

# **SUMMARY OF PRODUCT CHARACTERISTICS**

## **1 NAME OF THE MEDICINAL PRODUCT**

Cimetidine 400mg Film-Coated Tablets

## **2 QUALITATIVE AND QUANTITATIVE COMPOSITION**

Each film-coated tablet contains 400 mg cimetidine Ph. Eur as the active ingredient.

For full list of excipients, see section 6.1

## **3 PHARMACEUTICAL FORM**

Film coated tablets.  
(tablet).

Pale green, oblong, film-coated tablet, embossed with 'BL' on one side and "400" on the reverse.

## **4 CLINICAL PARTICULARS**

### **4.1 Therapeutic indications**

Cimetidine is a histamine H<sub>2</sub>-receptor antagonist which rapidly inhibits both basal and stimulated gastric secretion of acid and reduces pepsin output.

Cimetidine is indicated in the treatment of benign gastric and duodenal ulceration, including that associated with non-steroidal anti-inflammatory agents, recurrent and stomal ulceration, reflux oesophagitis, Zollinger - Ellison syndromes, and other conditions where gastric acid reduction by cimetidine is shown to be beneficial: persistent dyspeptic symptoms with or without ulceration, particularly meal-related upper abdominal pain, including such symptoms associated with non-steroidal anti-inflammatory agents; the prophylaxis of gastro-intestinal haemorrhage from stress ulceration in seriously ill patients; before general anaesthesia in patients thought to be

at risk of acid aspiration (Mendelson's) syndrome, particularly obstetric patients during labour.

To reduce malabsorption and fluid loss in the short bowel syndrome and in pancreatic insufficiency to reduce degradation of enzyme supplements.

## **4.2 Posology and method of administration**

The total daily dose should not normally exceed 2.4g. Dosage should be reduced in patients with impaired renal function (see section 4.4).

### Adults:

The usual dosage is 400 mg twice a day with breakfast and at bedtime. Alternatively for patients duodenal or benign gastric ulceration may be treated with a single daily dose of 800 mg at bedtime. Other effective regimens are 200 mg three times a day with meals and 400 mg at bedtime (1.0 g/day) and, if inadequate, 400mg four times a day (1.6g/day) with meals and at bedtime.

Treatment should be given initially for at least four weeks (six weeks in benign gastric ulcer eight weeks in ulcer associated with continued non-steroidal anti-inflammatory agents) even if symptomatic relief has been achieved sooner. Most ulcers will have healed by that stage, but those which have not will usually do so after a further course of treatment.

Treatment may be continued for longer periods in patients who may benefit from reduction of gastric secretion and the dosage may be reduced in those who have responded to treatment, for example to 400 mg at bedtime or 400 mg in the morning and at bedtime.

In patients with benign peptic ulcer disease who have responded to the initial course, relapse may be prevented by continued treatment. Usual dosage for maintenance treatment is 400 mg at bedtime but 400 mg in the morning and at bedtime has also been used. In oesophageal reflux disease, 400 mg four times a day with meals and at bedtime for four to eight weeks is recommended to heal oesophagitis and relieve associated symptoms.

In patients with very high gastric acid secretion (e.g. Zollinger-Ellison syndrome) it may be necessary to increase the dose to 400 mg four times a day, or in occasional cases further.

Antacids can be made available to all patients until symptoms disappear.

In the prophylaxis of haemorrhage from stress ulceration in seriously ill patients doses of 200-400mg can be given every four to six hours

In patients thought to be at risk of acid aspiration syndrome an oral dose of 400 mg can be given 90 - 120 minutes before induction of general anaesthesia or in, obstetric patients, at the start of labour. While such a risk persists, a dose of up to 400mg may be repeated at four hourly intervals as required up to the usual daily maximum of 2.4g The usual precautions to avoid acid aspiration should be taken.

In the short bowel syndrome, e.g. following substantial resection for Crohn's disease, the usual dosage (see above) can be used according to the individual response.

To reduce degradation of pancreatic enzyme supplements, 800-1600mg a day may be given according to response in four divided doses, one to one and a half hours before meals.

Use in the elderly:

The normal adult dosage should be used unless renal function is markedly impaired (see section 4.4).

Use in children over 1 year:

Experience in children is less than that in adults. 25 to 30 mg/kg body weight daily in divided doses may be administered.

Use in infants under 1 year:

The use of cimetidine in infants under one year old is not yet fully evaluated. 20mg/kg body weight per day in divided doses has been used.

Route of administration:

Oral

The tablets should be swallowed with a drink of water.

### **4.3 Contraindications**

Hypersensitivity to cimetidine

### **4.4 Special warnings and precautions for use**

Dosage should be reduced in patients with impaired renal function according to creatinine clearance. The following dosages are suggested:

Creatinine clearance of 0 to 15 ml/minute - 200 mg twice a day  
15 to 30 ml/minute - 200 mg three times a day  
30 to 50 ml/minute - 200 mg four times a day  
over 50 ml/minute - normal dosage

Cimetidine is removed by haemodialysis but not to any significant extent by peritoneal dialysis.

In patients on drug treatment or with illnesses that could cause falls in blood count, the possibility that H<sub>2</sub>- receptor antagonism could potentiate the effect should be borne in mind.

The safety of prolonged use is not fully established and care should be taken to observe periodically patients given prolonged treatment.

Care should be taken that patients with a history of peptic ulcer, particularly the elderly, being treated with cimetidine and a nonsteroidal anti-inflammatory agent are observed regularly.

Before initiating therapy with this preparation for any gastric ulceration, malignancy should be excluded by endoscopy and biopsy, if possible, because cimetidine tablets can relieve the symptoms and help the superficial healing of the gastric cancer. The consequences of potential delay in diagnosis should be borne in mind especially in middle aged patients or over, with new or recently changed dyspeptic symptoms.

Due to possible interaction with coumarins, close monitoring of prothrombin time is recommended when cimetidine is concurrently used.

Co-administration of therapeutic agents with a narrow therapeutic index, such as phenytoin or theophylline, may require dosage adjustment when starting or stopping concomitantly administered cimetidine (see Section 4.5).

#### **4.5 Interaction with other medicinal products and other forms of interaction**

Cimetidine can prolong the elimination of drugs metabolised by oxidation in the liver.

Although pharmacological interactions between cimetidine and a number of drugs have been demonstrated e.g. diazepam and propranolol, only those with oral anticoagulants, phenytoin, theophylline and intravenous lidocaine appear, to date, to be of clinical significance. Close monitoring of patients on cimetidine receiving oral anticoagulants or phenytoin is recommended and a reduction in the dosage of these drugs may be necessary.

In patients on drug treatment or with illnesses that could cause falls in blood cell count, the possibility that H<sub>2</sub>-receptor antagonism could potentiate this effect should be borne in mind.

Cimetidine has the potential to affect the absorption, metabolism or renal excretion of other drugs which is particularly important when drugs with a narrow therapeutic index are administered concurrently. The altered pharmacokinetics may necessitate dosage adjustment of the affected drug or discontinuation of treatment (see Section 4.4).

Interactions may occur by several mechanisms including:

- 1) Inhibition of certain cytochrome P450 enzymes (including CYP1A2, CYP2C9, CYP2D6 and CYP3A3/A4, and CYP2C18); Inhibition of these enzymes may result in increased plasma levels of certain drugs including warfarin-type coumarin anticoagulants (e.g. warfarin), tricyclic antidepressants (e.g. amitriptyline), class I antiarrhythmics (e.g. lidocaine), calcium channel blockers (e.g. nifedipine, diltiazem), oral sulfonylureas (e.g. glipizide), phenytoin, theophylline and metoprolol.
- 2) Competition for renal tubular secretion; This may result in increased plasma levels of certain drugs including procainamide, metformin, ciclosporin and tacrolimus.

- 3) Alteration of gastric pH; The bioavailability of certain drugs may be affected. This can result in either an increase in absorption (e.g. atazanavir) or a decrease in absorption (e.g. some azole antifungals such as ketoconazole, itraconazole or posaconazole).
- 4) Unknown mechanisms; Cimetidine may potentiate the myelosuppressive effects (e.g. neutropenia, agranulocytosis) of chemotherapeutic agents such as carmustine, fluorouracil, epirubicin, or therapies such as radiation. Isolated cases of clinically relevant interactions have been documented with narcotic analgesics (e.g. morphine).

#### **4.6 Fertility, pregnancy and lactation**

Although tests in animals and clinical evidence have not revealed any hazards from the administration of cimetidine during pregnancy or lactation, both these and studies in women have shown that it does cross the placental barrier and is excreted in milk. As with most drugs, the use of cimetidine should be avoided during pregnancy and lactation unless essential.

#### **4.7 Effects on ability to drive and use machines**

None known

#### **4.8 Undesirable effects**

Adverse experiences with cimetidine are listed below by system organ class and frequency. Frequencies are defined as: very common (>1/10), common (>1/100, <1/10), uncommon (>1/1000, <1/100), rare (>1/10000, <1/1000), very rare (<1/10000).

##### **Blood and lymphatic system disorders**

Uncommon: Leukopenia

Rare: Thrombocytopenia, aplastic anaemia

Very rare: Pancytopenia, agranulocytosis

##### **Immune system disorders**

Very rare: Anaphylaxis. Anaphylaxis is usually cleared on withdrawal of the drug.

##### **Psychiatric disorders**

Uncommon: Depression, confusional states, hallucinations. Confusional states, reversible within a few days of withdrawing cimetidine, have been reported, usually in elderly or ill patients.

### **Nervous system disorders**

Common: Headache, dizziness

### **Cardiac disorders**

Uncommon: Tachycardia

Rare: Sinus bradycardia

Very rare: Heart block

### **Gastrointestinal disorders**

Common: Diarrhoea

Very rare: Pancreatitis. Pancreatitis cleared on withdrawal of the drug.

### **Hepatobiliary disorders**

Uncommon: Hepatitis

Rare: Increased serum transaminase levels. Hepatitis and increased serum transaminase levels cleared on withdrawal of the drug.

### **Skin and subcutaneous tissue disorders**

Common: Skin rashes

Very rare: Reversible alopecia and hypersensitivity vasculitis.

Hypersensitivity vasculitis usually cleared on withdrawal of the drug.

### **Musculoskeletal and connective tissue disorders**

Common: Myalgia

Very rare: Arthralgia

### **Renal and urinary disorders**

Uncommon: Increases in plasma creatinine

Rare: Interstitial nephritis. Interstitial nephritis cleared on withdrawal of the drug. Small increases in plasma creatinine have been reported, unassociated with changes in glomerular filtration rate. The increases do not progress with continued therapy and disappear at the end of therapy.

### **Reproductive system and breast disorders**

Uncommon: Gynaecomastia and reversible impotence. Gynaecomastia is usually reversible upon discontinuation of cimetidine therapy. Reversible impotence has been reported particularly in patients receiving high doses (e.g. in Zollinger-Ellison Syndrome). However, at regular dosage, the incidence is similar to that in the general population.

Very rare: Galactorrhoea

### **General disorders and administration site conditions**

Common: Tiredness

Very rare: Fever. Fever cleared on withdrawal of the drug

#### **Reporting of suspected adverse reactions**

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the Yellow Card Scheme at: [www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard).

## **4.9 Overdose**

Acute overdosage of up to 20g has been reported several times with no significant ill-effects. The induction of vomiting and/or gastric lavage may be employed together with symptomatic and supportive therapy.

# **5 PHARMACOLOGICAL PROPERTIES**

## **5.1 Pharmacodynamic properties**

Cimetidine is an H<sub>2</sub> blocker with reversible competitive antagonism of the actions of histamine on H<sub>2</sub> receptors. It is highly selective in its action and is virtually without effect on H<sub>1</sub> receptors or, indeed on receptors for other autacoids or drugs. The most prominent of the effects of histamine that are mediated by H<sub>2</sub> receptors is stimulation of gastric acid secretion and they interfere remarkably little with physiological functions other than gastric secretion.

Cimetidine inhibits gastric acid secretion elicited by histamine or other H<sub>2</sub> antagonists in a dose-dependent, competitive manner; the degree of inhibition parallels the plasma concentration of the drug over a wide range. In addition, the H<sub>2</sub> blockers inhibit gastric secretion elicited by muscarinic agonists or by gastrin, although this effect is not always complete.

This breadth of inhibitory effect is not due to non-specific actions at the receptors for these other secretagogues. Rather, this effect, which is non-competitive and indirect,

appears to indicate either that these two classes of secretagogues utilise histamine as the final common mediator or, more probably, that ongoing histaminergic stimulation of the parietal cell is important for amplification of the stimuli provided by ACh or gastrin when they act on their own discrete receptors. Receptors for all three secretagogues are present on the parietal cell. The ability of H<sub>2</sub> blockers to suppress responses to all three physiological secretagogues makes them potent inhibitors of all phases of gastric acid secretion. Thus these drugs will inhibit basal (fasting) secretion and nocturnal secretion and also that stimulated by food, sham feeding, fundic distension, insulin, or caffeine. The H<sub>2</sub> blockers reduce the volume of juice secreted and its hydrogen ion concentration. Output of pepsin, which is secreted by the chief cells of the gastric glands (mainly under cholinergic control), generally falls in parallel with the reduction in volume of the gastric juice. Secretion of intrinsic factor is also reduced, but it is normally secreted in great excess, and absorption of vitamin B<sub>12</sub> is usually adequate even during long-term therapy with H<sub>2</sub> blockers.

Concentrations of gastrin in plasma are not significantly altered under fasting conditions; however, the normal prandial elevation of gastrin concentration may be augmented, apparently as a consequence of a reduction in the negative feedback that is normally provided by acid.

## **5.2 Pharmacokinetic properties**

Cimetidine is reported to be rapidly and virtually completely absorbed from the gastro-intestinal tract with an elimination half life of around 2 - 3 hours. Absorption is little impaired by food or antacids. Peak plasma concentrations are attained in about 1 - 2 hours. Hepatic first-pass metabolism results in bioavailabilities of about 60% for cimetidine.

Cimetidine is eliminated primarily by the kidneys and 60% or more may appear in the urine unchanged; much of the rest is oxidation products. Small amounts are recovered in the stool.

## **5.3 Preclinical safety data**

Not available

# **6 PHARMACEUTICAL PARTICULARS**

## **6.1 List of excipients**

Starch  
Povidone  
Magnesium Stearate  
Sodium Starch Glycollate

Purified Water  
Opadry OY-8839 (E104, E132, E171, E172)

## **6.2 Incompatibilities**

None known

## **6.3 Shelf life**

Shelf life of product as packaged for sale  
3 years from the date of manufacture

Shelf life after dilution or reconstitution according to directions  
Not applicable

Shelf life after first opening the container  
3 years from the date of manufacture.

## **6.4 Special precautions for storage**

Store below 25°C.

## **6.5 Nature and contents of container**

Blister packages of PVDC (60gsm) coated PVC (250 $\mu$ )/Aluminium blisters in the following pack sizes: 50, 56, 60, 100, 250, 500, 2500 & 5000.

## **6.6 Special precautions for disposal**

No special instructions.

**7      MARKETING AUTHORISATION HOLDER**

BRISTOL LABORATORIES LIMITED  
Unit 3, Canalside, Northbridge Road  
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PL 17907/0358

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