To reduce the development of drug-resistant bacteria and maintain the effectiveness of CLEOCIN HCl and other antibacterial drugs, CLEOCIN HCl should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria.

**WARNING**

Pseudomembranous colitis has been reported with nearly all antibacterial agents, including clindamycin, and may range in severity from mild to life-threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea following antibiotic therapy.

Because clindamycin therapy has been associated with severe colitis which may and may not be associated with pseudomembranous colitis, treatment with antibacterial agents alters the natural flora of the colon and may permit overgrowth of Clostridium difficile. Studies indicate that a toxin produced by Clostridium difficile is primary cause of "antibiotic-associated colitis". After the diagnosis of pseudomembranous colitis has been established, therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to drug discontinuation alone; in moderate to severe cases, consideration should be given to management with fluid and electrolyte replacement, protein and calorie supplements, and per os antibiotics effective against C. difficile colitis. Discontinue clindamycin and replace with another antibiotic effective against C. difficile colitis.

Diarrhea, colitis, and pseudomembranous colitis have been observed to develop up to several weeks following cessation of therapy with clindamycin.

**DESCRIPTION**

Clindamycin hydrochloride is the hydrochloride salt of clindamycin. Clindamycin is a semisynthetic antibacterial produced by a 7(S)-chloro-substitution of the 7(R)-hydroxyl group of the parent compound lincomycin. CLEOCIN HCl capsules contain clindamycin hydrochloride equivalent to 75 mg, 150 mg or 300 mg of clindamycin.

Inactive ingredients: 75 mg—corn starch, FD&C blue no. 1, FD&C yellow no. 5, gelatin, lactose, magnesium stearate, and starch; 150 mg—corn starch, FD&C blue no. 1, gelatin, lactose, magnesium stearate and starch; 300 mg—corn starch, FD&C blue no. 1, gelatin, lactose, magnesium stearate and starch.

The structural formula is represented below:

![Structural formula of clindamycin](https://example.com/structure.png)

The chemical name for clindamycin hydrochloride is 7-Chloro-6,7-dihydro-5-[2-(1-hydroxy-2,3-indolyl)ethyl]-2-(3-propyl-2-pyridyl)ethylidenamino]-1-thio-3-hydroxy-3-deoxystreptococcal monohydrochloride.

**CLINICAL PHARMACOLOGY**

**Human Pharmacology:** Serum levels with a 150 mg oral dose of clindamycin hydrochloride in 24 hours rapidly absorbed after oral administration. An average peak serum level of 3.5 mg/mL was reached in 45 minutes; serum levels averaged 1.5 mg/mL at 3 hours and 0.75 mg/mL at 6 hours. Absorption of an oral dose is virtually complete (90%), and the concomitant administration of food does not appreciably modify the serum concentrations; serum levels have been uniform and predictable from person to person and dose to dose.

Serum level studies following multiple doses of CLEOCIN HCl for up to 14 days show no evidence of accumulation or altered metabolism of drug. Serum half-life of clindamycin is increased slightly in patients with markedly reduced renal function.

**MICs for Clindamycin**

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>Susceptibility Interpretive Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staphylococcus aureus (ATCC 29213)</td>
<td>S (MIC ≤ 1)</td>
</tr>
<tr>
<td>Staphylococcus aureus (ATCC 43300)</td>
<td>S (MIC ≤ 1)</td>
</tr>
<tr>
<td>Eubacterium lentum</td>
<td>S (MIC ≤ 1)</td>
</tr>
<tr>
<td>Eubacterium nodatum</td>
<td>S (MIC ≤ 1)</td>
</tr>
</tbody>
</table>

**SUSCEPTIBILITY TESTING METHODS:**

**Note:** Susceptibility testing by dilution methods requires the use of clindamycin susceptible strains. When available, the results of in vitro susceptibility tests should be provided to the physician as an interpretive guide, and their correlation with in vivo activity will vary. These reports should aid the physician in selecting the most effective antimicrobial.

**Dilution Techniques:** Quantitative methods that require the measurement of zone diameters also provide a quality control component which测 of the antimicrobial minimum inhibitory concentration (MIC). These MICs provide estimates of the susceptibility of bacteria to antimicrobial compounds. The MIC is the lowest concentration of an antimicrobial compound which inhibits visible growth of a microorganism. These standards have been established in adequate and well-controlled clinical trials.

- **Staphylococcus aureus (ATCC 29213):** 0.06–0.5 µg/mL
- **Staphylococcus aureus (ATCC 43300):** 0.06–0.5 µg/mL
- **Eubacterium lentum:** 0.06–0.5 µg/mL
- **Eubacterium nodatum:** 0.06–0.5 µg/mL

**Tetracycline Hydrochloride Capsules, USP**

**INDICATIONS AND USAGE**

- **Infections due to susceptible bacteria:** Clindamycin capsules, USP are indicated for treatment of infections caused by susceptible bacteria including strains of **Staphylococcus aureus** and **Streptococcus pyogenes** in the conditions listed below.

**CLINICAL PHARMACOLOGY**

- **Microbiology:** Clindamycin prohibits bacterial protein synthesis by binding to the 50S subunit of the ribosome. It has activity against Gram-positive aerobes and anaerobes as well as the Gram-negative anaerobes. Clindamycin is bactericidal. Cross-resistance between clindamycin and erythromycin is complete. Antagonism in vitro has been demonstrated between clindamycin and erythromycin.

- **Pharmacokinetic Properties:** Clindamycin has been shown to be active even against most of the isolates of the following microorganisms, both in vitro and in clinical infections, as described in the **INDICATIONS AND USAGE** section.

**Gram-positive aerobes**

- **Staphylococcus aureus (methicillin-susceptible strain)**
- **Streptococcus pneumoniae (penicillin-susceptible strain)**
- **Penicillin G penicillinase**

- **Anaerobes**

- **Prevotella melaninogenica**
- **Fusobacterium nucleatum**
- **Peptostreptococcus asaccharolyticus**
- **Clostridium perfringens**

**A report of “Susceptible” indicates that the pathogen is likely to be inhibited if the antimicrobial compound in the blood reaches the concentrations usually achievable. A report of “Intermediate” indicates that the result should be considered equivocal, and that the pathogen should be considered likely to be inhibited if the antimicrobial compound in the blood is physiologically diluted in situations where high doses of the drug can be used. This category also provides a buffer that prevents small, uncontrolled technical factors from causing major discrepancies in interpretation. A report of “Resistant” indicates that the drug is likely to be inhibited if the antimicrobial compound in the blood reaches the concentrations usually achievable; other therapy should be selected.**

**Quality Control**

**Standardized susceptibility test procedures require the use of quality control microorganisms to control the technical aspects of the test procedure. Standard clindamycin should be used in the range of concentrations provided in standardized susceptibility test procedures. The sensitivity of clinical isolates of particular organisms to antimicrobial compounds may vary over a wide range. The physician should periodically evaluate the sensitivity of strains of particular organisms frequently involved in infections. The specific strains used for microbiological quality control are not clinically significant.**
Cleocin HCl, brand of clindamycin hydrochloride capsules, USP

Table 2. (continued)

<table>
<thead>
<tr>
<th>QC Level</th>
<th>Acceptable Quality Control Range</th>
<th>Minimum Inhibitory Concentration (MIC’s in μg/mL)</th>
<th>Minimum Inhibitory Disk Diffusion (Zone Diameter in mm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤0.5</td>
<td>≤0.5 (±0.2)</td>
<td>≤0.5</td>
<td>≤0.5</td>
</tr>
<tr>
<td>&gt;0.5</td>
<td>≤1.0 (±0.2)</td>
<td>&gt;0.5</td>
<td>&gt;0.5</td>
</tr>
<tr>
<td>&gt;1.0</td>
<td>&gt;1.0 (±0.2)</td>
<td>&gt;1.0</td>
<td>&gt;1.0</td>
</tr>
</tbody>
</table>

Cleocin HCl, brand of clindamycin hydrochloride capsules, USP

There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers

Cleocin HCl has been reported to appear in breast milk in the range of 0.7 to 3.8 mg/mL.

Pharmacology

When CLEOCIN HCl is administered to the pediatric patient (between birth and 12 years of age), monitoring of organ system functions is desirable.

Clinical studies of clindamycin did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently from younger patients. However, clinical experience indicates that antibiotic-associated colitis and diarrhea (due to Clostridium difficile) seen in association with most antibiotics occur more frequently in the elderly (>65 years) and may be more severe. These patients should be carefully monitored for the development of diarrhea.

Pharmacokinetic studies with clindamycin have shown no significant differences between young and elderly subjects with normal hepatic function and normal renal function following oral administration.

ADVERSE REACTIONS

The following reactions have been reported with the use of clindamycin.

Cardiovascular: Abdominal pain, pseudomembranous colitis, esophagitis, nausea, vomiting and diarrhea (see WARNINGS). The onset of pseudomembranous colitis symptoms may occur during or after antibacterial therapy (see WARNINGS). Drug Interactions

Flucloxacillin half-life has been found. However, it was not postulated from studies that when given every 8 hours, accumulation should rarely occur. Therefore, dosage modifications in patients with liver disease may be necessary if an increased number of clindamycin infections are to be treated. Total intravenous clindamycin concentrations should be made when treating patients with severe liver disease.

The 75 mg and 150 mg capsules contain FD&C yellow no. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Therefore, CLEOCIN HCl tablets should be taken in an individuals in patients who also have aspergillosis hyperferritinemia.

Pregnancy Category B

Fertility

Carcinogenesis, Mutagenesis, Impairment of Fertility studies in rats treated orally with up to 300 mg/kg/day (approximately 3.2 times the highest recommended adult human dose based on mg/m²) revealed no evidence of tumorigenicity. Should superinfections occur, appropriate antibiotic therapy should be administered.

Drugs which may cause disease. When CLEOCIN HCl is used as the preferred department committee (1996) to which they were submitted. No appreciable difference in pathological findings has been observed between groups of animals treated with clindamycin and comparable control groups. Rates receiving clindamycin hydrochloride at 650 mg/day (approximately 3.2 times the highest recommended adult human dose based on mg/m²) for 6 to 7 days, or orally (approximately 12.8 times the highest recommended adult human dose based on mg/m²), vomiting, could not eat, and lost weight.

REFERENCES


Made in Canada by
Pharmacia & Upjohn Company
A subsidiary of Pharmacia Corporation
Kalamazoo, MI 49001, USA
By Patheon YM, Inc., Toronto, Ontario
M3B 1Y2, Canada

Revised November 2003

810 570 928 003851

300 mg Light Blue Bottles of 10
NDC 0009-0395-13
Bottle of 100
NDC 0009-0395-14
Unit dose package of 100
NDC 0009-0395-02

Store at controlled room temperature 20° to 25°C (68° to 77°F) (see USP)

Animal Toxicology

One year oral toxicity studies in Sprague-Dawley rats and beagles at doses levels up to 300 mg/kg/day (approximately 1.5 and 5.4 times the highest recommended adult human dose based on mg/m², respectively) have shown clindamycin to be well tolerated. No appreciable difference in pathological findings has been observed between groups of animals treated with clindamycin and comparable control groups. Rates receiving clindamycin hydrochloride at 650 mg/day (approximately 3.2 times the highest recommended adult human dose based on mg/m²) for 6 to 7 days, or orally (approximately 12.8 times the highest recommended adult human dose based on mg/m²), vomiting, could not eat, and lost weight.

Black

Composition Unit 3566
Cleocin Phosphate®
cinamycin injection, USP and clindamycin injection in 5% dextrose

To reduce the development of drug-resistant bacteria and maintain the effectiveness of CLEOCIN PHOSPHATE and other antibacterial drugs, CLEOCIN PHOSPHATE should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. When determining the applicability of use of CLEOCIN PHOSPHATE in the treatment of a specific infection, consider the history of antibiotic use in the community and in the hospital. If there is a high frequency of resistance to clindamycin, other antibacterial drugs should be considered. When a course of therapy is completed, careful observation of the patient is essential. The patient should be reevaluated to determine the need for further antibiotic therapy.

Precautions
The use of antibacterial products is essential in the treatment of infections that are caused by susceptible bacteria. Clinical studies in bacteremia due to susceptible bacteria have shown that the effects of CLEOCIN PHOSPHATE are not significantly different between age groups. However, the use of CLEOCIN PHOSPHATE alone is not effective in the treatment of serious infections caused by susceptible anaerobic bacteria. The addition of a more effective antibacterial drug to CLEOCIN PHOSPHATE may be necessary to achieve a therapeutic effect.

Usage
CLEOCIN PHOSPHATE is indicated for the treatment of serious infections caused by susceptible anaerobic bacteria. These infections include those caused by anaerobic gram-positive bacteria, anaerobic gram-negative bacteria, and anaerobic facultative bacteria. CLEOCIN PHOSPHATE is not effective against aerobic bacteria.

Infections in Immunocompromised Patients
Infections in immunocompromised patients may require the use of a more active drug. The use of CLEOCIN PHOSPHATE alone may be insufficient to treat these infections. A more active drug may be added to CLEOCIN PHOSPHATE to achieve a therapeutic effect.

Usage in Pediatric Patients
The safety and effectiveness of CLEOCIN PHOSPHATE have not been established in pediatric patients. However, the use of CLEOCIN PHOSPHATE alone is not effective in the treatment of serious infections caused by susceptible anaerobic bacteria. The addition of a more effective antibacterial drug to CLEOCIN PHOSPHATE may be necessary to achieve a therapeutic effect.

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Cleocin Phosphate
brand of clindamycin injection, USP and clindamycin injection in 5% dextrose

If fever later occurs in the course of therapy, the medication should be discontinued, the patient treated appropriately, and a new diagnostic study performed. Antibiotics should not be administered as a sole therapeutic measure in the management of infections caused by anaerobic organisms.

Drug Interactions

Cleocin Phosphate contains a benzyl alcohol preservative. Benzyl alcohol has been associated with toxicity in neonates and premature infants, including fatalities. In a developmental toxicity study, benzyl alcohol alone was not teratogenic in rats and rabbits at doses up to 1 g/kg/day (40 times the human dose). However, when given in combination with clindamycin at 50 mg/kg/day for 10 days to rats during organogenesis, an increase in fetal mortality was noted. This increase in fetal mortality was associated with a maternal increase in body weight gain. A similar increase in fetal mortality occurred when clindamycin and benzyl alcohol were administered to rabbits at 50 mg/kg/day for 10 days during organogenesis. This increase in fetal mortality was associated with a maternal decrease in body weight gain. There are no adequate and well-controlled studies in pregnant women. If Clindamycin Phosphate is administered to a woman during pregnancy, or if the patient becomes pregnant while taking Clindamycin Phosphate, she should be apprised of the potential hazard to the fetus. Clindamycin has been associated with a congenital malformation in animals; however, there are no adequate and well-controlled studies in pregnant women. Caution should be exercised when Clindamycin Phosphate is administered to a pregnant woman. It is not known whether Clindamycin is excreted in human milk. Because many drugs are excreted in human milk, cautions should be exercised when Clindamycin Phosphate is administered to a nursing woman. In animals, milk concentrations were 0.2 to 0.5 times the human systemic serum concentration.

CLINICAL PHARMACOLOGY

Pharmacokinetics:

After the administration of a single intravenous dose of clindamycin, the peak serum concentrations of clindamycin occurred within 1 to 2 hours. The mean peak serum concentration for a 150 mg intravenous dose was 7.1 mcg/mL. At a 600 mg intravenous dose, the mean peak serum concentration was 20 mcg/mL. No significant differences in mean peak serum concentration were noted after oral or intravenous administration. The mean serum concentration-time profiles for a 300 mg oral dose of clindamycin and a 1200 mg intravenous dose of clindamycin were comparable. The mean serum concentration at 24 hours was 0.3 mcg/mL after a 300 mg oral dose and 0.2 mcg/mL after a 1200 mg intravenous dose. Serum concentrations remained above 1 mcg/mL (the MIC of clindamycin for 90% of aerobic and anaerobic pathogens) for at least 24 hours after a single intravenous dose of 600 mg clindamycin. The serum half-life of clindamycin is 1.0 to 1.5 hours. The area under the serum concentration-time curve (AUC) is proportional to the dosage over the range of 150 mg to 600 mg. The AUC:mg/kg is independent of the route of administration.

The plasma levels of clindamycin in healthy adult volunteers were determined by direct bioassay or bioassay after HPLC cleanup. The bioavailability of clindamycin is complete following oral administration. At therapeutic serum concentrations, the average plasma half-life is approximately 2 hours; at supratherapeutic serum concentrations, the average plasma half-life is approximately 1.5 to 2 hours. After a single oral dose of clindamycin of 150 mg, the peak serum concentration occurred within 1.5 hours. The average peak serum concentration was 8 mcg/mL. The total body clearance of clindamycin from plasma is 10 to 15 mL/kg/hour in healthy adult male volunteers and 13.5 to 17.5 mL/kg/hour in healthy adult female volunteers. The apparent volume of distribution for clindamycin is 0.75 to 1.0 liters/kg in healthy adult male volunteers and 0.8 to 1.3 liters/kg in healthy adult female volunteers. The average peak serum concentration of clindamycin in premature neonates was 10 mcg/mL after administration of 10 mg/kg intravenously as a 15-minute infusion.

The total body clearance of clindamycin is reduced in patients with severe hepatic disease. In patients with moderate to severe hepatic disease, the half-life of clindamycin may be prolonged. The volume of distribution of clindamycin is increased in patients with severe hepatic disease. In patients with moderate to severe hepatic disease, the half-life of clindamycin is increased. In patients with normal renal function, the mean half-life of clindamycin is prolonged from 1.2 to 2.4 hours.

Drug Elimination:

In patients with normal renal function, approximately 40 to 80% of a single oral dose of clindamycin is excreted in the urine. Clindamycin is eliminated by glomerular filtration and tubular secretion. The renal clearance of clindamycin is approximately 10% of the creatinine clearance. In patients with normal renal function, the renal clearance of clindamycin is approximately 7 to 10 mL/min and the renal clearance of clindamycin is approximately 0.5 to 1.0 mL/min.

CLINICAL PHARMACOKINETICS

Pharmacokinetics:

After the administration of a single intravenous dose of clindamycin, the peak serum concentrations of clindamycin occurred within 1 to 2 hours. The mean peak serum concentration for a 150 mg intravenous dose was 7.1 mcg/mL. At a 600 mg intravenous dose, the mean peak serum concentration was 20 mcg/mL. No significant differences in mean peak serum concentration were noted after oral or intravenous administration. The mean serum concentration-time profiles for a 300 mg oral dose of clindamycin and a 1200 mg intravenous dose of clindamycin were comparable. The mean serum concentration at 24 hours was 0.3 mcg/mL after a 300 mg oral dose and 0.2 mcg/mL after a 1200 mg intravenous dose. Serum concentrations remained above 1 mcg/mL (the MIC of clindamycin for 90% of aerobic and anaerobic pathogens) for at least 24 hours after a single intravenous dose of 600 mg clindamycin. The serum half-life of clindamycin is 1.0 to 1.5 hours. The area under the serum concentration-time curve (AUC) is proportional to the dosage over the range of 150 mg to 600 mg. The AUC:mg/kg is independent of the route of administration.

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In patients with normal renal function, approximately 40 to 80% of a single oral dose of clindamycin is excreted in the urine. Clindamycin is eliminated by glomerular filtration and tubular secretion. The renal clearance of clindamycin is approximately 10% of the creatinine clearance. In patients with normal renal function, the renal clearance of clindamycin is approximately 7 to 10 mL/min and the renal clearance of clindamycin is approximately 0.5 to 1.0 mL/min.
Cleocin Phosphate

cinamycin injection, USP and cinamycin injection in 5% dextrose

INDICATIONS AND USAGE

Cleocin Phosphate is indicated for the treatment of infections caused by susceptible bacteria.

CONTRAINDICATIONS

Cleocin Phosphate is contraindicated in patients with a history of hyper sensitivity to clindamycin, lincomycin or any component of the formulation.

PRECAUTIONS

Pediatric Use

The safety and efficacy of Cleocin Phosphate in children have not been established.

PREGNANCY

Pregnancy Category C

NURSING MOTHERS

Cleocin Phosphate is not recommended for use in nursing mothers.

ADVERSE REACTIONS

The most common adverse reactions associated with the use of Cleocin Phosphate are nausea, vomiting, and diarrhea.

PHARMACOKINETICS

Cleocin Phosphate is rapidly absorbed after oral administration and is well distributed to all body tissues except retroperitoneal fat.

CLINICAL PHARMACOLOGY

The pharmacokinetics of Cleocin Phosphate have not been fully evaluated, but it is believed to follow first-order kinetics.

DOSAGE AND ADMINISTRATION

The recommended dosage of Cleocin Phosphate is 600 mg IM q12h or 600 mg IV q8h.

SUSPENSIBILITY TESTING METHODS

NOTE: In vitro susceptibility tests should be performed using commercially available reference strain methods. These tests should be performed and interpreted according to the guidelines of the CLSI.

Table 1: Susceptibility Interpretive Criteria for Cleocin Phosphate

<table>
<thead>
<tr>
<th>Organism</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staphylococcus aureus</td>
<td>Sensitive</td>
</tr>
<tr>
<td>Staphylococcus epidermidis</td>
<td>Resistant</td>
</tr>
<tr>
<td>Streptococcus pneumoniae</td>
<td>Intermediate</td>
</tr>
<tr>
<td>Enterococcus faecalis</td>
<td>Sensitive</td>
</tr>
</tbody>
</table>

The safety and efficacy of Cleocin Phosphate have not been established in patients with gastrointestinal impairment.

The safety and efficacy of Cleocin Phosphate have not been established in children.

The safety and efficacy of Cleocin Phosphate have not been established in pregnant women. It is not recommended for use in nursing mothers.

The safety and efficacy of Cleocin Phosphate have not been established in patients with renal or hepatic impairment.

The safety and efficacy of Cleocin Phosphate have not been established in patients with a history of hyper sensitivity to clindamycin, lincomycin or any component of the formulation.

E. coli. The drug is distributed into all body tissues and fluids, including abscesses and pleural effusions.

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The safety and efficacy of Cleocin Phosphate have not been established in children.

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Cleocin Phosphate

brand of clindamycin injection, USP and clindamycin injection in 5% dextrose

AND ERTANUSY CORTICOSTEROIDS SHOULD ALSO BE ADMINISTERED FOR INFECTION PREVENTION.

Precautions

Review of experience to date suggests that a subgroup of older patients with associated severe these may tolerate higher doses and, therefore, they should be carefully monitored for change in dosage level.

CLEOCIN PHOSPHATE should be prescribed with caution in patients with a history of gastrointestinal disease, particularly pseudomembranous colitis.

In juvenile patients, the potential for the toxic effect in the pediatric population from the use of clindamycin in the single dose regimen for prophylaxis must be carefully considered.

Hepatic function has been studied in dogs, rabbits, and monkeys. Clindamycin has been shown to be metabolized in dogs, monkeys, and rabbits. In dogs, the major metabolite is the sulfate of the acetylated and glucuronidated conjugate. Similar metabolites have been observed in rabbits and monkeys. In rabbits, unchanged drug was the predominant metabolite. In monkeys, unchanged drug and the metabolite were equal. In dogs, the major metabolite was the glucuronide conjugate.

The use of CLEOCIN PHOSPHATE may result in overgrowth of nonsusceptible organisms—particularly yeasts. Therefore, appropriate therapy with antifungal agents should be initiated. Repetitive dosage with clindamycin may result in a superinfection with an overgrowth of nonsusceptible organisms—particularly yeasts. Therefore, appropriate therapy with antifungal agents should be initiated.

Cleocin Phosphate

brand of clindamycin injection, USP and clindamycin injection in 5% dextrose

For further information, see the complete prescribing information for CLEOCIN PHOSPHATE. Refer to separate instructions for ADD-diluent container. Refer to separate instructions for ADD-diluent container and container permit.

畏用的化学稳定性信息在任何情况下均不起作用，并不意味着溶液和容器适合。应按处方规定使用。

Cleocin Phosphate

brand of clindamycin injection, USP and clindamycin injection in 5% dextrose

References


For complete prescribing information for CLEOCIN PHOSPHATE, refer to separate instructions for ADD-diluent container and container permit. Refer to separate instructions for ADD-diluent container and container permit.

Additional information concerning changes in clindamycin (phosphate) injection as well as changes in the following information regarding container and product stability information for CLEOCIN PHOSPHATE, refer to separate instructions for ADD-diluent container and container permit.

References


