Macrolides – Ketolides

Therapeutic Class Review (TCR)

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FDA-APPROVED INDICATIONS

Drug	Mfg.	AECB	AOM	CAP	Pharyngitis /Tonsillitis	Skin	Sinusitis	Others
azithromycin (Zithromax®)[1]	generic	X	X (> six months old)	X (> six months old)	X (> two years old)	X	X (> six months old)	▪ Non-gonoccocal urethritis and cervicitis due to *Chlamydia trachomatis* ▪ Prevention (taken alone or in combination with rifabutin) and treatment (taken in combination with ethambutol) of disseminated MAC in HIV patients
azithromycin ER suspension (Zmax®)[2]	Pfizer	--	--	X (> six months old)	--	--	X (Adults only)	
clarithromycin (Biaxin®)[3]	generic	X	X (> six months old)	X (> six months old)	X (> six months old)	X (> six months old)	X (> six months old)	▪ Prevention and treatment of disseminated MAC in HIV patients (> 20 months old) ▪ In combination with other drugs to treat *Helicobacter pylori*
clarithromycin ER (Biaxin XL®)[4]	generic	X (Adults only)	--	X (Adults only)	--	--	X (Adults only)	
erythromycin[5]	generic	--	X	X	X	X	X	▪ Respiratory tract infections ▪ Pertussis ▪ Diphtheria ▪ Legionnaire's disease ▪ PID ▪ Urethritis and cervicitis ▪ Syphilis ▪ Acne vulgaris ▪ Prevent recurrent attacks of rheumatic fever ▪ Gonorrhea ▪ Surgical infection prophylaxis with bowel preparation

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FDA-Approved Indications (continued)

Drug	Mfg.	AECB	AOM	CAP	Pharyngitis /Tonsillitis	Skin	Sinusitis	Others
telithromycin (Ketek™)[6]	Sanofi-Aventis	--	--	X (including MDRSP; Adults only)	--	--	--	▪ In 2007, the FDA removed the indications for AECB and sinusitis

Key: AECB = acute exacerbations of chronic bronchitis; AOM = acute otitis media; CAP = community acquired pneumonia; Skin = skin and skin structure infections; MAC = *Mycobacterium avium* complex; HIV = human immunodeficiency virus; PID = pelvic inflammatory disease; MDRSP = Multi-drug resistant *Streptococcus pneumoniae*

OVERVIEW

Erythromycin, the first macrolide, was introduced in 1952. Activity against gram-positive cocci and atypical pathogens made erythromycin a good treatment option for upper and lower respiratory tract infections and soft tissue infections. However, erythromycin does have several limitations such as variable absorption, short elimination half-life, gastrointestinal irritation, and lack of activity against *Hemophilus influenzae*. Both azithromycin (Zithromax) and clarithromycin (Biaxin) demonstrate better tolerability with more convenient dosing regimens and improved activity against *H. influenzae*.[7,8]

Telithromycin (Ketek), a ketolide, concentrates inside phagocytes and is effective against intracellular respiratory pathogens. Telithromycin provides effective coverage against many respiratory pathogens in a once daily oral formulation for adults. Serious adverse effects, drug interactions, and having only one indication limit the usefulness of telithromycin.

Joint guidelines from the American Thoracic Society (ATS) and Infectious Diseases Society of America (IDSA) for treatment of community-acquired pneumonia (CAP) published in 2007 recommend macrolides (e.g., erythromycin, clarithromycin, and azithromycin – strong recommendation) or doxycycline (weak recommendation) for adult patients who are otherwise healthy without risk factors for multi-drug resistant *S. pneumoniae*.[9] For adult outpatients with comorbidities including chronic heart, lung, renal, hepatic disorders, diabetes, alcoholism, malignancies, asplenia, immunosuppression, use of any antibiotic within the last three months or other risk factors for multi-drug resistant *S. pneumoniae*, first line therapy may include a respiratory fluoroquinolone (moxifloxacin, gemifloxacin, or levofloxacin 750 mg) or a beta-lactam plus a macrolide (strong recommendation). Beta-lactam selection may include one of the following: high dose amoxicillin 1 gm three times daily or amoxicillin/clavulanate. Other beta-lactam alternatives include ceftriaxone, cefpodoxime, or cefuroxime. Doxycycline may be used as an alternative to macrolides in combination with a beta-lactam. Antibiotics should be used judiciously with appropriate dosing in an effort to avoid antibiotic resistance.

Symptoms of chronic obstructive pulmonary disease (COPD) exacerbation include increased breathlessness, wheezing, chest tightness, increased cough and sputum, change of color and/or tenacity of sputum, and fever. Increased sputum volume and purulence indicates a bacterial cause, as does prior history of chronic sputum production.[10] According to the 2011 update of the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines, all patients with symptoms of COPD exacerbation should be treated with additional bronchodilators with or without glucocorticosteroids. Antibiotics should be given to patients with the following three cardinal symptoms: increased dyspnea,

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increased sputum volume, increased sputum purulence; or to those patients with increased sputum purulence and one other cardinal symptom; or those who require mechanical ventilation.

Current recommendations (2005) from IDSA list erythromycin as an alternative antibiotic for the treatment of skin and skin structure infections including impetigo.[11] Azithromycin and clarithromycin are indicated for skin and skin structure infections. Some strains of *Staphylococcus aureus* and *Streptococcus pyogenes* may be resistant. Updated treatment guidelines for management of skin and skin structure from IDSA were expected in the fall of 2011, but to date (February 2012), new guidelines have not yet been released.

Macrolides have a limited role in the management of acute sinusitis. According to the 2007 American Academy of Otolaryngology guidelines on the treatment of adult sinusitis, adults with mild or moderate acute bacterial rhinosinusitis (ABRS) may be observed with watchful waiting. For those with severe ABRS, or the patient worsens or fails to improve with watchful waiting, therapy with amoxicillin should begin.[12] If treatment failure is observed following seven days of antibiotic therapy, a nonbacterial cause or infection with drug-resistant bacteria should be considered and should prompt a switch to alternate antibiotic therapy and re-evaluation of the patient. Optimal therapy of multidrug-resistant *Streptococcus pneumoniae* and beta-lactamase–producing *Hemophilus influenzae* and *Moraxella catarrhalis* would include high-dose amoxicillin-clavulanate (4 g per day amoxicillin equivalent) or a respiratory fluoroquinolone (levofloxacin, moxifloxacin, or gemifloxacin). These agents would also cover less common pathogens. Patients with penicillin allergy could receive a fluoroquinolone. Updated IDSA guidelines for the management of acute and chronic rhinosinusitis are expected in the spring of 2012.

The 2010 Centers for Disease Control and Prevention (CDC) guidelines for the treatment of sexually transmitted diseases (STDs) list azithromycin as a recommended regimen for the treatment of chancroid, nongonococcal urethritis, cervicitis, and *Chlamydia* infections.[13] Erythromycin base and erythromycin estolate are considered alternative regimens for several infections; however, the gastrointestinal adverse effects of erythromycin may reduce the effectiveness of the therapy if treatment is not completed.

The current CDC guidelines from 2005 (expected to be updated by the end of 2012) recommend erythromycin, azithromycin, or clarithromycin for the post-exposure prophylaxis or treatment of Pertussis.[14]

Azithromycin or clarithromycin are the preferred prophylactic agents for *Mycobacterium avium complex* (MAC) according to the 2009 joint guidelines from the CDC, IDSA, and NIH for prevention and treatment of opportunistic infections in HIV-infected adults and adolescents.[15] The combination of clarithromycin and rifabutin is no more effective than clarithromycin alone for chemoprophylaxis, is associated with a higher rate of adverse effects than either drug alone, and should not be used. The combination of azithromycin with rifabutin is more effective than azithromycin alone; however, the additional cost, increased occurrence of adverse effects, potential for drug interactions, and absence of a survival difference compared with azithromycin alone do not warrant a routine recommendation for this regimen.

Initial treatment of MAC disease should consist of two or more antimycobacterial drugs to prevent or delay the emergence of resistance with clarithromycin being a preferred first agent.[16] Clarithromycin has been studied more extensively than azithromycin in patients with acquired immunodeficiency syndrome (AIDS) and appears to have a more rapid clearance of MAC from the blood. Azithromycin

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may be used in place of clarithromycin when drug interactions or drug intolerance are a concern. Ethambutol is the recommended second drug for the treatment of MAC. Patients with a history of disseminated MAC disease should receive lifelong secondary prophylaxis (chronic maintenance therapy), unless immune reconstitution occurs as a result of antiretroviral therapy.

Macrolides have been shown to be useful agents in the treatment of upper respiratory bacterial infections including community-acquired pneumonia (CAP), acute sinusitis, and acute otitis media (AOM). Antibiotic resistance may limit the overall effectiveness of the agents in this class as multi-drug resistant bacteria become more prevalent.

PHARMACOLOGY

Macrolide and ketolide antibiotics bind to the 50S ribosomal subunit of susceptible bacteria inhibiting RNA-dependent protein synthesis.[17] They may be bacteriostatic or bactericidal, depending on drug concentration and are generally active against, gram positive cocci and bacilli, and to a lesser extent, gram negative cocci.[18] Telithromycin (Ketek) exhibits concentration-dependent bactericidal activity against isolates of *Streptococcus pneumoniae*, including multi-drug resistant *S. pneumoniae* (MDRSP). Telithromycin has been shown to be active against erythromycin- and azithromycin-resistant strains of *S. pneumoniae* and *Streptococcus pyogenes*.[19,20,21]

Bacterial resistance

Resistance to antibiotics is a public health problem. MDRSP is becoming a more common pathogen in CAP. In a US surveillance study, macrolide use was identified as a risk factor for macrolide-resistant *S. pneumoniae* when macrolides had been used in the six weeks prior to specimen collection.[22] Macrolide-resistant isolates of group A streptococci collected in 2002 and 2003 were observed in 6.1 percent of 2,797 pharyngeal isolates.[23]

PHARMACOKINETICS

Drug	Bioavailability (%)	Half-life (hrs)	Metabolites	Excretion (%)
azithromycin (Zithromax)[24]	38	68	--	Predominantly bile
azithromycin ER suspension (Zmax)[25]	83	59	--	Predominantly bile
clarithromycin (Biaxin)[26]	50 (250 mg)	3 – 4 (250 mg) 5 – 7 (500 mg)	14-OH clarithromycin (active)	Urine: dose dependent 20 (250mg) 30 (500mg) 40 (suspension)
clarithromycin (Biaxin XL)[27]	--	--	14-OH clarithromycin (active)	--
erythromycin[28]	Varies with salt and formulation	1.5 – 2	No active metabolites	Urine: <5 Predominantly bile
telithromycin (Ketek)[29]	57	10	4 metabolites	Urine: 13 Feces: 44

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CONTRAINDICATIONS/WARNINGS[30,31,32,33]

Clostridium difficile-associated diarrhea has been reported with nearly all antibacterials and may range in severity from mild diarrhea to fatal colitis. Treatment with antibacterial agents alters the normal flora of the colon leading to overgrowth of *C. difficile*. *C. difficile* produces toxins A and B, which contribute to the development of *C. difficile*-associated diarrhea. Hypertoxin-producing strains of *C. difficile* cause increased morbidity and mortality, as these infections can be refractory to antimicrobial therapy and may require colectomy. *C. difficile*-associated diarrhea must be considered in all patients who present with diarrhea following antibiotic use. Careful medical history is necessary since *C. difficile*-associated diarrhea has been reported to occur over two months after the administration of antibacterial agents. If *C. difficile*-associated diarrhea is suspected or confirmed, ongoing antibiotic use not directed against *C. difficile* may need to be discontinued. Appropriate fluid and electrolyte management, protein supplementation, antibiotic treatment of *C. difficile*, and surgical evaluation should be instituted as clinically indicated.

azithromycin (Zithromax, Zmax)[34,35]

Azithromycin is contraindicated in patients with known hypersensitivity to azithromycin, erythromycin or any other macrolide or ketolide antibiotic. Serious allergic reactions, including angioedema, anaphylaxis, and dermatologic reactions including Stevens-Johnson syndrome and toxic epidermal necrolysis have been reported rarely in patients receiving azithromycin. Despite initially successful symptomatic treatment of the allergic symptoms, when symptomatic therapy was discontinued, allergic symptoms recurred soon thereafter in some patients without further azithromycin exposure. These patients required prolonged periods of observation and symptomatic treatment. The relationship of these episodes to the long tissue half-life of azithromycin and subsequent prolonged exposure to antigen is unknown at present. If an allergic reaction occurs, the drug should be discontinued and appropriate therapy should be instituted. Physicians should be aware that reappearance of the allergic symptoms may occur when symptomatic therapy is discontinued.

Azithromycin is safe and effective in the treatment of CAP due to *Chlamydia pneumoniae, Haemophilus influenzae, Mycoplasma pneumoniae,* or *Streptococcus pneumoniae* in patients appropriate for oral therapy. Azithromycin should not be used in patients with pneumonia who are judged to be inappropriate for oral therapy because of moderate to severe illness or risk factors such as any of the following: patients with cystic fibrosis, patients with nosocomially acquired infections, patients with known or suspected bacteremia, patients requiring hospitalization, elderly or debilitated patients, or patients with significant underlying health problems that may compromise their ability to respond to their illness (including immunodeficiency or functional asplenia).

Exacerbations of symptoms of myasthenia gravis and new onset of myasthenic syndrome have been reported in patients receiving azithromycin and clarithromycin therapy.

Caution should be exercised when azithromycin ER suspension (Zmax) is administered to patients with glomerular filtration rate (GFR) <10 mL/min. This is due to a higher incidence of gastrointestinal adverse events (8 of 19 subjects) observed in a limited number of subjects with GFR <10 mL/min.

Prolonged cardiac repolarization and QT interval, imparting a risk of developing cardiac arrhythmia and torsades de pointes, have been seen in treatment with other macrolides. A similar effect with azithromycin cannot be completely ruled out in patients at increased risk for prolonged cardiac repolarization.

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Azithromycin is contraindicated in patients with a history of cholestatic jaundice/hepatic dysfunction associated with prior use of azithromycin. Abnormal liver function, hepatitis, cholestatic jaundice, hepatic necrosis, and hepatic failure have been reported, some of which have resulted in death. Discontinue azithromycin immediately if signs and symptoms of hepatitis occur.

clarithromycin (Biaxin, Biaxin XL)[36]

Clarithromycin is contraindicated in patients with hypersensitivity to clarithromycin or any other macrolide antibiotic. Clarithromycin is also contraindicated in combination with cisapride, pimozide, astemizole, terfenadine, ergotamine, and dihydroergotamine due to the risk of potentially fatal cardiac arrhythmias including QT prolongation, ventricular tachycardia, ventricular fibrillation, and torsades de pointes. Arrhythmias are likely due to inhibition of metabolism of erythromycin and clarithromycin.

For patients with severe renal impairment with or without coexisting hepatic impairment, decreased clarithromycin dosage or prolonged dosing intervals may be appropriate.

Concomitant administration of clarithromycin and colchicine is contraindicated in patients with renal or hepatic impairment.

Clarithromycin should not be given to patients with history of QT prolongation or ventricular cardiac arrhythmia, including *torsades de pointes*.

Clarithromycin should not be used concomitantly with HMG-CoA reductase inhibitors (statins), lovastatin or simvastatin, due to the risk of rhabdomyolysis. Treatment with these agents should be discontinued during clarithromycin treatment.

Clarithromycin should not be used in pregnant women except in clinical circumstances where no alternative therapy is appropriate. If pregnancy occurs while taking this drug, the patient should be apprised of the potential hazard to the fetus. Clarithromycin has demonstrated adverse effects of pregnancy outcome and/or embryo-fetal development in monkeys, rats, mice, and rabbits at doses that produced plasma levels two to 17 times the serrum levels achieved in humans treated at the maximum recommended human dose.

erythromycin[37]

Erythromycin is contraindicated in patients receiving any of the following drugs: cisapride, pimozide, astemizole, or terfenadine.

Allergic reactions ranging from urticaria to anaphylaxis have occurred with erythromycin. Skin reactions ranging from mild eruptions to erythema multiforme, Stevens-Johnson syndrome, and toxic epidermal necrolysis have been reported rarely.

There have been reports of hepatic function impairment, including increased liver enzymes, and hepatocellular and/or cholestatic hepatitis, with or without jaundice, occurring in patients receiving oral erythromycin.

Erythromycin may aggravate the weakness of patients with myasthenia gravis.

There have been reports of infantile hypertrophic pyloric stenosis (IHPS) occurring in infants following erythromycin therapy. A manufacturer noted one cohort of 157 newborns who were given erythromycin for pertussis prophylaxis, seven neonates (five percent) developed symptoms of non-bilious vomiting or irritability with feeding and were subsequently diagnosed as having IHPS requiring

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surgical pyloromyotomy. A possible dose-response effect was described with an absolute risk of IHPS of 5.1 percent for infants who took erythromycin for eight to 14 days and 10 percent for infants who took erythromycin for 15-21 days. Since erythromycin may be used in the treatment of conditions in infants which are associated with significant mortality or morbidity (such as pertussis or neonatal *Chlamydia trachomatis* infections), the benefit of erythromycin therapy needs to be weighed against the potential risk of developing IHPS. Parents should be informed to contact their physician if vomiting or irritability with feeding occurs.

telithromycin (Ketek)[38]

Telithromycin is contraindicated in patients with a history of hypersensitivity to telithromycin and/or any components of tablets, or any macrolide antibiotic. Telithromycin is contraindicated in patients with a history of jaundice and/or hepatitis secondary to any macrolide antibiotic. Concurrent administration of cisapride or pimozide with telithromycin is contraindicated.

Telithromycin is contraindicated in patients with myasthenia gravis. Fatal and life-threatening respiratory failure have been reported in patients with myasthenia gravis after receiving telithromycin and even within the first few hours after the first dose.

Telithromycin is a strong CYP 3A4 inhibitor, and an interaction may occur while using both drugs at their recommended doses. If coadministration of telithromycin and colchicine is necessary in patients with normal renal and hepatic function, the dose of colchicine should be reduced. Patients should be monitored for clinical symptoms of colchicine toxicity. Concomitant administration of telithromycin and colchicine is contraindicated in patients with renal or hepatic impairment.

Acute hepatic failure and severe liver toxicity, including fatal events and life-threatening events requiring liver transplantation, have been reported with telithromycin. Serious events reportedly occur after a few doses of telithromycin and progress very rapidly. If liver injury is suspected, patients should discontinue telithromycin immediately and be evaluated for liver injury (fulminant hepatitis and hepatic necrosis). Elevation of hepatic liver enzymes with hepatitis both with and without jaundice has been reported with telithromycin use. Events are generally reversible; however, more serious liver toxicity has recently been reported.[39]

Telithromycin also may cause QTc prolongation in patients with risk factors for QTc prolongation (uncorrected hypokalemia or hypomagnesemia, concurrent antiarrhythmics, or severe bradycardia) or those with congenital QTc interval prolongation. Cases of torsades de pointes have been reported following telithromycin.

Visual disturbances including the slowing of ability to accommodate and visual blurring have been reported. Females under 40 years of age appear to have the highest incidence of visual disturbance (2.1 versus zero percent for comparators). Patients should be aware of how this may impact driving and/or operating of machinery.

Transient loss of consciousness has been reported with telithromycin. Due to the potential for visual disturbances and loss of consciousness, patients should minimize driving or use of heavy machinery or other hazardous activities while on telithromycin.

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DRUG INTERACTIONS

azithromycin (Zithromax, Zmax)[40]

Antacids containing aluminum or magnesium salts reduce the bioavailability of azithromycin.

Although, in a study of 22 healthy men, a five-day course of azithromycin did not affect the prothrombin time from a subsequently administered dose of warfarin, spontaneous post-marketing reports suggest that concomitant administration of azithromycin may potentiate the effects of oral anticoagulants. Prothrombin times should be carefully monitored while patients are receiving azithromycin and oral anticoagulants concomitantly.

Coadministration of nelfinavir at steady-state with a single oral dose of azithromycin resulted in increased azithromycin serum concentrations. Although a dose adjustment of azithromycin is not recommended when administered in combination with nelfinavir, close monitoring for known side effects of azithromycin, such as liver enzyme abnormalities and hearing impairment, is warranted.

clarithromycin (Biaxin, Biaxin XL)[41]

Clarithromycin and erythromycin are substrates and inhibitors of the cytochrome (CYP) P450 3A enzyme family. Clinically significant drug interactions due to inhibition of the 3A family by clarithromycin include disopyramide and quinidine, which can lead to torsades de pointes; ergotamine and dihydroergotamine, which can lead to acute ergot toxicity including vasospasm and ischemia of extremities; triazolam and alprazolam, which can lead to increased pharmacological effect of the benzodiazepines; itraconazole, atazanavir (Reyataz®), saquinavir (Invirase®) (increased exposure of clarithromycin and antiretroviral), and simvastatin and lovastatin, which may lead to increased risk of myopathy. Concurrent administration of clarithromycin and terfenadine is contraindicated.

Colchicine is a substrate for CYP450 3A4 enzyme and the efflux transporter, P-glycoprotein (Pgp). Digoxin is thought to be a substrate for the efflux transporter, P-glycoprotein (Pgp). Clarithromycin is an inhibitor of both CYP450 3A4 and Pgp which may result in a higher exposure to colchicine and digoxin. Patients should be monitored for clinical symptoms of colchicine toxicity. Serum digoxin concentrations should be monitored while patients are receiving clarithromycin concurrently.

Clarithromycin has been shown to interact with carbamazepine, oral anticoagulants, theophylline, and ritonavir (Norvir®, Kaletra®). Consider monitoring carbamazepine levels. Prothrombin times or INR should be carefully monitored while patients are receiving clarithromycin and oral anticoagulants. Serum theophylline concentrations, monitoring should be considered for patients receiving high doses of theophylline or with baseline concentrations in the upper therapeutic range. Ritonavir increases clarithromycin levels significantly; however, dosage adjustments in patients with normal renal function are not necessary. Patients with impaired renal function and taking ritonavir should have clarithromycin dose reduced in the following manner: creatinine clearance (CrCl) 30-60 mL/min – reduce clarithromycin dose by 50 percent; CrCl<30 mL/min – reduce clarithromycin dose by 75 percent.

Bradyarrhythmias, hypotension, and lactic acidosis have been observed in patients receiving concurrent verapamil with clarithromycin.

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Interactions that have been reported with erythromycin and/or clarithromycin include alfentanil, bromocriptine, cyclosporine, disopyramide, hexobarbital, phenytoin, pimozide, rifabutin, tacrolimus, methylprednisolone, and valproate.

Clarithromycin tablets and zidovudine doses should be staggered to avoid the decreased absorption of zidovudine. There is no decrease in absorption of zidovudine when administered with clarithromycin suspension.

Coadministration of clarithromycin and erythromycin with sildenafil (Viagra®), tadalafil (Cialis®), or vardenafil (Levitra®) may result in increased phosphodiesterase inhibitor exposure. Reduction of sildenafil, tadalafil, and vardenafil dosages should be considered when these drugs are coadministered with clarithromycin.

Concurrent administration of oral midazolam and clarithromycin should be avoided as the midazolam area under the curve (AUC) is increased by seven-fold with coadministration with clarithromycin. Cautious use is warranted with administration of other benzodiazepines metabolized by the CYP 3A system, including triazolam and alprazolam.

Tolterodine (Detrol®, Detrol LA®) is metabolized by CYP2D6; however, in a subset of patients devoid of CYP2D6, the identified pathway of metabolism is via CYP3A. In this population subset, inhibition of CYP3A results in significantly higher serum concentrations of tolterodine. A reduction in tolterodine dosage may be necessary in the presence of CYP3A inhibitors, such as clarithromycin in the CYP2D6 poor metabolizer population.

erythromycin

Erythromycin has been shown to interact with oral anticoagulants, theophylline, and digoxin. Consider monitoring digoxin levels. Prothrombin times or INR should be carefully monitored while patients are receiving erythromycin and oral anticoagulants. Serum theophylline levels monitoring should be considered for patients receiving high doses of theophylline or with baseline concentrations in the upper therapeutic range.

Rhabdomyolysis with or without renal impairment has been reported in seriously ill patients receiving erythromycin concomitantly with lovastatin. Therefore, patients receiving concomitant lovastatin and erythromycin should be carefully monitored for creatine kinase (CK) and serum transaminase levels.

telithromycin (Ketek)[42]

Telithromycin has been shown to be a strong inhibitor of the CYP450 3A4 enzyme. Telithromycin is contraindicated with cisapride and pimozide. Concurrent use of telithromycin with atorvastatin (Lipitor®), lovastatin, or simvastatin should be avoided due to the potential for elevated serum levels of the statin and subsequent increased risk of myopathy.

Coadministration telithromycin and drugs metabolized by CYP450 3A4 enzyme, the following drugs may lead to increased levels or prolonged action of these drugs: carbamazepine, hexobarbital, cyclosporine, tacrolimus (Prograf®), and sirolimus (Rapamune®).

Due to enzyme induction by phenytoin, phenobarbital, and carbamazepine, lower telithromycin levels may occur. Patients on rifampin should not receive telithromycin due to enzyme induction by rifampin and expected lower levels of telithromycin.

Monitor digoxin levels with concurrent telithromycin therapy.

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Increased INR values have been observed with concurrent telithromycin and warfarin administration. Monitoring of the INR is recommended. Heart failure patients on metoprolol may have a greater exposure to metoprolol due to inhibition of CYP 2D6 by telithromycin. Monitoring to determine possible increased effects of metoprolol is recommended.

Coadministration of telithromycin and ergot alkaloid derivatives (such as ergotamine or dihydroergotamine) is not recommended and may result in acute ergot toxicity characterized by severe peripheral vasospasm and dysesthesia as it has been reported when macrolide antibiotics were coadministered.

Bradyarrhythmias, hypotension, and lactic acidosis have been observed in patients receiving concurrent calcium channel blockers with telithromycin.

In patients treated with metoprolol for heart failure, the increased exposure to metoprolol, a CYP 2D6 substrate, may be of clinical importance. Therefore, co-administration of telithromycin and metoprolol in patients with heart failure should be considered with caution.

ADVERSE EFFECTS

Drug	Diarrhea	Nausea	Abdominal pain	Rash	Dizziness	↑ ALT/AST
azithromycin (Zithromax)[43,44]	5	3	3	<1	<1	1-2
adults multiple dose single 1 gram dose	7	5	5	nr	nr	reported
children 30 mg/kg x 1 dose 10 mg/kg x 3days 5 day treatment	4.3 2.6 1.8-5.8	1 0.4 0.5-1.9	1.4 1.7 1.2-3.4	1 1.6 0.4-1.6	reported reported reported	reported reported reported
azithromycin (Zmax)[45] adults	12	4	3	<1	<1	<1/<1
children	7-10	4	2-4	5	nr	<1/<1
clarithromycin (Biaxin)[46] adults	3	3	2	3	reported	<1/<1
children	6	nr	3	3	nr	nr
clarithromycin (Biaxin XL)[47]	6	3	nr	nr	reported	<1/<1
erythromycin[48]	7.3	7.5	7.5	nr	2.3	nr
telithromycin (Ketek)[49]	10-10.8	7-7.9	nr	0.2-2	2.8-3.7	1.6 (> 3x ULN)

Adverse effects are reported as a percentage. Adverse effects data are obtained from package inserts and are not meant to be comparative or all inclusive. nr = not reported. AST = aspartate aminotransferase. ALT = alanine aminotransferase

Abnormal taste has been reported in three percent of adults and seven percent of pediatric patients receiving clarithromycin (Biaxin). With clarithromycin ER (Biaxin XL), abnormal taste was reported in seven percent of adult patients.[50] Reports of alterations of the sense of smell including smell loss,

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usually in conjunction with taste perversion or taste loss and tooth discoloration, usually reversible with professional dental cleaning in patient receiving clarithromycin (Biaxin).

SPECIAL POPULATIONS[51,52,53,54]

Pediatrics

Safety and efficacy of telithromycin (Ketek) in patients less than 18 years of age have not been established.

Clarithromycin (Biaxin) has been FDA-approved for treatment of children six months of age and older for acute otitis media, CAP, pharyngitis/tonsillitis, skin and skin structure infections, and acute bacterial sinusitis. For the management of MAC, clarithromycin has been studied in children 20 months of age and older. Clarithromycin ER (Biaxin XL) is not indicated for children.

Azithromycin (Zithromax) has been approved for use in children six months of age and older for the treatment of AOM, CAP, and acute sinusitis. Azithromycin has been approved for use in children two years of age and older in the treatment of pharyngitis and tonsillitis. The safety and efficacy of azithromycin in the prevention and treatment of disseminated MAC infections in HIV+ children have not been established. Limited safety data are available for children five months to 18 years of age who were treated for opportunistic infections. Azithromycin ER (Zmax) is approved for the treatment of CAP in children six months of age and older as a single dose treatment. Safety and effectiveness of azithromycin ER (Zmax) in children with acute bacterial sinusitis have not been established.

Pregnancy

Azithromycin and erythromycin are Pregnancy Category B. Clarithromycin, clarithromycin ER, and telithromycin are Pregnancy Category C. Clarithromycin should not be used in pregnancy unless the potential benefit justifies the potential risk to the fetus.

Alaska Native persons

A surveillance study evaluated the antimicrobial resistance in *Helicobacter pylori* isolates from Alaska Native persons during 1999 to 2003.[55] A total of 964 biopsy specimens were obtained from 687 patients with 51 percent of cultures being positive for *H. pylori*. Metronidazole resistance was noted in 44 percent of isolates. Clarithromycin resistance was observed in 31 percent of isolates and amoxicillin resistance was observed in two percent of isolates. No resistance to tetracyclines was observed in the trial. Females were more likely to have metronidazole resistance ($p<0.01$) and clarithromycin resistance ($p=0.05$). These resistance rates were higher than observed in other areas of the US, according to the authors.

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DOSAGES[56,57,58,59]

Drug	AECB Dosage	Duration (Days)	Sinusitis Dosage	Duration (Days)	AOM Dosage	Duration (Days)	CAP Dosage	Duration (Days)
azithromycin (Zithromax) 100, 200 mg/5mL suspension; 250, 500, 600 mg tablet; 1 g powder packet	500 mg for one dose, then 250 mg daily on days 2 – 5 or 500 mg daily for three days	3 – 5	500 mg daily **pediatrics**: > six months of age: 10 mg/kg for three days	3	**pediatrics**: > six months of age: 10 mg/kg for one dose, then 5 mg/kg daily on days 2 – 5 or 30 mg/kg for one dose, or 10 mg/kg/day for three days	1 - 5	500 mg for one dose, then 250 mg daily on days 2 – 5 or IV therapy: 500 mg daily IV for ≥ two days then oral 500 mg daily to complete seven to 10 days of therapy **pediatrics:** > six months of age: 10mg/kg for one dose, then 5 mg/kg daily on days 2 – 5	5 – 10
azithromycin ER suspension (Zmax) 2 g/60 mL suspension	--	--	2 g as one-time dose – take on empty stomach	1	--	--	2 g as one-time dose – take on empty stomach **pediatrics:** > six months of age: 60mg/kg as one-time dose, up to 2 g maximum. Take on empty stomach	1
clarithromycin (Biaxin) 125, 250 mg/5mL suspension; 250, 500 mg tablet	250 – 500 mg every 12 hours	7 – 14	500 mg every 12 hours **pediatrics**: > six months of age: 7.5 mg/kg every 12 hours	14	**pediatrics**: > six months of age: 7.5 mg/kg every 12 hours	10	250 mg every 12 hours **pediatrics**: > six months of age: 7.5 mg/kg every 12 hours	7 – 14

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Dosages (continued)

Drug	AECB Dosage	Duration (Days)	Sinusitis Dosage	Duration (Days)	AOM Dosage	Duration (Days)	CAP Dosage	Duration (Days)
clarithromycin ER (Biaxin XL) 500 mg ER tablet	1,000 mg daily	7	1,000 mg daily	14	--	--	1,000 mg daily	7
erythromycin (many)	--	--	250 – 500 mg (of base or stearate) every six hours or 400 – 800 mg (ethylsuccinate) every six hours **pediatrics**: 20 – 50 mg/kg/day in divided doses every six to 12 hours	7 – 14	**pediatrics**: 20 – 50 mg/kg/day in divided doses every six to 12 hours	10	250 – 500 mg (of base or stearate) every six hours or 400 – 800 mg (ethylsuccinate) every six hours **pediatrics**: 20 – 50 mg/kg/day in divided doses every six to 12 hours	7 – 14
telithromycin (Ketek) 300, 400 mg tablets	--	--	--	--	--	--	800 mg daily	7 – 10

- Azithromycin (Zithromax) oral suspension and azithromycin ER (Zmax) should be given at least one hour before or two hours after a meal. The tablets can be taken with or without food.
- If a patient vomits within five minutes of administration of azithromycin ER (Zmax), the health care provider should consider additional antibiotic treatment since minimal absorption of azithromycin would be expected. Since insufficient data exist on absorption of azithromycin if a patient vomits between five and 60 minutes following administration, alternative therapy should be considered. Neither a second dose of azithromycin ER nor alternative treatment is warranted if vomiting occurs ≥60 minutes following administration, in patients with normal gastric emptying. In patients with delayed gastric emptying, alternative therapy should be considered.
- Clarithromycin (Biaxin) tablets and oral suspension may be taken with or without food. Clarithromycin ER (Biaxin XL) should be taken with food.
- Telithromycin (Ketek) may be given without regard for food. Telithromycin (Ketek) dose should be reduced to 600 mg daily for patients with severe renal impairment (CrCl < 30 mL/min). No dosage adjustment is warranted for hepatic impairment unless concurrent renal impairment is also present.

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Dosages (continued)[60,61,62,63]

Drug	Prevention of disseminated MAC infections in HIV+ patients		Treatment of disseminated MAC infections in HIV+ patients	
	Adults	Children	Adults	Children
azithromycin (Zithromax)	1,200 mg weekly	--	600 mg daily	--
clarithromycin (Biaxin)	500 mg twice daily	7.5 mg/kg twice daily	500 mg twice daily	7.5 mg/kg twice daily

CLINICAL TRIALS

Search Strategies

Studies were identified through searches performed on PubMed and review of information sent by manufacturers. Search strategy included the FDA-approved uses for all drugs in this class. Randomized, controlled trials performed in the United States comparing agents in this class within the last five years for the currently approved indications are considered the most relevant in this category. Studies with children were also included in the search. Studies included for analysis in the review were published in English, performed with human participants, and randomly allocated participants to comparison groups. In addition, studies must contain clearly stated, predetermined outcome measure(s) of known or probable clinical importance, use data analysis techniques consistent with the study question, and include follow-up (endpoint assessment) of at least 80 percent of participants entering the investigation. Despite some inherent bias found in all studies including those sponsored and/or funded by pharmaceutical manufacturers, the studies in this therapeutic class review were determined to have results or conclusions that do not suggest systematic error in their experimental study design. While the potential influence of manufacturer sponsorship/funding must be considered, the studies in this review have also been evaluated for validity and importance.

Numerous clinical trials have been published comparing azithromycin and clarithromycin in both the inpatient and outpatient settings. There is little evidence that one drug is better than others for the approved indications. Due to the more rapid rise in macrolide resistance among *S. pneumoniae* isolates in the United States in the last several years, only studies published since 2000 are included. Nationwide and regional variances in pathogens and susceptibility and resistance rates must be taken into consideration when evaluating studies. Many trials utilize investigator-blinded study designs, especially in the pediatric studies, where double-blind studies with suspension products are difficult. Many short-term clinical trials in outpatients with minor infections lose a significant portion of patients (greater than 25 percent) to a lack of follow-up. Only studies evaluating infections treated as outpatients were included.

Many trials performed with the macrolides and ketolides compare these products to other broad-spectrum antibiotics such as the fluoroquinolones, cephalosporins, and penicillins.

azithromycin (Zithromax) versus clarithromycin (Biaxin)

In a randomized, double-blind, double-dummy multicenter trial, azithromycin and clarithromycin were compared in 322 adults with AECB in the outpatient setting.[64] Patients were randomized to azithromycin 500 mg once daily for three days or clarithromycin 500 mg twice daily for ten days. The primary outcome was clinical response on days 21 to 24 in the modified intent-to-treat analysis (n=318). The clinical cure rates were similar, with 85 percent in the azithromycin group and 82 percent

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in the clarithromycin group (95% CI, -5.9 to 12). No differences in clinical cure rates or bacteriological success rates were identified when specific pathogens were evaluated. Adverse effects were similar between the groups with the most common being abdominal pain, diarrhea, and nausea. The manufacturer of azithromycin supported the study.

azithromycin ER suspension (Zmax) versus clarithromycin ER (Biaxin XL)

A phase III, multicenter, randomized, double-blind, double-dummy trial compared single-dose azithromycin and clarithromycin ER in 501 adults with mild to moderate CAP.[65] Azithromycin was given as a single 2 g dose, and clarithromycin ER was given as 1 g daily for seven days. Clinical cure rates at days 14 to 21 were 92.6 (187/202 patients) and 94.7 percent (198/209 patients) for azithromycin and clarithromycin, respectively, in the clinical per protocol population. Pathogen eradication rates were 91.8 percent (123/134 patients) for the azithromycin group and 90.5 percent (153/169 patients) for the clarithromycin ER group. Adverse event rates were similar for both groups, with most reported as mild to moderate in severity.

clarithromycin (Biaxin) versus clarithromycin ER (Biaxin XL)

Clarithromycin and clarithromycin ER were compared in 485 patients with AECB in a double-blind, randomized, parallel-group study.[66] Patients were ambulatory patients with AECB, purulent sputum, and a diagnosis of COPD with a FEV_1 of less than 70 percent of predicted value. Patients were given clarithromycin 500 mg twice daily for seven days or clarithromycin ER 1,000 mg daily for five days. Test of cure visit was scheduled at days 14 to 40. A total of 391 patients completed the follow-up. Clinical cure rates were similar between the groups (both 84 percent; 95% CI, -7.9 to 7.2). Microbiological eradication rates were 87 and 89 percent for clarithromycin ER and clarithromycin groups, respectively. Clarithromycin ER and clarithromycin adverse reaction rates were 13 and 18 percent, respectively; the rate of gastrointestinal complaints and abnormal taste were less in the clarithromycin ER group. Clarithromycin ER had significantly lower rates of abnormal taste (three and eight percent, p=0.012) compared to clarithromycin.

telithromycin (Ketek) versus clarithromycin (Biaxin)

Telithromycin and clarithromycin were compared in 416 adult patients with diagnosed CAP in a randomized, double-blind, double-dummy, parallel-group multicenter clinical trial.[67] Patients received either telithromycin 800 mg once daily (administered as two 400 mg encapsulated tablets in the morning) and placebo (administered as two encapsulated tablets identical to telithromycin in the evening) or high-dose clarithromycin 500 mg administered as two 250 mg identical encapsulated tablets twice daily for ten days. Clinical outcome was evaluated post-therapy and days 17 to 24 after the completion of therapy. Clinical cure rates determined on days 31 to 45 were 88.3 percent with telithromycin and 88.5 percent with clarithromycin. Bacterial eradication rates were comparable between treatment groups (telithromycin 87.5 percent; clarithromycin 96.7 percent). Both treatments were fairly well tolerated with mostly mild adverse effects.

Efficacy and safety of telithromycin and clarithromycin were compared in 575 adult patients with mild to moderate CAP in a multicenter, double-blind, active-controlled study in Canada.[68] Patients were randomized to telithromycin 800 mg once daily for five or seven days or clarithromycin 500 mg twice daily for ten days. A total of 466 patients completed the study. Clinical cure rates were 89.3 percent (telithromycin five days), 88.8 percent (telithromycin seven days), and 91.8 percent (clarithromycin

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group). For the identified pathogens, bacteriological eradication rates were similar among the three treatment groups. Eradication of *S. pneumoniae* was 95.8, 96.7, and 88.5 percent for telithromycin five days, telithromycin seven days, and clarithromycin, respectively. For *H. influenzae*, bacteriological eradication rates were 88, 84, and 88.2 percent for telithromycin five days, telithromycin seven days, and clarithromycin, respectively. Clinical efficacy was demonstrated in both the telithromycin groups for all cases with pneumococcal bacteremia (19/19 cases), atypical pathogens (9/9 cases), and erythromycin-resistant *S. pneumoniae* isolates (5/5 cases). Most common adverse effects were gastrointestinal in nature. Hospitalization rates for patients enrolled in the study were evaluated in a separate analysis.[69] Hospitalizations occurred in seven patients in the clarithromycin group compared to three patients in the telithromycin five-day group (p=0.283) and one patient in the seven-day group (p=0.021).

SUMMARY

Azithromycin, clarithromycin, and telithromycin are generally active against bacteria susceptible to erythromycin although the newer macrolides have enhanced activity against *H. influenzae*. Telithromycin may be active against some bacteria resistant to erythromycin in the treatment of adults with CAP. However, the risk of serious adverse events and drug interactions limit the usefulness of telithromycin. All erythromycin products have been reported to have a high incidence of gastrointestinal adverse effects. The newer macrolides are given once or twice a day and may have a lower incidence of gastrointestinal adverse effects.

Azithromycin, clarithromycin, and erythromycin have been studied in children for a variety of FDA-approved indications whereas telithromycin (Ketek) and clarithromycin (Biaxin XL) have not been approved for use in pediatric patients. Extended-release formulations of clarithromycin and azithromycin (Zmax) offer less frequent administration; however, comparative clinical trial data are limited.

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