Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Anastrozole 1 mg film-coated tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 1 mg anastrozole.

Excipient with known effects: Each tablet contains 93 mg lactose monohydrate (see section 4.4).

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Film-coated tablet.
White film-coated round biconvex tablets, debossed with "ANA" and "1" on one side.

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

Anastrozole is indicated for the:
- Treatment of hormone receptor-positive advanced breast cancer in postmenopausal women.

4.2 Posology and method of administration

Posology
The recommended dose of anastrozole for adults including the elderly is one 1 mg tablet once a day.
For postmenopausal women with hormone receptor-positive early invasive breast cancer, the recommended duration of adjuvant endocrine treatment is 5 years.

Special populations

Paediatric population
Anastrozole is not recommended for use in children and adolescents due to insufficient data on safety and efficacy (see sections 4.4 and 5.1).

Renal impairment
No dose change is recommended in patients with mild or moderate renal impairment. In patients with severe renal impairment, administration of anastrozole should be performed with caution (see section 4.4 and 5.2).

Hepatic impairment
No dose change is recommended in patients with mild hepatic disease. Caution is advised in patients with moderate to severe hepatic impairment (see section 4.4).

Method of administration
Anastrozole should be taken orally.

4.3 Contraindications

Anastrozole is contraindicated in:
- Pregnant or breast-feeding women.
- Patients with known hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

4.4 Special warnings and precautions for use

General
Anastrozole should not be used in premenopausal women. The menopause should be defined biochemically (luteinizing-hormone [LH], follicle stimulating hormone [FSH], and/or estradiol levels) in any patient where there is doubt about menopausal status. There are no data to support the use of anastrozole with LHRH analogues.
Co-administration oftamoxifen or estrogen-containing therapies with anastrozole should be avoided as this may diminish its pharmacological action (see section 4.5 and 5.1).

Effectonbonemineraldensity
As anastrozole lowers circulating estrogen levels it may cause a reduction in bone mineral density with a possible consequent increased risk of fracture (see section 4.8).

Women with osteoporosis or at risk of osteoporosis, should have their bone mineral density formally assessed at the commencement of treatment and at regular intervals thereafter. Treatment or prophylaxis for osteoporosis should be initiated as appropriate and carefully monitored. The use of specific treatments, e.g., bisphosphonates, may stop further bone mineral loss caused by anastrozole in postmenopausal women and could be considered (see section 4.8).

Hepaticimpairment
Anastrozole has not been investigated in breast cancer patients with moderate or severe hepatic impairment. Exposure to anastrozole can be increased in subjects with hepatic impairment (see section 5.2); administration of anastrozole in patients with moderate and severe hepatic impairment should be performed with caution (see section 4.2). Treatment should be based on a benefit-risk evaluation for the individual patient.

Renalimpairment
Anastrozole has not been investigated in breast cancer patients with severe renal impairment. Exposure to anastrozole is not increased in subjects with severe renal impairment (GRF<30ml/min, see section 5.2); in patients with severe renal impairment, administration of anastrozole should be performed with caution (see section 4.2).

Paediatricpopulation

Anastrozole is not recommended for use in children and adolescents as safety and efficacy have not been established in this group of patients (see section 5.1).

Anastrozole should not be used in boys with growth hormone deficiency in addition to growth hormone treatment. In the pivotal clinical trial, efficacy was not demonstrated and safety was not established (see section 5.1). Since anastrozole reduces estradiol levels, anastrozole must not be used in girls with growth hormone deficiency in addition to growth hormone treatment. Long-term safety data in children and adolescents are not available.

Hypersensitivitytolactose

This product contains lactose. Patients with rare hereditary problems of galactose intolerance, the total lactase deficiency or glucose-galactose malabsorption should not take this medicine.

4.5 Interaction with other medicinal products and other forms of interactions

Anastrozole inhibit CYPs 1A2, 2C8/9 and 3A4 *in vitro*. Clinical studies with antipyrine and warfarin showed that anastrozole at a 1 mg dose did not significantly inhibit the metabolism of antipyrine and R– and S-warfarin indicating the co-administration of anastrozole with other medicinal products is unlikely to result in clinically significant medicinal product interactions mediated by CYP enzymes.

The enzymes mediating metabolism of anastrozole have not been identified. Cimetidine, a weak, unspecific inhibitor of CYP enzymes, did not affect the plasma concentrations of anastrozole. The effect of potent CYP inhibitors is unknown.

A review of a clinical trial safety database did not reveal evidence of clinically significant interaction in patients treated with anastrozole who also received other commonly prescribed medicinal products.
There were no clinically significant interactions with bisphosphonates (see section 5.1).

Co-administration of tamoxifen or estrogen-containing therapies with anastrozole should be avoided as this may diminish its pharmacological action (see section 4.4 and 5.1).

4.6 Fertility, pregnancy and lactation

Pregnancy
There are no data from the use of anastrozole in pregnant women. Studies in animals have shown reproductive toxicity (see section 5.3). Anastrozole is contraindicated during pregnancy (see section 4.3).

Breastfeeding
There are no data on the use of anastrozole during lactation. Anastrozole is contraindicated during breast-feeding (see section 4.3).

Fertility
The effects of anastrozole on fertility in humans have not been studied. Studies in animals have shown reproductive toxicity (see section 5.3).

4.7 Effects on ability to drive and use machines

Anastrozole has no or negligible influence the ability to drive and use machines. However, asthenia and sonmolence have been reported with the use of anastrozole and caution should be observed when driving or operating machinery while such symptoms persist.

4.8 Undesirable effects

The following table presents adverse reactions from clinical trials, post-marketing studies or spontaneous reports. Unless specified, the frequency categories were calculated from the number of adverse events reported in a large phase III study conducted in 9,366 postmenopausal women with operable breast cancer given adjuvant treatment for five years (the Arimidex, Tamoxifen, Alone or in Combination [ATAC] study).

Adverse reactions listed below are classified according to frequency and System Organ Class (SOC). Frequency groupings are defined according to the following convention: very common (2: 1110), common (2: 11100 to< 1110), uncommon (2: 111,000 to< 11100), rare (2: 1110,000 to <111,000), and very rare (<1110,000). The most frequently reported adverse reactions were headache, hot flushes, nausea, rash, arthralgia, joint stiffness, arthritis, and asthenia.

Adverse reactions by SOC and frequency		
Metabolism and nutrition disorders	Common	Anorexia Hypercholesterolaemia
	Uncommon	Hypercalcaemia (with or without an increase in parathyroid hormone)
Nervous system disorders	Very common	Headache
	Common	Sonmolence Carpal Tunnel Syndrome* Sensory disturbances (including paraesthesia, taste loss and taste perversion)
Vascular disorders	Very common	Hot flushes
Gastrointestinal disorders	Very common	Nausea
	Common	Diarrhoea Vomiting
Hepatobiliary disorders	Common	Increases in alkaline phosphatase, alanine aminotransferase and aspartate aminotransferase
	Uncommon	Increases in gamma-GT and bilirubin
		Hepatitis
Skin and subcutaneous tissue disorders	Very common	Rash
	Common	Hair thinning (alopecia) Allergic reactions

	Uncommon	Urticaria
	Rare	Erythema multiforme Anaphylactoid reaction Cutaneous vasculitis (including some reports ofHenoch-Schiinlein purpura)**
	Very rare	Stevens-Johnson syndrome Angioedema
Musculoskeletal and connective tissue disorders	Very common	Arthralgia/joint stiffness Arthritis Osteoporosis
	Common	Bone pain Myalgia
	Uncommon	Trigger finger
Reproductive system and breast Disorders	Common	Vaginal dryness Vaginal bleeding***
General disorders and administration site conditions	Very common	Asthenia

* Events of Carpal Tunnel Syndrome have been reported m patients rece1vmg anastrozole treatment m clinical trials in greater numbers than those receiving treatment with tamoxifen. However, the majority of these events occurred in patients with identifiable risk factors for the development of the condition.
** Since cutaneous vasculitis and Henoch-Schiinlein purpura was not observed in ATAC, the frequency category
*** for these events can be considered as 'Rare' (2: 0.01% and< 0.1%) based on the worst value of the point estimate. Vaginal bleeding has been reported commonly, mainly in patients with advanced breast cancer during the first few weeks after changing from existing hormonal therapy to treatment with anastrozole. If bleeding persists, further evaluation should be considered.

The table below presents the frequency of pre-specified adverse events in the ATAC study after a median follow-up of 68 months, irrespective of causality, reported in patients receiving trial therapy and up to 14 days after cessation of trial therapy.

Adverse events	Anastrozole (N 3,092)	Tamoxifen (N 3,094)
Hot flushes	1,104 (35.7%)	1,264 (40.9%)
Joint pain/stiffness	1,100 (35.6%)	911 (29.4%)
Mood disturbances	597 (19.3%)	554 (17.9%)
Fatigue/asthenia	575 (18.6%)	544 (17.6%)
Nausea and vomiting	393 (12.7%)	384 (12.4%)
Fractures	315 (10.2%)	209 (6.8%)
Fractures of the spine, hip or wrist/Colles	133 (4.3%)	91 (2.9%)
Wrist/Colles fractures	67 (2.2%)	50 (1.6%)
Spine fractures	43 (1.4%)	22 (0.7%)
Hip fractures	28 (0.9%)	26 (0.8%)
Cataracts	182 (5.9%)	213 (6.9%)
Vaginal bleeding	167 (5.4%)	317 (10.2%)
Ischaemic cardiovascular disease	127 (4.1%)	104 (3.4%)
Angina pectoris	71 (2.3%)	51 (1.6%)
Myocardial infarct	37 (1.2%)	34(1.1%)
Coronary artery disorder	25 (0.8%)	23 (0.7%)
Myocardial ischaemia	22 (0.7%)	14 (0.5%)
Vaginal discharge	109 (3.5%)	408 (13.2%)
Any venous thromboembolic event	87 (2.8%)	140 (4.5%)
Deep venous thromboembolic events including PE (pulmonary embolism)	48 (1.6%)	74 (2.4%)
Ischaemic cerebrovascular events	62 (2.0%)	88 (2.8%)
Endometrial cancer	4 (0.2%)	13 (0.6%)

Fracture rates of 22 per 1,000 patient-years and 15 per 1,000 patient-years were observed for the anastrozole and tamoxifen groups, respectively, after a median follow-up of 68 months. The observed fracture rate for anastrozole is similar to the range

reported in age-matched postmenopausal populations. The incidence of osteoporosis was 10.5% in patients treated with anastrozole and 7.3% in patients treated with tamoxifen.

It has not been determined whether the rates of fracture and osteoporosis seen in ATAC in patients on anastrozole treatment reflect a protective effect of tamoxifen, a specific effect of anastrozole, or both.

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 6767836. Website: www.hpra.ie; E-mail: medsafety@hpra.ie.

4.9 Overdose

There is limited clinical experience of accidental overdose. In animal studies, anastrozole demonstrated low acute toxicity. Clinical trials have been conducted with various dosages of anastrozole, up to 60 mg in a single dose given to healthy male volunteers, and up to 10 mg daily given to postmenopausal women with advanced breast cancer; these dosages were well tolerated. A single dose of anastrozole that results in life-threatening symptoms has not been established.

There is no specific antidote to overdose and treatment must be symptomatic.

In the management of an overdose, consideration should be given to the possibility that multiple agents may have been taken. Vomiting may be induced if the patient is alert. Dialysis may be helpful because anastrozole is not highly protein-bound. General supportive care, including frequent monitoring of vital signs and close observation of the patient, is indicated.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Enzyme inhibitors
ATC Code: L02B G03

Mechanismofactionandpharmaacodynamic effects
Anastrozole is a potent and highly selective non-steroidal aromatase inhibitor. In postmenopausal women, estradiol is produced primarily from the conversion of androstenedione to estrone through the aromatase enzyme complex in peripheral tissues. Estrone is subsequently converted to estradiol. Reducing circulating estradiol levels has been shown to produce a beneficial effect in women with breast cancer.

In postmenopausal women, anastrozole at a daily dose of 1 mg produced estradiol suppression of greater than 80% using a highly sensitive assay.

Anastrozole does not possess any progestogenic, androgenic or estrogenic activity.

Daily doses of anastrozole up to 10 mg do not have any effect on cortisol or aldosterone secretion, measured before or after standard adrenocorticotrophic hormone (ACTH) challenge testing. Corticoid supplements are therefore not needed.

Clinicalefficacyandsafety

Advancedbreastcancer

First-linetherapyinpostmenopausalwomenwithadvancedbreastcancer
Two double-blind, controlled clinical studies of similar design (Study 1033IL/0030 and Study 1033IL/0027) were conducted to assess the efficacy of anastrozole compared with tamoxifen as first-line therapy for hormone receptor- positive or hormone receptor-unknown locally advanced or metastatic breast cancer in postmenopausal women. A total of 1,021 patients were randomised to receive 1 mg of anastrozole once daily or 20 mg oftamoxifen once daily. The primary endpoints for both trials were time to tumour progression, objective tumour response rate, and safety.

For the primary endpoints, Study 1033IL/0030 showed that anastrozole had a statistically significant advantage over tamoxifen for time to tumour progression (Hazard ratio (HR) 1.42, 95% Confidence Interval (CI) [1.11, 1.82], Median time to progression 11.1 and 5.6 months for anastrozole and tamoxifen respectively, p 0.006); objective tumour response rates were similar for anastrozole and tamoxifen. Study 1033IL/0027 showed that anastrozole and tamoxifen had similar objective tumour response rates and time to tumour progression. Results from the secondary endpoints were supportive of the results of the primary efficacy endpoints. There were too few deaths occurring across treatment groups of both trials to drawconclusions on overall survival differences.

Second-linetherapyinpostmenopausalwomenwithadvancedbreastcancer
Anastrozole was studied in two controlled clinical trials (Study 0004 and Study 0005) in postmenopausal women with advanced breast cancer who had disease progression following tamoxifen therapy for either advanced or early breast cancer. A total of 764 patients were randomised to receive either a single daily dose of 1 mg or 10 mg of anastrozole or megestrol acetate 40 mg four times a day. Time to progression and objective response rates were the primary efficacy variables. The rate of prolonged (more than 24 weeks) stable disease, the rate of progression, and survival were also calculated. In both studies there were no significant differences between treatment arms with respect to any of the efficacy parameters.

BonemineraldensityCBMD!

In the phase III/IV study (Study of Anastrozole with the Bisphosphonate Risedronate [SABRE]), 234 postmenopausal women with hormone receptor-positive early breast cancer scheduled for treatment with anastrozole 1 mg/day were stratified to low, moderate and high risk groups according to their existing risk of fragility fracture. The primary efficacy parameter was the analysis of lumbar spine bone mass density using DEXA scanning. All patients received treatment with vitamin D and calcium. Patients in the low risk group received anastrozole alone (N 42), those in the moderate group were randomised to anastrozole plus risedronate 35 mg once a week (N 77) or anastrozole plus placebo (N 77) and those in the high risk group received anastrozole plus risedronate 35 mg once a week (N 38). The primary endpoint was change from baseline in lumbar spine bone mass density at 12 months.

The 12-month main analysis has shown that patients already at moderate to high risk of fragility fracture showed no decrease in their bone mass density (assessed by lumbar spine bone mineral density using DEXA scanning) when managed by using anastrozole 1 mg/day in combination with risedronate 35 mg once a week.

In addition, a decrease in BMD which was not statistically significant was seen in the low risk group treated with anastrozole 1 mg/day alone. These findings were mirrored in the secondary efficacy variable of change from baseline in total hip BMD at 12 months.

This study provides evidence that the use ofbisphosphonates could be considered in the management of possible bone mineral loss in postmenopausal women with early breast cancer scheduled to be treated with anastrozole.

Paediatric population

Anastrozole is not indicated for use in children and adolescents. Efficacy has not been established in the paediatric populations studied (see below). The number of children treated was too limited to draw any reliable conclusions on safety. No data on the potential long-term effects of anastrozole treatment in children and adolescents are available (see also section 5.3).

The European Medicines Agency has waived the obligation to submit the results of studies with anastrozole in one or several subsets of the paediatric population in short stature due to growth hormone deficiency (GHD), testotoxicosis, gynaecomastia, and McCune-Albright syndrome (see section 4.2).

ShortstatureduetoGrowthHormoneDeficiency
A randomised, double-blind, multi-centre study evaluated 52 pubertal boys (aged 11 to 16 years inclusive) with GHD treated for 12 to 36 months with anastrozole 1 mg/day or placebo in combination with growth hormone. Only 14 subjects on anastrozole completed 36 months.

No statistically significant difference from placebo was observed for the growth related parameters of predicted adult height, height, height SDS (standard deviation score), and height velocity. Final height data were not available. While the number of children treated was too limited to draw any reliable conclusions on safety, there was an increased fracture rate and a trend towards reduced bone mineral density in the anastrozole arm compared to placebo.

Testotoxicosis
An open-label, non-comparative, multi-centre study evaluated 14 male patients (aged 2 to 9 years) with familial male limited precocious puberty, also known as testotoxicosis, treated with combination of anastrozole and bicalutamide. The primary objective was to assess the efficacy and safety of this combination regimen over 12 months. Thirteen out of the 14 patients enrolled completed 12 months of combination treatment (one patient was lost to follow-up). There was no significant difference in growth rate after 12 months of treatment, relative to the growth rate during the 6 months prior to entering the study.

Gynaecomastia studies
Trial 0006 was a randomised, double-blind, multi-centre study of 82 pubertal boys (aged 11-18 years inclusive) with gynaecomastia of greater than 12 months duration treated with anastrozole 1 mg/day or placebo daily for up to 6 months. No significant difference in the number of patients who had a 50% or greater reduction in total breast volume after 6 months of treatment was observed between the anastrozole 1 mg treated group and the placebo group.

Trial 0001 was an open-label, multiple-dose pharmacokinetic study ofanastrozole 1 mg/day in 36 pubertal boys with gynaecomastia ofless than 12 months duration. The secondary objectives were to evaluate the proportion of patients with reductions from baseline in the calculated volume of gynaecomastia of both breasts combined of at least 50% between day 1 and after 6 months of study treatment, and patient tolerability and safety. A decrease in 50% or more of total breast volume was seen in 56% (20/36) of the boys after 6 months.

McCune-Albright Syndromestudy
Trial 0046 was an international, multi-centre, open-label exploratory trial of anastrozole in 28 girls (aged 2 to S 10 years) with McCune-Albright Syndrome (MAS). The primary objective was to evaluate the safety and efficacy of anastrozole 1 mg/day in patients with MAS. The efficacy of study treatment was based on the proportion of patients fulfilling defined criteria relating to vaginal bleeding, bone age, and growth velocity. No statistically significant change in the frequency of vaginal bleeding days on treatment was observed. There were no clinically significant changes in Tanner staging, mean ovarian volume, or mean uterine volume. No statistically significant change in the rate of increase in bone age on treatment compared to the rate during baseline was observed. Growth rate (in em/year) was significantly reduced ($p<0.05$) from pre- treatment through month 0 to month 12, and from pre-treatment to the second 6 months (month 7 to month 12).

5.2 Pharmacokinetic properties

Absorption
Absorption of anastrozole is rapid and maximum plasma concentrations typically occur within two hours of dosing (under fasted conditions). Food slightly decreases the rate but not the extent of absorption. The small change in the rate of absorption is not expected to result in a clinically significant effect on steady-state plasma concentrations during once daily dosing of anastrozole 1 mg tablets. Approximately 90 to 95% of plasma anastrozole steady-state concentrations are attained after 7 daily doses, and accumulation is 3- to 4-fold. There is no evidence of time or dose- dependency of anastrozole pharmacokinetic parameters.

Anastrozole pharmacokinetics are independent of age in postmenopausal women.

Distribution
Anastrozole is only 40% bound to plasma proteins.

Elimination
Anastrozole is eliminated slowly with a plasma elimination half-life of 40 to 50 hours. Anastrozole is extensively metabolised by postmenopausal women with less than 10% of the dose excreted in the urine unchanged within 72 hours of dosing. Metabolism of anastrozole occurs by N-dealkylation, hydroxylation and glucuronidation. The metabolites are excreted primarily via the urine. Triazole, the major metabolite in plasma, does not inhibit aromatase.

Renalorhepatic impairment
The apparent clearance (CLIF) of anastrozole, following oral administration, was approximately 30% lower in volunteers with stable hepatic cirrhosis than in matched controls (Study 1033IL/0014). However, plasma anastrozole concentrations in the volunteers with hepatic cirrhosis were within the range of concentrations seen in normal subjects in other trials. Plasma anastrozole concentrations observed during long-term efficacy trials in patients with hepatic impairment were within the range of plasma anastrozole concentrations seen in patients without hepatic impairment.

The apparent clearance (CLIF) of anastrozole, following oral administration, was not altered in volunteers with severe renal impairment (GFR <30ml/min) in Study 1033IL/0018, consistent with the fact that anastrozole is eliminated primarily by metabolism. Plasma anastrozole concentrations observed during long- term efficacy trials in patients with renal impairment were within the range of plasma anastrozole concentrations seen in patients without renal impairment. In patients with severe renal impairment, administration of anastrozole should be performed with caution (see section 4.2 and 4.4).

Paediatric population
In boys with pubertal gynaecomastia (10-17 years), anastrozole was rapidly absorbed, was widely distributed, and was eliminated slowly with a half-life of approximately 2 days. Clearance of anastrozole was lower in girls (3-10 years) than in the older boys and exposure higher. Anastrozole in girls was widely distributed and slowly eliminated.

5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, genotoxicity, carcinogenic potential, toxicity to reproduction for the indicated population.

Acute toxicity

In animal studies toxicity was only seen at high doses. In acute toxicity studies in rodents, the median lethal dose of anastrozole was greater than 100 mg/kg/day by the oral route and greater than 50 mg/kg/day by the intraperitoneal route. In an oral acute toxicity study in the dog, the median lethal dose was greater than 45 mg/kg/day.

Chronic toxicity

In animal studies adverse effects were only seen at high doses. Multiple dose toxicity studies utilized rats and dogs. No no-effect levels were established for anastrozole in the toxicity studies, but those effects that were observed at the low doses (1 mg/kg/day) and mid doses (dog 3 mg/kg/day; rat 5 mg/kg/day) were related to either the pharmacological or enzyme inducing properties of anastrozole and were unaccompanied by significant toxic or degenerative changes.

Mutagenicity

Genetic toxicology studies with anastrozole show that it is not a mutagen or a clastogen.

Reproductive toxicology

In a fertility study weanling male rats were dosed orally with 50 or 400 mg/l anastrozole via their drinking water for 10 weeks. Measured mean plasma concentrations were 44.4 (±14.7) ng/ml and 165 (±90) ng/ml respectively. Mating indices were adversely affected in both dose groups, whilst a reduction in fertility was evident only at the 400 mg/l dose level. The reduction was transient as all mating and fertility parameters were similar to control group values following a 9 week treatment-free recovery period.

Oral administration of anastrozole to female rats produced a high incidence of infertility at 1 mg/kg/day and increased pre-implantation loss at 0.02 mg/kg/day. These effects occurred at clinically relevant doses. An effect in man cannot be excluded. These effects were related to the pharmacology of the compound and were completely reversed after a 5-week compound withdrawal period.

Oral administration of anastrozole to pregnant rats and rabbits caused no teratogenic effects at doses up to 1.0 and 0.2 mg/kg/day respectively. Those effects that were seen (placental enlargement in rats and pregnancy failure in rabbits) were related to the pharmacology of the compound.

The survival of litters born to rats given anastrozole at 0.02 mg/kg/day and above (from Day 17 of pregnancy to Day 22 post-partum) was compromised. These effects were related to the pharmacological effects of the compound on parturition. There were no adverse effects on behaviour or reproductive performance of the first generation offspring attributable to maternal treatment with anastrozole.

Carcinogenicity

A two-year rat oncogenicity study resulted in an increase in incidence of hepatic neoplasms and uterine stromal polyps in females and thyroid adenomas in males at the high dose (25 mg/kg/day) only. These changes occurred at a dose which represents 100-fold greater exposure than occurs at human therapeutic doses, and are considered not to be clinically relevant to the treatment of patients with anastrozole.

A two-year mouse oncogenicity study resulted in the induction of benign ovarian tumours and a disturbance in the incidence of lymphoreticular neoplasms (fewer histiocytic sarcomas in females and more deaths as a result of lymphomas). These changes are considered to be mouse-specific effects of aromatase inhibition and not clinically relevant to the treatment of patients with anastrozole.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core
Lactose monohydrate
Sodium starch glycolate (type A)
Povidone (K31) (E1201)
Magnesium stearate (E572)

Film-coating
Macrogol 400
Hypromellose (E464)
Titanium dioxide (E171)

6.2 Incompatibilities

Not applicable

6.3 Shelf life

4 years

6.4 Special precautions for storage

This medicinal product does not require any special storage conditions.

6.5 Nature and contents of container

Cardboard boxes containing PVC/PE/PVDC/Aluminium blisters of 10, 14, 20, 28, 30, 50, 56, 60, 84, 90, 98, 100, 120 or 300 tablets and hospital blisters (PVC/PE/PVDC/ Aluminium) with 28, 50, 84, 98, 300 or 500 tablets.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

No special requirements.

7 MARKETING AUTHORISATION HOLDER

Accord Healthcare Ireland Ltd.
Euro House
Euro Business Park
Little Island
Cork T45 K857
Ireland

8 MARKETING AUTHORISATION NUMBER

PA2315/011/001

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 23rd October 2009

Date of last renewal: 10th May 2012

10 DATE OF REVISION OF THE TEXT

July 2019