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CONTENTS

Duricef—Cont.

HOW SUPPLIED

DURICEF® (cefadroxil monohydrate, USP) 500 mg Capsules: opaque, maroon and white hard gelatin capsules, imprinted with "PPP" and "784" on one end and with "DURICEF" and "500 mg" on the other end. Capsules are supplied as follows:

NDC 0087-0784-07	Bottle of 20
NDC 0087-0784-46	Bottle of 50
NDC 0087-0784-42	Bottle of 100
NDC 0087-0784-44	10 strips of 10 individually labeled blisters with 1 capsule per blister

Store at controlled room temperature (15°-30° C).

DURICEF® 1 gram Tablets: white to off white, top bisected, oval shaped, imprinted with "PPP" on one side of the bisect and "785" on the other side of the bisect. Tablets are supplied as follows:

NDC 0087-0785-43	Bottle of 50
NDC 0087-0785-42	Bottle of 100
NDC 0087-0785-45	4 packs of 10 individually labeled blisters with 1 tablet per blister

Store at controlled room temperature (15°-30° C).

DURICEF® for Oral Suspension is orange-pineapple flavored, and is supplied as follows:

125 mg/5 mL	**NDC** 0087-0786-42	50 mL Bottle
	NDC 0087-0786-41	100 mL Bottle
250 mg/5 mL	**NDC** 0087-0782-42	50 mL Bottle
	NDC 0087-0782-41	100 mL Bottle
500 mg/5 mL	**NDC** 0087-0783-42	50 mL Bottle
	NDC 0087-0783-05	75 mL Bottle
	NDC 0087-0783-41	100 mL Bottle

Prior to reconstitution: Store at controlled room temperature (15°-30° C).

REFERENCES

1. National Committee for Clinical Laboratory Standards, Approved Standard, *Performance Standards for Antimicrobial Disk Susceptibility Test*, 4th Edition, Vol. 10 (7): M2-A4, Villanova, PA, April, 1990. 2. National Committee for Clinical Laboratory Standards, Approved Standard: *Methods for Dilution Antimicrobial Susceptibility Tests for Bacteria that Grow Aerobically*, 2nd Edition, Vol. 10 (8): M7-A2, Villanova, PA, April, 1990.

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Bristol-Myers Squibb Company
Princeton, NJ 08543
USA

Shown in Product Identification Guide, page 307

ESTRACE® Rx
(ESTRADIOL VAGINAL CREAM, USP, 0.01%)
[es'trāce]

ESTRACE® Rx
(ESTRADIOL TABLETS, USP)

Rx only

WARNINGS

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA IN POSTMENOPAUSAL WOMEN.

Close clinical surveillance of all women taking estrogens is important. Adequate diagnostic measures, including endometrial sampling when indicated, should be undertaken to rule out malignancy in all cases of undiagnosed persistent or recurring abnormal vaginal bleeding. There is no evidence that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

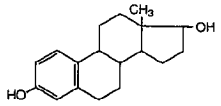
2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.

There is no indication for estrogen therapy during pregnancy or during the immediate postpartum period. Estrogens are ineffective for the prevention or treatment of threatened or habitual abortion. Estrogens are not indicated for the prevention of postpartum breast engorgement.

Estrogen therapy during pregnancy is associated with an increased risk of congenital defects in the reproductive organs of the fetus, and possibly other birth defects. Studies of women who received diethylstilbestrol (DES) during pregnancy have shown that female offspring have an increased risk of vaginal adenosis, squamous cell dysplasia of the uterine cervix, and clear cell vaginal cancer later in life; male offspring have an increased risk of urogenital abnormalities and possibly testicular cancer later in life. The 1985 DES Task Force concluded that use of DES during pregnancy is associated with a subsequent increased risk of breast cancer in the mothers, although a causal relationship remains unproven and the observed level of excess risk is similar to that for a number of other breast cancer risk factors.

DESCRIPTION

Estradiol (17β-estradiol) is a white, crystalline solid, chemically described as estra-1,3,5(10)-triene-3,17β-diol. It has an empirical formula of $C_{18}H_{24}O_2$ and molecular weight of 272.37. The structural formula is:



ESTRACE® (Estradiol Vaginal Cream, USP) contains 0.1 mg estradiol per gram in a nonliquefying base containing purified water, propylene glycol, stearyl alcohol, white ceresin wax, glyceryl monostearate, hydroxypropyl methylcellulose, 2208 4000 cps, sodium lauryl sulfate, methylparaben, edetate disodium and *tertiary*-butylhydroquinone.

ESTRACE® (Estradiol Tablets, USP) for oral administration contains 0.5, 1 or 2 mg of micronized estradiol per tablet.

ESTRACE Tablets, 0.5 mg, contain the following inactive ingredients: acacia, dibasic calcium phosphate, lactose, magnesium stearate, colloidal silicon dioxide, starch (corn), and talc.

ESTRACE Tablets, 1 mg, contain the following inactive ingredients: acacia, D&C Red No. 27 (aluminum lake), dibasic calcium phosphate, FD&C Blue No. 1 (aluminum lake), lactose, magnesium stearate, colloidal silicon dioxide, starch (corn), and talc.

ESTRACE Tablets, 2 mg, contain the following inactive ingredients: acacia, dibasic calcium phosphate, FD&C Blue No. 1 (aluminum lake), FD&C Yellow No. 5 (tartrazine) (aluminum lake), lactose, magnesium stearate, colloidal silicon dioxide, starch (corn), and talc.

CLINICAL PHARMACOLOGY

Estrogen drug products act by regulating the transcription of a limited number of genes. Estrogens diffuse through cell membranes, distribute themselves throughout the cell, and bind to and activate the nuclear estrogen receptor, a DNA-binding protein which is found in estrogen-responsive tissues. The activated estrogen receptor binds to specific DNA sequences, or hormone-response elements, which enhance the transcription of adjacent genes and in turn lead to the observed effects. Estrogen receptors have been identified in tissues of the reproductive tract, breast, pituitary, hypothalamus, liver, and bone of women.

Estrogens are important in the development and maintenance of the female reproductive system and secondary sex characteristics. By a direct action, they cause growth and development of the uterus, fallopian tubes, and vagina. With other hormones, such as pituitary hormones and progesterone, they cause enlargement of the breasts through promotion of ductal growth, stromal development, and the accretion of fat. Estrogens are intricately involved with other hormones, especially progesterone, in the processes of the ovulatory menstrual cycle and pregnancy, and affect the release of pituitary gonadotropins. They also contribute to the shaping of the skeleton, maintenance of tone and elasticity of urogenital structures, changes in the epiphyses of the long bones that allow for the pubertal growth spurt and its termination, and pigmentation of the nipples and genitals.

Estrogens occur naturally in several forms. The primary source of estrogen in normally cycling adult women is the ovarian follicle, which secretes 70 to 500 micrograms of estradiol daily, depending on the phase of the menstrual cycle. This is converted primarily to estrone, which circulates in roughly equal proportion to estradiol, and to small amounts of estriol. After menopause, most endogenous estrogen is produced by conversion of androstenedione, secreted by the adrenal cortex, to estrone by peripheral tissues. Thus, estrone—especially in its sulfate ester form—is the most abundant circulating estrogen in postmenopausal women. Although circulating estrogens exist in a dynamic equilibrium of metabolic interconversions, estradiol is the principal intracellular human estrogen and is substantially more potent than estrone or estriol at the receptor.

Estrogens used in therapy are well absorbed through the skin, mucous membranes, and gastrointestinal tract. When applied for a local action, absorption is usually sufficient to cause systemic effects. When conjugated with aryl and alkyl groups for parenteral administration, the rate of absorption of oily preparations is slowed with a prolonged duration of action, such that a single intramuscular injection of estradiol valerate or estradiol cypionate is absorbed over several weeks.

Administered estrogens and their esters are handled within the body essentially the same as the endogenous hormones. Metabolic conversion of estrogens occurs primarily in the liver (first pass effect), but also at local target tissue sites. Complex metabolic processes result in a dynamic equilibrium of circulating conjugated and unconjugated estrogenic forms which are continually interconverted, especially between estrone and estradiol and between esterified and nonesterified forms. Although naturally-occurring estrogens circulate in the blood largely bound to sex hormone-binding globulin and albumin, only unbound estrogens enter target tissue cells. A significant proportion of the circulating estrogen exists as sulfate conjugates, especially estrone sulfate, which serves as a circulating reservoir for the formation of more active estrogenic species. A certain proportion of the estrogen is excreted into the bile and then reabsorbed from the intestine. During this enterohepatic recirculation, estrogens are desulfated and resulfated and undergo degradation through conversion to less active estrogens (estriol and other estrogens), oxidation to nonestrogenic substances (catecholestrogens, which interact with catecholamine metabolism, especially in the central nervous system), and conjugation with glucuronic acids (which are then rapidly excreted in the urine).

When given orally, naturally-occurring estrogens and their esters are extensively metabolized (first pass effect) and circulate primarily as estrone sulfate, with smaller amounts of other conjugated and unconjugated estrogenic species. This results in limited oral potency. By contrast, synthetic estrogens, such as ethinyl estradiol and the nonsteroidal estrogens, are degraded very slowly in the liver and other tissues, which results in their high intrinsic potency. Estrogen drug products administered by non-oral routes are not subject to first-pass metabolism, but also undergo significant hepatic uptake, metabolism, and enterohepatic recycling.

INDICATIONS AND USAGE

ESTRACE® (Estradiol Vaginal Cream, USP, 0.01%) is indicated in the treatment of vulval and vaginal atrophy.

ESTRACE® (Estradiol Tablets, USP) is indicated in the:

1. Treatment of moderate to severe vasomotor symptoms associated with the menopause. There is no adequate evidence that estrogens are effective for nervous symptoms or depression which might occur during menopause and they should not be used to treat these conditions.

2. Treatment of vulval and vaginal atrophy.

3. Treatment of hypoestrogenism due to hypogonadism, castration or primary ovarian failure.

4. Treatment of breast cancer (for palliation only) in appropriately selected women and men with metastatic disease.

5. Treatment of advanced androgen-dependent carcinoma of the prostate (for palliation only).

6. Prevention of osteoporosis.

Since estrogen administration is associated with risk, selection of patients should ideally be based on prospective identification of risk factors for developing osteoporosis. Unfortunately, there is no certain way to identify those women who will develop osteoporotic fractures. Most prospective studies of efficacy for this indication have been carried out in white menopausal women, without stratification by other risk factors, and tend to show a universally salutary effect on bone. Thus, patient selection must be individualized based on the balance of risks and benefits. A more favorable risk/benefit ratio exists in a hysterectomized woman because she has no risk of endometrial cancer (see BOXED WARNINGS).

Estrogen replacement therapy reduces bone resorption and retards or halts postmenopausal bone loss. Case-control studies have shown an approximately 60 percent reduction in hip and wrist fractures in women whose estrogen replacement was begun within a few years of menopause. Studies also suggest that estrogen reduces the rate of vertebral fractures. Even when started as late as 6 years after menopause, estrogen prevents further loss of bone mass for as long as the treatment is continued. The results of a two-year, randomized, placebo-controlled, double-blind, dose-ranging study have shown that treatment with 0.5 mg estradiol daily for 23 days (of a 28 day cycle) prevents vertebral bone mass loss in postmenopausal women. When estrogen therapy is discontinued, bone mass declines at a rate comparable to the immediate postmenopausal period. There is no evidence that estrogen replacement therapy restores bone mass to premenopausal levels.

At skeletal maturity there are sex and race differences in both the total amount of bone present and its density, in favor of men and blacks. Thus, women are at higher risk than men because they start with less bone mass and, for several years following natural or induced menopause, the rate of bone mass decline is accelerated. White and Asian women are at higher risk than black women. Early menopause is one of the strongest predictors for the development of osteoporosis. In addition, other factors affecting the skeleton which are associated with osteoporosis include genetic factors (small build, family history), and endocrine factors (nulliparity, thyrotoxicosis, hyperparathyroidism, Cushing's syndrome, hyperprolactinemia, Type I diabetes), lifestyle (cigarette smoking, alcohol abuse, sedentary exercise habits) and nutrition (below average body weight, dietary calcium intake).

The mainstays of prevention and management of osteoporosis are estrogen, adequate lifetime calcium intake, and ex-

exercise. Postmenopausal women absorb dietary calcium less efficiently than premenopausal women and require an average of 1500 mg/day of elemental calcium to remain in neutral calcium balance. By comparison, premenopausal women require about 1000 mg/day and the average calcium intake in the USA is 400–600 mg/day. Therefore, when not contraindicated, calcium supplementation may be helpful. Weight-bearing exercise and nutrition may be important adjuncts to the prevention and management of osteoporosis. Immobilization and prolonged bed rest produce rapid bone loss, while weight-bearing exercise has been shown both to reduce bone loss and to increase bone mass. The optimal type and amount of physical activity that would prevent osteoporosis have not been established, however in two studies, an hour of walking and running exercise twice or three times weekly significantly increased lumbar spine bone mass.

CONTRAINDICATIONS

Estrogens should not be used in individuals with any of the following conditions:

1. Known or suspected pregnancy (see BOXED WARNINGS). Estrogens may cause fetal harm when administered to a pregnant woman.
2. Undiagnosed abnormal genital bleeding.
3. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease.
4. Known or suspected estrogen-dependent neoplasia.
5. Active thrombophlebitis or thromboembolic disorders.

WARNINGS

1. Induction of malignant neoplasms.

Endometrial cancer. The reported endometrial cancer risk among unopposed estrogen users is about 2- to 12-fold greater than in non-users, and appears dependent on duration of treatment and on estrogen dose. Most studies show no significant increased risk associated with use of estrogens for less than one year. The greatest risk appears associated with prolonged use—with increased risks of 15- to 24-fold for five to ten years or more. In three studies, persistence of risk was demonstrated for 8 to over 15 years after cessation of estrogen treatment. In one study a significant decrease in the incidence of endometrial cancer occurred six months after estrogen withdrawal. Concurrent progestin therapy may offset this risk but the overall health impact in postmenopausal women is not known (see PRECAUTIONS).

Breast Cancer. While the majority of studies have not shown an increased risk of breast cancer in women who have ever used estrogen replacement therapy, some have reported a moderately increased risk (relative risks of 1.3-2.0) in those taking higher doses or those taking lower doses for prolonged periods of time, especially in excess of 10 years. Other studies have not shown this relationship.

While the effects of added progestins on the risk of breast cancer are also unknown, available epidemiological evidence suggests that progestins do not reduce, and may enhance, the moderately increased breast cancer incidence that has been reported with prolonged estrogen replacement therapy (see PRECAUTIONS).

Congenital lesions with malignant potential. Estrogen therapy during pregnancy is associated with an increased risk of fetal congenital reproductive tract disorders, and possibly other birth defects. Studies of women who received DES during pregnancy have shown that female offspring have an increased risk of vaginal adenosis, squamous cell dysplasia of the uterine cervix, and clear cell vaginal cancer later in life; male offspring have an increased risk of urogenital abnormalities and possibly testicular cancer later in life. Although some of these changes are benign, others are precursors of malignancy.

2. Gallbladder disease. Two studies have reported a 2- to 4-fold increase in the risk of gallbladder disease requiring surgery in women receiving postmenopausal estrogens.

3. Cardiovascular disease. Large doses of estrogen (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown in a large prospective clinical trial in men to increase the risks of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. These risks cannot necessarily be extrapolated from men to women. However, to avoid the theoretical cardiovascular risk to women caused by high estrogen doses, the dose for estrogen replacement therapy should not exceed the lowest effective dose.

4. Elevated blood pressure. Occasional blood pressure increases during estrogen replacement therapy have been attributed to idiosyncratic reactions to estrogens. More often, blood pressure has remained the same or has dropped. One study showed that postmenopausal estrogen users have higher blood pressure than nonusers. Two other studies showed slightly lower blood pressure among estrogen users compared to nonusers. Postmenopausal estrogen use does not increase the risk of stroke. Nonetheless, blood pressure should be monitored at regular intervals with estrogen use.

5. Hypercalcemia. Administration of estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases. If this occurs, the drug should be stopped and appropriate measures taken to reduce the serum calcium level.

PRECAUTIONS

A. General

1. Addition of a progestin. Studies of the addition of a progestin for 10 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia than would be induced by estrogen treatment alone. Morphological and biochemical studies of endometria suggest that 10 to 14 days of progestin are needed to provide maximal maturation of the endometrium and to reduce the likelihood of hyperplastic changes.

There are, however, possible risks which may be associated with the use of progestins in estrogen replacement regimens. These include: (1) adverse effects on lipoprotein metabolism (lowering HDL and raising LDL) which could diminish the purported cardioprotective effect of estrogen therapy (see PRECAUTIONS below); (2) impairment of glucose tolerance; and (3) possible enhancement of mitotic activity in breast epithelial tissue, although few epidemiological data are available to address this point (see WARNINGS).

The choice of progestin, its dose, and its regimen may be important in minimizing these adverse effects, but these issues will require further study before they are clarified.

2. Cardiovascular risk. *A causal relationship between estrogen replacement therapy and reduction of cardiovascular disease in postmenopausal women has not been proven. Furthermore, the effect of added progestins on this putative benefit is not yet known.*

In recent years many published studies have suggested that there may be a cause-effect relationship between postmenopausal oral estrogen replacement therapy *without added progestins* and a decrease in cardiovascular disease in women. Although most of the observational studies which assessed this statistical association have reported a 20% to 50% reduction in coronary artery disease risk and associated mortality in estrogen takers, the following should be considered when interpreting these reports:

(1) Because only one of these studies was randomized and it was too small to yield statistically significant results, all relevant studies were subject to selection bias. Thus, the apparently reduced risk of coronary artery disease cannot be attributed with certainty to estrogen replacement therapy. It may instead have been caused by life-style and medical characteristics of the women studied with the result that healthier women were selected for estrogen therapy. In general, treated women were of higher socioeconomic and educational status, more slender, more physically active, more likely to have undergone surgical menopause, and less likely to have diabetes than the untreated women. Although some studies attempted to control for these selection factors, it is common for properly designed randomized trials to fail to confirm benefits suggested by less rigorous study designs. Thus, ongoing and future large-scale randomized trials may fail to confirm this apparent benefit.

(2) Current medical practice often includes the use of concomitant progestin therapy in women with intact uteri (see PRECAUTIONS and WARNINGS). While the effects of added progestins on the risk of ischemic heart disease are not known, all available progestins reverse at least some of the favorable effects of estrogens on HDL and LDL levels.

3. Physical examination. A complete medical and family history should be taken prior to the initiation of any estrogen therapy. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without reexamining the patient.

4. Hypercoagulability. Some studies have shown that women taking estrogen replacement therapy have hypercoagulability, primarily related to decreased antithrombin activity. This effect appears dose- and duration-dependent and is less pronounced than that associated with oral contraceptive use. Also, postmenopausal women tend to have increased coagulation parameters at baseline compared to pre-menopausal women. There is some suggestion that low dose postmenopausal mestranol may increase the risk of thromboembolism, although the majority of studies (of primarily conjugated estrogens users) report no such increase. There is insufficient information on hypercoagulability in women who have had previous thromboembolic disease.

5. Familial hyperlipoproteinemia. Estrogen therapy may be associated with massive elevations of plasma triglycerides leading to pancreatitis and other complications in patients with familial defects of lipoprotein metabolism.

6. Fluid retention. Because estrogens may cause some degree of fluid retention, conditions which might be exacerbated by this factor, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation.

7. Uterine bleeding and mastodynia. Certain patients may develop undesirable manifestations of estrogenic stimulation, such as abnormal uterine bleeding and mastodynia.

8. Impaired liver function. Estrogens may be poorly metabolized in patients with impaired liver function and should be administered with caution.

ESTRACE® (Estradiol Tablets, USP), 2 mg, contain FD&C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin hypersensitivity.

B. Information for the Patient. See text of Patient Package Insert below.

Advise patients that the number of doses per tube of ESTRACE® (Estradiol Vaginal Cream, USP, 0.01%) will vary with dosage requirements and patient handling.

C. Laboratory Tests. Estrogen administration should generally be guided by clinical response at the smallest dose, rather than laboratory monitoring, for relief of symptoms for those indications in which symptoms are observable. For prevention of osteoporosis, however, see DOSAGE AND ADMINISTRATION section under ESTRACE® (Estradiol Tablets, USP) item 5.

D. Drug/Laboratory Test Interactions.

1. Accelerated prothrombin time, partial thromboplastin time, and platelet aggregation time; increased platelet count; increased factors II, VII antigen, VIII antigen, VIII coagulant activity, IX, X, XII, VII-X complex, II-VII-X complex, and beta-thromboglobulin; decreased levels of anti-factor Xa and antithrombin III, decreased antithrombin III activity; increased levels of fibrinogen and fibrinogen activity; increased plasminogen antigen and activity.
2. Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 levels (by column or by radioimmunoassay) or T3 levels by radioimmunoassay. T3 resin uptake is decreased, reflecting the elevated TBG. Free T4 and free T3 concentrations are unaltered.
3. Other binding proteins may be elevated in serum, i.e., corticosteroid binding globulin (CBG), sex hormone-binding globulin (SHBG), leading to increased circulating corticosteroids and sex steroids, respectively. Free or biologically active hormone concentrations are unchanged. Other plasma proteins may be increased (angiotensinogen/renin substrate, alpha-1-antitrypsin, ceruloplasmin).
4. Increased plasma HDL and HDL-2 subfraction concentrations, reduced LDL cholesterol concentration, increased triglycerides levels.
5. Impaired glucose tolerance.
6. Reduced response to metyrapone test.
7. Reduced serum folate concentration.

E. Carcinogenesis, Mutagenesis, and Impairment of Fertility. Long term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, uterus, cervix, vagina, testis, and liver. See CONTRAINDICATIONS and WARNINGS.

F. Pregnancy Category X. Estrogens should not be used during pregnancy. See CONTRAINDICATIONS and BOXED WARNINGS.

G. Nursing Mothers. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk. In addition, estrogen administration to nursing mothers has been shown to decrease the quantity and quality of the milk.

F. Pediatric Use. Safety and effectiveness in pediatric patients have not been established. Large and repeated doses of estrogen over an extended period of time have been shown to accelerate epiphyseal closure, resulting in short adult stature if treatment is initiated before the completion of physiologic puberty in normally developing children. In patients in whom bone growth is not complete, periodic monitoring of bone maturation and effects on epiphyseal centers is recommended.

Estrogen treatment of prepubertal children also induces premature breast development and vaginal cornification, and may potentially induce vaginal bleeding in girls. In boys, estrogen treatment may modify the normal pubertal process. All other physiological and adverse reactions shown to be associated with estrogen treatment of adults could potentially occur in the pediatric population, including thromboembolic disorders and growth stimulation of certain tumors. Therefore, estrogens should only be administered to pediatric patients when clearly indicated and the lowest effective dose should always be utilized.

ADVERSE REACTIONS

The following additional adverse reactions have been reported with estrogen therapy (see WARNINGS regarding induction of neoplasia, adverse effects on the fetus, increased incidence of gallbladder disease, cardiovascular disease, elevated blood pressure, and hypercalcemia).

1. **Genitourinary system.**
   Changes in vaginal bleeding pattern and abnormal withdrawal bleeding or flow; breakthrough bleeding, spotting.
   Increase in size of uterine leiomyomata.
   Vaginal candidiasis.
   Change in amount of cervical secretion.

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