SODIUM CHLORIDE AND GLUCOSE INTRAVENOUS INFUSION BP

NAME OF THE DRUG

Composition:
Glucose (anhydrous) and Sodium Chloride in Water for Injections.

Chemical Structure/ molecular formula:
The chemical name of glucose is D-(+) glucopyranose. Molecular formulae of glucose and sodium chloride is C₆H₁₂O₆, and NaCl, respectively.

DESCRIPTION

Glucose is a monosaccharide, having physical characteristics as a white crystal or granular powder and freely soluble in water. Sodium chloride occurs as a colourless or white crystal and is freely soluble in water.

Sodium Chloride and Glucose Intravenous Infusions (IVI) are sterile, nonpyrogenic solutions. The concentrations of the active ingredients dissolved in a litre of Water for Injections are shown in Table 1 (see Presentation and Storage Conditions). They do not contain an antimicrobial agent or added buffer, and have a pH of 3.5 - 6.5. They are iso-osmotic as indicated by their osmolarity shown in Table 1 (Presentation and Storage Conditions), except Sodium Chloride 0.9% and Glucose 5% IVI, and Sodium Chloride 0.22% and Glucose 10% IVI which are hypertonic solutions (with osmolarity of 586 mOsmol/L and 630 mOsmol/L respectively).

PHARMACOLOGY

Mechanism of Action:
Glucose is readily metabolised into carbon dioxide and water, with a release of energy. As such, an administration of a glucose solution either by oral or parenteral route provides water for body hydration as well as energy (for conversion to kJ units, see Table 1 Presentation and Storage Conditions). In addition, it may reduce catabolic loss of nitrogen from the body and aid in prevention of depletion of liver glycogen. That is, in the absence of glucose, amino acids undergo deamination followed by oxidation in order to release energy.
Sodium is the major cation of extracellular fluid and functions principally in the control of water distribution, fluid and electrolyte balance and osmotic pressure of body fluids. Chloride, the major extracellular anion, closely follows the physiological disposition of the sodium cation in maintenance of acid-base balance, isotonicity and electrodynamic characteristic of the cells.

Thus, Sodium Chloride and Glucose Intravenous Infusion has a value as a source of water, electrolytes and energy.

**Pharmacokinetics:**
As Sodium Chloride and Glucose Intravenous Infusion is directly administered to the systemic circulation by infusion, the bioavailability (absorption) of the active components is complete (100%). Excess sodium is predominantly excreted by the kidney, with small amounts lost in faeces and sweat.

**INDICATIONS**

Sodium Chloride and Glucose Intravenous Infusion is indicated for replenishing fluid losses, as an energy source and for restoration or maintenance of sodium and chloride ion concentrations. It may be used as a vehicle of drug delivery where intravenous delivery is appropriate and the drug is compatible with this solution.

**CONTRAINDICATIONS**

Sodium Chloride and Glucose Intravenous Infusions are contraindicated in patients with the following medical conditions:
- know hypersensitivity to the product
- known allergy to corn or corn products, because cornstarch is used as raw material for glucose production
- cardiac failure including congestive heart failure
- lactacidosis
- uncontrolled diabetes
- clinically significant hyperglycaemia
- hyperkalaemia
- severe impairment of renal function
- bloating-ascitic syndrome in cirrhosis
- acute ischaemic stroke
- patients who have had a head trauma within 24 hours
- patients presenting with a clinical state in which there exists oedema with sodium retention, or with renal, hepatic or cardiac impairment with oedema, hypervolaemia, hypernatraemia.
Sodium Chloride and Glucose Intravenous Infusion containing ≤0.225% sodium chloride are contraindicated in patients presenting with severe hyponatraemia.

PRECAUTIONS

General
The safety of the Viaflex plastic container used to contain the Sodium Chloride and Glucose Intravenous Infusion preparations has been confirmed in tests with animals according to the USP biological tests for plastic container, as well as by tissue culture toxicity studies. Nevertheless, care should be exercised regarding a possible incompatibility outcomes resulted either from the interaction between the plastic container or active ingredients and the added therapeutic substances (see also Dosage and Administration).

When used as a vehicle of intravenous drug delivery, the product information document of these drugs must be examined to ensure compatibility with Sodium Chloride and Glucose Intravenous Infusion.

In a dilute condition, osmolarity/L is approximately the same with osmolality/kg. As shown in Table 1 (Presentation and Storage Conditions), Sodium Chloride 0.9% and Glucose 5.0%, and Sodium Chloride 0.22% and Glucose 10% IVI are hypertonic (with osmolarity of 586 mOsmol/L and 630 mOsmol/L respectively), whilst the other strengths are isotonic.

The administration of substantially hypertonic solution may lead to a wide variety of complications. These include crenation (shrinkage) of red blood cells and general cellular dehyration.

The administration of Sodium Chloride and Glucose Intravenous Infusion can cause fluid and/or solute overloading resulting in dilution of the serum electrolyte concentrations, overhydration, congested states, or pulmonary oedema. The risk of dilution states is inversely proportional to the electrolyte concentrations of the injections. The risk of solute overload causing congested states with peripheral and pulmonary oedema is directly proportional to the electrolyte concentrations of the injections. Thus, caution must be exercised when administering Sodium Chloride and Glucose Intravenous Infusion to patients with or at risk of:
- hypernatraemia
- hyperchloraemia
- metabolic acidosis
- hypervolaemia
- conditions that may cause sodium retention, fluid overload and oedema (central and peripheral), for example: hypertension, heart failure including congestive heart failure, peripheral or pulmonary oedema, impaired renal function, pre-eclampsia or other conditions associated with sodium retention.

Similarly, care should be exercised with the administration of these products to patients receiving corticosteroids or corticotropin, because of a potential sodium and water retention.
Patients receiving fluid replacement therapy should be monitored as fluid and electrolyte disturbances such as hyponatraemia and hypokalaemia may occur. Excessive administration of Sodium Chloride and Glucose Intravenous Infusion without addition of potassium, may result in significant hypokalaemia. Prolonged therapy should be monitored for changes in fluid balance, electrolyte concentration and acid-base balance.

Rapid correction of hyponatraemia and hypernatraemia is potentially dangerous (risk of serious neurologic complications). Dosage, rate and duration of administration should be determined by a physician experienced in intravenous fluid therapy.

Sodium Chloride and Glucose Intravenous Infusion should be used with caution in patients with thiamine deficiency, hypophosphataemia and diabetes mellitus (see **Interactions with Other Medicines**).

**Hypersensitivity Reactions**

Hypersensitivity/infusion reactions, including anaphylaxis, have been reported with Sodium and Glucose Intravenous Infusion (see **Adverse Effects**). If signs or symptoms of hypersensitivity/infusion reactions develop, stop the infusion immediately. Appropriate therapeutic countermeasures must be instituted as clinically indicated.

**Hyponatraemia**

The infusion of solutions with sodium concentrations < 0.9% may result in hyponatraemia, which may warrant close clinical monitoring. Hyponatraemia can lead to headache, nausea, seizures, lethargy, coma, cerebral oedema, and death, therefore acute symptomatic hyponatraemic encephalopathy is considered a medical emergency.

The risk of hyponatraemia is increased in children, elderly patients, women, postoperatively, in patients with psychogenic polydipsia and in patients treated with medications that increase the risk of hyponatraemia (such as certain antiepileptic and psychotropic medications).

The risk of developing hyponatraemic encephalopathy is increased, for example, in paediatric patients, women (in particular, premenopausal women), in patients with hypoxemia and in patients with underlying central nervous system disease.

The infusion of hypotonic fluids together with the non-osmotic secretion of ADH may also result in hyponatraemia.

**Hypokalaemia**

The infusion of Sodium and Glucose Intravenous Infusion may result in hypokalaemia. Sodium and Glucose Intravenous Infusion should be used with particular caution in patients with or at risk of hypokalaemia, close clinical monitoring may be warranted in patients with, but not limited to:

- metabolic alkalosis
thyrotoxic periodic paralysis, administration of intravenous glucose has been associated in aggravating hypokalaemia
- increased gastrointestinal losses (e.g. diarrhoea, vomiting)
- prolonged low potassium diet
- primary hyperaldosteronism
- medication and treatments that increase the risk of hypokalaemia (e.g. diuretics, beta-2 agonist, or insulin).

**Risk of hypo-/hyper-osmolality, serum electrolytes and water imbalance**
Depending on the volume and rate of infusion and depending on a patient’s underlying clinical condition and capability to metabolise glucose, intravenous administration of Sodium and Glucose Intravenous Infusion can cause:

- hypoosmolality
- hyperosmolality, osmotic diuresis and dehydration
- electrolyte disturbances such as hyponatraemia, hypokalaemia, hypophosphataemia and hypomagnesaemia
- overhydration/hypervolaemia and congested states, including central (eg. pulmonary congestion) and peripheral oedema
- an increase in serum glucose concentration is associated with an increase in serum osmolality. Osmotic diuresis associated with hyperglycaemia can result in or contribute to the development of dehydration and electrolyte losses.

Clinical evaluation and periodic laboratory determinations may be necessary to monitor changes to fluid balance, electrolyte concentrations, and acid-base balance during prolonged parenteral therapy or whenever the condition of the patient or the rate of administration warrants such evaluation.

**Hyperglycaemia**
Rapid administration of glucose solutions may produce substantial hyperglycaemia and hyperosmolar syndrome. In order to avoid hyperglycaemia the infusion rate should not exceed the patient’s ability to utilise glucose. To reduce the risk of hyperglycaemia-associated complications, the infusion rate must be adjusted and/or insulin administered if blood glucose levels exceed levels considered acceptable for the individual patient.

Intravenous glucose should be administered with caution in patients with, but not limited to:
- impaired glucose tolerance (such as in diabetes mellitus, renal impairment, or in the presence of sepsis, trauma, or shock),
- severe malnutrition (risk of precipitating a refeeding syndrome),
- thiamine deficiency (risk of severe lactic acidosis due to impaired oxidative metabolism of pyruvate),
- water and electrolyte disturbances that could be aggravated by increased glucose and/or free water load.

Other groups of patients in whom Sodium and Glucose Intravenous Infusion should be used with caution include:
- patients with ischaemic stroke. Hyperglycaemia has been implicated in increasing cerebral ischaemic brain damage and impairing recovery after acute ischaemic strokes.
- patients with severe traumatic brain injury. Early hyperglycaemia has been associated with poor outcomes in patients with severe traumatic brain injury.
- Newborns (See Paediatric Use).

Prolonged intravenous administration of glucose and associated hyperglycaemia may result in decreased rates of glucose-stimulated insulin secretion.

Refeeding Syndrome
Refeeding severely undernourished patients may result in the refeeding syndrome that is characterised by the shift of potassium, phosphorus, and magnesium intracellularly as the patient becomes anabolic. Thiamine deficiency and fluid retention may also develop. Careful monitoring and slowly increasing nutrient intake while avoiding overfeeding can prevent these complications.

Use in Patients with or at risk of Severe Renal Impairment
Sodium and Glucose Intravenous Infusion should be administered with particular caution, to patients with or at risk of (severe) renal impairment. In such patients, administration of Sodium and Glucose Intravenous Infusion may result in sodium retention and/or fluid overload.

Blood
Sodium and Glucose Intravenous Infusion should not be administered simultaneously with blood through the same administration set because of the possibility of pseudoagglutination or haemolysis.

Risk of Air Embolism
Do not connect flexible plastic containers in series in order to avoid air embolism due to possible residual air contained in the primary container. Pressurising intravenous solutions contained in flexible plastic containers to increase flow rates can result in air embolism if the residual air in the container is not fully evacuated prior to administration. Use of a vented intravenous administration set with the vent in the open position could result in air embolism. Vented intravenous administration sets with the vent in the open position should not be used with flexible plastic containers (see Dosage and Administration).

Use in pregnancy (Category C)
Animal reproduction studies have not been conducted with Sodium Chloride and Glucose Intravenous Infusion. It is also not known whether these dosage forms can cause foetal harm when administered to a pregnant woman or can affect reproduction capacity. Intrapartum maternal intravenous glucose infusion may result in foetal hyperglycaemia and metabolic acidosis as well as rebound neonatal hypoglycaemia due to foetal insulin production.
Physicians should carefully consider the potential risks and benefits for each specific patient before administering Sodium and Glucose Intravenous Infusion.

Use in lactation

Safety in lactation has not been established. Use this product in a nursing woman only when it is clearly needed and the potential benefits outweigh the potential risks to the baby.

Paediatric Use

Neonates, especially those born premature and with low birth weight, are at increased risk of developing hypo- or hyperglycaemia and therefore need close monitoring during treatment with intravenous glucose solutions to ensure adequate glycaemic control in order to avoid potential long term adverse effects. Hypoglycaemia in the neonate can cause prolonged seizures, coma and brain damage. Hyperglycaemia has been associated with cerebral injury, including intraventricular haemorrhage, late onset bacterial and fungal infection, retinopathy of prematurity, necrotising enterocolitis, increased oxygen requirements, bronchopulmonary dysplasia, prolonged length of hospital stay, and death.

Infants and children may have an impaired ability to regulate fluid and electrolytes. Fluid replacement therapy (including plasma electrolyte concentrations) should be closely monitored in these populations as fluid and electrolyte disturbances (such as hyponatraemia and hypokalaemia) may occur.

Children (including neonates and older children) are at increased risk of developing hyponatraemia as well as developing hyponatraemic encephalopathy. Hyponatraemia can lead to headache, nausea, seizures, lethargy, coma, cerebral oedema, and death. Therefore, acute symptomatic hyponatraemic encephalopathy is considered a medical emergency.

Rapid correction of hyponatraemia is potentially dangerous (risk of serious neurologic complications). Dosage, rate, and duration of administration should be determined by a physician experienced in paediatric intravenous fluid therapy.

Use in the Elderly

When selecting the type of infusion solution and the volume/rate of infusion for a geriatric patient, consider that geriatric patients are generally more likely to have cardiac, renal, hepatic, and other diseases or concomitant drug therapy.

Genotoxicity/ Carcinogenicity

The active ingredients glucose and sodium chloride are not carcinogenic or mutagenic. They are basic constituents in all living cells.
INTERACTIONS WITH OTHER MEDICINES

Sodium Chloride and Glucose Intravenous Infusion should not be administered simultaneously with blood preparation through the same administration set, because of the possibility of pseudo-agglutination or haemolysis.

If using this solution to administer drugs, the Product Information document(s) of such drug(s) must be reviewed to ensure compatibility, including pH and ion concentrations, with the solution.

Both the glycaemic effects of Sodium and Glucose Intravenous Infusion and its effects on water and electrolyte balance should be taken into account when using these products in patients treated with other substances that affect glycaemic control, or fluid and/or electrolyte balance.

Caution is advised in patients treated with lithium. Renal sodium and lithium clearance may be decreased during administration of Sodium and Glucose Intravenous Infusion and can result in increased lithium levels.

ADVERSE EFFECTS

Adverse effects of sodium salts are attributable to electrolyte imbalances from excess sodium. Retention of excess sodium in the body can lead to accumulation of extracellular fluid to maintain normal plasma osmolality, which may result in pulmonary and peripheral oedema with their consequent effects.

Hypernatraemia rarely occurs with therapeutic doses of sodium chloride, but may occur after inappropriate intravenous administration of hypertonic saline. The most serious consequence of this, is dehydration of the brain causing somnolence and confusion, progressing to convulsion, coma and ultimately respiratory failure and death. Other symptoms include thirst, reduced salivation and lachrymation, fever, tachycardia, hypertension, headache, dizziness, restlessness, weakness and irritability.

Metabolism and nutrition disorders: hyponatraemia, which could lead to death, have been reported.

Adverse reactions which may occur because of the solution (eg. contamination), additive drugs or the technique of administration include fever response (due to possible introduction of pyrogens), infection at the site of injection, local pain or reaction, vein irritation, venous thrombosis or phlebitis extending from the site of injection, extravasation and hypervolaemia.

Anaphylactic reactions, hypersensitivity and chills have also been reported.
If an adverse reaction does occur, discontinue the infusion, evaluate the patient, institute appropriate therapeutic countermeasures and save the remainder of the fluid for examination if deemed necessary. The nature of any additive should be considered in the event of other undesirable effects.

**Post-Marketing Adverse Reactions**
The following adverse reactions have been reported in the post-marketing experience, listed by MedDRA System Organ Class (SOC), then where feasible, by Preferred Term in order of severity.

- Immune System Disorders: Anaphylactic reaction, Hypersensitivity
- Metabolism and Nutrition Disorders: Hyponatraemia, Hyperglycaemia
- Vascular Disorders: Phlebitis
- Skin and Subcutaneous Tissue Disorders: Rash, Pruritus
- General Disorders and Administration Site Conditions: Injection site reactions including, Infusion site pain, Injection site vesicles, Chills, Pyrexia.

**Other Adverse reactions (Class Reactions)**
Other adverse reactions reported with isotonic saline and glucose injection/infusions include:

- hyponatraemia, which may be symptomatic
- acidosis hyperchloaemic.

**DOSAGE AND ADMINISTRATION**

**General directive**

To be used only as directed by the physician. The dosage of Sodium Chloride and Glucose Intravenous Infusion is dependent upon the age, weight, clinical condition of the patient, laboratory determinations and concomitant therapy. For patients with electrolyte and glucose abnormalities and for paediatric patients, consult a physician experienced in intravenous fluid therapy. Electrolyte supplementation may be indicated according to the clinical needs of the patient.

A gradual increase of flow rate should be considered when starting administration of glucose containing products.

Parenteral drug products should be inspected visually for particulate matter and discolouration prior to administration, whenever solution and container permit. Do not administer Sodium Chloride and Glucose Intravenous Infusion unless the solution is clear, colourless and free of particles, and the seals are intact.

Sterile and nonpyrogenic equipment must be used for intravenous administration. The equipment should be primed with the solution in order to prevent air embolism due to the residual air in the system. Use of an in-line filter is recommended during administration of
all parenteral solutions.

Additives may be introduced before infusion or during infusion through the injection site. Additives may be incompatible. Check relevant literature for additive, solution and container compatibility prior to use. Complete information is not available. Those additives known to be incompatible should not be used. Consult with a pharmacist, if available.

Before adding a substance or medication, verify that it is soluble and/or stable in Sodium and Glucose Intravenous Infusion and the pH range of Sodium and Glucose Intravenous Infusion is appropriate.

If in the informed judgment of the physician, it is deemed advisable to introduce additives, aseptic technique must be used. Mix thoroughly and carefully when additives have been introduced. After addition, check for a possible colour change and/or the appearance of precipitates, insoluble complexes or crystals. Do not store solutions containing additives.

The product should be used once only. Any unused portion should be discarded. Do not reconnect partially used bags.

The osmolarity of a final admixed solution must be taken into account when peripheral administration is considered (see Table 1 Presentation and Storage Conditions for the products’ osmolarity). Hyperosmolar solutions may cause venous irritation and phlebitis. Thus, any hyperosmolar solutions are recommended to be administered through a large central vein, for rapid dilution of the hypertonic solution. If hypertonic solutions are administered peripherally, a large arm vein should be used and, if possible, the injection site should be altered daily. Rapid infusion in peripheral arm veins may be harmful.

**Direction for use of Viaflex plastic container**

Do not remove unit from over-wrap until ready for use. The inner bag maintains the sterility of the product. Do not use plastic containers in series connections. Such use could result in embolism due to residual air being drawn from the primary container before administration of the fluid from the secondary container is completed.

Vented intravenous administration sets with the vent open, or pressurizing intravenous solutions contained in flexible plastic containers to increase flow rate can result in air embolism if the residual air in the container is not fully evacuated prior to administration. Therefore, vented intravenous administration sets with the vent in the open position should not be used with flexible containers.

**To open:**
Tear over-wrap down side at slit and remove solution container.

Check solution for limpidity and absence of foreign matter. If solution is not clear or contains foreign matter, discard the solution. Some opacity of the Viaflex plastic container due to moisture absorption during the sterilisation process may be observed. This is normal
and does not affect the solution quality or safety. The opacity will diminish gradually. Check for minute leaks by squeezing inner bag firmly. If leaks are found, discard solution as sterility may be impaired.

If supplemental medication is desired, follow directions below.

**Preparation for Administration:**
(1) Suspend container from eyelet support. (2) Remove plastic protector from outlet port at the bottom of container. (3) Attach administration set, use an aseptic method to set up the infusion.

**To Add Medication:** Additives may be incompatible. Check the Product Information Document(s) of the medication(s) prior to their addition to Sodium Chloride and Glucose Intravenous Infusion.

**To add medication before solution administration:** Prepare medication site. Using syringe with 19 to 22 gauge needle, puncture resealable medication port and inject. Mix solution and medication thoroughly. For high density medication such as potassium chloride, squeeze ports while ports are upright and mix thoroughly.

**To add medication during solution administration:** Close clamp on the set. Prepare medication site. Using syringe with 19 to 22 gauge needle, puncture resealable medication port and inject. Remove container from IV pole and/or turn to upright position. Evacuate both ports by squeezing them while container is in the upright position. Mix solution and medication thoroughly. Return container to in use position, re-open the clamp and continue administration.

**OVERDOSAGE**

Overdosage with Sodium Chloride and Glucose Intravenous Infusions can cause:
- hyperglycaemia, adverse effects on water and electrolyte balance, and corresponding complications. For example, severe hyperglycaemia and severe dilutional hyponatraemia, and their complications can be fatal.
- hyponatraemia, which can lead to CNS manifestations (including seizures, coma, cerebral oedema and death).
- hypernatraemia especially in patients with severe renal impairment. Retention of excess sodium when there is defective renal sodium excretion may result in pulmonary and peripheral oedema. The most serious effect of hypernatraemia is dehydration of the brain which causes somnolence and confusion progressing to convulsions, coma, respiratory failure and death. Other symptoms include thirst, reduced salivation and lacrimation, fever, tachycardia, headache, dizziness, restlessness, irritability and weakness.
- fluid overload, which can lead to central and/or peripheral oedema.

Excessive administration of chloride salts may cause a loss of bicarbonate with an
acidifying effect.

Prolonged or rapid administration of large volumes of isotonic solutions may cause oedema or water intoxication. Prolonged or rapid administration of hypertonic solutions containing glucose may result in dehydration as a consequence of the induced hyperglycaemia.

When assessing an overdose, any additives in the solution must also be considered. Clinically significant overdose of Sodium and Glucose Intravenous Infusion may therefore constitute a medical emergency. Interventions include discontinuation of Sodium and Glucose Intravenous Infusion administration, dose reduction, administration of insulin and other measures as indicated for the specific clinical group.

For information on the management of overdose, contact the Poisons Information Centre on 131126 (Australia).

**PRESENTATION AND STORAGE CONDITIONS**

Sodium Chloride (%) and Glucose (%) Intravenous Infusion dosage forms are supplied in Viaflex plastic bags as shown in Table 1.

**Table 1: Sodium Chloride and Glucose Intravenous Infusion preparations**

<table>
<thead>
<tr>
<th>Code No.</th>
<th>Product</th>
<th>Osmolality&lt;sup&gt;a&lt;/sup&gt; (mOsmol/L)</th>
<th>ARTG/AUST R</th>
<th>Pack Size* (mL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHB1023</td>
<td>Sodium Chloride 0.45% and Glucose 2.5% IV Infusion, 500 mL [209 kJ/ 500 mL]</td>
<td>294</td>
<td>19495</td>
<td>500</td>
</tr>
<tr>
<td>AHB1033</td>
<td>Sodium Chloride 0.3% and Glucose 3.3% IV Infusion, 500 mL [276 kJ/500 mL]</td>
<td>288</td>
<td>19498</td>
<td>500</td>
</tr>
<tr>
<td>AHB1034</td>
<td>Sodium Chloride 0.3% and Glucose 3.3% IV Infusion, 1000 mL [551 kJ/L]</td>
<td>285</td>
<td>48522</td>
<td>1000</td>
</tr>
<tr>
<td>AHB1243</td>
<td>Sodium Chloride 0.225% and Glucose 3.75% IV Infusion, 500 mL [313 kJ/ 500 mL]</td>
<td>284</td>
<td>19499</td>
<td>500</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Calories</td>
<td>EAN</td>
<td>Volume</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>AHB1253</td>
<td>Sodium Chloride 0.18% and Glucose 4% IV Infusion, 500 mL [334 kJ/ 500 mL]</td>
<td>282</td>
<td>19501</td>
<td>500</td>
</tr>
<tr>
<td>AHB1254</td>
<td>Sodium Chloride 0.18% and Glucose 4% IV Infusion, 1000 mL [668 kJ/L]</td>
<td>284</td>
<td>48523</td>
<td>1000</td>
</tr>
<tr>
<td>AHB1064</td>
<td>Sodium Chloride 0.9% and Glucose 5% IV Infusion, 1000 mL [835 kJ/L]</td>
<td>586</td>
<td>19502</td>
<td>1000</td>
</tr>
<tr>
<td>AHB2026</td>
<td>Sodium Chloride 0.22% and Glucose 10% IV Infusion, 500 mL [835 kJ/ 500 mL]</td>
<td>630</td>
<td>82805</td>
<td>500</td>
</tr>
</tbody>
</table>

**Note:** Osmolarities in (mOsmol/L) are calculated figures which equate to the approximate Osmolarities (mOsmol/kg); AHB1064 and AHB2026 are hypertonic solutions as indicated by the osmolarities of 586 mOsmol/L and 630 mOsmol/L respectively. 1 gram of glucose provides 16.7 kiloJoules (kJ) of energy.

*Not all packs are marketed.*

**Storage**

Exposure of the products to heat should be minimised.
Avoid excessive heat. It is recommended that the products be stored below 30°C.

**NAME AND ADDRESS OF THE SPONSOR**

Baxter Healthcare Pty Ltd
1 Baxter Drive,
Old Toongabbie, NSW, 2146, Australia.

**POISON SCHEDULE OF THE MEDICINE**

Unscheduled

**DATE OF FIRST INCLUSION IN THE AUSTRALIAN REGISTER OF THERAPEUTIC GOODS (ARTG)**

30 September 1991
AUST R 19495, 19498, 19499, 19501 and 19502

21 April 1994
AUST R 48522 and 48523
18 July 2002
AUST R 82805

DATE OF MOST RECENT AMENDMENT

10 February 2015