Genotoxicity: Clindamycin phosphate did not show evidence of mutagenicity when tested in the Ames Assay (Salmonella / Microsome Test) or the Micronucleus Test.

Reproductive and Developmental Toxicology:

Teratogenic and Reproductive Studies in the Rat and Rabbit

Oral and subcutaneous reproductive toxicity studies in rats and rabbits revealed no evidence of impaired fertility or harm to the fetus due to clindamycin, except at doses that caused maternal toxicity.

In oral embryo fetal development studies in rats and subcutaneous embryo fetal development studies in rats and rabbits, no developmental toxicity was observed except at doses that produced maternal toxicity.

17 SUPPORTING PRODUCT MONOGRAPHS

1. ^{Pr}DALACIN® C PHOSPHATE (Sterile Solution, 150 mg / mL), submission control 255973, Product Monograph, Pfizer Canada ULC. (JAN 10, 2022)
2. ^{Pr}CLINDAMYCIN IV INFUSION (Sterile Solution, 12 mg / mL and 18 mg / mL), submission control 272119, Product Monograph, Sandoz Canada Inc. (JUL 26, 2023)

PATIENT MEDICATION INFORMATION

PrClindamycin Injection in 5% Dextrose (as clindamycin phosphate)

Read this carefully before you start taking **Clindamycin Injection in 5% Dextrose** 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 Clindamycin Injection in 5% Dextrose.

Antibacterial drugs like Clindamycin Injection in 5% Dextrose treat only bacterial infections. They do not treat viral infections such as the common cold. Although you may feel better early in treatment, Clindamycin Injection in 5% Dextrose should be taken exactly as directed. Misuse or overuse of Clindamycin Injection in 5% Dextrose could lead to the growth of bacteria that will not be killed by Clindamycin Injection in 5% Dextrose (resistance). This means that Clindamycin Injection in 5% Dextrose may not work for you in the future.

What is Clindamycin Injection in 5% Dextrose used for?

Clindamycin Injection in 5% Dextrose is used for the treatment of serious bacterial infections.

How does Clindamycin Injection in 5% Dextrose work?

Clindamycin Injection in 5% Dextrose reduces the production of key proteins in bacteria. This prevents growth in bacteria and reduces the infection.

What are the ingredients in Clindamycin Injection in 5% Dextrose?

Medicinal ingredients: Clindamycin phosphate

Non-medicinal ingredients: Dextrose hydrous, edetate disodium dihydrate and water for injection. It may also contain hydrochloric acid and / or sodium hydroxide for pH adjustment.

Clindamycin Injection in 5% Dextrose comes in the following dosage forms:

Clindamycin Injection in 5% Dextrose is available in ready-to-use 50 mL GALAXY plastic containers containing clindamycin premixed with 5% Dextrose w / v as a sterile solution.

Each 50 mL GALAXY plastic container contains clindamycin phosphate equivalent to 600 mg or 900 mg clindamycin. The single dose GALAXY plastic containers are available as follows:

600 mg / 50 mL, case of 24

900 mg / 50 mL, case of 24

Clindamycin Injection in 5% Dextrose is for intravenous infusion only.

Do not use Clindamycin Injection in 5% Dextrose if:

You are allergic (hypersensitive) to:

- Clindamycin
- Lincomycin
- Other ingredients in the product (see list of non-medicinal ingredients).

To help avoid side effects and ensure proper use, talk to your healthcare professional before you take Clindamycin Injection in 5% Dextrose. Talk about any health conditions or problems you may have, including if you:

- have had intestinal disorders such as:
 - colitis (inflammation of the colon)
 - inflammatory bowel disease
- have diarrhea or get diarrhea when you take antibiotics.
- suffer from problems with your stomach or intestines (e.g. bowel disease, colitis).
- suffer from problems with your kidneys or liver.
- are pregnant or planning to become pregnant.
- are taking a drug called primaquine for an enzyme deficiency called glucose-6-phosphate dehydrogenase (G-6-PD). You need to have routine blood tests, to monitor for potential blood cell changes.

Other warnings you should know about:

Breastfeeding

If you are breastfeeding or planning to breastfeed while taking Clindamycin Injection in 5% Dextrose, talk to your doctor. Clindamycin will pass through your breast milk to your baby. Your doctor will decide if you should take this medicine while breastfeeding. If your doctor has told you that you can take Clindamycin Injection in 5% Dextrose while breastfeeding, monitor your baby for possible side effects such as: diarrhea, mouth infection (thrush: white lesions in your baby's mouth), diaper rash or blood in their stool. If your baby shows any signs, talk to your doctor and to your baby's doctor.

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 Clindamycin Injection in 5% Dextrose:

- Erythromycin (an antibiotic)
- Rifampin (an antibiotic)
- Muscle relaxants used during operations
- Primaquine (antimalarial)
- Aminoglycosides (a class of antibiotics)
- St. John's Wort (*Hypericum perforatum*)

Tell your doctor if you are taking or being administered any other topical or oral medication, including erythromycin or neuromuscular blocking agents.

How to take Clindamycin Injection in 5% Dextrose:

The healthcare professional will administer Clindamycin Injection in 5% Dextrose and will:

- Decide:
 - the dose and rate of administration of the medicine
- Ensure that:
 - the medicine will be given as an injection (infusion) through the vein
 - the medicine will be given for the full treatment period
 - the medicine will be inspected to determine there is:
 - no discolouration
 - no leaks
 - no solid particles floating in solution
 - no haziness in the solution

Usual dose:

Your doctor will determine the dose and for how long you should receive it.

Long term use of Clindamycin Injection in 5% Dextrose:

- If you have to use clindamycin for a long time, your doctor may arrange regular liver, kidney and blood tests.
- Do not miss these check-ups with your doctor.
- Long term use can also make you more likely to get other infections that do not respond to clindamycin treatment.

This particular product format in GALAXY plastic container is not suitable for use in children 12 years of age and under.

Overdose:

If you think you, or a person you are caring for, have taken too much Clindamycin Injection in 5% Dextrose, contact a healthcare professional, hospital emergency department, or regional poison control centre immediately, even if there are no symptoms.

Missed Dose:

Your healthcare professional will ensure that this product is administered each day and doses are not missed, as it works best when there is a constant amount in the body. If the medicine is stopped too soon, your symptoms may return. If you feel a dose has been missed, contact your healthcare professional.

Skipping doses or not completing the full course of therapy may (1) decrease the effectiveness of the immediate treatment and (2) increase the likelihood that bacteria will develop resistance and will not be treatable by clindamycin phosphate or other antibacterial drugs in the future.

What are possible side effects from using Clindamycin Injection in 5% Dextrose?

These are not all the possible side effects you may feel when taking Clindamycin Injection in 5% Dextrose. If you experience any side effects not listed here, contact your healthcare professional. Please also see Warnings and Precautions.

Clindamycin Injection in 5% Dextrose can cause side effects such as:

- skin reddening, rash, itching, hives
- throat ulcers, sore throat
- feeling sick, being sick
- stomach pain and diarrhea
- injection site irritation
- thrombophlebitis (inflammation of the vein due to blood clot)
- vaginal infection or vaginitis (inflamed vagina)

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	
VERY COMMON			
Liver problems with symptoms such a yellowing skin or eyes (jaundice), abdominal pain, nausea, vomiting			√
COMMON			
Diarrhea		√	
Rash		√	
RARE			
Acute kidney failure (severe kidney problems): confusion; tiredness; swelling; urinating less or not at all; shortness of breath; chest pain, seizures, coma			√
Skin reactions: itching	√		
UNKNOWN			
<i>Clostridium difficile</i> associated disease (bowel inflammation), with symptoms such as persistent or severe watery or bloody diarrhea, abdominal pain, fever, nausea and vomiting. This may happen months after the last dose of medication.			√
Injection site reactions with symptoms as pain, redness and skin irritation	√		
Hypersensitivity (severe allergic reaction): symptoms such as swelling of eyes, mouth, throat, difficulty breathing, sudden wheezing, blistering or peeling skin, rash, itching, fever, cough, feeling unwell.			√
Anemia (low red blood cells): bruising, bleeding.		√	

Neutropenia (low white blood cells): fatigue, fever, ache, infections, flu-like symptoms		√	
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If you have a troublesome symptom or side effect that is not listed here or becomes bad enough to interfere with your daily activities, tell 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:

The healthcare professional will store Clindamycin Injection in 5% Dextrose GALAXY plastic containers under appropriate conditions (15°C to 25°C). Avoid temperatures above 30°C.

Keep out of the reach and sight of children.

If you want more information about Clindamycin Injection in 5% Dextrose:

- 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 www.baxter.ca, or by calling 1-888-719-9955

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