SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Bell's Healthcare Codeine Linctus 15 mg per 5 ml Oral Solution

Relonchem Codeine Linctus 15 mg/5 ml Oral Solution

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each 5 ml dose contains:

Codeine Phosphate BP 15 mg

Each 5 ml solution contains Sucrose 4g

Each 5 ml solution contains 2 vol% ethanol (alcohol)

For a full list of excipients, see section 6.1

3. PHARMACEUTICAL FORM

Oral solution.

4 CLINICAL PARTICULARS

4.1. Therapeutic indications

Codeine linctus is indicated for a dry or painful cough.

4.2 Posology and method of administration

Duration of Treatment

Prior to starting treatment with opioids, a discussion should be held with patients to put in place a strategy for ending treatment with Codeine Linctus in order to minimise the risk of addiction and drug withdrawal syndrome (see section 4.4).

Adults and the elderly: 5 – 10 ml three to four times a day. Dosage should be reduced in elderly or debilitated patients.

Paediatric population:

Children aged less than 12 years: Codeine is contraindicated in children below the age of 12 years (see sections 4.3).

Children aged 12 years to 18 years: Codeine is not recommended for use in children aged 12 years to 18 years with compromised respiratory function (see section 4.4). Bell's Healthcare Codeine Linctus 15 mg per 5 ml Oral Solution should not be used longer than necessary.

4.3 Contraindications

- Hypersensitivity to codeine or to any of the excipients listed in section 6.1
- Ventilatory failure condition may be exacerbated.
- Liver disease: drug may accumulate
- In women during breastfeeding (see section 4.6)
- In patients for whom it is known they are CYP2D6 ultra-rapid metabolisers
- In children below the age of 12 years due to an increased risk of developing serious and life threatening adverse reactions.

4.4 Special warnings and precautions for use

Geriatric patients should be supervised while on this medication, and consideration of reduced dosage should be based on response. Codeine should only be used with caution in patients with kidney or liver impairment. Care should be taken in patients with asthma, hypothyroidism, and in patients with a history of drug abuse. Tolerance and dependency may occur with prolonged use.

CYP2D6 metabolism

Codeine is metabolised by the liver enzyme CYP2D6 into morphine, its active metabolite. If a patient has a deficiency or is completely lacking this enzyme an adequate analgesic therapeutic effect will not be obtained. Estimates indicate that up to 7% of the Caucasian population may have this deficiency. However, if the patient is an extensive or ultra-rapid metaboliser there is an increased risk of developing side effects of opioid toxicity even at commonly prescribed doses. These patients convert codeine into morphine rapidly resulting in higher-than-expected serum morphine levels. General symptoms of opioid toxicity include confusion, somnolence, shallow breathing, small pupils, nausea, vomiting, constipation, and lack of appetite. In severe cases this may include symptoms of circulatory and respiratory depression, which may be life-threatening and very rarely fatal. Estimates of prevalence of ultra-rapid metabolisers in different populations are summarised below:

Population	Prevalence %
African/Ethiopian	29%
African American	3.4% to 6.5%
Asian	1.2% to 2%
Caucasian	3.6% to 6.5%
Greek	6.0%

Hungarian	1.9%
Northern European	1%-2%

Children with compromised respiratory function

Codeine is not recommended for use in children in whom respiratory function might be compromised including neuromuscular disorders, severe cardiac or respiratory conditions, upper respiratory or lung infections, multiple trauma or extensive surgical procedures. These factors may worsen symptoms of morphine toxicity.

Tolerance and opioid use disorder (abuse and dependence)

Tolerance, physical and psychological dependence, and opioid use disorder (OUD) may develop upon repeated administration of opioids such as Bell's Healthcare Codeine Linctus 15 mg per 5 ml Oral Solution. Repeated use of Codeine linctus can lead to OUD. A higher dose and longer duration of opioid treatment can increase the risk of developing OUD. Abuse or intentional misuse of Codeine linctus may result in overdose and/or death. The risk of developing OUD is increased in patients with a personal or a family history (parents or siblings) of substance use disorders (including alcohol use disorder), in current tobacco users or in patients with a personal history of other mental health disorders (e.g. major depression, anxiety and personality disorders).

The patient should be made aware of the risks and signs of OUD as set out in the package leaflet. If these signs occur, patients should contact their physician.

For patients who experience signs and symptoms of OUD, and/or exibit drug seeking behaviours, review of concomitant opioids and psycho-active drugs (like benzodiazepines) and consultation with an addiction specialist may be required.

Before initiating treatment with Bell's Healthcare Codeine Linctus 15 mg per 5 ml Oral Solution and during the treatment, treatment goals and a discontinuation plan should be agreed with the patient (see section 4.2). Before and during treatment the patient should also be informed about the risks and signs of OUD. If these signs occur, patients should contact their physician.

Patients will require monitoring for signs of drug-seeking behaviour (e.g. too early requests for refills). This includes the review of concomitant opioids and psycho-active drugs (like benzodiazepines). For patients with signs and symptoms of OUD, consultation with an addiction specialist should be considered.

Drug withdrawal syndrome

Prior to starting treatment with any opioids, a discussion should be held with patients to put in place a withdrawal strategy for ending treatment with <active>.

Drug withdrawal syndrome may occur upon abrupt cessation of therapy or dose reduction. When a patient no longer requires therapy, it is advisable to taper the dose gradually to minimise symptoms of withdrawal. Tapering from a high dose may take weeks to months.

The opioid drug withdrawal syndrome is characterised by some or all of the following: restlessness, lacrimation, rhinorrhoea, yawning, perspiration, chills, myalgia, mydriasis and palpitations. Other symptoms may also develop including irritability, agitation, anxiety, hyperkinesia, tremor, weakness, insomnia, anorexia, abdominal cramps, nausea, vomiting, diarrhoea, increased blood pressure, increased respiratory rate or heart rate.

If women take this drug during pregnancy, there is a risk that their newborn infants will experience neonatal withdrawal syndrome.

Sleep-related breathing disorders

Opioids can cause sleep-related breathing disorders including central sleep apnoea (CSA) and sleep-related hypoxemia. Opioid use increases the risk of CSA in a dose-dependent fashion. In patients who present with CSA, consider decreasing the total opioid dosage.

Hyperalgesia

Hyperalgesia may be diagnosed if the patient on long-term opioid therapy presents with increased pain. This might be qualitatively and anatomically distinct from pain related to disease progression or to breakthrough pain resulting from development of opioid tolerance. Pain associated with hyperalgesia tends to be more diffuse than the pre-existing pain and less defined in quality. Symptoms of hyperalgesia may resolve with a reduction of opioid dose.

Sunset Yellow may cause allergic reactions.

Hepatobiliary disorders

Codeine may cause dysfunction and spasm of the sphincter of Oddi, thus increasing the risk of biliary tract symptoms and pancreatitis. Therefore, codeine has to be administered with caution in patients with pancreatitis and diseases of the biliary tract.

4.5 Interaction with other medicinal products and other forms of interaction

CNS depressants, anticholinergics, hydroxyzine and methadone – concurrent use of these medicines may result in potentiation of effects and hypotensive effects and CNS depressant effects may be increased; levallorphan is a morphine antagonist; the respiratory effects of neuromuscular blocking agents may be addictive to the central respiratory effects of the opioid analgesics; metoclopramide and codeine have opposing effects on gastro – intestinal activity; codeine causes delayed absorption of mexiletine; the effects of hypnotics and sedatives may be potentiated by codeine; hypertensive crisis may be caused by concurrent use of codeine and monoamine – oxidase inhibitors.
The concomitant use of Bell's Healthcare Codeine Linctus 15 mg per 5 ml Oral Solution with gabapentinoids (gabapentin and pregabalin) may result in respiratory depression, hypotension, profound sedation, coma or death (see section 4.4).

4.6 Fertility, pregnancy and lactation

Pregnancy

Risk – benefit must be considered before using codeine during pregnancy. Codeine crosses the placenta and is excreted in small amounts in breast milk. Regular use during pregnancy may cause drug dependence in the foetus, leading to withdrawal symptoms in the neonate. Teratogenic effects in humans have not been documented but controlled studies have not been done. There is a risk of gastric stasis in the mother during labour which may lead to inhalation pneumonia.

If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available.

Administration during labour may depress respiration in the neonate and an antidote for the child should be readily available.

Breast-feeding

Codeine is contraindicated in women during breastfeeding (see section 4.3). At normal therapeutic doses codeine and its active metabolite may be present in breast milk at very low doses and is unlikely to adversely affect the breast fed infant. However, if the patient is an ultra-rapid metaboliser of CYP2D6, higher levels of the active metabolite, morphine, may be present in breast milk and on very rare occasions may result in symptoms of opioid toxicity in the infant, which may be fatal.

If symptoms of opioid toxicity develop in either the mother or the infant, then all codeine containing medicines should be stopped and alternative nonopioid analgesics prescribed. In severe cases consideration should be given to prescribing naloxone to reverse these effects.

Administration to nursing women is not recommended as Codeine may be secreted in breast milk and may cause respiratory depression in the infant.

4.7 Effects on ability to drive and use machines

Codeine may cause drowsiness. Patients receiving this medication should not drive or operate machinery unless it has been shown not to affect mental or physical ability.

This medicine can impair cognitive function and can affect a patient's ability to drive safely. This class of medicine is in the list of drugs included in regulations under 5a of the Road Traffic Act 1988. When prescribing this medicine, patients should be told:

• The medicine is likely to affect your ability to drive
• Do not drive until you know how the medicine affects you
• It is an offence to drive while under the influence of this medicine
• However, you would not be committing an offence (called 'statutory defence') if:
o The medicine has been prescribed to treat a medical or dental problem and
o You have taken it according to the instructions given by the prescriber and in the information provided with the medicine and
o It was not affecting your ability to drive safely

4.8 Undesirable effects

Gastrointestinal side effects:

constipation is not uncommon; loss of appetite; flushing of face might occasionally occur; respiratory depression may be experienced; sputum

retention may occur particularly in patients with chronic bronchitis and bronchiectasis.

Not known: Pancreatitis

Psychiatric disorders:

Not known: Drug dependence (see section 4.4)

General disorders and administration site conditions:

Uncommon: drug withdrawal syndrome

Hepatobiliary disorders

Not known : sphincter of Oddi dysfunction

Drug dependence

Repeated use of Bell's Healthcare Codeine Linctus 15 mg per 5 ml Oral Solution can lead to drug dependence, even at therapeutic doses. The risk of drug dependence may vary depending on a patient's individual risk factors, dosage, and duration of opioid treatment (see section 4.4).

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. By reporting side effects you can help provide more information on the safety of this medicine.

4.9 Overdose

Patients should be informed of the signs and symptoms of overdose and to ensure that family and friends are also aware of these signs and to seek immediate medical help if they occur.

The effects in overdosage will be potentiated by simultaneous ingestion of alcohol and psychotropic drugs.

Symptoms are:
Respiratory depression may develop but is unlikely to be severe unless other sedative agents have been co-ingested, including alcohol, or the overdose is very large. The pupils may be pin point in size, nausea and vomiting are common. Hypotension and tachycardia are possible but unlikely.
Management
This should include general symptomatic and supportive measures including a clear airway and monitoring vital signs until stable. Consider administering activated charcoal if an adult presents within one hour of ingestion of more than 350 mg or if more than 2.5 mg/kg (in adults and children) has been ingested.
Give naloxone if respiratory depression is present. Naloxone is a competitive antagonist and has a short half-life. So large and repeated doses of naloxone

may be required in a seriously poisoned patient. Observe for at least four hours after ingestion, or eight hours if a sustained release preparation has been taken.

5.1 Pharmacodynamic properties

Morphine derivative. Antitussive – suppresses the cough reflex by a direct central action, probably in the medulla or pons.

Codeine is a centrally acting weak analgesic. Codeine exerts its effect through μ opioid receptors, although codeine has low affinity for these receptors, and its analgesic effect is due to its conversion to morphine. Codeine, particularly in combination with other analgesics such as paracetamol, has been shown to be effective in acute nociceptive pain.

5.2 Pharmacokinetic properties

Protein binding is very low.
Half life from 2.5 to 4 hours.
Duration of action approximately 4 hours.
Onset of action after oral administration is 30 to 45 minutes.
Excretion is primarily renal with 5 to 15% of the drug excreted unchanged.

5.3. Preclinical safety data

There are no preclinical data of relevance to the prescriber which are additional to those already included in other sections.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Anhydrous Citric Acid BP

Sunset yellow E110

Quinoline yellow E104

Glycerol BP

Invert Syrup BP

Benzoic Acid BP

Propylene Glycol BP

Ethanol 90% BP

Terpeneless Lemon Oil BP

Sucrose BP

Methyl Hydroxybenzoate Sodium BP

Purified Water BP

6.2. Incompatibilities

None known.

6.3. Shelf Life

Three years.

6.4. Special Precautions for Storage

Do not store above 25°C.
Protect from light.

6.5 Nature and contents of container

100 ml, 200 ml and 500 ml glass bottles, child resistant cap with EPE liner.

Not all packs may be marketed.

6.6. Instructions for Use, Handling and Disposal

None.

7 MARKETING AUTHORISATION HOLDER

Bell, Sons and Co (Druggists) Ltd [Trading Style – Bell's Healthcare]
Gifford House,
Slaidburn Crescent
Southport
Merseyside
PR9 9AL

8. MARKETING AUTHORISATION NUMBER

PL 03105/0063

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21st May 1998 / 15th December 1998

10 DATE OF REVISION OF THE TEXT

03/02/2026