1. NAME OF THE MEDICINAL PRODUCT

Paracetamol 500mg Tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains Paracetamol Ph. Eur. 500mg

For the full list of excipients, see section 6.1

3 PHARMACEUTICAL FORM

Tablet

White flat round bevel edged tablets debossed (stamped into) with a breakline and aP 500 on one side and plain on the other side. The break-line can be used to break the tablet for ease of swallowing but not to divide it into equal doses.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

A mild analgesic and antipyretic, recommended for the treatment of most painful and febrile conditions, for example, headache including migraine and tension headaches, toothache, backache, rheumatic and muscle pains, dysmenorrhoea, sore throat, and for relieving the fever, aches and pains of colds and flu.

Also recommended for the symptomatic relief of pain due to non-serious arthritis.

4.2 Posology and method of administration

Posology:

Adults, the elderly and children 16 years and over*:* One or two tablets to be taken every four to six hours, when necessary up to four times daily. Maximum dose of 8 tablets in 24 hours.

Children aged 10-15 years: One tablet to be taken every four to six hours, when necessary to a maximum of four doses in 24 hours.

Not suitable for children under 10 years of age.

Children should not be given tablets for more than 3 days without consulting a doctor.

These doses should not be repeated more frequently than every 4-6 hours nor should more

than 4 doses be given in any 24 hour period.

Method of administration:
Paracetamol tablets to be administered orally only.

4.3 Contraindications

Hypersensitivity to paracetamol or any of the other constituents.

4.4 Special warnings and precautions for use

Care is advised in the administration of paracetamol to patients with renal or hepatic impairment. The hazard of overdose is greater in those with non-cirrhotic alcoholic liver disease.

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 and 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.

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

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

Patients should be advised to consult a doctor if they suffer from non-serious arthritis and need to take painkillers every day.

If symptoms persist consult your doctor.

Keep medicines out of the sight and reach of children.

Pack Label:
Do not take more medicine than the label tells you to. If you do not get better, talk to your doctor.

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, 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 risk factors (see section 4.4).

4.6 Pregnancy and lactation

A large amount of data on pregnant women indicate neither malformative, nor feto/neonatal toxicity. Epidemiological studies on neurodevelopment in children exposed to paracetamol in utero show inconclusive results. If clinically needed, paracetamol can be used during pregnancy however it should be used at the lowest effective dose for the shortest possible time and at the lowest possible frequency. Paracetamol is excreted in breast milk but not in a clinically significant amount. Available published data do not contraindicate breast feeding.

4.7 Effects on ability to drive and use machines

None Stated.

4.8 Undesirable effects

Adverse events 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. Due to limited clinical trial data, the frequency of these adverse events is not known (cannot be estimated from available data), but post-marketing experience indicates that adverse reactions to paracetamol are rare and serious reactions are very rare.

Post marketing data

Body System	**Undesirable effect**
Blood and lymphatic system disorders	Thrombocytopenia Agranulocytosis
Immune system disorders	Anaphylaxis Cutaneous hypersensitivity reactions including skin rashes and angioedema
Respiratory, thoracic and mediastinal	Bronchospasm*

disorders	
Hepatobiliary disorders	Hepatic dysfunction
Skin and subcutaneous tissue disorders	Very rare cases of serious skin reactions have been reported.

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

Metabolism and nutrition disorders

High anion gap metabolic acidosis with frequency "Not known" (cannot be estimated from the available data)

Description of selected adverse reactions
High anion gap metabolic acidosis

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.

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

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, phenobarbital, 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 deplete 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 24h from ingestion should be discussed with the NPIS or a liver unit.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Other analgesics and antipyretics, Anilides.

ATC code: N02BE01

Paracetamol is an antipyretic analgesic. The mechanism of action is probably similar to that of aspirin and dependant 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 gastro-intestinal tract. The peak plasma concentrations occurring 30 minutes to 60 minutes and the plasma half-life 1-4

hours after therapeutic doses. Paracetamol is relatively uniformly distributed throughout most body fluids. Plasma protein binding is variable; 20 to 30% may be bound at the concentrations encountered during acute intoxication. Following therapeutic doses 90 to 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.

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

Potato Starch

Pregelatinised Starch

Purified Talc

Magnesium Stearate E572

Colloidal anhydrous silica

6.2 Incompatibilities

None

6.3 Shelf life

5 years from date of manufacture (60 Months)

6.4 Special precautions for storage

Store below 25°C.
For containers – Store in original container.
For blister packaging – Store in original packaging.
Keep in the outer carton to protect from light.

6.5 Nature and contents of container

Blister pack (Aluminium foil and PVC film or PVC/PVDC film): 8, 12, and 16
Pack Size: 8, 12 or 16

Securitainers (HDPE container and HDPE cap): 16
Pack Size: 16

6.6 Special precautions for disposal

None.

7. MARKETING AUTHORISATION HOLDER

Aspar Pharmaceuticals Ltd
Albany House,
Acrewood way,
St Albans,
AL4 0JY,
United Kingdom

8 MARKETING AUTHORISATION NUMBER(S)

PL 08977/0001

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

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10 DATE OF REVISION OF THE TEXT

04/12/2025