

## Name of Medicine

### PRIMAXIN<sup>®</sup>

*imipenem/cilastatin*

500 mg /500 mg injection

## Presentation

PRIMAXIN for intravenous use is supplied as a white sterile powder in 13 mL vials. Each vial contains 500 mg of imipenem equivalent and 500 mg cilastatin equivalent. The reconstituted solution is clear (however variations in colour from colourless to yellow do not affect the potency of the product).

Note: PRIMAXIN for intramuscular use is not available in New Zealand.

## Therapeutic Class

Cilastatin is a competitive, reversible and specific inhibitor of dehydropeptidase-I enzyme.

## Indications

The activity of PRIMAXIN against an unusually broad spectrum of pathogens makes it particularly useful in the treatment of polymicrobial mixed aerobic/anaerobic infections as well as initial therapy prior to the identification of the causative organisms. PRIMAXIN is indicated for the treatment of the following infections due to susceptible organisms:

- Intra-abdominal infections
- Lower respiratory tract infections
- Gynaecological infections
- Septicaemia
- Genitourinary tract infections
- Bone and joint infections
- Skin and soft tissue infections
- Endocarditis

PRIMAXIN is indicated for the treatment of mixed infections caused by susceptible strains of aerobic and anaerobic bacteria. The majority of these mixed infections are associated with contamination by faecal flora or flora originating from the vagina, skin and mouth. In these mixed infections, *Bacteroides fragilis* is the most commonly encountered anaerobic pathogen and is usually resistant to aminoglycosides, cephalosporins and penicillins. However, *Bacteroides fragilis* is usually susceptible to PRIMAXIN.

PRIMAXIN has demonstrated efficacy against many infections caused by aerobic and anaerobic gram-positive and gram-negative bacteria resistant to the cephalosporins, including cefazolin, cefoperazone, cephalothin, ceftazidime, cefotaxime, moxalactam, cefamandole, ceftazidime and ceftriaxone. Similarly, many infections caused by organisms resistant to aminoglycosides (gentamicin, amikacin, tobramycin) and/or penicillins (ampicillin, carbenicillin, penicillin-G, ticarcillin, piperacillin, azlocillin, mezlocillin) responded to treatment with PRIMAXIN.

PRIMAXIN is not indicated for the treatment of meningitis.

## Dosage and Administration

The dosage recommendations for PRIMAXIN (for intravenous use only) represent the quantity of imipenem to be administered. An equivalent amount of cilastatin is also present.

The total daily dosage of PRIMAXIN should be based on the type or severity of infection and given in equally divided doses based on consideration of degree of susceptibility of the pathogens, renal function and body-weight.

### Adult Dosage Schedule for Patients with Normal Renal Function

Doses cited in Table 1 are based on a patient with normal renal function (creatinine clearance of  $> 70 \text{ mL/min/1.73m}^2$ ) and a body weight of  $\geq 70 \text{ kg}$ . A reduction in dose must be made for a patient with a creatinine clearance  $\leq 70 \text{ mL/min/1.73m}^2$  (see Table 2) and/or a body weight  $< 70 \text{ kg}$ . The reduction for body weight is especially important for patients with much lower body weights and/or moderate/severe renal insufficiency.

Most infections respond to a daily dose of 1-2 g administered in 3-4 divided doses. For the treatment of moderate infection, a 1 g b.i.d. dosage regimen may also be used. In infections due to less susceptible organisms, the daily dosage of PRIMAXIN I.V. may be increased to a maximum of 4 g/day or 50 mg/kg/day, whichever is lower.

Each dose of  $\leq 500 \text{ mg}$  of PRIMAXIN I.V. should be given by intravenous infusion over 20 to 30 minutes. Each dose  $> 500 \text{ mg}$  should be infused over 40 to 60 minutes. In patients who develop nausea during the infusion, the rate of infusion may be slowed.

**TABLE 1**

### I.V. DOSAGE SCHEDULE FOR ADULTS WITH NORMAL RENAL FUNCTION AND BODY WEIGHT $\geq 70 \text{ KG}^*$

SEVERITY OF INFECTION	DOSE (mg of imipenem)	DOSAGE INTERVAL	TOTAL DAILY DOSAGE
Mild	250 mg	6 hrs	1 g
Moderate	500 mg 1000 mg	8 hrs 12 hrs	1.5 g 2 g
Severe - Fully susceptible	500 mg	6 hrs	2 g
Severe and/or Life threatening - due to less susceptible organisms (primarily some strains of <i>P. aeruginosa</i> )	1000 mg 1000 mg	8 hrs 6 hrs	3 g 4 g

\* A further proportionate reduction in dose administered must be made for patients with a body weight  $< 70 \text{ kg}$ .

Due to high antimicrobial activity of PRIMAXIN, it is recommended that the maximum total daily dosage not exceed 50 mg/kg/day or 4 g/day, whichever is lower. However cystic fibrosis patients with normal renal function have been treated with PRIMAXIN at doses up to 90 mg/kg/day in divided doses not exceeding 4 g/day.

PRIMAXIN has been used successfully as monotherapy in immunocompromised cancer patients for confirmed or suspected infections such as sepsis.

### Adult Dosage Schedule for Patients with Impaired Renal Function

To determine the reduced dose for adults with impaired renal function:

1. The total daily dose is chosen from Table 1 based on infection characteristics.
2. From Table 2 the appropriate reduced dosage regimen is selected based on the daily dose from Table 1 and the patient's creatinine clearance category. (For infusion times see Adult Dosage Schedule for Patients with Normal Renal Function).

**TABLE 2**

**REDUCED DOSAGE OF PRIMAXIN I.V. IN ADULTS WITH IMPAIRED RENAL FUNCTION AND BODY WEIGHT  $\geq$  70 kg\***

Total Daily Dose from Table 1	Creatinine Clearance (mL/min/1.73 m <sup>2</sup> )		
	41-70	21-40	6-20
1.0 g/day	250 mg q8h	250 mg q12h	250 mg q12h
1.5 g/day	250 mg q6h	250 mg q8h	250 mg q12h
2.0 g/day	500 mg q8h	250 mg q6h	250 mg q12h
3.0 g/day	500 mg q6h	500 mg q8h	500 mg q12h
4.0 g/day	750 mg q8h	500 mg q6h	500 mg q12h

\* A further proportionate reduction in dose administered must be made for patients with a body weight < 70 kg.

When the 500 mg dose is used in patients with creatinine clearances of 6 - 20 mL/min/1.73m<sup>2</sup> there may be an increased risk of seizures.

Patients with creatinine clearances of  $\leq$  5 mL/min/1.73 m<sup>2</sup> should not receive PRIMAXIN I.V. unless haemodialysis is instituted within 48 hours.

### Haemodialysis

When treating patients with creatinine clearances of  $\leq$  5 mL/min/1.73 m<sup>2</sup> who are undergoing haemodialysis, use the dosage recommendations for patients with creatinine clearances of 6 - 20 mL/min/1.73 m<sup>2</sup> (see Adult Dosage Schedule for Patients with Impaired Renal Function).

Both imipenem and cilastatin are cleared from the circulation during haemodialysis. The patient should receive PRIMAXIN after haemodialysis and at 12 hour intervals timed from the end of that haemodialysis session. Dialysis patients, especially those with background CNS disease, should be carefully monitored; for patients on haemodialysis, PRIMAXIN is recommended only when the benefit outweighs the potential risk of seizures (see Warnings and Precautions).

Currently there are inadequate data to recommend use of PRIMAXIN I.V. for patients on peritoneal dialysis.

Renal status of elderly patients may not be accurately portrayed by measurement of BUN or creatinine alone. Determination of creatinine clearance is suggested to provide guidance for dosing in such patients.

### Paediatric Dosing Schedule (3 months or older)

For children and infants the following dosage schedule is recommended:

- a. CHILDREN  $\geq 40$  kg body weight should receive adult doses.
- b. CHILDREN AND INFANTS  $< 40$  kg body weight should receive 15 mg/kg at six-hour intervals. The total daily dose should not exceed 2 g.

Clinical data are insufficient to recommend dosing for children less than 3 months of age, or paediatric patients with impaired renal function (serum creatinine  $> 2$  mg/dL).

PRIMAXIN is not recommended for the therapy of meningitis. If meningitis is suspected, an appropriate antibiotic should be used.

PRIMAXIN may be used in children with sepsis as long as they are not suspected of having meningitis.

### Reconstitution, Intravenous Solution

PRIMAXIN I.V. for intravenous infusion is supplied as a white sterile powder in vials containing 500 mg imipenem equivalent and 500 mg cilastatin equivalent.

PRIMAXIN I.V. is buffered with sodium bicarbonate to provide solutions in the pH range of 6.5 to 8.5. There is no significant change in pH when solutions are prepared and used as directed.

PRIMAXIN I.V. 500 contains 37.5 mg of sodium (1.6 mEq).

Sterile powder PRIMAXIN I.V. should be reconstituted as shown in Table 3. It should be shaken until a clear solution is obtained. Variations of colour from colourless to yellow do not affect the potency of the product.

TABLE 3

#### RECONSTITUTION OF PRIMAXIN I.V.

DOSE OF PRIMAXIN I.V. (mg of imipenem)	VOLUME OF DILUENT TO BE ADDED (mL)	APPROXIMATE AVERAGE CONCENTRATION OF PRIMAXIN I.V. (mg/mL of imipenem)
500	100	5

A suggested procedure is to add approximately 10 mL from the appropriate infusion solution to the vial. Shake well and transfer the resulting suspension to the infusion solution container.

### Stability, PRIMAXIN I.V.

Store the dry powder at room temperature (E.P. = 15-25°C).

Table 4 shows the stability period for PRIMAXIN I.V. when reconstituted with selected infusion solutions, and stored at room temperature or under refrigeration.

### CAUTION:

PRIMAXIN I.V. is chemically incompatible with lactate and should not be reconstituted in

diluents containing lactate.

PRIMAXIN I.V. can be administered, however, into an I.V. system through which a lactate solution is being infused.

PRIMAXIN I.V. should not be mixed with or physically added to other antibiotics.

**TABLE 4**

**STABILITY OF RECONSTITUTED PRIMAXIN I.V.**

Diluent	Stability Period	
	Room Temperature (25°C)	Refrigeration (4°C)
Isotonic Sodium Chloride	4 hrs	24 hrs
5% Dextrose in Water	4 hrs	24 hrs
10% Dextrose in Water	4 hrs	24 hrs
5% Dextrose & 0.9% NaCl	4 hrs	24 hrs
5% Dextrose & 0.45% NaCl	4 hrs	24 hrs
5% Dextrose & 0.225% NaCl	4 hrs	24 hrs
5% Dextrose & 0.15% KCl	4 hrs	24 hrs
Mannitol 5% and 10%	4 hrs	24 hrs

### Contraindications

Hypersensitivity to any component of this product.

### Warnings and Precautions

#### General

There is some clinical and laboratory evidence of partial cross-allergenicity between PRIMAXIN and the other beta-lactam antibiotics, penicillins and cephalosporins. Severe reactions (including anaphylaxis) have been reported with most beta-lactam antibiotics. Before therapy with PRIMAXIN, careful inquiry should be made concerning previous hypersensitivity reactions to beta-lactam antibiotics. If an allergic reaction to PRIMAXIN occurs, the medicine should be discontinued and appropriate measures undertaken.

The concomitant use of PRIMAXIN and sodium valproate is not recommended (see Interactions).

Pseudomembranous colitis has been reported with virtually all antibiotics and can range from mild to life-threatening in severity. Antibiotics should, therefore, be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis. It is important to consider a diagnosis of pseudomembranous colitis in patients who develop diarrhoea in association with antibiotic use. While studies indicate that a toxin produced by *Clostridium difficile* is a primary cause of antibiotic-associated colitis, other causes should also be considered.

#### Use in Pregnancy

There are no adequate and well controlled studies in pregnant women. PRIMAXIN should be used during pregnancy only if the potential benefit justifies the potential risk to the foetus.

#### Nursing Mothers

Imipenem has been detected in human milk. If the use of PRIMAXIN is deemed essential, the patient should stop nursing.

## Paediatric Use

Clinical data are insufficient to recommend the use of PRIMAXIN for children under 3 months of age or paediatric patients with impaired renal function (serum creatinine >2 mg/dL). (See also Paediatric Dosage Schedule.)

## Central Nervous System

As with other beta lactam antibiotics, CNS side effects such as myoclonic activity, confusional states, or seizures have been reported, especially when recommended dosages based on renal function and bodyweight were exceeded. These experiences have been reported most commonly in patients with CNS disorders (e.g. brain lesions or history of seizures) and/or compromised renal function in whom accumulation of the administered entities could occur. Hence, close adherence to recommended dosage schedules is urged, especially in these patients (see Dosage and Administration). Anticonvulsant therapy should be continued in patients with a known seizure disorder.

If focal tremors, myoclonus, or seizures occur, patients should be elevated neurologically and placed on anticonvulsant therapy if not already instituted. If CNS symptoms continue, the dosage of PRIMAXIN should be decreased or discontinued.

Patients with creatinine clearances of  $\leq 5$  mL/min/1.73 m<sup>2</sup> should not receive PRIMAXIN unless haemodialysis is instituted within 48 hours. For patients on haemodialysis, PRIMAXIN is recommended only when the benefit outweighs the potential risk of seizures.

## Animal Toxicity

Animal studies showed that the toxicity produced by imipenem, as a single entity, was limited to the kidney. Nephrotoxicity (characterised by proximal tubular necrosis) was observed in rabbits and monkeys receiving high doses of imipenem. The rabbit is more sensitive to the nephrotoxic effect of imipenem than the monkey. No adverse effects were observed after six months of imipenem administration in rats, at dosage levels up to 180 mg/kg/day, or in monkeys given up to 120 mg/kg/day.

No adverse effects were noted after intravenous administration of cilastatin to rats and monkeys at dosages up to 500 mg/kg/day for 14 weeks and five weeks, respectively. Acute studies with cilastatin supported the conclusion that this medicine is relatively non-toxic. In rats given 1250 mg/kg/day subcutaneously, or larger doses, very slight to slight proximal renal tubular degeneration was observed. After 5 weeks on these doses, no tubular necrosis was found, and there were no changes in any other tissues. Renal function remained normal.

Co-administration of cilastatin with imipenem in a 1:1 ratio prevented the nephrotoxic effects of imipenem in rabbits and monkeys, even when the dose of imipenem was 360 mg/kg/day or 180 mg/kg/day, respectively (dosage levels which are nephrotoxic when administered without cilastatin). This protective effect was seen in the monkey throughout six months of co-administration.

Rabbits receiving <sup>14</sup>C-imipenem, at a dose known to cause proximal tubular degeneration, showed accumulation in their renal cortex of two radiolabelled metabolites of imipenem, accounting for 8 percent of the administered doses. A majority of radioactivity was found as hydrolysed imipenem, the product of DHP-I mediated metabolism. A second metabolite accumulating in the kidney, but undetectable in either plasma or urine, has been identified as a cysteine-adduct of imipenem, generated by a pathway independent of DHP-I. Levels of free imipenem in the cortex were much lower than those of either of the two metabolites. Co-administration of a protective dose of cilastatin results in a major reduction in levels of accumulated hydrolysed imipenem but not of the cysteine-adduct. Neither of the two metabolites caused renal damage, when administered intravenously to the rabbit at high

dose rates.

Available evidence suggests that cilastatin prevents the nephrotoxicity of imipenem in animals, by preventing entry of imipenem into the tubular cells.

The intravenous LD<sub>50</sub> of imipenem is greater than 2000 mg/kg in the rat and approximately 1500 mg/kg in the mouse.

The intravenous LD<sub>50</sub> of cilastatin sodium is approximately 5000 mg/kg in the rat and approximately 8700 mg/kg in the mouse.

The intravenous LD<sub>50</sub> of PRIMAXIN is approximately 1000 mg/kg in the rat and approximately 1100 mg/kg in the mouse.

Genotoxicity studies were performed in a variety of bacterial and mammalian tests *in vivo* and *in vitro*. The tests were: V79 mammalian cell mutation assay (imipenem, PRIMAXIN), Ames test (cilastatin, imipenem), unscheduled DNA synthesis assay (PRIMAXIN) and *in vivo* mouse cytogenicity test (PRIMAXIN). None of these tests showed any evidence of genetic damage.

Reproduction tests in male and female rats were performed with PRIMAXIN in doses up to 320 mg/kg/day. Slight decreases in live foetal body-weight were observed at this high dosage level. No other adverse effects were observed in fertility, reproductive performance, foetal viability, growth or post-natal development of pups. Similarly, no adverse effects on the foetus or on lactation were observed when PRIMAXIN was administered to rats late in gestation.

Teratogenicity studies with cilastatin sodium in rabbits and rats at 10 and 33 times the usual human dose of PRIMAXIN I.V. (30 mg/kg/day) respectively, showed no evidence of adverse effect on the foetus. No evidence of teratogenicity or adverse effect on postnatal growth or behaviour was observed in rats given imipenem at dosage levels up to 30 times the usual human intravenous dose. Similarly, no evidence of adverse effect on the foetus was observed in teratology studies in rabbits with imipenem at 2 times the usual human intravenous dose.

Teratology studies with imipenem-cilastatin sodium at doses up to 11 times the usual human intravenous dose in pregnant mice and rats, during the period of major organogenesis, revealed no evidence of teratogenicity.

Imipenem-cilastatin sodium, when administered to pregnant rabbits at dosages equivalent to the usual human dose of the intravenous formulation and higher, caused body weight loss, diarrhoea, and maternal deaths. When comparable doses of imipenem-cilastatin sodium were given to non-pregnant rabbits, body weight loss, diarrhoea, and deaths were also observed. This intolerance is not unlike that seen with other beta-lactam antibiotics in this species and is probably due to alteration of gut flora.

A teratology study in pregnant cynomolgus monkeys given imipenem-cilastatin sodium at doses of 40 mg/kg/day (bolus intravenous injection) or 160 mg/kg/day (subcutaneous injection) resulted in maternal toxicity including emesis, inappetence, body weight loss, diarrhoea, abortion and death in some cases. In contrast, no significant toxicity was observed when non-pregnant cynomolgus monkeys were given doses of imipenem-cilastatin sodium up to 180 mg/kg/day (subcutaneous injection). When doses of imipenem-cilastatin sodium (approximately 100 mg/kg/day or approximately 3 times the usual recommended daily human intravenous dose) were administered to pregnant cynomolgus monkeys at an intravenous infusion rate which mimics human clinical use,

there was minimal maternal intolerance (occasional emesis), no maternal deaths, no evidence of teratogenicity, but an increase in embryonic loss relative to control groups.

### **Effects On Ability To Drive Or Operate Machinery**

There are some adverse effects associated with this product that may affect some patients' ability to drive or operate machinery (see Adverse Effects).

### **Adverse Effects**

PRIMAXIN is generally well tolerated. In controlled clinical studies, PRIMAXIN was found to be tolerated as well as cefazolin, cephalothin, and cefotaxime. Adverse effects rarely require cessation of therapy and are generally mild and transient; serious adverse effects are rare. The most common adverse reactions have been local reactions.

The following adverse effects have been reported during clinical studies and in post-marketing experience.

*Local Reactions:* Erythema, local pain and induration, thrombophlebitis.

*Allergic Reactions/Skin:* Rash, pruritus, urticaria, erythema multiforme, Stevens-Johnson syndrome, angioedema, toxic epidermal necrolysis (rarely), exfoliative dermatitis (rarely), candidiasis, fever, including fever induced by the medicine, anaphylactic reactions.

*Gastrointestinal Reactions:* Nausea, vomiting, diarrhoea, staining of teeth and/or tongue. In common with virtually all other broad spectrum antibiotics, pseudomembranous colitis has been reported.

*Blood:* Eosinophilia, leukopaenia, neutropenia, including agranulocytosis, thrombocytopaenia, thrombocytosis and decreased haemoglobin, pancytopaenia and prolonged prothrombin time, have been reported. A positive direct Coombs test may develop in some individuals.

*Liver Function:* Increases in serum transaminases, bilirubin and/or serum alkaline phosphatase; hepatic failure (rarely) hepatitis (rarely) and fulminant hepatitis (very rarely).

*Renal Function:* Oliguria/anuria, polyuria, acute renal failure (rarely). The role of PRIMAXIN in changes in renal function is difficult to assess, since factors predisposing to pre-renal azotaemia or to impaired renal function usually have been present.

Elevations in serum creatinine and blood urea nitrogen have been observed. Urine discolouration. This is harmless and should not be confused with haematuria.

*Nervous System/Psychiatric:* As with other beta-lactam antibiotics, CNS adverse experiences such as myoclonic activity, psychic disturbances, including hallucinations, confusional states, or seizures have been reported. Paresthesia, encephalopathy.

*Special Senses:* Hearing loss, taste perversion.

*Granulocytopaenic Patients:* Medicine-related nausea and/or vomiting appear to occur more frequently in granulocytopaenic patients than in non-granulocytopaenic patients treated with PRIMAXIN I.V.

*Other:* Bacterial or fungal superinfections.

## **Additional Adverse Effect**

For the following adverse effects, a causal relationship has not been established.

*Gastrointestinal:* Haemorrhagic colitis, gastroenteritis, abdominal pain, glossitis, tongue papillar hypertrophy, heartburn, pharyngeal pain, increased salivation.

*Central Nervous System:* Dizziness, somnolence, vertigo, headache.

*Special Senses:* Tinnitus.

*Respiratory:* Chest discomfort, dyspnoea, hyperventilation, thoracic spine pain.

*Cardiovascular:* Hypotension, palpitations, tachycardia.

*Skin:* Flushing, cyanosis, hyperhidrosis, skin texture changes, pruritus vulvae.

*Body As A Whole:* Polyarthralgia, asthenia/weakness.

*Blood:* Haemolytic anaemia, bone marrow depression.

## **Interactions**

Generalised seizures have been reported in patients who received ganciclovir and PRIMAXIN I.V. These medicines should not be used concomitantly unless the potential benefits outweigh the risks.

Also see Stability Section.

Decreases in serum valproic acid levels that may fall below the therapeutic range, have been reported in patients co-administered sodium valproate with carbapenem agents, including imipenem. The significant reductions in serum valproic acid levels (60% - 100%) have been reported within two days of other carbapenem administration and may lead to inadequate seizure control. Due to the rapid onset and the extent of the decrease in serum levels, co-administration of carbapenem agents in patients stabilised on sodium valproate is not considered to be manageable and should therefore be avoided.

If administration of PRIMAXIN is necessary, alternative or supplemental anti-convulsant therapy should be considered.

## **Overdosage**

No specific information is available on the treatment of overdosage with PRIMAXIN. Imipenem-cilastatin sodium is haemodialysable. However, usefulness of this procedure in the overdosage setting is unknown.

## **Actions**

Cilastatin is a competitive, reversible and specific inhibitor of dehydropeptidase-I enzyme, the renal enzyme which metabolises and inactivates imipenem. It is devoid of intrinsic antibacterial activity and does not affect the antibacterial activity of imipenem.

Imipenem is a beta-lactam antibiotic belonging to the thienamycin group. It is a potent inhibitor of bacterial cell wall synthesis and is bactericidal against a broad spectrum of pathogens - Gram-positive and Gram-negative, aerobic and anaerobic.

PRIMAXIN shares with the new cephalosporins and penicillins a broad spectrum of activity against Gram-negative species, but is unique in retaining the high potency against Gram-positive species, previously associated only with earlier narrow-spectrum beta-lactam antibiotics.

The spectrum of activity of PRIMAXIN includes *Pseudomonas aeruginosa*, *Staphylococcus aureus*, *Enterococcus faecalis* and *Bacteroides fragilis*, a diverse group of problem pathogens commonly resistant to other antibiotics.

PRIMAXIN is resistant to degradation by bacterial beta-lactamases, which makes it active against a high percentage of organisms such as *Pseudomonas aeruginosa*, *Serratia* spp., and *Enterobacter* spp. which are inherently resistant to most beta-lactam antibiotics.

The antibacterial spectrum of PRIMAXIN is broader than that of any other antibiotic studied, and includes virtually all clinically significant pathogens. Organisms against which PRIMAXIN is usually active *in vitro* include:

### **Gram-Negative Aerobes**

*Achromobacter* spp.  
*Acinetobacter* spp. (formerly *Mima-Herellea*)  
*Aeromonas hydrophilia*  
*Alcaligenes* spp.  
*Bordetella bronchicanis*  
*Bordetella bronchiseptica*  
*Bordetella pertussis*  
*Brucella melitensis*  
*Burkholderia pseudomallei* (formerly *Pseudomonas pseudomallei*)  
*Burkholderia stutzeri* (formerly *Pseudomonas stutzeri*)  
*Campylobacter* spp.  
*Capnocytophaga* spp.  
*Citrobacter* spp.  
*Citrobacter freundii*  
*Citrobacter koseri* (formerly *Citrobacter diversus*)  
*Eikenella corrodens*  
*Enterobacter* spp.  
*Enterobacter aerogenes*  
*Enterobacter agglomerans*  
*Enterobacter cloacae*  
*Escherichia coli*  
*Gardnerella vaginalis*.  
*Haemophilus ducreyi*  
*Haemophilus influenzae* (including beta lactamase-producing strains)  
*Haemophilus parainfluenzae*  
*Hafnia alvei*  
*Klebsiella* spp.  
*Klebsiella oxytoca*  
*Klebsiella ozaenae*  
*Klebsiella pneumoniae*  
*Moraxella* spp.  
*Morganella morganii* (formerly *Proteus morganii*)  
*Neisseria gonorrhoeae* (including penicillinase-producing strains)  
*Neisseria meningitidis*  
*Pasteurella* spp.  
*Pasteurella multocida*

*Plesiomonas shigelloides*  
*Proteus* spp.  
*Proteus mirabilis*  
*Proteus vulgaris*  
*Providencia* spp.  
*Providencia alcalifaciens*  
*Providencia rettgeri* (formerly *Proteus rettgeri*)  
*Providencia stuartii*  
*Pseudomonas* spp\*\*  
*Pseudomonas aeruginosa*  
*Pseudomonas fluorescens*  
*Pseudomonas putida*  
*Salmonella* spp.  
*Salmonella typhi*  
*Serratia* spp.  
*Serratia proteamaculans* (formerly *Serratia liquefaciens*)  
*Serratia marcescens*  
*Shigella* spp.  
*Yersinia* spp. (formerly *Pasteurella*)  
*Yersinia enterocolitica*  
*Yersinia pseudotuberculosis*  
\*\* *Stenotrophomonas maltophilia* (formerly *Xanthomonas maltophilia*, formerly *Pseudomonas maltophilia*) and some strains of *Burkholderia cepacia* (formerly *Pseudomonas cepacia*) are generally not susceptible to PRIMAXIN.

### **Gram-Positive Aerobes**

*Bacillus* spp.  
*Enterococcus faecalis*  
*Erysipelothrix rhusiopathiae*  
*Listeria monocytogenes*  
*Nocardia* spp.  
*Pediococcus* spp.  
*Staphylococcus aureus* (including penicillinase-producing strains)  
*Staphylococcus epidermidis* (including penicillinase-producing strains)  
*Staphylococcus saprophyticus*  
*Streptococcus agalactiae*  
*Streptococcus* Group C  
*Streptococcus* Group G  
*Streptococcus pneumoniae*  
*Streptococcus pyogenes*  
*Viridans group streptococci* (including alpha and gamma haemolytic strains)  
*Enterococcus faecium* and methicillin-resistant staphylococci are not susceptible to PRIMAXIN.

### **Gram-Negative Anaerobes**

*Bacteroides* spp.  
*Bacteroides distasonis*  
*Bacteroides fragilis*  
*Bacteroides ovatus*  
*Bacteroides thetaiotaomicron*  
*Bacteroides uniformis*  
*Bacteroides vulgatus*  
*Bilophila wadsworthia*  
*Fusobacterium* spp.  
*Fusobacterium necrophorum*

*Fusobacterium nucleatum*  
*Porphyromonas asaccharolytica* (formerly *Bacteroides asaccharolyticus*)  
*Prevotella bivia* (formerly *Bacteroides bivius*)  
*Prevotella disiens* (formerly *Bacteroides disiens*)  
*Prevotella intermedia* (formerly *Bacteroides intermedius*)  
*Prevotella melaninogenica* (formerly *Bacteroides melaninogenicus*)  
*Veillonella* spp.

### **Gram-Positive Anaerobes**

*Actinomyces* spp.  
*Bifidobacterium* spp.  
*Clostridium* spp.  
*Clostridium perfringens*  
*Eubacterium* spp.  
*Lactobacillus* spp.  
*Mobiluncus* spp.  
*Microaerophilic streptococcus*  
*Peptococcus* spp.  
*Peptostreptococcus* spp.  
*Propionibacterium* spp. (including *P. acnes*)

### **Other**

*Mycobacterium fortuitum*  
*Mycobacterium smegmatis*

*In vitro* tests show imipenem to act synergistically with amino- glycoside antibiotics against some isolates of *Pseudomonas aeruginosa*.

Imipenem is not active against mycoplasma or chlamydia.

### **Susceptibility Testing**

Clinical and Laboratory Standards Institute (CLSI) (Formerly NCCLS) - Methods of Susceptibility Testing

#### **SUSCEPTIBILITY TESTS**

When available, the results of *in vitro* susceptibility tests should be provided to the physician as periodic reports which describe the susceptibility profile of nosocomial and community-acquired pathogens. These reports should aid the physician in selecting the most effective antimicrobial.

#### **Dilution Techniques:**

Quantitative methods are used to determine antimicrobial minimum inhibitory concentrations (MICs). These MICs provide estimates of the susceptibility of bacteria to antimicrobial compounds. The MICs should be determined using a standardised procedure. Standardised procedures are based on a dilution method<sup>†</sup> (broth or agar) or equivalent with standardised inoculum concentrations and standardised concentrations of imipenem powder. The MIC values should be interpreted according to criteria provided in Table 5.

#### **Diffusion Techniques:**

Quantitative methods that require measurement of zone diameters also provide

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<sup>†</sup> Clinical and Laboratory Standards Institute (CLSI) (Formerly NCCLS). Methods for Dilution Antimicrobial Susceptibility Tests for Bacteria that Grow Aerobically. Seventh Edition. Approved Standard CLSI Document M7-A7. CLSI, Wayne, PA, January 2006.

reproducible estimates of the susceptibility of bacteria to antimicrobial compounds. One such standardised procedure<sup>††</sup> requires the use of standardised inoculum concentrations. This procedure uses paper disks impregnated with 10 mcg imipenem to test the susceptibility of microorganisms to imipenem. The disk diffusion interpretive criteria are provided in Table 5.

**Anaerobic Techniques:**

For anaerobic bacteria, susceptibility to imipenem as MICs can be determined by a standardised test method<sup>†††,§</sup>. The MIC values obtained should be interpreted according to the criteria provided in Table 5.

<b>Table 5 CLSI Interpretive Susceptibility Criteria for Imipenem</b>						
Pathogen	Dilution Test (MICs in mcg/mL)			Disk Diffusion Test (zone diameters in mm)		
	S	I	R	S	I	R
Aerobes and facultative anaerobes other than <i>Streptococcus</i> spp. and <i>Haemophilus</i> spp.	≤4	8	≥16	≤16	14-15	≤13
<i>Streptococcus pneumoniae</i> (penicillin-susceptible non-meningitis strains only) <sup>b</sup>	≤0.12	0.25-0.5	≥1	—	—	—
<i>Streptococcus</i> spp. other than <i>S. pneumoniae</i> <sup>c</sup>	—	—	—	—	—	—
<i>Haemophilus</i> spp. <sup>a, d</sup>	≤4	—	—	—	—	—
Anaerobes <sup>e</sup>	≤4	8	≥16	—	—	—

- a The current absence of data on resistant strains precludes defining any category other than “susceptible”. If strains yield MIC results other than susceptible, they should be submitted to a reference laboratory for further testing.
- b *Streptococcus pneumoniae* that are susceptible to penicillin by oxacillin disk (1-mcg oxacillin disk zone diameter ≥20 mm) or by penicillin MIC (penicillin MIC ≤0.06 mcg/mL) can be considered susceptible to imipenem. Disk diffusion testing with imipenem is not recommended as there are no interpretive criteria. Isolates with 1-mcg oxacillin zone diameter ≤19 mm should be tested against imipenem using an MIC method.
- c *Streptococcus* spp other than *S. pneumoniae* that are susceptible to penicillin (10-units penicillin disk zone diameter ≥24 mm [beta haemolytic streptococci only] or penicillin MIC ≤0.12 mcg/mL [beta haemolytic streptococci and viridans group]) can be considered susceptible to imipenem. There are no CLSI interpretive criteria for MIC testing of beta haemolytic *Streptococcus* spp or viridans group *Streptococci* against imipenem.

<sup>††</sup> Clinical and Laboratory Standards Institute (CLSI) (Formerly NCCLS). Performance Standards for Antimicrobial Disk Susceptibility Tests. Ninth Edition. Approved Standard, CLSI Document M2-A9. CLSI, Wayne, PA, January 2006.

<sup>†††</sup> Clinical and Laboratory Standards Institute (CLSI) (Formerly NCCLS). Methods for Antimicrobial Susceptibility Testing of Anaerobic Bacteria - Sixth Edition. Approved Standard, CLSI Document M11-A7. CLSI, Wayne, PA, January 2007.

<sup>§</sup> Clinical and Laboratory Standards Institute (CLSI) (Formerly NCCLS). Performance Standards for Antimicrobial Susceptibility Testing. Seventeenth Informational Supplement. Approved Standard, CLSI Document M100-S17. CLSI, Wayne, PA, January 2007.

- d These interpretative standards are applicable to the broth microdilution procedure using *Haemophilus* Test Medium (HTM) inoculated with a direct colony suspension and incubated in ambient air at 35°C for 20-24 hrs.
- e These interpretative standards are applicable only to agar dilution using *Brucella* agar supplemented with haemin, vitamin K1 and 5% defibrinated or laked sheep blood inoculated with a direct colony suspension or a 6- to 24-hour fresh culture in enriched thioglycollate medium and incubated in an anaerobic jar or chamber at 35-37°C for 42-48 hrs.

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

#### Quality Control:

Standardised susceptibility test procedures require the use of quality control microorganisms to control the technical aspects of the test procedures. Standard imipenem powder should provide the following range of values noted in Table 6. Quality control microorganisms are specific strains of organisms with intrinsic biological properties. QC strains are very stable strains which will give a standard and repeatable susceptibility pattern. The specific strains used for microbiological quality control are not clinically significant.

<b>Table 6 Acceptable Quality Control Ranges for Imipenem</b>			
QC Strain	ATCC <sup>®</sup>	Dilution Test (MICs in mcg/mL)	Disk Diffusion Test (zone diameters in mm)
<i>Enterococcus faecalis</i>	29212	0.5-2	Not Applicable
<i>Staphylococcus aureus</i>	29213	0.015-0.06	Not Applicable
<i>Streptococcus pneumoniae</i> <sup>f, g</sup>	49619	0.03-0.12	Not Applicable
<i>Escherichia coli</i>	25922	0.06-0.25	26-32
<i>Haemophilus influenzae</i> <sup>h</sup>	49766	0.25-1	Not Applicable
<i>Haemophilus influenzae</i> <sup>i</sup>	49247	Not Applicable	21-29
<i>Pseudomonas aeruginosa</i>	27853	1-4	20-28
<i>Bacteroides fragilis</i> <sup>j</sup>	25285	0.03-0.25	Not Applicable
<i>Bacteroides thetaiotaomicron</i> <sup>j</sup>	29741	0.25-1	Not Applicable
<i>Eubacterium lentum</i> <sup>j</sup>	43055	0.5-2	Not Applicable

<sup>f</sup> This organism is used for quality control of susceptibility testing of *Streptococcus pneumoniae* and *Streptococcus* spp.

<sup>g</sup> These quality control ranges are applicable to *Streptococcus pneumoniae* ATCC 49619 tested by broth microdilution using cation-adjusted Mueller-Hinton broth with 2 to 5% lysed horse blood inoculated with a direct colony suspension and incubated in ambient air at 35°C for 20-24 hrs.

- h These quality control ranges are applicable to *Haemophilus influenzae* ATCC 49766 tested by the broth microdilution procedure using *Haemophilus* Test Medium (HTM) inoculated with a direct colony suspension and incubated in ambient air at 35°C for 20-24 hrs.
- i These quality control ranges are applicable to *Haemophilus influenzae* ATCC 49247 tested by disk diffusion using *Haemophilus* Test Medium (HTM) agar inoculated with a direct colony suspension and incubated in 5% CO<sub>2</sub> at 35°C for 16-18 hrs.
- j These quality control ranges are applicable only to agar dilution using *Brucella* agar supplemented with haemin, vitamin K1 and 5% defibrinated or laked sheep blood inoculated with a direct colony suspension or a 6- to 24-hour fresh culture in enriched thioglycollate medium and incubated in an anaerobic jar or chamber at 35-37°C for 42-48 hrs.

## Pharmacokinetics

### Imipenem IV

In normal volunteers, intravenous infusion of PRIMAXIN over 20 minutes resulted in peak plasma levels of imipenem ranging from 21 - 58 mcg/mL for the 500 mg dose, and from 41 - 83 mcg/mL for the 1000 mg dose. The mean peak plasma levels of imipenem following the 500 and 1000 mg doses were 39 and 66 mcg/mL, respectively. At these doses, plasma levels of imipenem antimicrobial activity decline to below 1 mcg/mL in 4 - 6 hours. The plasma half-life of imipenem was one hour. Approximately 70% of the administered antibiotic was recovered intact in the urine within 10 hours, and no further urinary excretion of the medicine was detectable. Urine concentrations of imipenem exceeded 10 mcg/mL for up to 8 hours after a 500 mg dose of PRIMAXIN.

The remainder of the administered dose was recovered in the urine as anti-bacterially inactive metabolites, and faecal elimination of imipenem is essentially nil.

No accumulation of imipenem in plasma or urine has been observed with regimens of PRIMAXIN administered as frequently as every 6 hours in patients with normal renal function. Concomitant administration of PRIMAXIN and probenecid resulted in minimal increases in the plasma levels and plasma half-life of imipenem. The urinary recovery of active (non metabolised) imipenem decreased to approximately 60% of the dose when PRIMAXIN was administered with probenecid.

When administered alone, imipenem is metabolised in the kidneys by dehydropeptidase-I. Individual urinary recoveries of metabolites ranged from 5 to 40%, with an average recovery of 15-20% in several studies.

The binding of imipenem to human serum proteins is approximately 20%.

### TISSUE & BODY FLUID LEVELS OF IMIPENEM AFTER A 1 GRAM DOSE OF PRIMAXIN I.V.

Site	mcg/mL or mcg/g of tissue	Sampling Time (hr)
Vitreous humour	3.4	3.5
Aqueous humour	2.99	2.0
Lung Tissue	5.6	1.0
Sputum	2.1	1.0
Pleural	22.0	1.0
Peritoneal	23.9	2.0
Bile	5.3	2.25
CSF uninflamed meninges	1.0	4.0
inflamed meninges	2.6	2.0

Prostatic fluid	0.2	1.0 - 1.5
Prostatic tissue	5.3	1.0 - 2.75
Fallopian tubes	13.6	1.0
Endometrium	11.1	1.0
Myometrium	5.0	1.0
Bone	2.6	1.0
Interstitial fluid	16.4	1.0
Skin	4.4	1.0
Fascia	4.4	1.0

During the laboratory evaluation of imipenem as a single entity, generally low urinary recovery of the antibiotic was found in a number of species, including the chimpanzee, and this was subsequently confirmed in humans also. Metabolism was shown to occur primarily in the kidney, affecting the secreted and filtered fraction of the antibiotic after its clearance from the blood.

The major pathway of metabolism of imipenem in the kidney is by hydrolysis of the beta-lactam ring by a renal dipeptidase (EC.3.4.13.11). This enzyme is also known as dehydropeptidase-I (DHP-I) and is localised on the luminal (brush border) surface of the proximal renal tubular epithelium.

Thus, the enzyme has access to the antibiotic both in the glomerular filtrate and during the transcellular secretory process.

In man, urinary recovery of metabolites ranged from 5 to 40% of the administered dose, while good systemic persistence and blood levels were unaffected by metabolism in the kidney.

#### **Cilastatin I.V.**

Peak plasma levels of cilastatin, following a 20-minute intravenous infusion of PRIMAXIN, ranged from 21 to 55 mcg/mL for the 500 mg dose and from 56 to 88 mcg/mL for the 1000 mg dose. The mean peak plasma levels of cilastatin following the 500 and 1000 mg doses were 42 and 72 mcg/mL respectively. The plasma half-life of cilastatin is approximately one hour. Approximately 70-80% of the dose of cilastatin was recovered unchanged in the urine as the parent medicine within 10 hours of administration of PRIMAXIN. No further cilastatin appeared in the urine thereafter. Approximately 10% was found as the N-acetyl metabolite, which has inhibitory activity against dehydropeptidase comparable to that of the parent medicine. Activity of dehydropeptidase-I in the kidney returns to normal levels shortly after the elimination of cilastatin from the bloodstream.

Concomitant administration of PRIMAXIN and probenecid doubled the plasma level and half-life of cilastatin, but had no effect on urinary recovery of cilastatin.

The binding of cilastatin to human serum proteins is approximately 40%.

Low urinary tract bioavailability of imipenem is avoided by co-administration of cilastatin, a potent inhibitor of DHP-I isolated from a number of animal species.

The inhibition is competitive and freely reversible. Cilastatin did not significantly inhibit the activity of four other zinc metalloenzyme peptidases, including angiotensin converting enzyme. Cilastatin is devoid of antimicrobial activity per se, and has no significant effect on the antimicrobial activity of imipenem.

## Pharmaceutical Precautions

Store at room temperature (EP = 15-25°C). (See also Dosage and Administration section.)

## Medicine Classifications

Prescription medicine.

## Package Quantities

PRIMAXIN intravenous 1 vial (13 mL) contains 500 mg imipenem and 500 mg cilastatin.

PRIMAXIN intramuscular is not commercially available in New Zealand.

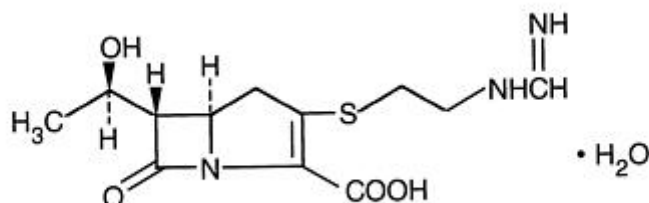
## Further Information

### Imipenem

The thienamycins are distinguished by novel structural features, the most important of which is the substitution of a methylene (-CH<sub>2</sub>-) group for the sulphur atom contained in the ring systems of most beta-lactam antibiotics. This substitution makes imipenem more reactive toward proteins in the bacterial cell wall and, therefore, more potent in its bactericidal effect. In further contrast to the penicillins and cephalosporins, the hydroxyethyl side chain of imipenem is attached to the beta-lactam ring in a trans orientation, and this unusual configuration endows imipenem with an unusually high stability to bacterial beta-lactamases.

The chemical name of imipenem is [5*R*-[5 $\alpha$ ,6 $\alpha$ (*R*<sup>\*</sup>)]]-6-(1-hydroxyethyl)-3-[[2-[(iminomethyl) amino]ethyl] thio]-7-oxo-1-azabicyclo[3.2.0]hept-2-ene-2-carboxylic acid monohydrate. The empirical formula of imipenem is C<sub>12</sub>H<sub>17</sub>N<sub>3</sub>O<sub>4</sub>S.H<sub>2</sub>O and the molecular weight is 317.37. It is a light tan to white, nonhygroscopic, ultraviolet light-sensitive, crystalline compound which is sparingly soluble in water, and slightly soluble in methanol.

Imipenem, also referred to as N-formimidoyl thienamycin monohydrate, is a semi-synthetic derivative of thienamycin, the parent compound produced by the filamentous bacterium *Streptomyces cattleya*. The structural formula of imipenem is:

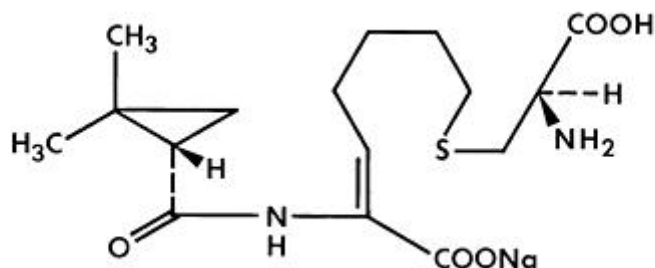


### Cilastatin sodium

Cilastatin sodium is a competitive, reversible and specific inhibitor of dehydropeptidase-I, the renal enzyme which metabolises and inactivates imipenem. It is devoid of intrinsic antibacterial activity and does not affect the antibacterial activity of imipenem.

The chemical name of the sodium salt of cilastatin is [*R*-[*R*<sup>\*</sup>,*S*<sup>\*</sup>-(*Z*)]]-7-[(2-amino-2-carboxyethyl)thio]-2-[[2,2-dimethylcyclopropyl]carbonyl] amino]-2-heptenoic acid, monosodium salt. The empirical formula of cilastatin sodium is C<sub>16</sub>H<sub>25</sub>N<sub>2</sub>NaO<sub>5</sub>S and the

molecular weight is 380.44. It is an off-white to yellowish-white, hygroscopic, amorphous compound which is very soluble in water or methanol. The structural formula of cilastatin sodium is:



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28 June 2010

DP-TEN-0809(280610)

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