# SUMMARY OF PRODUCT CHARACTERISTICS

## 1 NAME OF THE MEDICINAL PRODUCT

Ibuprofen 200 mg Coated Tablets
Sainsbury's Healthcare Ibuprofen 200mg Coated Tablets
Ibuprofen Optipharma 200mg Coated Tablets

## 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 200 mg Ibuprofen.
Excipient(s) with known effect:
Also contains lactose monohydrate and sucrose as excipients.
For the full list of excipients, see section 6.1.

## 3 PHARMACEUTICAL FORM

Coated tablet (Tablet)
White shiny sugar coated capsule shaped tablets.

## 4 CLINICAL PARTICULARS

### 4.1 Therapeutic indications

**Adults, elderly and children over 12 years:**

Rheumatic or muscular pain, backache, neuralgia, migraine, headache, dental pain, dysmenorrhoea, feverishness, symptoms of colds and influenza.

### *4.2 Posology and method of administration*

For oral administration and short-term use only.

**Adults, elderly and children over 12 years:**

The lowest effective dose should be used for the shortest duration necessary to relieve symptoms (see section 4.4).

The patient should consult a doctor if the symptoms persist or worsen, or the product is required for more than 10 days.

**Adolescents (age range: ≥ 12 years to < 18 years):** If this medicinal product is required for more than 3 days, or if symptoms persist or worsen, consult your doctor.

Take one or two tablets with water to start with, repeat up to three times a day as required.

Leave at least 4 hours between doses and do not take more than six tablets in any 24-hour period.

Not suitable for children under 12 years.

## 4.3 Contraindications

Hypersensitivity to Ibuprofen or any of the excipients in the product.

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.

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.
Severe heart failure (NYHA Class IV), renal failure or hepatic failure (see section 4.4)
Third trimester of pregnancy (see section 4.6 Fertility, pregnancy and lactation).
Children under 12 years.

## 4.4 Special warnings and precautions for use

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

The elderly have an increased frequency of adverse reactions to NSAIDs especially gastrointestinal bleeding and perforation which may be fatal.

*Respiratory:*
Bronchospasm may be precipitated in patients suffering from or with a previous history of bronchial asthma or allergic disease.

*Other NSAIDs:*
The use of Ibuprofen 200mg Coated Tablets with concomitant NSAIDs including cyclooxygenase-2 selective inhibitors should be avoided (see section 4.5).

*SLE and mixed connective tissue disease:*
Systemic lupus erythematosus and mixed connective tissue disease – increased risk

of aseptic meningitis (see section 4.8)

*Renal:*
Renal impairment as renal function may further deteriorate (see sections 4.3 and 4.8). There is a risk of renal impairment in dehydrated children and adolescents.

Renal tubular acidosis and hypokalaemia may occur following acute overdose and in patients taking ibuprofen products over long periods at high doses (typically greater than 4 weeks), including doses exceeding the recommended daily dose.

*Hepatic:*
Hepatic dysfunction (see sections 4.3 and 4.8)

*Cardiovascular and cerebrovascular effects:*
Caution (discussion with doctor or pharmacist) is required prior to starting treatment in patients with a history of hypertension and/or heart failure as fluid retention, hypertension and oedema have been reported in association with NSAID therapy.

Clinical studies suggest that use of ibuprofen, particularly at a high dose (2400 mg daily) may be associated with a small increased risk of arterial thrombotic events (for example myocardial infarction or stroke). Overall, epidemiological studies do not suggest that low dose ibuprofen (e.g. ≤ 1200 mg daily) is associated with an increased risk of arterial thrombotic events.
Patients with uncontrolled hypertension, congestive heart failure (NYHA II-III), established ischaemic heart disease, peripheral arterial disease, and/or cerebrovascular disease should only be treated with ibuprofen after careful consideration and high doses (2400 mg/day) should be avoided.

Careful consideration should also be exercised before initiating long-term treatment of patients with risk factors for cardiovascular events (e.g. hypertension, hyperlipidaemia, diabetes mellitus and smoking), particularly if high doses of ibuprofen (2400 mg/day) are required.

Cases of Kounis syndrome have been reported in patients treated with ibuprofen. Kounis syndrome has been defined as cardiovascular symptoms secondary to an allergic or hypersensitive reaction-associated with constriction of coronary arteries and potentially leading to myocardial infarction.

*Impaired female fertility:*
There is limited evidence that drugs which inhibit cyclo-oxygenase/ prostaglandin synthesis may cause impairment of female fertility by an effect on ovulation. This is reversible upon withdrawal of treatment.

*Gastrointestinal:*
NSAIDs should be given with care to patients with a history of gastrointestinal disease (ulcerative colitis, Crohn's disease) as these conditions may be exacerbated (see section 4.8).

GI bleeding, ulceration or perforation, which can be fatal, has been reported with all NSAIDs at anytime during treatment, with or without warning symptoms or a previous history of serious GI events.

The risk of GI bleeding, ulceration or perforation is higher with increasing NSAID doses, in patients with a history of ulcer, particularly if complicated with haemorrhage or perforation (see section 4.3), and in the elderly. These patients should commence treatment on the lowest dose available.

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

Caution should be advised in patients receiving concomitant medications which could increase the risk of ulceration or bleeding, such as oral corticosteroids, anticoagulants such as warfarin, selective serotonin-reuptake inhibitors or anti-platelet agents such as aspirin (see section 4.5).

When GI bleeding or ulceration occurs in patients receiving ibuprofen, the treatment should be withdrawn.

*Dermatological:*
Severe cutaneous adverse reactions (SCARs)
Severe cutaneous adverse reactions (SCARs), including exfoliative dermatitis, erythema multiforme, stevens- johnson syndrome, toxic epidermal necrolysis (TEN), Drug reactions with eosinophilia and systemic symptoms (DRESS syndrome), and acute generalised exanthematous pustulosis (AGEP), which can be life-threatening or fatal, have been reported in association with the use of ibuprofen (see section 4.8). Most of these reactions occurred within the first month.

If signs and symptoms suggestive of these reactions appear ibuprofen should be withdrawn immediately and an alternative treatment considered (as appropriate).

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. Ibuprofen 200mg Coated Tablets should be discontinued at the first appearance of skin rash, mucosal lesions, or any other sign of hypersensitivity.

Exceptionally, varicella can be at the origin of serious cutaneous and soft tissue infectious complications. To date, the contributing role of NSAIDs in the worsening of these infections cannot be ruled out. Thus, it is advisable to avoid use of Ibuprofen in case of varicella (see section 4.8).

*Masking of symptoms of underlying infections*
Ibuprofen 200 mg coated tablets can mask symptoms of infection, which may lead to delayed initiation of appropriate treatment and thereby worsening the outcome of the infection. This has been observed in bacterial community acquired pneumonia and bacterial complications to varicella. When Ibuprofen 200 mg coated tablets is administered for fever or pain relief in relation to infection, monitoring of infection is advised. In non-hospital settings, the patient should consult a doctor if symptoms persist or worsen.

*Intolerance to some sugars:*
Patients with rare hereditary problems of galactose intolerance, fructose intolerance, total lactase deficiency, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine.

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

**Ibuprofen should be avoided in combination with**:

- *Acetylsalicylic acid:* Unless low-dose acetylsalicylic acid (not above 75 mg daily) has been advised by a doctor, Concomitant administration of ibuprofen and acetylsalicylic acid is not generally recommended because of the potential of increased adverse effects (see section 4.4).
  Experimental data suggest that ibuprofen may competitively inhibit the effect of low dose acetylsalicylic acid on platelet aggregation when they are dosed concomitantly. Although there are uncertainties regarding extrapolation of these data to the clinical situation, the possibility that regular, long-term use of ibuprofen may reduce the cardioprotective effect of low-dose acetylsalicylic acid cannot be excluded. No clinically relevant effect is considered to be likely for occasional ibuprofen use (see section 5.1).

- *Other NSAIDS including cyclo-oxygenase-2 selective inhibitors:* Avoid concomitant use of two or more NSAIDs as this may increase the risk of adverse effects (see section 4.4).

**Ibuprofen should be used with caution in combination with:**

- *Anticoagulants:* NSAIDS may enhance the effects of anti-coagulants, such as warfarin (see section 4.4).

- *Antihypertensives and diuretics:* NSAIDs may diminish the effect of these drugs. In some patients with compromised renal function (e.g. dehydrated patients or elderly patients with compromised renal function) the co-administration of an ACE inhibitor or Angiotensin II antagonist and agents that inhibit cyclo-oxygenase may result in further deterioration of renal function, including possible acute renal failure, which is usually reversible. These interactions should be considered in patients taking a coxib concomitantly with ACE inhibitors or angiotensin II antagonists. Therefore, the combination should be administered with caution, especially in the elderly. Patients should be adequately hydrated and consideration should be given to monitoring of renal function after initiation of concomitant therapy, and periodically thereafter. Diuretics can increase the risk of nephrotoxicity of NSAIDs.

- *Corticosteroids:* Increased risk of gastrointestinal ulceration or bleeding (see section 4.4).

- *Anti-platelet agents and selective serotonin reuptake inhibitors (SSRIs):* increased risk of gastrointestinal bleeding (see section 4.4).

- *Cardiac glycosides:* NSAIDs may exacerbate cardiac failure, reduce GFR and increase plasma glycoside levels.

- *Lithium:* There is evidence for potential increases in plasma levels of lithium.

- *Methotrexate:* There is a potential for an increase in plasma methotrexate.

- *Ciclosporin:* Increased risk of nephrotoxicity.

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

- *Tacrolimus:* Possible increased risk of nephrotoxicity when NSAIDs are given with tacrolimus.

- *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.

- *Quinolone antibiotics:* Animal data indicate that NSAIDs can increase the risk of convulsions associated with quinolone antibiotics. Patients taking NSAIDs and quinolones may have an increased risk of developing convulsions.

## 4.6 Fertility, pregnancy and lactation

Pregnancy

Inhibition of prostaglandin synthesis may adversely affect the pregnancy and/or the embryo/foetal development. Data from epidemiological studies suggest an increased risk of miscarriage and of 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 been shown to result in increased pre- and post-implantation loss and embryo-foetal lethality. In addition, increased incidences of various malformations, including cardiovascular, have been reported in animals given a prostaglandin synthesis inhibitor during the organogenetic period.
From the 20$^{th}$ week of pregnancy onward, ibuprofen use may cause oligohydramnios resulting from foetal renal dysfunction. This may occur shortly after treatment initiation and is usually reversible upon discontinuation.
In addition, there have been reports of ductus arteriosus constriction following treatment in the second trimester, most of which resolved after treatment cessation.
Therefore, during the first and second trimester of pregnancy, ibuprofen should not be given unless clearly necessary.
If ibuprofen 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 and ductus arteriosus constriction should be considered after exposure to ibuprofen for several days from gestational week 20 onward. Ibuprofen should be discontinued if oligohydramnios or ductus arteriosus constriction are found.

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

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

the mother and the neonate, at the end of 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, ibuprofen is contraindicated during the third trimester of pregnancy (see section 4.3)

Breast-feeding

In limited studies, ibuprofen appears in breast milk in very low concentrations and is unlikely to affect the breast fed infant adversely.

Fertility

See section 4.4 regarding female fertility.

## 4.7 Effects on ability to drive and use machines

None expected at recommended doses and duration of therapy.

## 4.8 Undesirable effects

The following list of adverse effects relates to those experienced with ibuprofen at OTC doses (maximum 1200 mg ibuprofen per day), in short-term use. In the treatment of chronic conditions, under long-term treatment, additional adverse events may occur.

The adverse events which have been associated with Ibuprofen are given below, listed by system organ class and frequency. The frequencies are defined using the following convention: very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1,000 to ≤1/100); rare (≥1/10,000 to ≤1/1,000); very rare (≤1/10,000), not known (cannot be estimated from the available data).
Within each frequency grouping, adverse events are presented in order of decreasing seriousness.

The adverse events observed most often are gastrointestinal in nature. The adverse events are mostly dose-dependent, in particular the risk of occurrence of gastrointestinal bleeding is dependent on the dosage range and duration of treatment.

Clinical studies suggest that the use of ibuprofen, particularly at a high dose (2400 mg/day) may be associated with a small increased risk of arterial thrombotic events (for example myocardial infarction or stroke) (see section 4.4).

| System Organ Class | Frequency | Adverse Event |
|---|---|---|

| System Organ Class | Frequency | Adverse Event |
|---|---|---|
| Blood and Lymphatic System Disorders | Very rare | Haematopoietic disorders (anaemia, leucopenia, thrombocytopenia, pancytopenia, agranulocytosis). First signs are: fever, sore throat, superficial mouth ulcers, flu-like symptoms, severe exhaustion, unexplained bleeding and bruising. |
| Immune System Disorders | Uncommon | Hypersensitivity reactions consisting of[1]: Urticaria and pruritus |
| | Very rare | Severe hypersensitivity reactions. Symptoms could be facial, tongue and laryngeal swelling, dyspnoea, tachycardia, hypotension (anaphylaxis, angioedema or severe shock). |
| | Not known | Respiratory tract reactivity comprising asthma, aggravated asthma, bronchospasm or dyspnoea. |
| Nervous System Disorders | Uncommon | Headache |
| | Very rare | Aseptic meningitis[2] |
| Cardiac Disorders | Not known | Cardiac failure and oedema. Kounis syndrome. |
| Vascular Disorders | Not known | Hypertension |
| Gastrointestinal Disorders | Uncommon | Abdominal pain, nausea, dyspepsia |
| | Rare | Diarrhoea, flatulence, constipation and vomiting |

| System Organ Class | Frequency | Adverse Event |
|---|---|---|
| | Very rare | Peptic ulcer, perforation or gastrointestinal haemorrhage, melaena, haematemesis, sometimes fatal, particularly in the elderly. Ulcerative stomatitis, gastritis |
| | Not known | Exacerbation of colitis and Crohn's disease (section 4.4). |
| Hepatobiliary Disorders | Very rare | Liver disorders |
| Skin and Subcutaneous Tissue Disorders | Uncommon | Various skin rashes |
| | Very rare | Severe cutaneous adverse reactions (SCARs) (including erythema multiforme, exfoliative dermatitis, Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN)). |
| | Not Known | Drug reaction with eosinophilia and systemic symptoms (DRESS syndrome)<br>Acute generalised exanthematous pustulosis (AGEP)<br>Photosensitivity reactions |
| Renal and Urinary Disorders | Very rare | Acute renal failure, papillary necrosis, especially in long-term use, associated with increased serum urea and oedema. |
| | Not Known | Renal insufficiency,<br>Renal tubular acidosis[3],<br>Ureteric colic,<br>Dysuria,<br>Acute interstitial nephritis (AIN). |
| Investigations | Very rare | Decreased haemoglobin levels |
| Metabolism and nutrition disorders | Not Known | Hypokalaemia[3]<br>Decreased appetite |
| Infections and infestations | Very rare | Exacerbation of infection-related inflammations (e.g. development of necrotizing |

| System Organ Class | Frequency | Adverse Event |
|---|---|---|
| | | fasciitis) coinciding with the use of non-steroidal anti-inflammatory drugs has been described[4]. |

Description of Selected Adverse Reactions

[1] Hypersensitivity reactions have been reported following treatment with ibuprofen. These may consist of (a) non-specific allergic reactions and anaphylaxis,
(b) respiratory tract activity comprising asthma, aggravated asthma, bronchospasm, dyspnoea or (c) assorted skin disorders, including rashes of various types pruritus,
urticaria, purpura, angioedema and more rarely exfoliative and bullous dermatoses (including epidermal necrolysis and erythema multiforme).

[2]The pathogenic mechanism of drug-Induced aseptic meningitis is not fully understood. However, the available data on NSAID-related aseptic meningitis points to a hypersensitivity reaction (due to a temporal relationship with drug intake, and disappearance of symptoms after drug discontinuation). Of note, single cases of symptoms of aseptic meningitis (such as stiff neck, headache, nausea, vomiting, fever or disorientation) have been observed during treatment with ibuprofen, in patients with existing auto-immune disorders (such as systemic lupus erythematosus, mixed connective tissue disease).

[3]Reported in the post-marketing setting typically following prolonged use of the ibuprofen component at higher than recommended doses.

[4]This is possibly associated with the mechanism of action of the non-steroidal anti-inflammatory drugs. If signs of an infection occur or get worse during use of Ibuprofen the patient is therefore recommended to go to a doctor without delay. It is to be investigated whether there is an indication for anti- infective/antibiotic therapy.

**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 or search for MHRA Yellow Card in the Google Play or Apple App store. By reporting side effects you can help provide more information on the safety of this medicine.

## 4.9 Overdose

In children ingestion of more than 400mg/kg may cause symptoms. In adults the dose response effect is less clear cut. The half-life in overdose is 1.5 – 3 hours.

*Symptoms*
Most patients who have ingested clinically important amounts of NSAIDs will develop no more than nausea, vomiting, epigastric pain, or more rarely, diarrhoea. Tinnitus, headache and gastrointestinal bleeding are also possible. In more serious poisoning, toxicity is seen in the central nervous system, manifesting as drowsiness, occasionally excitation and disorientation or coma. Occasionally patients develop convulsions.
In serious poisoning metabolic acidosis may occur and the prothrombin time/INR may be prolonged, probably due to interference with the actions of circulating clotting factors.
Acute renal failure and liver damage may occur.
Exacerbation of asthma is possible in asthmatics.
Prolonged use at higher than recommended doses may result in severe hypokalaemia and renal tubular acidosis. Symptoms may include reduced level of consciousness and generalised weakness (see section 4.4 and section 4.8).

*Management.*
Management should be symptomatic and supportive and include the maintenance of a clear airway and monitoring of cardiac and vital signs until stable. Consider oral administration of activated charcoal if the patient presents within one hour of ingestion of a potentially toxic amount. If frequent or prolonged, convulsions should be treated with intravenous diazepam or lorazepam. Give bronchodilators for asthma.

## 5.1 Pharmacodynamic properties

ATC Code: M01A E01 Propionic acid derivative.

Ibuprofen is a propionic acid derivative NSAID that has demonstrated its efficacy by inhibition of prostaglandin synthesis. In humans, ibuprofen reduces inflammatory pain, swellings and fever. Furthermore, ibuprofen reversibly inhibits platelet aggregation.

Experimental data suggest that ibuprofen may competitively inhibit the effect of low dose acetylsalicylic acid on platelet aggregation when they are dosed concomitantly. Some pharmacodynamic studies show that when single dose of

ibuprofen 400 mg was taken within 8 h before or within 30 min after immediate release acetylsalicylic acid dosing (81mg), a decreased effect of acetylsalicylic acid on the formation of thromboxane or platelet aggregation occurred. Although there are uncertainties regarding extrapolation of these data to the clinical situation, the possibility that regular, long-term use of ibuprofen may reduce the cardio protective effect of low dose acetylsalicylic acid cannot be excluded. No clinically relevant effect is considered to be likely for occasional ibuprofen use (see section 4.5).

### 5.2 Pharmacokinetic properties

Ibuprofen is rapidly absorbed following administration and is rapidly distributed throughout the whole body. The excretion is rapid and complete via the kidneys.

Maximum plasma concentrations are reached 45 minutes after ingestion if taken on an empty stomach. When taken with food, peak levels are observed after 1 to 2 hours. These times may vary with different dosage forms.

The half-life of ibuprofen is about 2 hours.

In limited studies, ibuprofen appears in the breast milk in very low concentrations.

### 5.3 Preclinical safety data

There are no preclinical data of relevance to the prescriber which are additional to that already included.

## 6 PHARMACEUTICAL PARTICULARS

### 6.1 List of excipients

Lactose Monohydrate

Microcrystalline Cellulose

Sodium Starch Glycolate (Type A)

Colloidal Anhydrous Silica

Magnesium Stearate

Sucrose

Talc

Starch

Titanium Dioxide (E171)

Carnauba Wax

### 6.2 Incompatibilities

None stated

### 6.3 Shelf life

5 years

### 6.4 Special precautions for storage

Do not store above 25ºC. Store in the original package.

### 6.5 Nature and contents of container

Ibuprofen Tablets are available in blister packs of 6, 12, and 16 tablets.

Blister Pack Specification:

- PVC (white, rigid, opaque): 250 microns
- Aluminium foil (hard tempered): 20 microns
- Primer (nitrocellulose): 1.5 - 2.5 gsm
- Heat seal lacquer: 6.5 - 8.5 gsm

Not all pack sizes may be marketed.

### 6.6 Special precautions for disposal

None.

## 7 MARKETING AUTHORISATION HOLDER

Bell, Sons & Co (Druggists) Ltd,
Gifford House,
Slaidburn Crescent,
Southport,
Merseyside,
PR9 9AL,
United Kingdom.

## 8 MARKETING AUTHORISATION NUMBER(S)

PL 03105/0102

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

02/12/2024

## 10 DATE OF REVISION OF THE TEXT

01/05/2026