

Metronidazole Injection, USP

in Plastic Container

VIAFLEX Plus Container

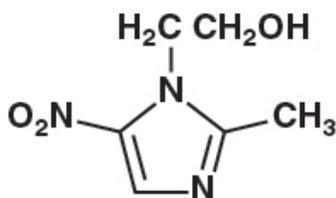
To reduce the development of drug-resistant bacteria and maintain the effectiveness of Metronidazole Injection, USP and other antibacterial drugs, Metronidazole Injection, USP should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria.

WARNING

Metronidazole has been shown to be carcinogenic in mice and rats (see **PRECAUTIONS**). Unnecessary use of the drug should be avoided. Its use should be reserved for the conditions described in the **INDICATIONS AND USAGE** section below.

DESCRIPTION

Metronidazole Injection, USP, is a parenteral formulation of the synthetic nitroimidazole antibacterial agent 2-methyl-5-nitro-1*H*-imidazole-1-ethanol.



Metronidazole, USP

Metronidazole Injection, USP, in 100 mL VIAFLEX Plus single dose plastic container, is a sterile, nonpyrogenic, iso-osmotic, buffered solution of 500 mg Metronidazole, USP, 790 mg Sodium Chloride, USP, 47.6 mg Dibasic Sodium Phosphate Dried, USP and 22.9 mg Citric Acid Anhydrous, USP. Metronidazole Injection, USP has an osmolarity of 310 mOsmol/L (calc) and a pH of 5.5 (4.5 to 7.0). Each container contains 14 mEq of sodium.

The plastic container is fabricated from a specially formulated polyvinyl chloride plastic. Water can permeate from inside the container into the overwrap in amounts insufficient to affect the solution significantly. Solutions in contact with the plastic container can

leach out certain of its chemical components in very small amounts within the expiration period, *e.g.*, di-2-ethylhexyl phthalate (DEHP), up to 5 parts per million. However, the safety of the plastic has been confirmed in tests in animals according to USP biological tests for plastic containers as well as by tissue culture toxicity studies.

CLINICAL PHARMACOLOGY

In patients treated with intravenous metronidazole, using a dosage regimen of 15 mg/kg loading dose followed 6 hours later by 7.5 mg/kg every 6 hours, the average peak steady-state plasma concentrations (C_{\max}) and trough concentrations (C_{\min}) were 25 mcg/mL and 18 mcg/mL, respectively. Plasma concentrations of metronidazole are proportional to the administered dose. An eight-hour intravenous infusion of 100 mg to 4,000 mg of metronidazole in normal subjects showed a linear relationship between dose and peak plasma concentration. The average elimination half-life of metronidazole in healthy subjects is eight hours.

Distribution

Metronidazole is the major component appearing in the plasma, with lesser quantities of metabolites also being present. Less than 20% of the circulating metronidazole is bound to plasma proteins. Metronidazole appears in cerebrospinal fluid, saliva and breast milk in concentrations similar to those found in plasma. Bactericidal concentrations of metronidazole have also been detected in pus from hepatic abscesses.

Following a single intravenous dose of metronidazole 500 mg, 4 healthy subjects who underwent gastrointestinal endoscopy had peak gastric juice metronidazole concentrations of 5 to 6 mcg/mL at one hour post-dose. In patients receiving intravenous metronidazole in whom gastric secretions are continuously removed by nasogastric aspiration, sufficient metronidazole may be removed in the aspirate to cause a reduction in serum levels.

Metabolism

The metabolites of metronidazole result primarily from side-chain oxidation [1-(β -hydroxyethyl)-2-hydroxymethyl-5-nitroimidazole and 2-methyl-5-nitroimidazole-1-yl-acetic acid] and glucuronide conjugation. Both the parent compound and the hydroxyl metabolite possess *in vitro* antimicrobial activity.

Excretion

The major route of elimination of metronidazole and its metabolites is via the urine (60-80% of the dose), with approximately 20% of the amount excreted appearing as

unchanged metronidazole. Renal clearance of metronidazole is approximately 10 mL/min/1.73 m². Fecal excretion accounts for 6-15% of the dose.

Renal Impairment

Decreased renal function does not alter the single-dose pharmacokinetics of metronidazole.

Subjects with end-stage renal disease (ESRD; $CL_{CR} = 8.1 \pm 9.1$ mL/min) and who received a single intravenous infusion of metronidazole 500 mg had no significant change in metronidazole pharmacokinetics but had 2-fold higher C_{max} of hydroxy-metronidazole and 5-fold higher C_{max} of metronidazole acetate, compared to healthy subjects with normal renal function ($CL_{CR} = 126 \pm 16$ mL/min). Thus, on account of the potential accumulation of metronidazole metabolites in ESRD patients, monitoring for metronidazole associated adverse events is recommended (see **PRECAUTIONS**).

Effect of Dialysis

Following a single intravenous infusion or oral dose of metronidazole 500 mg, the clearance of metronidazole was investigated in ESRD subjects undergoing hemodialysis or continuous ambulatory peritoneal dialysis (CAPD). A hemodialysis session lasting for 4 to 8 hours removed 40% to 65% of the administered metronidazole dose, depending on the type of the dialyzer membrane used and the duration of the dialysis session. If the administration of metronidazole cannot be separated from the dialysis session, supplementation of metronidazole dose following hemodialysis should be considered (see **DOSAGE AND ADMINISTRATION**). A peritoneal dialysis session lasting for 7.5 hours removed approximately 10% of the administered metronidazole dose. No adjustment in metronidazole dose is needed in ESRD patients undergoing CAPD.

Hepatic Impairment

Following a single intravenous infusion of 500 mg metronidazole, the mean AUC₂₄ of metronidazole was higher by 114% in patients with severe (Child-Pugh C) hepatic impairment, and by 54% and 53% in patients with a mild (Child-Pugh A) and moderate (Child-Pugh B) hepatic impairment, respectively, compared to healthy control subjects. There were no significant changes in the AUC₂₄ of hydroxy-metronidazole in these hepatically impaired patients. A reduction in metronidazole dosage by 50% is recommended in patients with severe (Child-Pugh C) hepatic impairment (see **DOSAGE AND ADMINISTRATION**). No dosage adjustment is needed for patients with mild to moderate hepatic impairment. Patients with mild to moderate hepatic impairment should

be monitored for metronidazole associated adverse events (see **PRECAUTIONS** and **DOSAGE AND ADMINISTRATION**).

Geriatric Patients

Following a single 500 mg oral or IV dose of metronidazole, subjects >70 years old with no apparent renal or hepatic dysfunction had a 40% to 80% higher mean AUC of hydroxy-metronidazole (active metabolite), with no apparent increase in the mean AUC of metronidazole (parent compound), compared to young healthy controls < 40 years old. In geriatric patients, monitoring for metronidazole associated adverse events is recommended (see **PRECAUTIONS**).

Pediatric Patients

In one study newborn infants appeared to demonstrate diminished capacity to eliminate metronidazole. The elimination half-life, measured during the first three days of life, was inversely related to gestational age. In infants whose gestational ages were between 28 and 40 weeks, the corresponding elimination half-lives ranged from 109 to 22.5 hours.

Microbiology

Mechanism of Action

Metronidazole, a nitroimidazole, exerts antibacterial effects in an anaerobic environment against most obligate anaerobes. Once metronidazole enters the organism by passive diffusion and is activated in the cytoplasm of susceptible anaerobic bacteria, it is reduced; this process includes intra-cellular electron transport proteins such as ferredoxin, transfer of an electron to the nitro group of the metronidazole, and formation of a short-lived nitroso free radical. Because of this alteration of the metronidazole molecule, a concentration gradient is created and maintained which promotes the drug's intracellular transport. The reduced form of metronidazole and free radicals can interact with DNA leading to inhibition of DNA synthesis and DNA degradation leading to death of bacteria. The precise mechanism of action of metronidazole is unclear.

Drug Resistance

A potential for development of resistance exists against metronidazole.

Resistance may be due to multiple mechanisms that include decreased uptake of the drug, altered reduction efficiency, overexpression of the efflux pumps, inactivation of the drug, and/or increased DNA damage repair.

Metronidazole does not possess any clinically relevant activity against facultative anaerobes or obligate aerobes.

Activity *In Vitro* and in Clinical Infections

Metronidazole has been shown to be active against most isolates of the following bacteria both *in vitro* and in clinical infections as described in the **INDICATIONS AND USAGE** section.

Gram-positive anaerobes

Clostridium species

Eubacterium species

Peptococcus species

Peptostreptococcus species

Gram-negative anaerobes

Bacteroides fragilis group (*B. fragilis*, *B. distasonis*, *B. ovatus*, *B. thetaiotaomicron*, *B. vulgatus*)

Fusobacterium species

The following *in vitro* data are available, **but their clinical significance is unknown.**

Metronidazole exhibits *in vitro* minimal inhibitory concentrations (MIC's) of 8 mcg/mL or less against most ($\geq 90\%$) isolates of the following bacteria; however, the safety and effectiveness of metronidazole in treating clinical infections due to these bacteria have not been established in adequate and well-controlled clinical trials.

Gram-negative anaerobes

Bacteroides fragilis group (*B. caccae*, *B. uniformis*)

Prevotella species (*P. bivia*, *P. buccae*, *P. disiens*)

Susceptibility Tests

When available, the clinical microbiology laboratory should provide results of *in vitro* susceptibility test results for antimicrobial drug products used in resident hospitals to the physician as periodic reports that describe the susceptibility profile of nosocomial or community-acquired pathogens. These reports should aid the physician in selecting an antibacterial drug product for treatment.

For Anaerobes

Quantitative methods are used to determine antimicrobial inhibitory concentrations (MICs). These MICs provide estimates of the susceptibility of bacteria to antimicrobial compounds. For anaerobic bacteria, the susceptibility to metronidazole can be determined by the reference broth and/or agar method.^{1,2}

The MIC values should be interpreted according to the criteria provided in the following table.

Susceptibility Test Interpretive Criteria for Metronidazole against Anaerobes^{*†}

MIC (mcg/mL)	Interpretation
≤ 8	Susceptible (S)
16	Intermediate (I)
≥ 32	Resistant (R)

* Agar dilution method is recommended for all anaerobes.

† Broth microdilution method is only recommended for testing *Bacteroides fragilis* group; for this group the MIC values for agar or broth microdilution are considered equivalent.

A report of *Susceptible* (S) indicates that the antimicrobial is likely to inhibit growth of the pathogen if the antimicrobial compound reaches the concentrations at the infection site necessary to inhibit growth of the pathogen.

A report of *Intermediate* (I) implies that an infection due to the isolate may be appropriately treated in the body sites where the drugs are physiologically concentrated or when a high dosage of drug is used.

A report of *Resistant* (R) indicates that the antimicrobial is not likely to inhibit growth of the pathogen if the antimicrobial compound reaches the concentrations usually achievable at the infection site; other therapy should be selected.

Quality Control

Standardized susceptibility test procedures require the use of laboratory controls to monitor and ensure the accuracy and precision of supplies and reagents used in the assay, and the techniques of the individuals performing the test.^{1,2} Standard metronidazole powder should provide a value within the MIC ranges noted in the following table:

Acceptable Quality Control Ranges for Metronidazole against Anaerobes

Quality Control Strain	<u>Minimum Inhibitory concentration (mcg/mL)</u>	
	Agar	Broth
<i>Bacteroides fragilis</i> ATCC 25285	0.25-1.0	0.25-2.0
<i>Bacteroides thetaiotaomicron</i> ATCC 29741	0.5-2.0	0.5-4.0
<i>Clostridium difficile</i> ATCC 700057	0.125-0.5	-
<i>Eggerthella lenta</i> ATCC 43055	-	0.125-0.5

INDICATIONS AND USAGE

Treatment of Anaerobic Bacterial Infections

Metronidazole Injection, USP is indicated in the treatment of serious infections caused by susceptible anaerobic bacteria. Indicated surgical procedures should be performed in conjunction with Metronidazole Injection, USP therapy. In a mixed aerobic and anaerobic infection, antibiotics appropriate for the treatment of the aerobic infection should be used in addition to Metronidazole Injection, USP.

Metronidazole Injection, USP is effective in *Bacteroides fragilis* infections resistant to clindamycin, chloramphenicol and penicillin.

Intra-Abdominal Infections, including peritonitis, intra-abdominal abscess and liver abscess, caused by *Bacteroides* species including the *B. fragilis* group (*B. fragilis*, *B. distasonis*, *B. ovatus*, *B. thetaiotaomicron*, *B. vulgatus*), *Clostridium* species, *Eubacterium* species, *Peptococcus* species and *Peptostreptococcus* species.

Skin and Skin Structure Infections caused by *Bacteroides* species including the *B. fragilis* group, *Clostridium* species, *Peptococcus* species, *Peptostreptococcus* species and *Fusobacterium* species.

Gynecologic Infections, including endometritis, endomyometritis, tubo-ovarian abscess and postsurgical vaginal cuff infection, caused by *Bacteroides* species including the *B. fragilis* group, *Clostridium* species, *Peptococcus* species, *Peptostreptococcus* species and *Fusobacterium* species.

Bacterial Septicemia caused by *Bacteroides* species including the *B. fragilis* group and *Clostridium* species.

Bone and Joint Infections, as adjunctive therapy, caused by *Bacteroides* species including the *B. fragilis* group.

Central Nervous System (CNS) Infections, including meningitis and brain abscess, caused by *Bacteroides* species including the *B. fragilis* group.

Lower Respiratory Tract Infections, including pneumonia, empyema and lung abscess, caused by *Bacteroides* species including the *B. fragilis* group.

Endocarditis caused by *Bacteroides* species including the *B. fragilis* group.

Prophylaxis

The prophylactic administration of Metronidazole Injection, USP preoperatively, intraoperatively and postoperatively may reduce the incidence of postoperative infection in patients undergoing elective colorectal surgery which is classified as contaminated or potentially contaminated. Prophylactic use of Metronidazole Injection, USP should be discontinued within 12 hours after surgery. If there are signs of infection, specimens for cultures should be obtained for the identification of the causative organism(s) so that appropriate therapy may be given (see **DOSAGE AND ADMINISTRATION**).

To reduce the development of drug-resistant bacteria and maintain the effectiveness of Metronidazole Injection, USP and other antibacterial drugs, Metronidazole Injection, USP should be used only to treat or prevent 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.

CONTRAINDICATIONS

Hypersensitivity

Metronidazole Injection, USP is contraindicated in patients with a prior history of hypersensitivity to metronidazole or other nitroimidazole derivatives.

Psychotic Reaction with Disulfiram

Use of oral metronidazole is associated with psychotic reactions in alcoholic patients who were using disulfiram concurrently. Do not administer metronidazole to patients who have taken disulfiram within the last two weeks (see **PRECAUTIONS-Drug Interactions**).

Interaction with Alcohol

Use of oral metronidazole is associated with a disulfiram-like reaction to alcohol, including abdominal cramps, nausea, vomiting, headaches, and flushing. Discontinue

consumption of alcohol or products containing propylene glycol during and for at least three days after therapy with metronidazole (see **PRECAUTIONS-Drug Interactions**).

WARNINGS

Central and Peripheral Nervous System Effects

Encephalopathy and peripheral neuropathy: Cases of encephalopathy and peripheral neuropathy (including optic neuropathy) have been reported with metronidazole.

Encephalopathy has been reported in association with cerebellar toxicity characterized by ataxia, dizziness, and dysarthria. CNS lesions seen on MRI have been described in reports of encephalopathy. CNS symptoms are generally reversible within days to weeks upon discontinuation of metronidazole. CNS lesions seen on MRI have also been described as reversible.

Peripheral neuropathy, mainly of sensory type has been reported and is characterized by numbness or paresthesia of an extremity.

Convulsive seizures have been reported in patients treated with metronidazole.

Aseptic meningitis: Cases of aseptic meningitis have been reported with metronidazole. Symptoms can occur within hours of dose administration and generally resolve after metronidazole therapy is discontinued.

The appearance of abnormal neurologic signs and symptoms demands the prompt evaluation of the benefit/risk ratio of the continuation of therapy (see **ADVERSE REACTIONS**).

PRECAUTIONS

General

Hepatic Impairment

Patients with hepatic impairment metabolize metronidazole slowly, with resultant accumulation of metronidazole in the plasma. For patients with severe hepatic impairment (Child-Pugh C), a reduced dose of METRONIDAZOLE INJECTION, USP is recommended. For patients with mild to moderate hepatic impairment, no dosage adjustment is needed but these patients should be monitored for metronidazole associated adverse events (see **CLINICAL PHARMACOLOGY** and **DOSAGE AND ADMINISTRATION**).

Renal Impairment

Patients with end-stage renal disease may excrete metronidazole and metabolites slowly in the urine, resulting in significant accumulation of metronidazole metabolites. Monitoring for metronidazole associated adverse events is recommended (see **CLINICAL PHARMACOLOGY**).

Fungal Superinfections

Known or previously unrecognized candidiasis may present more prominent symptoms during therapy with Metronidazole Injection, USP and requires treatment with a candidicidal agent.

Use in Patients with Blood Dyscrasias

Metronidazole is a nitroimidazole, and should be used with care in patients with evidence of or history of blood dyscrasia. A mild leukopenia has been observed during its administration; however, no persistent hematologic abnormalities attributable to metronidazole have been observed in clinical studies.

Monitoring for Leukopenia

Total and differential leukocyte counts are recommended before, during, and after prolonged or repeated courses of metronidazole therapy.

Sodium Retention

Administration of solutions containing sodium ions may result in sodium retention. Care should be taken when administering Metronidazole Injection, USP to patients receiving corticosteroids or to patients predisposed to edema.

Drug-Resistant Bacteria

Prescribing Metronidazole Injection, USP in the absence of a proven or strongly suspected bacterial infection or a prophylactic indication is unlikely to provide benefit to the patient and increases the risk of the development of drug-resistant bacteria.

Information for Patients

Interaction with Alcohol

Discontinue consumption of alcoholic beverages or products containing propylene glycol while taking Metronidazole Injection, USP and for at least three days afterward because abdominal cramps, nausea, vomiting, headaches, and flushing may occur (see **CONTRAINDICATIONS, PRECAUTIONS-Drug Interactions**).

Treatment of Bacterial Infections

Patients should be counseled that antibacterial drugs including Metronidazole Injection, USP should only be used to treat bacterial infections. They do not treat viral infections (*e.g.*, the common cold). When Metronidazole Injection, USP is prescribed to treat a bacterial infection, patients should be told that although it is common to feel better early in the course of therapy, the medication should be taken exactly as directed. 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 Metronidazole Injection, USP or other antibacterial drugs in the future.

Drug Interactions

Disulfiram

Psychotic reactions have been reported in alcoholic patients who are using metronidazole and disulfiram concurrently. Metronidazole should not be given to patients who have taken disulfiram within the last two weeks (see **CONTRAINDICATIONS**).

Alcoholic Beverages

Abdominal cramps, nausea, vomiting, headaches and flushing may occur if alcoholic beverages or products containing propylene glycol are consumed during or following metronidazole therapy (see **CONTRAINDICATIONS**).

Warfarin and other Oral Anticoagulants

Metronidazole has been reported to potentiate the anticoagulant effect of warfarin and other oral coumarin anticoagulants, resulting in a prolongation of prothrombin time. When Metronidazole Injection, USP is prescribed for patients on this type of anticoagulant therapy, prothrombin time and INR should be carefully monitored.

Lithium

In patients stabilized on relatively high doses of lithium, short-term metronidazole therapy has been associated with elevation of serum lithium and, in a few cases, signs of lithium toxicity. Serum lithium and serum creatinine levels should be obtained several days after beginning metronidazole to detect any increase that may precede clinical symptoms of lithium intoxication.

Busulfan

Metronidazole has been reported to increase plasma concentrations of busulfan, which can result in an increased risk for serious busulfan toxicity. Metronidazole should not be

administered concomitantly with busulfan unless the benefit outweighs the risk. If no therapeutic alternatives to metronidazole are available, and concomitant administration with busulfan is medically needed, frequent monitoring of busulfan plasma concentration should be performed and the busulfan dose should be adjusted accordingly.

Drugs that Inhibit CYP450 Enzymes

The simultaneous administration of drugs that decrease microsomal liver enzyme activity, such as cimetidine, may prolong the half-life and decrease plasma clearance of metronidazole.

Drugs that Induce CYP450 Enzymes

The simultaneous administration of drugs that induce microsomal liver enzyme activity, such as phenytoin or phenobarbital, may accelerate the elimination of metronidazole, resulting in reduced plasma levels; impaired clearance of phenytoin has also been reported.

Drug/Laboratory Test Interactions

Metronidazole may interfere with certain types of determinations of serum chemistry values, such as aspartate aminotransferase (AST, SGOT), alanine aminotransferase (ALT, SGPT), lactate dehydrogenase (LDH), triglycerides and glucose hexokinase. Values of zero may be observed. All of the assays in which interference has been reported involve enzymatic coupling of the assay to oxidation-reduction of nicotine adenine dinucleotide ($\text{NAD}^+ \rightleftharpoons \text{NADH}$). Interference is due to the similarity in absorbance peaks of NADH (340nm) and metronidazole (322nm) at pH 7.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Tumors affecting the liver, lung, mammary and lymphatic tissues have been detected in several studies of metronidazole in rats and mice, but not hamsters.

Pulmonary tumors have been observed in all six reported studies in the mouse, including one study in which the animals were dosed on an intermittent schedule (administration during every fourth week only). Malignant tumors were increased in male mice treated at approximately 1500 mg/m² (similar to the maximum recommended daily dose, based on body surface area comparisons). Malignant lymphomas and pulmonary neoplasms were also increased with lifetime feeding of the drug to mice. Mammary and hepatic tumors were increased among female rats administered oral metronidazole compared to concurrent controls. Two lifetime tumorigenicity studies in hamsters have been performed and reported to be negative.

Metronidazole has shown mutagenic activity in *in vitro* assay systems including the Ames test. Studies in mammals *in vivo* have failed to demonstrate a potential for genetic damage.

Metronidazole failed to produce any adverse effects on fertility or testicular function in male rats at doses up to 400 mg/kg/day (approximately 2 times the maximum recommended daily dose based on body surface area comparison) for 28 days. However, rats treated at the same dose for 6 weeks, or longer were infertile and showed severe degeneration of the seminiferous epithelium in the testes as well as marked decreases in testicular spermatid counts and epididymal sperm counts. Fertility was restored in most rats after an eight week, drug-free recovery period.

Fertility studies have been performed in male mice at doses up to six times the maximum recommended human dose based on mg/m^2 and have revealed no evidence of impaired fertility. However, metronidazole was associated with reversible adverse effects on the male reproductive system (significantly decreased testes and epididymides weight, decreased sperm viability, and increased the incidence of abnormal sperm).

Pregnancy

Teratogenic Effects

Pregnancy Category B

There are no adequate and well-controlled studies of Metronidazole Injection, USP in pregnant women. There are published data from case-control studies, cohort studies, and 2 meta-analyses that include more than 5000 pregnant women who used metronidazole during pregnancy. Many studies included first trimester exposures. One study showed an increased risk of cleft lip, with or without cleft palate, in infants exposed to metronidazole *in utero*; however, these findings were not confirmed. In addition, more than ten randomized, placebo-controlled clinical trials enrolled more than 5000 pregnant women to assess the use of antibiotic treatment (including metronidazole) for bacterial vaginosis on the incidence of preterm delivery. Most studies did not show an increased risk for congenital anomalies or other adverse fetal outcomes following metronidazole exposure during pregnancy. Three studies conducted to assess the risk of infant cancer following metronidazole exposure during pregnancy did not show an increased risk; however, the ability of these studies to detect such a signal was limited.

Metronidazole crosses the placental barrier and its effects on the human fetal organogenesis are not known. Reproduction studies have been performed in rats, rabbits and mice at doses similar to the maximum recommended daily dose based on body

surface area comparisons. There was no evidence of harm to the fetus due to metronidazole.

Nursing Mothers

Metronidazole is present in human milk at concentrations similar to maternal serum levels, and infant serum levels can be close to or comparable to infant therapeutic levels. Because of the potential for tumorigenicity shown for metronidazole in mouse and rat studies, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Alternatively, a nursing mother may choose to pump and discard human milk for the duration of metronidazole therapy, and for 24 hours after therapy ends and feed her infant stored human milk or formula.

Geriatric Use

In geriatric patients, monitoring for metronidazole associated adverse events is recommended (see **CLINICAL PHARMACOLOGY, PRECAUTIONS**). Decreased liver function in geriatric patients can result in increased concentrations of metronidazole that may necessitate adjustment of metronidazole dosage (see **DOSAGE AND ADMINISTRATION**).

Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

ADVERSE REACTIONS

The following reactions have been reported during treatment with metronidazole.

Central Nervous System

The most serious adverse reactions reported in patients treated with metronidazole have been convulsive seizures, encephalopathy, aseptic meningitis, optic and peripheral neuropathy, the latter characterized mainly by numbness or paresthesia of an extremity. Since persistent peripheral neuropathy has been reported in some patients receiving prolonged administration of metronidazole, patients should be specifically warned about these reactions and should be told to stop the drug and report immediately to their physicians if any neurologic symptoms occur. In addition, patients have reported headache, syncope, dizziness, vertigo, incoordination, ataxia, confusion, dysarthria, irritability, depression, weakness, and insomnia (see **WARNINGS**).

The following reactions have also been reported during treatment with metronidazole.

Gastrointestinal

The most common adverse reactions reported have been referable to the gastrointestinal tract, particularly nausea, sometimes accompanied by headache, anorexia and occasionally vomiting, diarrhea; epigastric distress; abdominal cramping; and constipation.

Mouth

A sharp, unpleasant metallic taste is not unusual. Furry tongue, glossitis and stomatitis have occurred; these may be associated with a sudden overgrowth of *Candida* which may occur during effective therapy.

Dermatologic

Erythematous rash and pruritus.

Hematopoietic

Reversible neutropenia (leukopenia); rarely, reversible thrombocytopenia.

Local Reactions

Thrombophlebitis after intravenous infusion. This reaction can be minimized or avoided by avoiding prolonged use of indwelling intravenous catheters.

Cardiovascular

Flattening of the T-wave may be seen in electrocardiographic tracings.

Hypersensitivity

Urticaria, erythematous rash, Stevens-Johnson syndrome, toxic epidermal necrolysis, flushing, nasal congestion, dryness of the mouth (or vagina or vulva) and fever.

Renal

Dysuria, cystitis, polyuria, incontinence, and a sense of pelvic pressure. Instances of darkened urine have been reported by approximately one patient in 100,000. Although the pigment which is probably responsible for this phenomenon has not been positively identified, it is almost certainly a metabolite of metronidazole and seems to have no clinical significance.

Other

Proliferation of *Candida* in the vagina, dyspareunia, decrease of libido, proctitis and fleeting joint pains sometimes resembling “serum sickness”. Rare cases of pancreatitis, which abated on withdrawal of the drug, have been reported.

Patients with Crohn's disease are known to have an increased incidence of gastrointestinal and certain extraintestinal cancers. There have been some reports in the medical literature of breast and colon cancer in Crohn's disease patients who have been treated with metronidazole at high doses for extended periods of time. A cause and effect relationship has not been established. Crohn's disease is not an approved indication for Metronidazole Injection, USP.

OVERDOSAGE

Use of dosages of intravenous metronidazole higher than those recommended has been reported. These include the use of 27 mg/kg three times a day for 20 days, and the use of 75 mg/kg as a single loading dose followed by 7.5 mg/kg maintenance doses. No adverse reactions were reported in either of the two cases.

Single oral dose of metronidazole, up to 15 g, have been reported in suicide attempts and accidental overdoses. Symptoms reported included nausea, vomiting and ataxia.

Oral metronidazole has been studied as a radiation sensitizer in the treatment of malignant tumors. Neurotoxic effects, including seizures and peripheral neuropathy, have been reported after 5 to 7 days of doses of 6 to 10.4 g every other day.

Treatment of Overdosage

There is no specific antidote for metronidazole overdose; therefore, management of the patient should consist of symptomatic and supportive therapy.

DOSAGE AND ADMINISTRATION

Treatment of Anaerobic Bacterial Infections

The recommended dosage schedule for adults is:

Loading Dose	15 mg/kg infused over one hour (approximately 1 g for a 70-kg adult).
Maintenance Dose	7.5 mg/kg infused over one hour every six hours (approximately 500 mg for a 70-kg adult). The first maintenance dose should be instituted six hours following the initiation of the loading dose.

Parenteral therapy may be changed to oral metronidazole when conditions warrant, based upon the severity of the disease and the response of the patient to Metronidazole Injection, USP treatment. The usual adult oral dosage is 7.5 mg/kg every six hours (approximately 500 mg for a 7-kg adult).

A maximum of 4 g should not be exceeded during a 24-hour period.

The usual duration of therapy is 7 to 10 days; however, infections of the bone and joint, lower respiratory tract and endocardium may require longer treatment.

Dosage Adjustments

Patients with Severe Hepatic Impairment

For patients with severe hepatic impairment (Child-Pugh C), the metronidazole dose should be reduced by 50% (see **CLINICAL PHARMACOLOGY** and **PRECAUTIONS**).

Patients Undergoing Hemodialysis

Hemodialysis removes significant amounts of metronidazole and its metabolites from systemic circulation. The clearance of metronidazole will depend on the type of dialysis membrane used, the duration of the dialysis session, and other factors. If the administration of metronidazole cannot be separated from a hemodialysis session, supplementation of metronidazole dosage following a hemodialysis session should be considered, depending on the patient's clinical situation (see **CLINICAL PHARMACOLOGY**).

Prophylaxis

For surgical prophylactic use, to prevent postoperative infection in contaminated or potentially contaminated colorectal surgery, the recommended dosage schedule for adults is:

- a. 15 mg/kg infused over 30 to 60 minutes and completed approximately one hour before surgery; followed by
- b. 7.5 mg/kg infused over 30 to 60 minutes at 6 and 12 hours after the initial dose.

It is important that (1) administration of the initial preoperative dose be completed approximately one hour before surgery so that adequate drug levels are present in the serum and tissues at the time of initial incision, and (2) Metronidazole Injection, USP be

administered, if necessary, at 6-hour intervals to maintain effective drug levels. Prophylactic use of Metronidazole Injection, USP should be limited to the day of surgery only, following the above guidelines.

Caution: Metronidazole Injection, USP is to be administered by slow intravenous drip infusion only, either as a continuous or intermittent infusion. Additives should not be introduced into Metronidazole Injection, USP. If used with a primary intravenous fluid system, the primary solution should be discontinued during metronidazole infusion. DO NOT USE EQUIPMENT CONTAINING ALUMINUM (e.g., NEEDLES, CANNULAE) THAT WOULD COME IN CONTACT WITH THE DRUG SOLUTION.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit.

HOW SUPPLIED

Metronidazole Injection, USP is supplied in 100 mL single dose plastic containers, each containing an iso-osmotic, buffered solution of 500 mg metronidazole as follows:

2B3421

NDC 0338-1055-48

500 mg/100 mL

Store at controlled room temperature (77°F or 25°C) and protect from light during storage. Do not remove unit from overwrap until ready for use. The overwrap is a moisture barrier. The inner bag maintains the sterility of the product. After removing overwrap, check for minute leaks by squeezing inner bag firmly. If leaks are found, discard solution as sterility may be impaired.

DIRECTIONS FOR USE OF VIAFLEX PLUS PLASTIC CONTAINER

Metronidazole Injection, USP is a ready-to-use iso-osmotic solution. **No dilution or buffering is required.** Do not refrigerate. Each container of Metronidazole Injection, USP contains 14 mEq of sodium.

Warning: 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 completed.

To open

Tear overwrap down side at slit and remove solution container. Visually inspect the container. If the outlet port protector is damaged, detached, or not present, discard

container as solution path sterility may be impaired. Some opacity of the plastic due to moisture absorption during the sterilization process may be observed. This is normal and does not affect the solution quality or safety. The opacity will diminish gradually. Check for leaks. **Do not add supplementary medication.**

Preparation for Administration

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

REFERENCES

1. Clinical and Laboratory Standards Institute (CLSI). *Methods for Antimicrobial Susceptibility Testing of Anaerobic Bacteria; Approved Standard—Eighth Edition*. CLSI Document M11-A8, CLSI, 950 West Valley Road, Suite 2500, Wayne, Pennsylvania 19087-1898 USA, 2012.
2. Clinical and Laboratory Standards Institute (CLSI). *Performance Standards for Antimicrobial Susceptibility Testing; Twenty-fifth Informational Supplement*, CLSI Document M100-S25, CLSI, 950 West Valley Road, Suite 2500, Wayne, Pennsylvania 19087-1898, USA, 2015.

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