

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Panadol OA 1000 mg Tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains paracetamol 1000 mg

For full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Film-coated tablet.

White, capsule-shaped tablets having flat edges, debossed with 'PAN 1G' on one side with a break-line on both sides.

The score line is only to facilitate breaking for ease of swallowing and not to divide into equal doses.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

For the management of mild to moderate pain, including osteoarthritis and for pyrexia.

4.2. Posology and method of administration

Panadol OA 1000 mg Tablets are for oral administration.

Adults (including the elderly) and children aged 16 years and over:
One tablet up to 4 times daily as required.

Not to be given to children under 16 years.

The minimum dosing interval is 4 hours and the maximum daily dose is 4000 mg (4 tablets).

4.3 Contraindications

Hypersensitivity to paracetamol or any of the other constituents.

4.4 Special warnings and precautions for use

Contains paracetamol. Do not use with any other paracetamol-containing products.

Underlying liver disease increases the risk of paracetamol related liver damage. Patients who have been diagnosed with liver or kidney impairment must seek medical advice before taking this medication.

Do not exceed the stated dose.

Patients should be advised to consult their doctor if their headaches become persistent.

Caution should be exercised in patients with glutathione depleted states, as the use of paracetamol may increase the risk of metabolic acidosis (refer also to section 4.9).

Use with caution in patients with glutathione depletion due to metabolic deficiencies.

Cases of high anion gap metabolic acidosis (HAGMA) due to pyroglutamic acidosis have been reported in patients with severe illness such as severe renal impairment and sepsis, or in patients with malnutrition or other sources of glutathione deficiency (e.g. chronic alcoholism) who were treated with paracetamol at therapeutic dose for a prolonged period or a combination of paracetamol and flucloxacillin. If HAGMA due to pyroglutamic acidosis is suspected, prompt discontinuation of paracetamol and close monitoring is recommended. The measurement of urinary 5-oxoproline may be useful to identify pyroglutamic acidosis as underlying cause of HAGMA in patients with multiple risk factors.

If symptoms persist, medical advice must be sought.

Keep out of the sight and reach of children.

Pack label:

Talk to a doctor at once if you take too much of this medicine even if you feel well.

Do not take anything else containing paracetamol while taking this medicine.

Patient Information Leaflet:

Talk to a doctor at once if you take too much of this medicine even if you feel well. This is because too much paracetamol can cause delayed, serious liver damage.

4.5 Interaction with other medicinal products and other forms of interaction

The speed of absorption of paracetamol may be increased by metoclopramide or domperidone and absorption reduced by colestyramine. The anticoagulant effect of warfarin and other coumarins may be enhanced by prolonged regular daily use of paracetamol with increased risk of bleeding; occasional doses have no significant effect.

Caution should be taken when paracetamol is used concomitantly with flucloxacillin as concurrent intake has been associated with high anion gap metabolic acidosis due to pyroglutamic acidosis, especially in patients with risks factors (see section 4.4).

4.6 Fertility, pregnancy and lactation

Epidemiological studies on neurodevelopment in children exposed to paracetamol in utero show inconclusive results. If clinically needed, paracetamol can be used during pregnancy if clinically needed, however, as with any medicine it should be used at the lowest effective dose for the shortest possible time.

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

4.7 Effects on ability to drive and use machines

None.

4.8 Undesirable effects

Adverse effects of paracetamol from historical clinical trial data are both infrequent and from small patient exposure. Accordingly, events reported from extensive post-marketing experience at therapeutic/labelled dose and considered attributable are tabulated below by system class and frequency.

The following convention has been utilised for the classification of the undesirable effects: very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1000$ to $< 1/100$), rare ($\geq 1/10,000$ to $< 1/1000$) and very rare ($< 1/10,000$), not known (cannot be estimated from available data).

Adverse event frequencies have been estimated from spontaneous reports received through post-marketing data.

Post marketing data

Body System	Undesirable effect	Frequency
Blood and lymphatic system disorders	Thrombocytopenia Agranulocytosis	Very rare
Immune system disorders	Anaphylaxis Cutaneous hypersensitivity reactions including, among others, skin rashes and angiodema. Very rare cases of serious skin reactions have been reported.	Very rare
Metabolism and nutrition disorders	High anion gap metabolic acidosis*	Not known
Respiratory, thoracic and mediastinal disorders	Bronchospasm**	Very rare
Hepatobiliary disorders	Hepatic dysfunction	Very rare

* Cases of high anion gap metabolic acidosis due to pyroglutamic acidosis have been observed in patients with risk factors using paracetamol (see section 4.4). Pyroglutamic acidosis may occur as a consequence of low glutathione levels in these patients.

** There have been cases of bronchospasm with paracetamol, but these are more likely in asthmatics sensitive to aspirin or other NSAIDs.

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 the Yellow Card Scheme at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App store.

4.9 Overdose

Paracetamol

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

Risk Factors:

If the patient

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

Or

- Regularly consumes ethanol in excess of recommended amounts.

Or

- Is likely to be glutathione deplete e.g. eating disorders, cystic fibrosis, HIV infection, starvation, cachexia.

Symptoms

Symptoms of paracetamol overdose 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 24h from ingestion should be discussed with the NPIS or a liver unit.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Paracetamol is an antipyretic analgesic. The mechanism of action is probably similar to that of aspirin and dependent on the inhibition of prostaglandin synthesis. This inhibition appears, however to be on a selective basis.

5.2 Pharmacokinetic properties

Paracetamol is rapidly and almost completely absorbed from the gastrointestinal tract. Concentration in plasma reaches a peak in 30 to 60 minutes. Plasma half-life is 1 - 4 hours

Paracetamol is relatively uniformly distributed throughout most body fluids. Binding of the drug to plasma proteins is variable; 20 to 30% may be bound at the concentrations encountered during acute intoxication. Following therapeutic doses 90-100% of the drug may be recovered in the urine within the first day. However, practically no paracetamol is excreted unchanged and the bulk is excreted after hepatic conjugation. Excretion is almost exclusively renal, in the form of conjugated metabolites.

5.3 Preclinical safety data

Conventional studies using the currently accepted standards for the evaluation of toxicity to reproduction and development are not available.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Maize starch
Pregelatinised starch
Potassium sorbate
Talc
Stearic acid

Povidone
Film coat:
Hypromellose
Triacetin.

6.2 Incompatibilities

Not applicable

6.3 Shelf life

5 years.

6.4 Special precautions for storage

Do not store above 25°C.

6.5 Nature and contents of container

Opaque high density, polyethylene (HDPE) bottles with a polypropylene screw closure and induction seal liner, containing 100 tablets.

6.6 Special precautions for disposal

No special requirements.

7 MARKETING AUTHORISATION HOLDER

Haleon UK Trading Limited
The Heights
Weybridge
Surrey
KT13 0NY

United Kingdom

8 MARKETING AUTHORISATION NUMBER(S)

PL 44673/0089

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

24/08/2009

10 DATE OF REVISION OF THE TEXT

03/02/2025