PROFESSIONAL INFORMATION

SCHEDULING STATUS

S1

1. NAME OF MEDICINE

PARACETAMOL GDC (TABLETS)

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains: Paracetamol 500 mg

Preservatives:	Nipastat	0,097 % m/m
	Benzoic acid	0,065 % m/m

Contains sugar: powdered sucrose 20 mg / tablet

For a full list of excipients, see section 6.1

3. PHARMACEUTICAL FORM

Tablets: A flat, round, white tablet with breakline on one side.

4. CLINICAL PARTICULARS

4.1. Therapeutic indications

For the relief of mild to moderate pain and fever

4.2. Posology and method of administration

DO NOT EXCEED THE RECOMMENDED DOSE.

Dose to be taken orally.

Children under 6 years: Not recommended

Children 6-12 years: Half to one tablet every 6 hours

Adults and Children over 12 years: One or two tablets every four to six hours, up to a maximum of eight (8) tablets daily.

4.3. Contra-indications

Hypersensitivity to any of the ingredients

Sever liver function impairment.

4.4. Special warning: and precautions for use

Do not use continuously for more than 10 days without consulting your doctor.

Dosages in excess of those recommended may cause severe liver damage.

Patients suffering from liver or kidney disease should take Paracetamol under medical supervision.

Consult your doctor if no relief is obtained with the recommended dosage.

In the event of overdosage or suspected overdose and not withstanding the fact that the person may be asymptomatic, the nearest doctor, hospital or Poison Centre must be contacted immediately.

Severe cutaneous adverse reactions (SCARs)

Severe cutaneous adverse reactions (SCARs) such as toxic epidermal necrolysis (TEN), Steven-Johnson syndrome (SJS), acute generalized exanthematous pustulosis (AGEP), eosinophilia and systemic (DRESS)/Drug-induced hypersensitivity syndrome (DIHS) and fixed drug eruptions (FDE) have been reported in patients treated with paracetamol containing medicines. If a patient develops SCAR, treatment with PARACETAMOL GDC must immediately be discontinued and appropriate treatment instituted (see section 4.8).

Contains sucrose 20 mg / tablet

Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine. If you have been told by your doctor that you have an intolerance to some sugars, contact your doctor before taking this medicinal product.

4.5. Interactions with other medicines and other forms of interaction

- Concomitant use of PARACETAMOL GDC with hepatotoxic and enzyme inducing medicines may increase the risk of hepatotoxicity with a possible decrease in therapeutic effects of paracetamol.
- Metoclopramide: absorption of paracetamol may be increased.
- Cholestyramine: absorption of paracetamol is reduced if given within one hour of cholestyramine.
- Salicylates:- prolonged concurrent use with paracetamol increases the risk of adverse renal effects.
- Warfarin and anticoagulants: concurrent, regular daily use of high-dose administration of paracetamol may enhance the anticoagulant effect with an increased risk of bleeding – use with caution. Increased monitoring of anticoagulant therapy may be appropriate for those taking paracetamol regularly.
- Antiepileptics: plasma-paracetamol concentrations considered an indication for antidote treatment should be halved in patients receiving enzyme inducing drugs such as carbamazepine, phenobarbital, phenytoin, or primidone.
- Probenecid: can decrease paracetamol clearance and increase its plasma half-life.
- Antibacterials: plasma-paracetamol concentrations considered as an indication for antidote treatment should be halved in patients receiving enzyme inducing drugs such as rifampicin. Severe hepatotoxicilty at therapeutic doses or moderate overdoses of paracetamol has been reported in patients receiving isoniazid, alone or with other medicines for tuberculosis.
- Antivirals: paracetamol enhances the antiviral effect of interferon alfa.

4.6. Fertility, pregnancy and lactation

Safety of use has not been established.

4.7. Effects on ability to drive and use machines

None expected (see section 4.8).

4.8. Undesirable effects

Blood and lymphatic system disorders

The use of paracetamol has been associated with the occurrence of leucopenia, neutropenia and pancytopenia.

Skin and subcutaneous tissue disorders

Skin rashes and other allergic reactions may occur. The rash is usually erythematous or urticarial but sometimes more serious and may be accompanied by drug fever and mucosal lesions.

Serious cutaneous adverse reactions (SCAR) include toxic epidermal necrolysis (TEN), Steven-Johnson syndrome (SJS), acute generalized exanthematous pustulosis (AGEP), eosinophilia and systemic (DRESS)/Drug-induced hypersensitivity syndrome (DIHS) and fixed drug eruptions (FDE) (see section 4.4).

Post-Marketing experience

The risk of SCARs is very serious, potentially life-threatening / fatal and appear to be unpredictable.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Health care providers are asked to report any suspected adverse reactions to SAHPRA via the “6.04 Adverse Drug Reactions Reporting Form”, found online under SAHPRA’s publications: https://www.sahpra.org.za/Publications/Index/8.

4.9. Overdose

Prompt treatment is essential. In the event of an overdosage, consult a doctor immediately, or take the person to a hospital directly. A delay in starting treatment may mean that antidote is given too late to be effective. Evidence of liver damage is often delayed until after the time for effective treatment has lapsed.

Susceptibility to paracetamol toxicity is increased in patients who have taken repeated high doses (greater than 5 -10 g/day) of paracetamol for several days, in chronic alcoholism, chronic liver disease, AIDS, malnutrition, and with the use of drugs that induce liver microsomal oxidation such

as barbiturates, isoniazid, rifampicin, phenytoin and carbamazepine.

Symptoms of paracetamol overdosage in the first 24 hours include pallor, nausea, vomiting, anorexia and possibly abdominal pain. Mild symptoms during the first two days of acute poisoning do not reflect the potential seriousness of the overdosage. Liver damage may become apparent 12 to 48 hours, or later after ingestion, initially by elevation of the serum transaminase and lactic dehydrogenase activity, increased serum bilirubin concentration and prolongation of the prothrombin time. Liver damage may lead to encephalopathy, coma and death. Acute renal failure with acute tubular necrosis may develop even in the absence of severe liver damage. Abnormalities of glucose metabolism and metabolic acidosis may occur. Cardiac arrhythmias have been reported.

Treatment for Paracetamol overdosage:

Although evidence is limited it is recommended that any adult person who has ingested 5 - 10 grams or more of paracetamol (or a child who has had more than 140 mg/kg) within the preceding four hours, should have the stomach emptied by lavage (emesis may be adequate for children) and a single dose of 50 g activated charcoal given via the lavage tube. Ingestion of amounts of paracetamol smaller than this may require treatment in patients susceptible to paracetamol poisoning (see above). In patients who are stuperose or comatose endotracheal intubation should precede gastric lavage in order to avoid aspiration.

N-acetylcysteine should be administered to all cases of suspected overdose as soon as possible preferably within eight hours of overdosage, although treatment up to 36 hours after ingestion may still be of benefit, especially if more than 150 mg/kg of paracetamol was taken.

IV: An initial dose of 150 mg/kg in 200 ml glucose injection, given intravenously over 15 minutes, followed by an intravenous infusion of 50 mg/kg in 500 ml of glucose injection over the next 4 hours, and then 100 mg/kg in 1 000 ml over the next 16 hours. The volume of intravenous fluids should be modified for children.

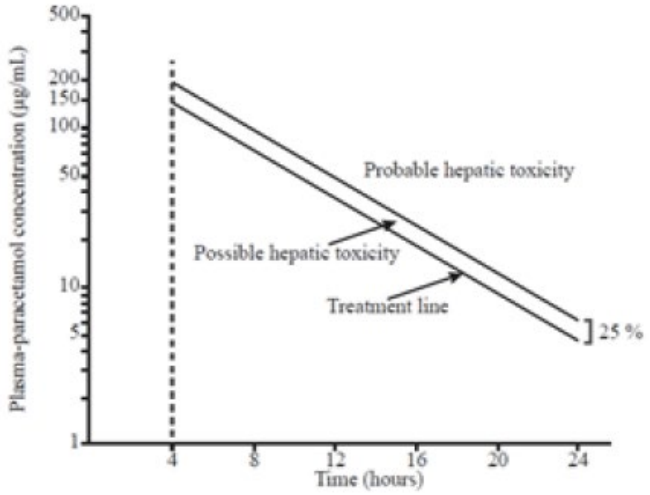
Orally: Although the oral formulation is not the treatment of choice, 140 mg/kg dissolved in water may be administered initially, followed by a 70 mg/kg solution every 4 hours

for 17 doses.

A plasma paracetamol level should be determined four hours after ingestion in all cases of suspected overdosage. Levels done before four hours, unless high, may be misleading. Patients at risk of liver damage, and hence requiring continued treatment with N-acetylcysteine, can be identified according to their plasma paracetamol level. The plasma paracetamol level can be plotted against time since ingestion in the nomogram below.

Those whose plasma paracetamol levels are above the “normal treatment line”, should continue N-acetylcysteine treatment with 100 mg/kg IV over sixteen hours repeatedly until recovery. Patients with increased susceptibility to liver damage as identified above, should continue treatment if concentrations are above the “high risk treatment line”. Prothrombin index correlates best with survival.

Monitor all patients with significant ingestions for at least ninety-six hours.



Source: Martindale: The Complete Drug Reference -37th edition

5. PHARMACOLOGICAL PROPERTIES

5.1. Pharmacodynamic properties

Pharmacological class

A 2.7 Anti-pyretic or anti-pyretic and anti-inflammatory analgesics.

ATC code: N02BE01

Pharmacological action

PARACETAMOL GDC has analgesic and anti-pyretic action

5.2. Pharmacokinetic properties

Paracetamol is readily absorbed from the gastrointestinal tract with peak plasma concentrations occurring after 0,5 to 1 hour after oral administration.

Once absorbed, the plasma half-life of paracetamol is about 2 hours.

It is distributed into most body tissues. Plasma-protein binding varies. It crosses the placenta and is presented in breast milk.

Paracetamol is metabolised predominantly in the liver conjugation with glucuronic acid (about 60 %), sulphuric acid (about 35 %) and cysteine (about 3 %) and excreted in the urine primarily as inactive conjugated metabolites.

6. PHARMACEUTICAL PARTICULARS

6.1. List of excipients

Starch maize, powdered sucrose, Nipastat, spirit chloroform, gelatin, benzoic acid, magnesium stearate,

6.2. Incompatibilities

Not applicable

6.3. Shelf life

PVC/Al blisters, PVC container, PP vial: 36 months

HDPE containers: 60 months

PRP: 15 months

Store in a cool dry place, in well-closed containers, below 25°C. Protect from light.

6.4. Nature and content of container

Blisters in strips of 10 tablets.

Plastic bottle with a white cap containing 100, 500 or 1 000 tablets.

Plastic bucket with a white lid containing 5 000 tablets.

6.5. Special precautions for disposal and handling

None

7. HOLDER OF CERTIFICATE OF REGISTRATION

Gulf Drug Company (Pty) Ltd.

22 Burnside Drive

Old Mill Industrial Park

Mount Edgecombe, 4300

8. REGISTRATION NUMBER

28/2.7/0511

9. DATE OF FIRST AUTHORISATION

17 January 1997

10. DATE OF REVISION OF TEXT

21 September 2023

P/280511/5