

Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Esomeprazole 40 mg gastro-resistant tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains: 40 mg esomeprazole (as esomeprazole magnesium amorphous).

Excipient with known effect:

Each tablet also contains not more than 54.90 mg Sucrose.

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Gastro-resistant tablet

40 mg: Light brick red to brown coloured, oval, biconvex, film-coated tablets with 'E6' debossed on one side and plain on other side.

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

Adults

Esomeprazole Gastro-resistant tablets are indicated for:

Gastro-oesophageal Reflux Disease (GORD)

- treatment of erosive reflux esophagitis

Prolonged treatment after IV induced prevention of rebleeding of peptic ulcers

Treatment of Zollinger Ellison Syndrome

In combination with appropriate antibacterial therapeutic regimens for the eradication of *Helicobacter pylori* and

- healing of *Helicobacter pylori* associated duodenal ulcer and
- prevention of relapse of peptic ulcers in patients with *Helicobacter pylori* associated
- ulcers

Patients requiring continued NSAID therapy

Healing of gastric ulcers associated with NSAID therapy.

Prevention of gastric and duodenal ulcers associated with NSAID therapy, in patients at risk.

Prolonged treatment after i.v. induced prevention of rebleeding of peptic ulcers.

Treatment of Zollinger Ellison Syndrome

Adolescents from the age of 12 years

Gastro-oesophageal Reflux Disease (GORD)

- treatment of erosive reflux esophagitis

- long-term management of patients with healed esophagitis to prevent relapse
- symptomatic treatment of gastro-oesophageal reflux disease (GORD)

In combination with antibiotics in treatment of duodenal ulcer caused by *Helicobacter pylori*

4.2 Posology and method of administration

Posology

Adults and adolescents from the age of 12 years

Gastro-oesophageal Reflux Disease (GORD)

treatment of erosive reflux esophagitis

40 mg once daily for 4 weeks

An additional 4 weeks treatment is recommended for patients in whom esophagitis has not healed or who have persistent symptoms.

Adults

Prolonged treatment after i.v. induced prevention of rebleeding of peptic ulcers

40 mg once daily for 4 weeks after i.v. induced prevention of rebleeding of peptic ulcers.

Treatment of Zollinger Ellison Syndrome

The recommended initial dosage is Esomeprazole 40 mg twice daily. The dosage should then be individually adjusted and treatment continued as long as clinically indicated. Based on the clinical data available, the majority of patients can be controlled on doses between 80 to 160 mg esomeprazole daily. With doses above 80 mg daily, the dose should be divided and given twice daily.

Special populations

Children below the age of 12 years

Esomeprazole should not be used in children younger than 12 years since no data is available. Other pharmaceutical forms of esomeprazole may be more suitable for this age group; ask your doctor or pharmacist

Patients with renal impairment

Dose adjustment is not required in patients with impaired renal function. Due to limited experience in patients with severe renal insufficiency, such patients should be treated with caution. (See section 5.2).

Patients with hepatic impairment

Dose adjustment is not required in patients with mild to moderate liver impairment. For patients with severe liver impairment, a maximum dose of 20 mg Esomeprazole should not be exceeded. (See section 5.2).

Older people

Dose adjustment is not required in the older people.

Method of administration

The tablets should be swallowed whole with liquid. The tablets should not be chewed or crushed. For patients who have difficulty in swallowing the tablets can also be dispersed in half a glass of non-carbonated water. No other liquids should be used as the enteric coating may be dissolved. Stir until the tablets disintegrate and drink the liquid with the pellets immediately or within 30 minutes. Rinse the glass with half a glass of water and drink. The pellets must not be chewed or crushed.

For patients who cannot swallow, the tablets can be dispersed in non-carbonated water and administered through a gastric tube. It is important that the appropriateness of the selected syringe and tube is carefully tested.

For preparation and administration instructions see section 6.6.

4.3 Contraindications

Known hypersensitivity to esomeprazole, substituted benzimidazoles or any other constituents of the formulation listed in section 6.1

Esomeprazole should not be used concomitantly with nelfinavir (See section 4.5).

4.4 Special warnings and precautions for use

In the presence of any alarm symptom (e.g. significant unintentional weight loss, recurrent vomiting, dysphagia, haematemesis or melaena) and when gastric ulcer is suspected or present, malignancy should be excluded, as treatment with Esomeprazole may alleviate symptoms and delay diagnosis.

Patients on long-term treatment (particularly those treated for more than a year) should be kept under regular surveillance.

Patients on on-demand treatment should be instructed to contact their physician if their symptoms change in character. When prescribing esomeprazole for on demand therapy, the implications for interactions with other pharmaceuticals, due to fluctuating plasma concentrations of esomeprazole should be considered. See section 4.5.

When prescribing esomeprazole for eradication of *Helicobacter pylori* possible drug interactions for all components in the triple therapy should be considered. Clarithromycin is a potent inhibitor of CYP3A4 and hence contraindications and interactions for clarithromycin should be considered when the triple therapy is used in patients concurrently taking other active substances metabolised via CYP3A4 such as cisapride.

Treatment with proton pump inhibitors may lead to slightly increased risk of gastrointestinal infections such as Salmonella and Campylobacter (see section 5.1).

Co-administration of esomeprazole with atazanavir is not recommended (see section 4.5). If the combination of atazanavir with a proton pump inhibitor is judged unavoidable, close clinical monitoring is recommended in combination with an increase in the dose of atazanavir to 400 mg with 100 mg of ritonavir; esomeprazole 20 mg should not be exceeded.

Esomeprazole, as all acid-blocking medicines, may reduce the absorption of vitamin B12 (cyanocobalamin) due to hypo- or achlorhydria. This should be considered in patients with reduced body stores or risk factors for reduced vitamin B12 absorption on long-term therapy.

Esomeprazole is a CYP2C19 inhibitor. When starting or ending treatment with esomeprazole, the potential for interactions with drugs metabolised through CYP2C19 should be considered. An interaction is observed between clopidogrel and esomeprazole (see section 4.5). The clinical relevance of this interaction is uncertain. As a precaution, concomitant use of esomeprazole and clopidogrel should be discouraged.

Hypomagnesaemia

Severe hypomagnesaemia has been reported in patients treated with proton pump inhibitors (PPIs) like esomeprazole for at least three months, and in most cases for a year. Serious manifestations of hypomagnesaemia such as fatigue, tetany, delirium, convulsions, dizziness and ventricular arrhythmia can occur but they may begin insidiously and be overlooked. In most affected patients, hypomagnesaemia improved after magnesium replacement and discontinuation of the PPI.

For patients expected to be on prolonged treatment or who take PPIs with digoxin or drugs that may cause hypomagnesaemia (e.g., diuretics), health care professionals should consider measuring magnesium levels before starting PPI treatment and periodically during treatment.

Proton pump inhibitors, especially if used in high doses and over long durations (>1 year), may modestly increase the risk of hip, wrist and spine fracture, predominantly in the elderly or in presence of other recognised risk factors. Observational studies suggest that proton pump inhibitors may increase the overall risk of fracture by 10–40%. Some of this increase may be due to other risk factors. Patients at risk of osteoporosis should receive care according to current clinical guidelines and they should have an adequate intake of vitamin D and calcium.

Interference with laboratory tests

The increased Chromogranin A (CgA) level may interfere with investigations for neuroendocrine tumours. To avoid this interference, esomeprazole treatment should be stopped for at least 5 days before CgA measurements (see section 5.1).

Sucrose

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

4.5 Interaction with other medicinal products and other forms of interaction

Interaction studies have only been performed in adults.

Effects of esomeprazole on the pharmacokinetics of other medicinal products*Medicinal products with pH dependent absorption*

Gastric acid suppression during treatment with esomeprazole and other PPIs might decrease or increase the absorption of medicinal products with a gastric pH dependent absorption. As with other medicinal products that decrease intragastric acidity, the absorption of medicinal products such as ketoconazole, itraconazole and erlotinib can decrease and the absorption of digoxin can increase during treatment with esomeprazole. Concomitant treatment with omeprazole (20 mg daily) and digoxin in healthy subjects increased the bioavailability of digoxin by 10% (up to 30% in two out of ten subjects). Digoxin toxicity has been rarely reported. However, caution should be exercised when esomeprazole is given at high doses in older patients. Therapeutic drug monitoring of digoxin should then be reinforced.

Omeprazole has been reported to interact with some protease inhibitors. The clinical importance and the mechanisms behind these reported interactions are not always known. Increased gastric pH during omeprazole treatment may change the absorption of the protease inhibitors. Other possible interaction mechanisms are via inhibition of CYP2C19. For atazanavir and nelfinavir, decreased serum levels have been reported when given together with omeprazole and concomitant administration is not recommended. Co-administration of omeprazole (40 mg once daily) with atazanavir 300 mg/ritonavir 100 mg to healthy volunteers resulted in a substantial reduction in atazanavir exposure (approximately 75% decrease in AUC, C_{max} and C_{min}). Increasing the atazanavir dose to 400 mg did not compensate for the impact of omeprazole on atazanavir exposure. The co-administration of omeprazole (20 mg qd) with atazanavir 400 mg/ritonavir 100 mg to healthy volunteers resulted in a decrease of approximately 30% in the atazanavir exposure as compared with the exposure observed with atazanavir 300 mg/ritonavir 100 mg qd without omeprazole 20 mg qd. Co-administration of omeprazole (40 mg qd) reduced mean nelfinavir AUC, C_{max} and C_{min} by 36–39 % and mean AUC, C_{max} and C_{min} for the pharmacologically active metabolite M8 was reduced by 75-92%. For saquinavir (with concomitant ritonavir), increased serum levels (80-100%) have been reported during concomitant omeprazole treatment (40 mg qd). Treatment with omeprazole 20 mg qd had no effect on the exposure of darunavir (with concomitant ritonavir) and amprenavir (with concomitant ritonavir). Treatment with esomeprazole 20 mg qd had no effect on the exposure of amprenavir (with and without concomitant ritonavir). Treatment with omeprazole 40 mg qd had no effect on the exposure of lopinavir (with concomitant ritonavir). Due to the similar pharmacodynamic effects and pharmacokinetic properties of omeprazole and esomeprazole, concomitant administration with esomeprazole and atazanavir is not recommended and concomitant administration with esomeprazole and nelfinavir is contraindicated.

Medicinal products metabolised by CYP2C19

Esomeprazole inhibits CYP2C19, the major esomeprazole metabolising enzyme. Thus, when esomeprazole is combined with other medicinal products metabolised by CYP2C19, such as diazepam, citalopram, imipramine, clomipramine, phenytoin etc., the plasma concentrations of these active substances may be increased and a dose reduction could be needed. This should be considered especially when prescribing esomeprazole for on demand therapy. Concomitant administration of 30 mg esomeprazole resulted in a 45% decrease in clearance of the CYP2C19 substrate diazepam. Concomitant administration of 40 mg esomeprazole resulted in a 13% increase in trough plasma levels of phenytoin in epileptic patients. It is recommended to monitor the plasma concentrations of phenytoin when treatment with esomeprazole is introduced or withdrawn. Omeprazole (40 mg once daily) increased voriconazole (a CYP2C19 substrate) C_{max} and AUC_{τ} by 15% and 41%, respectively.

Concomitant administration of 40 mg esomeprazole to warfarin-treated patients in a clinical trial showed that coagulation times were within the accepted range. However, post-marketing, a few isolated cases of elevated INR of clinical significance have been reported during concomitant treatment. Monitoring is recommended when initiating and ending concomitant esomeprazole treatment during treatment with warfarin or other coumarine derivatives.

Omeprazole as well as esomeprazole act as inhibitors of CYP2C19. Omeprazole, given in doses of 40 mg to healthy subjects in a cross-over study, increased C_{max} and AUC for cilostazol by 18% and 26% respectively, and one of its active metabolites by 29% and 69% respectively.

In healthy volunteers, concomitant administration of 40 mg esomeprazole resulted in a 32% increase in area under the plasma concentration-time curve (AUC) and a 31% prolongation of elimination half-life ($t_{1/2}$) but no significant increase in peak plasma levels of cisapride. The slightly prolonged QTc interval observed after administration of cisapride alone, was not further prolonged when cisapride was given in combination with esomeprazole (see also section 4.4).

Esomeprazole has been shown to have no clinically relevant effects on the pharmacokinetics of amoxicillin, quinidine.

Studies evaluating concomitant administration of esomeprazole and either naproxen or rofecoxib did not identify any clinically relevant pharmacokinetic interactions during short-term studies.

Results from studies in healthy subjects have shown a pharmacokinetic (PK)/ pharmacodynamic (PD) interaction between clopidogrel (300 mg loading dose/75 mg daily maintenance dose) and esomeprazole (40 mg p.o.daily) resulting in decreased exposure to the active metabolite of clopidogrel by an average of 40% and resulting in decreased maximum inhibition of (ADP induced) platelet aggression by an average of 14%.

When clopidogrel was given together with a fixed dose combination of esomeprazole 20 mg + ASA 81 mg compared to clopidogrel alone in a study in healthy subjects there was a decreased exposure by almost 40% of the active metabolite of clopidogrel. However, the maximum levels of inhibition of (ADP induced) platelet aggregation in these subjects were the same in the clopidogrel and the clopidogrel + the combined (esomeprazole + ASA) product groups.

Inconsistent data on the clinical implications of a PK/PD interaction of esomeprazole in terms of major cardiovascular events have been reported from both observational and clinical studies. As a precaution concomitant use of clopidogrel should be discouraged.

Unknown mechanism

Concomitant administration of esomeprazole has been reported to increase the serum levels of tacrolimus.

When given together with PPIs, methotrexate levels have been reported to increase in some patients. In high-dose methotrexate administration a temporary withdrawal of esomeprazole may need to be considered.

Effects of other medicinal products on the pharmacokinetics of esomeprazole

Medicinal products which inhibit CYP2C19 and/or CYP3A4

Esomeprazole is metabolised by CYP2C19 and CYP3A4. Concomitant administration of esomeprazole and a CYP3A4 inhibitor, clarithromycin (500 mg b.i.d.), resulted in a doubling of the exposure (AUC) to esomeprazole. Concomitant administration of esomeprazole and a combined inhibitor of CYP2C19 and CYP 3A4 may result in more than doubling of the esomeprazole exposure. The CYP2C19 and CYP3A4 inhibitor voriconazole increased omeprazole AUC_τ by 280%. A dose adjustment of esomeprazole is not regularly required in either of these situations. However, dose adjustment should be considered in patients with severe hepatic impairment and if long-term treatment is indicated.

Medicinal products which induce CYP2C19 and/or CYP3A4

Drugs known to induce CYP2C19 or CYP3A4 or both (such as rifampicin and St. John's wort) may lead to decreased esomeprazole serum levels by increasing the esomeprazole metabolism.

4.6 Fertility, pregnancy and lactation

Pregnancy

For Esomeprazole, clinical data on exposed pregnancies are insufficient. With the racemic mixture, omeprazole, data on a larger number of exposed pregnancies from epidemiological studies indicate no malformative nor foetotoxic effect. Animal studies with esomeprazole do not indicate direct or indirect harmful effects with respect to embryonal/fetal development. Animal studies with the racemic mixture do not indicate direct or indirect harmful effects with respect to pregnancy, parturition or postnatal development. Caution should be exercised when prescribing to pregnant women.

Breast-feeding

It is not known whether esomeprazole is excreted in human breast milk. No studies in lactating women have been performed. Therefore Esomeprazole should not be used during breast-feeding.

4.7 Effects on ability to drive and use machines

Esomeprazole has no influence on the ability to drive and use machines.

4.8 Undesirable effects

The following adverse drug reactions have been identified or suspected in the clinical trials programme for esomeprazole and post-marketing. None was found to be dose-related. The reactions are classified according to the MedDRA frequency convention: very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1,000$ to $< 1/100$), rare ($\geq 1/10,000$ to $< 1/1,000$), very rare ($< 1/10,000$), not known (cannot be estimated from the available data)

Blood and lymphatic system disorders

Rare: Leukopenia, thrombocytopenia

Very rare: Agranulocytosis, pancytopenia

Immune system disorders

Rare: Hypersensitivity reactions e.g. fever, angioedema and anaphylactic reaction/shock

Metabolism and nutrition disorders

Uncommon: Peripheral oedema

Rare: Hyponatraemia

Not known: Hypomagnesaemia (see section 4.4); severe hypomagnesaemia can correlate with hypocalcaemia

Psychiatric disorders

Uncommon: Insomnia

Rare: Agitation, confusion, depression

Very rare: Aggression, hallucinations

Nervous system disorders

Common: Headache

Uncommon: Dizziness, paraesthesia, somnolence

Rare: Taste disturbance

Eye disorders

Rare: Blurred vision

Ear and labyrinth disorders

Uncommon: Vertigo

Respiratory, thoracic and mediastinal disorders

Rare: Bronchospasm

Gastrointestinal disorders

Common: Abdominal pain, constipation, diarrhoea, flatulence, nausea/vomiting

Uncommon: Dry mouth

Rare: Stomatitis, gastrointestinal candidiasis

Not known: Microscopic colitis

Hepatobiliary disorders

Uncommon: Increased liver enzymes

Rare: Hepatitis with or without jaundice

Very rare: Hepatic failure, encephalopathy in patients with pre-existing liver disease

Skin and subcutaneous tissue disorders

Uncommon: Dermatitis, pruritus, rash, urticaria

Rare: Alopecia, photosensitivity

Very rare: Erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis (TEN)

Musculoskeletal and connective tissue disorders

Uncommon: Fracture of the hip, wrist or spine (see section 4.4)

Rare: Arthralgia, myalgia

Very rare: Muscular weakness

Renal and urinary disorders

Very rare: Interstitial nephritis; in some patients renal failure has been reported concomitantly.

Reproductive system and breast disorders

Very rare: Gynaecomastia

General disorders and administration site conditions

Rare: Malaise, increased sweating

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, Earlsfort Terrace, IRL - Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: <http://www.hpra.ie/>; E-mail: medsafety@hpra.ie.

4.9 OverdoseSymptoms

There is very limited experience to date with deliberate overdose. The symptoms described in connection with 280 mg were gastrointestinal symptoms and weakness. Single doses of 80 mg esomeprazole were uneventful.

Treatment

No specific antidote is known. Esomeprazole is extensively plasma protein bound and is therefore not readily dialyzable. As in any case of overdose, treatment should be symptomatic and general supportive measures should be utilised.

5 PHARMACOLOGICAL PROPERTIES**5.1 Pharmacodynamic properties**

Pharmacotherapeutic group: proton pump inhibitor

ATC Code: A02B C05

Esomeprazole is the S-isomer of omeprazole and reduces gastric acid secretion through a specific targeted mechanism of action. It is a specific inhibitor of the acid pump in the parietal cell. Both the R- and S-isomer of omeprazole have similar pharmacodynamic activity.

Site and mechanism of action

Esomeprazole is a weak base and is concentrated and converted to the active form in the highly acidic environment of the secretory canaliculi of the parietal cell, where it inhibits the enzyme H^+K^+ -ATPase – the acid pump and inhibits both basal and stimulated acid secretion.

Effect on gastric acid secretion

After oral dosing with esomeprazole 20 mg and 40 mg the onset of effect occurs within one hour. After repeated administration with 20 mg esomeprazole once daily for five days, mean peak acid output after pentagastrin stimulation is decreased 90% when measured 6-7 hours after dosing on day five.

After five days of oral dosing with 20 mg and 40 mg of esomeprazole, intragastric pH above 4 was maintained for a mean time of 13 hours and 17 hours, respectively over 24 hours in symptomatic GORD patients. The proportion of patients maintaining an intragastric pH above 4 for at least 8, 12 and 16 hours respectively were for esomeprazole 20 mg 76%, 54% and 24%. Corresponding proportions for esomeprazole 40 mg were 97%, 92% and 56%.

Using AUC as a surrogate parameter for plasma concentration, a relationship between inhibition of acid secretion and exposure has been shown.

Therapeutic effects of acid inhibition

Healing of reflux esophagitis with esomeprazole 40 mg occurs in approximately 78% of patients after four weeks, and in 93% after eight weeks.

One week treatment with esomeprazole 20 mg b.i.d. and appropriate antibiotics, results in successful eradication of *H. pylori* in approximately 90% of patients.

After eradication treatment for one week there is no need for subsequent monotherapy with antisecretory medicinal products for effective ulcer healing and symptom resolution in uncomplicated duodenal ulcers.

In a randomized, double blind, placebo-controlled clinical study, patients with endoscopically confirmed peptic ulcer bleeding characterised as Forrest Ia, Ib, IIa or IIb (9%, 43%, 38% and 10 % respectively) were randomized to receive esomeprazole solution for infusion (n=375) or placebo (n=389). Following endoscopic hemostasis, patients received either 80 mg esomeprazole as an intravenous infusion over 30 minutes followed by a continuous infusion of 8 mg per hour or placebo for 72 hours. After the initial 72 hour period, all patients received open-label 40 mg oral esomeprazole for 27 days for acid suppression. The occurrence of rebleeding within 3 days was 5.9% in the esomeprazole treated group compared to 10.3% for the placebo group. At 30 days post-treatment, the occurrence of rebleeding in the esomeprazole treated versus the placebo treated group 7.7% vs 13.6%.

Other effects related to acid inhibition

During treatment with antisecretory medicinal products serum gastrin increases in response to the decreased acid secretion. Also CgA increases due to decreased gastric acidity. The increased CgA level may interfere with investigations for neuroendocrine tumours. Literature reports indicate that proton pump inhibitor treatment should be stopped at least 5 days before CgA measurement. If CgA and gastrin levels have not normalised after 5 days, measurements should be repeated 14 days after cessation of esomeprazole treatment.

An increased number of ECL cells possibly related to the increased serum gastrin levels, have been observed in both children and adults during long term treatment with esomeprazole. The findings are considered to be of no clinical significance.

During long-term treatment with antisecretory medicinal products gastric glandular cysts have been reported to occur at a somewhat increased frequency. These changes are a physiological consequence of pronounced inhibition of acid secretion, are benign and appear to be reversible.

Decreased gastric acidity due to any means including proton pump inhibitors, increases gastric counts of bacteria normally present in the gastrointestinal tract. Treatment with proton pump inhibitors may lead to slightly increased risk of gastrointestinal infections such as *Salmonella* and *Campylobacter* and, in hospitalised patients, possibly also *Clostridium difficile*.

In two studies with ranitidine as an active comparator, esomeprazole showed better effect in healing of gastric ulcers in patients using NSAIDs, including COX-2 selective NSAIDs.

In two studies with placebo as comparator, esomeprazole showed better effect in the prevention of gastric and duodenal ulcers in patients using NSAIDs (aged >60 and/or with previous ulcer), including COX-2 selective NSAIDs.

Paediatric population

In a study in paediatric GORD patients (<1 to 17 years of age) receiving long-term PPI treatment, 61% of the children developed minor degrees of ECL cell hyperplasia with no known clinical significance and with no development of atrophic gastritis or carcinoid tumours.

5.2 Pharmacokinetic properties

Absorption and distribution

Esomeprazole is acid labile and is administered orally as enteric-coated granules. *In vivo* conversion to the R-isomer is negligible. Absorption of esomeprazole is rapid, with peak plasma levels occurring approximately 1-2 hours after dose. The absolute bioavailability is 64% after a single dose of 40 mg and increases to 89% after repeated once-daily administration. For 20 mg esomeprazole the corresponding values are 50% and 68% respectively. The apparent volume of distribution at steady state in healthy subjects is approximately 0.22 l/kg body weight. Esomeprazole is 97% plasma protein bound.

Food intake both delays and decreases the absorption of esomeprazole although this has no significant influence on the effect of esomeprazole on intragastric acidity.

Biotransformation and elimination

Esomeprazole is completely metabolised by the cytochrome P450 system (CYP). The major part of the metabolism of esomeprazole is dependent on the polymorphic CYP2C19, responsible for the formation of the hydroxy- and desmethyl metabolites of esomeprazole. The remaining part is dependent on another specific isoform, CYP3A4, responsible for the formation of esomeprazole sulphone, the main metabolite in plasma.

The parameters below reflect mainly the pharmacokinetics in individuals with a functional CYP2C19 enzyme, extensive metabolisers.

Total plasma clearance is about 17 l/h after a single dose and about 9 l/h after repeated administration. The plasma elimination half-life is about 1.3 hours after repeated once-daily dosing. The pharmacokinetics of esomeprazole has been studied in doses up to 40 mg b.i.d. The area under the plasma concentration-time curve increases with repeated administration of esomeprazole. This increase is dose-dependent and results in a more than dose proportional increase in AUC after repeated administration. This time - and dose-dependency is due to a decrease of first pass metabolism and systemic clearance probably caused by an inhibition of the CYP2C19 enzyme by esomeprazole and/or its sulphone metabolite. Esomeprazole is completely eliminated from plasma between doses with no tendency for accumulation during once-daily administration.

The major metabolites of esomeprazole have no effect on gastric acid secretion. Almost 80% of an oral dose of esomeprazole is excreted as metabolites in the urine, the remainder in the faeces. Less than 1% of the parent drug is found in urine.

Special patient populations

Approximately 2.9 ±1.5% of the population lack a functional CYP2C19 enzyme and are called poor metabolisers. In these individuals the metabolism of esomeprazole is probably mainly catalysed by CYP3A4. After repeated once-daily administration of 40 mg esomeprazole, the mean area under the plasma concentration-time curve was approximately 100% higher in poor metabolisers than in subjects having a functional CYP2C19 enzyme (extensive metabolisers).

Mean peak plasma concentrations were increased by about 60%. These findings have no implications for the posology of esomeprazole.

The metabolism of esomeprazole is not significantly changed in older subjects (71-80 years of age).

Following a single dose of 40 mg esomeprazole the mean area under the plasma concentration-time curve is approximately 30% higher in females than in males. No gender difference is seen after repeated once-daily administration. These findings have no implications for the posology of esomeprazole.

Impaired organ function

The metabolism of esomeprazole in patients with mild to moderate liver dysfunction may be impaired. The metabolic rate is decreased in patients with severe liver dysfunction resulting in a doubling of the area under the plasma concentration-time curve of esomeprazole. Therefore, a maximum of 20 mg should not be exceeded in patients with severe dysfunction. Esomeprazole or its major metabolites do not show any tendency to accumulate with once-daily dosing.

No studies have been performed in patients with decreased renal function. Since the kidney is responsible for the excretion of the metabolites of esomeprazole but not for the elimination of the parent compound, the metabolism of esomeprazole is not expected to be changed in patients with impaired renal function.

Paediatric population

Adolescents 12-18 years:

Following repeated dose administration of 20 mg and 40 mg esomeprazole, the total exposure (AUC) and the time to reach maximum plasma drug concentration (t_{max}) in 12 to 18 year-olds was similar to that in adults for both esomeprazole doses.

5.3 Preclinical safety data

Preclinical bridging studies reveal no particular hazard for humans based on conventional studies of repeated dose toxicity, genotoxicity, and toxicity to reproduction. Carcinogenicity studies in the rat with the racemic mixture have shown gastric ECL-cell hyperplasia and carcinoids. These gastric effects in the rat are the result of sustained, pronounced hypergastrinaemia secondary to reduced production of gastric acid and are observed after long-term treatment in the rat with inhibitors of gastric acid secretion.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablets core
 Sugar spheres (sucrose and maize starch)
 Hydroxypropyl cellulose (E463)
 Crospovidone (TypeB)
 Povidone K30
 Macrogol-400
 Talc (E553b)
 Hypromellose phthalate (HP-55S)
 Hypromellose phthalate (HP-50)
 Diethylphthalate
 Macrogol 6000
 Crospovidone (TypeA)
 Microcrystalline cellulose (PH 101)
 Microcrystalline cellulose (PH 112)
 Sodium stearyl fumarate

Coat
Macrogol-4000
Opadry 03B86651 Brown
(HPMC 2910/Hypromellose 6cP (E464)
Titanium Dioxide (E171)
Macrogol/PEG 400
Talc (E553b)
Iron Oxide red (E172))

6.2 Incompatibilities

Not applicable

6.3 Shelf life

3 years

6.4 Special precautions for storage

Store below 30°C
Keep in blister in order to protect from moisture.

6.5 Nature and contents of container

OPA-AI-PE-dessicant-HDPE/AI blister 7, 14, 15, 28, 30, 50, 56, 60, 90, 98 and 100 tablets
Not all pack sizes may be marketed

6.6 Special precautions for disposal and other handling

Any unused medicinal product or waste material should be disposed of in accordance with local requirements

Administration through gastric tube

1. Put the tablet into an appropriate syringe and fill the syringe with approximately 25 mL water and approximately 5mL air. For some tubes, dispersion in 50 mL water is needed to prevent the pellets from clogging the tube.
2. Immediately shake the syringe for approximately 2 minutes to disperse the tablet.
3. Hold the syringe with the tip up and check that the tip has not clogged.
4. Attach the syringe to the tube whilst maintaining the above position.
5. Shake the syringe and position it with the tip pointing down. Immediately inject 5 – 10 mL into the tube. Invert the syringe after injection and shake (the syringe must be held with the tip pointing up to avoid clogging of the tip)
6. Turn the syringe with the tip down and immediately inject another 5-10 mL into the tube. Repeat this procedure until the syringe is empty.
7. Fill the syringe with 25 mL of water and 5 mL of air and repeat step5 if necessary to wash down any sediment left in the syringe. For some tubes, 50 mL water is needed.

7 MARKETING AUTHORISATION HOLDER

Ranbaxy Ireland Limited,
Spafield,
Cork Road,
Cashel,
Co. Tipperary.

8 MARKETING AUTHORISATION NUMBER

PA 408/81/2

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 4th February 2011

Date of last renewal: 30th November 2014

10 DATE OF REVISION OF THE TEXT

October 2014