SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Idotrim 100 mg film-coated tablets
Idotrim 160 mg film-coated tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

One film-coated tablet contains 100 mg or 160 mg trimethoprim.

Excipient with known effect: 52.3 mg or 83.6 mg lactose (as monohydrate), respectively

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Film-coated tablet (tablet).

100 mg tablets are white, film-coated, round, convex with a score line, with a diameter of 9 mm.
160 mg tablets are white, film-coated, round, convex with a score line, with a diameter of 11 mm.

The score line is not intended for breaking the tablet.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Uncomplicated lower urinary tract infection. Long-term prophylaxis of recurrent urinary tract infections.

4.2 Posology and method of administration

Posology
Adults
Treatment of uncomplicated lower urinary tract infection:
150–200 mg twice daily, or 300 mg for the night.

Long-term prophylaxis of recurrent urinary tract infections:
100 mg as a night dose.

Paediatric population
Treatment of uncomplicated lower urinary tract infection:
Children over 3 months: 3 mg/kg twice daily.
Children over 12 years: 150–200 mg twice daily, or 300 mg for the night.

Long-term prophylaxis of recurrent urinary tract infections:
Children over 3 months: 1–2 mg/kg/day as a night dose.
Children over 12 years: 100 mg as a night dose.

Patients with reduced renal function
In patients with renal impairment there is a risk for accumulation (see section 4.4).

The dose and/or dosing frequency of trimethoprim should be reduced for patients with renal impairment (eGFR < 30 ml/min) according to the severity of the condition.

Advised dosage schedule in patients with renal impairment:

eGFR (ml/min)	Dosage advised
Over 30	Normal
15–30	Normal for 3 days then half dose
Under 15	Half normal dose

Monitoring of renal function and serum electrolytes should be considered particularly with longer term use, in patients with impaired renal function.

Trimethoprim should only be initiated and used in dialysis patients under close supervision.

Trimethoprim is removed by dialysis.

Monitoring treatment
When treating older patients, patients with compromised general health status or patients suffering from malnutrition, and when antiepilectic drugs such as phenytoin, primidone and barbiturates are administered simultaneously, folic acid and blood count status must be checked regularly during treatment. Folic acid deficiency is reversible with leucovorin therapy.

4.3 Contraindications

- hypersensitivity to the active substance or to any of the excipients listed in section 6.1
- first trimester of pregnancy (see section 4.6)
- severe hepatic impairment
- megaloblastic anemia
- blood dyscrasia.

4.4. Special warnings and precautions for use

Trimethoprim may cause a depression of hematopoiesis due to interference of the drug in the metabolism of folic acid, particularly when given over a prolonged period or in high doses. The presence of clinical signs such as sore throat, fever, pallor, or purpura may be early indications of serious blood disorders.

The possibility that folic acid status and blood count may be affected must be taken into consideration. Caution should be administered if folate deficiency is suspected or proven. Regular haematological tests should be undertaken in long-term treatment of children and elderly patients and folate deficient patients. Supplementation with folinic acid may be considered during treatment.

Trimethoprim is known to be substantially excreted by the kidney, and the risk of toxic reactions may be greater in patients with impaired renal function. Caution should be exercised in the treatment of patients with impaired renal function and the dose adjustment should be considered according to the severity of the condition to avoid accumulation of trimethoprim (see section 4.2).

Monitoring of renal function and serum electrolytes should be considered particularly with longer term use.

Careful monitoring of serum potassium levels in patients at risk of hyperkalaemia. Concomitant use of medicinal products known to cause hyperkalaemia (e.g. spironolactone) with trimethoprim may result in severe hyperkalaemia.

Diarrhoea/pseudomembranous colitis caused by Clostridium difficile may occur. Patients with diarrhoea must therefore be carefully monitored.

Trimethoprim should be avoided in patients with porphyria.

Rises in serum creatinine and blood-urea nitrogen have been reported although it is unclear whether this represents genuine renal dysfunction or inhibition of tubular secretion of creatinine.

Severe cutaneous adverse reactions (SCARs)

Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), drug reaction with eosinophilia and systemic symptoms (DRESS), which can be life-threatening or fatal, have been reported in association with trimethoprim treatment (see section 4.8).

Patients should be advised of the signs and symptoms and monitored closely for skin reactions.

If signs and symptoms suggestive of these reactions appear, trimethoprim should be withdrawn immediately and an alternative treatment considered (as appropriate).

If the patient has developed a serious reaction such as SJS, TEN or DRESS with the use of trimethoprim, the treatment must not be restarted in this patient at any time.

Idotrim contains lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicinal product.

4.5. Interaction with other medicinal products and other forms of interaction

The following combinations with Idotrim may require dose adjustment:

Cyclosporine. Reversible deterioration of renal function has been observed in patients with kidney transplants who were treated simultaneously with trimethoprim and cyclosporine.

Phenytoin. Trimethoprim inhibits the metabolism of phenytoin, thus strengthening its effect. During combined therapy, plasma concentrations of phenytoin should be monitored.

Glibenclamide. In the Swedish side effect material, several cases of hypoglycaemia have occurred in patients treated with different sulfonylureas (chlorpropamide, glibenclamide, glipizide) when they received trimethoprim+sulfamethoxazole. In experimental studies, both components have been shown to reduce tolbutamide clearance. Interaction studies in the relevant patient group show that trimethoprim-sulfamethoxazole does not interact pharmacokinetically with glibeclamide.

Rifampicin. In HIV-infected patients treated with trimethoprim+sulfamethoxazole, the plasma concentration decreased by 47 % (trimethoprim) and 23 % (sulfamethoxazole) when rifampicin was started due to concomitant tuberculosis infection.

Zidovudine. Trimethoprim inhibits renal clearance of zidovudine and its glucuronide by 50 % and 20 %, respectively. This interaction may be of clinical significance during concomitant inhibition of glucuronidation, e.g. in the case of liver disease.
Zidovudine prolongs the half-life of trimethoprim by 77 %. This suggests that zidovudine increases the risk of dose-dependent side effects of trimethoprim.

Warfarin. Trimethoprim + sulfamethoxazole inhibits the metabolism of warfarin, increasing its effects. The metabolism of warfarin is inhibited stereoselectively in that the plasma concentration of the most potent enantiomer of warfarin increases. It has been suggested that also trimethoprim alone may potentiate the effects of warfarin.

Drug that can cause hyperkalemia (e.g. potassium-sparing diuretics e.g. spironolactone and ACE inhibitors). In addition to other medicinal products known to cause hyperkalaemia concomitant use of trimethoprim with e.g. spironolactone may result in clinically relevant hyperkalaemia. Caution should be exercised in concomitant use with trimethoprim due to risk for hyperkalaemia.

Trimethoprim may increase risk of diuretic-induced hyponatraemia.

Trimethoprim may increase the serum concentration of digoxin and dapsone. Dapsone may also increase the serum trimethoprim concentration.

The risk of folic acid deficiency and megaloblastic anaemia may be increased by the concomitant use of pyrimethamine and methotrexate.

Concomitant use with bone marrow depressants may increase the risk of bone marrow aplasia.

Administration of trimethoprim may interfere with the Jaffe alkaline picrate reaction assay for creatinine.

4.6. Fertility, pregnancy and lactation

Pregnancy

Trimethoprim is contraindicated during the first trimester of pregnancy (see section 4.3). Studies in animals have shown a teratogenic effect.

Epidemiological studies have shown an increased risk of spontaneous abortion and congenital malformations, in particular neural tube defects, oral clefts and cardiovascular defects, in children of mothers treated with trimethoprim during the first trimester of pregnancy. The presumed mechanism of action is thought to be interference with folates.

In the second and third trimesters, use should be avoided, unless clinically necessary. If trimethoprim treatment during pregnancy is regarded as absolutely necessary, the patient’s folic acid status should be monitored and leucovorin administered.

Breastfeeding
Trimethoprim is excreted in human milk, but at therapeutic doses of Idotrim no effects on the breastfed newborns/infants are anticipated.

4.7. Effects on ability to drive and use machines

Idotrim has no or negligible influence on the ability to drive and use machines.

4.8. Undesirable effects

The most common side effects are gastrointestinal reactions (6 %) and skin rash (3 %).

Side effects are classified as follows: very common (≥ 1/10), 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), frequency not known (cannot be estimated from the available data)

Organ system	Frequency	Side effects
Blood and lymphatic system disorders	Uncommon	Eosinophilia, leukopaenia
	Rare	Megaloblastic anaemia, thrombocytopaenia, agranulocytosis
	Not known	Neutropenia, methemoglobinemia
Metabolism and nutrition disorders	Very rare	Hyperkalaemia
Psychiatric disorders	Very rare	Hallucinations
Nervous system disorders	Rare	Aseptic meningitis
Eye disorder	Rare	Conjunctivitis
	Very rare	Uveitis
Gastrointestinal disorders	Common	Nausea, vomiting, glossitis
	Rare	Pseudomembranous colitis, diarrhoea
Hepatobiliary disorders	Not known	Disturbances of liver enzyme values, cholestasis and cholestatic jaundice
Skin and subcutaneous tissue disorders	Common	Itching, exanthem
	Uncommon	Urticaria
	Rare	Photo-sensitisation. Stevens-Johnson syndrome, erythema multiforme
	Very rare	Toxic epidermal necrolysis
	Not known	Drug reaction with eosinophilia and systemic symptoms (DRESS)
General disorders and administration site conditions	Rare	Hypersensitivity reactions such as fever, angiooedema and anaphylactic reactions
	Very rare	Serum sickness

Fungal overgrowth in the oral cavity and genital area may occur.

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 the national reporting system listed in Appendix V.

4.9. Overdose

Toxicity:

Up to 700 mg as a single dose to children aged 2–3 years gave no symptoms. 8 g to an adult gave mild intoxication.

Symptoms: Nausea, vomiting, diarrhoea. Headache, vertigo. Skin reactions. Symptoms of folic acid deficiency with effect on e.g. blood-producing organs and the liver are mostly attributed to long-term administration at high doses and to high dose and very poor kidney function.
Treatment: Active coal. Ensure good diuresis. Symptomatic treatment. (Calcium folinate is given as prophylaxis to avoid changes in blood count in the case of very poor kidney function and high dose and in the case of long-term administration of high doses).

5. PHARMACOLOGICAL PROPERTIES

5.1. Pharmacodynamic properties

Pharmacotherapeutic group: Antibacterials for systemic use,Trimethoprim and derivatives. ATC code: J01EA01.

Mechanism of action
Trimethoprim is a bacteriostatic substance, which specifically inhibits dihydrofolic acid reductase of microorganisms.

Susceptibility testing breakpoints
MIC (minimum inhibitory concentration) interpretive criteria for susceptibility testing have been established by the European Committee on Antimicrobial Susceptibility Testing (EUCAST) for trimethoprim and are listed here: https://www.ema.europa.eu/documents/other/minimum-inhibitory-concentration-mic-breakpoints_en.xlsx

Antibacterial spectrum

Sensitive	Enterococci *Staphylococcus saprophyticus* *E coli, Enterobacter, Klebsiella* and *Proteus*
Resistant	Beta-haemolytic Group B streptococci *Acinetobacter* *Pseudomonas* Anaerobic bacteria

Resistance occurs (1–10 %) in *Staphylococcus saprophyticus* and is common (> 10 %) in gram-negative gut bacteria.

Resistance varies geographically. Information about the local resistance conditions should be obtained from a local microbiology laboratory.

5.2. Pharmacokinetic properties

Absorption
Trimethoprim is practically fully absorbed after peroral administration. Maximum serum concentration is reached after about 2 hours.

Distribution
Binding to plasma proteins is about 40 %.

Elimination
Half-life in the serum is about 10 hours. Elimination mostly takes place via kidneys; about 50 % is excreted in unchanged form within 24 hours.
At continuous dosing of Idotrim 100 mg as a night dose urine concentration varies between 30 and 80 µg/ml, which is a sufficient concentration in prevention of recurrence of urinary tract infection caused by sensitive bacteria.

Patients with renal impairment
In patients with severe renal impairment (creatinine clearance <30 ml/min) the half-life of trimethoprim is prolonged which requires dose adjustment (see section 4.2).

5.3. Preclinical safety data

There are no relevant preclinical data for safety assessment besides those already taken into account in the summary of product characteristics.

6. PHARMACEUTICAL PARTICULARS

6.1. List of excipients

100 and 160 mg film-coated tablets:
Tablet core
Lactose monohydrate
Maize starch
Starch, pregelatinised
Povidone
Polysorbate 80
Crospovidone
Cellulose, microcrystalline
Magnesium stearate.

Film-coating
Hypromellose
Propylene glycol.

6.2. Incompatibilities

Not applicable.

6.3. Shelf life

3 years.

6.4. Special precautions for storage

This medicinal product does not require any special temperature storage conditions. Store in the original package in order to protect from light.

6.5. Nature and contents of container

100 mg tablets: Plastic bottles of 30 and 100 tablets.

160 mg tablets: Plastic bottles of 14, 20 and 100 tablets.

Not all pack sizes may be marketed.

6.6. Special precautions for disposal and other handling

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

7. MARKETING AUTHORISATION HOLDER

Orion Corporation
Orionintie 1
FI-02200 Espoo
Finland

8. MARKETING AUTHORISATION NUMBER

To be completed nationally

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

To be completed nationally

10. DATE OF REVISION OF THE TEXT

2026-05-13