

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Dexamethasone 8 mg tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 8.0 mg dexamethasone.

Excipients with known effect

Each tablet contains 148.00 mg lactose (as lactose monohydrate).

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Tablet

White to off-white, oval shaped, flat-faced tablet with a diameter of 11 mm, engraved by number “8” on the one.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Neurology

Cerebral oedema (only with symptoms of intracranial pressure evidenced by computerised tomography) caused by a brain tumour, neuro-surgical intervention, cerebral abscess.

Pulmonary and respiratory diseases

Acute asthma exacerbations when use of an oral corticosteroid (OCS) is appropriate.

Croup.

Dermatology

Initial treatment of extensive, severe, acute, skin diseases responding to glucocorticoids, e.g. erythroderma, pemphigus vulgaris.

Autoimmune disorders/rheumatology

Initial treatment of autoimmune disorders like systemic lupus erythematoses.

Active phases of systemic vasculitides like panarteritis nodosa (treatment duration should be limited to two weeks in cases of concomitant positive hepatitis B serology).

Severe progressive course of active rheumatoid arthritis, e.g. fast proceeding destructive forms and/or extraarticular manifestations.

Severe systemic course of juvenile idiopathic arthritis (Still's disease).

Haematological disorder

Idiopathic thrombocytopenic purpura in adults.

Infectology

Tuberculous meningitis only in conjunction with anti-infective therapy.

Dexamethasone is indicated in the treatment of coronavirus disease 2019 (COVID-19) in adult and adolescent patients (aged 12 years and older with body weight at least 40 kg) who require supplemental oxygen therapy.

Oncology

Palliative treatment of neoplastic diseases.

Prophylaxis and treatment of emesis induced by cytostatics, emetogenic chemotherapy within antiemetic treatment.

Treatment of symptomatic multiple myeloma, acute lymphoblastic leukaemia, Hodgkin's disease and non-Hodgkin's lymphoma in combination with other medicinal products.

Various

Prevention and treatment of postoperative vomiting, within antiemetic treatment.

4.2 Posology and method of administration

Posology

Dexamethasone is given in usual doses of 0.5 to 10 mg daily, depending on the disease being treated. In more severe disease conditions doses above 10 mg per day may be required. The dose should be titrated to the individual patient response and disease severity. In order to minimize side effects, the lowest effective possible dose should be used.

Unless otherwise prescribed, the following dosage recommendations apply:

The below mentioned dosing recommendations are given for guidance only. The initial and daily doses should always be determined based on individual patient response and disease severity.

- **Cerebral oedema:** Initial dose and duration of treatment depending on the cause and severity, 6-16 mg (up to 24 mg)/day orally, divided into 3-4 individual doses.
- **Acute asthma:** Adults: 16 mg/day for two days. Children: 0.6 mg/kg body weight for one or two days.
- **Croup:** Children: 0.15mg/kg-0.6 mg/kg in a single dose.
- **Acute skin diseases:** Depending on the nature and extent of the disease daily doses of 8-40 mg, in some cases up to 100 mg, which should be followed by down titration according to clinical need.
- **Active phase of rheumatic system disorders:** Systemic lupus erythematosus 6-16 mg / day.

- **Active rheumatoid arthritis with severe progressive course form:** running at fast destructive forms 12-16 mg/day, with extra-articular manifestations 6-12 mg/day.
- **Idiopathic thrombocytopenic purpura:** 40 mg for 4 days in cycles.
- **Tuberculous meningitis:** Patients with grade II or III disease received intravenous treatment for four weeks (0.4 mg per kilogram per day for week 1, 0.3 mg per kilogram per day for week 2, 0.2 mg per kilogram per day for week 3, and 0.1 mg per kilogram per day for week 4) and then oral treatment for four weeks, starting at a total of 4 mg per day and decreasing by 1 mg each week. Patients with grade I disease received two weeks of intravenous therapy (0.3 mg per kilogram per day for week 1 and 0.2 mg per kilogram per day for week 2) and then four weeks of oral therapy (0.1 mg per kilogram per day for week 3, then a total of 3 mg per day, decreasing by 1 mg each week).
- **Palliative treatment of neoplastic diseases:** Initial dose and duration of treatment depending on the cause and severity, 3-20 mg / day. Very high doses up to 96 mg may also be used for palliative treatment.
- **Prophylaxis and treatment of emesis induced by cytostatics, emetogenic chemotherapy within antiemetic treatment:** 8-20 mg dexamethasone prior to chemotherapy treatment, then 4-16 mg/day on day 2 and 3.
- **Prevention and treatment of postoperative vomiting, within antiemetic treatment:** single dose of 8 mg before the surgery.
- **Treatment of symptomatic multiple myeloma, acute lymphocytic leukemia, acute lymphoblastic leukemia, Hodgkin's disease and non-Hodgkin's lymphoma in combination with other medicinal products:** the usual posology is 40 mg or 20 mg once per day.

For the treatment of Covid-19

- Adult patients 6 mg PO, once a day for up to 10 days.
- *Paediatric population:* Paediatric patients (adolescents aged 12 years and older) are recommended to take 6mg/dose PO once a day for up to 10 days.
- Duration of treatment should be guided by clinical response and individual patient requirements.
- *Elderly, renal impairment, hepatic impairment:* No dose adjustment is needed.

The dose and administration frequency varies with the therapeutic protocol and the associated treatment(s). Dexamethasone administration should follow instructions for dexamethasone administration when described in the Summary of Product Characteristics of the associated treatment(s). If this is not the case, local or international treatment protocols and guidelines should be followed. Prescribing physicians should carefully evaluate which dose of dexamethasone to use, taking into account the condition and disease status of the patient.

Renal impairment

Patients undergoing active hemodialysis may show an increased clearance of drug via the dialysate and thus require an adjustment of steroid dose.

Hepatic impairment

In patients with severe liver disease dose adjustment may be necessary. In patients with a severe liver impairment, the biological effects of

dexamethasone may be potentiated due to its slower metabolism (prolonged plasma half-life) and hypoalbuminaemia (increased plasma levels of free drug), which may also cause more side effects.

Elderly

Treatment of elderly patients, particularly if long term, should be planned bearing in mind the more serious consequences of the common side effects of corticosteroids in old age (osteoporosis, diabetes mellitus, hypertension, reduced immunity, psychological changes). In such patients, the plasma concentrations of dexamethasone may be higher and its excretion slower than in younger patients, therefore its dose should be reduced accordingly.

Paediatric population

The usual dose is 0.01-0.1 mg/kg of body weight daily. The excretion of dexamethasone is approximately equal in children and adults if dosage is adjusted to their body area. Dosage should be planned bearing in mind possible effects upon growth and development and for signs of adrenal suppression.

Long term treatment

For the long-term treatment of several conditions, after initial therapy, glucocorticoid treatment should be switched from dexamethasone to prednisone/prednisolone to reduce suppression on the function of the adrenal cortex.

Discontinuation of treatment

Acute adrenocortical failure may occur after abrupt discontinuation of long-term treatment with large doses of glucocorticoids. Therefore, glucocorticoid doses should be gradually reduced in such cases and treatment should be discontinued gradually. (see section 4.4)

Method of administration

Dexamethasone should be taken with or after food to minimise irritation to the gastrointestinal tract. Drinks containing alcohol or caffeine should be avoided.

Dexamethasone is in the form of tablets 4 mg, 8 mg and 20 mg. The tablets 20 mg can be divided into equal halves and can provide additional 10 mg strengths and make it easier for the patient to swallow the tablet.

When alternate-day therapy is not possible, the entire daily dose of glucocorticoid can usually be administered as a single morning dose; however, some patients will require divided daily doses of glucocorticoids.

For posology that cannot be reached with these strengths, other medicinal products are available in the market.

4.3 Contraindications

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

Systemic infection unless specific anti-infective therapy is employed. Stomach ulcer or duodenal ulcer.

Vaccination with live vaccines during treatment with large therapeutic doses of dexamethasone (and other corticosteroids) is contraindicated due to the possibility of viral infection (see section 4.4 and 4.5).

In general no contraindications apply in conditions where the use of glucocorticoids may be lifesaving.

4.4 Special warnings and precautions for use

Adrenocortical insufficiency

An adrenocortical insufficiency, which is caused by glucocorticoid treatment, can, depending on the dose and length of treatment, remain for many months, and in some cases more than a year, after discontinuation of treatment. During treatment with dexamethasone for specific physical stress conditions (trauma, surgery, childbirth, etc.), a temporary increase in dose may be required. Because of the possible risk in stressful conditions, a corticosteroid ID should be made for patients undergoing long-term treatment. Even in cases of prolonged adrenocortical insufficiency after discontinuation of treatment, the administration of glucocorticoids can be necessary in physically stressful situations. An acute therapy-induced adrenocortical insufficiency can be minimized by slow dose reduction until a planned discontinuation time.

Treatment with dexamethasone should only be implemented in the event of the strongest indications and, if necessary, additional targeted anti-infective treatment administered for the following illnesses:

- Acute viral infections (Herpes zoster, Herpes simplex, Varicella, herpetic keratitis)
- HBsAG-positive chronic active hepatitis
- Approx. 8 weeks prior through 2 weeks after vaccinations with live vaccines (see section 4.3 and 4.5)
- Systemic mycoses and parasitosis (e.g. Nematodes)
- Poliomyelitis
- Lymphadenitis after BCG vaccination
- Acute and chronic bacterial infections
- With a history of tuberculosis (reactivation risk) use only under tuberculostatic protection
- Known or suspected Strongyloidiasis (threadworm infestation). Treatment with glucocorticoids may lead to lead to Strongyloides hyperinfection and dissemination with widespread larval migration.

In addition, treatment with dexamethasone should only be implemented under strong indications and, if necessary, additional specific treatment must be implemented for:

- Gastrointestinal ulcers
- Severe osteoporosis (as corticosteroids have a negative effect on the calcium balance)
- Difficult to regulate high blood pressure
- Difficult to regulate diabetes mellitus
- Psychiatric disorders (including history)

- Angle closure glaucoma and wide-angle glaucoma
- Corneal ulcerations and corneal injuries
- Severe heart failure

Particular care is required when considering the use of systemic corticosteroids in patients with the following conditions and frequent patient monitoring is necessary

- a. Osteoporosis (post-menopausal females are particularly at risk)
- b. Hypertension or congestive heart failure
- c. Existing or previous history of severe affective disorders (especially previous steroid psychosis)
- d. Diabetes mellitus (or a family history of diabetes)
- e. History of tuberculosis
- f. Glaucoma (or a family history of glaucoma)
- g. Previous corticosteroid-induced myopathy
- h. Liver failure
- i. Renal insufficiency
- j. Hypothyroidism
- k. Epilepsy
- l. Peptic ulceration
- m. Migraine
- n. Certain parasitic infestations in particular amoebiasis
- o. Incomplete natural growth since glucocorticoids on prolonged administration may accelerate epiphyseal closure

Anaphylactic reaction

After administration of glucocorticoids serious anaphylactoid reactions such as glottis oedema, urticaria and bronchospasm have occasionally occurred particularly in patients with a history of allergy.

If such an anaphylactoid reaction occurs, the following measures are recommended: immediate slow intravenous injection of 0.1-0.5ml of adrenaline (solution of 1:1000: 0.1-0.5mg adrenaline dependent on body weight), intravenous administration of aminophylline and artificial respiration if necessary.

Tendinitis

The risk of tendinitis and tendon rupture is increased in patients treated concomitantly with glucocorticoids and fluoroquinolones.

Myasthenia gravis

Pre-existing myasthenia gravis may initially deteriorate in the beginning of dexamethasone treatment.

Visual disturbance

Visual disturbance may be reported with systemic and topical corticosteroid use. If a patient presents with symptoms such as blurred vision or other visual disturbances, the patient should be considered for referral to an ophthalmologist for evaluation of possible causes which may include cataract, glaucoma or rare diseases such as central serous chorioretinopathy (CSCR) which have been reported after use of systemic and topical corticosteroids.

Prolonged use of corticosteroids may cause posterior subcapsular cataracts, glaucoma with possible damage to the optic nerve and can increase the risk of

secondary ocular infections due to fungi or viruses. Corticosteroids should be used cautiously in patients with ocular herpes simplex because of possible corneal perforation.

Intestinal perforation

Because of the risk of an intestinal perforation, dexamethasone must only be used under urgent indication and under appropriate monitoring for:

- Severe ulcerative colitis with threatened perforation
- Diverticulitis
- Entero-anastomosis (immediately postoperative)

Signs of peritoneal irritation after gastrointestinal perforation may be absent in patients receiving high doses of glucocorticoids.

Diabetes

The desired effects of hypoglycaemic agents (including insulin), antihypertensives and diuretics are antagonised by corticosteroids. A higher need for insulin, or oral antidiabetics, must be taken into consideration when administering dexamethasone to diabetics.

Cardiovascular disorders

Regular blood pressure monitoring is necessary during treatment with dexamethasone, particularly during administration of higher doses and with patients with difficult to regulate high blood pressure. Because of the risk of deterioration, patients with severe cardiac insufficiency should be carefully monitored.

Bradycardia may occur in patients treated with high doses of dexamethasone. Caution should be exercised when using corticosteroids in patients who have recently suffered myocardial infarction as myocardial rupture has been reported.

Infections

Treatment with dexamethasone can conceal the symptoms of an existing, or developing infection thereby making a diagnosis more difficult. The prolonged use of even small amounts of dexamethasone leads to an increased risk of infection, even by microorganisms which otherwise rarely cause infections (so-called opportunistic infections).

Vaccination

Vaccinations with inactivated vaccine are always possible. However, it should be noted that the immune reaction and thereby the success of inoculation, can be affected by higher doses of corticoids.

Regular checkups with doctors (including vision checkups in three-month intervals) are advised during long-term treatment with dexamethasone.

Metabolic disorders

At high doses, sufficient calcium intake and sodium restriction, as well as serum potassium levels should be monitored. Depending on the length and dosage of the treatment, a negative influence on calcium metabolism can be expected, so that an osteoporosis prophylaxis is recommended. This applies, above all, to co-existing risk factors like familial disposition, increased age, after menopause, insufficient protein and calcium intake, heavy smoking, excessive alcohol intake, as well as insufficient exercise. Prevention consists of

sufficient calcium and vitamin D intake and physical activity. Additional medical treatment should be considered in the event of pre-existing osteoporosis.

Corticosteroids should be used cautiously in patients with migraine, as corticosteroids may cause fluid retention.

Psychological changes

Patients and/or carers should be warned that potentially severe psychiatric adverse reactions may occur with systemic steroids (see section 4.8). Symptoms typically emerge within a few days or weeks of starting the treatment. Risks may be higher with high doses/systemic exposure (see also section 4.5 for pharmacokinetic interactions that can increase the risk of side effects), although dose levels do not allow prediction of the onset, type, severity or duration of reactions. Most reactions recover after either dose reduction or withdrawal, although specific treatment may be necessary. Patients/carers should be encouraged to seek medical advice if worrying psychological symptoms develop, especially if depressed mood or suicidal ideation is suspected. Patients/carers should also be alert to possible psychiatric disturbances that may occur either during or immediately after dose tapering/withdrawal of systemic steroids, although such reactions have been reported infrequently.

Particular care is required when considering the use of systemic corticosteroids in patients with existing or previous history of severe affective disorders in themselves or in their first degree relatives. These would include depressive or manic-depressive illness and previous steroid psychosis.

Cerebral oedema or increased intracranial pressure

Corticosteroids should not be used in conjunction with a head injury since they will probably not be of benefit or may even do harm.

Anti-inflammatory/Immunosuppressive effects and Infection

Suppression of the inflammatory response and immune function increases the susceptibility to infections and their severity. The clinical presentation may often be atypical, and serious infections such as septicaemia and tuberculosis may be masked and may reach an advanced stage before being recognised. Appropriate anti-microbial therapy should accompany glucocorticoid therapy when necessary e.g. in tuberculosis and viral and fungal infections of the eye.

Chickenpox is of particular concern since this normally minor illness may be fatal in immunosuppressed patients. Patients (or parents of children) without a definite history of chickenpox should be advised to avoid close personal contact with chickenpox or herpes zoster and if exposed they should seek urgent medical attention. Passive immunisation with varicella zoster immunoglobulin (VZIG) is needed by exposed non-immune patients who are receiving systemic corticosteroids or who have used them within the previous 3 months; this should be given within 10 days of exposure to chickenpox. If a diagnosis of chickenpox is confirmed, the illness warrants specialist care and urgent treatment. Corticosteroids should not be stopped and the dose may need to be increased.

Measles. Patients should be advised to take particular care to avoid exposure to measles and to seek immediate medical advice if exposure occurs; prophylaxis with intramuscular normal immunoglobulin may be needed.

Tumour lysis syndrome

In post marketing experience tumour lysis syndrome (TLS) has been reported

in patients with haematological malignancies following the use of dexamethasone alone or in combination with other chemotherapeutic agents. Patient at high risk of TLS, such as patients with high proliferative rate, high tumour burden, and high sensitivity to cytotoxic agents, should be monitored closely and appropriate precaution taken.

Discontinuation of treatment

Adrenal cortical atrophy develops during prolonged therapy and may persist for years after stopping treatment. Withdrawal of corticosteroids after prolonged therapy must therefore always be gradual to avoid acute adrenal insufficiency, being tapered off over weeks or months according to the dose and duration of treatment.

In patients who have received more than physiological doses of systemic corticosteroids (approximately 1mg dexamethasone) for greater than 3 weeks, withdrawal should not be abrupt. How dose reduction should be carried out depends largely on whether the disease is likely to relapse as the dose of systemic corticosteroids is reduced. Clinical assessment of disease activity may be needed during withdrawal. If the disease is unlikely to relapse on withdrawal of systemic corticosteroids but there is uncertainty about HPA suppression, the dose of systemic corticosteroid may be reduced rapidly to physiological doses. Once a daily dose of 1mg dexamethasone is reached, dose reduction should be slower to allow the HPA axis to recover.

Abrupt withdrawal of systemic corticosteroid treatment, which has continued up to 3 weeks is appropriate if it is considered that the disease is unlikely to relapse. Abrupt withdrawal of doses of up to 6mg daily of dexamethasone for 3 weeks is unlikely to lead to clinically relevant HPA-axis suppression in the majority of patients. In the following patient groups, gradual withdrawal of systemic corticosteroid therapy should be considered even after courses lasting 3 weeks or less:

- Patients who have had repeated courses of systemic corticosteroids, particularly if taken for greater than 3 weeks.
- When a short course has been prescribed within one year of cessation of long term therapy (months or years).
- Patients who may have reasons for adrenocortical insufficiency other than exogenous corticosteroid therapy.
- Patients receiving doses of systemic corticosteroid greater than 6mg daily of dexamethasone.
- Patients repeatedly taking doses in the evening.

During prolonged therapy any intercurrent illness, trauma or surgical procedure will require a temporary increase in dosage; if corticosteroids have been stopped following prolonged therapy they may need to be temporarily re-introduced.

Patients should carry 'Steroid treatment' cards which give clear guidance on the precautions to be taken to minimise risk and which provide details of prescriber, drug,

dosage and the duration of treatment.

Other

Pheochromocytoma crisis, which can be fatal, has been reported after administration of systemic corticosteroids. Corticosteroids should only be administered to patients with suspected or identified pheochromocytoma after an appropriate risk/benefit evaluation.

Systemic corticosteroids should not be stopped for patients who are already treated with systemic (oral) corticosteroids for other reasons (e.g. patients with chronic obstructive pulmonary disease) but not requiring supplemental oxygen.

The results of a randomised, placebo-controlled study suggest an increase in mortality if methylprednisolone therapy starts more than two weeks after the onset of Acute Respiratory Distress Syndrome (ARDS). Therefore, treatment of ARDS with corticosteroids should be initiated within the first two weeks of onset of ARDS.

Paediatric population

Corticosteroids cause a dose-dependent inhibition of growth in infancy, childhood, and adolescence since corticosteroids may give rise to early closing of the epiphyses, which may be irreversible. Therefore, during long-term treatment with dexamethasone, the indication should be very strongly presented in children and their growth rate should be checked regularly.

Preterm neonates:

Available evidence suggests long-term neurodevelopmental adverse events after early treatment (< 96 hours) of premature infants with chronic lung disease at starting doses of 0.25mg/kg twice daily.

Undesirable effects may be minimised by using the lowest effective dose for the minimum period, and by administering the daily requirement as a single morning dose or whenever possible as a single morning dose on alternative days. Frequent patient review is required to appropriately titrate the dose against disease activity.

Elderly

The common adverse effects of systemic corticosteroids can have serious consequences especially in old age, mainly osteoporosis, hypertension, hypokalemia, diabetes, susceptibility to infection and skin atrophy. Close clinical monitoring is required to prevent life-threatening reactions.

Influence of diagnostic tests

Glucocorticoids can suppress skin reaction to allergy testing. They can also affect the nitroblue tetrazolium test for bacterial infections and cause false- negative results.

Note on doping

The use of doping tests when taking dexamethasone can lead to positive results.

This medicine contains lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine.

Sodium

This medicine contains less than 1 mmol sodium (23 mg) per dose, that is to say essentially 'sodium-free'.

4.5 Interaction with other medicinal products and other forms of interaction

Prior to the use of Dexamethasone in combination with any other medicinal product, reference should be made to the Summary of Product Characteristics of that product.

Pharmacodynamic interactions

Patients taking NSAIDs should be monitored, as NSAIDs may increase the incidence and/or severity of gastro-intestinal ulcers. Acetylsalicylic acid should be used carefully in combination with corticosteroids in hypoprothrombinaemia.

The renal clearance of salicylates is increased by corticosteroids. Therefore, the dosage of salicylates may be reduced once the steroids are discontinued. Steroid withdrawal may result in salicylate intoxication due to the increase of salicylate concentration in the serum.

Corticosteroids reduce the effect of antidiabetic agents such as insulin, sulfonylurea, and metformin. Hyperglycaemia and diabetic ketoacidosis may occur occasionally.

Therefore, at the beginning of treatment, diabetics should have more frequent blood and urine tests.

The hypokalemic effect of acetazolamide, loop diuretics, thiazide diuretics, kaliuretics, amphotericin B injections (glucomineral)-corticosteroids, tetracosactide carbenoxolone and laxatives will increase. Hypokalemia promotes cardiac arrhythmias, especially torsade de pointes, and increases the toxicity of cardiac glycosides. Before the start of corticosteroid treatment, hypokalemia should be corrected and patients should be monitored clinically, for electrolytes and by electrocardiography. Furthermore, there are case reports in which the simultaneous use of amphotericin B and hydrocortisone led

to an enlarged heart and heart failure.

Antiulcer drugs: Carbenoxolone increases the risk of hypokalemia.

Chloroquine, hydroxychloroquine and mefloquine: Increased risk of myopathies a

Concomitant administration of ACE inhibitors creates an increased risk of blood disorders. The blood pressure-lowering effects of antihypertensive drugs may be affected by corticosteroids. The dose of the anti-hypertensive treatment may have to be adjusted during the treatment with dexamethasone.

Thalidomide: Great care should be taken during co-administration with thalidomide, as there have been reported cases of toxic epidermal necrolysis.

The effect of vaccinations may be reduced during treatment with dexamethasone. Vaccination with live vaccines during treatment with large therapeutic doses of dexamethasone (and other corticosteroids) is contraindicated due to the possibility of viral infection. In this case, vaccination should be postponed for at least 3 months after the completion of treatment with corticosteroids. Other types of immunisation during treatment with large therapeutic doses of corticosteroids are dangerous due to the risk of neurological complications and decreased or absent increase in the antibody titers (in comparison with expected values) and therefore a smaller protective effect. However, patients who have received corticosteroids locally (parenteral) or for a short period of time (less than 2 weeks), in smaller doses may be immunised.

Cholinesterase inhibitors: Concomitant use of cholinesterase inhibitors and corticosteroids may cause serious muscle weakness in patients with myasthenia gravis. If possible, cholinesterase inhibitors should be discontinued at least 24 hours before the start of corticosteroid therapy.

The risk of tendinitis and tendon rupture is increased in patients treated concomitantly with glucocorticoids and fluoroquinolones.

Co-treatment with CYP3A inhibitors, including cobicistat-containing products, is expected to increase the risk of systemic side-effects. The combination should be avoided unless the benefit outweighs the increased risk of systemic corticosteroid side-effects, in which case patients should be monitored for systemic corticosteroid side-effects.

Pharmacokinetic interactions

Effects of other medicinal products on dexamethasone:

Dexamethasone is metabolized via the cytochrome P450 3A4 (CYP3A4). The administration of dexamethasone with inducers of CYP3A4, such as ephedrine, barbiturates, rifabutin, rifampicin, phenobarbital, phenytoin, primidone, aminoglutethimide, indinavir, erythromycin and carbamazepine can lead to reduced plasma

concentrations of dexamethasone, so the dose must be increased.

Co-treatment with CYP3A inhibitors, including cobicistat-containing products, is expected to increase the risk of systemic side-effects. The combination should be avoided unless the benefit outweighs the increased risk of systemic corticosteroid side-effects, in which case patients should be monitored for systemic corticosteroid side-effects.

Aminoglutethimide can accelerate the reduction of dexamethasone and reduce its efficacy. If necessary, the dexamethasone dosage should be adjusted.

Bile acid resins, such as cholestyramine, may decrease the absorption of dexamethasone.

Topically applied gastrointestinal drugs, antacids (especially those containing magnesium trisilicate), activated charcoal: Decreased glucocorticoid resorption has been described during co-administration of prednisolone and dexamethasone. Therefore, the administration of glucocorticoids and topically applied gastrointestinal drugs, antacids (especially those containing magnesium trisilicate), activated charcoal should be postponed (with an interval of at least two hours). Doses of one agent should be spaced as far as possible from the other.

The administration of dexamethasone with inhibitors of CYP3A4, such as azole antifungals (e.g. ketoconazole, itraconazole), HIV protease inhibitors (e.g. ritonavir) and macrolide antibiotics (e.g. erythromycin) may lead to increased plasma concentrations and reduced clearance of dexamethasone. If required, the dexamethasone dose should be reduced.

Ketoconazole may not only increase the plasma concentration of dexamethasone by inhibition of CYP3A4, but also suppress adrenal corticosteroid synthesis and cause adrenal insufficiency upon discontinuation of corticosteroid treatment.

Oral contraceptives (oestrogens and progestogens) increase plasma concentration of corticosteroids. The antiviral drug ritonavir also increases the plasma concentration of dexamethasone.

Dexamethasone reduces the plasma concentration of the antiviral drugs indinavir and saquinavir.

Patients taking methotrexate and dexamethasone have an increased risk of haematological toxicity.

Effects of dexamethasone on other medicinal products

Dexamethasone is a moderate inducer of CYP3A4. The administration of dexamethasone with substances metabolized by CYP3A4 can lead to increased clearance and decreased plasma concentrations of these substances.

Tuberculostatics: A reduction of isoniazid plasma concentrations was observed during concurrent use of prednisolone. Patients taking isoniazid should be monitored closely.

Cyclosporine: Concomitant administration of cyclosporine and corticosteroids may lead to an increased effect of both substances. There is an increased risk of cerebral seizures.

Praziquantel: Reduced praziquantel plasma concentrations create a risk of treatment failure due to the increased hepatic metabolism of dexamethasone.

Oral anticoagulants (coumarin): Concomitant corticosteroid therapy may either potentiate or lead to a weakening of the effect of oral anticoagulants. In case of high doses or of treatment lasting over 10 days there is a risk of bleeding specific to corticosteroid therapies (gastrointestinal mucosa, vascular fragility). Patients who use corticosteroids combined with oral anticoagulants should be closely monitored (controls on day 8, then every two weeks during and after treatment). Concurrent corticosteroid therapy and close monitoring of the INR or prothrombin time is required to avoid spontaneous bleeding.

The effects of anticholinesterases are antagonised by corticosteroids in myasthenia gravis.

Atropine and other anticholinergics: Intraocular pressure increases may be noted during coadministration with dexamethasone.

Non-depolarizing muscle relaxants: the muscle relaxing effect may last longer.

Somatotropin: the effect of the growth hormone can be reduced.

Protirelin: Reduced increase in TSH may be noted during administration of protirelin.

4.6 Fertility, pregnancy and lactation

Pregnancy

The ability of corticosteroids to cross the placenta varies between individual drugs, however, dexamethasone readily crosses the placenta. Administration of corticosteroids to pregnant animals can cause abnormalities in foetal development, including cleft palate, intrauterine growth retardation and effects on brain growth and development. There is no evidence that corticosteroids result in an increased incidence of congenital abnormalities, such as cleft palate/lip in man (see also section 5.3). However, when administered for prolonged periods or repeatedly during pregnancy, corticosteroids may increase the risk of intrauterine growth retardation. Hypoadrenalism may, in theory, occur in the neonate following prenatal exposure to corticosteroids but usually resolves spontaneously following birth and is rarely clinically important. As with all drugs, corticosteroids should only be prescribed when the benefits to the mother and child outweigh the risks. When corticosteroids are essential however, patients with normal pregnancies may be treated as though they were in the non-gravid state.

Breast-feeding

Corticosteroids may pass into breast milk, although no data are available for dexamethasone. Infants of mothers taking high doses of systemic corticosteroids for prolonged periods may have a degree of adrenal suppression.

A decision on whether to continue/discontinue breast feeding or to continue/discontinue therapy with dexamethasone should be made taking into account the benefit of breast feeding to the child and the benefit of dexamethasone therapy to the woman.

Fertility

Dexamethasone decreases testosterone biosynthesis and endogenous ACTH secretion which has an effect on the spermatogenesis and the ovarian cycle.

4.7 Effects on ability to drive and use machines

There have been no studies on the effects on the ability to drive and use machines.

Dexamethasone may cause confusional state, hallucinations, dizziness, somnolence, fatigue, syncope and blurred vision (see section 4.8). If affected, patients should be instructed not to drive, use machines or perform hazardous tasks while being treated with dexamethasone.

4.8 Undesirable effects

Summary of the safety profile

The incidence of anticipated adverse effects including hypothalamic-pituitary-adrenal suppression correlates with the relative potency of the substance, dose, time of day of administration and duration of treatment (see section 4.4). During a short-term therapy, in compliance with the dosage recommendations and close monitoring of patients, the risk of side effects is low.

The usual side effects of short-term dexamethasone treatment (days/weeks) include weight gain, psychological disorders, glucose intolerance and transitory adrenocortical insufficiency. Long-term dexamethasone treatment (months/years) usually causes central obesity, skin fragility, muscle atrophy, osteoporosis, growth retardation and long-term suprarenal insufficiency (see also section 4.4 Special warnings and precautions for use).

Tabulated list of adverse reactions

	Not known
Infections and infestations	Increased susceptibility to, or exacerbation of (latent) infections* (including septicaemia, recurrence of dormant tuberculosis, eye infections, chickenpox, measles, fungal and viral infections) with masking of clinical symptoms, opportunistic infections
Blood and lymphatic system disorders	Leukocytosis, lymphopenia, eosinopenia, polycythemia, abnormal coagulation
Immune system disorders	Hypersensitivity reactions including anaphylaxis and angioedema, immunosuppression (see also under "Infections and parasitic diseases")
Endocrine disorders	Suppression of the hypothalamic-pituitary-adrenal axis and induction of Cushing's syndrome (typical symptoms: fullmoon face, plethora, truncal obesity), secondary adrenal and pituitary insufficiency* (especially in stress such as trauma or surgery), growth suppression in infancy, childhood and adolescence, menstrual irregularity and amenorrhoea, hirsutism
Metabolism and nutrition disorders	Weight gain, negative protein and calcium balance*, increased appetite, sodium and water retention*, potassium loss* (caution: rhythm disorders), hypokalemic alkalosis, manifestation of latent diabetes mellitus, impaired carbohydrate tolerance with increased dose requirements of antidiabetic therapy*, hypercholesterolemia, hypertriglyceridaemia
Psychiatric disorders*	Psychological dependence, depression, insomnia, aggravated schizophrenia, mental illness, from euphoria to manifest psychosis, affective disorders (such as irritable,

	<p>euphoric, depressed and labile mood and suicidal thoughts), psychotic reactions (including mania, delusions, hallucinations and aggravation of schizophrenia), behavioural disturbances, irritability, anxiety, sleep disturbances and cognitive dysfunction including confusion and amnesia</p> <p>Reactions are common and may occur in both adults and children. In adults, the frequency of severe reactions has been estimated to be 5-6%.</p> <p>Psychological effects have been reported on withdrawal of corticosteroids; the frequency is unknown.</p>
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Nervous system disorders	Increased intracranial pressure with papilloedema in children (pseudotumor cerebri) usually following discontinuation of treatment; manifestation of latent epilepsy, increased seizures in overt epilepsy, vertigo, headache
Eye disorders	Elevated intraocular pressure, glaucoma*, papilloedema, cataract*, mainly with posterior subcapsular opacity, corneal and scleral atrophy, increased ophthalmic viral, fungal and bacterial infections, worsening of symptoms associated with corneal ulcers*, chorioretinopathy, vision blurred
Cardiac disorders	Cardiac muscle rupture after recent history of myocardial infarction, congestive heart failure in predisposed patients, cardiac decompensation*
Vascular disorders	Hypertension, vasculitis, increased atherosclerosis and risk of thrombosis/thromboembolism (increase in coagulability of blood may lead to thromboembolic complications)
Respiratory, thoracic and mediastinal disorders	Hiccough
Gastrointestinal disorders	Dyspepsia, abdominal distension*, gastric ulcers with perforation and bleeding, acute pancreatitis, ulcerative esophagitis, oesophageal candidiasis, flatulence, abdominal distension, nausea, vomiting
Skin and subcutaneous tissue disorders	Hypertrichosis, skin atrophy, bruising, telangiectasia, striae, erythema, steroid acne, petechiae, ecchymosis, allergic dermatitis, urticaria, angioneurotic oedema, thinning hair, pigment disorders, increased capillary fragility, perioral dermatitis, hyperhidrosis, tendency to bruise
Musculoskeletal and connective tissue disorders	Premature epiphyseal closure, osteoporosis, fractures of the spine and long bones, aseptic necrosis of the femoral and the humeral bones, tendon tears, proximal myopathy, muscle weakness, loss of muscle mass, avascular osteonecrosis
Reproductive system and breast disorders	Impotence
General disorders and administration site conditions	Reduced response to vaccination and skin tests. Delayed wound healing, discomfort, malaise, steroid withdrawal syndrome: a too rapid reduction in corticosteroid dose after prolonged treatment can lead to acute adrenal insufficiency, hypotension, and death. A withdrawal syndrome may present with fever, myalgia, arthralgia, rhinitis, conjunctivitis, painful itchy skin nodules and weight loss.

* see also section 4.4 Special warnings and precautions for use

Description of selected adverse reactions

Adrenocortical insufficiency

An adrenocortical insufficiency, which is caused by glucocorticoid treatment, can, depending on the dose and length of treatment, remain for many months

and in some cases more than a year, after discontinuation of treatment. (see section 4.4 Special warnings and precautions for use)

Psychological changes

Psychological changes are manifested in various forms, the most common being euphoria. Depression, psychotic reactions and suicidal tendencies may also appear. These illnesses can be serious. Usually they start within a few days or weeks of starting the medicine. They are more likely to happen at high doses. Most of these problems go away if the dose is lowered or the medicine is stopped. (see section 4.4 Special warnings and precautions for use)

Infections

Treatment with dexamethasone can conceal the symptoms of an existing, or developing infection thereby making a diagnosis more difficult and can lead to an increased risk of infection. (see section 4.4 Special warnings and precautions for use)

Intestinal perforation

Corticosteroids can be associated with an increased risk of colonic perforation in severe ulcerative colitis with threatened perforation, diverticulitis and entero-anastomosis (immediately postoperative).

Signs of peritoneal irritation after gastrointestinal perforation may be absent in patients receiving high doses of glucocorticoids. (see section 4.4 Special warnings and precautions for use).

Cardiovascular disorders

Bradycardia, deterioration of severe cardiac insufficiency and difficult to regulate high blood pressure may occur. Caution should be exercised when using corticosteroids in patients who have recently suffered myocardial infarction as myocardial rupture has been reported. (see section 4.4 Special warnings and precautions for use).

Paediatric population

Corticosteroids cause a dose-dependent inhibition of growth in infancy, childhood, and adolescence since corticosteroids may give rise to early closing of the epiphyses, which may be irreversible. (see section 4.4 Special warnings and precautions for use).

Elderly

The common adverse effects of systemic corticosteroids can have serious consequences especially in old age, mainly osteoporosis, hypertension, hypokalemia, diabetes, susceptibility to infection and skin atrophy (thinning of the skin). Close clinical supervision is required to avoid life-threatening reaction. (see section 4.4 Special warnings and precautions for use).

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 or search for MHRA Yellow Card in the Google Play or Apple App Store

4.9 Overdose

Symptoms

It is difficult to define an excessive dose of a corticosteroid as the therapeutic

dose will vary according to indication and patient requirements.

Reports of acute toxicity and/or deaths following overdose with glucocorticoids are rare.

Overdose or prolonged use may exaggerate glucocorticoid adverse effects.

Management

No antidote is available. Treatment should be symptomatic and supportive with the dosage of dexamethasone being reduced or slowly withdrawn where possible. Treatment is probably not indicated for reactions due to chronic poisoning unless the patient has a condition that would render him unusually susceptible to ill effects from corticosteroids. In this case, the stomach should be emptied and symptomatic treatment should be instituted as necessary. Anaphylactic and hypersensitivity reactions may be treated with epinephrine (adrenaline), positive-pressure artificial respiration and aminophylline. The patient should be kept warm and quiet. The biological half-life of dexamethasone in plasma is about 190 minutes.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: corticosteroids for systemic use, glucocorticoids, ATC code: H02AB02.

Mechanism of action

Dexamethasone is a highly potent and long-acting glucocorticoid with negligible sodium retaining properties and is therefore, particularly suitable for the use in patients with cardiac failure and hypertension.

Its anti-inflammatory potency is 7 times greater than prednisolone and, like other glucocorticoids, dexamethasone also has anti-allergic, antipyretic and immunosuppressive properties.

Dexamethasone has a biological half-life of 36 - 54 hours and therefore is suitable in conditions where continuous glucocorticoid action is required.

5.2 Pharmacokinetic properties

Absorption and distribution

Dexamethasone is well absorbed when given by mouth; peak plasma levels are reached between 1 and 2 hours after ingestion and show wide interindividual variations. The mean plasma half-life is 3.6 ± 0.9 h. They are also well absorbed from sites of local application. Water-soluble forms of corticosteroids are given by intravenous injection for a rapid response; more prolonged effects are achieved using lipid-soluble forms of corticosteroids by intramuscular injection. Dexamethasone is bound (to about 77%) to plasma proteins, mainly mainly to globulin and less so to albumin. The corticosteroid-binding globulin has high affinity but low binding capacity, while the albumin has low affinity but large binding capacity. The synthetic corticosteroids are less extensively protein bound than hydrocortisone (cortisol). They also tend to have longer half-lives. Percentage protein binding of dexamethasone, unlike that of cortisol, remains practically unchanged with increasing steroid concentrations. Corticosteroids are rapidly distributed to all body tissues. They cross the placenta and may be excreted in small amounts in breast milk.

Biotransformation

Dexamethasone is metabolised mainly in the liver but also in the kidney.

Elimination

Dexamethasone and its metabolites are excreted in the urine. The slower metabolism of the synthetic corticosteroids with their lower proteinbinding affinity may account for their increased potency compared with the natural corticosteroids.

5.3 Preclinical safety data

In animal studies, cleft palate was observed in rats, mice, hamsters, rabbits, dogs and primates: not in horses and sheep. In some cases these divergences were combined with defects of the central nervous system and of the heart. In primates, effects in the brain were seen after exposure. Moreover, intra-uterine growth can be delayed. All these effects were seen at high dosages.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Lactose monohydrate
Maize starch, pregelatinised
Silica, colloidal anhydrous (E551)
Magnesium stearate (E572)
Sodium stearyl fumarate

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

36 months

6.4 Special precautions for storage

This medicine does not require any special temperature storage conditions. Store in the original package in order to protect from light.

6.5 Nature and contents of container

PVC/PVDC90/Aluminium foil blisters, in a cardboard box.

Available in pack sizes of 20, 30, 50 or 100 tablets.
Not all pack sizes may be marketed.

6.6 Special precautions for disposal

No special requirements for disposal.

7 MARKETING AUTHORISATION HOLDER

Manx Healthcare Limited
Unit 2
Bosworth Avenue
Tournament Fields
Warwick
CV34 6UQ
UK

8 MARKETING AUTHORISATION NUMBER

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