

SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Palladone 1.3 mg hard capsules

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Palladone 1.3 mg hard capsules contain hydromorphone hydrochloride 1.30 mg equivalent to 1.16 mg hydromorphone.

Excipients with known effect:

Each *Palladone* 1.3 mg hard capsule contains 39.35 mg of lactose.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Capsule, hard (capsule).

Palladone hard capsules 1.3 mg are gelatin capsules with clear uncoloured caps and opaque orange bodies, containing white to off-white spherical pellets. The capsule is marked HNR 1.3.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

For the relief of severe pain

4.2 Posology and method of administration

Posology

Adults and adolescents over 12 years:

The dosage is dependent upon the severity of the pain and the patient's previous history of analgesic requirements. 1.3 mg of hydromorphone hydrochloride has an efficacy equivalent to 10 mg of morphine sulphate given orally. 1.3 mg and 2.6 mg capsules are available. Treatment should normally be started at a dosage of 1.3 mg or 2.6 mg hydromorphone hydrochloride 4 hourly. Increasing severity of pain will require increased dosage of hydromorphone using 1.3 mg and 2.6 mg capsules alone or in combination with prolonged release hydromorphone products to achieve the desired relief.

Transferring patients between oral and parental hydromorphone:

Switching patients from parenteral hydromorphone to oral hydromorphone should be guided by the sensitivity of the individual patient. The oral starting dose should not be overestimated (for oral bioavailability see section 5.2).

Elderly

As with adults, the elderly should be dose-titrated with *Palladone* capsules in order to achieve adequate analgesia. It should be noted however, that the elderly may require a lower dosage than adults to achieve adequate analgesia.

Paediatric population

Not recommended for use in children under 12 years.

Patients with renal and hepatic impairment

These patients may require lower doses than other patient groups to achieve pain control. Patients should be carefully titrated to clinical effect.

Method of administration

Oral use

The capsules can be swallowed whole or opened and their contents sprinkled on to cold soft food.

Treatment goals and discontinuation

Before initiating treatment with **Palladone** capsules, a treatment strategy including treatment duration and treatment goals, and a plan for end of the treatment, should be agreed together with the patient, in accordance with pain management guidelines. During treatment, there should be frequent contact between the physician and the patient to evaluate the need for continued treatment, consider discontinuation and to adjust dosages if needed. When a patient no longer requires therapy with hydromorphone, it may be advisable to taper the dose gradually to prevent symptoms of withdrawal. In absence of adequate pain control, the possibility of hyperalgesia, tolerance and progression of underlying disease should be considered (see section 4.4).

Duration of treatment

Hydromorphone should not be used longer than necessary.

4.3 Contraindications

Hydromorphone products are contraindicated in patients with:

- Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.
- Severe respiratory depression with hypoxia and/or hypercapnia
- Severe chronic obstructive lung disease
- Severe bronchial asthma
- Paralytic ileus
- Acute abdomen
- Coma
- Concurrent administration of monoamine oxidase inhibitors or within two weeks of discontinuation of their use.

4.4 Special warnings and precautions for use

The primary risk of opioid excess is respiratory depression.

Hydromorphone has to be administered with caution in patients with:

- Severely impaired respiratory function
- Sleep apnoea
- CNS depressants co-administration (see below and section 4.5)
- Tolerance, physical dependence and withdrawal (see below)
- Chronic obstructive pulmonary disease
- Reduced respiratory reserve
- Psychological dependence [addiction], abuse profile and history of substance and/or alcohol abuse (see below)
- Debilitated elderly
- Head injury, intracranial lesions or increased intracranial pressure, reduced level of consciousness of uncertain origin (due to the risk of opioids to cause increased intracranial pressure)
- Hypotension with hypovolaemia
- Pancreatitis

- Hypothyroidism
- Toxic psychosis
- Prostatic hypertrophy
- Biliary tract diseases
- Biliary or ureteric colic
- Adrenocortical insufficiency (e.g., Addison's disease)
- Severely impaired renal function
- Severely impaired hepatic function
- Alcoholism
- Delirium tremens
- Convulsive disorders
- Pre-existing constipation
- Obstructive or inflammatory bowel disorders

In all these patients, reduced dosage may be advisable.

Sleep-related breathing disorders

Opioids can cause sleep-related breathing disorders including central sleep apnoea (CSA) and sleep-related hypoxemia. Opioid use increases the risk of CSA in a dose-dependent manner (see section 4.8). In patients who present with CSA, consider decreasing the total opioid dosage.

Risk from concomitant use of sedative medicines such as benzodiazepines or related drugs:

Concomitant use of **Palladone** capsules and sedative medicines such as benzodiazepines or related drugs may result in profound sedation, respiratory depression, coma, and death. Because of these risks, concomitant prescribing of these sedative medicines should be reserved for patients for whom alternative treatment options are not possible. If a decision is made to prescribe **Palladone** capsules concomitantly with sedative medicines, the lowest effective dose should be used, and the duration of treatment should be as short as possible.

The patients should be followed closely for signs and symptoms of respiratory depression and sedation. In this respect, it is strongly recommended to inform patients and their caregivers to be aware of these symptoms (see section 4.5).

Tolerance and Opioid Use Disorder (abuse and dependence)

Tolerance and physical and/or psychological dependence may develop upon repeated administration of opioids such as hydromorphone.

Repeated use of **Palladone** capsules can lead to Opioid Use Disorder (OUD). A higher dose and longer duration of opioid treatment can increase the risk of developing OUD. Abuse or intentional misuse of **Palladone** capsules may result in overdose and/or death. The risk of developing OUD is increased in patients with a personal or a family history (parents or siblings) of substance use disorders (including alcohol use disorder), in current tobacco users or in patients with a personal history of other mental health disorders (e.g. major depression, anxiety and personality disorders).

Before initiating treatment with **Palladone** capsules and during the treatment, treatment goals and a discontinuation plan should be agreed with the patient (see section 4.2). Before and during treatment the patient should also be informed about the risks and signs of OUD. If these signs occur, patients should be advised to contact their physician.

Patients will require monitoring for signs of drug-seeking behaviour (e.g. too early requests for refills). This includes the review of concomitant opioids and psycho-active drugs (like benzodiazepines). For patients with signs and symptoms of OUD, consultation with an addiction specialist should be considered.

The Patient may develop tolerance to the drug with chronic use and require progressively higher doses to maintain pain control. There may also be cross-tolerance with other opioids. Prolonged

use of this product may lead to physical dependence and a withdrawal syndrome may occur upon abrupt cessation of therapy. When a patient no longer requires therapy with hydromorphone, it may be advisable to taper the dose gradually to prevent symptoms of withdrawal.

Abuse of oral dosage forms by parenteral administration can be expected to result in serious adverse events, which may be fatal.

Palladone should not be used where there is the possibility of paralytic ileus occurring. Should paralytic ileus be suspected or occur during use, hydromorphone treatment must be discontinued immediately.

Palladone capsules should be used with caution preoperatively and within 24 hours postoperatively. After this time, they should be used with caution particularly following abdominal surgery.

Patients about to undergo additional pain relieving procedures (e.g. surgery, plexus blockade) should not receive hydromorphone for 4 hours prior to the intervention. If further treatment with **Palladone** is indicated then the dosage should be adjusted to the new post-operative requirement.

It should be emphasised that patients, once titrated to an effective dose of a certain opioid, should not be changed to other opioid analgesic preparations without clinical assessment and careful retitration as necessary. Otherwise a continuous analgesic action is not ensured.

Opioids, such as hydromorphone, may influence the hypothalamic-pituitary-adrenal or -gonadal axes. Some changes that can be seen include an increase in serum prolactin, and decreases in plasma cortisol and testosterone. Clinical symptoms may manifest from these hormonal changes.

Caution should be exercised when treating patients with pre-existing constipation. Appropriate use of laxative treatment should be considered.

Hyperalgesia that will not respond to a further dose increase of hydromorphone may occur in particular in high doses. A hydromorphone dose reduction or change in opioid may be required.

This medicinal product contains less than 1 mmol sodium (23 mg) per ml, i.e. essentially “sodium-free”.

Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption, should not take this medicine.

4.5 Interaction with other medicinal products and other forms of interaction

Central nervous system (CNS):

The concomitant use of opioids with sedative medicines such as benzodiazepines or related drugs increases the risk of sedation, respiratory depression, coma and death because of additive CNS depressant effect. The dose and duration of concomitant use should be limited (see section 4.4). Drugs which depress the CNS include, but are not limited to: other opioids, anxiolytics, hypnotics and sedatives (incl. benzodiazepines), antipsychotics, anaesthetics (e.g. barbiturates), antidepressants, antiemetics, antihistaminic drugs, phenothiazines and alcohol.

The concomitant use of opioids and gabapentinoids (gabapentin and pregabalin) increases the risk of opioid overdose, respiratory depression and death.

Concurrent administration of hydromorphone and mono-amine oxidase inhibitors or within two weeks of discontinuation of their use must be avoided.

No formal studies of drug interaction with **Palladone** capsules have been performed.

4.6 Fertility, pregnancy and lactation

Palladone capsules are not recommended in pregnancy or in the breast-feeding mother.

Pregnancy

No clinical data on exposed pregnancies are available.

Animal studies revealed no teratogenic effects at doses that give exposure greater than those expected in humans (see Section 5.3).

Palladone capsules should not be used during pregnancy and labour due to impaired uterine contractility and the risk of neonatal respiratory depression. Prolonged use of hydromorphone during pregnancy can result in neonatal withdrawal syndrome.

Lactation

No data are available on the use of hydromorphone during lactation. **Palladone** capsules should therefore not be used in breast-feeding mothers, otherwise breast-feeding should be stopped.

Fertility

Animal studies revealed no evidence of an effect on fertility or reproductive parameters at oral doses as high as 5 mg/kg/day. Peri-natal toxicity was noted in rats treated with 2 and 5 mg/kg/day.

4.7 Effects on ability to drive and use machines

Hydromorphone may impair the ability to drive and use machines. This is particularly likely at the initiation of treatment with hydromorphone, after dose increase or product rotation and if hydromorphone is combined with alcohol or other CNS depressant agents. Patients stabilised on a specific dosage will not necessarily be restricted. Therefore, patients should consult with their physician as to whether driving or the use of machinery is permitted.

4.8 Undesirable effects

The following frequency categories form the basis for classification of the undesirable effects:

Very common: $\geq 1/10$

Common: $\geq 1/100$ to $< 1/10$

Uncommon: $\geq 1/1000$ to $< 1/100$

Rare: $\geq 1/10000$ to $< 1/1000$

Very rare: $< 1/10000$

Not known: cannot be estimated from the available data

	Very common	Common	Uncommon	Rare	Not known
Immune system disorders					Anaphylactic reactions Hypersensitivity (including oropharyngeal swelling)
Metabolism		Decreased			

	Very common	Common	Uncommon	Rare	Not known
and nutrition disorders		appetite			
Psychiatric disorders		Anxiety Confusional state Insomnia	Agitation Depression Euphoric mood Hallucination Nightmares	Aggression	Drug dependence (see section 4.4) Dysphoria
Nervous system disorders	Dizziness Somnolence	Headache	Tremor Myoclonus Paraesthesia	Sedation Lethargy	Convulsions Dyskinesia Hyperalgesia Central sleep apnoea syndrome (see section 4.4)
Eye disorders			Visual impairment		Miosis
Cardiac disorders				Bradycardia Palpitations Tachycardia	
Vascular disorders			Hypotension		Flushing
Respiratory, thoracic and mediastinal disorders			Dyspnoea	Respiratory depression Bronchospasm	
Gastrointestinal disorders	Constipation Nausea	Abdominal pain Dry mouth Vomiting	Dyspepsia Diarrhoea Dysgeusia		Paralytic ileus
Hepatobiliary disorders			Hepatic enzymes increased	Elevation of pancreatic enzymes	
Skin and subcutaneous tissue disorders		Pruritus Hyperhidrosis	Rash		Urticaria
Renal and urinary disorders		Urgency	Urinary retention		
Reproductive system and breast disorders			Decreased libido Erectile dysfunction		
General disorders and administration site conditions		Asthenia	Drug withdrawal syndrome* Fatigue Malaise Peripheral		Drug tolerance Drug withdrawal syndrome neonatal

	Very common	Common	Uncommon	Rare	Not known
			oedema		

* A withdrawal syndrome may occur and include symptoms such as agitation, anxiety, nervousness, insomnia, hyperkinesia, tremor and gastrointestinal symptoms.

Drug dependence

Repeated use of **Palladone** capsules can lead to drug dependence, even at therapeutic doses. The risk of drug dependence may vary depending on a patient's individual risk factors, dosage, and duration of opioid treatment (see section 4.4).

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

Signs of hydromorphone toxicity and overdose include miotic pupils, bradycardia, respiratory depression, hypotension, pneumonia aspiration, somnolence progressing to stupor and coma. Circulatory failure and deepening coma may occur in more severe cases and may lead to a fatal outcome.

Toxic leukoencephalopathy has been observed with hydromorphone overdose.

In unconscious patients with respiratory arrest intubation and assisted respiration may be required. Naloxone 0.8 mg should be administered intravenously. This should be repeated at 2-3 minute intervals as necessary, or by an infusion of 2 mg in 500 ml of sodium chloride solution or 5% w/v glucose solution (0.004 mg ml⁻¹). The infusion should be run at a rate relative to the previous bolus administered and should be in accordance with the patient's response. Respiration should be assisted if necessary. Fluid and electrolyte levels should be maintained.

Close monitoring (at least for 24 hours) is required, since the effect of the opioid antagonist is shorter than that of hydromorphone, so that repeated occurrence of the signs of overdose like respiratory insufficiency are to be expected.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Opioid analgesic; natural opium alkaloid.
ATC code: N02A A03.

Like morphine, hydromorphone is an opioid agonist with no antagonist activity. The pharmaceutical actions of hydromorphone and morphine do not differ significantly. Hydromorphone and related opioids produce their major effects on the central nervous system and bowel. Its therapeutic action is mainly analgesic, anxiolytic, antitussive and sedative. Moreover, mood swings, respiratory depression, reduced gastrointestinal motility, nausea, vomiting and alteration of the endocrine and vegetative nervous system may occur.

There have been no long term clinical studies with ***Palladone*** capsules.

Endocrine System

See section 4.4.

Hepatobiliary System

Opioids may induce biliary spasm.

Other Pharmacologic System

In vitro animal studies indicate various effects of natural opioids, such as morphine, on components of the immune system; the clinical significance of these findings is unknown. Whether hydromorphone, a semisynthetic opioid, has immunological effects similar to natural opioids is unknown.

5.2 Pharmacokinetic properties

Absorption

Hydromorphone is absorbed from the gastrointestinal tract and undergoes pre-systemic elimination resulting in a mean oral bioavailability of about 32 % (range 17 – 62%).

Distribution

Plasma protein binding of hydromorphone is low (< 10 %). This percentage remains constant up to very high plasma levels of approximately 80 ng/ml, which are only very rarely achieved with very high hydromorphone doses.

Biotransformation

Hydromorphone is metabolised by direct conjugation or reduction of the keto group with subsequent conjugation. Hydromorphone is primarily metabolised to hydromorphone-3-glucuronide, hydromorphone-3-glucoside and dihydroisomorphine-6-glucuronide. Smaller portions of the metabolites dihydroisomorphine-6-glucoside, dihydromorphone and dihydroisomorphine have also been found. Hydromorphone is metabolised via the liver; a smaller portion is excreted unchanged via the kidneys.

Elimination

Hydromorphone metabolites were found in plasma, urine and human hepatocyte test systems. There are no indications to hydromorphone being metabolised *in vivo* via the cytochrome P 450 enzyme system. *In vitro*, hydromorphone has but a minor inhibition effect (IC₅₀ > 50 µM) on recombinant CYP isoforms, including CYP1A2, 2A6, 2C8, 2D6 und 3A4. Hydromorphone is therefore not expected to inhibit the metabolism of other active substances which metabolise via these CYP isoforms.

5.3 Preclinical safety data

Reproductive and Developmental Toxicity

No effects have been observed on male or female fertility or sperm parameters in rats at oral hydromorphone doses as high as 5 mg/kg/day (30 mg/m²/day or 1.4 times the expected human dose on a surface area basis).

Hydromorphone was not teratogenic in pregnant rats nor rabbits given oral doses during the major period of organ development. Reduced foetal development was observed in rabbits at 50 mg/kg (the developmental no-effect level dose of 25 mg/kg or 380 mg/m² at a drug exposure, AUC, approximately 4 times that expected in humans). No evidence of foetal toxicity was observed in rats at oral hydromorphone doses as high as 10 mg/kg (308 mg/m² at an AUC approximately 1.8 times that expected in humans). Evidence of a teratogenic effect in mice and hamsters has been reported in the literature.

A pre- and post-natal study in rats showed that there was an increase in pup mortality at 2 and 5 mg/kg/day and reduced body weight gain in the early postnatal period, associated with maternal toxicity. No effects on continued pup development or reproductive performance were observed.

Carcinogenicity

Hydromorphone was non-genotoxic in a bacterial mutation test, in the *in vitro* human lymphocyte chromosome aberration assay and the *in vivo* mouse micronucleus assay, but positive in mouse lymphoma assay with metabolic activation. Similar findings have been reported with other opioid analgesics.

Long term carcinogenicity studies have not been performed.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Capsule contents:

Microcrystalline cellulose

Lactose anhydrous

Capsule shells:

Gelatin

Erythrosine (E127)

Iron oxide yellow (E172)

Titanium dioxide (E171)

Sodium laurilsulfate

Black printing ink containing:

Shellac

Propylene glycol

Iron oxide (E172)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

2 years.

6.4 Special precautions for storage

Do not store above 25°C. Store in the original package.

6.5 Nature and contents of container

PVC/PVdC blister packs with aluminium backing foil containing 56 capsules.

6.6 Special precautions for disposal/and other handling

No special requirements.

7. MARKETING AUTHORISATION HOLDER

Mundipharma Pharmaceuticals Limited
United Drug House Magna Drive
Magna Business Park
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8. MARKETING AUTHORISATION NUMBER(S)

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