

# Summary of Product Characteristics

## 1 NAME OF THE MEDICINAL PRODUCT

Diclac 100mg Suppositories

## 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each suppository contains 100mg of diclofenac sodium

For the full list of excipients, see section 6.1.

## 3 PHARMACEUTICAL FORM

Suppository

White to cream coloured torpedo shaped suppositories, odourless.

## 4 CLINICAL PARTICULARS

### 4.1 Therapeutic indications

Relief of all grades of pain and inflammation in a wide range of conditions.

Treatment of:

- Inflammatory and degenerative forms of rheumatism: rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis, osteoarthritis and spondylarthritis, psoriatic arthropathy, painful syndromes of the vertebral column, non-articular rheumatism.
- Acute attacks of gout.
- Post-traumatic and post-operative pain, inflammation, and swelling, e.g. following dental or orthopaedic surgery.
- Painful and/or inflammatory conditions in gynaecology, e.g. primary dysmenorrhoea or adnexitis and associated menorrhagia.
- Acute musculo-skeletal disorders such as periarthrits (for example frozen shoulder), tendonitis, tenosynovitis, bursitis.
- Migraine attacks.
- As an adjuvant in severe painful inflammatory infections of the ear, nose, or throat, e.g. pharyngotonsillitis, otitis.

In keeping with general therapeutic principles, the underlying disease should be treated with basic therapy, as appropriate.

Fever alone is not an indication.

### 4.2 Posology and method of administration

Undesirable effects may be minimised by using the lowest effective dose for the shortest duration necessary to control symptoms (see section 4.4 Special warnings and precautions for use).

The suppositories should be inserted well into the rectum. It is recommended to use the suppository after passing stools.

Not to be taken by mouth as for rectal use only.

#### Adults:

The recommended initial daily dosage is 100 to 150 mg. In milder cases, as well as for long-term therapy, 75 to 100 mg daily is usually sufficient.

The total daily dosage should generally be divided into 2 to 3 doses. To suppress nocturnal pain and morning stiffness, treatment with tablets during the day can be supplemented by the administration of a suppository at bedtime (up to a total maximum daily dose of 150mg).

In primary dysmenorrhoea, the daily dosage should be individually adjusted and is generally 50 -to 150mg. Initially a dose of 50 to 100 mg should be given and, if necessary, increased over the course of several menstrual cycles up to a maximum of 200 mg/day. Treatment should be started upon appearance of the first symptoms and, depending on the symptomatology, continued for a few days.

Treatment of migraine attacks with Diclac suppositories should be started with a dose of 100mg at the first sign of an impending attack. Additional suppositories up to 100mg may be taken on the same day if required. Should the patient require further therapy on the following days, the daily maximum dose should be limited to 150mg in divided doses.

### **Children and adolescents:**

Diclac 100mg suppositories are not suitable for children and adolescents.

### **Elderly (patients aged 65 or above):**

Although the pharmacokinetics of DICLAC are not impaired to any clinically relevant extent in elderly patients, non-steroidal anti-inflammatory drugs should be used with particular caution in such patients who generally are more prone to adverse reactions. In particular it is recommended that the lowest effective dosage be used in frail elderly patients or those with a low body weight (see also precautions).

### **Renal impairment**

Diclofenac is contraindicated in patients with severe renal impairment (see section 4.3).

No specific studies have been carried out in patients with renal impairment, therefore, no specific dose adjustment recommendations can be made.

Caution is advised when administering diclofenac to patients with mild to moderate renal impairment (see section 4.3 and 4.4).

### **Hepatic impairment**

Diclofenac is contraindicated in patients with severe hepatic impairment (see section 4.3).

No specific studies have been carried out in patients with hepatic impairment, therefore, no specific dose adjustment recommendations can be made.

Caution is advised when administering diclofenac to patients with mild to moderate hepatic impairment (see section 4.3 and 4.4).

## **4.3 Contraindications**

- Known hypersensitivity to the active substance or to any of the excipients listed in section 6.1.
- Active gastric or intestinal ulcer, bleeding or perforation
- History of gastrointestinal bleeding or perforation related to previous NSAIDs therapy. Active, or history of recurrent peptic ulcer/haemorrhage (two or more distinct episodes of proven ulceration or bleeding).
- Third trimester of pregnancy (see section 4.6 Pregnancy and Lactation)
- Hepatic failure

- Chronic Kidney Disease Grade 5 (GFR < 15)
- Like other non-steroidal anti-inflammatory drugs (NSAIDs), diclofenac is also contra-indicated in patients in whom the use of acetylsalicylic acid or other NSAIDs can precipitate asthma, angioedema, urticaria, or acute rhinitis
- Established congestive heart failure (NYHA II-IV), ischemic heart disease, peripheral arterial disease and/or cerebrovascular disease.
- Proctitis

#### 4.4 Special warnings and precautions for use

As with other NSAIDs, allergic reactions, including anaphylactic/anaphylactoid reactions, can also occur in rare cases with diclofenac without earlier exposure to the drug. Hypersensitivity reactions can also progress to Kounis syndrome, a serious allergic reaction that can result in myocardial infarction. Presenting symptoms of such reactions can include chest pain occurring in association with an allergic reaction to diclofenac.

Undesirable effects may be minimized by using the lowest effective dose for the shortest duration necessary to control symptoms (see section 4.2 and GI and cardiovascular risks below).

The concomitant use of diclofenac with systemic NSAIDs including cyclooxygenase-2 selective inhibitors, should be avoided due to the absence of any evidence demonstrating synergistic benefits and the potential for additive undesirable effects.

Caution is indicated in the elderly on basic medical grounds. In particular, it is recommended that the lowest effective dose be used in frail elderly patients or those with a low body weight.

As with other nonsteroidal anti-inflammatory drugs including diclofenac, allergic reactions, including anaphylactic/anaphylactoid reactions, can also occur without earlier exposure to the drug (see section 4.8)

Like other NSAIDs, diclofenac may mask the signs and symptoms of infection due to its pharmacodynamic properties.

#### Gastrointestinal effects:

Gastrointestinal bleeding, (haematemesis, melaena) ulceration or perforation, which can be fatal, have been reported with all NSAIDs including diclofenac and may occur at any time during treatment, with or without warning symptoms or a previous history of serious gastrointestinal events. They generally have more serious consequences in the elderly. If gastrointestinal bleeding or ulceration occurs in patients receiving diclofenac, the medicinal product should be withdrawn.

As with all NSAIDs, including diclofenac, close medical surveillance is imperative and particular caution should be exercised when prescribing diclofenac in patients with symptoms indicative of gastrointestinal (GI) disorders or with a history suggestive of gastric or intestinal ulceration, bleeding or perforation (see section 4.8). The risk of GI bleeding, ulceration or perforation is higher with increasing NSAID doses, in patients with a history of ulcer, particularly if complicated with haemorrhage or perforation (see section 4.3). The elderly have an increased frequency of adverse reactions to NSAIDs especially gastrointestinal bleeding, and perforation, which may be fatal.

NSAIDs, including diclofenac, may be associated with increased risk of gastro-intestinal anastomotic leak. Close medical surveillance and caution are recommended when using diclofenac after gastro-intestinal surgery.

To reduce the risk of GI toxicity in patients with a history of ulcer, particularly if complicated with haemorrhage or perforation, and in the elderly. The treatment should be initiated and maintained at the lowest effective dose.

Combination therapy with protective agents (e.g. proton pump inhibitors or misoprostol) should be considered for these patients, and also for patients requiring concomitant use of medicinal products containing low-dose acetylsalicylic acid (ASA)/aspirin or other medicinal products likely to increase gastrointestinal risk (see below and section 4.5).

Patients with a history of GI toxicity, particularly the elderly, should report any unusual abdominal symptoms (especially GI bleeding), particularly in the initial stages of treatment. Caution is recommended in patients receiving concomitant medications which could increase the risk of ulceration or bleeding, such as oral corticosteroids, anticoagulants such as warfarin, anti-platelet agents such as aspirin or selective serotonin-reuptake inhibitors (see section 4.5).

Close medical surveillance and caution should also be exercised in patients with ulcerative colitis or Crohn's disease, as their condition may be exacerbated (see section 4.8).

### **Hepatic effects:**

Close medical surveillance is required when prescribing diclofenac to patients with impaired hepatic function, as their condition may be exacerbated.

As with other NSAIDs, including diclofenac, values of one or more liver enzymes may increase. During prolonged treatment with diclofenac, regular monitoring of hepatic is indicated as a precautionary measure. If abnormal liver function tests persist or worsen, if clinical signs or symptoms consistent with liver disease develop, or if other manifestations occur (e.g. eosinophilia, rash), diclofenac should be discontinued. Hepatitis may occur with use of diclofenac without prodromal symptoms.

Caution is called for when using diclofenac in patients with hepatic porphyria, since it may trigger an attack.

### **Renal effects:**

As fluid retention and oedema have been reported in association with NSAID therapy, including diclofenac, particular caution is called for in patients with impaired cardiac or renal function, history of hypertension, the elderly, patients receiving concomitant treatment with diuretics or medicinal products that can significantly impact renal function, and in those patients with substantial extracellular volume depletion from any cause, e.g. before or after major surgery (see section 4.3). Monitoring of renal function is recommended as a precautionary measure when using diclofenac in such cases. Discontinuation of therapy is usually followed by recovery to the pre-treatment state.

### **Skin Effects:**

Serious skin reactions, some of them fatal, including exfoliative dermatitis, Stevens-Johnson syndrome and toxic epidermal necrolysis, have been reported very rarely in association with the use of NSAIDs, including diclofenac (see section 4.8). Patients appear to be at highest risk of these reactions early in the course of therapy, the onset of the reaction occurring in the majority of cases within the first month of treatment. Diclofenac should be discontinued at the first appearance of skin rash, mucosal lesions or any other sign of hypersensitivity.

Serious skin reactions, some of them fatal, including exfoliative dermatitis, Stevens-Johnson syndrome, toxic epidermal necrolysis, and generalized bullous fixed drug eruption have been reported very rarely in association with the use of diclofenac (see section 4.8). Patients appear to be at highest risk of these reactions early in the course of therapy, the onset of the reaction occurring in the majority of cases within the first month of treatment. Diclofenac should be discontinued at the first appearance of skin rash, mucosal lesions or any other sign of hypersensitivity.

### **SLE and mixed connective tissue disease:**

In patients with systemic lupus erythematosus (SLE) and mixed connective tissue disorders there may be an increased risk of aseptic meningitis (see section 4.8)

### **Cardiovascular and cerebrovascular effects:**

Appropriate monitoring and advice are required for patients with a history of hypertension and/or congestive heart failure (NYHA-1), as fluid retention and oedema have been reported in association with NSAID therapy.

Clinical trial and epidemiological data suggest that the use of diclofenac, particularly at high dose (150mg daily) and in long term treatment may be associated with a small increased risk of arterial thrombotic events (for example myocardial infarction or stroke). To minimize the potential risk of an adverse cardiovascular event in patients taking a NSAID, especially in those with cardiovascular risk factors, the lowest effective dose should be used for the shortest possible duration.

Patients with congestive heart failure (NYHA-1) and patients with significant risk factors for cardiovascular events (e.g. hypertension, hyperlipidaemia, diabetes mellitus, smoking) should only be treated with diclofenac after careful consideration. As the cardiovascular risks of diclofenac may increase with dose and duration of exposure the shortest duration possible and the lowest effective daily dose should be used. The patient's need for symptomatic relief and response to therapy should be re-evaluated periodically.

Patients with uncontrolled hypertension, congestive heart failure, established ischaemic heart disease, peripheral arterial disease, and/or cerebrovascular disease should only be treated with diclofenac after careful consideration.

Patients should remain alert for the signs and symptoms of serious arteriothrombotic events (e.g. chest pain, shortness of breath, weakness, slurring of speech), which can occur without warnings. Patients should be instructed to see a physician immediately in case of such an event.

### **Haematological effects:**

During prolonged treatment with diclofenac, as with other NSAIDs, monitoring of the blood count is recommended. Like other NSAIDs, diclofenac may temporarily inhibit platelet aggregation. Patients with defects of haemostasis should be carefully monitored.

### **Pre-existing asthma**

In patients with asthma, seasonal allergic rhinitis, swelling of the nasal mucosa (i.e. nasal polyps), chronic obstructive pulmonary diseases or chronic infections of the respiratory tract (especially if linked to allergic rhinitis-like symptoms), reactions on NSAIDs like asthma exacerbations (so-called intolerance to analgesics/analgesics-asthma), Quincke's oedema or urticaria are more frequent than in other patients. Therefore, special precaution is recommended in such patients (readiness for emergency). This is applicable as well for patients who are allergic to other substances, e.g. with skin reactions, pruritus or urticaria.

Like other drugs that inhibit prostaglandin synthetase activity, diclofenac sodium and other NSAID's can precipitate bronchospasm if administered to patients suffering from, or with a previous history of bronchial asthma.

### **Female Fertility**

The use of diclofenac may impair female fertility and is not recommended in women attempting to conceive. In women who may have difficulties conceiving or who are undergoing investigation of infertility, withdrawal of diclofenac should be considered (see section 4.6).

## **4.5 Interaction with other medicinal products and other forms of interaction**

The following interactions include those observed with diclofenac suppositories and/or other pharmaceutical forms of diclofenac.

### ***Observed Interactions to be considered***

**Potent CYP2C9 inhibitors:** Caution is recommended when co-prescribing diclofenac with potent CYP2C9 inhibitors (such as voriconazole), which could result in a significant increase in peak plasma concentrations and exposure to diclofenac due to inhibition of diclofenac metabolism.

**Lithium:** If used concomitantly, diclofenac may raise plasma concentrations of lithium. Monitoring of the serum lithium level is recommended.

**Digoxin:** If used concomitantly, diclofenac may raise plasma concentrations of digoxin. Monitoring of the serum digoxin level is recommended.

**Diuretics and antihypertensive agents:** Like other NSAIDs, concomitant use of diclofenac with diuretics and antihypertensive agents (e.g. beta-blockers, angiotensin converting enzyme (ACE) inhibitors may cause a decrease in their antihypertensive effect via inhibition of vasodilatory prostaglandin synthesis. Therefore, the combination should be administered with caution and patients, especially the elderly, should have their blood pressure periodically monitored. Patients should be adequately hydrated and consideration should be given to monitoring of renal function after initiation of concomitant therapy and periodically thereafter, particularly for diuretics and ACE inhibitors due to the increased risk of nephrotoxicity (see section 4.4).

**Drugs known to cause hyperkalemia:** Concomitant treatment with potassium-sparing diuretics, ciclosporin, tacrolimus or trimethoprim may be associated with increased serum potassium levels, which should therefore be monitored frequently (see section 4.4).

**Quinolone antibacterials:** There have been isolated reports of convulsions which may have been due to concomitant use of quinolones and NSAIDs. This may occur in patients with or without a previous history of epilepsy or convulsions. Therefore, caution should be exercised when considering the use of a quinolone in patients who are already receiving an NSAID.

### ***Anticipated Interactions to be considered***

**Other NSAIDs** including cyclooxygenase-2 selective inhibitors **and corticosteroids:** Concomitant administration of diclofenac and other systemic NSAIDs or corticosteroids may increase the risk of gastrointestinal bleeding or ulceration. Avoid concomitant use of two or more NSAID's (see section 4.4).

**Anticoagulants and anti-platelet agents:** caution is recommended since concomitant administration could increase the risk of bleeding. Although clinical investigations do not appear to indicate that diclofenac affects the action of anticoagulants, there are reports of an increased risk of haemorrhage in patients receiving diclofenac and anticoagulants concomitantly. Close monitoring of such patients is therefore recommended. As with other non-steroidal anti-inflammatory agents, diclofenac in a high dose can reversibly inhibit platelet aggregation.

### **Selective serotonin reuptake inhibitors (SSRIs):**

Concomitant administration of systemic NSAID including diclofenac and SSRIs may increase the risk of gastrointestinal bleeding (see section 4.4).

**Antidiabetics:** Clinical studies have shown that diclofenac can be given together with oral antidiabetic agents without influencing their clinical effect. However, there have been isolated reports of both hypoglycaemic and hyperglycaemic effects necessitating changes in the dosage of the antidiabetic agents during treatment with diclofenac. For this reason, monitoring of the blood glucose level is recommended as a precautionary measure during concomitant therapy.

**Methotrexate:** Diclofenac can inhibit the tubular renal clearance of methotrexate hereby increasing methotrexate levels. Caution is recommended when NSAIDs including diclofenac are administered less than 24 hours before or after treatment with methotrexate, since blood concentrations of methotrexate may rise and the toxicity of this substance be increased. Cases of serious toxicity have been reported when methotrexate and NSAID's including diclofenac are given within 24 hours of each other. This interaction is mediated through accumulation of methotrexate resulting from impairment of renal excretion in the presence of the NSAID.

**Ciclosporin:** Diclofenac, like other NSAIDs, may increase the nephrotoxicity of ciclosporin due to the effect on renal prostaglandins. Therefore, it should be given at doses lower than those that would be used in patients not receiving ciclosporin.

**Tacrolimus:** Possible increased risk of nephrotoxicity when NSAIDs are given with tacrolimus. This might be mediated through renal antiprostaglandin effects of both NSAID and calcineurin inhibitor.

**Cardiac glycosides:** Concomitant use of cardiac glycosides and NSAIDs in patients may exacerbate cardiac failure, reduce GFR and increase plasma glycoside levels.

**Mifepristone:** NSAIDs should not be used for 8-12 days after mifepristone administration as NSAIDs can reduce the effect of mifepristone.

### **Colestipol and cholestyramine:**

These agents can induce a delay or decrease in absorption of diclofenac. Therefore, it is recommended to administer diclofenac at least one hour before or 4 to 6 hours after administration of colestipol/cholestyramine.

**Phenytoin:** When using phenytoin concomitantly with diclofenac, monitoring of phenytoin plasma concentrations is recommended due to an expected increase in exposure of phenytoin.

## 4.6 Fertility, pregnancy and lactation

### Pregnancy

Inhibition of prostaglandin synthesis may adversely affect the pregnancy and/or the embryo/foetal development. Data from epidemiological studies suggest an increased risk of miscarriage and of cardiac malformation and gastroschisis after use of a prostaglandin synthesis inhibitor in early pregnancy. The absolute risk for cardiovascular malformation was increased from less than 1%, up to approximately 1.5 %.

The risk is believed to increase with dose and duration of therapy. In animals, administration of a prostaglandin synthesis inhibitor has been shown to result in increased pre- and post-implantation loss and embryo-foetal lethality.

In addition, increased incidences of various malformations, including cardiovascular, have been reported in animals given a prostaglandin synthesis inhibitor during the organogenetic period. From the 20th week of pregnancy onward, diclofenac use may cause oligohydramnios resulting from foetal renal dysfunction. This may occur shortly after treatment initiation and is usually reversible upon discontinuation. In addition, there have been reports of ductus arteriosus constriction following treatment in the second trimester, most of which resolved after treatment cessation. Therefore, during the first and second trimester of pregnancy, diclofenac should not be given unless clearly necessary. If diclofenac is used by a woman attempting to conceive, or during the first and second trimester of pregnancy, the dose should be kept as low and duration of treatment as short as possible. Antenatal monitoring for oligohydramnios and ductus arteriosus constriction should be considered after exposure to diclofenac for several days from gestational week 20 onward. Diclofenac should be discontinued if oligohydramnios or ductus arteriosus constriction are found.

During the third trimester of pregnancy, all prostaglandin synthesis inhibitors may expose the foetus to:

- cardiopulmonary toxicity (premature constriction/closure of the ductus arteriosus and pulmonary hypertension);
- renal dysfunction, (see above);

the mother and the neonate, at the end of pregnancy, to:

- possible prolongation of bleeding time, an anti-aggregating effect which may occur even at very low doses.
- inhibition of uterine contractions resulting in delayed or prolonged labour.

Consequently, diclofenac is contraindicated during the third trimester of pregnancy (see sections 4.3 and 5.3).

### Lactation

Like other NSAIDs, diclofenac passes into the breast milk, but in small amounts. Therefore, diclofenac should not be administered during breast feeding in order to avoid undesirable effects in the infant.

### Fertility

As with other NSAIDs, the use of diclofenac may impair female fertility and is not recommended in women attempting to conceive. In women who have difficulties conceiving or who are undergoing investigation of infertility, withdrawal of diclofenac should be considered.

## 4.7 Effects on ability to drive and use machines

Patients who experience dizziness, vertigo, somnolence or other central nervous system disturbances, including visual disturbances, while taking NSAIDs, should refrain from driving or using machines.

## 4.8 Undesirable effects

Adverse drug reactions from clinical trials and/or spontaneous or literature cases are listed by MedRA system order class. Within each system organ class, the adverse drug reactions are ranked under frequency, with the most frequent reactions first. Within each frequency grouping, adverse drug reactions are presented in order of decreasing seriousness. In addition, the corresponding frequency category for each adverse drug reaction is based on the following convention (CIOMS III): very common ( $>1/10$ ); common ( $\geq 1/100$ ,  $<1/10$ ); uncommon ( $\geq 1/1,000$ ,  $<1/100$ ); rare ( $\geq 1/10,000$ ,  $<1/1,000$ ); very rare ( $<1/10,000$ ).

The most commonly observed adverse events are gastrointestinal in nature. Peptic ulcers, perforation or GI bleeding, sometimes fatal, particularly in the elderly, may occur (see section 4.4). Nausea, vomiting, diarrhoea, flatulence, constipation,

dyspepsia, abdominal pain, melaema, haematemesis, ulcerative stomatitis, exacerbation of colitis and Crohn's disease (see section 4.4) have been reported following administration.

Less frequently, gastritis has been observed.

The following undesirable effects include those reported with diclofenac suppositories and/or other pharmaceutical forms of diclofenac, with either short-term or long-term use.

#### Blood and lymphatic disorders

Very rare: Thrombocytopenia, leukopenia, anaemia (including haemolytic and aplastic anaemia), agranulocytosis

#### Immune system disorders

Rare: Hypersensitivity reactions such as asthma, systemic anaphylactic and anaphylactoid reactions (including hypotension and shock)

Very rare: Angioedema (including face oedema)

#### Psychiatric disorders

Very rare: Disorientation, depression, insomnia, nightmare, irritability, psychotic disorder

#### Nervous system disorders

Common: Headache, dizziness

Rare: Somnolence, tiredness

Very rare: Paraesthesia, memory impairment, convulsion, anxiety, tremor, aseptic meningitis, dysgeusia, cerebrovascular accident

#### Eye disorders

Very rare: Visual impairment (blurred vision, diplopia)

Unknown: Optic neuritis

#### Ear and labyrinth disorders

Common: Vertigo

Very rare: Tinnitus, hearing impaired

#### Cardiac disorders

Uncommon\*: myocardial infarction, cardiac failure, palpitations, chest pain

Not known: Kounis syndrome

#### Vascular disorders

Very rare: Hypertension, vasculitis

#### Respiratory, thoracic and mediastinal disorders

Rare: Asthma/bronchospasm (including dyspnoea)

Very rare: Pneumonitis

#### Gastrointestinal disorders

Common: Nausea, vomiting, diarrhoea, dyspepsia, abdominal pain, flatulence, decreased appetite

Rare: Gastritis, gastrointestinal haemorrhage, haematemesis, diarrhoea, haemorrhagic melaena,, gastrointestinal ulcer with or without bleeding or perforation, (sometimes fatal particularly in the elderly) proctitis

Very rare: Colitis (including haemorrhagic colitis and exacerbation of ulcerative colitis or Crohn's disease), constipation, stomatitis (including ulcerative stomatitis), glossitis, oesophageal disorder, diaphragm-like intestinal strictures, pancreatitis, haemorrhoids.

Not known: ischaemic colitis

#### Hepatobiliary disorders

Common: Transaminases increased

Rare: Hepatitis, jaundice, liver disorder

Very rare: Fulminant hepatitis, hepatic necrosis, hepatic failure

#### Skin and subcutaneous tissue disorders

Common: Rash

Rare: Urticaria

Very rare: Bullous eruptions, eczema, erythema, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis (Lyell's syndrome), dermatitis exfoliative, alopecia, photosensitivity reaction, purpura, purpura including allergic purpura, Henoch-Schonlein purpura, pruritus

Frequency not known: Fixed drug eruption, generalized bullous fixed drug eruption

Renal and urinary disorders

Very rare: Acute renal failure, haematuria, proteinuria, nephritic syndrome, tubulointerstitial nephritis, renal papillary necrosis

Reproductive system and breast disorders:

Very rare: Impotence

General disorders and administration site conditions

Rare: Oedema, application site irritation

\* The frequency reflects data from long-term treatment with a high dose (150mg/day).

Clinical trial and epidemiological data consistently point towards an increased risk of arterial thrombotic events (for example myocardial infarction or stroke associated with the use of diclofenac, particularly at high dose (150mg daily and in long term treatment (see section 4.3 and 4.4 for Contraindications and Special warnings and special precautions for use).

Oedema, hypertension and cardiac failure have been reported in association with NSAID treatment.

#### 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 preferably via HPRA Pharmacovigilance, website: [www.hpra.ie](http://www.hpra.ie)

## 4.9 Overdose

### Symptoms

There is no typical clinical picture resulting from diclofenac overdosage. Overdosage can cause symptoms such as vomiting, gastrointestinal haemorrhage, diarrhoea, dizziness, tinnitus or convulsions. In the event of significant poisoning, acute renal failure and liver damage are possible.

### Therapeutic measures

Management of acute poisoning with NSAIDs, including diclofenac, consists essentially of supportive measures and symptomatic treatment. Supportive measures and symptomatic treatment should be given for complications such as hypotension, renal failure, convulsions, gastrointestinal disorder, and respiratory depression.

Special measures such as forced diuresis, dialysis or haemoperfusion are probably unlikely to be helpful in accelerating the elimination of NSAIDs, including diclofenac, because of their high protein binding and extensive metabolism.

## 5 PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

#### **Pharmacotherapeutic group:**

Non-steroidal anti-inflammatory and antirheumatic products, non-steroids, acetic acid derivatives and related substances (NSAID) (ATC code: M01A B05).

#### **Mechanism of action**

Diclofenac contains diclofenac sodium, a non-steroidal compound with pronounced antirheumatic, anti-inflammatory, analgesic, and antipyretic properties. Inhibition of prostaglandin biosynthesis, which has been demonstrated in experiments, is

considered fundamental to its mechanism of action. Prostaglandins play a major role in causing of inflammation, pain, and fever.

Diclofenac sodium *in vitro* does not suppress proteoglycan biosynthesis in cartilage at concentrations equivalent to those reached in humans.

### Pharmacodynamic effects

In rheumatic diseases, the anti-inflammatory and analgesic properties of diclofenac elicit a clinical response characterised by marked relief from signs and symptoms such as pain at rest, pain on movement, morning stiffness, and swelling of the joints, as well as by an improvement in function.

In post-traumatic and post-operative inflammatory conditions, diclofenac rapidly relieves both spontaneous pain and pain on movement and reduces inflammatory swelling and wound oedema.

In clinical trials diclofenac has also been found to exert a pronounced analgesic effect in moderate and severe pain of non-rheumatic origin. Clinical studies have also revealed that, in primary dysmenorrhoea, diclofenac is capable of relieving the pain and reducing the extent of bleeding.

There is limited clinical trial experience of the use of diclofenac in Juvenile Rheumatoid Arthritis (JRA)/Juvenile Idiopathic Arthritis (JIA) paediatric patients. In a randomized, double-blind, 2-week, parallel group study in children aged 3-15 years with JRA/JIA, the efficacy and safety of daily 2-3 mg/kg BW diclofenac was compared with acetylsalicylic acid (ASS, 50-100 mg/kg BW/d) and placebo – 15 patients in each group. In the global evaluation, 11 of 15 diclofenac patients, 6 of 12 aspirin and 4 of 15 placebo patients showed improvement with the difference being statistically significant ( $p < 0.05$ ). The number of tender joints decreased with diclofenac and ASS but increased with placebo. In a second randomized, double-blind, 6-week, parallel group study in children aged 4-15 years with JRA/JIA, the efficacy of diclofenac (daily dose 2-3 mg/kg BW,  $n=22$ ) was comparable with that of indomethacin (daily dose 2-3mg/kg BW,  $n=23$ ).

## 5.2 Pharmacokinetic properties

### Absorption:

Diclofenac shows a rapid onset of absorption from suppositories, although the rate of absorption is slower than from gastro-resistant tablets administered orally. After the administration of 50mg suppositories, peak plasma concentrations are attained on average within 1 hour, but maximum concentrations per dose unit are about two thirds of those reached after administration of gastro-resistant tablets.

Since about half of diclofenac is metabolized during its first passage through the liver ("first pass" effect), the area under the concentration curve (AUC) following oral or rectal administration is about half that following an equivalent parenteral dose.

The amount absorbed is linearly related to the size of the dose.

Pharmacokinetic behaviour does not change on repeated administration. Accumulation does not occur, provided the recommended dosage intervals are observed.

The plasma concentrations attained in children given equivalent doses (mg/kg body weight) are similar to those obtained in adults.

### Distribution:

The active substance is 99.7% protein bound, mainly to albumin (99.4%).

Diclofenac enters the synovial fluid, where maximum concentrations are measured 2-4 hours after the peak plasma values have been attained. The apparent half-life for elimination from the synovial fluid is 3-6 hours.

Two hours after reaching the peak plasma values, concentrations of the active substance are already higher in the synovial fluid than they are in the plasma and remain higher for up to 12 hours.

Diclofenac was detected in a low concentration (100ng/ml) in breast milk in one nursing mother. The estimated amount ingested by an infant consuming breast milk is equivalent to a 0.03mg/kg/day dose.

### Biotransformation/Metabolism:

Biotransformation of diclofenac takes place partly by glucuronidation of the intact molecule, but mainly by single and multiple hydroxylation and methyloxylation, resulting in several phenolic metabolites, most of which are converted to glucuronide conjugates. Two phenolic metabolites are biologically active, but to a much lesser extent than diclofenac.

#### Elimination:

Total systemic clearance of diclofenac in plasma is  $263 \pm 56$  ml/min (mean value SD). The terminal half-life in plasma is 1-2 hours. Four of the metabolites, including the two active ones, also have short plasma half-lives of 1-3 hours.

About 60% of the administered dose is excreted in the urine as the glucuronide conjugate of the intact molecule and as metabolites, most of which are also converted to glucuronide conjugates. Less than 1% is excreted as unchanged substance. The rest of the dose is eliminated as metabolites through the bile in the faeces.

#### Special Populations:

*Elderly:* No relevant age-dependent differences in the drug's absorption, metabolism or excretion have been observed, other than the finding that in five elderly patients, a 15 minute IV infusion resulted in 50% higher plasma concentrations than expected with young healthy subjects.

*Patients with renal impairment:* In patients suffering from renal impairment, no accumulation of the unchanged active substance can be inferred from the single-dose kinetics when applying the usual dosage schedule. At a creatinine clearance of  $<10$  ml/min, the calculated steady-state plasma levels of the hydroxyl metabolites are about 4 times higher than in normal subjects. However, the metabolites are ultimately cleared through the bile.

*Patients with hepatic disease:* In patients with chronic hepatitis or non-decompensated cirrhosis, the kinetics and metabolism of diclofenac are the same as in patients without liver disease.

### 5.3 Preclinical safety data

Preclinical data from acute and repeated dose toxicity studies, as well as from genotoxicity, mutagenicity, and carcinogenicity studies with diclofenac revealed no specific hazard for humans at the intended therapeutic doses. In standard preclinical animal studies, there was no evidence that diclofenac had a teratogenic potential in mice, rats or rabbits.

Diclofenac had no influence on the fertility of parent animals in rats. Except for minimal fetal effects at maternally toxic doses the prenatal, perinatal and postnatal development of the offspring was not affected.

Administration of NSAIDs (including diclofenac) inhibited ovulation in the rabbit and implantation and placentation in the rat, and led to premature closure of the ductus arteriosus in the pregnant rat. Maternally toxic doses of diclofenac were associated with dystocia, prolonged gestation, decreased fetal survival, and intrauterine growth retardation in rats. The slight effects of diclofenac on reproduction parameters and delivery as well as constriction of the ductus arteriosus in utero are pharmacologic consequences of this class of prostaglandin synthesis inhibitors (see sections 4.3 and 4.6).

## 6 PHARMACEUTICAL PARTICULARS

### 6.1 List of excipients

Hard fat

### 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 the original package.

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## **6.5 Nature and contents of container**

DICLAC Suppositories 100 mg are packed in opaque strips of non-toxic polyvinylchloride/polyethylene with preshaped plastic pits and are available in pack sizes of 10 suppositories.

Not all pack sizes may be marketed.

## **6.6 Special precautions for disposal of a used medicinal product or waste materials derived from such medicinal product and other handling of the product**

No special requirements.

## **7 MARKETING AUTHORISATION HOLDER**

Rowex Limited,  
Newtown  
Bantry  
Co. Cork  
Ireland

## **8 MARKETING AUTHORISATION NUMBER**

PA0711/009/009

## **9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION**

Date of first authorisation: 05 March 1992

Date of last renewal: 05 March 2007

## **10 DATE OF REVISION OF THE TEXT**

October 2025