PROFESSIONAL INFORMATION

SCHEDULING STATUS

S0 All pack sizes containing less than 25 tablets

S1 All pack sizes containing 25 or more tablets

1. NAME OF THE MEDICINE

DIS-CHEM PARACETAMOL 500 mg tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 500 mg paracetamol.

Preservatives: Nipastat 0,10 % *m/m* and benzoic acid 0,06 % *m/m.*

Sugar free.

Excipient with known effect:

Contains sodium metabisulphite.

For the full list of excipients, see section 6 .1.

3. PHARMACEUTICAL FORM

Tablets.

A flat, round, white, odourless tablet.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

For the relief of mild to moderate pain and fever such as headaches, toothache and pain associated with colds and flu, in adults and children older than 6 years.

4.2 Posology and method of administration

DO NOT EXCEED THE RECOMMENDED DOSE.

Not recommended for children under 6 years of age.

Children 6 – 12 years: Half to one tablet every 6 hours. Maximum of 4 tablets per 24 hours.

Adults and children over 12 years: One to two tablets every four to six hours. Maximum of 8 tablets per 24 hours.

4.3 Contraindications

- Hypersensitivity to paracetamol or to any of the other ingredients (see section 6.1).
- Severe liver function impairment.

4.4 Special warnings and precautions for use

DIS-CHEM PARACETAMOL contains paracetamol which may be fatal in overdose. In the event of overdosage or suspected overdose, and notwithstanding the fact that the person may be asymptomatic, the nearest doctor, hospital or poison centre must be contacted immediately.

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

Do not use continuously for more than 7 days for pain in adults (5 days for children) and more than 3 days for fever without consulting a doctor.

A medical practitioner should be consulted if pain or fever persists or gets worse at the recommended dosage, if new symptoms occur, or if redness and swelling is present, as it may be sign of a more serious condition.

Patients suffering from liver and kidney disease should take DIS-CHEM PARACETAMOL under medical supervision.

Patients should be advised to consult a doctor if they suffer from non-serious arthritis and need to take painkillers every day.

Caution should be exercised in patients with glutathione depleted states, as the use of DIS-CHEM PARACETAMOL may increase therisk of metabolic acidosis.

Use with caution in patients with glutathione depletion due to metabolic deficiencies.

DIS-CHEM PARACETAMOL contains sodium metabisulphite, which may rarely cause severe hypersensitivity reactions and bronchospasm.

4.5 Interaction with other medicines and other forms of interaction

Concomitant use of DIS-CHEM PARACETAMOL with hepatotoxic medicines or medicines that induce liver enzymes may increase the risk of toxicity of DIS-CHEM PARACETAMOL.

Metoclopramide and domperidone may accelerate the absorption of paracetamol.

Probenecid may decrease the clearance and increase the plasma half-life of paracetamol.

Colestyramine reduces the absorption of paracetamol if given within one hour of DIS-CHEM PARACETAMOL.

Prolonged concurrent use of DIS-CHEM PARACETAMOL with salicylates increases the risk of adverse renal effects.

The anticoagulant effect of warfarin and other anticoagulants may be enhanced by regular daily use of DIS-CHEM PARACETAMOL, with increased risk of bleeding.

Chronic use of isoniazid may increase the risk of liver damage when combined with DIS-CHEM PARACETAMOL, even at recommended doses.

4.6 Fertility, pregnancy and lactation

Safety in pregnancy and lactation has not been established.

DIS-CHEM PARACETAMOL is excreted in breastmilk.

4.7 Effects on ability to drive and use machines

DIS-CHEM PARACETAMOL has no or negligible influence on the ability to drive and use machines.

4.8 Undesirable effects

Blood and lymphatic system disorders

Less frequent: Agranulocytosis, thrombocytopenia, leucopenia, pancytopenia, neutropenia and anaemia.

Gastrointestinal disorders

Less frequent: Pancreatitis.

Hepato-biliary disorders

Less frequent: Hepatitis.

Skin and subcutaneous tissue disorders

Less frequent: Dermatitis, skin rashes (erythematous or urticarial, with or without fever and mucosal lesions) and other allergic reactions.

Renal and urinary disorders

Less frequent: Renal colic, nephropathy, renal failure and sterile pyuria.

Post-marketing data:

Immune system disorders

Less frequent: Anaphylaxis, cutaneous hypersensitivity reactions including, among others, skin rashes and angioedema. Cases of serious skin reactions have been reported.

Respiratory, thoracic and mediastinal disorders

Less frequent: There have been cases of bronchospasm with paracetamol, but these are more likely in asthmatics sensitive to aspirin or other nonsteroidal anti-inflammatory drugs (NSAIDs).

Hepato-biliary disorders

Less frequent: Hepatic dysfunction.

Reporting of suspected adverse reactions:

Reporting suspected adverse reactions after authorisation of DIS-CHEM PARACETAMOL is important. It allows continued monitoring of the benefit/risk balance of DIS-CHEM PARACETAMOL. 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 directly to a hospital. 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 medicines 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 dysrhythmias have been reported.

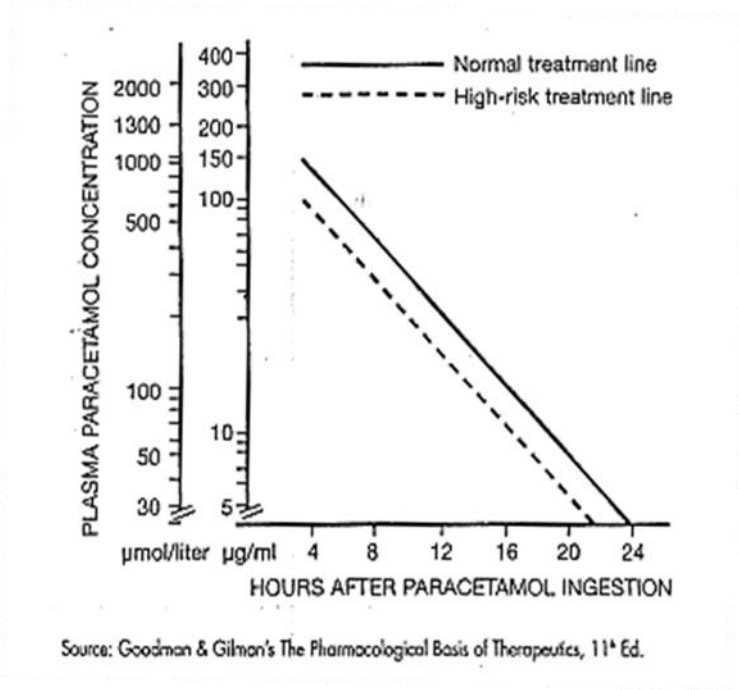
Treatment for paracetamol overdosage:

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 stuporous 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. An initial dose of 150 mg/kg *N*-acetylcysteine in 200 mL dextrose injection given **intravenously** over 15 minutes, followed by an infusion of 50 mg/kg in 500 mL dextrose injection over the next four hours, and then 100 mg/kg in 1 000 mL dextrose injection over the next sixteen hours. **The volume of intravenous fluid should be modified for children.**

Although the oral formulation is not the treatment of choice, 140 mg/kg dissolved in water may be administered initially, followed by 70 mg/kg every four hours for seventeen doses.

A plasma paracetamol level should be determined four hours after ingestion in all cases of suspected overdosage. Levels done before four hours may be misleading. Patients at risk of liver damage, and hence requiring continued treatment with *N*-acetylcysteine, can be identified according to their 4-hour plasma paracetamol level. The plasma paracetamol level can be plotted against time since ingestion in the nomogram below. The nomogram should be used only in relation to a single acute ingestion.



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.

For overdose with an extended/modified release preparation the value of the nomogram is unknown. As there is no information on the plasma levels of paracetamol after an overdose of extended/modified release paracetamol preparations, all patients with suspected or known overdose with such preparations should receive *N*-acetylcysteine. Because of lack of data for extended/modified release formulations, a level below the treatment line of the nomogram may not exclude the possibility of toxicity.

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

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Category and class: A 2.7 Antipyretics or antipyretic and anti-inflammatory analgesics.

Pharmacotherapeutic group: Other analgesics and antipyretics.

ATC code: N02BE01.

Paracetamol has analgesic and antipyretic actions. Paracetamol acts by inhibiting prostaglandin synthesis.

5.2 Pharmacokinetic properties

Paracetamol is well absorbed from the gastrointestinal tract. After oral administration peak plasma levels occur within 30 – 60 minutes. The plasma half-life after a therapeutic dose is about 2 hours. Paracetamol binding to plasma proteins is variable. Paracetamol is eliminated in the urine after hepatic conjugation with glucuronic acid, sulphuric acid or cysteine.

5.3 Preclinical safety data

No information of relevance available.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Gelatine

Magnesium stearate

Sodium metabisulphite

Sodium starch glycolate

Starch

Benzoic acid

Nipastat

Talc.

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

24 months.

6.4 Special precautions for storage

Store at or below 25 °C.

Store tablets in the original container.

Protect from light.

6.5 Nature and contents of container

20 tablets: Blister strip of clear PVC film and aluminium foil containing 10 tablets each.

100 tablets: White, round securitainer with snap on cap, with desiccant and foam wadding.

6.6 Special precautions for disposal and other handling

Not applicable.

7. HOLDER OF CERTIFICATE OF REGISTRATION

Phyto OTC Health (Pty) Ltd

49 New Road

Midrand

1685

8. REGISTRATION NUMBER

29/2.7/0287

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

30 July 1998

10. DATE OF REVISION OF THE TEXT

25 March 2021