

## **SUMMARY OF PRODUCT CHARACTERISTICS**

### **1. NAME OF THE MEDICINAL PRODUCT**

Phenoxymethylpenicillin 250mg/5ml Oral Solution Sugar Free BP

### **2. QUALITATIVE AND QUANTITATIVE COMPOSITION**

Each 5ml of Oral Solution contains 250mg of Phenoxymethylpenicillin as Phenoxymethylpenicillin Potassium Ph. Eur.

For the full list of excipients, see section 6.1

### **3. PHARMACEUTICAL FORM**

Powder for oral solution

### **4. CLINICAL PARTICULARS**

#### ***4.1 Therapeutic Indications***

Phenoxymethylpenicillin and phenoxymethylpenicillin potassium are indicated in the treatment of mild to moderately severe infections associated with micro-organisms whose susceptibility to penicillin is within the range of serum levels attained with the dosage form.

Phenoxymethylpenicillin is indicated for the treatment of the following infections (see section 4.4 and 5.1)

Streptococcal infections:

Pharyngitis

Scarlet fever

Skin and soft tissue infections (e.g erysipelas)

Pneumococcal infections:

Pneumonia

Otitis media

Vincent's gingivitis and pharyngitis

Phenoxymethylpenicillin is also indicated for (see section 5.1):

Prophylaxis of rheumatic fever and/or chorea

Prophylaxis of pneumococcal infection (e.g. in asplenia and inpatients with sickle cell disease

Consideration should be given to official guidance on the appropriate use of antibacterial agents.

#### ***4.2 Posology and Method of Administration***

##### **Posology**

For oral administration only

The dosage and frequency of Phenoxymethylpenicillin depends on the severity and localisation of the infection and expected pathogens.

Phenoxymethylpenicillin Solution should be taken at least 30 minutes before or 2 hours after food, as ingestion of Phenoxymethylpenicillin with meals slightly reduces the absorption of the drug.

Phenoxymethylpenicillin 250mg is approximately equivalent to 400,000 units.

The usual dosage recommendations are as follows:

**Adults and children over 12 years:** 250mg - 500mg every six hours

**Children: Infants (up to 1 year): 62.5mg every 6 hours**

**1-5 years:** 125mg every six hours

**6-12 years:** 250mg every six hours

### **Prophylactic Use**

Prophylaxis of rheumatic fever/chorea: 250mg twice daily on a continuing basis

Prophylaxis of pneumococcal infection (e.g. in asplenia and in sickle cell disease):

Adults and children over 12 years: 500mg every 12 hours

Children 6-12 years: 250mg every 12 hours

Children below 5 years: 125mg every 12 hours.

### **Elderly**

The dosage is as for adults. The dosage should be reduced if renal function is markedly impaired.

### **Renal impairment**

The dosage should be reduced if renal function is markedly impaired.

### **Hepatic impairment**

Dosage adjustment may be necessary in patients with impaired liver function when they also have renal failure. In this situation the liver may be a major excretion route.

### **Method of Administration**

For instructions on dilution of the product before administration, see section 6.6.

## ***4.3 Contraindications***

Phenoxymethylpenicillin is contraindicated in patients known to be hypersensitive to Penicillin and should be used with caution in patients with known histories of allergy.

### **Sorbitol:**

Patients with rare hereditary problems of fructose intolerance should not take this medicine.

## ***4.4 Special Warnings and Precautions for Use***

Penicillin should be used with caution in individuals with histories of significant allergies and/or asthma.

All degrees of hypersensitivity, including fatal anaphylaxis, have been observed with oral penicillin. These reactions are more likely to occur in individuals with a history of sensitivity to penicillins, cephalosporins and other allergens. Enquiries should be made for such a history before therapy is begun. If any allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents (e.g. adrenaline and other pressor amines, antihistamines and corticosteroids).

Oral therapy should not be relied upon for patients with severe illness, or with nausea, vomiting, gastric dilation, achalasia or intestinal hypermotility. Occasionally patients do not absorb therapeutic amounts of orally administered penicillin.

Administer with caution in the presence of markedly impaired renal function, as safe dosage may be lower than the usually recommended doses.

Streptococcal infections should be treated for a minimum of 10 days, and post therapy cultures should be performed to confirm the eradication of the organisms.

Prolonged use of antibiotics may promote the over growth of non-susceptible organisms, including fungi. If super infection occurs, appropriate measures should be taken.

Severe empyema, bacteraemia, pericarditis, meningitis and arthritis should not be treated with Penicillin V during the acute phase.

Patients with a past history of rheumatic fever receiving continuous prophylaxis may harbour penicillin-resistant organisms. In these patients, the use of another prophylactic agent should be considered.

Oral penicillin should not be used as adjunctive prophylaxis for genito - urinary instrumentation or surgery, lower intestinal tract surgery, sigmoidoscopy and child birth.

#### ***4.5 Interaction with other medicinal products and Other Forms of Interaction***

Aminoglycosides: Neomycin is reported to reduce the absorption of phenoxymethylpenicillin.

Anticoagulants: Penicillins may interfere with anticoagulant control.

Bacteriostatic antibiotics: Certain bacteriostatic antibiotics such as Chloramphenicol, Erythromycin and Tetracyclines have been reported to antagonise the bactericidal activity of penicillins and concomitant use is not recommended.

Guar gum: Reduced absorption of phenoxymethylpenicillin

Methotrexate: Use of Phenoxymethylpenicillin while taking methotrexate can cause reduced excretion of methotrexate thereby increasing the risk of toxicity.

Probenecid: Reduced excretion of phenoxymethylpenicillin by competing with it for renal tubular secretion.

Sulfinpyrazone: Excretion of penicillins reduced by sulfinpyrazone.

Typhoid vaccine (oral): Penicillins may inactivate oral typhoid vaccine if ingested concomitantly.

#### 4.6 Fertility, pregnancy and Lactation

##### Pregnancy:

There are no or a limited amount of data from the use of Phenoxymethylpenicillin in pregnant women. As a precautionary measure, it is preferable to avoid the use of Phenoxymethylpenicillin during pregnancy.

##### Lactation:

Phenoxymethylpenicillin metabolites are excreted in human milk to such an extent that effects on breastfed newborns are likely.

#### 4.7 Effects on Ability to Drive and Use Machines

None known

#### 4.8 Undesirable Effects

The most common reactions to oral penicillin are gastrointestinal effects and hypersensitivity reactions. Although hypersensitivity reactions have been reported much less frequently after oral than after parenteral therapy, it should be remembered that all forms of hypersensitivity, including fatal anaphylaxis have been observed with oral penicillin.

|   |           |   |
|---|-----------|---|
| The following convention has been utilised for the classification of undesirable effects:-<br>Very common ( $\geq 1/10$ )<br>Common ( $\geq 1/100, < 1/10$ )<br>Uncommon ( $\geq 1/1000, < 1/100$ )<br>Rare ( $\geq 1/10,000, < 1/1000$ )<br>Very rare ( $< 1/10,000$ )<br>Not known (cannot be estimated from the available data). |           |   |
| Infections and infestations   | Not known | Pseudomembranous colitis  |
| Blood and lymphatic disorders   | Very rare | Changes in blood counts, including, thrombocytopenia, neutropenia, leucopenia, eosinophilia and haemolytic anaemia. |
|   | Not known | Coagulation disorders (including prolongation of bleeding time and defective platelet function)                     |
| Gastrointestinal disorders  | Common    | Nausea, vomiting, abdominal pain, diarrhoea   |
|   | Not known | Sore mouth and black hairy tongue (discolouration of tongue)  |
| Hepatobiliary disorders   | Very rare | Hepatitis and cholestatic jaundice  |
| Immune disorders  | Common    | Allergic reactions (typically manifest as skin reactions (See Skin and subcutaneous disorders)).                    |
|   | Rare      | Severe allergic reactions causing angioedema, laryngeal oedema and anaphylaxis                                      |
|   | Unknown   | Serum sickness-like reactions characterised by fever, chills,   |

|                                 |           |   |
|---------------------------------|-----------|---|
|                                 |           | arthralgia and oedema   |
| Nervous system disorders        | Unknown   | Central nervous system toxicity including convulsions (especially with high doses or in severe renal impairment); paraesthesia may occur with prolonged use, Neuropathy (usually associated with high doses of parenteral penicillin) |
| Renal and urinary disorders     | Very rare | Interstitial nephritis  |
|                                 | Uncommon  | Nephropathy (usually associated with high doses of parenteral penicillin)   |
| Skin and subcutaneous disorders | Common    | Urticarial, erythematous or morbilliform rash and pruritus  |
|                                 | Rare      | Exfoliative dermatitis  |

### Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the yellow card scheme at [www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard).

### 4.9 Overdose

**Symptoms:** A large oral overdose of penicillin may cause nausea, vomiting, stomach pain, diarrhoea, and rarely, major motor seizures. If other symptoms are present, consider the possibility of an allergic reaction. Hyperkalaemia may result from overdosage, particularly for patients with renal insufficiency.

**Management:** No specific antidote is known. Symptomatic and supportive therapy is recommended. Activated charcoal with a cathartic, such as sorbitol may hasten drug elimination. Penicillin may be removed by haemodialysis.

## 5. PHARMACEUTICAL PROPERTIES

### 5.1 Pharmacodynamic properties

ATC code: J01CE02

Phenoxymethylpenicillin is a beta-lactamase sensitive natural penicillin.

Mechanism of Action:

Phenoxymethylpenicillin acts through interference with the final stage of synthesis of the bacterial cell wall. The action depends on its ability to bind certain membrane-bound proteins, (penicillin-binding proteins or PBPs) that are located beneath the cell wall. These proteins are involved in maintaining cell wall structure, in cell wall synthesis and in cell division, and appear to possess transpeptidase and carboxypeptidase activity.

### PK/PD relationship

The time above the minimum inhibitory concentration (T>MIC) is considered to be the major determinant of efficacy for phenoxymethylpenicillin.

### Mechanism(s) of Resistance:

Phenoxymethylpenicillin is inhibited by penicillinase and other beta-lactamases that are produced by certain micro-organisms. The incidence of beta-lactamase producing organisms is increasing.

### Mechanisms of resistance

The two main mechanisms of resistance to phenoxymethylpenicillin are:

- Inactivation by bacterial penicillinases and other beta-lactamases
- Alteration of PBPs, which reduce the affinity of the antibacterial agent for the target.

Impermeability of bacteria or efflux pump mechanisms may cause or contribute to bacterial resistance.

EUCAST clinical MIC breakpoints to separate susceptible (S) pathogens from resistant (R) pathogens (version 1.0 22.11.210) are:

The susceptibility of streptococci Groups A, C and G and *S. pneumoniae* to phenoxymethylpenicillin is inferred from the susceptibility to benzylpenicillin.

| <b>EUCAST Species-related breakpoints (Susceptible≤/Resistant&gt;) Units: mg/L</b> |             |
|--|-------------|
| Staphylococcus   | ≤0.12/>0.12 |
| Streptococcus A, C, G  | ≤0.25/>0.25 |
| <i>S. pneumoniae</i>   | ≤ 0.06/>2   |

**Staphylococci:** Most staphylococci are penicillinase-producers. Penicillinase-producing strains are resistant. The benzylpenicillin breakpoint (shown) will mostly, but not unequivocally, separate beta-lactamase producers from non-producers.

**Streptococcus pneumoniae:** For phenoxymethylpenicillin, report *S. pneumoniae* with benzylpenicillin MICs above 0.06 mg/L resistant.

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. Expert advice should be sought as necessary when the local prevalence of resistance is such that the utility of the agent in at least some types of infection is questionable.

|   |
|---|
| <b>Commonly susceptible species</b>                           |
| Streptococcus A, C, G   |
| <b>Species for which acquired resistance may be a problem</b> |
| <i>Staphylococcus aureus</i>                                  |
| <i>Streptococcus pneumoniae</i>                               |
| <i>Staphylococcus epidermidis</i>                             |
|   |

## **5.2 Pharmacokinetic Properties**

**Absorption:** Rapidly but incompletely absorbed after oral administration (about 60% of an oral dose is absorbed). Calcium and potassium salts are better absorbed than the free acid. Absorption appears to be reduced in patients with coeliac disease. Absorption appears to be more rapid in fasting than non-fasting subjects.

**Blood concentration:** after an oral dose of 125mg, peak serum concentrations of 200 to 700ng/ml are attained in 2 hours. After an oral dose of 500mg, peak serum concentrations reach 3 to 5micrograms/ml in 30 to 60 minutes.

**Half-life:** Biological half-life is about 30 minutes, increased to about 4 hours in severe renal impairment.

**Distribution:** Widely distributed throughout the body and enters pleural and ascitic fluids and also in cerebrospinal fluid when the meninges are inflamed; Phenoxymethylpenicillin crosses the placenta and is secreted in trace amounts in breast milk; (protein binding 50% to 80% bound plasma proteins).

**Biotransformation:** It is metabolised in the liver; several metabolites have been identified, including penicilloic acid.

**Elimination:** Unchanged drug and metabolites are excreted rapidly in the urine. (20% to 35% of an oral dose is excreted in the urine in 24 hours).

## **5.3 Preclinical Safety Data**

There are no pre-clinical data of relevance to the prescriber which are additional to that already included in other sections of this SPC.

## **6. PHARMACEUTICAL PARTICULARS**

### **6.1 List of Excipients**

Sodium Benzoate Ph. Eur.

Saccharin Sodium Ph. Eur.

Trusil Orange Flavour HSE

Orange Colour 175 78 8 HSE

(Containing sunset yellow E110 & Ponceau 4R E124)

Sorbitol 60W

Mono Ammonium Glycyrrhizinate

### **6.2 Incompatibilities**

Not applicable

### **6.3 Shelf life**

Unopened container: 24 months

Reconstituted oral solution: a shelf life of 7 days

### **6.4 Special Precautions for Storage**

Unconstituted powder: Store in a dry place below 25°C. Protect from light

Reconstituted oral solution: Store for 7 days in a refrigerator (2°C - 8°C).

### ***6.5 Nature and Contents of Container***

Natural high density polyethylene bottle 150ml with white cap with a blue TE band containing 100ml of oral solution on reconstitution.

Natural high density polyethylene bottle 150ml with a child resistant /tamper evident cap containing 100 ml of oral Solution on reconstitution

May also contain

Hugo Meding – polypropylene spoon – Article number 7229

Or

5ml Medispoon

Or

A dosing syringe with bottle neck adaptor

### ***6.6 Special precautions for disposal and other handling***

To reconstitute: Loosen powder, add **84** ml water and shake well.

No special requirements for disposal.

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

## **7. Marketing Authorisation Holder**

Athlone Pharmaceuticals Limited,  
Ballymurray,  
Co. Roscommon,  
Ireland

## **8. Marketing Authorisation Number**

PL 30464/0073

## **9. Date of First Authorisation/Renewal of Authorisation**

24/08/2012

## **10. Date of Partial Revision of Text**

22 Mar 2016