

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Cefalexin 250 mg Capsules

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each capsule contains 250 mg of Cefalexin (as monohydrate)

Excipient(s) with known effect

Each capsule contains 26.6 mg lactose.

For full list of excipients, see section 6.1

3 PHARMACEUTICAL FORM

Capsules, hard

Size 2 grey/orange capsule containing white powder printed CHX 250.

4.1 Therapeutic indications

Cefalexin is a semi synthetic cephalosporin antibiotic for oral administration.

Cefalexin is indicated in the treatment of the following infections due to susceptible micro-organisms:

Respiratory tract infections.

Otitis media.

Skin and soft tissue infections.

Bone and joint infections.

Genito-urinary tract infections, including acute prostatitis.

Dental infections.

4.2. Posology and Method of Administration

Posology

Adults

The adult dosage ranges from 1-4 g daily in divided doses; most infections will respond to a dosage of 500 mg every 8 hours. For skin and soft tissue infections, streptococcal pharyngitis and mild, uncomplicated urinary tract

infections, the usual dosage is 250 mg every 6 hours, or 500 mg every 12 hours.

For more severe infections or those caused by less susceptible organisms, larger doses may be needed. If daily doses of cefalexin greater than 4g are required parenteral cephalosporins, in appropriate doses, should be considered.

Elderly and patients with impaired renal function:

As for adults although dosage should be reduced to a daily maximum of 500mg if renal function is severely impaired (glomerular filtration rate < 10ml/min) (see section 4.4).

Paediatric population

The recommended daily dosage for children is 25-50mg/kg (10-20mg/lb) in divided doses. For skin and soft tissue infections, streptococcal pharyngitis and mild, uncomplicated urinary tract infections, the total daily dose may be divided and administered every 12 hours. For most infections the following schedule is suggested:

Children under 5 years: 125mg every 8 hours.

Children 5 years and over: 250mg every 8 hours.

In severe infections, the dosage may be doubled. In the therapy of otitis media, clinical studies have shown that a dosage of 75-100mg/kg/day in 4 divided doses is required.

In the treatment of beta-haemolytic streptococcal infections, a therapeutic dose should be administered for at least 10 days.

Method of administration

For oral use.

4.3. Contra-indications

Hypersensitivity to the active substance or to any of the excipients listed in section 6.1. Cefalexin is contraindicated in patients with known allergy to the cephalosporins group of antibiotics

4.4. Special Warnings and Precautions for Use

Before instituting therapy with cefalexin, every effort should be made to determine whether the patient has had previous hypersensitivity reactions to the cephalosporins, penicillins or other drugs. Cefalexin should be given cautiously to penicillin-sensitive patients. There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and cephalosporins. Patients have had severe reactions (including anaphylaxis) to both drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics, including macrolides, semisynthetic penicillins and cephalosporins. It is important, therefore, to consider its diagnosis in patients who develop diarrhoea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening. Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, appropriate measures should be taken.

If an allergic reaction to cefalexin occurs the drug should be discontinued and the patient treated with the appropriate agents.

Prolonged use of cefalexin may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Reports of neurotoxicity have been identified in association with cephalosporin treatment. Symptoms may include encephalopathy, myoclonus and seizures.

Elderly patients, patients with severe renal impairment or central nervous system disorders are particularly at risk. Cefalexin should be administered with caution in the presence of markedly impaired renal function. Careful clinical and laboratory studies should be made because safe dosage may be lower than that usually recommended. If dialysis is required for renal failure, the daily dose of cefalexin should not exceed 500mg. If cefalexin associated neurotoxicity is suspected, discontinuation of cefalexin should be considered.

Concurrent administration with certain other drug substances, such as aminoglycosides, other cephalosporins, or furosemide, (frusemide) and similar potent diuretics, may increase the risk of nephrotoxicity.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In haematological studies, or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side, or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognised that a positive Coombs' test may be due to the drug.

A false positive reaction for glucose in the urine may occur with Benedict's or Fehling's solutions or with copper sulphate test tablets.

Acute generalized exanthematous pustulosis (AGEP) has been reported in association with cefalexin treatment. At the time of prescription patients should be advised of the signs and symptoms and monitored closely for skin reactions. If signs and symptoms suggestive of these reactions appear, cefalexin should be withdrawn immediately and

an alternative treatment considered. Most of these reactions occurred most likely in the first week during treatment.

Cefalexin capsule contains lactose

Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine.

4.5 Interaction with other medicinal products and other forms of interaction

As with other beta-lactam drugs, renal excretion of cephalexin is inhibited by probenecid. Probenecid causes reduced excretion of cephalexin leading to increased plasma concentrations. Cephalosporins may have an increased risk of nephrotoxicity in the presence of amphotericin, loop diuretics, aminoglycosides, capreomycin or vancomycin.

In a single study of 12 healthy subjects given single 500mg doses of cephalexin and metformin, plasma metformin C_{max} and AUC increased by an average of 34% and 24%, respectively, and metformin renal clearance decreased by an average of 14%. No side-effects were reported in the 12 healthy subjects in this study. No information is available about the interaction of cephalexin and metformin following multiple dose administration. The clinical significance of this study is unclear, particularly as no cases of “lactic acidosis” have been reported in association with concomitant metformin and cephalexin treatment. Hypokalaemia has been described in patient taking cytotoxic drugs for leukaemia when they were given gentamicin and cephalexin.

4.6 Fertility, pregnancy and lactation

Pregnancy

Although laboratory and clinical studies have shown no evidence of teratogenicity, caution should be exercised when prescribing for the pregnant patient.

Breastfeeding

The excretion of cephalexin in human breast milk increased up to 4 hours following a 500mg dose. The drug reached a maximum level of 4 micrograms/ml then decreased gradually and had disappeared 8 hours after administration. Caution should be exercised when cephalexin is administered to a nursing mother, since the neonate is presented with the risk of candidiasis and CNS toxicity due to immaturity of the blood-brain barrier. There is a theoretical possibility of later sensitisation.

4.7 Effects on ability to drive and use machines

Not relevant.

4.8 Undesirable effects

Gastro-intestinal: Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side-effect has been diarrhoea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred.

As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

Hypersensitivity: Allergic reactions have been observed in the form of rash, urticaria, angioedema, rarely erythema multiforme, Stevens-Johnson syndrome and toxic epidermal necrolysis. These reactions usually subside upon discontinuation of the drug, although in some cases supportive therapy may be necessary. Anaphylaxis has also been reported.

Haemic and Lymphatic System: Eosinophilia, neutropenia, thrombocytopenia, haemolytic anaemia have been reported.

Hepatic: As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely. Slight elevations of AST and ALT have been reported.

Skin and subcutaneous tissue disorders:

Acute generalised exanthematous pustulosis (AGEP) has been reported with unknown frequency.

Other: These reactions have included genital and anal pruritus, genital candidiasis, vaginitis and vaginal discharge, dizziness, fatigue, headache, agitation, confusion, hallucinations, arthralgia, arthritis and joint disorder acute generalised exanthematous pustulosis (AGEP). Hyperactivity, nervousness, sleep disturbances and hypertonia have also been reported. Reversible interstitial nephritis has been reported rarely. Slight elevations in AST and ALT have been reported. There have been reports of neurological sequelae including tremor, myoclonia, convulsions, encephalopathy with drugs belonging to the class of cephalosporins. Most cases occurred in patients with renal impairment who received doses that exceeded the recommended dose and resolved following discontinuation of treatment.

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:

www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

4.9 Overdose

Symptoms of oral overdosage may include nausea, vomiting, epigastric distress, diarrhoea and haematuria.

In the event of severe overdosage, general supportive care is recommended including close clinical and laboratory monitoring of haematological, renal and hepatic functions and coagulation status until the patient is stable. Forced diuresis, peritoneal dialysis, haemodialysis, or charcoal haemoperfusion have not been established as beneficial for an overdose of cefalexin. It would be extremely unlikely that one of these procedures would be indicated.

Unless 5 - 10 times the normal total daily dose has been ingested, gastrointestinal decontamination should not be necessary.

There have been reports of haematuria without impairment of renal function in children accidentally ingesting more than 3.5g of cefalexin in a day. Treatment has been supportive (fluids) and no sequelae have been reported.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antibacterials for systemic use, first generation cephalosporins, ATC code: J01DB01

Cefalexin is bactericidal and has antimicrobial activity similar to that of cephaloridine or cephalothin against both gram-positive and gram-negative organisms.

In vitro tests demonstrate that cephalosporins are bactericidal because of their inhibition of cell-wall synthesis.

Cefalexin is active against the following organisms in vitro:

Beta haemolytic streptococci

Staphylococci, including coagulase positive, coagulase negative and penicillinase-producing strains.

Streptococcus pneumoniae

Escherichia coli

Proteus mirabilis

Klebsiella species

Haemophilus influenzae

Branhamella catarrhalis

Most strains of enterococci (*Streptococcus faecalis*) and a few strains of *staphylococci* are resistant to cefalexin. It is not active against most strains of *Enterobacter* species, *Morganella morganii* and *Pr. vulgaris*. It has no activity against *Pseudomonas* or *Herellea species* or *Acinetobacter calcoaeticus*. Penicillin-resistant *Streptococcus pneumoniae* is usually cross-resistant to beta-lactam antibiotics. When tested by in vitro methods, staphylococci exhibit cross resistance between cefalexin and methicillin type antibiotics

5.2. Pharmacokinetic Properties

Absorption

Human pharmacology - Cefalexin is acid stable and may be given without regard to meals.

It is rapidly absorbed after oral administration from the gastro-intestinal tract and produces peak plasma concentrations about 1 hour after administration. Following doses of 250mg, 500mg and 1g, average peak serum levels of approximately 9, 18 and 32mg/L respectively were obtained at 1 hour.

Measurable levels were present 6 hours after administration.

Cefalexin is almost completely absorbed from the gastro-intestinal tract, and 75-100% is rapidly excreted in active form in the urine. If cefalexin is taken with food there is delayed and slightly reduced absorption and there may be delayed elimination from the plasma. The half-life is approximately 60 minutes in patients with normal renal function. Haemodialysis and peritoneal dialysis will remove cefalexin from the blood.

The biological half-life has been reported to range from 0.6 to at least 1.2 hours and this increases with reduced renal function. About 10 to 15% of a dose is bound to plasma proteins.

Distribution

Peak blood levels are achieved one hour after administration, and therapeutic levels are maintained for 6-8 hours. About 80% of the active drug is excreted in the urine within 6 hours. No accumulation is seen with dosages above the therapeutic maximum of 4g/day. The half-life may be increased in neonates due to their renal immaturity, but there is no accumulation when given at up to 50mg/kg/day.

Elimination

Cefalexin is excreted in the urine by glomerular filtration and tubular secretion. Studies showed that over 90% of the drug was excreted unchanged in the urine within 8 hours. During this period peak urine concentrations following the 250mg, 500mg and 1g doses were approximately 1000, 2200 and 5000mg/L respectively.

5.3 Preclinical safety data

The daily oral administration of cefalexin to rats in doses of 250 or 500mg/kg prior to and during pregnancy, or to rats and mice during the

period of organogenesis only, had no adverse effect on fertility, foetal viability, foetal weight, or litter size.

Cefalexin showed no enhanced toxicity in weanling and newborn rats as compared with adult animals.

The oral LD₅₀ of cefalexin in rats is 5,000mg/kg.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Lactose

Magnesium stearate

Capsule shell

Black iron oxide (E172)

Titanium dioxide (E171)

Erythrosin (E127)

Quinoline yellow (E104)

Gelatin

6.2 Incompatibilities

None known

6.3 Shelf life

36 months.

6.4 Special precautions for storage

Do not store above 25°C.

Keep the container tightly closed (for bottles).

Store in the original package (for blisters).

6.5 Nature and contents of container

Each container consists of a polypropylene tubular container with an open end equipped to accept a polyethylene closure, with a tamper-evident tear strip, or PVC/aluminium blisters, or PVDC coated PVC/ Aluminium blisters (60g/m² PVDC on 250µm PVC/20µm Al) of an appropriate size to accommodate 7, 14, 20, 21, 28, 30, 50, 56, 60, 100, or 500 capsules. Not all sizes may be marketed.

6.6 Special precautions for disposal

No special instructions

7 MARKETING AUTHORISATION HOLDER

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18/09/2024