PRODUCT MONOGRAPH

[Pr]Cytarabine Injection

100 mg/mL
(2 g / 20 mL)

Manufacturer's Standard

Sterile Solution

Antileukemic Agent

SteriMax Inc.
2770 Portland Drive
Oakville, Ontario
L6H 6R4

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PART I: HEALTH PROFESSIONAL INFORMATION

SUMMARY PRODUCT INFORMATION

Route of Administration	Dosage Form / Strength	Non-medicinal Ingredients
Intravenous infusion, Subcutaneous injection, Intrathecal injection.	Solution for Injection 100 mg/mL	Water for Injection, Hydrochloric acid and/or Sodium hydroxide (pH adjusters).

INDICATIONS AND CLINICAL USE

Cytarabine Injection (cytarabine) is indicated primarily for induction and maintenance of remission in acute leukemia in both adults and children.

It has been found useful in the treatment of acute myelocytic leukemia, chronic myelocytic leukemia (blast phase), acute lymphocytic leukemia and erythroleukemia. Cytarabine Injection may be used alone or in combination with other antineoplastic agents; the best results are obtained with combination therapy.

Children with non-Hodgkin's lymphoma have benefited from a combination drug program (LSA_2L_2) that included cytarabine.

Cytarabine has been used intrathecally in newly diagnosed children with acute lymphocytic leukemia as well as in the treatment of meningeal leukemia.

Cytarabine, in high dose 2 - 3 g/m^2 as an i.v. infusion over 1 - 3 hours given every 12 hours for 2 - 6 days with or without additional cancer chemotherapeutic agents, has been shown to be effective in the treatment of poor-risk leukemia, refractory leukemia, and relapsed acute leukemia.

Remissions induced by cytarabine not followed by maintenance treatment have been brief.

CONTRAINDICATIONS

Cytarabine Injection (cytarabine) is contraindicated in those patients who are hypersensitive to the drug. Anaphylactic reactions have occurred with cytarabine treatment (see **WARNINGS AND PRECAUTIONS, Sensitivity/Resistance**).

WARNINGS AND PRECAUTIONS

Serious Warnings and Precautions

Cytarabine Injection (cytarabine) should be prescribed only by physicians experienced with cancer therapy drugs. Patients should be monitored and blood counts as well as renal and hepatic function tests should be performed regularly (see **WARNINGS AND PRECAUTIONS, Hematologic, Hepatic/Biliary/Pancreatic, Renal, Monitoring and Laboratory Tests** and **OVERDOSAGE**).

Do not use a diluent that contains benzyl alcohol when giving to premature or low birth weight infants as benzyl alcohol has been associated with the "gasping syndrome" (see **WARNINGS AND PRECAUTIONS, General** and **Special Populations, Pediatrics**). Do not use a diluent that contains benzyl alcohol for high dose therapy or when using intrathecally (see **ADVERSE REACTIONS, High Dose Therapy** and **DOSAGE AND ADMINISTRATION, Reconstitution**).

The following are clinically significant adverse events:

- Cardiomyopathy with subsequent death (see **WARNINGS AND PRECAUTIONS, Cardiovascular** and **ADVERSE REACTIONS, High Dose Therapy**).
- GI toxicity, at times fatal (see **WARNINGS AND PRECAUTIONS, Gastrointestinal** and **ADVERSE REACTIONS, High Dose Therapy**).
- Acute pancreatitis (see **WARNINGS AND PRECAUTIONS, Hepatic/Biliary/Pancreatic**).
- CNS toxicity, severe neurological adverse reactions, paraplegia, necrotizing leukoencephalopathy and spinal cord toxicity. Patients with impaired hepatic or renal function may be at increased risk after high dose Cytarabine Injection (see **WARNINGS AND PRECAUTIONS, Hepatic/Biliary/Pancreatic, Neurologic** and **Renal; ADVERSE REACTIONS, High Dose Therapy and Intrathecal Therapy; DRUG INTERACTIONS, Serious Interactions; DOSAGE AND ADMINISTRATION, Meningeal Leukemia – Intrathecal Use, OVERDOSAGE**, and **ACTION AND CLINICAL PHARMACOLOGY**).
- Infection (see **WARNINGS AND PRECAUTIONS, Immune** and **ADVERSE REACTIONS, Infections and Infestations**).
- Pulmonary toxicity, adult respiratory distress syndrome and pulmonary edema (see **WARNINGS AND PRECAUTIONS, Respiratory** and **ADVERSE REACTIONS, High Dose Therapy**).
- Myelosuppression (see **WARNINGS AND PRECAUTIONS, Hematologic; ADVERSE REACTIONS, Blood and Lymphatic System Disorders** and **OVERDOSAGE**).

General

Before instituting a programme of combined therapy, the physician should be familiar with the literature, adverse reactions, warnings and precautions, and contraindications applicable to all the drugs in the programme (see **DOSAGE AND ADMINISTRATION, Combined Chemotherapy**).

For induction therapy, patients should be treated in a facility with laboratory and supportive resources sufficient to monitor drug tolerance and protect and maintain a patient compromised by drug toxicity. The main toxic effect of cytarabine is bone marrow suppression with leukopenia, thrombocytopenia and anemia. Less serious toxicity includes nausea, vomiting, diarrhea and abdominal pain, oral ulceration, and hepatic dysfunction (see **ADVERSE REACTIONS**).

The physician must judge possible benefit to the patient against known toxic effects of this drug in considering the advisability of therapy with cytarabine. Before making this judgment or beginning treatment, the physician should be familiar with the following text.

When large intravenous doses are given quickly, patients are frequently nauseated and may vomit for several hours post injection. This problem tends to be less severe when the drug is infused.

Benzyl alcohol has been reported to be associated with a fatal "Gasping Syndrome" in pediatric patients. As premature and low birth weight infants may be at increased risk of developing this toxicity, they should not be given cytarabine reconstituted with a diluent containing benzyl alcohol (see **WARNINGS AND PRECAUTIONS, Special Populations, Pediatrics**).

Carcinogenesis and Mutagenesis

Extensive chromosomal damage, including chromatoid breaks have been produced by cytarabine and malignant transformation of rodent cells in culture has been reported (see **DETAILED PHARMACOLOGY**).

Cardiovascular

High dose schedules: An increase in cardiomyopathy with subsequent death has been reported following experimental high dose cytarabine and cyclophosphamide therapy when used for bone marrow transplant preparation. This may be schedule dependent (see also **DRUG INTERACTIONS**).

Gastrointestinal

Abdominal tenderness (peritonitis) and typhlitis with concurrent neutropenia and thrombocytopenia have been reported in patients treated with conventional doses of cytarabine in combination with other drugs. Patients have responded to nonoperative medical management.

High dose schedule: Severe and at times fatal, GI toxicity (different from that seen with conventional therapy regimens of cytarabine) has been reported following high dose (2 - 3 g/m^2) schedules of cytarabine. These reactions include severe gastrointestinal ulceration, including pneumatosis cystoides intestinalis, leading to peritonitis, bowel necrosis; and necrotizing colitis.

Genitourinary

Tumor Lysis Syndrome: Like other cytotoxic drugs, Cytarabine Injection may induce hyperuricemia secondary to rapid lysis of neoplastic cells. The clinician should monitor the patient's blood uric acid level and be prepared to use such supportive and pharmacologic measurements as might be necessary to control this problem.

Hematologic

Cytarabine is a potent bone marrow suppressant; the severity depends on the dose of the drug and schedule of administration. Therapy should be started cautiously in patients with pre-existing drug-induced bone marrow suppression. Patients receiving this drug must be under close medical supervision and during induction therapy, should have leukocyte and platelet counts performed daily. Bone marrow examinations should be performed frequently after blasts have disappeared from the peripheral blood. Facilities should be available for management of complications (possibly fatal) of bone marrow suppression (infection resulting from granulocytopenia and other impaired body defenses, and hemorrhage secondary to thrombocytopenia). Periodic checks of bone marrow should be performed in patients receiving cytarabine.

Hepatic/Biliary/Pancreatic

The human liver may detoxify a substantial fraction of an administered cytarabine dose. In particular, patients with hepatic function impairment may have a higher likelihood of CNS toxicity after high dose treatment with Cytarabine Injection. Use the drug with caution and at reduced dose in patients whose liver function is poor.

Periodic checks of liver function should be performed in patients receiving Cytarabine Injection.

Pancreatitis: Acute pancreatitis has been reported to occur in patients being treated with cytarabine in combination with other drugs.

High dose schedules: Other reactions have been reported following high dose (2 - 3 g/m^2) schedules of cytarabine and include sepsis and liver abscess, and liver damage with increased hyperbilirubinemia.

Immune

Immunosuppressant Effects/Increased Susceptibility to Infections: Administration of live or live-attenuated vaccines in patients immunocompromised by chemotherapeutic agents, including cytarabine, may result in serious or fatal infections. Vaccination with a live vaccine should be avoided in patients receiving cytarabine. Killed or inactivated vaccines may be administered; however, the response to such vaccines may be diminished.

Neurologic

High dose schedules: Severe and at times fatal, CNS toxicity (different from that seen with conventional therapy regimens of cytarabine) has been reported following high dose (2 - 3 g/m^2) schedules of cytarabine. These reactions include cerebral and cerebellar dysfunction including personality changes, somnolence, convulsion and coma, usually reversible.

Delayed progressive ascending paralysis resulting in death has been reported in children with AML following intrathecal and intravenous cytarabine at conventional doses in combination with other drugs.

Cases of severe neurological adverse reactions that ranged from headache to paralysis, coma and stroke-like episodes have been reported mostly in pediatric patients given intravenous cytarabine in combination with intrathecal methotrexate.

Ophthalmologic

High dose schedules: The following reactions have been reported following high dose (2 - 3 g/m^2) schedules of cytarabine: reversible corneal toxicity and hemorrhagic conjunctivitis, which may be prevented or diminished by prophylaxis with a local corticosteroid eye drop.

Renal

Patients with renal function impairment may have a higher likelihood of CNS toxicity after high dose treatment with cytarabine. Periodic checks of kidney function should be performed in patients receiving cytarabine.

Respiratory

High dose schedules: Severe and sometimes fatal pulmonary toxicity, adult respiratory distress syndrome and pulmonary edema have occurred following high dose schedules with cytarabine therapy. A syndrome of sudden respiratory distress, rapidly progressing to pulmonary edema and radiographically pronounced cardiomegaly has been reported following experimental high dose cytarabine therapy used for the treatment of relapsed leukemia.

Sensitivity/Resistance

Anaphylactic reactions have occurred with cytarabine treatment. Anaphylaxis that resulted in acute cardiopulmonary arrest and required resuscitation has been reported. This occurred immediately after the intravenous administration of cytarabine.

Sexual Function/Reproduction

Male Fertility: cytarabine may present in the semen. Male patients who are not surgically sterile must agree to use effective contraception during treatment with cytarabine to prevent pregnancy in female partners (see **WARNINGS AND PRECAUTIONS, Special Populations, Pregnant Women** and **TOXICOLOGY**).

Skin

Palmar plantar erythrodysaesthesia: Palmar plantar erythrodysaesthesia (PPE) has occurred with cytarabine treatment in adults and children. Severe cytarabine associated PPE that resulted in treatment discontinuation has been reported.

High dose schedules: Rarely, severe skin rash, leading to desquamation has been reported. Complete alopecia is more commonly seen with high dose therapy than with standard cytarabine treatment programs.

Special Populations

Pregnant Women:

Cytarabine is embryotoxic and teratogenic and produced peri- and postnatal toxicity in various species. Sperm head abnormalities were observed following cytarabine treatment in mice (see **TOXICOLOGY**).

There are no studies on the use of cytarabine in pregnant women. Use of this drug in women who are or who may become pregnant should be undertaken only after due consideration of potential benefit and potential hazard to both mother and child. Women of childbearing potential should be advised to avoid becoming pregnant (see also **WARNINGS AND PRECAUTIONS, Sexual Function/Reproduction**).

Normal infants have been born to mothers exposed to cytarabine during pregnancy (alone or in combination with other drugs); some of these infants were premature or of low birth weight. Some of the normal infants were followed up at ages ranging from six weeks to seven years following exposure, and showed no abnormalities. One apparently normal infant died at 80 days of gastroenteritis.

Congenital abnormalities have been reported, particularly when the fetus has been exposed to systemic therapy with cytarabine during the first trimester. These include upper and lower distal limb defects, and extremity and ear deformities.

Reports of pancytopenia, leucopenia, anemia, thrombocytopenia, electrolyte abnormalities, transient oesinophilia, increased IgM levels and hyperpyrexia, sepsis and death have occurred during the neonatal period to infants exposed to cytarabine *in utero*. Some of these infants were also premature.

Therapeutic abortions have been done in pregnant women on cytarabine. Normal fetuses have been reported while other reported fetal effects included enlarged spleen and Trisomy C chromosome abnormality in the chorionic tissue.

Because of the potential for abnormalities with cytotoxic therapy, particularly during the first trimester, a patient who is or who becomes pregnant while on Cytarabine Injection should be apprised of the potential risk to the fetus and the advisability of pregnancy continuation. There is a definite, but considerably reduced risk if therapy is initiated during the second or third trimester. Although normal infants have been delivered to patients treated in all three trimesters of pregnancy, follow-up of such infants would be advisable.

Do not use a diluent that contains benzyl alcohol. Benzyl alcohol can cross the placenta (see **WARNINGS AND PRECAUTIONS, Special Populations, Pediatrics**).

Nursing Women:
It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from cytarabine, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatrics:
The safety of this drug for use in infants (under 1 year of age) is not established.

Gasping Syndrome: Cytarabine should not be given to premature and low birth weight infants when using a diluent that contains benzyl alcohol. The preservative benzyl alcohol has been associated with serious adverse events, including the "gasping syndrome", and death in pediatric patients. Symptoms of gasping syndrome may include metabolic acidosis, seizure, bradycardia,

gasping respiration and cardiovascular collapse. Although normal therapeutic doses of this product ordinarily deliver amounts of benzyl alcohol that are substantially lower than those reported in association with the "gasping syndrome", the minimum amount of benzyl alcohol at which toxicity may occur is not known. The risk of benzyl alcohol toxicity depends on the quantity administered and the hepatic capacity to detoxify the chemical. Premature and low birth weight infants may be more likely to develop toxicity. If cytarabine is used in high dose or intrathecal therapy, do not use a diluent containing benzyl alcohol. The preservative-free 0.9% sodium chloride can be used for reconstitution (see also **SERIOUS WARNINGS AND PRECAUTIONS**).

See also **WARNING AND PRECAUTIONS, Neurologic** and **Skin**.

Monitoring and Laboratory Tests
Patients receiving Cytarabine Injection (cytarabine) must be monitored closely. Frequent platelet and leukocyte counts and bone marrow examinations are mandatory. Consider suspending or modifying therapy when drug-induced marrow depression has resulted in a platelet count under 50 000 or a polymorphonuclear granulocyte count under 1000/mm^3. Counts of formed elements in the peripheral blood may continue to fall after the drug is stopped and reach lowest values after drug-free intervals of 12 of 24 days. When indicated, restart therapy when definite signs of marrow recovery appear (on successive bone marrow studies). Patients whose drug is withheld until "normal" peripheral blood values are attained, may escape from control.

ADVERSE REACTIONS

Adverse Drug Reaction Overview
The following listing is based on adverse events reported in clinical trials and/or spontaneous adverse event reports from post-marketing experience. When a frequency cannot be estimated from the available data it is classified as "not known".

Blood and Lymphatic System Disorders
Because cytarabine is a bone marrow suppressant, anemia, leukopenia, thrombocytopenia, megaloblastosis, and reduced reticulocytes can be expected as a result of its administration. The severity of these reactions is dose and schedule dependent. Cellular changes in the morphology of bone marrows and peripheral smears can be expected.

Following 5-day constant infusions or acute injections of 50 mg/m^2 to 600 mg/m^2, white cell depression follows a biphasic course. Regardless of initial count, dosage level, or schedule, there is an initial fall starting the first 24 hours with a nadir at days 7 to 9. This is followed by a brief rise which peaks around the twelfth day. A second and deeper fall reaches nadir at days 15 to 24. Then there is a rapid rise to above baseline in the next 10 days. Platelet depression is noticeable at 5 days with a peak depression occurring between days 12 to 15. Thereupon, a rapid rise to above baseline occurs in the next 10 days.

Infections and Infestations
Viral, bacterial, fungal, parasitic, or saprophytic infections, in any location on the body, may be associated with the use of Cytarabine Injection alone or in combination with other immunosuppressive agents following immunosuppressive doses that affect cellular or humoral

immunity. These infections may be mild, but can be severe and at times fatal.

Musculoskeletal and Connective Tissue Disorders

The Cytarabine Syndrome

A cytarabine syndrome has been described by Castleberry et al. 1981. It is characterized by fever, myalgia, bone pain, occasionally chest pain, maculopapular rash, conjunctivitis and malaise. It usually occurs 6 to 12 hours following drug administration. Corticosteroids have been shown to be beneficial in treating or preventing this syndrome. If the symptoms of the syndrome are deemed treatable, corticosteroids should be contemplated as well as continuation of therapy with Cytarabine Injection.

Other Adverse Reactions

Conventional Dose Therapy

Nausea and vomiting are most frequent following rapid intravenous injection.

Table 1 – Frequencies of Adverse Reactions with Cytarabine Convential Dose Therapy

The reported adverse reactions are listed below by MedDRA System Organ Class and by frequency.

ADR frequencies are based on CIOMS convention: Very common (>10%), Common (>1%, ≤10%), Uncommon (>0.1%, ≤1%), Rare (>0.01%, ≤0.1%), and Frequency not known (cannot be estimated from available data).

Blood and Lymphatic System Disorders:	
Very common	Bone marrow failure, thrombocytopenia, anaemia, anaemia megaloblastic, leukopenia, reticulocyte count decreased
Frequency not known	Bleeding (all sites)
Cardiac Disorders:	
Frequency not known	Pericarditis
Eye Disorders:	
Frequency not known	Conjunctivitis[a]
Gastrointestinal Disorders:	
Very common	Stomatitis, mouth ulceration, anal ulcer, anal inflammation, diarrhoea, vomiting, nausea, abdominal pain
Frequency not known	Bowel necrosis, pancreatitis, oesophageal ulcer, oesophagitis
General Disorders and Administration Site Conditions:	
Very common	Pyrexia
Frequency not known	Chest pain, injection site reaction[b]
Hepatobiliary Disorders:	
Very common	Hepatic function abnormal
Frequency not known	Jaundice
Immune System Disorders:	

Frequency not known	Anaphylactic reaction, allergic oedema

Infections and Infestations:	
Very common	Sepsis, pneumonia, infection[c]
Frequency not known	Injection site cellulitis
Investigations:	
Very common	Biopsy bone marrow abnormal, blood smear test abnormal
Metabolism and Nutrition Disorders:	
Frequency not known	Decreased appetite
Musculoskeletal, Connective Tissue and Bone Disorders:	
Very common	Cytarabine syndrome
Nervous System Disorders:	
Frequency not known	Neurotoxicity, neuritis, dizziness, headache
Renal and Urinary Disorders:	
Frequency not known	Renal impairment, urinary retention
Respiratory, Thoracic and Mediastinal Disorders:	
Frequency not known	Dyspnea, oropharyngeal pain
Skin and Subcutaneous Tissue Disorders:	
Very common	Alopecia, rash
Common	Skin ulcer
Frequency not known	Palmar-plantar erythrodysaesthesia syndrome, urticaria, pruritus, freckling
Vascular Disorders:	
Frequency not known	Thrombophlebitis

[a] May occur with rash and may be hemorrhagic with high dose therapy.
[b] Pain and inflammation at subcutaneous injection site.
[c] May be mild, but can be severe and at times fatal.

High Dose Therapy

Severe and at times fatal CNS, GI and pulmonary toxicity (different from that seen with conventional therapy regimens of cytarabine) has been reported following high dose schedules (2.0 g to 3.0 g/m^2 given every 12 hours for 12 doses).

Table 2 – Frequencies of Adverse Reactions with Cytarabine High Dose Therapy

The reported adverse reactions are listed below by MedDRA System Organ Class and by frequency.

ADR frequencies are based on CIOMS convention: Very common (>10%), Common (>1%, ≤10%), Uncommon (>0.1%, ≤1%), Rare (>0.01%, ≤0.1%), and Frequency not known (cannot be estimated from available data).

Cardiac Disorders:	
Frequency not known	Cardiomyopathy[a]
Eye Disorders:	
Very common	Corneal disorder
Frequency not known	Hemorrhagic conjunctivitis[b]
Gastrointestinal Disorders:	
Common	Necrotising colitis
Frequency not known	Gastrointestinal necrosis, gastrointestinal ulcer, pneumatosis intestinalis, peritonitis
Hepatobiliary Disorders:	
Frequency not known	Liver injury, hyperbilirubinemia
Infections and Infestations:	
Very common	Sepsis
Frequency not known	Liver abscess
Nervous System Disorders:	
Very common	Cerebral disorder, cerebellar disorder, somnolence
Frequency not known	Coma, convulsion, peripheral motor neuropathy, peripheral sensory neuropathy
Psychiatric Disorders:	
Frequency not known	Personality change[c]
Respiratory, Thoracic and Mediastinal Disorders:	
Very common	Acute respiratory distress syndrome, pulmonary edema
Skin and Subcutaneous Tissue Disorders:	
Common	Skin exfoliation

[a] With subsequent death.

[b] May be prevented or diminished by prophylaxis with a local corticosteroid eyedrop.

[c] Personality change was reported in association with cerebral and cerebellar dysfunction.

Peripheral motor and sensory neuropathies after consolidation with high dose cytarabine, daunorubicin, and asparaginase have occurred in adult patients with acute non lymphocytic leukemia. Patients treated with high dose Cytarabine Injection should be observed for neuropathy since dose schedule alterations may be needed to avoid irreversible neurologic disorders.

Corneal toxicity consisting of ocular pain, tearing, foreign-body sensation, photophobia and blurred vision has been reported.
Rarely, severe skin rash, leading to desquamation has been reported. Complete alopecia is more commonly seen with high dose therapy than with standard cytarabine treatment programs.

If high dose therapy is used, do not use a diluent containing benzyl alcohol.

Intermediate-Dose Therapy
A diffuse interstitial pneumonitis without clear cause that may have been related to cytarabine was reported in patients treated with experimental intermediate doses of cytarabine (1 g/m^2) with and without other chemotherapeutic agents (meta-AMSA, daunorubicin, VP-16).

Intrathecal Therapy
Cytarabine given intrathecally may cause systemic toxicity and careful monitoring of the hemopoietic system is indicated. Modification of other anti-leukemia therapy may be necessary. Major toxicity is rare. The most frequently reported reactions after intrathecal administration were nausea, vomiting and fever; these reactions are mild and self-limiting. Paraplegia has been reported. Necrotizing leukoencephalopathy with or without convulsion has been reported; in some cases, patients had also been treated with intrathecal methotrexate and/or hydrocortisone, as well as by central nervous system radiation. Isolated neurotoxicity has been reported. Blindness occurred in two patients in remission whose treatment had consisted of combination systemic chemotherapy, prophylactic central nervous system radiation and intrathecal cytarabine. When cytarabine is administered both intrathecally and intravenously within a few days, there is an increased risk of spinal cord toxicity, however, in serious life-threatening disease, concurrent use of intravenous and intrathecal cytarabine is left to the discretion of the treating physician.

DRUG INTERACTIONS

Serious Drug Interactions

- **Methotrexate:** Intravenous cytarabine given concomitantly with intrathecal methotrexate may increase the risk of severe neurological adverse reactions such as headache, paralysis, coma and stroke-like episodes.

Drug-Drug Interactions

Digoxin: Reversible decreases in steady-state plasma digoxin concentrations and renal glycoside excretion were observed in patients receiving beta-acetyldigoxin and chemotherapy regimens containing cyclophosphamide, vincristine and prednisone with or without cytarabine or procarbazine. Steady-state plasma digitoxin concentrations did not appear to change. Therefore, monitoring of plasma digoxin levels may be indicated in patients receiving similar combination

chemotherapy regimens. The utilization of digitoxin for such patients may be considered as an alternative.

Gentamicin: An *in vitro* interaction study between gentamicin and cytarabine showed a cytarabine-related antagonism for the susceptibility of *K. pneumoniae* strains. This study suggests that in patients on cytarabine being treated with gentamicin for a *K. pneumoniae* infection, the lack of a prompt therapeutic response may indicate the need for re-evaluation of antibacterial therapy.

Fluorocytosine: Clinical evidence showed possible inhibition of fluorocytosine efficacy therapy with cytarabine. This may be due to potential competitive inhibition of its uptake.

Experimental high dose cytarabine and cyclophosphamide therapy: An increase in cardiomyopathy with subsequent death has been reported when used for bone marrow transplant preparation. This may be schedule dependent (see **WARNINGS AND PRECAUTIONS, Cardiovascular**).

Drug-Food Interaction
Interactions with food have not been established.

Drug-Herb Interactions
Interactions with herbal product have not been established.

Drug-Laboratory Test Interactions
Interactions with laboratory tests have not been established.

Drug-Lifestyle Interactions
Interactions associated with lifestyle have not been established.

DOSAGE AND ADMINISTRATION

Dosing Considerations

Clinical experience accumulated to date suggests that success with cytarabine is dependent more on adeptness in modifying day-to-day dosage to obtain maximum leukemic cell kill with tolerable toxicity than on the basic treatment schedule chosen at the outset of therapy. Toxicity necessitating dosage alteration almost always occurs.

In many chemotherapeutic programs, cytarabine is used in combination with other cytotoxic drugs. The addition of these cytotoxic drugs has necessitated changes and dose alterations. The dosage schedules for combination therapy outlined below have been reported in the literature (see **REFERENCES**).

Recommended Dose and Dosage Adjustment

Acute Myelocytic Leukemia - Induction Remission: Adults
Cytarabine 200 mg/m^2 daily by continuous infusion for 5 days (120 hours) - total dose 1000 mg/m^2. This course is repeated approximately every 2 weeks. Modifications must be made based on hematologic response.

Acute Myelocytic Leukemia - Maintenance: Adults
Maintenance programs are modifications of induction programs and, in general, use similar schedules of drug therapy as were used during induction. Most programs have a greater time spacing between courses of therapy during remission maintenance.

Acute Myelocytic Leukemia - Induction and Maintenance in Children
Numerous studies have shown that childhood AML responds better than adult AML given similar regimens. Where the adult dosage is stated in terms of body weight or surface area, the children's dosage may be calculated on the same basis. When specified amounts of a drug are indicated for the adult dosage, these should be adjusted for children on the basis of such factors as age, body weight or body surface area.

Acute Myelocytic Leukemia – Adults and Children
The following tables outline the results of treatment with cytarabine alone and in combination with other chemotherapeutic agents, in the treatment of acute myelocytic leukemia in adults and children.

The treatment regimens outlined in the tables should not be compared for efficacy. These were independent studies with a number of variables involved, such as patient population, duration of disease, and previous treatment.

The responsiveness and course of childhood acute myelocytic leukemia (AML) appear to be different from that in adults. Numerous studies show response rates to be higher in children than in adults with similar treatment schedules. Experience indicates that at least with induction and initial drug responsiveness, childhood AML appears to be more similar to childhood acute lymphocytic leukemia (ALL) than to its adult variant.

Patients with hepatic impairment: Cytarabine and dose adjustment has not been studied in individuals with hepatic impairment (see also **WARNINGS AND PRECAUTIONS**, **Hepatic/Biliary/Pancreatic**).

Patients with renal impairment: Cytarabine and dose adjustment has not been studied in individuals with renal impairment (see also **WARNINGS AND PRECAUTIONS, Renal**).

Table I
Acute Myelocytic Leukemia- Remission Induction: Adults

Drug Dosage Schedule*		No. of Patients Evaluated	Complete Remissions	Investigator
Cytarabine Single-Dose Therapy	(Infusion) 10 mg/m^2 12 hrs/day 30 mg/m^2 12 hrs/day 10 mg/m^2 24 hrs/day 30 mg/m^2 24 hrs/day	 12 41 9 36	 2 (17%) 10 (24%) 2 (22 %) 2 (6%)	Ellison (1968)
	(Infusion) 200 mg/m^2 24 hrs/5 days	36	9 (25%)	Bodey (1969)
	10 mg/m^2 i.v. injection initially, then infusions of 30 mg/m^2 per 12 hrs or 60 mg/m^2/day for 4 days	49	21 (43%)	Goodell (1970)
	(Infusion Therapy) 800 mg/m^2/ 2 days 1000 mg/m^2/ 5days	 53 60	 12 (23%) 24 (40%)	Southwest Oncology Group (1974)
	100 mg/m^2/day 1 hr infusion	49	7 (14%)	Carey (1975)
	5 to 12.5 mg/kg/12 hrs infusion following i.v. synchronizing dose**	5	5 (100%)	Lampkin (1976)
Combined Therapy	cytarabine- doxorubicin	41	30 (73%)	Preisler (1979)
	cytarabine- thioguanine daunorubicin	28	22 (79%)	Gale (1977)
	cytarabine- doxorubicin vincristine prednisolone	35	23 (66%)	Weinstein (1980)
	cytarabine- daunorubicin thioguanine prednisone vincristine	139	84 (60%)	Glucksberg (1981)
	cytarabine- daunorubicin	21	14 (67%)	Cassileth (1977)
High-Dose Therapy	Cytarabine	7	6 (86%)	Lister (1983)
	Cytarabine	21	12 (57%)	Herzig (1983)
	Cytarabine	11	8 (73%)	Preisler (1983)
	cytarabine- doxorubicin	14	7 (50%)	Willemze (1982)
	cytarabine- asparaginase	13	9 (69%)	Capizzi (1983)

* Unless otherwise stated, all doses given until drug effect - modifications then based on hematologic reasons. See **REFERENCES**.
** Highly experimental - requires ability to study mitotic indices.

Table II
Acute Myelocytic Leukemia- Remission Induction: Children (21 and under)

Drug Therapy	No. of Patients Evaluated	Complete Remissions	Investigator
Cytarabine (5-12.5 mg/kg following i.v. synchronizing dose**)	16	12 (75%)	Lampkin (1976)
Cytarabine, vincristine, doxorubicin, prednisolone	48	35 (73%)	Weinstein (1980)
Cytarabine, thioguanine, doxorubicin	11	8 (72%)	Hagbin (1975)
Cytarabine, thioguanine	47	20 (43%)	Pizzo (1976)
Cytarabine, cyclophosphamide	12	7 (58%)	Pizzo (1976)

** Highly experimental - requires ability to study mitotic indices.

Acute Lymphocytic Leukemia

In general, dosage schedules are similar to those used in acute myelocytic leukemia with some modification. Cytarabine has been used in the treatment of acute lymphocytic leukemia in both adults and children. When cytarabine was used with other antineoplastic agents as part of a total therapy program, results were equal to or better than reported with such programs which did not include cytarabine. Used singly, or in combination with other agents, cytarabine has also been effective in treating patients who had relapsed on other therapy. Tables III and IV summarize the results obtained in previously treated patients. Since these are independent studies with such variables as patient population, duration of disease and previous treatment, results shown should not be used for comparing the efficacy of the outlined treatment programs.

Table III
Acute Lymphocytic Leukemia- Remission Induction: Previously Treated Patients Adults and Children

Drug Therapy	No. of Patients Evaluated	Complete Remissions	Response	Investigator
Cytarabine 3 - 5 mg/kg/day (IV injection)	43	2 (5%)	15 (35%)	Howard (1968)
Cytarabine- asparaginase	9	8 (89%)	8 (89%)	McElwain (1969)
Cytarabine- cyclophosphamide	11	7 (64%)	9 (82%)	Bodey (1970)
Cytarabine- prednisone	83	---	(49%)	Nesbitt (1970)
Cytarabine- 150 - 200 mg/m^2/ 5 days (infusion)	34	1 (3%)	4 (12%)	Wang (1970)
Cytarabine- L-asparaginase- prednisone- vincristine- doxorubicin	91	72 (79%)	---	Klemperer (1978)
Cytarabine- L-asparaginase- prednisone- vincristine- doxorubicin	55	42 (76%)	---	Klemperer (1978)
Cytarabine- asparaginase	22	13 (59%)	15 (68%)	Ortaga (1972)
Cytarabine- thioguanine	19	9 (47%)	9 (47%)	Bryan (1974)

Table IV

Drug Therapy		No. of patients evaluated	Complete Remissions	Investigator
High Dose Therapy	Cytarabine	8	3 (38%)	Rohatinar (1983)
	Cytarabine-doxorubicin	3	2 (67%)	Willemze (1982)
	Cytarabine-asparaginase	10	3 (30%)	Capizzi (1983)

Non-Hodgkin's Lymphoma in Children
Cytarabine has been used as part of a multi-drug program (LSA_2L_2) to treat non-Hodgkin's lymphoma in children. See Appendix A for complete dosage schedule.

High Dose Chemotherapy
Before instituting a program of high dose chemotherapy, the physician should be familiar with the literature, adverse reactions, precautions, contraindications, and warnings applicable to all the drugs involved in the program.

Cytarabine Injection
Cytarabine: 2 g/m^2 infused over 3 hours every 12 hours x 12 doses (Days 1 - 6).

Cytarabine Injection
Cytarabine: 3 g/m^2 infused over 1 hour every 12 hours x 12 doses (Days 1 - 6).

Cytarabine Injection
Cytarabine: 3 g/m^2 infused over 75 minutes every 12 hours x 12 doses (Days 1 - 6).

Cytarabine Injection - doxorubicin
Cytarabine: 3 g/m^2 infused over 2 hours every 12 hours x 12 doses (Days 1 - 6).
Doxorubicin: 30 mg/m^2 i.v. on Days 6-7.

Cytarabine Injection - asparaginase
Cytarabine: 3 g/m^2 infused over 3 hours at 0 hours, 12 hours, 24 hours, and 36 hours.
At 42 hours, 6000 units/m^2 of asparaginase i.m. (Days 1 - 2); repeat same schedule Days 8 - 9.

Combined Chemotherapy
Before instituting a program of combined chemotherapy, the physician should be familiar with the literature, adverse reactions, precautions, contraindications, and warnings applicable to all the drugs involved in the program.

Cytarabine Injection, doxorubicin
Cytarabine: 100 mg/m^2/day, continuous i.v. infusion (Days 1 - 10).
Doxorubicin: 30 mg/m^2/day, i.v. infusion of 30 minutes (Days 1 - 3).

Additional (complete or modified) courses as necessary at 2 - 4 week intervals if leukemia is persistent.

Cytarabine Injection, thioguanine, daunorubicin

Cytarabine: 100 mg/m^2, i.v. infusion over 30 minutes every 12 hours (Days 1 - 7).
Thioguanine: 100 mg/m^2, orally every 12 hours (Days 1 - 7).
Daunorubicin: 60 mg/m^2/day, i.v. infusion (Days 5 - 7).

Additional (complete or modified) courses as necessary at 2 - 4 week intervals if leukemia is persistent.

Cytarabine Injection, doxorubicin, vincristine, prednisone

Cytarabine: 100 mg/m^2/day, continuous i.v. infusion (Days 1 - 7).
Doxorubicin: 30 mg/m^2/day, i.v. infusion (Days 1 - 3).
Vincristine: 1.5 mg/m^2/day, i.v. infusion (Days 1, 5)
Prednisolone: 40 mg/m^2/day, i.v. infusion every 12 hours (Days 1 - 5).

Additional (complete or modified) courses as necessary at 2 - 4 week intervals if leukemia is persistent.

Cytarabine Injection, daunorubicin, thioguanine, prednisone, vincristine

Cytarabine: 100 mg/m^2/day, i.v. infusion (Days 1 - 10).
Daunorubicin: 70 mg/m^2/day, i.v. infusion (Days 1 - 3).
Thioguanine: 100 mg/m^2, orally every 12 hours (Days 1 - 7).
Prednisone: 40 mg/m^2/day, orally (Days 1 - 7).
Vincristine: 1 mg/m^2/day, i.v. infusion (Days 1, 7).

Additional (complete or modified) courses as necessary at 2 - 4 week intervals if leukemia is persistent.

Cytarabine Injection, daunorubicin

Cytarabine: 100 mg/m^2/day, continuous i.v. infusion (Days 1 - 7).
Daunorubicin: 45 mg/m^2/day, i.v. push (Days 1 - 3).

Additional (complete or modified) courses as necessary at 2 - 4 week intervals if leukemia is persistent.

Meningeal Leukemia - Intrathecal Use

Cytarabine has been used intrathecally in acute leukemia in doses ranging from 5 mg/m^2 to 75 mg/m^2 of body surface area. The frequency of administration varied from once a day for 4 days to once every 4 days. The most frequently used dose was 30 mg/m^2 every 4 days until cerebrospinal fluid findings were normal, followed by one additional treatment. The dosage schedule is usually governed by the type and severity of central nervous system manifestations and the response to previous therapy.

Cytarabine has been used intrathecally with hydrocortisone sodium succinate and methotrexate, both as prophylaxis in newly diagnosed children with acute lymphocytic leukemia, as well as in the treatment of meningeal leukemia. Sullivan et al. has reported that prophylactic triple therapy has prevented late CNS disease and given overall cure and survival rates similar to those seen in patients in whom CNS radiation and intrathecal methotrexate was used as initial CNS

prophylaxis. The dose of cytarabine was 30 mg/m^2, hydrocortisone sodium succinate 15 mg/m^2, and methotrexate 15 mg/m^2 (an absolute maximum single dose of 15 mg of methotrexate). The physician should be aware of this regimen and note that methotrexate dosage in pediatric patients is otherwise based on age rather than body surface area. Prescribers should consult related Product Monographs for more information.

Prophylactic triple therapy following the successful treatment of the acute meningeal episode may be useful. The physician should familiarize himself with the current literature before instituting such a program.

Cytarabine given intrathecally may cause systemic toxicity and careful monitoring of the hemopoietic system is indicated. Modification of the anti-leukemia therapy may be necessary. Major toxicity is rare. The most frequently reported reactions after intrathecal administration were nausea, vomiting and fever; these reactions are mild and self-limiting. Paraplegia has been reported. Necrotizing leukoencephalopathy occurred in 5 children; these patients had also been treated with intrathecal methotrexate and hydrocortisone, as well as by central nervous system radiation. Isolated neurotoxicity has been reported.

Blindness occurred in two patients in remission whose treatment had consisted of combination systemic chemotherapy, prophylactic central nervous system radiation and intrathecal cytarabine.

Focal leukemic involvement of the central nervous system may not respond to intrathecal cytarabine and may better be treated with radiotherapy.

If used intrathecally, do not use a diluent containing benzyl alcohol. Reconstitute with preservative-free saline and use immediately.

Dosage Modification
The dosage of Cytarabine Injection (cytarabine) must be modified or suspended when signs of serious hematologic depression appear. In general, consider discontinuing the drug if the patient has less than 50 000 platelets or 1000 polymorphonuclear granulocytes/mm^3 in his peripheral blood. These guidelines may be modified depending on signs of toxicity in other systems and on the rapidity of fall in formed blood elements. Restart the drug when there are signs of marrow recovery and the above platelet and granulocyte levels have been attained. Withholding therapy until the patient's blood values are normal may result in escape of the patient's disease from control by the drug.

Hepatic Insufficiency: Use cytarabine with caution or possibly at reduced doses in patients whose liver function is poor (see also **WARNINGS AND PRECAUTIONS, Hepatic/Biliary/Pancreatic**).

Renal Insufficiency: Use cytarabine with caution or possibly at reduced doses in patients whose kidney function is poor (see also **WARNINGS AND PRECAUTIONS, Renal**).
Administration

Cytarabine is not active orally. The schedule and method of administration varies with the program of therapy to be used. Cytarabine may be given by intravenous infusion, injection/subcutaneously or intrathecally. When preparing cytarabine for intravenous high dose

therapy or intrathecal use, do not use diluents containing benzyl alcohol (see **SERIOUS WARNINGS AND PRECAUTIONS** and **DOSAGE AND ADMINISTRATION**). It is recommended that Cytarabine Injection be reconstituted with preservative-free 0.9% sodium chloride for injection and used immediately.

Thrombophlebitis has occurred at the site of drug injection or infusion in some patients, and rarely patients have noted pain and inflammation at subcutaneous injection sites. In most instances, however, the drug has been well tolerated.

Patients can tolerate higher total doses when they receive the drug by rapid intravenous injection as compared with slow infusion. This phenomenon is related to the drug's rapid inactivation and brief exposure of susceptible normal and neoplastic cells to significant levels after rapid injection. Normal and neoplastic cells seem to respond to somewhat parallel fashion to these different modes of administration and no clear-cut clinical advantage has been demonstrated for either.

Relatively constant plasma levels can be achieved by continuous intravenous infusion.

Reconstitution

Subcutaneous and Intravenous Injection
Cytarabine Injection is suitable for subcutaneous or intravenous injection.

Intravenous Infusion
Cytarabine Injection may be further diluted to 0.1 mg/mL for intravenous infusion with any of the solutions listed below.

Water for Injection, USP
5% Dextrose Injection, USP
0.9% Sodium Chloride, USP
Lactated Ringer's Injection, USP

Single-use only. Discard any unused portion. If a precipitate has formed as a result of exposure to low temperatures, redissolve by warming to 55°C for no longer than 30 minutes and then shake until the precipitate has dissolved. Allow to cool prior to use.

FOR INTRATHECAL USE: DO NOT USE DILUENT CONTAINING BENZYL ALCOHOL. RECONSTITUTE WITH PRESERVATIVE-FREE 0.9 % SODIUM CHLORIDE FOR INJECTION. USE IMMEDIATELY.

Cytarabine is usually administered as a 5 mg/mL concentration in 5 to 15 mL of solution, after an equivalent volume of CSF is removed.

FOR HIGH DOSE USE: DO NOT USE DILUENT CONTAINING BENZYL ALCOHOL.

OVERDOSAGE

There is no antidote for Cytarabine Injection (cytarabine) overdosage.

Discontinuation of the drug and supportive therapy are of course indicated. Transfusions of platelets should be given if there is any sign of hemorrhage. Patients should be carefully observed for intercurrent infection and, if such appears, they should be rapidly and rigorously treated with appropriate antibiotic therapy.

Chronic overdosage may cause serious bone marrow suppression. Daily hematological evaluation should be performed to prevent overdosage. Nausea and vomiting, although a general side effect of the drug, may be an additional warning of overdosage. Severe hemorrhage into the gastrointestinal tract may indicate overdosage as may severe generalized infections.

Doses exceeding recommended dosage schedules have been used clinically and have been tolerated. The major toxicity with the use of 3 g/m^2 intravenous infusion over 1 hour every 12 hours for 12 doses and 3 g/m^2 continuous infusion for 4 days, other than reversible bone marrow suppression, has been reversible corneal, cerebral and cerebellar dysfunction. Doses of 4.5 g/m^2 intravenous infusion over 1 hour every 12 hours for 12 doses has caused an unacceptable increase in irreversible CNS toxicity and death.

For management of a suspected drug overdose, contact your regional Poison Control Centre.

ACTION AND CLINICAL PHARMACOLOGY

Pharmacodynamics

Cytarabine is capable of obliterating immune responses in man during administration. Suppression of antibody responses to E-coli-VI antigen and tetanus toxoid been demonstrated. This suppression was obtained during both primary and secondary antibody responses.

Cytarabine also suppressed the development of cell-mediated immune responses such as delayed hypersensitivity skin reaction to dinitrochlorobenzene. However, it has no effect on already established delayed hypersensitivity reactions.

Following 5-day courses of intensive therapy with Cytarabine the immune response was suppressed, as indicated by the following parameters: macrophage ingress into skin windows; circulating antibody response following primary antigenic stimulation; lymphocyte blastogenesis with phytohemagglutinin. A few days after termination of therapy there was a rapid return to normal.

Pharmacokinetics

Absorption:
Cytarabine is rapidly metabolized and is not effective orally; less than 20% of the orally administered dose is absorbed from the gastrointestinal tract.

After subcutaneous or intramuscular administration of cytarabine, peak plasma levels of radioactivity are achieved about 20 to 60 minutes after injection and are considerably lower than those after intravenous administration.

Distribution:
Cerebrospinal fluid levels of cytarabine are low in comparison to plasma levels after single intravenous injection. However, in one patient in whom cerebrospinal levels were examined after 2 hours of constant intravenous infusion, levels approached 40% of the steady state plasma level. With intrathecal administration, levels of cytarabine in the cerebrospinal fluid declined with a first order half-life of about 2 hours. Because cerebrospinal fluid levels of deaminase are low, little conversion to ara-U was observed.

Metabolism:
Cytarabine Injection (cytarabine) is metabolized by deoxycytidine kinase and other nucleotide kinases to the nucleotide triphosphate, an effective inhibitor of DNA polymerase; it is inactivated by pyrimidine nucleoside deaminase which converts it to the non-toxic uracil derivative. It appears that the balance of kinase and deaminase levels may be an important factor in determining sensitivity or resistance of the cell to cytarabine.

Excretion:
Following rapid intravenous injection of Cytarabine Injection, the disappearance from plasma is biphasic. There is an initial distributive phase with a half-life of about 10 minutes, followed by a second elimination phase with a half-life of about 1 to 3 hours. After the distributive phase, over 80% of plasma radioactivity can be accounted for by the inactive metabolite 1-β-D-arabinofuranosyluracid (ara-U). Within 24 hours about 80% of the administered radioactivity can be recovered in the urine, approximately 90% of which is excreted as ara-U.

Special Populations and Conditions

Hepatic Insufficiency: Use cytarabine with caution or possibly at reduced doses in patients whose liver function is poor (see **WARNINGS AND PRECAUTIONS, Hepatic/Biliary/Pancreatic** and **DOSAGE AND ADMINISTRATION**).

Renal Insufficiency: Use cytarabine with caution or possibly at reduced doses in patients whose kidney function is poor (see **WARNINGS AND PRECAUTIONS, Renal** and **DOSAGE AND ADMINISTRATION**).

STORAGE AND STABILITY

Stability and Storage Recommendations

Store Cytarabine Injection between 15°C and 30°C. Protect from light and freezing. Cytarabine Injection is supplied in single-use vials. The solution must be used within 24 hours after opening when stored at 15°C to 30°C, and the unused portion discarded.

Further diluted solutions should be used within 24 hours from the time of the initial puncture when stored at 15°C to 30°C or within 72 hours when refrigerated (2°C to 8°C).

Further diluted unpreserved solutions for intrathecal injection must be used immediately, since bacterially contaminated intrathecal solutions could pose very grave risks.

As with all parenteral drug products, intravenous admixtures should be inspected visually for clarity, particulate matter, precipitate, discolouration and leakage prior to administration, whenever solution and container permit. Solutions showing haziness, particulate matter, precipitate, discolouration or leakage should not be used.

Cytarabine Injection, when admixed with 0.9% Sodium Chloride Injection to a concentration of 37.5 mg/mL of cytarabine, is chemically stable for a period of 6 days at room temperature, protected from light (refer to **WARNING** below).

WARNING

a) **Although the admixture is chemically stable for up to 6 days when stored at room temperature and protected from light, due to the possibility of microbial contamination during preparation, unpreserved admixtures should be used within 24 hours after preparation when stored at room temperature, or 72 hours when stored under refrigeration.**

b) **Storage beyond these recommended times should only be permitted if the institution has a recognized intravenous admixture program.**

Drug Incompatibilities

Cytarabine has been known to be physically incompatible with heparin, insulin, 5-fluorouracil, penicillin G, methyl prednisolone and sodium succinate.

AS WITH ALL INTRAVENOUS ADMIXTURES, DILUTION SHOULD BE MADE JUST PRIOR TO ADMINISTRATION AND THE RESULTING UNPRESERVED SOLUTION USED WITHIN 24 HOURS.

SPECIAL HANDLING INSTRUCTIONS

CAUTION

The following precautionary measures are recommended in proceeding with the preparation and handling of cytotoxic agents such as Cytarabine Injection.

1. The procedure should be carried out in a vertical laminar flow hood (Biological Safety Cabinet - Class II).

2. Personnel should wear: PVC gloves, safety glasses, disposable gowns and masks.

3. All needles, syringes, vials, and other materials which have come in contact with Cytarabine Injection should be segregated and destroyed by incineration (sealed containers may explode). If incineration is not available, neutralization should be carried out using 5% sodium hypochlorite, or 5% sodium thiosulfate.

4. Personnel regularly involved in the preparation and handling of Cytarabine Injection should have bi-annual hematologic examinations.

DOSAGE FORMS, COMPOSITION AND PACKAGING

Cytarabine Injection is supplied in single-use Type 1 clear glass vials of 2 g / 20 mL.

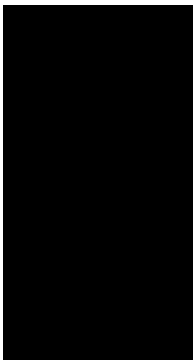
Cytarabine Injection is a sterile, preservative-free solution of cytarabine 100 mg/mL in water for injection. May contain sodium hydroxide or hydrochloric acid as pH adjusters.

PART II: SCIENTIFIC INFORMATION

PHARMACEUTICAL INFORMATION

Drug Substance

Chemical Structure:



Proper Name: Cytarabine

Chemical Name: 4-amino-1-β-D-arabinofuranosyl-2(1H)-pyrimidinone

Molecular Formula: $C_9H_{13}N_3O_5$

Molecular Weight: 243.2 g/mol

Description: Cytarabine occurs as an odourless, white to off-white crystalline powder. It is soluble in 1 in 10 of water and 1 in 1000 of alcohol and chloroform. A 2% solution in water has a pH of 4 to 6.

Composition: Cytarabine Injection is a sterile, preservative-free solution of cytarabine 100 mg/mL in water for injection. May contain sodium hydroxide or hydrochloric acid as pH adjusters.

DETAILED PHARMACOLOGY

Cell Culture Studies

Cytarabine is cytotoxic to a wide variety of proliferating mammalian cells in culture. It exhibits cell phase specificity, primarily killing cells undergoing DNA synthesis (S-phase) and under certain conditions blocking the progression of cells from the G_1 phase to S-phase. Although the mechanism of action is not completely understood, it appears that cytarabine acts through the inhibition of DNA polymerase. A limited, but significant, incorporation of cytarabine into both DNA and RNA has also been reported. Extensive chromosomal damage, including chromatoid breaks has been produced by cytarabine and malignant transformation of rodent cells in culture has been reported. Deoxycytidine prevents or delays (but does not reverse) the cytotoxic activity.

Animal Studies

In experimental studies with mouse tumors, cytarabine was most effective in those tumors with a high growth fraction. The effect was dependent on the treatment schedule; optimal effects were achieved when the schedule (multiple closely spaced doses or constant infusion) ensured contact of the drug with the tumor cells when the maximum number of cells was in the susceptible S-phase. The best results were obtained when courses of therapy were separated by intervals sufficient to permit adequate host recovery.

TOXICOLOGY

Animal Studies

Toxicity of cytarabine in experimental animals, as well as activity, is markedly influenced by the schedule of administration. For example, in mice, the LD_{10} for single intraperitoneal administration is greater than 6000 mg/m^2. However, when administered in 8 doses, each separated by 3 hours, the LD_{10} is less than 750 mg/m^2 total dose. Similarly, although a total dose of 1920 mg/m^2 administered as 12 injections at 6-hour intervals was lethal to beagle dogs (severe bone marrow hypoplasia with evidence of liver and kidney damage), dogs receiving the same total dose administered as 8 injections (again at 6-hour intervals) over a 48-hour period survived with minimal signs of toxicity.

The most consistent observation in surviving dogs was elevated transaminase levels. In all experimental species, the primary limiting toxic effect is marrow suppression with leukopenia. In addition, cytarabine causes abnormal cerebellar development in the neonatal hamster and is teratogenic to the rat fetus.

The major dose-limiting toxicity of cytarabine observed in all tested species is myelosuppression, manifested by megaloblastosis, reticulocytopenia, leukopenia and thrombocytopenia. Other target organs include liver, kidney, and brain. Extensive chromosomal damage, including chromatoid breaks, has been produced by cytarabine and malignant transformation of rodent cells in culture has been reported. Cytarabine is embryotoxic and teratogenic and produced peri- and postnatal toxicity in various species. No formal fertility studies have been reported, however sperm head abnormalities were observed following cytarabine treatment in mice.

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APPENDIX A

LSA_2-L_2 Protocol

Woolner N, Burchenal JH, Lieberman PH, et al: Non-Hodgkin's Lymphoma in Children - A Comparative Study of Two Modalities of Therapy. Cancer 1976; 37:123-134.

Induction Phase
Day 1. Cyclophosphamide 1200 mg/m^2 single push injection.
Day 3 to 31. Prednisone 60 mg/m^2 po divided into three daily doses.
Day 3, 10, 17, 24. Vincristine 1.5 to 2.25 mg/m^2 intravenously.
Day 5, 27, 30. Spinal tap and intrathecal injection of Methotrexate 6.25 mg/m^2.
Day 12, 13. Daunomycin 60 mg/m^2 intravenously.

At the end of induction (last dose of intrathecal methotrexate), patient rests for 3 - 5 days before consolidation.

Consolidation Phase
Day 34 or 36, daily intravenous injections of cytosine arabinoside (Ara-C) 150 mg/m^2 for a total of 15 injections are given. (Injections are given from Monday through Friday.) Thioguanine 75 mg/m^2 is given orally, 8 - 12 hours after the injection of Ara-C. If the white blood count is 1500 or more and the platelet count 150 000 or more on the 5th day of Ara-C, the patient continues to receive the same dosage of thioguanine over the weekend. However, both are discontinued temporarily when there is evidence of marrow depression; this usually occurs after the initial seventh to tenth doses of the combination and ordinarily recovers within 7 - 10 days. Hence, the patients may receive more than 15 doses of thioguanine orally, but receive only 15 doses of i.v. cytosine arabinoside (Ara-C). This first phase of the consolidation takes an average of 30 - 35 days. The second phase of the consolidation should be started immediately after completion of the 15 doses of Ara-C; it entails daily i.v. administration of L-asparaginase, 60000 U/m^2 for a total of 12 injections, excluding weekends.

Two days after the last injection of the L-asparaginase, two more intrathecal (i.t.) injections of methotrexate are given 2 days apart. Three days after the last i.t. methotrexate, BCNU [1, 3- Bis (2 chloroethyl 1-1-nitrosourea)] 60 mg/m^2 is given i.v., which completes the consolidation. The average duration of the induction and consolidation is 85 - 100 days.

Maintenance Phase
The maintenance period consists of five cycles of 5 days each and is started 3 - 4 days after completion of consolidation.

Cycle I:
Oral thioguanine 300 mg/m^2 for 4 consecutive days: i.v. cyclophosphamide 600 mg/m^2 on the 5th day.
Rest 7 - 10 days.

Cycle II:
Oral hydroxyurea 2400 mg/m^2 for 4 consecutive days: i.v. daunomycin 45 mg/m^2 on the 5th day.
Rest 7 - 10 days.

Cycle III:
Oral methotrexate 10 mg/m^2 for 4 consecutive days: i.v. BCNU 60 mg/m^2 on the 5th day.
Rest 7 - 10 days.

Cycle IV:
I.V. Ara-C 150 mg/m^2 for 4 consecutive days: i.v. vincristine 1.5 mg/m^2 on day 5.
Rest 7 - 10 days.

Cycle V:
Two doses of i.t. methotrexate 6.25 mg/m^2 2-3 days apart.
Rest 7 - 10 days and restart with Cycle I.

PART III: CONSUMER INFORMATION

[Pr] Cytarabine Injection
100 mg/mL

This leaflet is part III of a three-part "Product Monograph" published when Cytarabine Injection was approved for sale in Canada and is designed specifically for Consumers. This leaflet is a summary and will not tell you everything about Cytarabine Injection. Contact a member of your healthcare team if you have any questions about the drug.

ABOUT THIS MEDICATION

What the medication is used for:
Cytarabine Injection (Cytarabine) is used to treat patients with cancer of the blood (leukemia) or cancer of the lymph nodes (lymphoma). It is used alone or in combination with other medicines.

What it does:
Cytarabine slows or stops the growth of cancer cells.

When it should not be used:
Do not take Cytarabine Injection (Cytarabine):
- If you/ the child in your care are allergic (hypersensitive) to cytarabine or any other ingredients in Cytarabine Injection (see "**What the nonmedicinal ingredients are**" section of this leaflet).

What the medicinal ingredient is:
Cytarabine.

What the nonmedicinal ingredients are:
Water for injection, may contain hydrochloric acid and/or sodium hydroxide to adjust the pH.

What dosage forms it comes in:
Cytarabine Injection is available in single-use vials of 2 g / 20 mL.

WARNINGS AND PRECAUTIONS

Serious Warnings and Precautions

Cytarabine Injection should be prescribed and monitored only by doctors with experience with cancer medicines.

The following are serious side effects of Cytarabine Injection:

- **Serious Allergic Reaction:** Symptoms include sudden wheeziness, difficulty in breathing, swelling of eyelids, face or lips, rash or itching (especially affecting the whole body), hives.
- **Cytarabine Injection can cause damage to the heart.** Tell your doctor right away if you/the child in your care have chest pain, shortness of breath, swelling of the legs or irregular heartbeat.
- **Cytarabine Injection can cause changes to the lungs.** Tell your doctor right away if you/the child in your care develop wheezing, cough, fever or feeling of breathlessness, or if existing breathing problems get worse.
- **Cytarabine Injection can have harmful effects on the nervous system.** Tell your doctor right away if you/the child in your care feel drowsy or confused, dizzy or unsteady, get headaches or personality changes.
- **Cytarabine Injection can have harmful effects on the stomach and gut that can sometimes be fatal.** Tell your doctor right away if you/the child in your care feel sick or vomit, have diarrhea, a loss of appetite or abdominal pain.
- **Cytarabine Injection can cause a decrease in the number of white blood cells, red blood cells, and platelets** (low blood cell counts). This means that you/the child in your care may bruise or bleed more easily. Tell your doctor right away if you/the child in your care get infection, bleeding, fever, or chills with shivering, bruising or rash.

While you/the child in your care are being given Cytarabine Injection your doctor will monitor your blood counts (white blood cells, red blood cells, platelets) as well as your liver and kidney function by doing regular blood tests.
A preservative called **benzyl alcohol** should not be given to low birth weight or premature babies.

Cytarabine Injection may cause Tumour Lysis Syndrome (TLS). This happens when Cytarabine Injection makes the cancer cells break down very quickly. This releases uric acid (a waste product) into the blood. The kidneys usually get rid of uric acid but may not be able to cope with large amounts. This can cause serious imbalances in the blood that affect the kidneys and the heart. Tell your doctor immediately if you/ the child in your care have palpitations/irregular heartbeats; vomiting; fatigue/weakness; difficulty concentrating/trouble thinking; swelling, numbness or tingling in hands, face or feet; back pain; muscle cramps; fainting or trouble breathing.

Vaccination with a live vaccine should be avoided while being treated with Cytarabine Injection. Tell your doctor that you/the child in your care are on Cytarabine Injection before getting any vaccine.

Cases of sudden inflammation of the pancreas, and cases of paralysis, at times fatal in children, have been reported with the use of cytarabine in combination with other drugs.

Serious nervous system side effects that ranged from headache to paralysis, coma and stroke-like episodes have been reported mostly in children (under 18 years of age) given intravenous (injected into the vein) cytarabine in combination with intrathecal (injected into the spinal cord) methotrexate.

The safety of Cytarabine Injection in infants (under 1 year of age) is not known.

Before starting treatment with Cytarabine Injection, tell your doctor if you, or the child in your care, have any of the following:

- Liver or kidney problems;
- Heart problems;
- Lung problems;
- Stomach or gut problems;
- Low blood cell counts;
- Skin problems.

Pregnancy, Breastfeeding and Fertility:
Cytarabine Injection may harm your baby/ unborn baby.

Do not become pregnant while being treated with Cytarabine Injection. Women who may become pregnant must use effective birth control during treatment and for 3 months after treatment has finished.

If you are pregnant, think you might be pregnant or are planning to have a baby, ask your doctor for advice before starting treatment with Cytarabine Injection.

Tell your doctor immediately if you become pregnant.

Do not breastfeed while you are being treated with Cytarabine Injection. .

Male Fertility:
Do not father a child while being treated with Cytarabine Injection and for 3 months after stopping treatment. Use condoms and do not donate sperm during treatment and for 3 months after your treatment has finished. If you plan to father a child, talk to your doctor before starting treatment with Cytarabine Injection.

Driving and using machines
If you feel drowsy or dizzy, do not drive or use machinery.

INTERACTIONS WITH THIS MEDICATION

Serious Drug Interactions
If Cytarabine Injection is given to you/the child in your care with methotrexate (another drug used to treat cancer), you have more chances of having serious side effects on your nervous system such as headache, paralysis, coma and stroke-like episodes.

Tell your doctor or pharmacist about any medicines you or the child in your care are on or have taken (including the ones that you don't need a prescription for), especially the following:

- 5-Fluorocytosine (a medicine used to treat fungal infections);
- Digoxin (a heart medicine);
- Gentamicin (an antibiotic);
- Cyclophosphamide, vincristine and prednisone.

PROPER USE OF THIS MEDICATION

Cytarabine Injection will be given to you or the child in your care as an injection or an infusion. It can be given:

- Into the spinal cord
- Into a vein (through a "drip")
- Under the skin

Chemotherapy is usually given during several cycles of treatment over a few months. The length of your/the child in your care's treatment and the number of cycles you or the child in your care need will depend on the type of cancer you/they have. Your doctor will discuss your treatment plan with you.

Usual dose:
The dose of Cytarabine Injection you or the child in your care will be given will be calculated by your doctor based on your/the child's weight and height.

Overdose

If you think you have taken too much Cytarabine Injection, contact your healthcare professional, hospital emergency department or regional poison control centre immediately, even if there are no symptoms."

Missed dose:
Call your doctor for instructions if you/the child in your care miss an appointment for your Cytarabine Injection.

SIDE EFFECTS AND WHAT TO DO ABOUT THEM

Side effects of Cytarabine Injection may include:

- Viral, bacterial, or fungal infections: Infections can be serious and may lead to death. Contact your doctor if you or the child in your care have fever, chills, or any other signs or symptoms of a possible infection.
- Cytarabine Syndrome: Cytarabine Injection may cause a reaction called Cytarabine Syndrome 6 to 12 hours after it has been given. Contact your doctor if you or the child in your care develop fever, muscle pain, bone pain, chest pain, rash, eye problems (pain, itching, redness, discharge, blurred vision), or generally feel unwell.
- Feeling tired or weak.
- Headaches or feeling dizzy, fainting.
- Feeling of pins and needles.
- Nausea, vomiting, diarrhea, loss of appetite, abdominal pain.
- Eye infection, irritation, pain and blurred vision.
- Hair loss, skin rash or open sores, peeling of the skin, itching or increased freckles.
- Swelling of the throat, heartburn, sores and bleeding in the mouth, lips, or on the anus.
- Feeling hot and feverish.
- Sore throat.
- Muscle pain, bone pain.
- Fast heartbeat.
- Rash or blisters on the palms of the hands and soles of the feet.

If any of these affects you severely, tell your doctor, nurse or pharmacist.

During treatment, you or the child in your care will need to have regular blood tests. Your doctor will tell you how often this should be done. It is important that you do not miss any of these tests.

SERIOUS SIDE EFFECTS AND WHAT TO DO ABOUT THEM				
Symptom / Effect		Talk to your healthcare professional		Stop taking drug and get immediate medical help
		Only if severe	In all cases	
Very common	**Anemia:** symptoms include fatigue, loss of energy, weakness, shortness of breath.		√	
	Decreased platelets: symptoms include bruising, bleeding, fatigue and weakness.		√	
	Decreased white blood cells: symptoms include infections, fever, chills with shivering, fatigue, aches pains and flu-like symptoms.		√	
	Infection of the blood: symptoms include feeling dizzy or faint, confusion or disorientation, diarrhea, nausea, vomiting, slurred speech, severe muscle pain.			√
	Megaloblastic anemia: symptoms include fatigue, weakness, loss of appetite, nausea, diarrhea, fast heartbeat, smooth or tender tongue, tingling or numbness in hands and feet.		√	
	Pneumonia: symptoms include cough with or without mucus, fever, chills, shortness of breath.		√	
	Serious stomach or gut problems: symptoms include severe vomiting, severe diarrhea (increased number of bowel movements, watery or bloody stool), stomach pain and/or cramps.		√	
Frequency not known	**Serious allergic reaction**: symptoms include rash, hives, swelling of the face, lips, tongue or throat, difficulty swallowing or breathing. It may lead to a heart attack.			√
	Edema: symptoms include swelling of the stomach, legs, ankles or feet.		√	
	Inflammation of the pancreas: symptoms include abdominal pain that lasts and gets worse when you lie down, fever, nausea, vomiting.		√	
	Injection site reaction: symptoms include pain, redness, warmth, swelling at the injection site or along the vein.			√
	Kidney disorder: symptoms include decreased urination, nausea, vomiting, swelling of extremities, fatigue, difficulty or pain when urinating, blood in the urine.		√	

SERIOUS SIDE EFFECTS AND WHAT TO DO ABOUT THEM				
Symptom / Effect		Talk to your healthcare professional		Stop taking drug and get immediate medical help
		Only if severe	In all cases	
	Liver disorder: symptoms include yellowing of the skin or eyes, dark urine, abdominal pain, nausea, vomiting, loss of appetite.		√	
	Serious bleeding problems: symptoms include blood in your stool or urine, bleeding that lasts for a long time or that you cannot control, coughing up blood or blood clots, increased bruising, feel dizzy or weak, confusion, change in your speech, or a headache that lasts a long time.			√
	Serious eye problems: symptoms include sensitivity to light, blurry vision, eye pain, tearing, feeling like there is something stuck in your eye.		√	
	Serious heart problems: symptoms include shortness of breath, swelling of the legs, irregular heartbeat, chest pain.			√
	Serious nervous system problems: symptoms include headache, paralysis, coma, stroke-like episodes, drowsiness or confusion, dizziness or unsteadiness, personality changes, shaking and fits, speech problems, involuntary movements.			√
	Tumor Lysis Syndrome: symptoms include nausea, vomiting, decreased urination, irregular heartbeat, confusion, delirium, seizures.			√

If you have a troublesome symptom or side effect that is not listed here or becomes bad enough to interfere with your daily activities, talk to your healthcare professional.

HOW TO STORE IT

Keep out of reach and sight of children.

This drug will be given to you in a hospital or doctor's office. You will not store it at home.

Medicines should not be thrown down the drain or in the garbage. Ask your pharmacist how to dispose of medicines you no longer need. This will help to protect the environment.

Reporting Side Effects

You can report any suspected side effects associated with the use of health products to Health Canada by:

- Visiting the Web page on Adverse Reaction Reporting (https://www.canada.ca/en/health-canada/services/drugs-health-products/medeffect-canada/adverse-reaction-reporting.html) for information on how to report online, by mail or by fax; or
- Calling toll-free at 1-866-234-2345.

NOTE: Contact your health professional if you need information about how to manage your side effects. The Canada Vigilance Program does not provide medical advice.

MORE INFORMATION

This document plus the full product monograph, prepared for health professionals, can be obtained by contacting the sponsor, SteriMax Inc., at **1-800-881-3550.**

This leaflet was prepared by:
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