SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Paracetamol or Paralink Suppositories 500mg

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each suppository contains Paracetamol Ph.Eur. 500mg

3 PHARMACEUTICAL FORM

White, tapered, cylindrical suppositories with a smooth surface and rounded head, containing 500mg Ph.Eur.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

For the treatment of mild to moderate pain and pyrexia. The suppositories may be particularly useful in patients unable to take oral forms of Paracetamol e.g. post-operatively or with nausea and vomiting.

4.2 Posology and method of administration

Adults, elderly and children 12 – 18 years: 1 – 2 suppositories; maximum of 4g in 24 hours

Dose may be repeated every 4 – 6 hours with a maximum of 4 doses in 24 hours.

The dose should be based on age and weight i.e.

12 years (39kg) – (500mg) 1 suppository

Adults and the elderly (1g) 2 suppositories

4.3 Contraindications

Hypersensitivity to paracetamol or any of the other constituents.

4.4 Special warnings and precautions for use

Care is advised in the administration of paracetamol to patients with severe renal or severe hepatic impairment. The hazard of overdose is greater in those with non-cirrhotic alcoholic liver disease. Do not exceed the recommended dose. Patients should be advised not to take other paracetamol-containing products concurrently. If symptoms persist, consult your doctor. Keep out of sight and reach of children.

Cases of high anion gap metabolic acidosis (HAGMA) due to pyroglutamic acidosis have been reported in patients with severe illness such as severe renal impairment and sepsis, or in patients with malnutrition or other sources of glutathione deficiency (e.g. chronic alcoholism) who were treated with paracetamol at therapeutic dose for a prolonged period or a combination of paracetamol and flucloxacillin. If HAGMA due to pyroglutamic acidosis is suspected, prompt discontinuation of paracetamol and close monitoring, is recommended. The measurement of urinary 5-oxoproline may be useful to identify pyroglutamic acidosis as underlying cause of HAGMA in patients with multiple risk factors.

4.5 Interaction with other medicinal products and other forms of interaction

The anticoagulant effect of warfarin and other coumarins may be enhanced by prolonged regular daily use of paracetamol with increased risk of bleeding; occasional doses have no significant effect. The rate of absorption of paracetamol may be increased by metoclopramide or domperidone and absorption reduced by coleystyramine.

Caution should be taken when paracetamol is used concomitantly with flucloxacillin as concurrent intake has been associated with high anion gap metabolic acidosis due to pyroglutamic acidosis, especially in patients with risks factors (see section 4.4)

4.6 Fertility, Pregnancy and lactation

Pregnancy

A large amount of data on pregnant women indicate neither malformative, nor feto/neonatal toxicity. Epidemiological studies on neurodevelopment in children exposed to paracetamol in utero show inconclusive results. If clinically needed, paracetamol can be used during pregnancy however it should be used at the lowest effective dose for the shortest possible time and at the lowest possible frequency.

Lactation

Paracetamol is excreted in breast milk but not in a clinically significant amount. Available published data do not contraindicate breast feeding.

4.7 Effects on ability to drive and use machines

None

4.8 Undesirable effects

Adverse effects of paracetamol are rare but hypersensitivity including skin rash may occur. Very rare cases of serious skin reactions have been reported. There have been a few reports of blood dyscrasias including thrombocytopenia and agranulocytosis but these were not necessarily causally related to paracetamol.

SOC: Metabolism and nutrition disorders
"High anion gap metabolic acidosis'' with frequency ''Not known'' (cannot be estimated from the available data)

Description of selected adverse reactions

High anion gap metabolic acidosis
Cases of high anion gap metabolic acidosis due to pyroglutamic acidosis have been observed in patients with risk factors using paracetamol (see section 4.4). Pyroglutamic acidosis may occur as a consequence of low glutathione levels in these patients.

Reporting of suspected adverse reactions
Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance

of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the Yellow Card Scheme at: www.mhra.gov.uk/yellowcard

4.9 Overdose

Liver damage is possible in adults who have taken 10g or more of paracetamol.

Ingestion of 5g or more of paracetamol may lead to liver damage if the patient has risk factors (see below).

Risk Factors

If the patient

A, Is on long term treatment with carbamazepine, phenobarbitone, phenytoin,

primidone, rifampicin, St. John's Wort or other drugs that induce liver enzymes.

Or

B, Regularly consumes ethanol in excess of recommended amounts.

Or

C, It is likely to be glutathione deplete e.g. eating disorders, cystic fibrosis, HIV infection, starvation, cachexia.

Symptoms

Symptoms of paracetamol overdosage in the first 24 hours are pallor, nausea, vomiting, anorexia and abdominal pain. Liver damage may become apparent 12 to 48 hours after ingestion. Abnormalities of glucose metabolism and metabolic acidosis may occur. In severe poisoning, hepatic failure may progress to encephalopathy, haemorrage, hypoglycaemia, cerebral oedema and death. Acute renal failure with acute tubular necrosis, strongly suggested by loin pain, haematuria and proteinuria, may develop even in the absence of severe liver damage. Cardiac arrhythmias and pancreatitis have been reported.

Management

Immediate treatment is essential in the management of paracetamol overdose.

Despite a lack of significant early symptoms, patients should be referred to

hospital urgently for immediate medical attention. Symptoms may be limited to nausea or vomiting and may not reflect the severity of overdose or the risk of organ damage. Management should be in accordance with established treatment guidelines, see BNF overdose section.

Treatment with activated charcoal should be considered if the overdose has been taken within 1 hour. Plasma paracetamol concentration should be measured at 4 hours or later after ingestion (earlier concentrations are unreliable). Treatment with N-acetylcysteine may be used up to 24 hours after ingestion of Paracetamol, however, the maximum protective effect is obtained up to 8 hours post-ingestion.

The effectiveness of the antidote declines sharply after this time. If required the patient should be given intravenous N-acetylcysteine, in line with the established dosage schedule. If vomiting is not a problem, oral methionine may be a suitable alternative for remote areas, outside hospital Management of patients who present

with serious hepatic dysfunction beyond 24h from ingestion should be discussed with the NPIS or a liver unit.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Paracetamol is an antipyretic and analgesic proven in paediatric use. Paracetamol produces antipyresis through action on the hypothalamic heat-regulation centre and analgesia by elevation of the pain threshold. Paracetamol has analgesic and antipyretic actions similar to those of aspirin but it has no useful anti-inflammatory properties.

5.2 Pharmacokinetic properties

Paracetamol has analgesic and antipyretic actions but only weak anti-inflammatory properties.

Paracetamol is rapidly and almost completely absorbed from the gastro-intestinal tract. Peak plasma concentrations occur within 0.5 to 2 hours, with slightly faster absorption of liquid preparations. Usual analgesic doses produce total serum concentrations of 5 to 20µg/ml. A good correlation between serum concentration and analgesic effect has not been found. Serum protein binding varies from 20% to 50% at toxic serum concentrations.

Paracetamol is excreted in the urine mostly as metabolites; 2-4% is excreted unchanged. The average elimination half-life is 1 to 4 hours: half-life is slightly prolonged in neonates (2.2 to 5 hours) and in cirrhotics.

The overall elimination rate constant for paracetamol in children, from birth to 12 years of age, is the same as for adults but neonates have diminished capacity to form glucuronide conjugates of paracetamol.

5.3 Preclinical safety data

Conventional studies using the currently accepted standards for the evaluation of toxicity to reproduction and development are not available.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Hard Fat

Macrogol Stearate

6.2 Incompatibilities

None

6.3 Shelf life

2 years

6.4 Special precautions for storage

Store at a temperature not exceeding 25ºC

6.5 Nature and contents of container

Each suppository filled by the machine is contained in a plastic cavity, part of a strip of five. Two strips (10 suppositories) are then packed into a cardboard carton.

The layer of the cavity next to the suppository is composed of polyethylene, the outside layer is polyvinylchloride and they are held together with polyurethane.

6.6 Special precautions for disposal

For use on one occasion only. Discard any unused material. Do not use if the mould is damaged.

7 MARKETING AUTHORISATION HOLDER

Phoenix Healthcare Limited
Suite 12, Bunkilla Plaza
Bracetown Business Park
Clonee, County Meath
Ireland

8 MARKETING AUTHORISATION NUMBER(S)

PL 42727/0003

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10 DATE OF REVISION OF THE TEXT

04/06/2025