

Part II

Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Serevent Inhaler

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each metered dose actuation delivers 25 micrograms salmeterol (as xinafoate).

3 PHARMACEUTICAL FORM

Pressurised inhalation, suspension.

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

Adults

Salmeterol provides long-lasting (12 hour) bronchodilatation in reversible airways obstruction due to asthma, chronic bronchitis, emphysema and COPD. It is suitable for long-term regular twice-daily treatment to control symptoms, but in view of its slower onset of action (10 to 20 minutes) it should not be used to relieve acute asthmatic symptoms, for which a faster acting (within 5 minutes) inhaled bronchodilator (e.g. salbutamol) should be given.

Serevent is indicated when a regular bronchodilator is required, and to prevent night-time symptoms and/or day-time fluctuations caused by reversible airways obstruction (e.g. before exercise or unavoidable allergen challenge).

Serevent, as twice-daily regular treatment, can replace a short-acting (4-hour) inhaled bronchodilator (e.g. salbutamol), when it is required more than once a day, or an oral bronchodilator (e.g. salbutamol, theophylline).

There is no evidence that salmeterol is a replacement for corticosteroids and these should not be stopped or reduced when salmeterol is prescribed. In patients not already receiving anti-inflammatory therapy, this should be considered when starting salmeterol.

Patients must be warned not to stop steroid therapy or reduce it without medical advice, even if they feel better on Serevent.

Regular treatment of reversible airways obstruction in asthma including long-lasting prevention of exercise-induced bronchospasm.

Bronchodilators should not be the only or the main treatment in patients with severe or unstable asthma. Severe asthma requires regular medical assessment as death may occur. Patients with severe asthma have constant symptoms and frequent exacerbations, with limited physical capacity, and PEF values below 60% predicted at baseline with greater than 30% variability, usually not returning entirely to normal after a bronchodilator. These patients will require high dose inhaled (e.g. >1mg/day beclomethasone dipropionate) or oral corticosteroid therapy. With optimal background steroid therapy, Serevent can offer additional symptomatic treatment. Sudden worsening of symptoms may require increased corticosteroid dosage which should be administered under urgent medical supervision.

4.2 Posology and method of administration

Serevent is administered by the inhaled route only.

It is intended that each prescribed dose is given by a minimum of two inhalations.

In order to gain full therapeutic benefit regular usage of salmeterol is recommended in the treatment of reversible airways obstruction. The onset of effective bronchodilation (>15% improvement in FEV1) occurs within 10 to 20 minutes in asthma patients. The full benefits will be apparent after the first few doses of the drug. The bronchodilator effects of salmeterol usually lasts for 12 hours. This is particularly useful in the treatment of nocturnal asthma symptoms, and in the management of exercise induced asthma.

Patients should be instructed not to take additional doses to treat symptoms but to take a short-acting inhaled beta-2 agonist.

In patients who find co-ordination of a pressurised metered-dose inhaler difficult a Volumatic spacer may be used with Serevent Inhaler. Alternatively, Serevent Rotadisks using a Diskhaler inhaler or Serevent Diskus may be used.

As there may be adverse effects associated with excessive dosing of this class of drug, the dosage or frequency of administration should only be increased on medical advice.

The response to starting salmeterol is usually seen within a few days. If such improvement is not seen, the dose of salmeterol required may need to be increased to the maximum dose of 100 micrograms bd. If improvement is still not seen within 1 week of commencing therapy, salmeterol should be withdrawn and alternative therapy instituted.

Adults:

Treatment of asthma, COPD and chronic bronchitis:

Two inhalations (2 x 25 microgram of salmeterol) twice daily.

In patients with more severe airways obstruction in whom symptoms persist, up to four inhalations (4 x 25 microgram of salmeterol) twice daily may be of benefit.

Children:

There are insufficient clinical data at present to recommend the use of salmeterol in children.

Special patient groups:

There is no need to adjust the dose in elderly patients or in those with renal impairment

4.3 Contraindications

Hypersensitivity to any ingredient of the preparation.

4.4 Special warnings and precautions for use

The management of asthma should normally follow a stepwise programme, and patient response should be monitored clinically and by lung function tests.

Serevent should not be initiated in patients with significantly worsening or acutely deteriorating asthma.

Sudden and progressive deterioration in asthma control is potentially life-threatening and consideration should be given to starting or increasing corticosteroid therapy. In patients considered at risk, daily peak flow monitoring may be instituted.

Bronchodilators should not be the only or the main treatment in patients with severe or unstable asthma. Severe asthma requires regular medical assessment, including lung function testing, as patients are at risk of severe attacks and even death. Physicians should consider using oral corticosteroid therapy and/or maximum recommended dose of inhaled corticosteroid in these patients.

Increasing use of bronchodilators, in particular short-acting inhaled beta-2 agonist, to relieve symptoms indicates deterioration of asthma control. If patients find that short acting relief bronchodilator treatment becomes less effective or they need more inhalations than usual, medical attention must be sought. In this situation patients should be reassessed and consideration given to the need for increased anti-inflammatory therapy (e.g. higher doses of inhaled corticosteroids or a course of oral corticosteroids). Severe exacerbations of asthma must be treated in the normal way with nebulised or parenteral bronchodilators and parenteral corticosteroids, together with other supportive measures.

Serevent is not a replacement for oral or inhaled corticosteroids. Its use is complementary to them. Patients must be warned not to stop steroid therapy and not to reduce it without medical advice even if they feel better on Serevent.

Serevent is not designed to relieve acute asthmatic symptoms, for which an inhaled short-acting bronchodilator (e.g. salbutamol) is required. Patients should be advised to have such relief medication available.

Patients' inhaler technique should be checked to make sure that aerosol actuation is synchronised with inspiration of breath for optimum delivery of the drug to the lungs.

Salmeterol should be administered with caution in patients with thyrotoxicosis.

4.5 Interaction with other medicinal products and other forms of interaction

Both non-selective and selective beta-blockers should be avoided in patients with reversible obstructive airways disease, unless there are compelling reasons for their use.

4.6 Pregnancy and lactation

In animal studies, some effects on the foetus, typical for a beta-2 agonist, occurred at exposure levels substantially higher than those that occur with therapeutic use. Extensive experience with other beta-2 agonists has provided no evidence that such effects are relevant for women receiving clinical doses.

As yet, experience of the use of salmeterol during pregnancy is limited.

As with any medicine, use during pregnancy should be considered only if the expected benefit to the mother is greater than any possible risk to the foetus.

Plasma levels of salmeterol after inhaled therapeutic doses are negligible and therefore levels in milk should be correspondingly low. Nevertheless as there is limited experience of the use of salmeterol in nursing mothers its use in such circumstances should only be considered if the expected benefit to the mother is greater than any possible risk to the infant.

Studies in lactating animals support the view that salmeterol is likely to be secreted in only very small amounts into breast milk.

4.7 Effects on ability to drive and use machines

None reported.

4.8 Undesirable effects

The pharmacological side-effects of beta-2 agonist treatment, such as tremor, subjective palpitations and headache, have been reported, but tend to be transient and to reduce with regular therapy. Tachycardia may occur in some patients.

As with other inhalational therapy, paradoxical bronchospasm may occur with an immediate increase in wheezing after dosing. This should be treated immediately with a fast-acting inhaled bronchodilator. Serevent Inhaler should be

discontinued immediately, the patient assessed, and if necessary alternative therapy instituted.

There have been reports of arthralgia and hypersensitivity reactions including rash, oedema and angioedema.

There have been reports of oropharyngeal irritation.

There have been very rare reports of muscle cramps.

4.9 Overdose

The symptoms and signs of salmeterol overdosage are tremor, headache and tachycardia.

The preferred antidote for overdosage with salmeterol inhaler is a cardioselective beta-blocking agent.

Cardioselective beta-blocking drugs should be used with caution in patients with a history of bronchospasm.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Mechanism of action:

Salmeterol is a selective long-lasting (12 hour) beta-2 adrenoceptor agonist with a long side-chain which binds to the exo-site of the receptor. These pharmacological properties of salmeterol offer more effective protection against histamine-induced bronchoconstriction and produce a longer duration of bronchodilation, lasting for at least 12 hours, than recommended doses of conventional short-acting beta-2 agonists. *In-vitro* tests have shown salmeterol is a potent and long-lasting inhibitor of the release – from human lung – of mast cell mediators (such as histamine, leukotrienes and prostaglandin D₂.) In man salmeterol inhibits the early and late phase response to inhaled allergen; the latter persisting for over 30 hours after a single dose when the bronchodilator effect is no longer evident. Single dosing with salmeterol attenuates bronchial hyper-responsiveness.

These properties indicate that salmeterol has additional non-bronchodilator activity but the full clinical significance is not yet clear. The mechanism is different from the anti-inflammatory effect of corticosteroids, which should not be stopped or reduced when salmeterol is prescribed.

5.2 Pharmacokinetic properties

Salmeterol acts locally in the lung therefore plasma levels are not predictive of therapeutic effect. In addition there are only limited data available on the pharmacokinetics of salmeterol because of the technical difficulty of assaying the drug in plasma because of the very low plasma concentrations (approximately 200 pg/ml or less) achieved after inhaled dosing. After regular dosing with salmeterol xinafoate, hydroxynaphthoic acid can be detected in the systemic circulation, reaching steady state concentrations of approximately 100 ng/ml. These concentrations are up to 1000 fold lower than steady state levels observed in toxicity studies and in long term regular dosing (more than 12 months) in patients with airways obstruction, have been shown to produce no ill effects.

5.3 Preclinical safety data

In reproduction studies in animals, some effects on the foetus, typical of a β_2 -agonist, have been observed at very high doses.

Salmeterol xinafoate produced no genetic toxicity in a range of studies using either prokaryotic or eukaryotic cell systems in vitro or in vivo in the rat.

Long-term studies with salmeterol xinafoate, induced class-related benign tumours of smooth muscle in the

mesovarium of rats and the uterus of mice. The scientific literature and our own pharmacological studies provide good evidence that these effects are species-specific and have no relevance for clinical use.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Lecithin
Dichlorodifluoromethane
Trichlorofluoromethane

6.2 Incompatibilities

Not applicable.

6.3 Shelf Life

The shelf life expiry date for this product is the date shown on the container and outer carton of the product as marketed in the country of origin.

6.4 Special precautions for storage

Do not store above 30°C. Protect from frost and direct sunlight.

As with most inhaled medications in aerosol canisters, the therapeutic effect of this medication may decrease when the canister is cold.

The canister should not be broken, punctured or burnt, even when apparently empty.

6.5 Nature and contents of container

An aluminium can closed with a metering valve. The filled canister is fitted into a polypropylene actuator to form a complete inhaler. Each inhaler is packed into a carton.

Each canister contains 120 actuations.

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 PARALLEL PRODUCT AUTHORISATION HOLDER

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England.

8 PARALLEL PRODUCT AUTHORISATION NUMBER

PPA 1071/004/001

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 06 December 2002

10 DATE OF REVISION OF THE TEXT

22 August 2002