SUMMARY OF PRODUCT CHARACTERISTICS

1.	**Name of the Medical Product**
	1.1 Product Name : Co-Orixo (Ofloxacin and Ornidazole Tablets)
	1.2 Strength : Each film coated tablet contains: Ofloxacin USP 200 mg Ornidazole 500 mg
	1.3 Pharmaceutical Dosage Form : Tablet
2.	**Qualitative & Quantitative Composition:** Each film coated tablet contains: Ofloxacin USP 200 mg Ornidazole 500 mg Colour: Titanium Dioxide For a full list of excipients, see section 6.1 of SmPC
3.	**Pharmaceutical Form:**
	Tablet White to off white coloured, caplet shaped, biconvex, film coated tablets, wrth break line on one side and plain on other side.
4.	**Clinical Particulars**
	4.1 Therapeutic Indications: Co-Orixo Tablets are indicated for the treatment of gastrointestinal infections such as acute diarrhea or dysentery, gynecological infections, lung infections and urinary infections in adults.
	4.2 Posology and Method of administration: One tablet of Co-Orixo is recommended as twice-daily therapy or as prescribed by Physician. **Administration:** For oral use.
	4.3 Contraindications: Co-Orixo tablets are contraindicated • in persons with a history of hypersensitivity associated with the use of ofloxacin, ornidazole or any member of the quinolone or nitroimidazole group of antimicrobial agents. • In patients with epilepsy. • In patients with history of tendon disorders related to fluoroquinolone administration. • In children or adolescents in the growth phase. * • During pregnancy. * • In breast-feeding women. *

	• Patients with pre-existing CNS lesions involving a lowered convulsion threshold. ** because, judging from animal experiments, a risk of damage to the growth-plate cartilage in the growing organism cannot be entirely excluded*.
	4.4 Special warning and precautions for use: **Ofloxacin** • The use of ofloxacin should be avoided in patients who have experienced serious adverse reactions in the past when using quinolone or fluoroquinolones containing products. Treatment of these patients with ofloxacin should only be initiated in the absence of alternative treatment options and after careful benefit/risk assessment. • Prolonged, disabling and potentially irreversible serious adverse drug reactions. Very rare cases of prolonged (continuing months or years), disabling and potentially irreversible serious adverse drug reactions affecting different, sometimes multiple, body systems (musculoskeletal, nervous, psychiatric and senses) have been reported in patients receiving quinolones and fluoroquinolones irrespective of their age and pre-existing risk factors. Ofloxacin should be discontinued immediately at the first signs or symptoms of any serious adverse reaction and patients should be advised to contact their prescriber for advice. • *Methicillin-resistant S. aureus* are very likely to possess co-resistance to fluoroquinolones, including ofloxacin. Therefore, ofloxacin is not recommended for the treatment of known or suspected MRSA infections unless laboratory results have confirmed susceptibility of the organism to ofloxacin (and commonly recommended antibacterial agents for the treatment of MRSA-infections are considered inappropriate). • *Neisseria gonorrhoea* infections - Due to increase in resistance to N. gonorrhoeae, ofloxacin should not be used as empirical treatment option in suspected gonococcal infection (urethral gonococcal infection, pelvic inflammatory disease and epididymo-orchitis), unless the pathogen has been identified and confirmed as susceptible to ofloxacin. If clinical improvement is not achieved after 3 days of treatment, the therapy should be reconsidered. • Pelvic inflammatory disease - For pelvic inflammatory disease, ofloxacin should only be considered in combination with anaerobe coverage. • *Escherichia coli* infection - Resistance to fluoroquinolones of *E. coli* – the most common pathogen involved in urinary tract infections – varies across the European Union. Prescribers are advised to take into account the local prevalence of resistance in *E. coli* to fluoroquinolones. • Severe cutaneous adverse reactions - Cases of severe bullous skin reactions such as Stevens-Johnson syndrome or toxic epidermal necrolysis have been reported with ofloxacin. Patients should be advised to contact their doctor immediately prior to continuing treatment if skin and/or mucosal reactions occur. • Hypersensitivity and allergic reactions have been reported for fluoroquinolones after first administration. Anaphylactic and anaphylactoid reactions can progress to life-threatening shock, even after the first administration. In these cases, ofloxacin should be discontinued and suitable treatment (e.g treatment for shock) should be initiated.

- *Clostridium difficile* – associated disease - Diarrhoea, particularly if severe, persistent and/or bloody, during or after treatment with ofloxacin (including several weeks after treatment), may be symptomatic of pseudomembranous colitis (CDAD). CDAD may range in severity from mild to life threatening, the most severe form of which is pseudomembranous colitis. It is therefore important to consider this diagnosis in patients who develop serious diarrhoea during or after treatment with ofloxacin. If pseudo-membranous colitis is suspected, ofloxacin must be stopped immediately.

  Appropriate specific antibiotic therapy must be started without delay (e.g. oral vancomycin, oral teicoplanin or metronidazole). Products inhibiting the peristalsis are contraindicated in this clinical situation.
- Patients predisposed to seizures - Quinolones may lower the seizure threshold and may trigger seizures. Ofloxacin is contraindicated in patients with a history of epilepsy and, as with other quinolones, ofloxacin should be used with extreme caution in patients predisposed to seizures.

  Such patients may be patients with pre-existing central nervous system lesions, concomitant treatment with fenbufen and similar non-steroidal anti-inflammatory drugs or with drugs which lower the cerebral seizure threshold, such as theophylline.
  If seizure develops, treatment with ofloxacin should be discontinued.
- Tendinitis and tendon rupture - Tendinitis and tendon rupture (especially but not limited to Achilles tendon), sometimes bilateral, may occur as early as within 48 hours of starting treatment with quinolones and fluoroquinolones and have been reported to occur even up to several months after discontinuation of treatment. The risk of tendinitis and tendon rupture is increased in older patients, patients with renal impairment, patients with solid organ transplants, and those treated concurrently with corticosteroids. Therefore, concomitant use of corticosteroids should be avoided.

  At the first sign of tendinitis (e.g. painful swelling, inflammation) the treatment with ofloxacin should be discontinued and alternative treatment should be considered. The affected limb(s) should be appropriately treated (e.g. immobilisation). Corticosteroids should not be used if signs of tendinopathy occur.
- Patients with renal impairment - Since ofloxacin is mainly excreted by the kidneys, the dose of ofloxacin should be adjusted in patients with renal impairment.
- Patients with impaired liver function - Ofloxacin should be used with caution in patients with impaired liver function, as liver damage may occur. Cases of fulminant hepatitis potentially leading to liver failure (including fatal cases) have been reported with fluoroquinolones. Patients should be advised to stop treatment and contact their doctor if signs and symptoms of hepatic disease develop such as anorexia, jaundice, dark urine, pruritus or tender abdomen.
- Patients treated with vitamin K antagonists - Due to possible increase in coagulation tests (PT/INR) and/or bleeding in patients treated with fluoroquinolones, including ofloxacin, in combination with a vitamin K antagonist (e.g. warfarin), coagulation tests should be monitored when these drugs are given concomitantly.
- Myasthenia gravis - Fluoroquinolones, including ofloxacin, have neuromuscular blocking activity and may exacerbate muscle weakness in patients with myasthenia gravis. Post - marketing serious adverse reactions, including deaths and the requirement

for respiratory support, have been associated with fluoroquinolone use in patients with myasthenia gravis. Ofloxacin is not recommended in patients with a known history of myasthenia gravis

- Prevention of photosensitization - Photosensitization has been reported with ofloxacin. It is recommended that patients should not expose themselves unnecessarily to strong sunlight or to artificial UV rays (e.g. sunray lamp, solarium), during treatment and for 48 hours following treatment discontinuation in order to prevent photosensitisation.
- Super Infection - As with other antibiotics, the use of ofloxacin, especially if prolonged, may result in the overgrowth of non-susceptible organisms. Repeated evaluation of the patient's condition is essential. If secondary infection occurs during therapy, appropriate measures should be taken.
- Risks of resistance - The prevalence of acquired resistance may vary geographically and over time for selected species. Therefore, local information on resistance is required; microbiological diagnosis with isolation of the pathogen and demonstration of its susceptibility should be sought, especially for severe infections or failure to respond to treatment.
- QT interval prolongation - Cases of QT interval prolongation have been reported in patients taking fluoroquinolones including ofloxacin.

  Caution should be taken when using fluoroquinolones, including ofloxacin, in patients with known risk factors for prolongation of the QT interval such as, for example:
  - congenital long QT syndrome
  - concomitant use of drugs that are known to prolong the QT interval (e.g. Class IA and III antiarrhythmics, tricyclic antidepressants, macrolides, antipsychotics).
  - uncorrected electrolyte imbalance (e.g. hypokalemia, hypomagnesemia)
  - cardiac disease (e.g. heart failure, myocardial infarction, bradycardia)
  - Elderly patients and women may be more sensitive to QTc-prolonging medications. Therefore, caution should be taken when using fluoroquinolones, including ofloxacin, in these populations.
- Dysglycaemia - Disturbances in blood glucose, including both hypoglycaemia and hyperglycaemia have been reported with fluoroquinolones including ofloxacin and occur more frequently in the elderly. In diabetic patients receiving concomitant treatment with an oral hypoglycaemic agent (e.g., glibenclamide) or with insulin, cases of hypoglycaemic coma have been reported. In these diabetic patients, careful monitoring of blood glucose is recommended.

  Ofloxacin treatment should be stopped immediately if a patient reports blood glucose disturbance and alternative non-fluoroquinolone antibacterial therapy should be considered.
- Peripheral neuropathy - Cases of sensory or sensorimotor polyneuropathy resulting in paraesthesia, hypaesthesia, dysesthesia, or weakness have been reported in patients receiving quinolones and fluoroquinolones. Patients under treatment with ofloxacin should be advised to inform their doctor prior to continuing treatment if symptoms of neuropathy such as pain, burning, tingling, numbness, or weakness develop in order to prevent the development of potentially irreversible condition.

- Patients with glucose-6-phosphate-dehydrogenase deficiency - Patients with a latent or diagnosed glucose-6-phosphate-dehydrogenase deficiency may be predisposed to haemolytic reactions if they are treated with quinolones. Therefore, if ofloxacin has to be used in these patients, potential occurrence of haemolysis should be monitored.
- Patients with history of psychotic disorder - Psychotic reactions have been reported in patients receiving fluoroquinolones, sometimes only after a single dose. In some cases, these have progressed to suicidal thoughts or self-endangering behaviour including suicide attempt, sometimes after a single dose of ofloxacin. In the event that a patient develops these reactions, ofloxacin should be discontinued immediately at the first signs or symptoms of these reactions and patients should be advised to contact their prescriber for advice.

  Alternative non-fluoroquinolone antibacterial therapy should be considered, and appropriate measures instituted.
  Ofloxacin should be used with caution in patients with a history of psychotic disorder or in patients with psychiatric disorder.
- Vision disorders - If vision becomes impaired or any effects on the eyes are experienced, an eye specialist should be consulted immediately.
- Interference with laboratory tests - In patients treated with ofloxacin, determination of opiates in urine may give false positive results. It may be necessary to confirm positive opiate screens by more specific method.
- Patients with rare hereditary disorders - Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine.
- Aortic aneurysm and dissection -Epidemiologic studies report an increased risk of aortic aneurysm and dissection after intake of fluoroquinolones, particularly in the older population.
  Therefore, fluoroquinolones should only be used after careful benefit-risk assessment and after consideration of other therapeutic options in patients with positive family history of aneurysm disease, or in patients diagnosed with pre-existing aortic aneurysm and/or aortic dissection, or in presence of other risk factors or conditions predisposing for aortic aneurysm and dissection (e.g. Marfan syndrome, vascular Ehlers-Danlos syndrome, Takayasu arteritis, giant cell arteritis, Behcet's disease, hypertension, known atherosclerosis).
  In case of sudden abdominal, chest or back pain, patients should be advised to immediately consult a physician in an emergency department.

Ornidazole

- Interrupt treatment in case of ataxia, dizziness, mental confusion.
- Take into account the risk of worsening of the neurological state in patients with severe, fixed or progressive central and peripheral neurological disorders.
- Precautions for use
  - Check the leukocyte count in patients with a history of blood dyscrasias, or high-dose treatment and / or prolonged treatment;
  - This product belongs to the family of nitro-5-imidazole why cases of potentiation with vecuronium (non-depolarizingneuromuscular blocking) were reported.

4.5 Interactions with other medicinal products and other forms of Interactions :
Ofloxacin

- *Antacids, Sucralfate, Metal Cations*

Antacids containing aluminium (including sucralfate) and magnesium hydroxides, aluminium phosphate, zinc, iron, are liable to reduce the absorption of ofloxacin tablets.
Ofloxacin should be administered approximately 2 hours apart from antacids.

- *Theophylline, fenbufen or similar non-steroidal anti-inflammatory drugs*

No pharmacokinetic interactions of ofloxacin were found with theophylline in a clinical study. However, a pronounced lowering of the cerebral seizure threshold may occur when quinolones are given concurrently with theophylline, non-steroidal anti-inflammatory drugs, or other drugs, which lower the seizure threshold.

- Vitamin K antagonists

Increased coagulation tests (PT/INR) and/or bleeding, which may be severe, have been reported in patients treated with ofloxacin in combination with a vitamin K antagonist (e.g. warfarin). Coagulation should be monitored in patients treated with vitamin K antagonists.

- Probenecid, cimetidine, furosemide or methotrexate

Probenecid decreased the total clearance of ofloxacin by 24%, and increased AUC by 16%. The proposed mechanism is a competition or inhibition for active transport at the renal tubular excretion. Caution should be exercised when ofloxacin is co-administered with drugs that affect the tubular renal secretion (such as probencid, cimetidine, furosemide or methotrexate). Sudden reduction in blood pressure may occur when Ofloxacin is administered with hypotensive agents. In such cases, or if the drug is given concomitantly with barbiturate anaesthetics, cardiovascular function should be monitored.

- Drugs known to prolong QT interval

Ofloxacin, like other fluoroquinolones, should be used with caution in patients receiving drugs known to prolong the QT interval (e.g. Class IA and III anti-arrhythmics, tricyclic antidepressants, macrolides, and antipsychotics).

- Anticoagulant Therapy

Concurrent administration with anticoagulant therapy may require adjustment of the dose of the latter as prolongation of bleeding time has been reported. In a study with phencourmarin no interactions were noted.

- Glibenclamide

Ofloxacin may cause a slight increase in serum concentrations of glibenclamide administered concurrently; it is therefore recommended that patients treated concomitantly with ofloxacin and glibenclamide be monitored particularly closely.
Concomitant use with some phenylpropionic acid derived non-steroidal anti-inflammatory drugs may lead to toxicity possibly because of renal effects.
Ofloxacin may inhibit the growth of Mycobacterium tuberculosis, and, therefore, may give false-negative results in the bacteriological diagnosis of tuberculosis.

- Opiates

In patients treated with ofloxacin, determination of opiates or porphyrins in urine may give false-positive results. It may be necessary to confirm positive opiate screens by more specific method.

	Ornidazole Not recommended associations • Alcohol consumption Anti-abuse effect (heat, redness, vomiting, tachycardia). Avoid taking alcoholic drinks and drugs containing alcohol. Associations to take into account • Fluorouracil (and by extrapolation, tegafur and capecitabine) Increase in the toxicity of fluorouracil by reducing its clearance. Special monitoring of the combination with coumarin-type anticoagulants, although the potentiation of the anticoagulant effect was not observed with ornidazole. Particular problems of the INR imbalance: Many cases of increased activity of oral anticoagulants have been reported in patients receiving antibiotics. The marked infectious or inflammatory context, the age and general condition of the patient appear to be risk factors. Under these circumstances, it appears difficult to distinguish between the infectious pathology and its treatment in the occurrence of the INR imbalance. However, certain classes of antibiotics are more involved: these include fluoroquinolones, macrolides, cyclins, co-trimoxazole and certain cephalosporins.
	4.6 Pregnancy and Lactation: **Ofloxacin** ***Pregnancy*** Based on a limited amount of human data, the use of fluoroquinolones in the first trimester of pregnancy has not been associated with an increased risk of major malformations or other adverse effects on pregnancy outcome. Animal studies have shown damage to the joint cartilage in immature animals but no teratogenic effects. Therefore, Ofloxacin must not be prescribed in pregnancy or in women at risk of pregnancy. ***Breast-feeding*** Ofloxacin is excreted in human breast milk in small amounts. Because of the potential for arthropathy and other serious toxicity in the nursing infant, breast feeding should be discontinued during treatment with ofloxacin. **Ornidazole** The administration of ornidazole during pregnancy and lactation should be avoided due to the lack of useful clinical and experimental data.
	4.7 Effects on ability to drive and use machine: Some adverse reactions (e.g. dizziness/vertigo, drowsiness, visual disturbance) may impair the patient's ability to concentrate and react, and therefore may constitute a risk in situations where these abilities are of special importance (e.g. driving a car or operating machinery). Therefore, patients should be warned of the potential risk of dizziness and confusion and advised not to drive or use machines if this type of disorder occurs.
	4.8 Undesirable Effects: **Ofloxacin** The information given below is based on data from clinical studies and on extensive post marketing experience.

System organ class	Common (≥1/100 to <1/10)	Uncommon (≥1/1,000 to <1/100)	Rare (≥1/10,000 to <1/1,000)	Very rare (< 1/10,000)	Not known (cannot be estimated from available data)*
Infections and infestations		Fungal infection, Pathogen resistance			
Blood and the lymphatic system disorders				Anaemia Haemolytic anaemia, Leukopenia, Eosinophilia, Thrombo-cytopenia	Agranulocytosis, Bone marrow failure
Immune system disorders			Anaphylactic reaction*, Anaphylactoid reaction*, Angioedema*	Anaphylactic shock*, Anaphylactoid shock*	
Metabolism and Nutrition disorders			Anorexia, Hypoglycaemic coma		Hypoglycaemia in diabetics treated with hypoglycaemic agents Hyperglycaemia
Psychiatric disorders**			Agitation, Sleep disorder, Insomnia	Psychotic disorder (for e.g. hallucination), Anxiety, Confusional state, Nightmares, Depression, Delirium, Memory impairment	Psychotic disorder and depression with self-endangering behaviour including suicidal ideation or suicide attempt Nervousness
Nervous system disorders**		Dizziness, Headache	Somnolence, Paraesthesia, Dysgeusia, Parosmia	Peripheral sensory neuropathy* Peripheral sensory motor neuropathy* Convulsion*, Extra-pyramidal symptoms or other disorders of muscular coordination	Tremor Dyskinesia Ageusia Syncope, Benign intracranial hypertension
Eye disorders**		Eye irritation	Visual disturbance		Uveitis

	Ear and labyrinth disorders**		Vertigo		Tinnitus, Hearing loss	Hearing impaired
	Cardiac disorders			Tachycardia		QT interval prolongation, **Ventricular arrhythmias, torsades de pointes (reported predominantly in patients with risk factors for QT prolongation)**
	Vascular disorders			Hypotension		
	Respiratory, thoracic and mediastinal disorders		Cough, Naso-pharyngitis	Dyspnoea, Bronchospasm		Allergic pneumonitis, Severe dyspnoea
	Gastro-intestinal disorders		Abdominal pain, Diarrhoea, Nausea, Vomiting	Enterocolitis, sometimes haemorrhagic	Pseudo-membranous colitis*	Dyspepsia Flatulence Constipation Pancreatitis, stomatitis
	Hepato-bilary disorders			Hepatic enzymes increased (ALAT, ASAT, LDH, gamma-GT and/or alkaline phosphatase) Blood bilirubin increased	Jaundice cholestatic	Hepatitis, which may be severe*, **Severe liver injury, including cases with acute liver failure, sometimes fatal, have been reported with ofloxacin, primarily in patients with underlying liver disorders**
	Skin and subcutaneous tissue disorders		Pruritus, Rash	Urticaria, Hot flushes, Hyperhidrosis Pustular rash	Erythema multiforme, Toxic epidermal necrolysis, Photo-sensitivity reaction*, Drug eruption Vascular purpura,	Stevens-Johnson syndrome; Acute generalized exanthemous pustulosis; drug rash,

				Vasculitis, which can lead in exceptional cases to skin necrosis	Exfoliative dermatitis
Musculoskeletal and Connective tissue disorders**			Tendonitis	Arthralgia, Myalgia, Tendon rupture (e.g. Achilles tendon) which may occur within 48 hours of treatment start and may be bilateral.	Rhabdomyolysis and/or Myopathy, Muscular weakness which may be of special importance in patients with myasthenia gravis, Muscle tear, muscle rupture Ligament rupture Arthritis
Renal and Urinary disorders			Blood creatinine increased	Acute renal failure	Acute interstitial nephritis
Congenital and familial/genetic disorders					Attacks of porphyria in patients with porphyria
General disorders and administration site conditions**					Asthenia Pyrexia Pain (including pain in back, chest, and extremities)

* post-marketing experience

**Very rare cases of prolonged (up to months or years), disabling and potentially irreversible serious drug reactions affecting several, sometimes multiple, system organ classes and senses (including reactions such as tendonitis, tendon rupture, arthralgia, pain in extremities, gait disturbance, neuropathies associated with paraesthesia, depression, fatigue, memory impairment, sleep disorders, and impairment of hearing, vision, taste and smell) have been reported in association with the use of quinolones and fluoroquinolones in some cases irrespective of pre-existing risk factors.

Ornidazole

Rarely: nausea, stomach pain, ataxia, dizziness, headache, confusion, rash.

Very rare cases of hepatitis have been reported.

At high dosage or in case of prolonged treatment: leukopenia.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It
allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via Pharmacovigilance Electronic Reporting System (PvERS) https://pv.pharmacyboardkenya.org/

	4.9 Overdosage: **Ofloxacin** The most important signs to be expected following acute overdose are CNS symptoms such as confusion, dizziness, impairment of consciousness and seizures, increases in QT interval as well as gastrointestinal reactions such as nausea and mucosal erosions.

	CNS effects including confusional state, convulsion, hallucination, and tremor have been observed in post marketing experience. In the event of overdose, symptomatic treatment should be implemented. ECG monitoring should be undertaken, because of the possibility of QT interval prolongation. Antacids may be used for protection of gastric mucosa. A fraction of ofloxacin may be removed from the body with haemodialysis. Peritoneal dialysis and CAPD are not effective in removing ofloxacin from the body. No specific antidote exists. **Ornidazole** No data available
5.	**Pharmacological properties**
	ATC code: J01RA09 **Therapeutic class: Antibiotic** **5.1 Pharmacodynamic Properties:** **Ofloxacin** Ofloxacin is a quinolone-carbolic acid derivative with a wide range of antibacterial activity against both gram negative and gram positive organisms. It inhibits bacterial DNA replication by blocking DNA topo-isomerases, in particular DNA gyrase. Therapeutic doses of ofloxacin are devoid of pharmacological effects on the voluntary or autonomic nervous systems. Fluoroquinolones have a concentration-dependent bactericidal activity, with a moderate post antibiotic effect. For this class of antimicrobials, the ratio between AUC and MIC or Cmax and MIC is predictive of clinical success. The antibacterial spectrum of ofloxacin is as follows (the sensitivity to ofloxacin may vary, depending on the epidemiology and level of resistance in the country concerned.) The prevalence of resistance may vary geographically and with time for selected species and local information on resistance is desirable, particularly when treating severe infections. As necessary, expert advice should be sought when the local prevalence of resistance is such that the utility of the agent in at least some types of infections is questionable. Resistance to ofloxacin is acquired through a stepwise process by target site mutations in both type II topoisomerases, DNA gyrase and topoisomerase IV. Other resistance mechanisms such as permeation barriers (common in Pseudomonas aeruginosa) and efflux mechanisms may also affect susceptibility to ofloxacin. **Ornidazole** Ornidazole is an anti-infective from the 5-nitro-imidazole family. It is converted to reduction products that interact with DNA to cause destruction of the helical DNA structure and strand, leading to a protein synthesis inhibition and cell death in susceptible organisms. Ornidazole is effective against *Trichomonas vaginalis, Entamoeba histolytica and Giardia lamblia (Giardia intestinalis)*, and also against certain anaerobic bacteria such as *Bacteroides and Clostridium spp., Fusobacterium spp., and anaerobic cocci.*
	5.2 Pharmacokinetics Properties: **Ofloxacin** Ofloxacin is an oxyquinolone anti-infective that is well absorbed, widely distributed, slightly metabolised in liver to inactive metabolites and excreted in urinary tract with T½ of 6 – 8

	hours. Ofloxacin concentrations in the urine and at the site of urinary tract infections exceed those measured in serum by 5 to 100-fold. **Ornidazole** *Absorption* Absorption is rapid. Maximum plasma concentration is reached within 2 to 3 hours after oral administration. *Distribution* After oral administration of a single 750 mg dose of ornidazole, the maximum plasma concentration is 11 µg / ml. The plasma half-life is 12-14 hours Ornidazole diffuses throughout the body, passes into the CSF and the placenta. Plasma protein binding is less than 15%. *Biotransformation* Ornidazole is metabolized by the liver at 95% Five free metabolites or glucuro- and sulfo-conjugates are identified. *Excretion* The elimination of ornidazole occurs mainly in the form of inactive metabolites, via the renal (65%) and biliary routes.
	5.3 Preclinical Safety data: **Ofloxacin** Toxicological studies have shown that administration of oxoquinolone antibacterial agents at doses higher than the therapeutic range can produce erosion of the cartilage in weight-bearing joints in immature animals of some species. No such lesions have been shown to occur in man to date. This product should not be prescribed for children. **Ornidazole** Ornidazole has been shown to be carcinogenic in animals, the relevance of these results in humans is not known.
6.	**Pharmaceutical particulars**
	6.1 List of Excipients: Microcrystalline cellulose, Croscarmellose Sodium, Disodium Edetate, Povidone (P.V.P.K.30), Purified Water, Colloidal Silicon Dioxide, Magnesium Stearate and Wincoat WT 2009 White IH (Hypromellose, Polyethylene Glycol 400, Titanium Dioxide and Purified Talc).
	6.2 Incompatibilities: Not applicable
	6.3 Shelf life: 24 months
	6.4 Special Precautions for storage: Store below 30°C.
	6.5 Nature and contents of container: 10 tablets in Alu-Alu blister pack, one such blisters in a printed carton along with pack insert.
	6.6 Special precautions for disposal: Not applicable
7.	**Marketing Authorization Holder:** Ajanta Pharma Limited Ajanta House, Charkop, Kandivli (West), Mumbai- 400 067,

	India **Manufacturing Site Address:** Ajanta Pharma Ltd. Mirza - Palashbari road Vill- Kokjhar Kamrup (R), Assam, India. Telephone : (0091) 022- 66061000 Fax : (0091) 022-66061200/300 e-mail : info@ajantapharma.com
8.	**Marketing Authorization Numbers:** H2022/CTD9157/20165
9.	**Date of first registration /renewal of the registration:** May 2022
10.	**Date of revision of text:**