**Clindamycin IV**

Currently marketed formulations of clindamycin IV:

<table>
<thead>
<tr>
<th>DIN</th>
<th>Company</th>
<th>Product</th>
<th>A.I. Name</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>0238571</td>
<td>SANDOZ</td>
<td>CLINDAMYCIN INJECTION 2 &amp; 4 ml amps</td>
<td>CLINDAMYCIN PHOSPHATE</td>
<td>150 MG / ML</td>
</tr>
<tr>
<td>02230535</td>
<td>SANDOZ</td>
<td>CLINDAMYCIN INJECTION 60 &amp; 120 ml</td>
<td>CLINDAMYCIN PHOSPHATE</td>
<td>150 MG / ML</td>
</tr>
<tr>
<td>02230540</td>
<td>SANDOZ</td>
<td>CLINDAMYCIN INJECTION 2, 4 &amp; 6 ml</td>
<td>CLINDAMYCIN PHOSPHATE</td>
<td>150 MG / ML</td>
</tr>
<tr>
<td>00260436</td>
<td>PFIZER</td>
<td>DALACIN C PHOSPHATE 2, 4, 6 &amp; 60 ml</td>
<td>CLINDAMYCIN PHOSPHATE</td>
<td>150 MG / ML</td>
</tr>
</tbody>
</table>

**Indications for IV clindamycin**
- Severe infections caused by susceptible strain of gram positive staphylococci, streptococci (except *E. faecalis*), pneumococci and anaerobic bacteria when oral therapy is not feasible:
- Bacterial endocarditis prophylaxis

**Considerations when choosing alternative:**
- Clindamycin should be used IV ONLY if patient is NPO as oral absorption is excellent.²
- Clindamycin is often an alternative to penicillins and cephalosporins for beta-lactam allergies.³⁴ **Ensure there is a valid rationale for avoiding first line penicillins and cephalosporins.** Recent information suggests there is very limited cross-sensitivity between penicillins and cephalosporins:
  - Cross-reactivity between penicillins and MOST 1st and 2nd generation cephalosporins is negligible. However, patients with a history of an anaphylactic reaction to amoxicillin or ampicillin should avoid cefradoxil, cefaclor, ceftirizine, and cefprozil.
  - Cross-reactivity between penicillins and ALL 3rd and 4th generation cephalosporins e.g. cefixime, ceftriaxone, cefipime is negligible.
  - Overall cross reactivity between penicillins and cephalosporins: reported penicillin allergy 1%; confirmed penicillin allergy 2.5%.
  - Anaphylactic reactions to cephalosporins are very rare - 0.0001 to 0.1 percent.
Alternatives to IV clindamycin:

- **Anaerobic coverage in antibiotic combinations** - substitute metronidazole 500 mg IV BID (adult); 30mg/kg/d divided q12 (pediatric)
  Ex: Severe aspiration pneumonia - levofloxacin or moxifloxacin + metronidazole

- **Penicillin allergy** – cephalosporin as per guidelines for condition being treated
  Ex: Severe complicated cutaneous infections – cefazolin 2 g IV q8h; cefazolin 75mg/kg/d IV div q8h divided q12h x 10d (pediatric)

- **Cephalosporin allergy** – vancomycin or linezolid
  Ex: Severe pneumonia treated in-hospital: levofloxacin 750mg IV daily + vancomycin 25-30mg/kg IV once then 15mg/kg IV q8-12h x 5-10d (adult)

- **Pneumocystis pneumonia** if alternative to first line treatment TMP/SMX or trimethoprim is needed: pentamidine 4mg/kg/day IV x 21 days.

- **Endocarditis prophylaxis** for dental and upper respiratory procedures: Allergic to penicillin and NPO - cefazolin or ceftriaxone - 1g IM or IV (adult); 50mg/kg IM or IV (pediatric)

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References: