SCHEDULING STATUS

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1. NAME OF THE MEDICINE

GO-PAIN P 120 mg/5 mL Syrup

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each 5 mL syrup contains:

Paracetamol	120 mg
Methyl hydroxybenzoate (Preservative)	0,12 % *m/v*
Propyl hydroxybenzoate (Preservative)	0,02 % *m/v*
Ethanol 96 % *v/v*	10,56 % *v/v* ethanol
Contains sugar as	
Sucrose	1,565 g/5 mL
Liquid glucose	2,0 g/5 mL
Contains sweetener as	
Sodium cyclamate	15 mg/5 mL
Saccharin sodium	5 mg/5 mL

GO-PAIN P syrup contains TARTRAZINE.

For full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Syrup

A green syrup

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

GO-PAIN P is indicated for the symptomatic treatment of mild to moderate pain and fever.

4.2 Posology and method of administration

DO NOT EXCEED THE RECOMMENDED DOSE.

Infants 3 to 12 months: 2,5 mL every six to eight hours

Children 1 to 6 years: 5 mL to 10 mL every six to eight hours

Children 7 to 12 years: 10 mL to 20 mL every six to eight hours

While symptoms persist, to be repeated every 4 hours if needed to a maximum of 4 doses per 24 hours for not longer than 5 days.

Method of administration

Dose to be taken orally.

4.3 Contraindications

- Hypersensitivity to paracetamol or to any of the excipients listed in section 6.1
- Severe liver function impairment.

4.4 Special warnings and precautions for use

GO-PAIN P contains paracetamol which may be fatal in overdose. In the event of over dosage 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 of GO-PAIN P in excess of those recommended may cause severe liver damage.
- Consult a medical practitioner if pain or fever persists or gets worse at the recommended dosage, if new symptoms occur or if redness and swelling is present, as these could be signs of a more serious condition.
- Do not use this product continuously without consulting a medical practitioner:
  - for pain – for more than seven days in adults (5 days for children)
  - for fever – for more than 3 days.
- Store in a safe place out of reach of children.
- Patients suffering from hepatitis or alcoholism, or recovering from any form of liver disease, should not take excessive quantities of GO-PAIN P.
- Use with caution in renal disease.
- Severe cutaneous adverse reactions (SCARs) such as toxic epidermal necrolysis (TEN), Stevens–Johnson syndrome (SJS), acute generalized exanthematous pustulosis (AGEP), drug reaction with eosinophilia and systemic symptoms (DRESS)/ drug-induced hypersensitivity syndrome (DIHS) and fixed drug eruption (FDE) have been reported in patients treated with paracetamol containing medicines. If a patient develops SCAR, treatment with GO-PAIN P must immediately be discontinued and appropriate treatment instituted (see Section 4.8).

Excipients with known effect

GO-PAIN P contains FD & C Yellow No 5 (Tartrazine) which may cause allergic reactions.

GO-PAIN P contains 1,565 g/5 mL of sucrose and 2,0 g/5 mL glucose. This should be taken into account in patients with diabetes mellitus.

Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine.

GO-PAIN P contains 10,56 % *v/v* of ethanol, that corresponds to 8,45 % *w/v* or 8,45 g/100 mL of ethanol. A dosage of 5 mL GO-PAIN P contains 422,50 mg ethanol. A dose of 5 mL of GO-PAIN P administered to a child 1 to 6 years of age and weighing 10 kg would result in exposure to 39,10 mg/kg/dose of ethanol which may cause a rise in blood alcohol concentration (BAC) of about 7,04 mg/100 mL. For comparison, for an adult drinking a glass of wine or 500 mL of beer, the BAC is likely to be about 50 mg/100 mL.

GO-PAIN P contains 1,0 mg propylene glycol in each 5 mL which may induce serious adverse effects in neonates. It may lead to the accumulation of ethanol as in GO-PAIN P and induce adverse effects, in particular in young children with low or immature metabolic capacity.

GO-PAIN P contains methyl- and propyl parahydroxybenzoate (as preservatives) which may cause allergic reactions (possibly delayed).

4.5 Interactions with other medicines and other forms of interaction

Hepatotoxic medicines – Increased risk of hepatoxicity.

Enzyme inducing medicines – Increased risk of hepatoxicity. Possible decrease in therapeutic effects of GO-PAIN P.

Metoclopramide – Absorption of GO-PAIN P may be accelerated.

Cholestyramine – Absorption of GO-PAIN P is reduced if given within one hour of cholestyramine.

Prolonged concurrent use of GO-PAIN P with salicylates increases the risk of adverse renal effects.

Warfarin and anticoagulants – Concurrent, chronic, high-dose administration of GO-PAIN P may increase the anticoagulant effect.
Paracetamol is recommended as the general analgesic and antipyretic of choice in patients on oral anticoagulant therapy. However, caution is needed since, although it has no effect on the gastric mucosa or on platelet function, some studies (with warfarin, anisindione, dicoumarol, or phenprocoumon) and isolated reports have found an increased risk of bleeding in patients taking regular doses of paracetamol while on an oral anticoagulant. An increase in INR has also been reported in controlled studies of the use of paracetamol in patients stabilised on warfarin. Increased monitoring of anticoagulant therapy may be appropriate for those also taking paracetamol regularly.

Antiepileptics – The plasma-paracetamol concentrations considered an indication for antidote treatment should be halved in patients receiving enzyme inducing medicines such as carbamazepine, phenobarbital, phenytoin, or primidone.

Probenecid – Pre-treatment with probenecid can decrease paracetamol clearance and increase its plasma half-life. Although urinary excretion of the sulphate and glucuronide conjugates of paracetamol are reduced, that of paracetamol is unchanged.

Antibacterials – The plasma-paracetamol concentrations considered an indication for antidote treatment should be halved in patients receiving enzyme inducing medicines such as rifampicin. Severe hepatotoxicity at therapeutic doses or moderate overdoses of paracetamol has been reported in patients receiving isoniazid, alone or with other medicines for tuberculosis.

Antivirals – Severe hepatotoxicity has occurred after use of paracetamol in a patient taking zidovudine and co-trimoxazole. However, neither short-term nor long-term studies (the latter also in an individual patient) have shown any alteration of zidovudine elimination in patients taking zidovudine and paracetamol. Paracetamol has also been found to enhance the antiviral effect of interferon alfa.

4.6 Fertility, pregnancy and lactation

Pregnancy and lactation

Safety and efficacy in pregnancy and lactation have not been established.

4.7 Effects on ability to drive and use machines

It is not always possible to predict to what extent GO-PAIN P may interfere with the daily activities of a patient. Patients should ensure that they do not engage in the above activities until they are aware of the measure to which GO-PAIN P affects them.

4.8 Undesirable effects

Tabulated summary of adverse reactions

System Organ Class	Frequency	Adverse reactions
Blood and lymphatic system disorders	Less frequent	Agranulocytosis, thrombocytopenia, leukopenia, pancytopenia, neutropenia, anaemia.
Immune system disorders	Frequency unknown	Hypersensitivity reactions characterised by urticaria, dyspnoea, and hypotension.
Metabolism and nutrition disorders	Frequency unknown	Pyroglutamic aciduria (5-oxoprolinuria) and high-anion gap metabolic acidosis
Ear and labyrinth disorders	Frequency unknown	Hearing loss
Vascular disorders	Frequency unknown	Possible increase in the risk of hypertension
Gastrointestinal disorders	Less frequent	Pancreatitis
	Frequency unknown	Nausea and vomiting
Hepato-biliary disorders	Less frequent	Hepatitis
Skin and subcutaneous tissue disorders	Less frequent	Dermatitis, skin rashes severe cutaneous adverse reactions (SCARs) such as toxic epidermal necrolysis (TEN), Stevens–Johnson syndrome (SJS), acute

System Organ Class	Frequency	Adverse reactions
		generalized exanthematous pustulosis (AGEP), drug reaction with eosinophilia and systemic symptoms (DRESS)/ drug-induced hypersensitivity syndrome (DIHS) and fixed drug eruption (FDE)
Renal and urinary disorders	Less frequent	Renal colic, renal failure and sterile pyuria.
	Frequency unknown	Nephropathy

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. Healthcare professionals are asked to report any suspected adverse reactions to SAHPRA via the "6.04 Adverse Drug Reaction 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 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 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

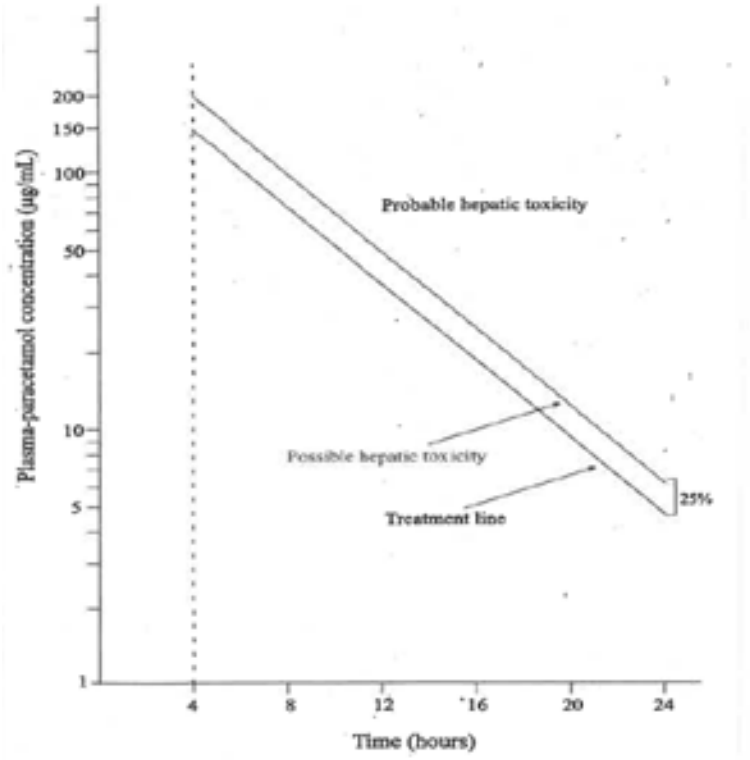
for children) and a single dose of 50 g activated charcoal given via the lavage tube. Ingestion of amounts of paracetamol smaller than this may require treatment in patients susceptible to paracetamol poisoning (see above). In patients who are stuperose or comatose endotracheal intubation should precede 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. 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 1000 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, 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.

A semi-logarithmic plot of plasma-paracetamol concentration against hours after 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.

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

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacological classification: A 2.7 Antipyretics or antipyretic and anti-inflammatory analgesics.

Pharmacotherapeutic group: Other analgesics and antipyretics

ATC code: N02BE01

Mechanism of action

Paracetamol has analgesic and antipyretic properties. It acts predominantly by inhibiting prostaglandin synthesis.

5.2 Pharmacokinetic properties

Absorption

Following oral administration, paracetamol is well absorbed, with peak plasma concentrations obtained after 0,5 to 1 hour. The plasma half-life is about 2 hours.

Distribution

Plasma protein binding is variable.

Paracetamol is distributed into most body tissues. It crosses the placenta and is present in breast milk.

Biotransformation

Paracetamol is metabolised in the liver primarily by conjugation with glucuronic acid (about 60 %), sulfuric acid (about 35 %) and cysteine (about 3 %).

Elimination

Paracetamol is renally excreted primarily as conjugated metabolites.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Apple Green F1569 (CI19140/44090)

Crème de Menthe

Ethanol 96 % *v/v*

Liquid glucose

Methyl hydroxybenzoate

Propyl hydroxybenzoate

Propylene glycol

Purified water

Sodium cyclamate

Saccharin sodium

Sucrose

Toffee Creamy Flavour F1744 (Butterscotch)

Vanilla Cream Flavour F646

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

24 months.

6.4 Special precautions for storage

Store in a cool dry place, in well closed containers, at or below 25 °C.

Protect from light.

6.5 Nature and contents of container

Round, amber plastic (PVC – Polyvinyl Chloride) / (PET – Polyethylene Terephthalate) bottles with a white LLDPE (Linear Low-Density Polyethylene) snap on cap or a white Polypropylene (PP) lid with liner, containing 50 mL, 100 mL or 500 mL of syrup, or amber

plastic (HDPE – High Density Polyethylene) bottles with a white LLDPE snap on cap containing 2,5 L of syrup.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

No special requirements.

7. HOLDER OF CERTIFICATE OF REGISTRATION

Pharmacorp (Pty) Ltd

29 Victoria Link

Route 21 Corporate Park

Irene, 0178

8. REGISTRATION NUMBER

X/2.7/0242

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

18 April 2011

10. DATE OF REVISION OF THE TEXT

21 September 2023