



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

## **4.2 Posology and method of administration**

### ***Method of Administration***

Metronidazole 500mg/100ml Intravenous Infusion should be infused intravenously at an approximate rate of 5 ml/minute (or one bag infused over 20 to 60 minutes). Oral medication should be substituted as soon as feasible.

### ***Prophylaxis against postoperative infections caused by anaerobic bacteria:***

Primarily in the context of abdominal, (especially colorectal) and gynaecological surgery.

Antibiotic prophylaxis duration should be short, mostly limited to the post operative period (24 hours but never more than 48 hours). Various schedules are possible.

Adults: Intra-venous injection of single dose of 1000mg-1500mg, 30-60 minutes preoperatively or alternatively 500mg immediately before, during or after operation, then 500mg 8 hourly.

Children < 12 years: 20-30 mg/kg as a single dose given 1-2 hours before surgery.

Newborns with a gestation age <40 weeks: 10 mg/kg body weight as a single dose before operation.

### ***Anaerobic infections:***

Intravenous route is to be used initially if patient symptoms preclude oral therapy. Various schedules are possible.

Adults: 1000mg – 1500mg daily as a single dose-or alternatively 500mg every 8 hours.

Children > 8 weeks to 12 years of age: The usual daily dose is 20-30mg/kg/day as a single dose or divided into 7.5 mg/kg every 8 hours. The daily dose may be increased to 40 mg/kg, depending on the severity of the infection. Duration of treatment is usually 7 days.

Children < 8 weeks of age: 15 mg/kg as a single dose daily or divided into 7.5 mg/kg every 12 hours.

In newborns with a gestation age < 40 weeks, accumulation of metronidazole can occur during the first week of life, therefore the concentrations of metronidazole in serum should preferably be monitored after a few days of therapy.

Oral medication could be given, at the same dose regimen. Oral medication should be substituted as soon as feasible.

## Duration of Treatment

Treatment for seven to ten days should be satisfactory for most patients but, depending upon clinical and bacteriological assessments, the physician might decide to prolong treatment e.g.; for the eradication of infection from sites which cannot be drained or are liable to endogenous recontamination by anaerobic pathogens from the gut, oropharynx or genital tract.

### ***Bacterial vaginosis:***

Adolescents: 400 mg twice daily for 5-7 days or 2000 mg as a single dose

### ***Urogenital trichomoniasis***

Adults and adolescents: 2000 mg as a single dose or 200 mg 3 times daily for 7 days or 400 mg twice daily for 5-7 days

Children < 10 years: 40 mg/kg orally as a single dose or 15 – 30 mg/kg/day divided in 2-3 doses for 7 days; not to exceed 2000 mg/dose

### ***Giardiasis:***

> 10 years: 2000 mg once daily for 3 days, or 400 mg three times daily for 5 days, or 500 mg twice daily for 7 to 10 days

Children 7 to 10 years: 1000 mg once daily for 3 days

Children 3 to 7 years: 600 to 800 mg once daily for 3 days

Children 1 to 3 years: 500 mg once daily for 3 days

Alternatively, as expressed in mg per kg of body weight: 15-40 mg/kg/day divided in 2-3 doses.

### ***Amoebiasis:***

> 10 years: 400 to 800 mg 3 times daily for 5-10 days

Children 7 to 10 years: 200 to 400 mg 3 times daily for 5-10 days

Children 3 to 7 years: 100 to 200 mg 4 times daily for 5-10 days

Children 1 to 3 years: 100 to 200 mg 3 times daily for 5-10 days

Alternatively, doses may be expressed by body weight 35 to 50 mg/kg daily in 3 divided doses for 5 to 10 days, not to exceed 2400 mg/day

### ***Eradication of *Helicobacter pylori* in paediatric patients:***

As a part of a combination therapy, 20 mg/kg/day not to exceed 500 mg twice daily for 7-14 days.

Official guidelines should be consulted before initiating therapy

### ***Elderly Population***

Caution is advised in the elderly, particularly at high doses, although there is limited information available on modification of dosage.

### ***Patients with renal failure***

Routine adjustments of the dosage of Metronidazole are not considered necessary in the presence of renal failure.

No routine adjustment in the dosage of Metronidazole needs to be made in patients with renal failure undergoing intermittent peritoneal dialysis (IDP) or continuous ambulatory peritoneal dialysis (CAPD). However dosage reduction may be necessary when excessive concentrations of metabolites are found.

In patients undergoing haemodialysis, Metronidazole should be re-administered immediately after haemodialysis

### ***Patients with advanced hepatic insufficiency***

In patients with advanced hepatic insufficiency a dosage reduction with serum level monitoring is necessary.

## **4.3 Contraindications**

Hypersensitivity to the active substance, to other imidazole derivatives or to any of the excipients listed in section 6.1.

## **4.4 Special warnings and precautions for use**

### ***Liver disease:***

Caution is needed in patients with severe hepatic impairment. The dose of metronidazole should be reduced as necessary. Metronidazole is mainly metabolised by hepatic oxidation. Substantial impairment of Metronidazole clearance may occur in the presence of advanced hepatic insufficiency. The risk/benefit ratio of using Metronidazole to treat trichomoniasis in such patients should be carefully considered (for dosage adjustment see section 4.2). Plasma levels of Metronidazole should be closely monitored.

Caution is needed in patients with hepatic encephalopathy. Patients with severe hepatic encephalopathy metabolize metronidazole slowly, with resultant accumulation of metronidazole. This may cause exacerbation of CNS adverse effects. The dose of metronidazole should be reduced as necessary.

### Hepatotoxicity in patients with Cockayne Syndrome

Cases of severe hepatotoxicity/acute hepatic failure, including cases with a fatal outcome with very rapid onset after treatment initiation in patients with Cockayne syndrome have been reported with products containing metronidazole for systemic use. In this population, metronidazole not be used unless the benefit is considered to outweigh the risk and if no alternative treatment is available. Liver function tests must be performed just prior to the start of therapy, throughout and after end of treatment until liver function is within normal ranges, or until the baseline values are reached. If the liver function tests become markedly elevated during treatment, the drug should be discontinued.

Patients with Cockayne syndrome should be advised to immediately report any symptoms of potential liver injury to their physician and stop taking metronidazole (see section 4.8).

### *Active Central Nervous System disease:*

Metronidazole should be used with caution in patients with active disease of the Peripheral and Central Nervous System. Severe neurological disturbances (including seizures and peripheral and optic neuropathies) have been reported in patients treated with metronidazole. Stop metronidazole treatment if any abnormal neurologic symptoms occur such as ataxia, hypoacusis, dizziness, confusion, or any other CNS adverse reaction. The risk of aggravation of the neurological state should be considered in patients with fixed or progressive paraesthesia, epilepsy and active disease of the central nervous system except for brain abscess.

Encephalopathy has been reported in association with cerebellar toxicity characterized by ataxia, dizziness, dysarthria, and accompanied by CNS lesions seen on magnetic resonance imaging (MRI). CNS symptoms and CNS lesions, are generally reversible within days to weeks upon discontinuation of metronidazole.

Aseptic meningitis can occur with metronidazole. Symptoms can start within hours of dose administration and generally resolve after metronidazole therapy is discontinued (see section 4.8).

### *Blood Dyscrasias*

Metronidazole should be used with caution in patients with evidence or history of blood dyscrasia as agranulocytosis, leukopenia and neutropenia have been observed following metronidazole administration.

### *Renal Disease:*

**Metronidazole is removed during haemodialysis and should be administered after the procedure is finished.**

**Patients with renal impairment, including patients receiving peritoneal dialysis, should be monitored for signs of toxicity due to the potential accumulation of toxic metronidazole metabolites.**

### *Sodium restricted patients:*

**This medicinal product contains 13.5 mmol (310 mg) sodium per 100 mL. To be taken into consideration by patients on a controlled sodium diet.**

*Alcohol:*

Patients should be advised to discontinue consumption of alcoholic beverages or alcohol-containing products before, during, and up to 72 hours after taking metronidazole because of a disulfiram-like effect (abdominal cramps, nausea, headaches, flushing, vomiting and tachycardia). See section 4.5.

**Intensive or prolonged Metronidazole therapy:**

As a rule, the usual duration of therapy with i.v Metronidazole or other imidazole derivatives is usually less than 10 days. This period may only be exceeded in individual cases after a very strict benefit-risk assessment. Only in the rarest possible case should the treatment be repeated. Limiting the duration of treatment is necessary because damage to human germ cells cannot be excluded.

**Intensive or prolonged Metronidazole therapy should be conducted only under conditions of close surveillance for clinical and biological effects and under specialist direction. If prolonged therapy is required, the physician should bear in mind the possibility of peripheral neuropathy or leucopenia. Both effects are usually reversible.**

In case of prolonged treatment, occurrence of undesirable effects such as paraesthesia, ataxia, dizziness and convulsive crises should be checked. High dose regimes have been associated with transient epileptiform seizures.

*Monitoring:*

**Due to increased risk for adverse reactions, regular clinical and laboratory monitoring (including blood count) are advised in cases of high-dose, prolonged or repeated treatment, in case of antecedents of blood dyscrasia, in case of severe infection and in severe hepatic insufficiency.**

**General:**

Patients should be warned that Metronidazole may darken urine (due to Metronidazole metabolite).

## **4.5 Interaction with other medicinal products and other forms of interaction**

*Not recommended concomitant therapy:*

Disulfiram: Concurrent use of metronidazole and disulfiram may result in psychotic reactions and confusion. Metronidazole should not be given to patients who have taken disulfiram within the last two weeks.

Alcohol: Disulfiram-like effect (warmth, redness, vomiting, tachycardia).

Alcohol beverage and drugs containing alcohol should be avoided. Patients should be advised not to take alcohol during Metronidazole therapy and at least 72 hours afterwards because of a disulfiram-like (antabuse effect) reaction (flushing, vomiting, tachycardia).

*Concomitant therapy requiring special precautions:*

Oral anticoagulants (warfarin): metronidazole may increase the anticoagulant effects of warfarin and other oral anticoagulants, resulting in a prolongation of the prothrombin time and increased risk of haemorrhage (decrease in its liver catabolism). Patients taking metronidazole and warfarin or other oral coumarins concomitantly should have their prothrombin time and international normalized ratio (INR) monitored more frequently. Patients should be monitored for signs and symptoms of bleeding.

A large number of patients have been reported showing an increase in oral anticoagulant activity whilst receiving concomitant antibiotic therapy. The infectious and inflammatory status of the patient, together with their age and general well-being are all risk factors in this context. However, in these circumstances it is not clear as to the part played by the disease itself or its treatment in the occurrence of prothrombin time disorders. Some classes of antibiotics are more likely to result in this interaction, notably fluoroquinolones, macrolides, cyclines, cotrimoxazole and some cephalosporins.

Vecuronium (non depolarising curaremimetic): Metronidazole can potentialise the effects of vecuronium.

*Combinations to be considered:*

5 Fluoro-uracile: increase in the toxicity of 5 fluoro-uracile due to a decrease of its clearance.

Lithium: lithium retention accompanied by evidence of possible renal damage has been reported in patients treated simultaneously with lithium and Metronidazole. Lithium treatment should be tapered or withdrawn before administering Metronidazole. Plasma concentrations of lithium, creatinine and electrolytes should be monitored in patients under treatment with lithium while they receive Metronidazole.

Cholestyramine may delay or reduce the absorption of Metronidazole.

Phenytoin, barbiturates (phenobarbital): concomitant administration of drugs that induce microsomal liver enzyme activity, such as phenytoin or phenobarbital, may accelerate the elimination of metronidazole and therefore decrease its efficacy.

Cimetidine: concomitant administration of drugs that decrease microsomal liver enzyme activity, such as cimetidine, may cause decreased metabolism and reduced plasma clearance of metronidazole which may result in metronidazole toxicity.

Concomitant use of metronidazole and CYP3A4 substrates (e.g., amiodarone, tacrolimus, cyclosporine, carbamazepine, and quinidine) may increase respective CYP3A4-substrate plasma levels. Monitoring of plasma concentrations of CYP3A4 substrates may be necessary.

Busulfan: Plasma concentrations of busulfan may increase during concomitant treatment with metronidazole, which can result in serious busulfan toxicity such as sinusoidal obstruction syndrome, gastrointestinal mucositis, and hepatic veno-occlusive disease.

*Laboratory tests:*

Metronidazole may immobilise *Treponema* and thus may lead to falsely positive Nelson's test.

Metronidazole may interfere with serum aspartate transaminase (AST), alanine transaminase (ALT), lactate dehydrogenase (LDH), triglycerides, and glucose hexokinase determinations. Metronidazole causes an increase in ultraviolet absorbance at 340 nm resulting in falsely decreased values.

#### **4.6 Fertility, pregnancy and lactation**

##### *Pregnancy*

Metronidazole crosses the placental barrier.

Clinical data on a large number of exposed pregnancies and animal data did not show a teratogenic or foetotoxic effect. However unrestricted administration of nitroimidazole to the mother may be associated with a carcinogenic or mutagenic risk for the unborn or newborn child.

Therefore Metronidazole should not be given during pregnancy unless clearly necessary.

##### *Lactation*

Metronidazole is excreted in breast milk. During lactation either breast-feeding or Metronidazole should be discontinued.

##### *Fertility*

There are no clinical data relating to the effect of metronidazole on fertility. Animal studies demonstrated adverse effects on the male reproductive system that are wholly or partially reversible after treatment withdrawal (see section 5.3).

#### **4.7 Effects on ability to drive and use machines**

No studies have been performed following intravenous treatment with Metronidazole on the ability to drive and use machines. Some adverse reactions to metronidazole such as seizure, dizziness, optic neuropathy, may impair the ability to drive or operate machines (see section 4.8).

Therefore it is recommended that patients should not drive or use machines.

#### **4.8 Undesirable effects**

There are no data available on adverse reactions from Baxter-sponsored clinical trials conducted with Metronidazole. The following adverse reactions have been reported with Metronidazole, listed by MedDRA System Organ Class (SOC), Preferred Term and frequency. The following frequency groupings are used: very common ( $\geq 1/10$ ); common ( $\geq 1/100$  and  $< 1/10$ ); uncommon ( $\geq 1/1,000$  and  $< 1/100$ ); rare ( $\geq 1/10,000$  and  $< 1/1,000$ ); very rare ( $< 1/10,000$ ) and not known (cannot be estimated from the available data).

Frequency, type and severity of adverse reactions in children are the same as in adults.

| System Organ Class (SOC)                        | Preferred MedDRA Term  | Frequency  |
|---|--|--|
| Blood and Lymphatic System Disorders            | Leukopenia<br>Agranulocytosis<br>Pancytopenia<br>Neutropenia<br>Thrombocytopenia<br>Eosinophilia   | uncommon<br>rare<br>rare<br>rare<br>rare<br>not known  |
| Immune System Disorder                          | Anaphylactic shock<br>Jarisch-Herxheimer reaction<br>Hypersensitivity  | rare<br>rare<br>not known  |
| Metabolism and Nutrition Disorders              | Decreased appetite   | not known  |
| Psychiatric Disorders                           | Hallucinations<br>Depression<br>Confusional state<br>Insomnia  | rare<br>not known<br>not known<br>not known  |
| Nervous System Disorders                        | Dysgeusia<br>Headache<br>Encephalopathy<br>Meningitis aseptic<br>Seizure<br>Somnolence<br>Neuropathy peripheral<br>Ataxia<br>Dizziness<br>Hypoacusis<br>Dysarthria<br>Hypoesthesia<br>Paraesthesia | common<br>uncommon<br>rare<br>rare<br>rare<br>rare<br>rare<br>rare<br>rare<br>rare<br>not known<br>not known<br>not known<br>not known |
| Eye Disorders                                   | Optic neuropathy<br>Diplopia<br>Myopia   | rare<br>rare<br>rare   |
| Cardiac Disorders                               | Tachycardia<br>Palpitations  | not known<br>not known   |
| Respiratory, Thoracic and Mediastinal Disorders | Dyspnoea   | not known  |
| Gastrointestinal Disorders                      | Glossitis<br>Stomatitis<br>Dry mouth<br>Pancreatitis<br>Abdominal pain upper<br>Diarrhoea<br>Nausea<br>Vomiting<br>Constipation<br>Tongue discoloration  | common<br>common<br>common<br>rare<br>rare<br>rare<br>rare<br>rare<br>rare<br>not known<br>not known                                   |
| Hepatobiliary disorders                         | Jaundice cholestatic   | rare   |

| System Organ Class (SOC)                        | Preferred MedDRA Term      | Frequency |
|---|----------------------------|-----------|
| Skin and Subcutaneous Disorders                 | Stevens-Johnson syndrome   | rare      |
|   | Toxic epidermal necrolysis | rare      |
|   | Angioedema                 | rare      |
|   | Erythema multiforme        | rare      |
|   | Fixed eruption             | not known |
|   | Pruritus                   | not known |
|   | Swelling face              | not known |
|   | Urticaria                  | not known |
|   | Hyperhidrosis              | not known |
| Rash  | not known                  |           |
| Musculoskeletal and Connective Tissue Disorders | Myalgia                    | common    |
|   | Muscle spasms              | not known |
|   | Arthralgia                 | not known |
| Renal and urinary disorders                     | Chromaturia                | rare      |
|   | Dysuria                    | not known |
| General and Administration Site Conditions      | Asthenia                   | uncommon  |
|   | Mucosal inflammation       | rare      |
|   | Pyrexia                    | rare      |
|   | Injection site reaction    | not known |
|   | Malaise                    | not known |
|   | Face oedema                | not known |
|   | Oedema peripheral          | not known |
|   | Chest pain                 | not known |
| Chills  | not known                  |           |
| Investigations                                  | Hepatic enzyme increased   | not known |

Cases of severe irreversible hepatotoxicity/acute liver failure, including cases with fatal outcomes with very rapid onset after initiation of systemic use of metronidazole, have been reported in patients with Cockayne Syndrome (see section 4.4).

#### 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. Website: [www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard) or search for MHRA Yellow Card in the Google Play or Apple App Store.

## 4.9 Overdose

### *Symptoms*

In cases of overdose in adults, the clinical symptoms are usually limited to nausea, vomiting and neurotoxic effects, including ataxia, slight disorientation, confusion, seizures and peripheral neuropathy.

### *Treatment*

There is no specific treatment for Metronidazole overdose, Metronidazole infusion should be discontinued. Patients should be treated symptomatically.

## 5. PHARMACOLOGICAL PROPERTIES

### 5.1. Pharmacodynamic Properties

Metronidazole is an anti-infectious drug belonging to the pharmacotherapeutic group of nitroimidazole derivatives, which have effect mainly on strict anaerobes. This effect is probably caused by interaction with DNS and different metabolites.

Pharmacotherapeutic group: Anti bacterials for systemic use: imidazole derivatives

ATC Code: J01XD01

and

Pharmacotherapeutic group: Anti-protozoals: nitroimidazole derivatives

ATC Code: P01AB01.

Metronidazole has anti bacterial and antiprotozoal actions and is effective against anaerobic bacteria and against *Trichomonas vaginalis* and other protozoa including *Entamoeba histolytica* and *Giardia lamblia*.

#### *Anti-Microbial Spectrum:*

The MIC breakpoints separating susceptible from intermediately susceptible and intermediately susceptible from resistant organisms are as following:

$$S \leq 4 \text{ mg/l} \quad \text{and} \quad R > 4 \text{ mg/l}$$

The prevalence of acquired resistance may vary geographically and with time for selected species and local information is desirable, particularly when treating severe infections. This information gives only approximate guidance on probabilities whether microorganisms will be susceptible to Metronidazole or not.

| <i>Categories</i>                                |
|--|
| <u><i>SUSCEPTIBLE</i></u>                        |
| <i>Gram negative aerobes</i>                     |
| <i>Helicobacter pylori</i>                       |
| <i>Anaerobes</i>                                 |
| <i>Bacteroides fragilis</i>                      |
| <i>Bifidobacterium</i> >> <i>resistant (70%)</i> |
| <i>Bilophila</i>                                 |

|   |
|---|
| <p><i>Clostridium</i><br/> <i>Clostridium difficile</i><br/> <i>Clostridium perfringens</i><br/> <i>Eubacterium</i><br/> <i>Fusobacterium</i><br/> <i>Peptostreptococcus</i><br/> <i>Prevotella</i><br/> <i>Porphyromonas</i><br/> <i>Veillonella</i></p> |
| <p><u>RESISTANT</u></p> <p><i>Gram positive aerobes</i><br/> <i>Actinomyces</i><br/> <br/> <i>Anaerobes</i><br/> <i>Mobiluncus</i><br/> <i>Propionibacterium acnes</i></p>  |
| <p><u>ANTIPARASITIC ACTIVITY</u></p> <p><i>Entamoeba histolytica</i><br/> <i>Giardia intestinalis</i><br/> <i>Trichomonas vaginalis</i></p>   |

Cross-resistance with tinidazole occurs.

## 5.2 Pharmacokinetic properties

**Distribution:** After administration of a single 500 mg dose, mean Metronidazole peak plasma concentrations of ca. 14 – 18 µg/ml are reached at the end of a 20 minute infusion. 2-hydroxy-metabolite peak plasma concentrations of ca. 3 µg/ml are obtained after a 1 g single i.v. dose. Steady state Metronidazole plasma concentrations of about 17 and 13 µg/ml are reached after administration of Metronidazole every 8 or 12 hours, respectively.

Plasma protein binding is less than 10%, and the volume of distribution  $1.1 \pm 0.4$  l/kg.

**Metabolism:** Metronidazole is metabolised in the liver by hydroxylation, oxidation and glucuronidation. The major metabolites are a 2-hydroxy- and an acetic acid metabolite.

**Elimination:** More than 50% of the administered dose is excreted in the urine, as unchanged Metronidazole (ca. 20% of the dose) and its metabolites. About 20% of the dose is excreted with faeces. Clearance is  $1.3 \pm 0.3$  ml/min/kg, while renal

clearance is about 0.15 ml/min/kg. The plasma elimination half-life of Metronidazole is ca. 8 hours, and of the 2-hydroxy-metabolite ca. 10 hours.

Special patient groups: The plasma elimination half-life of Metronidazole is not influenced by renal impairment, however this may be increased for 2-hydroxy- and an acetic acid metabolite. In the case of haemodialysis, Metronidazole is rapidly excreted and the plasma elimination half-life is decreased to ca. 2.5 h. Peritoneal dialysis does not appear to affect the elimination of Metronidazole or its metabolites compared to patients with renal impairment.

In patients with impaired liver function, the metabolism of Metronidazole is expected to decrease, leading to an increase in the plasma elimination half-life. In patients with severe liver impairment, clearance may be decreased up to ca. 65%, resulting in an accumulation of Metronidazole in the body.

### **5.3 Preclinical safety data**

Metronidazole has been shown to be non-mutagenic in mammalian cells *in vitro* and *in vivo*.

Metronidazole and a metabolite have been shown to be mutagenic in some tests with non mammalian cells.

Although Metronidazole has been shown to be carcinogenic in certain species of mice, it was not carcinogenic in either rats or guinea pigs. There is no suspicion of carcinogenicity in man.

Daily peroral metronidazole at 5-times the maximum human daily dose for greater than 4 weeks caused testicular toxicity and infertility in male rats. Fertility was restored in most subjects by 8 weeks after cessation of treatment, whereas the lower testicular and epididymal weights and sperm counts had improved but were still observed.

Daily peroral metronidazole at approximately 6-times the maximum human daily dose for  $\geq 2$  weeks caused testicular toxicity in male mice. Most indices of testicular toxicity were restored within 2 months after cessation of treatment, whereas the lower testicular and epididymal weights had improved but were still observed.

These studies demonstrate that the adverse effects of metronidazole on the male reproductive system are wholly or partially reversible after treatment withdrawal (see section 4.6).

## **6. PHARMACEUTICAL PARTICULARS**

### **6.1 List of Excipients**

Disodium phosphate dodecahydrate  
Citric acid monohydrate  
Sodium chloride  
Water for Injections

## **6.2 Incompatibilities**

Do not use equipment containing aluminum (e.g., needles, cannulae) that would come in contact with the drug solution as precipitates may form.

Metronidazole is incompatible with (includes but is not limited to):

- Aztreonam
- Cefamandole nafate
- Cefoxitin
- Penicillin G

In the absence of compatibility studies, this medicinal product must not be mixed with other medicinal product except for those mentioned in 6.6.

## **6.3 Shelf-Life**

2 years.

## **6.4 Special precautions for storage**

Keep container in the outer carton in order to protect from light.

## **6.5 Nature and contents of container**

The bags are composed of polyolefin/polyamide co-extruded plastic (PL 2442) known as Viaflo.

The bags are overwrapped with a protective plastic pouch composed of polyamide/polypropylene, which serves only to provide physical protection to the bags.

The bag size is 100mL.

Outer carton contents: 20 bags of 100mL, 50 bags of 100mL and 60 bags of 100mL

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

Use only if the solution is clear, without visible particles and if the container is undamaged. Administer immediately following the insertion of infusion set.

Do not remove unit from overpouch until ready for use.

The inner bag maintains the sterility of the product.

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 the administration of the fluid from the secondary container is completed.

Pressurizing intravenous solutions contained in flexible plastic containers to increase flow rates can result in air embolism if the residual air in the container is not fully evacuated prior to administration.

Use of a vented intravenous administration set with the vent in the open position could result in air embolism. Vented intravenous administration sets with the vent in the open position should not be used with flexible plastic containers.

The solution should be administered with sterile equipment using an aseptic technique. The equipment should be primed with the solution in order to prevent air entering the system.

In patients maintained on intravenous fluids, Metronidazole 500mg/100ml Intravenous Infusion may be diluted with appropriate volumes of 0.9% sodium chloride solution, dextrose 5% - 0.9% sodium chloride solution, dextrose 5% w/v or potassium chloride infusions (20 and 40 mmol/litre).

Using an incorrect administration technique might cause the appearance of fever reactions due to the possible introduction of pyrogens. In the case of adverse reaction, infusion must be stopped immediately.

*Additives:*

Additives known or determined to be incompatible should not be used.

Before adding a substance or medication, verify that it is soluble and stable in metronidazole, and that the pH range of metronidazole is appropriate. Additives may be incompatible. When introducing additives, the instructions for use of the medication to be added and other relevant literature must be consulted (see Section 6.2).

Mix the solution thoroughly when additives have been introduced.

After addition, if there is a color change and/or the appearance of precipitates, insoluble complexes or crystals, do not use.

Do not store solutions containing additives.

The product should be used immediately after opening.

Discard after single use.

Discard any unused portion.

Do not reconnect partially used bags.

1. Opening

- a. Remove the Viaflo container from the overpouch just before use.

- b. Check for minute leaks by squeezing inner bag firmly. If leaks are found, discard solution, as sterility may be impaired.
- c. Check the solution for limpidity and absence of foreign matters. If solution is not clear or contains foreign matters, discard the solution.

2. Preparation for administration

Use sterile material for preparation and administration.

- a. Suspend container from eyelet support.
- b. Remove plastic protector from outlet port at bottom of container:
  - grip the small wing on the neck of the port with one hand,
  - grip the large wing on the cap with the other hand and twist,
  - the cap will pop off
- c. Use an aseptic method to set up the infusion
- d. Attach administration set. Refer to complete directions accompanying set for connection, priming of the set and administration of the solution.

## **7      MARKETING AUTHORISATION HOLDER**

Baxter Healthcare Ltd.  
Caxton Way  
Thetford  
Norfolk  
IP24 3SE  
UK

## **8      MARKETING AUTHORISATION NUMBER(S)**

PL 00116/0353

## **9      DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION**

12/11/2006

## **10     DATE OF REVISION OF THE TEXT**

02/04/2026