

SUMMARY OF PRODUCT CHARACTERISTICS

1. Trade Name of the Medicinal Product

Non-Drowsy Sudaplus Tablets
Paracetamol 500mg
Pseudoephedrine hydrochloride 30mg

2. Qualitative and Quantitative Composition

Each tablet contains 30mg Pseudoephedrine Hydrochloride and 500mg Paracetamol

For a full list of excipients, see section 6.1

3. Pharmaceutical Form

Tablets
White round biconvex tablets

4. Clinical Particulars

4.1 Therapeutic Indications

Symptomatic relief of nasal congestion when combined with fever and/or pain such as, sore throat, sinus pain or headache in the common cold or influenza.

4.2 Posology and Method of Administration

Posology:

Adults and Children aged 16 years and over:

Two tablets to be taken every four to six hours up to four times daily as required for relief of symptoms.

Maximum daily dose: 8 tablets (240 mg pseudoephedrine and 4 g paracetamol).

Children aged 12 to 15 years:

One tablet every four to six hours, up to four times a day. Maximum daily dose: 4 tablets (i.e. 120 mg pseudoephedrine hydrochloride, 2 g paracetamol).

Children under 12 years:

This medicine is contraindicated in children under the age of 12 years.

Hepatic Impairment:

In patients with hepatic impairment or Gilbert's Syndrome, the dose should be reduced or the dosing interval prolonged.

The daily dose should not exceed 2g paracetamol/day unless directed by a physician.

Renal Impairment:

Caution should be exercised when administering this medicine to patients with mild to moderate renal impairment.

It is recommended, when giving paracetamol to patients with renal impairment, to reduce the dose and to increase the minimum interval between each administration to at least 6 hours unless directed otherwise by a physician. See Table below:

Adults:

Glomerular filtration rate	Dose
10-50 ml/min	500mg every 6 hours
<10ml/min	500mg every 8 hours

Use in the Elderly

Experience has indicated that normal adult dosage is usually appropriate. However, in frail, immobile, elderly subjects or in elderly patients with renal or hepatic impairment, a reduction in the amount or frequency of dosing may be appropriate.

The maximum daily dose should not exceed 60mg/kg/day (up to a maximum of 2g paracetamol per day) in the following situations, unless directed by a physician:

- Weight less than 50kg
- Chronic alcoholism
- Dehydration
- Chronic malnutrition

Duration of use:

Patients should be advised not to use this product for more than 5 days and to seek medical advice if symptoms persist.

Method of administration:

For oral use.

4.3 Contra-Indications

Hypersensitivity to paracetamol, pseudoephedrine or to any of the other excipients listed in section 6.1.

This product is contra-indicated in patients with:

- Cardiovascular disease including hypertension
- Diabetes mellitus
- Pheochromocytoma
- Hyperthyroidism
- Closed angle glaucoma

- Severe acute or chronic kidney disease/renal failure

This product should not be used concomitantly with (see Section 4.5):

- Monoamine oxidase inhibitors (MAOI's) or within 14 days of stopping MAOIs. The concomitant use of pseudoephedrine and these products may cause a rise in blood pressure and/or hypertensive crisis.
- Other sympathomimetic decongestants.
- Beta-blockers

This medicine is contraindicated in patients at risk of developing respiratory failure.

This medicine is contraindicated in children under 12 years of age.

4.4 Special Warnings and Precautions for Use

Paracetamol

Paracetamol should be administered with caution under the following circumstances (see section 4.2)

- Hepatic impairment
- Chronic alcoholism
- Renal impairment ($GFR \leq 50\text{ml/min}$)
- Gilberts syndrome (familial non-haemolytic jaundice)
- Concomitant treatment with medicinal products affecting hepatic function
- Glucose-6-phosphate dehydrogenase deficiency
- Haemolytic anaemia
- Glutathione deficiency
- Dehydration
- Chronic malnutrition
- Weight less than 50kg
- Elderly patients

In general, medicinal products containing paracetamol should be taken for only a few days without the advice of a physician or dentist and not at high doses.

If high fever or signs of secondary infection occur or if symptoms persist for longer than 3 days, a physician should be consulted.

Prolonged or frequent use is discouraged.

Patients should be advised not to take other paracetamol-containing products concurrently.

Taking multiple daily doses in one administration can severely damage the liver. In such cases, medical assistance should be sought immediately

The hazards of overdose are greater in those with non-cirrhotic alcoholic liver disease.

Cases of high anion gap metabolic acidosis (HAGMA) due to pyroglutamic acidosis have been reported in patients with severe illness such as severe renal impairment and sepsis, or in patients with malnutrition or other sources of glutathione deficiency (e.g. chronic alcoholism) who were treated with paracetamol at therapeutic dose for a prolonged period or a combination of paracetamol and flucloxacillin. If HAGMA due to pyroglutamic acidosis is suspected, prompt discontinuation of paracetamol and close monitoring, is recommended. The measurement of urinary 5-oxoproline may be useful to identify pyroglutamic acidosis as underlying cause of HAGMA in patients with multiple risk factors.

Serious skin reactions such as acute generalised exanthematous pustulosis (AGEP), Stevens-Johnson syndrome (SJS), and toxic epidermal necrolysis (TEN), have been reported very rarely in patients receiving paracetamol. Patients should be informed about the signs of serious skin reactions and use of the product should be discontinued at the first appearance of skin rash or any other sign of hypersensitivity.

Pseudoephedrine

Although pseudoephedrine has virtually no pressor effects in normotensive patients, this medicine should be used with caution in patients taking antihypertensive agents, tricyclic antidepressants or other sympathomimetic agents (such as appetite suppressants and amphetamine-like psychostimulants). The effects of a single dose on the blood pressure of these patients should be observed before recommending repeated or unsupervised treatment.

The physician or pharmacist should check that sympathomimetic containing preparations are not simultaneously administered by several routes i.e. orally and topically (nasal, aural and eye preparations) (see Sections 4.3 and 4.5).

Patients with difficulty in urination and/or enlargement of the prostate should be advised to consult a physician before using this product

Patients with thyroid disease who are receiving thyroid hormones should not take pseudoephedrine unless directed by a physician.

A variety of allergic skin reactions, with or without systemic features such as bronchospasm, angioedema have been reported following use of pseudoephedrine (see Section 4.8).

Severe Skin reactions

Severe skin reactions such as acute generalized exanthematous pustulosis (AGEP) may occur with pseudoephedrine-containing products. This acute pustular eruption may occur within the first 2 days of treatment, with fever, and numerous, small, mostly non-follicular pustules arising on a widespread oedematous erythema and mainly localized on the skin folds, trunk, and upper extremities. Patients should be carefully monitored. If signs and symptoms such as pyrexia, erythema, or many small pustules are observed,

administration of this medicine should be discontinued and appropriate measures taken if needed.

Ischaemic colitis

Some cases of ischaemic colitis have been reported with pseudoephedrine. Pseudoephedrine should be discontinued and medical advice sought if sudden abdominal pain, rectal bleeding or other symptoms of ischaemic colitis develop.

Ischaemic optic neuropathy

Cases of ischaemic optic neuropathy have been reported with pseudoephedrine. Pseudoephedrine should be discontinued if sudden loss of vision or decreased visual acuity such as scotoma occurs.

Posterior reversible encephalopathy syndrome (PRES) and reversible cerebral vasoconstriction syndrome (RCVS)

Cases of PRES and RCVS have been reported with the use of pseudoephedrine-containing products (see section 4.8). The risk is increased in patients with severe or uncontrolled hypertension, or with severe acute or chronic kidney disease/renal failure (see section 4.3).

Pseudoephedrine should be discontinued and immediate medical assistance sought if the following symptoms occur: sudden severe headache or thunderclap headache, nausea, vomiting, confusion, seizures and/or visual disturbances. Most reported cases of PRES and RCVS resolved following discontinuation and appropriate treatment.

This product may act as a cerebral stimulant giving rise to hyperpyrexia, tremor and epileptiform convulsions. Care should be taken when used in epileptic patients

If any of the following occur, this product should be stopped:

- Hallucinations
- Restlessness
- Sleep disturbances

Use with caution in occlusive vascular disease.

Pseudoephedrine may induce positive results in certain anti-doping tests.

Risks of abuse

Pseudoephedrine carries the risk of abuse. Increased doses may ultimately produce toxicity. Continuous use can lead to tolerance resulting in an increased risk of overdosing. The recommended maximum dose and treatment duration should not be exceeded (see section 4.2).

4.5 Interaction with other Medicaments and other forms of Interaction

Pseudoephedrine

MAOIs and/or RIMAs: Pseudoephedrine exerts its vasoconstricting properties by stimulating α -adrenergic receptors and displacing noradrenaline from neuronal storage sites. Since MAOIs impede the metabolism of sympathomimetic amines and increase the store of releasable noradrenaline in adrenergic nerve endings, MAOIs may potentiate the pressor effect of pseudoephedrine. This medicine should not be given to patients taking monoamine inhibitors or within 14 days of stopping treatment as there is an increased risk of hypertensive crisis.

Moclobemide: risk of hypertensive crisis.

Sympathomimetic agents: Concomitant use of this medicine with tricyclic antidepressants (TCAs), or with sympathomimetic agents (such as appetite suppressants and amphetamine-like psychostimulants) may cause a rise in blood pressure.

Anticholinergic drugs: The effects of anti-cholinergics e.g., some psychotropic drugs (such as tricyclic antidepressants) and atropine, may be potentiated by this product giving rise to tachycardia, mouth dryness, gastrointestinal disturbances, e.g., colic, urinary retention and headache.

Antihypertensives: Pseudoephedrine may antagonise the hypotensive action of antihypertensive drugs which interfere with sympathetic activity, including bretylium, betanidine, reserpine, debrisoquine, guanethidine, methyl dopa, adrenergic neurone blockers and beta-blockers (see section 4.3 and 4.4).

Because of its pseudoephedrine content, concomitant use of this medicine with oxytocin or cardiac glycosides may cause of a risk of hypertension or an increased risk of dysrhythmias, respectively.

When used concurrently with ergot alkaloids (ergotamine & methysergide), this product can increase the risk of ergotism.

Anaesthetic agents: Concurrent use with halogenated anaesthetic agents such as chloroform, cyclopropane, halothane, enflurane or isoflurane may provoke or worsen ventricular arrhythmias.

Paracetamol

Chronic alcohol can increase the hepatotoxicity of paracetamol overdose and may have contributed to the acute pancreatitis reported in one patient who had taken an overdose of paracetamol. Acute alcohol intake may diminish an individual's ability to metabolise large doses of paracetamol, the plasma half-life of which can be prolonged.

The use of drugs which induce hepatic microsomal enzymes, such as anticonvulsants and oral contraceptive steroids, may increase the extent of metabolism of paracetamol, resulting in reduced plasma concentrations of the drug and a faster elimination rate.

The speed of absorption of paracetamol may be increased by metoclopramide or domperidone and absorption reduced by cholestyramine.

Because of its paracetamol content, the anticoagulant effect of warfarin and other coumarins may be enhanced by prolonged regular use of this medicine with increased risk of bleeding; occasional doses have little or no significant effect.

Caution should be taken when paracetamol is used concomitantly with flucloxacillin as concurrent intake has been associated with high anion gap metabolic acidosis due to pyroglutamic acidosis, especially in patients with risks factors (see section 4.4).

4.6 Fertility, Pregnancy and Lactation

There are no adequate and well controlled clinical studies in pregnant or breast feeding women for the combination of paracetamol and pseudoephedrine.

Pregnancy

This medicine should not be used during pregnancy unless the potential benefit of treatment to the mother outweighs the possible risks to the developing foetus.

Paracetamol

A large amount of data on pregnant women indicate neither malformative, nor foeto/neonatal toxicity.

Epidemiological studies on neurodevelopment in children exposed to paracetamol in utero show inconclusive results.

If clinically needed, paracetamol can be used during pregnancy however it should be used at the lowest possible dose, for the shortest possible time at the lowest possible frequency.

When given to the mother in therapeutic doses, paracetamol crosses the placenta into the foetal circulation as early as 30 minutes after ingestion and is effectively metabolised by foetal sulphate conjugation.

Pseudoephedrine

Although pseudoephedrine has been in widespread use for many years without apparent ill consequence, there are no specific data on its use during pregnancy. Caution should therefore be exercised by balancing the potential benefit of treatment to the mother against any possible hazards to the developing foetus.

Breast-feeding

This medicine should not be used during lactation unless the potential benefit of treatment to the mother outweighs the possible risks to the nursing infant.

Paracetamol

Paracetamol is excreted in breast milk but not in a clinically significant amount. Available published data do not contraindicate breast feeding. A pharmacokinetic study of paracetamol in 12 nursing mothers revealed that less than 1% of a 650 mg oral dose of paracetamol appeared in the breast-milk. Similar findings have been reported in other studies, therefore maternal ingestion of therapeutic doses of paracetamol does not appear to present a risk to the infant.

Pseudoephedrine

Pseudoephedrine is excreted in breast milk in small amounts but the effect of this on breast-fed infants is not known. It has been estimated that approximately 0.4 to 0.7% of a single 60 mg dose of pseudoephedrine ingested by a nursing mother will be excreted in the breast milk over 24 hours. Data from a study of lactating mothers taking 60 mg pseudoephedrine every 6 hours suggests that from 2.2 to 6.7% of the maximum daily dose (240 mg) may be available to the infant from a breastfeeding mother.

Fertility

There is no information on the effects of this medicine on human fertility (see Section 5.3).

4.7 Effects on Ability to Drive and Use Machines

This product may have a minor influence on the ability to drive and use machines.

This product may cause dizziness. Patients should be cautioned about engaging in activities such as driving a car or operating machinery, until they have established their own response to the drug.

4.8 Undesirable Effects

Adverse drug reactions (ADRs) identified during clinical trials and post-marketing experience with paracetamol, pseudoephedrine, or the combination are listed below by System Organ Class (SOC).

The frequencies are defined according to the following convention:

Very common $\geq 1/10$

Common $\geq 1/100$ and $< 1/10$

Uncommon $\geq 1/1,000$ and $< 1/100$

Rare $\geq 1/10,000$ and $< 1/1,000$

Very rare $< 1/10,000$

Not known (cannot be estimated from the available data)

ADRs identified are presented by frequency category based on 1) incidence in adequately designed clinical trials or epidemiology studies, if available, or 2)

when incidence cannot be estimated, frequency category is listed as ‘Not known’.

System Class (SOC)	Organ and	Product	Frequency	Adverse Drug Reaction (Preferred Term)
Blood and Lymphatic System Disorders		Paracetamol	Not known	Agranulocytosis Haemolytic anaemia Thrombocytopenic purpura
Immune System Disorders		Paracetamol	Not known	Anaphylactic reaction
		Pseudoephedrine and Paracetamol single actives	Rare	Hypersensitivity (cross-sensitivity may occur with other sympathomimetics)
Psychiatric Disorders		Pseudoephedrine	Common	Insomnia Nervousness
		Pseudoephedrine	Rare	Hallucinations
		Pseudoephedrine	Not known	Agitation Anxiety Delusion Euphoric mood Hallucination, visual Irritability Restlessness Sleep disorder
Nervous System Disorders		Pseudoephedrine	Very common	Headache
		Pseudoephedrine	Common	Dizziness
		Pseudoephedrine	Not known	Psychomotor hyperactivity Somnolence Cerebrovascular accident Paraesthesia Posterior reversible encephalopathy syndrome (PRES) (see section 4.4) / Reversible cerebral vasoconstriction syndrome (RCVS) (see section 4.4) Tremor
Eye Disorders		Pseudoephedrine	Not known	Ischaemic optic neuropathy
Cardiac Disorders		Pseudoephedrine	Not known	Arrhythmia Myocardial infarction/Myocardial ischaemia Palpitations Tachycardia
Vascular Disorders		Pseudoephedrine	Not known	Hypertension

System Organ Class (SOC)	Product	Frequency	Adverse Drug Reaction (Preferred Term)
Gastrointestinal Disorders	Pseudoephedrine	Common	Dry mouth Nausea
	Pseudoephedrine / Paracetamol combination	Not known	Abdominal pain Diarrhoea
	Pseudoephedrine		Vomiting, Ischaemic colitis
Hepatobiliary Disorders	Paracetamol	Not known	Hepatic function abnormal Hepatic necrosis
Skin and Subcutaneous Tissue Disorders	Pseudoephedrine	Not known	Severe skin reactions, including acute generalised exanthematous pustulosis (AGEP)
	Paracetamol		Fixed eruption Rash pruritic Urticaria
	Pseudoephedrine / Paracetamol combination		Angioedema Pruritus
	Pseudoephedrine and Paracetamol single actives	Rare	Rash
Renal and Urinary Disorders	Paracetamol	Uncommon	Nephropathy toxic
	Pseudoephedrine	Not known	Dysuria Urinary retention (in men - prostatic enlargement could have been an important predisposing factor)
	Paracetamol		Renal papillary necrosis (after prolonged administration)
Investigations	Paracetamol	Not known	Transaminases increased
Metabolism and nutrition Disorders	Paracetamol	Not known	High anion gap metabolic acidosis

No differences between adult and paediatric safety profiles have been identified.

Liver damage has been reported after daily ingestion of excessive amounts of paracetamol. A review of a group of patients with chronic active hepatitis failed to reveal differences in the abnormalities of liver function in those who were long-term users of paracetamol nor was the control of their disease improved after paracetamol withdrawal.

Low level transaminase elevations may occur in some patients taking therapeutic doses of paracetamol; these elevations are not accompanied with liver failure and usually resolve with continued therapy or discontinuation of paracetamol.

Very rare cases of serious skin reactions have been reported.

High anion gap metabolic acidosis

Cases of high anion gap metabolic acidosis due to pyroglutamic acidosis have been observed in patients with risk factors using paracetamol (see section 4.4). Pyroglutamic acidosis may occur as a consequence of low glutathione levels in these patients.

Reporting of Suspected Adverse Reactions.

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, Website: www.hpra.ie.

4.9 Overdose

Paracetamol

Please refer to local guidelines for the treatment of paracetamol overdose.

Paracetamol overdose can result in liver damage which may be fatal.

Symptoms generally appear within the first 24 hours and may comprise nausea, vomiting, anorexia, pallor, hyperhidrosis, malaise and abdominal pain or patients may be asymptomatic.

Overdose of paracetamol can cause liver cell necrosis likely to induce complete and irreversible necrosis, resulting in hepatocellular insufficiency, metabolic acidosis and encephalopathy which may lead to coma and death. Simultaneously, increased levels of hepatic transaminases (AST, ALT), lactate dehydrogenase and bilirubin are observed together with increased prothrombin levels that may appear 12 to 48 hours after administration.

Liver damage is likely in adults and adolescents who have taken more than the recommended amount of paracetamol. It is considered that excess quantities of a toxic metabolite become irreversibly bound to liver tissue.

Some patients may be at increased risk of liver damage from paracetamol toxicity:

Risk factors include:

- Patients with liver disease

- Elderly patients
- Young children
- Patients receiving long term treatment with carbamazepine, phenobarbitone, phenytoin, primidone, rifampicin, St John's Wort or other drugs that induce liver enzymes.
- Patients who regularly consume ethanol in excess of recommended amounts.
- Patients with glutathione depletion e.g. eating disorders, cystic fibrosis, HIV infection, starvation, cachexia.

Symptoms

The following sequelae to acute hepatic failure associated with paracetamol overdose are considered expected and may be fatal.

Expected Sequelae to Acute Hepatic Failure Associated with Paracetamol Overdose:

System Organ Class (SOC)	Adverse event
Infections and infestations	Bacterial infection Fungal infection Sepsis
Blood and lymphatic system disorders	Coagulopathy Disseminated intravascular coagulation Thrombocytopenia
Metabolism and nutrition disorders	Hypoglycaemia Hypophosphatemia Lactic acidosis Metabolic acidosis
Nervous system disorders	Brain oedema Coma (with massive paracetamol overdose or multiple drug overdose) Encephalopathy
Cardiac disorders	Cardiomyopathy Cardiac arrhythmias
Vascular disorders	Hypotension
Respiratory, thoracic and mediastinal disorders	Respiratory failure
Gastrointestinal disorders	Gastrointestinal haemorrhage Pancreatitis
Renal and urinary disorders	Acute renal failure* with acute tubular necrosis
General disorders and administration site conditions	Multi-organ failure

*Acute renal failure with acute tubular necrosis may also develop.

Cardiac arrhythmias and pancreatitis have also been reported.

Haemolytic anaemia (in patients with glucose-6-phosphate dehydrogenase [G6PD] deficiency): Haemolysis has been reported in patients with G6PD deficiency, with use of paracetamol in overdose.

Management

Immediate transfer to hospital.

Blood sampling to determine initial paracetamol plasma concentration. In the case of a single acute overdose, paracetamol plasma concentration should be measured 4 hours post ingestion. Administration of activated charcoal should be considered if the overdose of paracetamol has been ingested within the previous hour.

The antidote N-acetylcysteine, should be administered as soon as possible in accordance with national treatment guidelines.

Symptomatic treatment should be implemented.

Pseudoephedrine

Symptoms

Overdosage may result in:

Metabolism and nutrition disorders: hyperglycaemia, hypokalaemia

Psychiatric disorders: CNS stimulation, insomnia; irritability, restlessness, anxiety, agitation; confusion, delirium, hallucinations, psychoses

Nervous system disorders: seizures, tremor, intracranial haemorrhage including intracerebral haemorrhage, drowsiness in children

Eye disorders: mydriasis

Cardiac disorders: palpitations, tachycardia, reflex bradycardia, supraventricular and ventricular arrhythmias, dysrhythmias, myocardial infarction

Vascular disorders: hypertension, hypertensive crisis

Gastrointestinal disorders: nausea, vomiting, ischaemic bowel infarction

Musculoskeletal and connective tissue disorders: rhabdomyolysis

Renal and urinary disorders: acute renal failure, difficulty in micturition

Management

Measures should be taken to maintain and support respiration and control convulsions.. Catheterisation of the bladder may be necessary. If desired, the elimination of pseudoephedrine can be accelerated by acid diuresis or by dialysis.

5. Pharmacological Properties

5.1 Pharmacodynamic Properties

ATC Code N02B E51

Non-Drowsy Sudaplus Tablets is a mild to moderate analgesic, antipyretic and decongestant.

The analgesic and antipyretic actions of paracetamol are believed to be due, at least in part, to inhibition of prostaglandin synthesis in the central nervous system. Paracetamol 1 g has been shown to be an effective analgesic and antipyretic.

Pseudoephedrine acts on the alpha adrenergic receptors in the mucosa of the respiratory tract producing vasoconstriction which results in shrinkage of swollen nasal mucous membranes, reduction of nasal congestion and increase in nasal airway patency.

Pseudoephedrine 60 mg has been shown to be an effective nasal decongestant, as measured by nasal airflow, in patients with the common cold and rhinitis.

At therapeutic doses, pseudoephedrine has no clinically significant effect on blood pressure in normotensive patients. Studies in patients with controlled hypertension have demonstrated that pseudoephedrine 60 mg has no, or minimal, effect on blood pressure and does not have sedative effects.

5.2 Pharmacokinetic Properties

Paracetamol:

Absorption: The absorption of paracetamol by the oral route is rapid and complete. Maximum plasma concentrations are reached 30 to 60 minutes following ingestion.

Distribution: Paracetamol is distributed rapidly throughout all tissues. Concentrations are comparable in blood saliva and plasma. Protein binding is low.

Metabolism: Paracetamol is metabolised mainly in the liver, following two major metabolic pathways: Glucuronic acid and sulfuric acid conjugates. The latter route is rapidly saturated at doses higher than the therapeutic dosages. A minor route, catalyzed by the Cytochrome P 450 (mostly CYP2E1), results in the formation of an intermediate reagent (N-acetyl-p-benzoquinoneimine) which under normal conditions of use, is rapidly detoxified by glutathione and eliminated in the urine, after conjugation with cysteine and mercapturic acid. Conversely, when massive intoxication occurs, the quantity of this toxic metabolite is increased.

Elimination: Elimination is essentially through the urine. 90% of the ingested dose is eliminated via the kidneys within 24 hours, principally as glucuronide (60-80%) and sulphate conjugates (20-30%). Less than 5% is eliminated in unchanged form.

Elimination half life is about 2 hours.

Physiopathological variations

Renal Insufficiency: In cases of severe renal insufficiency (creatinine clearance lower than 10ml/min) the elimination of paracetamol and its metabolites is delayed.

Elderly subjects: Conjugation capacity is not modified.

Pseudoephedrine:

Absorption: Pseudoephedrine is rapidly and completely absorbed from the gastrointestinal tract after oral administration with no presystemic metabolism. Peak plasma levels are achieved after 1-2 hours.

Distribution: Pseudoephedrine is rapidly distributed throughout the body. No protein binding data are available. The volume of distribution ranges from 2.64 to 3.51 l/kg in both single and multiple dose studies.

Metabolism: There is little metabolism of pseudoephedrine in man with approximately 90% being excreted in the urine unchanged. Approximately 1% is eliminated by hepatic metabolism, by N-demethylation to norpseudoephedrine.

Elimination: The plasma half-life varies from 4.3-7.0 hours in adults. As a weak base the extent of renal excretion is dependent on urinary pH. At low pH tubular resorption is minimal and urine flow rate will not influence clearance of the drug. At high pH (>7.0) pseudoephedrine is extensively reabsorbed in the renal tubule and renal clearance will depend on urine flow rate.

Renal Insufficiency: Renal impairment will result in increased plasma levels.

Elderly subjects: Elimination capacity is not modified.

A steady state pharmacokinetic interaction study in healthy volunteers has demonstrated that the rate (C_{max} , t_{max}) and extent ($AUC_{0-6 \text{ hours}}$) of absorption from Paracetamol and Pseudoephedrine tablet is equivalent to those of paracetamol alone and of pseudoephedrine alone.

In the same study the median t_{max} values for the paracetamol and pseudoephedrine components of Paracetamol and Pseudoephedrine tablet were 0.7 hours and 1.2 hours, respectively.

In a limited study, three mothers nursing healthy infants were given an antihistamine-decongestant preparation containing 60 mg of pseudoephedrine and 2.5 mg of triprolidine. Milk concentrations of pseudoephedrine were higher than plasma levels in all three patients, with peak milk concentrations occurring at 1.0–1.5 hours. The investigators calculated that 1000 ml of milk produced during 24 hours would contain approximately 0.5%–0.7% of the maternal dose. However, following a single-blind, crossover study of a single dose of pseudoephedrine 60 mg vs. placebo conducted in 8 lactating mothers, and assuming maternal intake of 60 mg pseudoephedrine hydrochloride four times daily, the estimated infant dose of pseudoephedrine based on AUC and

an estimated milk production rate of 150 ml/kg/day was 4.3% (95% CI, 3.2, 5.4%; range 2.2 to 6.7%) of the weight-adjusted maternal dose.

5.3 Preclinical Safety Data

Mutagenicity

Paracetamol

Conventional studies using the currently accepted standards for the evaluation of toxicity to reproduction and development are not available.

Pseudoephedrine

The results of a wide range of tests indicate that pseudoephedrine does not post a mutagenic risk to man.

Carcinogenicity

Paracetamol

There is inadequate evidence to determine the carcinogenic potential of paracetamol in humans. A positive association between the use of paracetamol and cancer of the ureter (but not of other sites of the urinary tract) was observed in a case-control study in which approximate lifetime consumption of paracetamol (whether acute or chronic) was estimated. However, other similar studies have failed to demonstrate statistically significant association between paracetamol and cancer of the urinary tract, or paracetamol and renal cell carcinoma.

There is limited evidence for the carcinogenicity of paracetamol in experimental animals. Liver cell tumours can be detected in mice and liver and bladder carcinomas can be detected in rats, following chronic feeding 500 mg/kg/day paracetamol.

Pseudoephedrine

There is insufficient information available to determine whether pseudoephedrine has carcinogenic potential.

Teratogenicity

Paracetamol

Conventional studies using the currently accepted standards for the evaluation of toxicity to reproduction and development are not available.

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Pseudoephedrine

Systemic administration of pseudoephedrine, up to 50 times the human daily dosage in rats and up to 35 times the human daily dosage in rabbits did not produce teratogenic effects.

Fertility

Paracetamol

Conventional studies using the currently accepted standards for the evaluation of toxicity to reproduction and development are not available.

Pseudoephedrine

Systemic administration of pseudoephedrine to rats, up to 7 times the human daily dosage in females and 35 times the human daily dosage in males, did not impair fertility or alter foetal morphological development and survival.

6. Pharmaceutical Particulars

6.1 List of Excipients

Microcrystalline cellulose
Pregelatinised maize starch
Crospovidone
Sodium starch glycolate (Type A)
Povidone
Stearic acid
Magnesium stearate

6.2 Incompatibilities

Not applicable

6.3 Shelf Life

3 years

6.4 Special Precautions for Storage

Do not store above 25°C. Store in original pack to protect from light.

6.5 Nature and Contents of Container

Opaque white PVC and PVPC/Aluminium foil blister packs
Pack of 4, 12, 15 and 24 tablets.
Not all pack sizes may be marketed.

6.6 Special precautions for the disposal

No special requirements
Any unused product or waste material should be disposed of in accordance with local requirements

7. Marketing Authorisation Holder

JNTL Consumer Health I (Ireland) Ltd.
Block 5
High Street
Tallaght

Dublin 24
Ireland

8 Marketing Authorisation Number

PA 23490/021/001

9. Date of First Authorisation/Renewal of Authorisation

Date of first authorisation: 29 June 2011
Date of last renewal: 29 June 2016

10. Date of Revision of the Text

March 2025