

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Diclo-SR 75

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains Diclofenac Sodium 75mg.

Excipient(s) with known effect

Ethanol

Each tablet contains 61.1 mg Lactose monohydrate

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Prolonged release tablet

Light pink, round convex tablets

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Adults and elderly:

Relief of all grades of pain and inflammation in a wide range of conditions including:

- (i) arthritic conditions: rheumatoid arthritis, osteoarthritis, ankylosing spondylitis, acute gout.
- (ii) acute musculo-skeletal disorders such as peri-arthritis (for example frozen shoulder), tendinitis, tenosynovitis, bursitis.
- (iii) other painful conditions resulting from trauma, including fracture, low back pain, sprains, strains, dislocations, orthopaedic, dental and other minor surgery.

Children

Diclo-SR tablets are not suitable for children

4.2 Posology and method of administration

Posology

Undesirable effects may be minimised by using the lowest effective dose for the shortest duration necessary to control symptoms (see section 4.4).

Adults: One tablet once or twice daily

The recommended maximum daily dose of diclofenac sodium is 150mg.

Special populations

Elderly: Although the pharmacokinetics of Diclo-SR 75 are not impaired to any clinically relevant extent in elderly patients, nonsteroidal anti-inflammatory drugs should be used with particular caution in such patients who generally are more prone to adverse reactions. If Diclo-SR 75 is considered necessary the lowest effective dosage should be used in frail elderly patients or those with a low body weight (see section 4.4 Special warnings and precautions for use) for the shortest possible duration. The patient should be monitored regularly for GI bleeding during NSAID therapy.

Cardiovascular and significant cardiovascular risk factors

Diclofenac is contraindicated in patients with established congestive heart failure (NYHA II-IV), ischemic heart disease, peripheral arterial disease and/or cerebrovascular disease (see section 4.3 Contraindications).

Patients with congestive heart failure (NYHA-I) or significant risk factors for cardiovascular disease should be treated with diclofenac only after careful consideration. Since cardiovascular risks with diclofenac may increase with dose and duration of exposure, the lowest effective daily dose should be used and for the shortest duration possible (see section 4.4 Special warnings and precautions for use).

Renal impairment: Diclofenac is contraindicated in patients with renal impairment (see section 4.3). No specific studies have been carried out in patients with renal impairment, therefore, no specific dose adjustment recommendations can be made. Caution is advised when administering diclofenac to patients with mild to moderate renal impairment (see section 4.4).

Hepatic impairment: Diclofenac is contraindicated in patients with hepatic impairment (see section 4.3). No specific studies have been carried out in patients with hepatic impairment, therefore, no specific dose adjustment recommendations can be made. Caution is advised when administering diclofenac to patients with mild to moderate hepatic impairment (see section 4.4).

Paediatric population: Diclofenac sodium is not recommended for use in children as dosage recommendations and indications for use in this group of patients have not been established.

Method of administration

For oral use only.

To be taken whole with liquid, preferably with or after food.

4.3 Contraindications

- Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.
- Active, or gastric or intestinal ulcer, bleeding or perforation.
- Active, or history of recurrent peptic ulcer/haemorrhage (two or more distinct episodes of proven ulceration or bleeding).
- History of gastrointestinal bleeding or perforation, related to previous NSAID therapy.
- NSAIDs are contraindicated in patients who have previously shown hypersensitivity reactions (e.g. asthma, rhinitis, angioedema or urticaria) in response to ibuprofen, aspirin, or other non-steroidal anti-inflammatory drugs.
- hepatic failure and renal failure (see section 4.4).
- During the last trimester of pregnancy (see section 4.6).
- Established congestive heart failure (NYHA II-IV), ischemic heart disease, peripheral arterial disease and/or cerebrovascular disease.
- Like other non-steroidal anti-inflammatory drugs (NSAIDs), diclofenac is also contraindicated in patients in whom attacks of asthma, angioedema, urticaria or acute rhinitis are precipitated by ibuprofen, acetylsalicylic acid or other nonsteroidal anti-inflammatory drugs

4.4 Special warnings and precautions for use

General:

Undesirable effects may be minimised by using the lowest effective dose for the shortest duration necessary to control symptoms (see section 4.2, and GI and cardiovascular risks below).

The concomitant use of diclofenac with systemic NSAIDs including cyclooxygenase-2 selective inhibitors should be avoided due to the absence of any evidence demonstrating synergistic benefits and the potential for additive undesirable effects (see section 4.5).

Elderly:

Caution is indicated in the elderly on basic medical grounds. The elderly have an increased frequency of adverse reactions to NSAIDs, especially gastrointestinal bleeding and perforation, which may be fatal (see section 4.2). It is recommended that the lowest effective dose be used in frail elderly patients or those with a low body weight (see section 4.2).

As with other nonsteroidal anti-inflammatory drugs including diclofenac, allergic reactions, including anaphylactic/anaphylactoid reactions, can also occur without earlier exposure to the drug (see section 4.8). Hypersensitivity reactions can also progress to Kounis syndrome, a serious allergic reaction that can result in myocardial infarction. Presenting symptoms of such reactions can include chest pain occurring in association with an allergic reaction to diclofenac.

Like other NSAIDs, diclofenac may mask the signs and symptoms of the infection due to its pharmacodynamic properties.

Respiratory disorders:

In patients with asthma, seasonal allergic rhinitis, swelling of the nasal mucosa (i.e. nasal polyps), chronic obstructive pulmonary diseases or chronic infections of

the respiratory tract (especially if linked to allergic rhinitis-like symptoms), reactions on NSAIDs like asthma exacerbations (so called intolerance to analgesics / analgesics asthma), Quincke's oedema or urticaria are more frequent than in other patients. Therefore, special precaution is recommended in such patients (readiness for emergency). This is applicable as well for patients who are allergic to other substances, e.g. with skin reactions, pruritus or urticaria.

Like other drugs that inhibit prostaglandin synthetase activity, diclofenac sodium and other NSAIDs can precipitate bronchospasm if administered to patients suffering from, or with a previous history of bronchial asthma.

Renal effects:

As fluid retention and oedema have been reported in association with NSAID therapy, including diclofenac, particular caution is called for in patients with impaired cardiac or renal function, history of hypertension, the elderly, patients receiving concomitant treatment with diuretics or medicinal products that can significantly impact renal function, and in those patients with substantial extracellular volume depletion from any cause, e.g. before or after major surgery (see section 4.3). Monitoring of renal function is recommended as a precautionary measure when using diclofenac in such cases. Discontinuation of therapy is usually followed by recovery to the pre-treatment state.

Hepatic effects:

Close medical surveillance is required when prescribing diclofenac to patients with impairment of hepatic function as their condition may be exacerbated.

As with other NSAIDs, including diclofenac, values of one or more liver enzymes may increase. During prolonged treatment with Diclofenac, regular monitoring of hepatic function is indicated as a precautionary measure. If abnormal liver function tests persist or worsen, clinical signs or symptoms consistent with liver disease develop or if other manifestations occur (eosinophilia, rash), diclofenac should be discontinued.

Hepatitis may occur with diclofenac without prodromal symptoms. Caution is called for when using diclofenac in patients with hepatic porphyria, since it may trigger an attack.

Cardiovascular and cerebrovascular effects:

Appropriate monitoring and advice are required for patients with a history of hypertension and congestive heart failure (NYHA-I) as fluid retention and oedema have been reported in association with NSAID therapy including diclofenac.

Clinical trial and epidemiological data consistently point towards increased risk of arterial thrombotic events (for example myocardial infarction or stroke) associated with the use of diclofenac, particularly at high dose (150mg daily) and in long term treatment.

Patients with uncontrolled hypertension, congestive heart failure, established ischaemic heart disease, peripheral arterial disease, and/or cerebrovascular disease should only be treated with diclofenac after careful consideration.

Patients with significant risk factors for cardiovascular events (e.g. hypertension, hyperlipidaemia, diabetes mellitus, smoking) should only be treated with diclofenac after careful consideration.

As the cardiovascular risks of diclofenac may increase with dose and duration of exposure, the shortest duration possible and the lowest effective daily dose should be used. The patient's need for symptomatic relief and response to therapy should be re-evaluated periodically.

Patients should remain alert for the signs and symptoms of serious arteriothrombotic events (e.g. chest pain, shortness of breath, weakness, slurring of speech), which can occur without warnings. Patients should be instructed to see a physician immediately in case of such an event.

Gastrointestinal effects:

Gastrointestinal bleeding (haematemesis, melaena), ulceration or perforation, which can be fatal, has been reported with all NSAIDs including diclofenac and may occur at any time during treatment, with or without warning symptoms or a previous history of serious gastrointestinal (GI) events. They generally have more serious consequences in the elderly. If gastrointestinal bleeding or ulceration occurs in patients receiving diclofenac, the medicinal product should be withdrawn.

As with all NSAIDs, including diclofenac, close medical surveillance is imperative and particular caution should be exercised when prescribing diclofenac in patients with symptoms indicative of gastrointestinal disorders, or with a history suggestive of gastric or intestinal ulceration, bleeding or perforation (see section 4.8). The risk of gastrointestinal bleeding, ulceration or perforation is higher with increasing NSAID doses including diclofenac, and in patients with a history of ulcer, particularly if complicated with haemorrhage or perforation (see section 4.3).

The elderly have increased frequency of adverse reactions to NSAIDs especially gastro intestinal bleeding and perforation which may be fatal (see section 4.2). To reduce the risk of gastrointestinal toxicity in patients with a history of ulcer,

particularly if complicated with haemorrhage or perforation, and in the elderly, the treatment should be initiated and maintained at the lowest effective dose.

These patients should commence treatment and be maintained on the lowest dose available. Combination therapy with protective agents (e.g. misoprostol or proton pump inhibitors) should be considered for these patients, and also for patients requiring concomitant use of medicinal products containing low dose acetylsalicylic acid (ASA/aspirin) or other medicinal products likely to increase gastrointestinal risk (see below and section 4.5).

Patients with a history of gastrointestinal toxicity, particularly the elderly, should report any unusual abdominal symptoms (especially gastrointestinal bleeding), particularly in the initial stages of treatment.

Caution is recommended in patients receiving concomitant medications which could increase the risk of ulceration or bleeding, such as systemic corticosteroids, anticoagulants such as warfarin, selective serotonin-reuptake inhibitors (SSRIs) or anti-platelet agents such as acetylsalicylic acid (see section 4.5).

Close medical surveillance and caution should also be exercised in patients with ulcerative colitis, or with Crohn's disease as these conditions may be exacerbated (see section 4.8).

An increased risk of anastomotic dehiscence has been noted in patients receiving oral diclofenac for analgesia after colon resection surgery.

NSAIDs, including diclofenac, may be associated with increased risk of gastrointestinal anastomotic leak. Close medical surveillance and caution are recommended when using diclofenac after gastro-intestinal surgery.

Haematological effects:

During prolonged treatment with diclofenac, as with other NSAIDs, monitoring of the blood count is recommended. Diclofenac may reversibly inhibit platelet aggregation (see section 4.5). Patients with defects of haemostasis, bleeding diathesis or haematological abnormalities should be carefully monitored.

SLE and mixed connective tissue disease:

In patients with systemic lupus erythematosus (SLE) and mixed connective tissue disorders there may be an increased risk of aseptic meningitis (see section 4.8).

Skin effects:

Serious skin reactions, some of them fatal, including exfoliative dermatitis, Stevens-Johnson syndrome, toxic epidermal necrolysis, and generalized bullous fixed drug eruption have been reported very rarely in association with the use of diclofenac (see section 4.8). Patients appear to be at highest risk for these reactions early in the

course of therapy: the onset of the reaction occurring in the majority of cases within the first month of treatment. Diclofenac should be discontinued at the first appearance of skin rash, mucosal lesions or other signs of hypersensitivity.

Porphyria

Diclofenac should only be used with extreme caution in patients with porphyria where no suitable alternative is available.

Female fertility:

The use of diclofenac may impair female fertility and is not recommended in women attempting to conceive. In women who have difficulties conceiving or who are undergoing investigation of infertility, withdrawal of diclofenac should be considered (see section 4.6).

Excipients

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

This medicinal product contains small amounts of ethanol (alcohol), less than 100 mg per dose.

Information on Sodium content

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

4.5 Interaction with other medicinal products and other forms of interaction

The following interactions include those observed with diclofenac gastro-resistant tablets and/or other pharmaceutical forms of diclofenac.

Diclofenac is bound practically completely to plasma albumin (99.7%) and consequently displacement reactions with high protein binding affinity must be borne in mind.

Care should be taken in patients treated with any of the following drugs as interactions have been reported in some patients.

Diuretics and antihypertensive agents: Like other NSAIDs, concomitant use of diclofenac with diuretics or antihypertensive agents (e.g. beta-blockers, angiotensin converting enzyme (ACE) inhibitors) may cause a decrease in their antihypertensive effect via inhibition of vasodilatory prostaglandin synthesis.

Therefore, the combination should be administered with caution and patients, especially the elderly, should have their blood pressure periodically monitored. Patients should be adequately hydrated and consideration should be given to

monitoring of renal function after initiation of concomitant therapy and periodically thereafter, particularly for diuretics and ACE inhibitors due to the increased risk of nephrotoxicity.

Cardiac glycosides: Concomitant use of cardiac glycosides and NSAIDs in patients may exacerbate cardiac failure, reduce GFR and increase plasma glycoside levels.

Digoxin: If used concomitantly, diclofenac may raise plasma concentrations of digoxin. Monitoring of the serum digoxin level is recommended.

Lithium: If used concomitantly, diclofenac may increase plasma concentrations of lithium. Monitoring of the serum lithium level is recommended.

Methotrexate: Diclofenac can inhibit the tubular renal clearance of methotrexate hereby increasing methotrexate levels. Caution is recommended when NSAIDs, including diclofenac, are administered less than 24 hours before treatment with methotrexate, since blood concentrations of methotrexate may rise and the toxicity of this substance be increase Cases of serious toxicity have been reported when methotrexate and NSAIDs including diclofenac are given within 24 hours of each other. This interaction is mediated through accumulation of methotrexate resulting from impairment of renal excretion in the presence of the NSAID.

Ciclosporin: Diclofenac, like other NSAIDs, may increase the risk of nephrotoxicity of ciclosporin due to the effect on renal prostaglandins. Therefore, it should be given at doses lower than those that would be used in patients not receiving ciclosporin.

Mifepristone: NSAIDs should not be used 8-12 days after mifepristone administration as NSAIDs can reduce the effect of mifepristone.

Other NSAIDs including cyclooxygenase-2 selective inhibitors and corticosteroids: Co-administration of diclofenac and other systemic NSAIDs or corticosteroids may increase the risk of gastrointestinal bleeding or ulceration.

Avoid concomitant use of two or more NSAIDs (including aspirin) as this may increase the risk of adverse effects (see section 4.4).

Anticoagulants and anti-platelet agents: Caution is recommended since concomitant administration could increase the risk of bleeding (see section 4.4). Although clinical investigations do not appear to indicate that diclofenac has an influence on the effect of anticoagulants, there are reports of an increased risk of haemorrhage in patients receiving diclofenac and anticoagulant concomitantly (see section 4.4). Therefore, to be certain that no change in anticoagulant dosage is required, close monitoring of such patients is required. As with other nonsteroidal anti-inflammatory agents, diclofenac in a high dose can reversibly inhibit platelet aggregation.

Selective serotonin reuptake inhibitors (SSRIs): Concomitant administration of SSRIs may increase the risk of gastrointestinal bleeding (see section 4.4).

Quinolone antibiotics: Convulsions may occur due to an interaction between quinolones and NSAIDs. This may occur in patients with or without a previous history of epilepsy or convulsions. Therefore, caution should be exercised when

considering the use of a quinolone in patients who are already receiving an NSAID.

Tacrolimus: Possible increased risk of nephrotoxicity when NSAIDs are given with tacrolimus. This might be mediated through renal antiprostaglandin effects of both NSAID and calcineurin inhibitor.

Zidovudine: Increased risk of haematological toxicity when NSAIDs are given with zidovudine. There is evidence of an increased risk of haemarthroses and haematoma in HIV(+) haemophiliacs receiving concurrent treatment with zidovudine and ibuprofen.

Drugs known to cause hyperkalemia: Concomitant treatment with potassium-sparing diuretics, ciclosporin, tacrolimus or trimethoprim may be associated with increased serum potassium levels, which should therefore be monitored frequently.

Phenytoin: When using phenytoin concomitantly with diclofenac, monitoring of phenytoin plasma concentrations is recommended due to an expected increase in exposure to phenytoin.

Antidiabetics: Clinical studies have shown that diclofenac can be given together with oral antidiabetic agents without influencing their clinical effect. However, there have been isolated reports of hypoglycaemic and hyperglycaemic effects necessitating changes in the dosage of the antidiabetic agents during treatment with diclofenac. For this reason, monitoring of the blood glucose level is recommended as a precautionary measure during concomitant therapy.

Colestipol and cholestyramine: These agents can induce a delay or decrease in absorption of diclofenac. Therefore, it is recommended to administer diclofenac at least one hour before or 4 to 6 hours after administration of colestipol/cholestyramine.

Potent CYP2C9 inhibitors: Caution is recommended when co-prescribing diclofenac with potent CYP2C9 inhibitors (such as voriconazole), which could result in a significant increase in peak plasma concentrations and exposure to diclofenac due to inhibition of diclofenac metabolism.

4.6 Fertility, pregnancy and lactation

Pregnancy

Inhibition of prostaglandin synthesis may adversely affect the pregnancy and/or the embryo/fetal development. Data from epidemiological studies suggest an increased risk of miscarriage and or cardiac malformation and gastroschisis after use of a prostaglandin synthesis inhibitor in early pregnancy. The absolute risk for cardiovascular malformation was increased from less than 1% up to approximately 1.5%. The risk is believed to increase with dose and duration of therapy. In animals, administration of a prostaglandin synthesis inhibitor has shown to result in increased pre- and post-implantation loss and embryo-fetal lethality.

In addition, increased incidences of various malformations, including cardiovascular, have been reported in animals given a prostaglandin synthesis inhibitor during organogenetic period.

From the 20th week of pregnancy onward, diclofenac use may cause oligohydramnios resulting from foetal renal dysfunction. This may occur shortly after treatment initiation and is usually reversible upon discontinuation. During the first and second trimester of pregnancy, diclofenac should not be given unless clearly necessary. If diclofenac is used by a woman attempting to conceive, or during the first and second trimester of pregnancy, the dose should be kept as low and duration of treatment as short as possible. Antenatal monitoring for oligohydramnios should be considered after exposure to diclofenac for several days from gestational week 20 onward. Diclofenac should be discontinued if oligohydramnios is found.

During the third trimester of pregnancy, all prostaglandin synthesis inhibitors may expose the fetus to:

- cardiopulmonary toxicity (with premature closure of the ductus arteriosus and pulmonary hypertension);
- renal dysfunction (see above);

The mother and the neonate, at the end of the pregnancy, to:

- possible prolongation of bleeding time, an anti-aggregating effect which may occur even at very low doses;
- inhibition of uterine contractions resulting in delayed or prolonged labour.

Consequently, diclofenac is contraindicated during the third trimester of pregnancy (see sections 4.3 and 5.3).

Breast-feeding

In the limited studies so far available, NSAIDs can appear in the breast milk in very low concentrations. NSAIDs should, if possible, be avoided in breastfeeding in order to avoid undesirable effects in the infant (see section 5.2).

Female fertility

As with other NSAIDs, the use of diclofenac may impair female fertility and is not recommended in women attempting to conceive. In women who may have difficulties conceiving or who are undergoing investigation of infertility, withdrawal of diclofenac should be considered (see section 4.4).

4.7 Effects on ability to drive and use machines

Patients who experience visual disturbances, dizziness, vertigo, somnolence, central nervous system disturbances, drowsiness or fatigue while taking NSAIDs should refrain from driving or operating machinery.

4.8 Undesirable effects

Adverse reactions are ranked under the heading of frequency, the most frequent first, using the following convention: very common: (>1/10); common (\geq 1/100 to <1/10); uncommon (\geq 1/1,000 to <1/100); rare (\geq 1/10,000 to <1/1000); very rare (<1/10,000); not known: cannot be estimated from the available data.

The following undesirable effects include those reported with other short-term or long-term use.

Blood and lymphatic system disorders	
Very rare	Thrombocytopenia, leucopenia, anemia (including hemolytic and aplastic anemia), agranulocytosis
Immune system disorders	
Rare	Hypersensitivity, anaphylactic and anaphylactoid reactions (including hypotension and shock).
Very rare	Angioneurotic oedema (including face oedema).
Psychiatric disorders	
Very rare	Disorientation, depression, insomnia, nightmare, irritability, psychotic disorder.
Nervous system disorders	
Common	Headache, dizziness.
Rare	Somnolence, tiredness.
Very rare	Paraesthesia, memory impairment, convulsion, anxiety, tremor, aseptic meningitis, taste disturbances, cerebrovascular accident.
Unknown	Confusion, hallucinations, disturbances of sensation, malaise.
Eye disorders	
Very rare	Visual disturbance, vision blurred, diplopia.
Unknown	Optic neuritis.
Ear and labyrinth disorders	
Common	Vertigo.

Very rare	Tinnitus, hearing impaired.
Cardiac disorders	
Uncommon*	Palpitations, chest pain, cardiac failure, myocardial infarction.
Not known	Kounis syndrome
Vascular disorders	
Very rare	Hypertension, hypotension, vasculitis.
Respiratory, thoracic and mediastinal disorders	
Rare	Asthma (including dyspnoea).
Very rare	Pneumonitis.
Gastrointestinal disorders	
Common	Nausea, vomiting, diarrhea, dyspepsia, abdominal pain, flatulence, anorexia.
Rare	Gastritis, gastrointestinal haemorrhage, haematemesis, diarrhea haemorrhagic, melaena, gastrointestinal ulcer with or without bleeding or perforation (sometimes fatal particularly in the elderly).
Very rare	Colitis (including haemorrhagic colitis and exacerbation of ulcerative colitis or Crohn's disease), constipation, stomatitis (including ulcerative stomatitis), glossitis, oesophageal disorder, diaphragm-like intestinal strictures, pancreatitis.
Unknown	Ischaemic colitis
Hepatobiliary disorders	
Common	Transaminases increased.
Rare	Hepatitis, jaundice, liver disorder.
Very rare	Fulminant hepatitis, hepatic necrosis, hepatic failure.
Skin and subcutaneous tissue disorders	

Common	Rash.
Rare	Urticaria.
Very rare	Bullous eruptions, eczema, erythema, erythema multiforme, Stevens- Johnson syndrome, toxic epidermal necrolysis (Lyell's syndrome), dermatitis exfoliative, loss of hair, photosensitivity reaction, purpura, allergic purpura, pruritus.
Not known	Fixed Drug eruption Generalised Bullous fixed drug eruption
Renal and urinary disorders	
Very rare	Acute renal failure, hematuria, proteinuria, nephrotic syndrome, interstitial nephritis, renal papillary necrosis.
Reproductive system and breast disorders	
Very rare	Impotence.
General disorders and administration site conditions	
Rare	Oedema

*The frequency reflects data from long-term treatment with a high dose (150 mg/day).

Clinical trial and epidemiological data consistently point towards an increased risk of arterial thrombotic events (for example myocardial infarction or stroke) associated with the use of diclofenac, particularly at high dose (150mg daily) and in long term treatment. (see section 4.3 and 4.4 for Contraindications and Special warnings and special precautions for use).

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorization 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

A) Symptoms

There is no typical clinical picture resulting from diclofenac over dosage. Symptoms include headache, nausea, vomiting, epigastric pain, gastrointestinal haemorrhage,, diarrhea, dizziness, disorientation, excitation, coma, drowsiness, dizziness, tinnitus, fainting or convulsions. In the cases of significant poisoning acute renal failure and liver damage are possible.

B) Therapeutic measures

Management of acute poisoning with NSAIDs, including diclofenac, essentially consists of supportive measures and symptomatic treatment. Supportive measures and symptomatic treatment should be given for complications such as hypotension, renal failure, convulsions, gastrointestinal disorder, and respiratory depression.

Special measures such as forced diuresis, dialysis or haemo-perfusion are probably of no help in eliminating NSAIDs, including diclofenac, due to the high protein binding and extensive metabolism.

Activated charcoal may be considered after ingestion of a potentially toxic overdose, and gastric decontamination (e.g vomiting, gastric lavage) after should be considered within one hour of ingestion of a potentially life-threatening overdose.

Good urine output should be ensured. Renal and liver function should be closely monitored.

Patients should be observed for at least four hours after ingestion of potentially toxic amounts.

Frequent or prolonged convulsions should be treated with intravenous diazepam.

Other measures may be indicated by the patient's clinical condition.

5.1. Pharmacodynamic properties

Pharmacotherapeutic group: Acetic acid derivatives and related substances, ATC code: M01AB05.

Mechanism of action

Diclofenac is a non-steroidal agent with marked analgesic/anti-inflammatory properties. It is an inhibitor of prostaglandin synthetase, (cyclo-oxygenase). Diclofenac sodium in vitro does not suppress proteoglycan biosynthesis in cartilage at concentrations equivalent to the concentrations reached in human beings.

5.2 Pharmacokinetic properties

After ingestion of the diclofenac slow release tablet, the active principle is slowly released into the gastrointestinal contents. Once released from the tablet, diclofenac is rapidly absorbed from the gastrointestinal tract but is subject to first-pass metabolism. Peak plasma concentrations occur about 4.5 hours after administration

of the prolonged release tablets when taken with a meal. Food and antacids decrease the rate but not the extent of absorption of diclofenac. The systemic availability of diclofenac from the SR formulations is on average 82% of that achieved with the same dose of enteric-coated tablets (possibly due to release rate dependent first-pass metabolism).

The active substance is 99.7% protein bound proteins, mainly albumin.

Diclofenac enters the synovial fluid and peak synovial fluid concentrations at steady state exceed plasma concentrations. Furthermore, elimination from the synovial fluid is slower than from plasma. Diclofenac and its metabolites cross the placenta and traces of diclofenac have been found in the milk of lactating women. The half-life for the terminal elimination phase is 3 hours.

Approximately 60% of the administered dose is excreted via the kidneys in the form of metabolites and less than 1% in unchanged form. The remainder of the dose is excreted via the bile in metabolised form. In patients with impaired renal function, no accumulation of diclofenac has been reported. However, half-life of diclofenac may be prolonged in patients with severe renal impairment.

Five Diclofenac metabolites have been identified in human plasma and urine. The metabolites include 4'-hydroxy-, 5-hydroxy-, 3'-hydroxy-, 4',5-dihydroxy and 3'-hydroxy-4'-methoxy-Diclofenac. The major Diclofenac metabolite, 4'-hydroxy-Diclofenac, has very weak pharmacologic activity. The formation of 4'-hydroxy-Diclofenac is primarily mediated by CYP2C9. Both Diclofenac and its oxidative metabolites undergo glucuronidation or sulfation followed by biliary excretion. Acylglucuronidation mediated by UGT2B7 and oxidation mediated by CYP2C8 may also play a role in Diclofenac metabolism. CYP3A4 is responsible for the formation of minor metabolites, 5-hydroxy and 3'-hydroxy-Diclofenac. In patients with renal dysfunction, peak concentrations of metabolites 4'-hydroxy- and 5-hydroxy-Diclofenac were approximately 50% and 4% of the parent compound after single oral dosing compared to 27% and 1% in normal healthy subjects

5.3 Preclinical safety data

Dog: Oral LD50: 59mg/kg No toxic effects noted

Mouse: Oral LD50: 125mg/kg No toxic effects noted

Rat: Oral LD50: 53mg/kg Behavioural (altered sleep time, ataxia), lungs, thorax or respiration (respiratory stimulation)

Rabbit: Oral LD50: 157mg/kg No toxic effects noted

(Registry of toxic effects of chemical substances 1985-6)

6.1. List of excipients

Ethanol

Lactose Monohydrate

Magnesium stearate

Methylhydroxypropylcellulose

Microcrystalline Cellulose

Povidone

Talc
Pigment Blend (PB24916 Pink) containing
Lactose Monohydrate and
Iron Oxide Red (E172)
*Not present in the final product

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

2 years

6.4 Special precautions for storage

Do not store above 25°C

6.5 Nature and contents of container

Aluminium foil/PVDC/PVC blister strips: Pack sizes 10, 20, 28, 30, 50, 56, 60, 90 and 100 tablets.

6.6 Special precautions for disposal

No special requirements.

7 MARKETING AUTHORISATION HOLDER

Strides Pharma UK Ltd
Unit 4, The Metro Centre
Dwight Road, Watford
WD18 9SS
United Kingdom

8 MARKETING AUTHORISATION NUMBER(S)

PL 13606/0145

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

20/01/2003 / 24/02/2009

10 DATE OF REVISION OF THE TEXT

03/09/2025