Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

DYPRACET 30 mg/500 mg Tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

DYPRACET 30 mg/500 mg Tablets contain Paracetamol 500 mg and Dihydrocodeine Tartrate 30 mg.

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Tablet

DYPRACET 30 mg/500 mg Tablets are oblong, white tablets, 19 mm x 7 mm long with the marking P500 D30 on one side.

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

DYPRACET 30 mg/500 mg Tablets: For the treatment of severe pain where there is a higher analgesic requirement.

4.2 Posology and method of administration

Posology

Adults over 18 years

1 or 2 tablets every four to six hours.

Do not exceed 8 tablets in any 24-hour period.

Paediatric population

Adolescents 16-18 years
1 or 2 tablets every six hours when necessary up to a maximum of 8 tablets in any 24 hour period.

Children 12-15 years
1 tablet every six hours when necessary up to a maximum of 4 tablets in any 24 hour period.

Children under 12 years

Not recommended.

Elderly

1 tablet every –four to six hours increasing to two tablets every 4 - 6 hours if required and tolerated. Caution should be exercised when increasing the dose in the elderly.

Method of administration

Oral.

DYPRACET 30 mg\500 mg tablets should, if possible, be taken during or after meals.

4.3 Contraindications

Hypersensitivity to the active substances or to any of the excipients listed in section 6.1.

Respiratory depression.

Obstructive airways disease.

4.4 Special warnings and precautions for use

DYPRACET 30 mg/500 mg Tablets should be given with caution in patients with allergic disorders and should not be given during an attack of asthma. Caution should also be observed if there is marked impairment of liver function, advanced kidney disease and in chronic alcoholics.

Do not exceed the recommended dose.

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

Dosage should be reduced in the elderly, in hypothyroidism and in chronic hepatic disease. An overdose can cause hepatic necrosis.

Dihydrocodeine should be used with caution in patients taking monoamine oxidase inhibitors and should be avoided in those patients with raised intracranial pressure or head injury.

Use with caution in patients with prostatic hypertrophy since dihydrocodeine may cause urinary retention.

The risk-benefit of continued use should be assessed regularly by the prescriber, and in particular the prescriber should take care to avoid any unnecessary increase in dosage especially where there is evidence of a previous history of drug dependence or abuse.

4.5 Interaction with other medicinal products and other forms of interaction

Additive CNS depression may occur with alcohol, and other CNS depressants such as anxiolytics, anti-depressants, hypnotics and anti-psychotics. The rate of absorption of paracetamol may be increased by metoclopramide or domperidone and absorption of paracetamol may be reduced by cholestyramine.

The anti-coagulant effect of warfarin and other coumarins may be enhanced by prolonged regular use of paracetamol with increased risk of bleeding.

4.6 Fertility, pregnancy and lactation

Pregnancy
Epidemiological studies in human pregnancy have shown no effects due to paracetamol or dihydrocodeine. However, both drugs should be avoided during pregnancy unless considered essential by the physician.

Breastfeeding
Paracetamol is excreted in breast milk but not in a clinically significant amount. Available published data do not contraindicate breast feeding.

At normal therapeutic doses codeine may be present in breast milk at very low doses and is unlikely to adversely affect the breast fed infant.

However, if the patient is an ultra-rapid metaboliser of CYP2D6, higher levels of codeine may be present in breast milk and on very rare occasions may result in symptoms of opioid toxicity in the infant.

If symptoms of opioid toxicity develop in either the mother or the infant, then all codeine containing medicines should be stopped and alternative non-opioid analgesics prescribed. In severe cases consideration should be given to prescribing nalaxone to reverse these effects.

Fertility
There are insufficient fertility data available to indicate whether paracetamol or dihydrocodeine has any effect on fertility.

4.7 Effects on ability to drive and use machines

Dihydrocodeine may cause drowsiness and, if affected, patients should not drive or operate machinery.

4.8 Undesirable effects

Constipation, if it occurs, is readily treated with a mild laxative.

Other side-effects of dihydrocodeine, which may occur in a few patients, are nausea, vomiting, headache, vertigo, giddiness, urinary retention, pruritus, sedation, dysphoria, hallucinations and allergic reactions including skin rashes.

Adverse effects of paracetamol are rare but hypersensitivity reactions including skin rash, blood dyscrasias, acute pancreatitis have been reported.

Dependence may occur. Regular prolonged use of dihydrocodeine is known to lead to addiction and tolerance. Symptoms of restlessness and irritability may result when treatment is then stopped.

Prolonged use of a painkiller can make conditions such as headache worse.

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: www.hpra.ie; E-mail: medsafety@hpra.ie.

4.9 Overdose

Paracetamol

Liver damage is possible in adults who have taken 10g or more of paracetamol. Ingestion of 5g or more of paracetamol may lead to liver damage if the patient has risk factors (see below).

Risk factors

If the patient

a) Is on long term treatment with carbamazepine, phenobarbitone, phenytoin, primidone, rifampicin, St John's Wort or other drugs that induce liver enzymes.

Or

b) Regularly consumes ethanol in excess of recommended amounts.

Or

c) Is likely to be glutathione depleted e.g. eating disorders, cystic fibrosis, HIV infection, starvation, cachexia.

Symptoms

Symptoms of paracetamol overdosage in the first 24 hours are pallor, nausea, vomiting, anorexia and abdominal pain. Liver damage may become apparent 12 to 48 hours after ingestion. Abnormalities of glucose metabolism and metabolic acidosis may occur. In severe poisoning, hepatic failure may progress to encephalopathy, haemorrhage, hypoglycaemia, cerebral oedema, and death. Acute renal failure with acute tubular necrosis, strongly suggested by loin pain, haematuria and proteinuria, may develop even in the absence of severe liver damage. Cardiac arrhythmias and pancreatitis have been reported.

Management

Immediate treatment is essential in the management of paracetamol overdose. Despite a lack of significant early symptoms, patients should be referred to hospital urgently for immediate medical attention. Symptoms may be limited to nausea or vomiting and may not reflect the severity of overdose or the risk of organ damage. Management should be in accordance with established treatment guidelines, see BNF overdose section.

Treatment with activated charcoal should be considered if the overdose has been taken within 1 hour. Plasma paracetamol concentration should be measured at 4 hours or later after ingestion (earlier concentrations are unreliable). Treatment with N-acetylcysteine may be used up to 24 hours after ingestion of paracetamol, however, the maximum protective effect is obtained up to 8 hours post-ingestion. The effectiveness of the antidote declines sharply after this time. If required the patient should be given intravenous N-acetylcysteine, in line with the established dosage schedule. If vomiting is not a problem, oral methionine may be a suitable alternative for remote areas, outside hospital. Management of patients who present with serious hepatic dysfunction beyond 24 hours from ingestion should be discussed with the NPIS or a liver unit.

Dihydrocodeine

Symptoms

Acute overdosage with dihydrocodeine can be manifested by somnolence progressing to stupor or coma, miotic pupils, rhabdomyolysis, non-cardiac pulmonary oedema, bradycardia, hypotension and respiratory depression or apnoea.

Management

Primary attention should be given to the establishment of a patent airway and institution of assisted or controlled ventilation.

In the case of massive overdosage, administer naloxone intravenously (0.4 to 2 mg for an adult and 0.01 mg/kg body weight for children) if the patient is in a coma or respiratory depression is present. Repeat the dose at 2 minute intervals if there is no response, or by an infusion. An infusion of 60% of the initial dose per hour is a useful starting point. A solution of 10 mg made up in 50 ml dextrose will produce 200 micrograms/ml for infusion using an IV pump (dose adjusted to the clinical response). Infusions are not a substitute for frequent review of the patient's clinical state. Intramuscular naloxone is an alternative in the event that IV access is not possible.

As the duration of action of naloxone is relatively short, the patient must be carefully monitored until spontaneous respiration is reliably re-established. Naloxone is a competitive antagonist and large doses (4 mg) may be required in seriously poisoned patients. For less severe overdosage, administer naloxone 0.2 mg intravenously followed by increments of 0.1 mg every 2 minutes if required.

Naloxone should not be administered in the absence of clinically significant respiratory or circulatory depression secondary to dihydrocodeine overdosage. Naloxone should be administered cautiously to persons who are known, or suspected, to be physically dependent on dihydrocodeine. In such cases, an abrupt or complete reversal of opioid effects may precipitate pain and an acute withdrawal syndrome.

Consider activated charcoal (50 g for adults, 10-15 g for children), if a substantial amount has been ingested within 1 hour, provided the airway can be protected.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Paracetamol is an effective analgesic possessing a remarkably low level of side effects. Its broad clinical utility has been extensively reported, and it now largely replaces aspirin for routine use. Paracetamol is well tolerated; having a bland effect on gastric mucosa, unlike aspirin, it neither exacerbates symptoms of peptic ulcer nor precipitates bleeding. Dihydrocodeine tartrate has been widely used for a number of years as a powerful analgesic.

In addition the compound exhibits well-defined anti-tussive activity.

Fortifying paracetamol with dihydrocodeine tartrate provides an effective combination of drugs for the treatment of severe pain.

5.2 Pharmacokinetic properties

Dihydrocodeine is well absorbed from the gastrointestinal tract. Like other phenanthrene derivatives, dihydrocodeine is mainly metabolised in the liver with the resultant metabolites being excreted mainly in the urine.

Metabolism of dihydrocodeine includes 0-demethylation, N-demethylation and 6-keto reduction.

Paracetamol is readily absorbed from the gastrointestinal tract with peak plasma concentrations occurring 30 minutes to 2 hours after ingestion. It is metabolised in the liver and excreted in the urine as the glucuronide and sulphate conjugates.

5.3 Preclinical safety data

There are no pre-clinical data of relevance to the prescriber which are additional to that already included in other sections of the SPC.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Microcrystalline cellulose
Povidone K30
Colloidal anhydrous silica
Magnesium stearate

6.2 Incompatibilities

None known.

6.3 Shelf life

2 years

6.4 Special precautions for storage

This medicinal product does not require any special storage conditions.

6.5 Nature and contents of container

DYPRACET 30 mg/500 mg Tablets are available in HDPE containers with polypropylene lids containing 56 tablets or in PVC foiled aluminium blisters containing 56 tablets.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

No special requirements.

7 MARKETING AUTHORISATION HOLDER

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8 MARKETING AUTHORISATION NUMBER

PA 1352/012/002

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10 DATE OF REVISION OF THE TEXT

May 2017