Only for the use of medical Professionals

AVLOTRIN®

Presentation:
AVLOTRIN® DS Tablets: White, oval shape, one side engraved with ACI and the other side with a break line. Each tablet contains 160mg Trimethoprim BP and 800mg Sulphamethoxazole BP.
AVLOTRIN® Tablets: White, round tablets, engraved with 'AVLOTRIN'; each tablet contains 80 mg Trimethoprim BP and 400 mg Sulphamethoxazole BP.
AVLOTRIN® Suspension: White, pleasant, tasting suspension; each 5ml contain 40 mg Trimethoprim BP and 200 mg Sulphamethoxazole BP.

Uses:
AVLOTRIN® is an antibacterial agent, effective in vitro against a wide range of Gram-positive and Gram-negative organisms. It is not active against Mycobacterium tuberculosis, Mycoplasma or Treponema pallidum, Pseudomonas aeroginosa is usually insensitive.

AVLOTRIN® is of value in the treatment of the following infections:

Respiratory tract: Acute and chronic bronchitis, bronchiestasis, lobar and bronchopneumonia, otitis media, sinusitis and Pneumocystis carinii pneumonitis.

Genito-urinary tract: Acute upper and lower urinary tract infections, bacterial prostatitis and male and female gonorrhea.

Gastro-intestinal tract: Typhoid and paratyphoid fever, chronic carriage of Salmonella typhi and paratyphoid, cholera and shigellosis.

Skin Infections: Pyoderma, abscesses and wound infections.

Others bacterial infections: Acute and chronic osteomyelitis, acute brucellosis, septicemia and other infections caused by sensitive organism.

Dosage and administration:
It may be preferable to take AVLOTRIN® with some food or drink to minimize the possibility of gastrointestinal disturbances.

AVLOTRIN® DS Tablets:
Adults: Standard dosage: 1 tablet twice daily.
Children over 12 Years: As for adults.
6-12 years: 1/2 tablet twice daily.

AVLOTRIN® Tablets:
Adults: Standard dosage: 2 tablets twice daily.
For severe infections: 3 tablets twice daily.
Children over 12 years: As for adults.
6-12 years: 1 tablet twice daily.

AVLOTRIN® Suspension:
Children 6-12 years: 10 ml twice daily.
6 months to 6 years: 5 ml twice daily.
6 weeks to 6 months: 2.5 ml twice daily.

In acute infections, AVLOTRIN® should be given for at least five days or until the patient has been symptom-free for two days. If clinical improvement is not evident after seven days therapy, the patient should be reassessed. As an alternative to standard therapy for acute uncomplicated lower urinary tract infections, short-term therapy of one to three days duration has been shown 10 be effective.

Impaired renal function: If AVLOTRIN® is given to patients with renal impairment, the following dosage scheme is suggested (no information is available for children with renal failure).

Creatinine clearance (ml/ min)	Serum creatinine (m mol / l)	Dosage
Above 25	Men <265 Women <175	Standard dosage
15-25	Men 265-620 Women 175-400	Standard dosage for a maximum of three days followed by half the standard dosage.
Below 25	Men >620 Women >400	Not to be administered unless haemodialysis facilities are available. Under this condition half the standard dosage may be given.

Measurements of plasma concentrations of sulphamethoxazole at intervals of two to three days are recommended in samples obtained 12 hours alter administration or AVLOTRIN®. If the concentration of total sulphamethoxazole exceeds 150 mcg/ml, then treatment should be interrupted until the value falls below 120 mcg/ml.
Long term prophylaxis of recurrent or suppression or chronic infection following sterilization of the urine:
Adults and children over 12 years: 1 AVLOTRIN® tablet or 1/2 AVLOTRIN® DS tablet nightly.
Children under 12 years: A single nightly dose of 2 mg trimethoprim and 10 mg sulphamethoxazole per kg body weight.
Treatment may be continued for 3 to 12 months or more as appropriate.
Chronic prostatitis: It may be advisable to use a higher than standard dose initially. The course of treatment should last for three months to reduce the risk of relapse.

Pneumocystis carinii pneumonitis:

Treatment: 20 mg Trimethoprim and 100 mg sulphamethoxazole per kg body weight per day in two or more divided doses for two weeks.
Prevention: Standard dosage tor the duration of the period at risk.
Gonorrhea: In uncomplicated cases 4 tablets every 12 hours for two days or 5 tablets followed by a further dose of 5 tablets eight hours later.
Acute brucellosis: It may be advisable to use a higher than standard dose initially.

Treatment should continue for a period of at least four weeks and repeated courses may be beneficial.

Typhoid ant paratyphoid carriage: Treatment should be continued for at least 1-3 months.

Contra-indications, Warnings, etc.:
Contra-indications: Co-trimoxazole should not be given to patients with a history of hypersensitivity to sulphonamide, trimethoprim or co-trimoxazole.
It is contra-indicated in patients showing marked liver parenchymal damage.
Except in certain circumstances it should not be given to patients with serious haematological disorders.
It is contra-indicated in severe renal insufficiency where repeated measurements of the plasma concentration cannot be performed.
Co-trimoxazole should not be given lo premature babies nor to full-term infants during the first six weeks of life.

Precautions: Co-trimoxazole should be discontinued if a skin rash appears. In cases with renal impairment a modified dosage schedule as described above is indicated. In such patients, measurements of the plasma concentration of the drug are advisable and an adequate urinary output should be maintained. A folate supplement should be considered when treating potentially folate deficient patients or with prolonged high dosage of co-trimoxazole.
If treatment is prolonged, especially in patients with suspected impairment of folate metabolism. It is suggested that complete blood counts including thrombocytes be performed at monthly intervals.

Drug interactions: Co-trimoxazole has been shown to potentiate the anticoagulant activity of warfarin via stereo-selective inhibition of its metabolism. Careful control of the anticoagulant therapy during treatment with co-trimoxazole is advisable.
Co-trirmoxazole prolongs the half life of phenytoin and if co-administered, close monitoring of the patient's condition and serum phenytoin levels are advisable.
Interaction with sulphonylurea hypoglycemic agents is uncommon but potentiation has been reported. Reversible deterioration in renal function has been observed in patients related with co-trimoxazole and cyclosporin following renal transplantation.
Occasional reports suggest that patients receiving pyrimethamine as malarial prophylaxis at doses in excess of 25mg weekly may develop megaloblaslic anaemia should co-trimoxazole be prescribed concurrently.
In elderly patients concurrently receiving diuretics, mainly thiazides, the risk of thrombocytopenia with or without purpura is higher.

Side-effects: Nausea. Vomiting, diarrhea, glossitis and skin rashes can occur. Pseudomembranous colitis has been reported rarely. Severe skin sensitivity reactions such as erythema multiforme bullosa (Stevens-Johnson syndrome) and toxic epidermal necrolysis (Lyell syndrome) have occurred infrequently.
The possibility of blood dyscrasias like those associated with sulphonamides should be borne in mind. The changes reported with co-trimoxazole mainly consist of thrombocytopenia, purpura leucopenia, neutropenia and very rarely agranulocytosis.
They have usually proved to be reversible withdrawal of the drug. Elderly patient are more susceptible to this blood changes. Co-trimoxazole may induce haemolysis certain susceptible gtucose-6-phosphate dehydrogenase deficient patients. Jaundice and very rarely, hepatic necrosis has been reported.
There have been a few reports of subjective experiences such as headache, depression, dizziness and hallucinations but their relationship to therapy remains unproven. During

long-term therapy, isolated cases or megaloblastic changes in the bone marrow have been reported; these are reversible by folinic acid therapy.

Use in pregnancy and lactation: The safety of co-trimoxazole in human pregnancy has not been established. The drug should not be given during pregnancy.
Animal studies have shown teratogenic effects typical of a folate aniagonist in rats but not rabbits at high doses; these were prevented by administration of dietary folates.
Sulphonamide-containing products should not be administered in late pregnancy because of the risk of kernicterus. The usual caution in prescribing any drug for women of child-bearing age should be exercised with co-trimoxazole.
Both sulphamethoxazole and trimethoprim may be found in breast milk but the administration of co-trimoxazole lo lactating women represents a negligible risk to the suckling infant.

Toxicity and treatment of overdosage: Symptoms of acute overdosage are likely to be nausea, vomiting, abdominal pain, dizziness and confusion. Treatment should consist of gastric lavage if within an hour of ingestion. Increased fluid intake will increase the elimination of sulphamethoxazole. Alkalinisation of the urine will also increase the elimination of sulphamethoxazole but decrease that of the trimethoprim. Calcium folinate (3-6mg/day) given orally or intramuscularly for five to seven days should reverse any folate deficiency effect trimethoprim. General supportive measures are recommended
Both trimethoprim and sulphamethoxazole are dialyzable by renal dialysis.

Pharmaceutical precautions:
Store below 35^0c in a dry place. Protect from light.

Package quantities:
AVLOTRIN® DS Tablets: Cartons of 100 tablets in strips.
AVLOTRIN® Tablets: Cartons of 250 tablets in strips.
AVLOTRIN® Suspension: Bottles of 60 ml.

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