

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Loratadine 5 mg/ 5 ml syrup

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each ml of syrup contains 1 mg of loratadine.

Excipients with known effect:

Loratadine syrup contains 600 mg of sucrose per ml, methyl hydroxybenzoate and propyl hydroxybenzoate.

For the full list of excipients see section 6.1.

3 PHARMACEUTICAL FORM

Syrup

Clear, slightly viscous solution.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Loratadine syrup is indicated for the symptomatic treatment of allergic rhinitis and chronic idiopathic urticaria in adults and children over the age of 2 years.

4.2 Posology and method of administration

Posology

Adults and children and adolescents over 12 years of age
10 ml (10 mg) of the syrup once daily.

Paediatric population (under 12 years of age)

Children 2 to 12 years of age **are dosed by weight:**

Body weight more than 30 kg: 10 ml (10 mg) of the syrup once daily.

Body weight 30 kg or less: 5 ml (5 mg) of the syrup once daily.

The safety and efficacy of loratadine syrup in children under 2 years of age has not been established. No data are available.

Patients with hepatic impairment

Patients with severe liver impairment should be administered a lower initial dose because they may have reduced clearance of loratadine. An initial dose of 10 mg every other day is recommended for adults and children weighing more than 30 kg and for children weighing 30 kg or less, 5 ml (5 mg) every other day is recommended.

Patients with renal impairment

No dosage adjustments are required in patients with renal insufficiency.

Elderly

No dosage adjustments are required in the elderly.

Method of administration

For oral use.

The syrup may be taken without regard to mealtime.

4.3 Contraindications

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

4.4 Special warnings and precautions for use

Loratadine syrup should be administered with caution in patients with severe liver impairment (see section 4.2).

Loratadine syrup contains 600 mg of sucrose per ml. This should be taken into account in patients with diabetes mellitus. Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine.

The administration of loratadine syrup should be discontinued at least 48 hours before skin tests since antihistamines may prevent or reduce otherwise positive reactions to dermal reactivity index.

4.5 Interaction with other medicinal products and other forms of interaction

When administered concomitantly with alcohol, loratadine syrup has no potentiating effects as measured by psychomotor performance studies.

Potential interaction may occur with all known inhibitors of CYP3A4 or CYP2D6 resulting in elevated levels of loratadine, which may cause an increase in adverse events (see sections 4.8 and 5.2).

Increase in plasma concentrations of loratadine has been reported after concomitant use with ketoconazole, erythromycin and cimetidine in controlled trials, but without clinically significant changes (including electrocardiographic).

Paediatric population

Interaction studies have only been performed in adults.

4.6 Fertility, pregnancy and lactation

Pregnancy

A large amount of data on pregnant women (more than 1000 exposed outcomes) indicate no malformative nor foeto/ neonatal toxicity of loratadine. Animal studies do not indicate direct or indirect harmful effects with respect to reproduction toxicity (see section 5.3). As a precautionary measure, it is preferable to avoid the use of loratadine during pregnancy.

Breast-feeding

Loratadine is excreted in breast milk. A risk to the newborns/infants cannot be excluded. The use of loratadine is not recommended in breast-feeding women.

Fertility

There are no data available on male and female fertility.

4.7 Effects on ability to drive and use machines

In clinical trials that assessed driving ability, no impairment occurred in patients receiving loratadine. However, patients should be informed that very rarely some people experience drowsiness, which may affect their ability to drive or use machines.

4.8 Undesirable effects

Summary of the safety profile

In clinical trials involving adults and adolescents in a range of indications including allergic rhinitis (AR) and chronic idiopathic urticaria (CIU), at the recommended dose of 10 mg daily, adverse reactions with loratadine were reported in 2% of patients in excess of those treated

with placebo. The most frequent adverse reactions reported in excess of placebo were somnolence (1.2%), headache (0.6%), increased appetite (0.5%) and insomnia (0.1%). Other adverse reactions reported very rarely during the post-marketing period are listed in the following table by System Organ Class.

Tabulated of list of adverse reactions

Frequencies are defined as: very common ($\geq 1/10$); common ($\geq 1/100$ to $<1/10$); uncommon ($\geq 1/1,000$ to $< 1/100$); rare ($\geq 1/10,000$ to $<1,000$); very rare ($< 1/10,000$); not known (cannot be estimated from the available data).

Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness.

System organ class	Frequency	Adverse Term
Immune system disorders	Very rare	Hypersensitivity reactions (including angioedema and anaphylaxis)
Nervous system disorders	Very rare	Dizziness, convulsion
Cardiac disorders	Very rare	Tachycardia, palpitation
Gastrointestinal disorders	Very rare	Nausea, dry mouth, gastritis
Hepatobiliary disorders	Very rare	Abnormal hepatic function
Skin and subcutaneous tissue disorders	Very rare	Rash, alopecia
General disorders and administration site conditions	Very rare	Fatigue
Investigations	Not known	Weight increased

Paediatric population

In clinical trials in a paediatric population, children aged 2 through 12 years, common adverse reactions reported in excess of placebo were headache (2.7%), nervousness (2.3%), and fatigue (1%).

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 Yellow Card Scheme Website: www.mhra.gov.uk/yellowcard.

4.9 Overdose

Overdosage with loratadine increased the occurrence of anticholinergic symptoms. Somnolence, tachycardia, and headache have been reported with overdoses.

In the event of overdose, general symptomatic and supportive measures are to be instituted and maintained for as long as necessary. Administration of activated charcoal as a slurry with water may be attempted. Gastric lavage may be considered. Loratadine is not removed by haemodialysis and it is not known if loratadine is removed by peritoneal dialysis. Medical monitoring of the patient is to be continued after emergency treatment.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antihistamines for systemic use, other antihistamines for systemic use, ATC code: R06A X13.

Mechanism of action

Loratadine, the active ingredient in Loratadine syrup, is a tricyclic antihistamine with selective, peripheral H₁-receptor activity.

Pharmacodynamic effects

Loratadine has no clinically significant sedative or anticholinergic properties in the majority of the population and when used at the recommended dosage.

During long-term treatment there were no clinically significant changes in vital signs, laboratory test values, physical examinations or electrocardiograms.

Loratadine has no significant H₂-receptor activity. It does not inhibit norepinephrine uptake and has practically no influence on cardiovascular function or on intrinsic cardiac pacemaker activity.

Human histamine skin wheal studies following a single 10 mg dose has shown that the antihistamine effects are seen within 1-3 hours reaching a peak at 8-12 hours and lasting in excess of 24 hours. There was no evidence of tolerance to this effect after 28 days of dosing with loratadine.

Clinical efficacy and safety

Over 10,000 subjects (12 years and older) have been treated with loratadine 10 mg tablets in controlled clinical trials. Loratadine 10 mg tablets once daily was superior to placebo and similar to clemastine in improving the effects on nasal and non-nasal symptoms of AR. In these studies somnolence occurred less frequently with loratadine than with clemastine and about the same frequency as terfenadine and placebo.

Among these subjects (12 years and older), 1000 subjects with CIU were enrolled in placebo controlled studies. A once daily 10 mg dose of loratadine was superior to placebo in the management of CIU as demonstrated by the reduction of associated itching, erythema and hives. In these studies the incidence of somnolence with loratadine was similar to placebo.

Paediatric population

Approximately 200 paediatric subjects (6 to 12 years of age) with seasonal allergic rhinitis received doses of loratadine syrup up to 10 mg once daily in controlled clinical trials. In another study, 60 paediatric subjects (2 to 5 years of age) received 5 mg of loratadine syrup once daily. No unexpected adverse events were observed.

The paediatric efficacy was similar to the efficacy observed in adults.

5.2 Pharmacokinetic properties

Absorption

Loratadine is rapidly and well absorbed. Concomitant ingestion of food can delay slightly the absorption of loratadine but without influencing the clinical effect. The bioavailability parameters of loratadine and of the active metabolite are dose proportional.

Distribution

Loratadine is highly bound (97% to 99 %) and its active metabolite moderately bound (73% – 76%) to plasma proteins.

In healthy subjects, plasma distribution half-lives of loratadine and its active metabolite are approximately 1 and 2 hours, respectively.

Biotransformation

After oral administration, loratadine is rapidly and well absorbed and undergoes an extensive first pass metabolism, mainly by CYP3A4 and CYP2D6. The major metabolite-desloratadine (DL)- is pharmacologically active and responsible for a large part of the clinical effect. Loratadine and DL achieve maximum plasma concentrations (T_{max}) between 1–1.5 hours and 1.5–3.7 hours after administration, respectively.

Elimination

Approximately 40 % of the dose is excreted in the urine and 42% in the faeces over a 10 day period and mainly in the form of conjugated metabolites. Approximately 27% of the dose is eliminated in the urine during the first 24 hours. Less than 1% of the active substance is excreted unchanged in the active form, as loratadine or DL.

The mean elimination half-lives in healthy adult subjects were 8.4 hours (range = 3 to 20 hours) for loratadine and 28 hours (range = 8.8 to 92 hours) for the major active metabolite.

Elderly

The pharmacokinetic profile of loratadine and its active metabolite is comparable in healthy adult volunteers and in healthy geriatric volunteers.

Renal impairment

In patients with chronic renal impairment, both the AUC and peak plasma levels (C_{max}) increased for loratadine and its active metabolite as compared to the AUCs and peak plasma levels (C_{max}) of patients with normal renal function. The mean elimination half-lives of loratadine and its metabolite were not significantly different from that observed in normal subjects. Haemodialysis does not have an effect on the pharmacokinetics of loratadine or its active metabolite in subjects with chronic renal impairment.

Hepatic impairment

In patients with chronic alcoholic liver disease, the AUC and peak plasma levels (C_{max}) of loratadine were double while the pharmacokinetic profile of the active metabolite was not significantly changed from that in patients with normal liver function. The elimination half-lives for loratadine and its active metabolite were 24 hours and 37 hours, respectively, and increased with increasing severity of liver disease.

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, and carcinogenic potential.

In reproductive toxicity studies, no teratogenic effects were observed. However, prolonged parturition and reduced viability of offspring were observed in rats at plasma levels (AUC) 10 times higher than those achieved with clinical doses.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Propylene glycol

Glycerol

Citric acid monohydrate

Sucrose

Methyl parahydroxybenzoate (E218)

Propyl parahydroxybenzoate (E216)

Purified water

Artificial strawberry flavour (F153),

Components of flavour:

Flavouring substances and natural flavouring substances

Propylene glycol 70%

Water
Triacetin E-1518
Ethyl Alcohol
Butylated Hydroxyanisole (BHA) E-320
Alfa Tocopherol E-307

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

Type III amber glass bottles with polyethylene screw caps and plexan disc. The plexan disc is an EPE/PE sealing material that consists of an expanded polyethylene support and low-density compact polyethylene coating.

Pack sizes of 60 ml, 100 ml and 120 ml.

6.6 Special precautions for disposal
None

7 MARKETING AUTHORISATION HOLDER

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Potters Bar,
Hertfordshire,
EN6 1TL,
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PL 04569/0520

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12/11/2008

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15/05/2026