Summary of Product Characterstics

Slate® Capsules

Slate® Suspension / Drops

Slate®
(Cefaclor)

1. NAME OF THE PRODUCT
Slate® (Cefaclor) 250mg Capsules
Slate® (Cefaclor) 500mg Capsules

2. QUALITATIVE AND QUANTITATIVE COMPOSITION
Slate® **250mg Capsules**
Each capsule contains:
Cefaclor Monohydrate equivalent to
Cefaclor.....250mg

Slate® **500mg Capsules**
Each capsule contains:
Cefaclor Monohydrate equivalent to
Cefaclor.....500mg

3. PHARMACEUTICAL FORM
Capsule

Appearance:
Slate® **250mg Capsules:** White to off white powder in hard gelatin capsules having dark blue opaque cap with Slate® printed and light green opaque body with 250 printed in body in black color.
Slate® **500mg Capsules:** White to off white powder in hard gelatin capsules having light blue opaque cap with Slate® printed and scarlet red opaque body with 500 printed in black color.

4. CLINICAL PARTICULARS
4.1. THERAPEUTIC INDICATIONS:
Slate® is indicated for the treatment of the following infections due to susceptible micro-organisms:

- Respiratory tract infections, including pneumonia, bronchitis, exacerbations of chronic bronchitis, pharyngitis and tonsillitis, and as part of the management of sinusitis
- Otitis media
- Skin and soft tissue infections
- Urinary tract infections, including pyelonephritis and cystitis
- Slate® has been found to be effective in both acute and chronic urinary tract infections.

- Slate® is generally effective in the eradication of streptococci from the nasopharynx, however, data establishing efficacy in the subsequent prevention of either rheumatic fever or bacterial endocarditis are not available.

4.2. POSOLOGY AND METHOD OF ADMINISTRATION:

Posology:

Adults: The usual adult dosage is 250mg every eight hours. For more severe infections or those caused by less susceptible organisms, doses may be doubled. Doses of 4g per day have been administered safely to normal subjects for 28 days, but the total daily dosage should not exceed this amount. Slate® may be administered in the presence of impaired renal function. Under such conditions dosage is usually unchanged.

Patients undergoing haemodialysis: Haemodialysis shortens serum half-life by 25-30%. In patients undergoing regular haemodialysis, a loading dose of 250mg-1g administered prior to dialysis and a therapeutic dose of 250-500mg every six to eight hours maintained during interdialytic periods is recommended.

The elderly: As for adults.

Paediatric population: The usual recommended daily dosage for children is 20mg/kg/day in divided doses every eight hours, as indicated. For bronchitis and pneumonia, the dosage is 20mg/kg/day in divided doses administered 3 times daily. For otitis media and pharyngitis, the total daily dosage may be divided and administered every 12 hours. Safety and efficacy have not been established for use in infants aged less than one month.

In more serious infections, otitis media, sinusitis and infections caused by less susceptible organisms, 40mg/kg/day in divided doses is recommended, up to a daily maximum of 1g.

In the treatment of beta-haemolytic streptococcal infections, therapy should be continued for at least 10 days.

Method of administration:

Slate® is administered orally.

4.3. CONTRAINDICATIONS:

- Hypersensitivity to the active substance or to any of the excipients.
- Hypersensitivity to other cephalosporins.

4.4. SPECIAL WARNINGS AND PRECAUTIONS FOR USE:

Warnings: Before instituting therapy with cefaclor, every effort should be made to determine whether the patient has had previous hypersensitivity reactions to cefaclor, cephalosporins, penicillins or other drugs. Cefaclor should be given cautiously to penicillin-sensitive patients, because cross-hypersensitivity, including anaphylaxis, among beta-lactam antibiotics has been clearly

documented. If an allergic reaction to cefaclor occurs, the drug should be discontinued and the patient treated with the appropriate agents. Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics, including macrolides, semi-synthetic 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 usually respond to drug discontinuance alone. In moderate to severe cases, appropriate measures should be taken.

Precautions: 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. Cefaclor should be administered with caution in the presence of markedly impaired renal function. Since the half-life of cefaclor in anuric patients is 2.3 to 2.8 hours, dosage adjustments for patients with moderate or severe renal impairment are not usually required. If cefaclor associated neurotoxicity is suspected, discontinuation of cefaclor should be considered. Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastro-intestinal disease, particularly colitis. Prolonged use of cefaclor may result in the overgrowth of non-susceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken. Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In haematological studies or in transfusion cross-matching procedures, when anti-globulin 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.

4.5. INTERACTION WITH OTHER MEDICINAL PRODUCTS AND OTHER FORM OF INTERACTIONS:

There have been rare reports of increased prothrombin time, with or without clinical bleeding, in patients receiving cefaclor and warfarin concomitantly. It is recommended that in such patients, regular monitoring of prothrombin time should be considered, with adjustment of dosage if necessary. The renal excretion of cefaclor is inhibited by probenecid.

4.6. FERTILITY, PREGNANCY AND LACTATION:

Pregnancy: There are no adequate or well-controlled studies in pregnant women, caution should be exercised when prescribing for the pregnant patient.

Breast-feeding: The effect on nursing infants is not known, caution should be exercised when cefaclor is administered to a nursing woman.

4.7. EFFECTS ON ABILITY TO DRIVE AND USE MACHINES:

Not relevant.

4.8. UNDESIRABLE EFFECTS:

Gastro-intestinal: The most frequent side-effect has been diarrhoea. It is rarely severe enough to warrant cessation of therapy. Colitis, including rare instances of pseudomembranous colitis, has been reported. Nausea and vomiting have also occurred.

Hypersensitivity: Allergic reactions such as morbilliform eruptions, pruritus and urticaria have been observed. These reactions usually subside upon discontinuation of therapy. Serum sickness-like reactions (erythema multiforme minor, rashes or other skin manifestations accompanied by arthritis/arthralgia, with or without fever) have been reported. Lymphadenopathy and proteinuria are infrequent, there are no circulating immune complexes and no evidence of sequelae. Occasionally, solitary symptoms may occur, but do not represent a serum sickness-like reaction. Serum sickness-like reactions are apparently due to hypersensitivity and have usually occurred during or following a second (or subsequent) course of therapy with cefaclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and usually subside within a few days of cessation of therapy. Antihistamines and corticosteroids appear to enhance resolution of the syndrome. No serious sequelae have been reported. There are rare reports of erythema multiforme major (Stevens-Johnson syndrome), toxic epidermal necrolysis, and anaphylaxis. Anaphylaxis may be more common in patients with a history of penicillin allergy. Anaphylactoid events may present as solitary symptoms, including angioedema, asthenia, oedema (including face and limbs), dyspnoea, paraesthesias, syncope, or vasodilatation. Rarely, hypersensitivity symptoms may persist for several months.

Haematological: Eosinophilia, positive Coombs' tests and, rarely, thrombocytopenia. Transient lymphocytosis, leucopenia and, rarely, haemolytic anaemia, aplastic anaemia, agranulocytosis and reversible neutropenia of possible clinical significance.

Hepatic: Transient hepatitis and cholestatic jaundice have been reported rarely, slight elevations in AST, ALT or alkaline phosphatase values.

Renal: Reversible interstitial nephritis has occurred rarely, also slight elevations in blood urea or serum creatinine or abnormal urinalysis.

Central Nervous System: Reversible hyperactivity, agitation, nervousness, insomnia, confusion, hypertonia, dizziness, hallucinations and somnolence have been reported rarely. 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.
Miscellaneous: Genital pruritus, vaginitis and vaginal moniliasis.

4.9. OVERDOSE:

Symptoms: Symptoms of nausea, vomiting, epigastric distress and diarrhoea would be anticipated.
Treatment: Unless 5 times the normal total daily dose has been ingested, gastro-intestinal decontamination will not be necessary. General management may consist of supportive therapy.

5. PHARMACOLOGICAL PROPERTIES

5.1. PHARMACODYNAMIC PROPERTIES:

Pharmacotherapeutic group: Second-generation cephalosporins antibiotics.
ATC code: J01DC04
Mechanism of action:
Cefaclor is active against the following organisms *in vitro*:
Alpha- and beta-haemolytic *streptococci*
Staphylococci; including coagulase-positive, coagulase-negative and penicillinase-producing strains
Streptococcus pneumoniae
Streptococcus pyogenes (group A beta-haemolytic streptococci)
Branhamella catarrhalis
Escherichia coli
Proteus mirabilis
Klebsiella species
Haemophilus influenzae, including ampicillin-resistant strains
Cefaclor has no activity against *Pseudomonas* species or *Acinetobacter* species. Methicillin-resistant staphylococci and most strains of *enterococci* (e.g., *Str. faecalis*) are resistant to cefaclor. Cefaclor is not active against most strains of *Enterobacter* spp, *Serratia* spp, *Morganella morganii*, *Proteus vulgaris* and *Providencia rettgeri.*

5.2. PHARMACOKINETICS PROPERTIES:

Absorption: Cefaclor is well absorbed after oral administration. Total absorption is the same whether the drug is given with or without food; however, when it is taken with food, the peak concentration achieved is 50 -75% and generally appears from ¾ to one hour later.
Distribution: Following administration of 250mg, 500mg doses and 1g, average peak serum levels of approximately 7, 13 and 23mg/L respectively were obtained within 30 - 60 minutes.
Metabolism: The serum half-life in normal subjects is 0.6 - 0.9 hours. In patients with reduced renal function, the serum half-life of cefaclor is slightly

prolonged. In those with complete absence of renal function, the plasma half-life of the intact molecule is 2.3 - 2.8 hours. Haemodialysis shortens the half-life by 25 - 30%.

Excretion: Approximately 60 - 85% of the drug is excreted unchanged in the urine within eight hours, the greater portion being excreted within the first two hours. During the eight-hour period, peak urine concentrations following the 250mg, 500mg and 1g doses were approximately 600, 900 and 1,900mg/L respectively. Excretion pathways in patients with markedly impaired renal function have not been determined.

5.3. PRECLINICAL SAFETY DATA:

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, genotoxicity, carcinogenic potential, toxicity to reproduction and development.

6. PHARMACEUTICAL PARTICULARS

6.1. LIST OF EXCIPIENTS:

Slate® **250mg Capsules:**

Maize Starch
Cross Carmellose Sodium
Magnesium Stearate
Simethicone
Silicon Dioxide
Sodium Starch Glycolate
Hard Gelatin Capsule

Slate® **500mg Capsules:**

Maize Starch
Cross Carmellose Sodium
Magnesium Stearate
Simethicone
Silicon Dioxide
Sodium Starch Glycolate
Hard Gelatin Capsule

6.2. INCOMPATIBILITIES:

Not applicable

6.3. SHELF LIFE:

See expiry on the pack.

6.4. SPECIAL PRECAUTIONS FOR STORAGE:

Do not store over 30°C, and protect from heat and moisture.
Improper storage may deteriorate the medicine.
Keep out of reach of children.

6.5. NATURE AND CONTENTS OF CONTAINER:

Slate® **250mg Capsules:** Alu/PVC blister, pack size is 12's.
Slate® **500mg Capsules:** Alu/PVC blister, pack size is 12's.

6.6. SPECIAL PRECAUTIONS FOR DISPOSAL AND OTHER HANDLING:

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

6.7. DRUG PRODUCT SPECIFICATION:

Slate® **250mg Capsules:** USP Specs.
Slate® **500mg Capsules:** USP Specs.

7. REGISTRATION / MARKETING AUTHORISATION HOLDER

Manufactured by:
Healthtek (Pvt.) Limited
Plot No. 14, Sector 19, Korangi
Industrial Area Karachi – Pakistan
ML No. 000618

Associate of:
SAMI Pharmaceuticals (Pvt.) Ltd.
Karachi-Pakistan
www.samipharma.com
ML No. 000072

8. REGISTRATION / MARKETING AUTHORISATION NUMBER(S)

Slate® **250mg Capsules:** 047028
Slate® **500mg Capsules:** 047029

9. DATE OF FIRST AUTHORISATION / RENEWAL OF THE AUTHORISATION

Slate® **250mg Capsules:** 4th September, 2007
Slate® **500mg Capsules:** 4th September, 2007

10. DATE OF REVISION OF THE TEXT

سلیٹ® کیپسول
(سیفاکلور)

ہدایات:

خوراک ڈاکٹر کی ہدایت کے مطابق استعمال کریں۔

صرف رجسٹرڈ ڈاکٹر کے نسخے کے مطابق فروخت کریں۔

بچوں کی پہنچ سے دور رکھیں۔

دوا کو ۳۰ ڈگری سینٹی گریڈ سے زیادہ درجہ حرارت پر نہ رکھیں،
گرمی اور نمی سے محفوظ رکھیں ورنہ دوا خراب ہو جائیگی۔

Slate®
(Cefaclor)

1. NAME OF THE PRODUCT

Slate® (Cefaclor) 125mg/5ml Suspension
Slate® (Cefaclor) 187mg/5ml Suspension
Slate® (Cefaclor) 250mg/5ml Suspension
Slate® (Cefaclor) 50mg/ml Drops

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Slate® **125mg/5ml Suspension**
After reconstitution each 5ml suspension contains:
Cefaclor Monohydrate equivalent to Cefaclor ……125mg

Slate® **187mg/5ml Suspension**
Each 5ml of reconstituted suspension contains:
Cefaclor Monohydrate equivalent to Cefaclor ……187mg

Slate® **250mg/5ml Suspension**
After reconstitution each 5ml suspension contains:
Cefaclor Monohydrate equivalent to Cefaclor.....…….....250mg

Slate® **50mg/ml Drops**
Each ml of reconstituted suspension contains:
Cefaclor Monohydrate equivalent to Cefaclor ……..50mg

3. PHARMACEUTICAL FORM

Granules for Oral Suspension

Appearance:
Slate® **125mg/5ml Suspension:** Light orange to orange brown colored granular free flowing powder, having no lumps and foreign particle, with characteristic odor of strawberry flavor.
Slate® **187mg/5ml Suspension:** Light green to dark green colored granular free flowing powder, having no lumps and foreign particle, with characteristic odor of strawberry flavor.
Slate® **250mg/5ml Suspension:** Light to dark pink colored granular powder, with white to pale yellow background, having characteristic odor of strawberry flavor.
Slate® **50mg/ml Drops:** Light to dark pink colored granular powder, with white to pale yellow background, having characteristic odor of strawberry flavor.

4. CLINICAL PARTICULARS

4.1. THERAPEUTIC INDICATIONS:

Slate® is indicated for the treatment of the following infections due to susceptible micro-organisms:

- Respiratory tract infections, including pneumonia, bronchitis, exacerbations of chronic bronchitis, pharyngitis and tonsillitis, and as part of the management of sinusitis
- Otitis media
- Skin and soft tissue infections
- Urinary tract infections, including pyelonephritis and cystitis
- Slate® has been found to be effective in both acute and chronic urinary tract infections.
- Slate® is generally effective in the eradication of streptococci from the nasopharynx, however, data establishing efficacy in the subsequent prevention of either rheumatic fever or bacterial endocarditis are not available.

4.2. POSOLOGY AND METHOD OF ADMINISTRATION:

Posology:

Adults: The usual adult dosage is 250mg every eight hours. For more severe infections or those caused by less susceptible organisms, doses may be doubled. Doses of 4g per day have been administered safely to normal subjects for 28 days, but the total daily dosage should not exceed this amount. Slate® may be administered in the presence of impaired renal function. Under such conditions dosage is usually unchanged.

Patients undergoing haemodialysis: Haemodialysis shortens serum half-life by 25-30%. In patients undergoing regular haemodialysis, a loading dose of 250mg-1g administered prior to dialysis and a therapeutic dose of 250-500mg every six to eight hours maintained during interdialytic periods is recommended.

The elderly: As for adults.

Paediatric population: The usual recommended daily dosage for children is 20mg/kg/day in divided doses every eight hours, as indicated. For bronchitis and pneumonia, the dosage is 20mg/kg/day in divided doses administered 3 times daily. For otitis media and pharyngitis, the total daily dosage may be divided and administered every 12 hours. Safety and efficacy have not been established for use in infants aged less than one month.

Slate® **Suspension:**

	125mg/5ml	**250mg/5ml**
<1 year (9kg)	2.5ml tid	
1-5 years (9-18kg)	5.0ml tid	
Over 5 years		5.0ml tid

In more serious infections, otitis media, sinusitis and infections caused by less susceptible organisms, 40mg/kg/day in divided doses is recommended, up to a daily maximum of 1g.
In the treatment of beta-haemolytic streptococcal infections, therapy should be continued for at least 10 days.

Method of administration:
Slate® is administered orally.
Direction from reconstitution:
Shake bottle to loosen the mass. Add freshly boiled and cooled water below the mark given on bottle label then shake to make homogeneous suspension. Add further same water up to the mark of bottle label and shake vigorously to form uniform suspension.

4.3. CONTRAINDICATIONS:

- Hypersensitivity to the active substance or to any of the excipients.
- Hypersensitivity to other cephalosporins.

4.4. SPECIAL WARNINGS AND PRECAUTIONS FOR USE:

Warnings:
Before instituting therapy with cefaclor, every effort should be made to determine whether the patient has had previous hypersensitivity reactions to cefaclor, cephalosporins, penicillins or other drugs. Cefaclor should be given cautiously to penicillin-sensitive patients, because cross-hypersensitivity, including anaphylaxis, among beta-lactam antibiotics has been clearly documented. Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrose – isomaltase insufficiency should not take this medicine. If an allergic reaction to cefaclor occurs, the drug should be discontinued and the patient treated with the appropriate agents. Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics, including macrolides, semi-synthetic 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 usually respond to drug discontinuance alone. In moderate to severe cases, appropriate measures should be taken.
Precautions:
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. Cefaclor should be administered with caution in the presence of markedly impaired renal function. Since the half-life of cefaclor in anuric patients is 2.3 to 2.8 hours, dosage adjustments for patients

with moderate or severe renal impairment are not usually required. If cefaclor associated neurotoxicity is suspected, discontinuation of cefaclor should be considered. Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastro-intestinal disease, particularly colitis. Prolonged use of cefaclor may result in the overgrowth of non-susceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken. Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In haematological studies or in transfusion cross-matching procedures, when anti-globulin 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. This medicinal product contains less than 1mmol sodium (23mg) per 5ml, that is to say essentially 'sodium-free'.

4.5. INTERACTION WITH OTHER MEDICINAL PRODUCTS AND OTHER FORM OF INTERACTIONS:

There have been rare reports of increased prothrombin time, with or without clinical bleeding, in patients receiving cefaclor and warfarin concomitantly. It is recommended that in such patients, regular monitoring of prothrombin time should be considered, with adjustment of dosage if necessary. The renal excretion of cefaclor is inhibited by probenecid.

4.6. FERTILITY, PREGNANCY AND LACTATION:

Pregnancy: There are no adequate or well-controlled studies in pregnant women, caution should be exercised when prescribing for the pregnant patient.
Breast-feeding: Small amounts of cefaclor have been detected in breast milk following administration of single 500mg doses. Average levels of about 0.2µg/ml or less were detected up to 5 hours later. Trace amounts were detected at one hour. As the effect on nursing infants is not known, caution should be exercised when cefaclor is administered to a nursing woman.

4.7. EFFECTS ON ABILITY TO DRIVE AND USE MACHINES:

Not relevant.

4.8. UNDESIRABLE EFFECTS:

Gastro-intestinal: The most frequent side-effect has been diarrhoea. It is rarely severe enough to warrant cessation of therapy. Colitis, including rare instances of pseudomembranous colitis, has been reported. Nausea and vomiting have also occurred.
Hypersensitivity: Allergic reactions such as morbilliform eruptions, pruritus and urticaria have been observed. These reactions usually subside upon

discontinuation of therapy. Serum sickness-like reactions (erythema multiforme minor, rashes or other skin manifestations accompanied by arthritis/arthralgia, with or without fever) have been reported. Lymphadenopathy and proteinuria are infrequent, there are no circulating immune complexes and no evidence of sequelae. Occasionally, solitary symptoms may occur, but do not represent a serum sickness-like reaction. Serum sickness-like reactions are apparently due to hypersensitivity and have usually occurred during or following a second (or subsequent) course of therapy with cefaclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and usually subside within a few days of cessation of therapy. Antihistamines and corticosteroids appear to enhance resolution of the syndrome. No serious sequelae have been reported.

There are rare reports of erythema multiforme major (Stevens-Johnson syndrome), toxic epidermal necrolysis, and anaphylaxis. Anaphylaxis may be more common in patients with a history of penicillin allergy. Anaphylactoid events may present as solitary symptoms, including angioedema, asthenia, oedema (including face and limbs), dyspnoea, paraesthesias, syncope, or vasodilatation. Rarely, hypersensitivity symptoms may persist for several months.

Haematological: Eosinophilia, positive Coombs' tests and, rarely, thrombocytopenia. Transient lymphocytosis, leucopenia and, rarely, haemolytic anaemia, aplastic anaemia, agranulocytosis and reversible neutropaenia of possible clinical significance.

Hepatic: Transient hepatitis and cholestatic jaundice have been reported rarely, slight elevations in AST, ALT or alkaline phosphatase values.

Renal: Reversible interstitial nephritis has occurred rarely, also slight elevations in blood urea or serum creatinine or abnormal urinalysis.

Central Nervous System: Reversible hyperactivity, agitation, nervousness, insomnia, confusion, hypertonia, dizziness, hallucinations and somnolence have been reported rarely. 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.

Miscellaneous: Genital pruritus, vaginitis and vaginal moniliasis.

4.9. OVERDOSE:

Symptoms: Symptoms of nausea, vomiting, epigastric distress and diarrhoea would be anticipated.

Treatment: Unless 5 times the normal total daily dose has been ingested, gastro-intestinal decontamination will not be necessary. General management may consist of supportive therapy.

5. PHARMACOLOGICAL PROPERTIES

5.1. PHARMACODYNAMIC PROPERTIES:

Pharmacotherapeutic group: Second-generation cephalosporins antibiotics.
ATC code: J01DC04
Mechanism of action:
Cefaclor is active against the following organisms *in vitro*:
Alpha- and beta-haemolytic *streptococci*
Staphylococci; including coagulase-positive, coagulase-negative and penicillinase- producing strains
Streptococcus pneumoniae
Streptococcus pyogenes (group A beta-haemolytic streptococci)
Branhamella catarrhalis
Escherichia coli
Proteus mirabilis
Klebsiella species
Haemophilus influenzae, including ampicillin-resistant strains
Cefaclor has no activity against *Pseudomonas species* or *Acinetobacter* species. *Methicillin-resistant staphylococci* and most strains of *enterococci* (e.g., *Str. faecalis*) are resistant to cefaclor. Cefaclor is not active against most strains of *Enterobacter* spp, *Serratia* spp, *Morganella morganii*, *Proteus vulgaris* and *Providencia rettgeri*.

5.2. PHARMACOKINETICS PROPERTIES:

Absorption: Cefaclor is well absorbed after oral administration. Total absorption is the same whether the drug is given with or without food; however, when it is taken with food, the peak concentration achieved is 50 -75% and generally appears from ¾ to one hour later.
Distribution: Following administration of 250mg, 500mg doses and 1g, average peak serum levels of approximately 7, 13 and 23mg/L respectively were obtained within 30 - 60 minutes.
Metabolism: The serum half-life in normal subjects is 0.6 - 0.9 hours. In patients with reduced renal function, the serum half-life of cefaclor is slightly prolonged. In those with complete absence of renal function, the plasma half-life of the intact molecule is 2.3 - 2.8 hours. Haemodialysis shortens the half-life by 25 - 30%.
Excretion: Approximately 60 - 85% of the drug is excreted unchanged in the urine within eight hours, the greater portion being excreted within the first two hours. During the eight-hour period, peak urine concentrations following the 250mg, 500mg and 1g doses were approximately 600, 900 and 1,900 mg/L respectively. Excretion pathways in patients with markedly impaired renal function have not been determined.

5.3. PRECLINICAL SAFETY DATA:

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, genotoxicity, carcinogenic potential, toxicity to reproduction and development.

6. PHARMACEUTICAL PARTICULARS

6.1. LIST OF EXCIPIENTS:

Slate® **125mg/5ml Suspension:**

- Sucrose
- Metolose
- Xanthan Gum
- Microcrystalline Cellulose & Carboxymethyl Cellulose Sodium
- Sodium Lauryl Sulphate
- Simethicone
- Strawberry Powder Flavour
- Sunset Yellow Lake Color

Slate® **187mg/5ml Suspension:**

- Sucrose
- Metolose
- Xanthan Gum
- Microcrystalline Cellulose & Carboxymethyl Cellulose Sodium
- Sodium Lauryl Sulphate
- Simethicone
- Strawberry Powder Flavour
- Apple Green Lake Color

Slate® **250mg/5ml Suspension:**

- Sucrose
- Metolose
- Xanthan Gum
- Microcrystalline Cellulose & Carboxymethyl Cellulose Sodium
- Sodium Lauryl Sulphate
- Simethicone
- Strawberry Powder Flavour
- Erythrosine Lake Color

Slate® **50mg/ml Drops:**

- Sucrose
- Metolose
- Xanthan Gum

- Microcrystalline Cellulose & Carboxymethyl Cellulose Sodium
- Sodium Lauryl Sulphate
- Simethicone
- Strawberry Powder Flavour
- Erythrosine Lake Color

6.2. INCOMPATIBILITIES:

Not applicable

6.3. SHELF LIFE:

See expiry on the pack.

6.4. SPECIAL PRECAUTIONS FOR STORAGE:

Tightly close the cap after use.
Keep out of reach of children.
Do not store over 30°C and protect from heat, light and moisture.
Improper storage may deteriorate the medicine.
The reconstituted suspension should be kept at 2-8°C to avoid significant loss of potency and be used within 14 days.

6.5. NATURE AND CONTENTS OF CONTAINER:

Slate® **125mg/5ml Suspension:** Amber glass bottle with tamper-proof aluminium cap with conical plug, contains 5ml measuring spoon. Pack size is 60ml.

Slate® **187mg/5ml Suspension:** Amber glass bottle with tamper-proof aluminium cap with conical plug, contains 5ml measuring spoon. Pack size is 60ml.

Slate® **250mg/5ml Suspension:** Amber glass bottle with tamper-proof aluminium cap with conical plug, contains 5ml measuring spoon. Pack size is 60ml.

Slate® **50mg/ml Drops:** Amber glass bottle with tamper-proof aluminium cap with conical plug, contains 1ml measuring dropper. Pack size is 15ml.

6.6. SPECIAL PRECAUTIONS FOR DISPOSAL AND OTHER HANDLING:

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

6.7. DRUG PRODUCT SPECIFICATION:

Slate® **125mg/5ml Suspension:** USP Specs.
Slate® **187mg/5ml Suspension:** USP Specs.
Slate® **250mg/5ml Suspension:** USP Specs.
Slate® **50mg/ml Drops:** USP Specs.

7. REGISTRATION / MARKETING AUTHORISATION HOLDER

Manufactured by:
Healthtek (Pvt.) Limited
Plot No. 14, Sector 19, Korangi
Industrial Area Karachi – Pakistan
ML No. 000618

Associate of:
SAMI Pharmaceuticals (Pvt.) Ltd.
Karachi-Pakistan
www.samipharma.com
ML No. 000072

8. REGISTRATION / MARKETING AUTHORISATION NUMBER(S)

Slate® **125mg/5ml Suspension:** 047015
Slate® **187mg/5ml Suspension:** 076303
Slate® **250mg/5ml Suspension:** 047016
Slate® **50mg/ml Drops:** 075939

9. DATE OF FIRST AUTHORISATION / RENEWAL OF THE AUTHORISATION

Slate® **125mg/5ml Suspension:** 4th September, 2007
Slate® **187mg/5ml Suspension:** 21st April, 2014
Slate® **250mg/5ml Suspension:** 4th September, 2007
Slate® **50mg/ml Drops:** 29th May, 2013

10. DATE OF REVISION OF THE TEXT

سلیٹ® سسپینشن
(سیفاکلور)

ہدایات:

خوراک ڈاکٹر کی ہدایت کے مطابق استعمال کریں۔
صرف رجسٹرڈ ڈاکٹر کے نسخے کے مطابق فروخت کریں۔
بچوں کی پہنچ سے دور رکھیں۔
دوا کو ۳۰ ڈگری سینٹی گریڈ سے زیادہ درجہ حرارت پر نہ رکھیں،
گرمی، روشنی اور نمی سے محفوظ رکھیں ورنہ دوا خراب ہو جائیگی۔
تیار شدہ سسپینشن کو ۲ سے ۸ ڈگری سینٹی گریڈ پر رکھیں
تا کہ دوا کی تاثیر برقرار رہے اور ۱۴ یوم کے اندر استعمال کر لیں۔