**Title Page**

**Title**: Fixed-dose combination antibiotics: the search for evidence using the example of ampicillin-cloxacillin

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**Abstract:** High consumption of irrational fixed-dose combination (FDC) antibiotics may pose a threat of antimicrobial resistance. In India, ampicillin-cloxacillin was the second highest sold FDC antibiotic behind amoxicillin and clavulanic acid. There however remain questions about its efficacy and safety and a lack of regulatory approval. We undertook a literature review for ampicillin-cloxacillin to identify available data on the safety and efficacy of its used as FDC. We identified 1071 studies for screening and 81 studies were considered for inclusion. Only 12 studies in English language were accessible full texts for final review. None of the studies identified provided strong evidence that ampicillin-cloxacillin differed in safety or efficacy to other treatments used, and in particular to the component antibiotics used alone. To fully assess the efficacy and safety of ampicillin-cloxacillin and other FDCs, a standardised search format would be required. This should include broad international collaboration, including contacting the relevant regulatory authorities to facilitate a more evidence based approach to their use.

**What is already known about this subject**

* FDC antibiotics are being consumed in large quantities in India, one of the highest consumers of antibiotics worldwide
* The inappropriate use of FDC antibiotics may be contributing to AMR
* There is a lack of summarised international evidence to support the use of FDC antibiotics

**What this study adds**

* An insight in to the lack of efficacy and safety evidence for one of the most consumed FDC antibiotics in India, ampicillin-cloxacillin
* An overview of the difficulties such a search entails and potential solutions for FDC antibiotic evaluation at national and global level.

**Introduction**

Emerging antimicrobial resistance (AMR) is a global public health crisis. One major concern is high consumption of clinically irrational fixed-dose combination (FDC) antibiotics, as it may potentially pose a threat to tackling AMR [1], an issue identified as early as the 1960s [2]. However, there remains limited data on FDC antibiotic use at an international level. Determining the evidence for the use of FDC antibiotics will be important for policy makers to strengthen regulations for manufacturing these drugs. For example, India is one of the largest consumers of antibiotics [3], and ampicillin-cloxacillin is the second highest sold FDC antibiotic in this country [1]. It is second only to co-amoxiclav; one of the most commonly used FDC antibiotics worldwide [4], an FDC comprising the penicillin class antibiotic amoxicillin and clavulanic acid, a β-lactam class drug that combats AMR by inhibiting bacterial β-lactamases [5]. In contrast, ampicillin-cloxacillin when sold as an FDC contains two different functional antibiotics, and has not been approved by the Central Drugs Standard Control Organization (CDSCO) in India, the UK Medicines and Healthcare Products Regulatory Agency (MHRA), the European Medicines Agency (EMA) or the US Food and Drug Administration (FDA) [1]. Although ampicillin-cloxacillin as FDC formulation has not been granted approval by many regulatory agencies, ampicillin and cloxacillin are listed separately in the WHO Model List of Essential Drugs. In India, ampicillin and cloxacillin were approved by CDSCO in August 1965. Dicloxacilin was approved by CDSCO in July 1978. In December 2006, CDSCO granted approval for ampicillin (250 mg) and dicloxacillin (250 mg) as FDC formulation in India. It also needs to be addressed that many FDCs are granted approvals by local authorities not CDSCO in India. Although there is not a clear clinical reason for using ampicillin-cloxacillin as an FDC, its continued use may be also related to the unavailability of cloxacillin independently in India [6]. In India and Nigeria, the use of this FDC has been reported for intravenous antibiotic prophylaxis in surgery and by oral or parenteral administration as empiric antibiotic therapy for infectious diseases in adults and children [7, 8]. There however remain questions about its efficacy and safety.

We undertook a literature review of papers for ampicillin-cloxacillin with the primary objective of summarising available data on the safety and efficacy of ampicillin-cloxacillin used as an FDC. A secondary objective was to explore the feasibility and potential challenges of systematically reviewing the safety and efficacy of FDC antibiotics generally.

**Methods**

We searched the PubMed database in November 2018, without language or date restrictions, using the terms “ampicillin AND cloxacillin” for clinical studies of ampicillin-cloxacillin FDCs administered to humans. Our broad search strategy aimed to be as inclusive as possible. We aimed to identify studies presenting data on efficacy or toxicity of ampicillin-cloxacillin as an FDC in any population. We excluded studies where ampicillin and cloxacillin were not used in FDCs, reviews, news articles, pharmacokinetic studies, in vitro studies and animal studies. We also searched ClinicalTrials.gov, the ISRCTN registry and the WHO International Clinical Trials Registry to identify any ongoing clinical trials for this FDC. Single screening of titles, abstracts and full text articles was carried out by BS, BB and YH; if a reviewer was unsure of a study’s eligibility, another reviewer was consulted.

**Results**

We identified 15 studies had accessible full texts (open access or available through our institutional library) with 1 further available study identified from the reference list (Figure 1). A total of 12 papers with accessible full texts were published in English. Ten papers were published before 1980 and 2 papers were after 2000.

One double-blind clinical trial from 1973 assessing ampicillin and cloxacillin prophylactic use in oral, pharyngeal and laryngeal cancer surgery [9]. The double-blind study from 1973 compared ampicillin and cloxacillin with a placebo in patients undergoing oral, laryngeal or pharyngeal surgery for neoplastic lesions [9]. The study reported the frequency of postoperative wound and respiratory infections to be higher among the placebo‐treated patients (36% versus 17%, p<0.05 [no further statistical details given]) and did not report any untoward effects from the FDC therapy. There were two randomised clinical trials which utilised ampicillin/cloxacillin FDCs as prophylaxis in elective Caesarean sections both published in the 2000s [10, 11]. There was limited data from the two most recent studies looking at its use as prophylaxis in Caesarean sections, carried out in Nigeria [10] and Sudan [11] respectively. The study carried out in Nigeria compared a single dose of ceftriaxone with multiple doses of a regimen comprising ampicillin-cloxacillin, gentamicin and metronidazole [10], so the relative efficacy of ampicillin-cloxacillin used alone could not be calculated. The study in Sudan compared a single dose of ceftriaxone with three doses of ampicillin-cloxacillin and did not find evidence of a difference in efficacy in preventing post-operative infection; however, the number of events recorded was small.

There was also a single-blind randomised trial comparing trimethoprim-sulphamethoxazole and ampiclox (ampicillin-cloxacillin in FDC) in older patients with severe exacerbations of chronic bronchitis that required hospitalization in 1970 [12]. The study included only 25 patients (12 receiving ampiclox and 13 receiving trimethoprim-sulphamethoxazole); treatment failed for one patient in each group. One case of sensitivity dermatitis was reported in the ampiclox group but no further side effects were reported [12].

A case series of children with septic arthritis in 1975 reported good outcomes with a treatment regimen including oral ampicillin/cloxacillin but did not include comparisons with other treatments and did not specify whether it was used in a FDC [13]. A separate case series looked at the side effects of different antibiotic therapies and the subsequent reported colitis and diarrhoea as a potential side effect of their use in orthopaedic inpatients in London during a 19-month period from 1973-74 [14]. Of 145 courses of ampicillin/cloxacillin prescribed, 25 (17.2%) were associated with diarrhoea. This was higher than reported for most of the other antibiotics and combinations reported, including ampicillin alone (4/42, 9.5%). Four of the full texts accessed were case reports [15-18]; these papers looked at the use of ampicillin and cloxacillin in a series of different contexts and for different populations, with some unclear as to whether it was used as a FDC so it is very difficult to draw firm conclusions from these.

One additional paper was identified from the reference lists of the screened studies [19] .This randomized, prospective study compared the efficacy of cefamandole naftate with a combination of ampicillin and cloxacillin as prophylaxis in cardiac surgery in 1982 [20].They reported the overall rate of infection to be lower for the group given cefamandole instead of ampicillin and cloxacillin (total infections equal to 1.7% for the group given cefamandole and 13.7% for the group given ampicillin plus cloxacillin) [20].

None of these studies provided strong evidence that ampicillin/cloxacillin differed in safety or efficacy to the other treatments used, and in particular to the component antibiotics used alone. However, difficulties interpreting the results of these1 studies include a lack of clarity as to whether ampicillin/cloxacillin was administered as an FDC or as separate drugs [13]; presentation of data for the ampicillin/cloxacillin group combined with other treatments [10]; publication before the development of reporting standards for trials and observational studies; and lack of comparison groups in case series and case reports.

Of the 66 papers considered for full text screening but not available as full text, 40 had abstracts available (30 in English and 10 in other languages: 4 in Japanese, 3 in French, 1 in German, 1 in Italian and 1 in Norwegian). A further 8 studies in Japanese did not have abstracts available and were mostly published in the Japanese Journal of Antibiotics. A further 6 potentially informative studies were in Italian, of which neither abstract nor full text were available in English, 4 German, 3 French (2 only abstracts and 1 unavailable) amongst several others including Norwegian, Thai and Russian. None of these papers appeared to report randomised controlled trials.

Our search of clinical trials registries identified one potentially relevant ongoing study: an open label trial comparing ampicillin/cloxacillin and ceftriaxone for empirical treatment of infective endocarditis in a hospital in Japan, although it is not explicitly stated that ampicillin/cloxacillin is given as an FDC [21].

**Discussion**

Given the high levels of use of antibiotic FDCs such as ampicillin-cloxacillin, including in the absence of relevant regulatory approvals [3], it is critical to evaluate their efficacy and safety. Our literature review highlights the paucity of the literature in one of the most commonly used FDC. It is unclear from the available data for which indications most FDCs are being used.

Although we did not aim to review the use of ampicillin-cloxacillin in routine practice, the studies which we identified were conducted in very specific indications, such as surgical prophylaxis and may not reflect the indications for which this FDC is used more generally (e.g. more common clinical scenarios such as skin and soft tissue infection). There is also very limited data in the older studies of the rationale for the dosing regimen used, while a range of dosing regimens may be available for the FDC in different countries. Most commonly no formal safety data has been submitted for registration to the relevant competent authorities and as no Summary of Product Characteristics (SPC) is available this has not been updated regularly as new data has been published.

This literature review also highlights difficulties in accessing some potentially informative literature, particularly older studies and those published in non-English language journals. Searching of other databases may also have yielded further results. In addition, national regulatory agencies may have access to further efficacy and safety data submitted by manufacturers applying for regulatory approval, which must also be considered in any assessment of the utility of antibiotic FDCs.

Despite the lack of evidence on FDC antibiotics, there is a need for appropriate FDC formulation for treatment. In 2018, Indian government took a courageous decision to ban 328 FDCs in Indian market. Their determination to tighten regulation on inappropriate FDC formulations is a role model for other countries to follow [22]. It is important to strengthen regulatory system to manufacture appropriate FDCs for clinical treatment.

**Conclusion**

To fully assess the efficacy and safety of ampicillin-cloxacillin and other FDCs, a standardised search format, including data on current use, efficacy, dosing and safety would be required for both national and international approaches. In addition, prospective and retrospective evaluation of evidence is needed at each national level. The rationale for using FDC antibiotics should be further explored and require studies to assess their efficacy, safety, and potential to accelerate antimicrobial resistant. This should include broad international collaboration, including contacting the relevant international regulatory authorities. Furthermore, international initiatives are needed to regulate the manufacturing and sales of these antibiotics. The next step would be an assessment of the most frequently used FDCs internationally and the development of a common protocol for their formal assessment.

The data that support the findings of this study are available from the

corresponding author upon reasonable request

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**Author contribution:**

YF and MS contributed to the concept. BS, BB, YF designed the search strategy and selection criteria. All authors contributed to the interpretation of the data. BS wrote the first draft of the manuscript. All authors reviewed and contributed to subsequent drafts and essential revisions of the manuscript. The corresponding author confirms that she had full access to all the data in the data and had final responsibility for the decision to submit the manuscript for publication.

**Data availability statement:**

The data that support the findings of this study are available from the corresponding author upon request.

**Conflict of Interest Statement:**

The authors declare no conflict of interest.

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**References**

1. McGettigan P, Roderick P, Kadam A, Pollock A. Threats to global antimicrobial resistance control: Centrally approved and unapproved antibiotic formulations sold in India. Br J Clin Pharmacol. 2019; 85:59-70.
2. Garland J. Editorial: Antibiotics in Fixed Combination. N Engl J Med. 1960; 262:255-256.
3. Van Boeckel TP, Gandra S, Ashok A, Caudron Q, Grenfell BT, Levin SA, Laxminarayan R. Global antibiotic consumption 2000 to 2010: an analysis of national pharmaceutical sales data. Lancet Infect Dis. 2014; 14:742-750.
4. Jackson C, Hsia Y, Bielicki JA, Ellis S, Stephens P, Wong ICK, Sharland M. Estimating global trends in total and childhood antibiotic consumption, 2011-2015. BMJ Glob Health. 2019; 27; 4:e001241.
5. Geddes AM, Klugman KP, Rolinson GN. Introduction: historical perspective and development of amoxicillin/clavulanate. Int J Antimicrob Agents. 2007; 30: Suppl 2:S109-S112.
6. Srinivasaraghavan R. and Dhandapany D. Non-availability of Cloxacillin – A Deterrent for Rational Antimicrobial Practice. Indian Pediatr. 2016; 53: 1032-1033
7. Umar, L.W., et al., Prescribing pattern and antibiotic use for hospitalized children in a Northern Nigerian Teaching Hospital. Ann Afr Me. 2018. 17: 26-32.
8. Dass, R., et al., Empyema thoracis: analysis of 150 cases from a tertiary care centre in North East India. Indian J Pediatr. 2011. 78: 1371-1377.
9. Dor P, Klastersky J. Prophylactic antibiotics in oral, pharyngeal and laryngeal surgery for cancer: (a double-blind study). Laryngoscope. 1973; 83:1992-1998.
10. E. T. Ahmed, O. A. Mirghani, A. S. Gerais and I. Adam. Ceftriaxone versus ampicillin/cloxacillin as antibiotic prophylaxis in elective caesarean section. East Mediterr Health J. 2004; 10:277-288.
11. L. O. Alekwe, O. Kuti, E. O. Orji and S. O. Ogunniyi. Comparison of ceftriaxone versus triple drug regimen in the prevention of cesarean section infectious morbidities. J Matern Fetal Neonatal Med. 2008; 21:638-642.
12. Kaplan L, Stegman TM. Single-blind comparative trial of trimethoprim-sulphamethoxazole and ampiclox. S Afr Med J. 1972; 46:318-321.
13. Cole WG, Elliott BG, Jensen F. The management of septic arthritis in childhood. Aust N Z J Surg. 1975; 45(2):178-182.
14. Beavis JP, Parsons RL, Salfield J. Colitis and diarrhoea: a problem with antibiotic therapy. Br J Surg. 1976; 63(4):299-304.
15. Brodie MJ, Boot PA, Girdwood RW. Severe Yersinia pseudotuberculosis infection diagnosed at laparoscopy. Br Med J. 1973. 13;4(5884):88.
16. R Caird, N Conway, I K McMillan. Purulent pericarditis followed by early constriction in young children. Br Heart J. 1973; 35(2): 201–203.
17. Farrand RJ. Haemophilus influenzae infections of the genital tract. J Med Microbiol. 1971; 4(3):357-358.
18. R. J. Farrand, J. M. Johnstone , A. F. McCabe. Haemophilus osteomyelitis and arthritis. Br Med J. 1968; 2(5601): 334–336.
19. Carter MJ. Cefamandole versus ampicillin/cloxacillin. Ann Thorac Surg. 1984; 37(2):180-181.
20. Ghoneim AT, Tandon AP, Ionescu MI. Comparative study of cefamandole versus ampicillin plus cloxacillin: prophylactic antibiotics in cardiac surgery. Ann Thorac Surg. 1982; 33(2):152-158.
21. WHO International Clinical Trials Registry Platform. An open-label randomized controlled trial of ampicillin/cloxacillin and ceftriaxone for empirical treatment of infective endocarditis. Available at: <http://apps.who.int/trialsearch/Trial2.aspx?TrialID=JPRN-UMIN000032006>. (last accessed 15 May 2020).
22. Miranda MRH, Dubey A, G S R, Charyulu RN. Fixed-dose combinations banned in India: is it the right decision? An eye-opening review. Expert Opin Drug Saf. 2019;18(10):977-985.