

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Paracetamol 1000 mg Film Coated Tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 1000 mg of paracetamol. For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Film-coated tablet.

White coloured, caplet shaped tablets with 'K', bisect break line and '02' on one side and a break line on the other side.

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

Adults (including the elderly) and children aged 16 years and over:

One tablet up to 4 times daily as required.

Paediatric population

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).

Method of administration

Oral administration only.

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

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 (see 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

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

Do not take anything else containing paracetamol while taking this medicine. Talk to a doctor at once if you take too much of this medicine, even if you feel well.

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. If your symptoms continue or your headache becomes persistent, see your doctor.

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 however 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. 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 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 ($\geq 1/1,000$ to $< 1/100$), rare ($\geq 1/10,000$ to $< 1/1,000$), very rare ($< 1/10,000$), not known (frequency cannot be estimated from the available data).

Adverse event frequencies have been estimated from spontaneous reports received through 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, angioedema. 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
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* There have been cases of bronchospasm with paracetamol, but these are more likely in asthmatics sensitive to aspirin or other NSAIDs.

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.yellowcard.mhra.gov.uk 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 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

Pharmacotherapeutic group: analgesics and antipyretics, anilides, ATC-code: N02BE01

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

Absorption

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

Distribution

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 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. 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

Tablet core

Maize starch

Pregelatinised starch

Talc

Povidone

Magnesium stearate

Film coating

Hypromellose (E464)

Titanium dioxide (E171)

Macrogol (E1521)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

PVC/ Alu Child-resistant Blister – 60 months

HDPE Bottle with Polypropylene screw closure– 36 months

6.4 Special precautions for storage

This medicinal product does not require any special storage conditions.

6.5 Nature and contents of container

PVC/ Alu Child-resistant blister packs – 12, 16 & 100 tablets.

HDPE Bottle with Polypropylene screw closure – 32, 100, 300 & 500 tablets.

Not all pack sizes may be marketed

6.6 Special precautions for disposal

No special requirements.

Any unused medicinal products and waste materials should be disposed of in accordance with local requirements.

7 MARKETING AUTHORISATION HOLDER

Dawa Limited
5 Sandridge
Close, Harrow,
Middlesex, HA1
1XD, UK

8 MARKETING AUTHORISATION NUMBER(S)

PL 30684/0233

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

16/01/2025

10 DATE OF REVISION OF THE TEXT

15/04/2026