

PRODUCT INFORMATION

Codapane Forte

Paracetamol and codeine phosphate hemihydrate

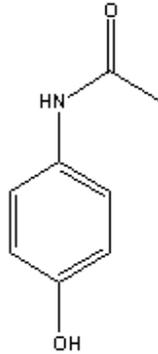


NAME OF THE MEDICINE

Active ingredient : Paracetamol

Chemical name : N-(4-Hydroxyphenyl)acetamide

Structural formula :



Molecular formula : C₈H₉NO₂

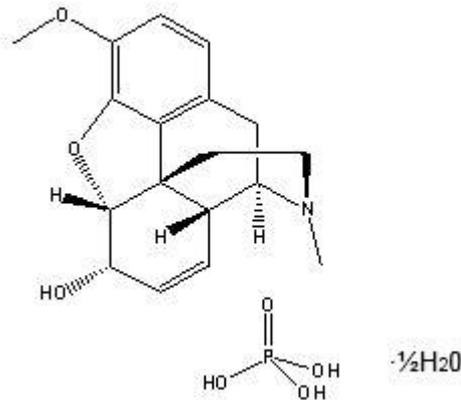
Molecular weight : 151.17

CAS Registry no. : 103-90-2

Active ingredient : Codeine phosphate hemihydrate

Chemical name : 7,8-Didehydro-4,5 α -epoxy-3-methoxy-17-methylmorphinan-6 α -ol phosphate hemihydrate

Structural formula :



Molecular formula : C₁₈H₂₄NO₇P, ½H₂O

Molecular weight : 406.37

CAS Registry no. : 41444-62-6

DESCRIPTION

Paracetamol is a white crystalline powder, sparingly soluble in water, freely soluble in alcohol, very slightly soluble in ether and in methylene chloride. Codeine phosphate hemihydrate appears as white, crystalline powder or small colourless crystals, freely soluble in water, slightly soluble in alcohol, practically insoluble in ether.

Codapane Forte tablets contain 500 mg of paracetamol (present as “Compap L”) and 30 mg of codeine phosphate hemihydrate as the active ingredients. Codapane Forte tablets also contain the following inactive ingredients: crospovidone, colloidal anhydrous silica, sodium lauryl sulfate, stearic acid and magnesium stearate.

PHARMACOLOGY

Analgesic and antipyretic: There is evidence to suggest that a combination of paracetamol with codeine is superior in analgesic action to either drug administered alone.

Pharmacokinetics

Paracetamol

Absorption

After oral administration, paracetamol is absorbed rapidly and completely from the small intestine; peak plasma levels occur 15 to 75 minutes after administration. These results are not significantly different to those of Panadeine® Forte. Food intake delays paracetamol absorption.

Distribution

Paracetamol is uniformly distributed throughout most body fluids; the apparent volume of distribution is 1 to 1.2 L/kg.

Paracetamol can cross the placenta and is excreted in milk. Plasma protein binding is negligible at usual therapeutic concentrations but increases with increasing concentrations.

Metabolism

Paracetamol is metabolised by the hepatic microsomal enzyme system. In adults, at therapeutic doses paracetamol is mainly conjugated with glucuronide (45 - 55%) or sulfate (20 - 30%). A minor proportion (less than 20%) is metabolised to catechol derivatives, and mercapturic acid compounds via oxidation. Paracetamol is metabolised differently by infants and children compared to adults, the sulfate conjugate being predominant.

Excretion

Paracetamol is excreted in the urine mainly as the glucuronide and sulphate conjugates. Less than 5% is excreted as unchanged paracetamol with 85 - 90% of the administered dose eliminated in the urine within 24 hours of ingestion. The elimination half-life varies from 1 to 4 hours.

Codeine

Codeine has about one-sixth of the analgesic activity of morphine. It is well absorbed from the gastrointestinal tract and does not interfere with paracetamol absorption.

It is metabolised in the liver to morphine and norcodeine. Patients who metabolise drugs poorly via CYP2D6 are likely to obtain reduced benefit from codeine due to reduced formation of the active metabolite.

Codeine and its metabolites are excreted in the urine, partly as conjugates with glucuronic acid. Excretion is almost complete within 24 hours.

INDICATIONS

Relief of moderate to severe pain, and fever.

CONTRAINDICATIONS

Codapane Forte must not be used in patients with known hypersensitivity to paracetamol, codeine or any of the excipients used in this product.

Codapane Forte must not be used in patients with known glucose-6-phosphate-dehydrogenase deficiency or pre-existing respiratory depression, for example acute asthma, acute exacerbations of chronic obstructive pulmonary disease (COPD) since codeine may exacerbate the condition.

Paracetamol should not be used in patients with a history of intolerance to the drug.

Paracetamol should not be used in patients with severe hepatocellular insufficiency.

Due to codeine's structural similarity to morphine and oxycodone, patients experiencing systemic allergy (generalised rash, shortness of breath) to these drugs should not receive codeine.

Codeine is contraindicated in patients with diarrhoea caused by poisoning, until the toxic substance has been eliminated from the gastrointestinal tract, or diarrhoea associated with pseudomembranous colitis caused by antibiotic administration since codeine may slow the elimination of the toxic material or antibiotic.

Paracetamol should not be used in patients with active alcoholism as chronic excessive alcohol ingestion predisposes patients to paracetamol hepatotoxicity.

Codeine is contraindicated in the events of impending childbirth or in case of risk of premature birth (see **PRECAUTIONS** – Use in Pregnancy).

Codapane Forte is contraindicated during breast-feeding (see **PRECAUTIONS** – Use in Lactation).

Codapane Forte is contraindicated for use in patients who are:

- younger than 12 years (see **PRECAUTIONS** – Paediatric Use).
- aged between 12 – 18 years in whom respiratory function might be compromised, including post tonsillectomy and / or adenoidectomy for obstructive sleep apnoea, due to an increased risk of developing serious and life-threatening adverse reactions (see **PRECAUTIONS** – Paediatric Use)

Codapane Forte is contraindicated for use in patients who are CYP2D6 ultra-rapid metabolisers (see **PRECAUTIONS** – CYP2D6 metabolism).

PRECAUTIONS

Codapane Forte should be administered with caution to patients with renal or hepatic dysfunction, viral hepatitis, and to patients taking other drugs which affect the liver. Hepatotoxicity may occur with paracetamol even at therapeutic doses, after short treatment duration and in patients without pre-existing liver dysfunction. In view of the increased risk of hepatotoxicity, the benefit should be weighed against the risk when administering Codapane Forte to patients with viral hepatitis or pre-existing hepatic disease. In such patients, hepatic function determinations may be required at periodic intervals during high dose or long-term therapy.

To avoid the risk of overdose, check that paracetamol is absent from the composition of other medicinal products taken concomitantly.

Caution is advised in patients with underlying sensitivity to aspirin and/or to non-steroidal anti-inflammatory drugs (NSAIDs).*

Severe cutaneous adverse reactions (SCARs): Life-threatening cutaneous reactions Stevens-Johnson syndrome (SJS), and Toxic epidermal necrolysis (TEN) have been reported with the use of paracetamol. Patients should be advised of the signs and symptoms and monitored closely for skin reactions. If symptoms or signs of SJS and TEN (e.g. progressive skin rash often with blisters or mucosal lesions) occur, patients should stop paracetamol treatment immediately and seek medical advice.

Paracetamol should be used with caution in patients with:

- recent cessation of alcohol intake
- low glutathione reserves
- Gilbert's syndrome

Codeine should be used with caution in patients with CNS depression or decreased respiratory reserve e.g. in emphysema, kyphoscoliosis, hypoxia, hypercapnia or even severe obesity or cor pulmonale, or chronic obstructive pulmonary disease (COPD). Codeine should be administered with caution in patients with impaired cardiac, hepatic or renal function, and in cases of benign prostatic hyperplasia, urethral stenosis, chronic colitis ulcerative, gall bladder conditions, multiple sclerosis, hypothyroidism, adrenocortical insufficiency (e.g. Addison's disease), shock, myxoedema, acute alcohol intoxication or delirium tremens since codeine may exacerbate the symptoms or increase the risk of respiratory and/or CNS depression.

Codeine should be administered with great caution in patients with head injury, brain tumour or increased intracranial pressure since codeine may increase the risk of respiratory depression and further elevate intracranial pressure. In addition codeine can produce side effects such as confusion, miosis and vomiting which are important signs in following the clinical course of patients with head injuries.

Extensive use of analgesics to relieve headaches or migraines, especially at high doses, may induce headaches that must not be treated with increased doses of the drug. In such cases the analgesic should not continue to be taken without medical advice.

Codeine should be used with caution in patients with a history of drug abuse. Prolonged use of high doses of codeine may produce dependence and/or addiction. Tolerance may also result following repeated administration.

Codeine has a primary potential for dependence. Tolerance, psychological and physical dependence develop with prolonged use of high doses with withdrawal symptoms after sudden discontinuation of the drug. Cross-tolerance with other opioids exists. Rapid relapses can be expected in patients with pre-existing opiate dependence (including those in remission).

Administration must be discontinued gradually after prolonged treatments.

Monitoring after prolonged use should include blood count, liver function and renal function.

Codeine should only be used with careful risk-benefit assessment and great caution in the case of:

- Opioid dependence
- Chronic constipation
- Conditions with elevated intracranial pressure and head trauma. Codeine can increase the pressure of cerebrospinal fluid and may increase the respiratory depressant effect. Like other narcotics, it causes adverse reactions that can obscure the clinical course of patients with head injury.
- Impaired consciousness
- Compromised respiratory function (due to emphysema, kyphoscoliosis, severe obesity) and chronic obstructive airway disease

Codapane Forte may cause drowsiness, disturbances of visuomotor coordination and visual acuity and/or dizziness. Due to the preparation's sedative action, impairment of the mental and/or physical abilities required for the performance of potentially hazardous activities may occur. Hence children engaging in bike riding and other hazardous activities should be supervised to avoid potential harm.

Patients treated with this medication should not drive, operate machinery, or drink alcohol whilst taking this medication.

Patients with known analgesic intolerance or known bronchial asthma must only use Codapane Forte after having consulted a physician (hypersensitivity reactions including bronchospasm possible).

Codeine should be administered with caution in patients with acute abdominal conditions since codeine may obscure the diagnosis or the course of the disease. Codeine should be administered with caution in patients with severe inflammatory bowel disease (risk of toxic megacolon may be increased, especially with repeated dosing). Codapane Forte should also be used with caution in patients who have had recent gastrointestinal tract surgery.

Patients who have had a cholecystectomy should be treated with caution. The contraction of the sphincter of Oddi can cause symptoms resembling those of myocardial infarction or intensify the symptoms in patients with pancreatitis.

Codeine should be administered with caution in patients with a history of convulsive disorders (convulsions may be induced or exacerbated by codeine).

Codeine should be administered with caution in patients with prostatic hypertrophy, urethral stricture or recent urinary tract surgery since codeine may cause urinary retention.

Codeine should be used with caution in elderly or debilitated patients because of the danger of respiratory or cardiac depression.

Codeine should be administered with caution in patients taking Monoamine Oxidase Inhibitors (MAOI's) (see **INTERACTIONS WITH OTHER MEDICINES**).

Risks from Concomitant Use of Opioids and Benzodiazepines

Concomitant use of opioids, including codeine, with benzodiazepines may result in sedation, respiratory depression, coma and death. Because of these risks, reserve concomitant prescribing of opioids and benzodiazepines for use in patients for whom alternative treatment options are inadequate.

If a decision is made to prescribe codeine concomitantly with benzodiazepines, prescribe the lowest effective dosages and minimum durations of concomitant use, and follow patients closely for signs and symptoms of sedation and respiratory depression (see **INTERACTIONS WITH OTHER MEDICINES**).

Patients should be advised to first consult their healthcare professional before taking codeine if they are taking a benzodiazepine (see **INTERACTIONS WITH OTHER MEDICINES**).

Risks from Concomitant Use of Opioids and Alcohol

Concomitant use of opioids, including codeine, with alcohol may result in sedation, respiratory depression, coma and death. Concomitant use with alcohol is not recommended (see **INTERACTIONS WITH OTHER MEDICINES**).

CYP2D6 metabolism

Codapane Forte is contraindicated for use in patients who are CYP2D6 ultra-rapid metabolisers.

Codeine is metabolised by the liver enzyme CYP2D6 into morphine, its active metabolite. If a patient has a deficiency or is completely lacking this enzyme an adequate analgesic effect will not be obtained. However, if the patient is an extensive or ultra-rapid metaboliser there is an increased risk of developing side effects of opioid toxicity even at commonly prescribed doses. These patients convert codeine into morphine rapidly resulting in

higher than expected serum morphine levels. General symptoms of opioid toxicity include confusion, somnolence, shallow breathing, small pupils, nausea, vomiting, constipation and lack of appetite. In severe cases this may include symptoms of circulatory and respiratory depression, which may be life-threatening and very rarely fatal. Children are particularly susceptible due to their immature airway anatomy. Deaths have been reported in children with rapid metabolism who were given codeine for analgesia post adenotonsillectomy. Morphine can also be ingested by infants through breast milk, causing risk of respiratory depression to infants of rapid metaboliser mothers who take codeine.

The prevalence of codeine ultra-rapid metabolism by CYP2D6 in children is not known, but is assumed to be similar to that reported in adults. The prevalence of ultra-rapid metabolisers is estimated to be 1 % in those of Chinese, Japanese and Hispanic descent, 3 % in African Americans and 1 %- 10 % in Caucasians. The highest prevalence (16 %-28 %) occurs in North African, Ethiopian and Arab populations. (See also the sections on Paediatric Use and Use in Lactation.)

Use in Pregnancy (Category A)

Paracetamol crosses the placenta; however, problems in humans have not been documented.

Opioid analgesics cross the placenta. Regular use during pregnancy may cause physical dependence in the foetus, leading to withdrawal symptoms in the neonate. Administration of codeine during labour may cause respiratory depression in the newborn infant. Codeine may cause respiratory depression and withdrawal syndrome in neonates born to mothers who use codeine during the third trimester of pregnancy. As a precautionary measure, use of Codapane Forte should be avoided during the third trimester of pregnancy and during labour. Codeine is contraindicated in the event of impending childbirth or in case of risk of premature birth (see **CONTRAINDICATIONS**). Codapane Forte should only be used during pregnancy under medical supervision if the potential benefit justifies the potential risk to the foetus. If administered during pregnancy, morphinomimetic properties of codeine should be taken into account.

Australian Pregnancy Categorisation Definition of Category A: Drugs which have been taken by a large number of pregnant women and women of childbearing age without any proven increase in the frequency of malformations or other direct or indirect harmful effects on the fetus having been observed.

Use in Lactation

Codapane Forte is contraindicated during breast-feeding (see **PRECAUTIONS** – CYP2D6 metabolism) due to risk of respiratory depression in the infant.

Analgesic doses excreted in breast milk are generally low. However, infants of breast feeding mothers taking codeine may have an increased risk of morphine overdose if the mother is an ultra-rapid metaboliser of codeine. Codeine is excreted into human breast milk. Codeine is partially metabolised by cytochrome P450 2D6 (CYP2D6) into morphine, which is excreted into breast milk. If nursing mothers are CYP2D6 ultra-rapid metabolisers, higher levels of morphine may be present in their breast milk. This may result in symptoms of opioid toxicity in both mother and the breast-fed infant. Life-threatening adverse events or neonatal death may occur even at therapeutic doses (see **PRECAUTIONS** – CYP2D6 metabolism).

Therefore, Codapane Forte is contraindicated for use during breastfeeding. However, in circumstances where a breastfeeding mother requires codeine therapy, breastfeeding should be suspended and alternative arrangements should be made for feeding the infant for any period during codeine treatment.

Breast feeding mothers should be told how to recognise signs of high morphine levels in themselves and their babies. For example, in a mother symptoms include extreme sleepiness and trouble caring for the baby. In the baby, symptoms include signs of increased sleepiness (more than usual), difficulty breastfeeding, breathing difficulties, or limpness. Medical advice should be sought immediately.

Paediatric Use

Codapane Forte is contraindicated for use in children:

- younger than 12 years.

- aged between 12-18 years in whom respiratory function might be compromised, including post tonsillectomy and / or adenoidectomy for obstructive sleep apnoea. Respiratory depression and death have occurred in some children who received codeine following tonsillectomy and / or adenoidectomy and had evidence of being ultra-rapid metabolisers of codeine due to a CYP2D6 polymorphism. (See also **PRECAUTIONS** – CYP2D6 metabolism.)

Use in the Elderly

Elderly people may be more sensitive to the effects of this medicinal product. The elderly are more likely to have hypertrophy, prostatic obstruction and age-related renal impairment and may be more susceptible to the undesirable effects due to opioid-induced urinary retention and the respiratory effects of opioid analgesics. Dose reduction may be required.

Carcinogenicity

Clinical toxicity studies in animals have shown that high doses of paracetamol cause testicular atrophy and inhibition of spermatogenesis; the relevance of this finding to use in humans is not known.

Effects on Laboratory Tests

Plasma amylase and lipase activity:

Codeine may cause increased biliary tract pressure, thus increasing plasma amylase and/or lipase concentrations.

Gastric emptying studies:

Gastric emptying is delayed by codeine so gastric emptying studies will not be valid.

Uric acid and blood glucose:

Intake of paracetamol may affect the laboratory determination of uric acid by phosphotungstic acid and of blood glucose by glucose oxidase-peroxidase.

INTERACTIONS WITH OTHER MEDICINES

Salicylates and NSAIDs:

Prolonged concurrent use of paracetamol and salicylates or non-steroidal anti-inflammatory drugs may increase the risk of adverse renal effects.

Coumarins:

Paracetamol may increase the risk of bleeding in patients taking warfarin and other coumarin derivatives (antivitamin K). Monitoring of coagulation and bleeding complications is required.

Chloramphenicol:

Paracetamol may slow down the excretion of chloramphenicol, entailing the risk of increased toxicity.

Diflunisal:

Diflunisal may increase the plasma concentrations of paracetamol by 50%.

Anticholinergics:

Concomitant use of codeine and anticholinergic agents may increase the risk of severe constipation and/or urinary retention. Drugs, which decrease gastric emptying, may decrease the absorption of paracetamol.

Cholestyramine:

Cholestyramine reduces the absorption of paracetamol if given within one hour of paracetamol administration.

Chelating resin:

Chelating resin can decrease the intestinal absorption of paracetamol and potentially decrease its efficacy if taken simultaneously.

Propantheline:

Decreases gastric emptying which may decrease the absorption of paracetamol.

Rifampicin:

Concomitant use may increase the likelihood of paracetamol toxicity (see Hepatotoxic drugs and liver microsomal enzymes inducers below).

Flucloxacillin:

Co-administration of flucloxacillin with paracetamol may lead to metabolic acidosis, particularly in patients presenting risk factors of glutathione depletion, such as sepsis, malnutrition or chronic alcoholism.

Alcohol:

Codeine may potentiate the effects of alcohol and increase the likelihood of paracetamol toxicity (see Hepatotoxic drugs and liver microsomal enzymes inducers below). The concomitant use of alcohol and opioids increases the risk of sedation, respiratory depression, coma and death because of additive CNS depressant effect. Concomitant use with alcohol is not recommended (see **PRECAUTIONS**).

Metoclopramide:

Codeine may antagonise the effects of metoclopramide on gastrointestinal motility. Paracetamol absorption is increased by drugs, which increase gastric emptying.

Domperidone:

The absorption rate of paracetamol may be increased by domperidone.

Opioid analgesics:

Concurrent use of codeine and other opioid agonists is usually inappropriate as additive CNS depression, respiratory depressant and hypotensive effects may occur. Narcotic analgesics may decrease gastric emptying and therefore decrease the absorption of paracetamol.

Morphinic agonists-antagonists:

Concomitant use of codeine with a partial agonist (e.g. buprenorphine) or antagonist (e.g. naltrexone) can precipitate or delay codeine effects.

Tranquillisers, sedatives, hypnotics, general anaesthetics and CNS depressants:

Codeine may potentiate the effects of these drugs. Concomitant use of tranquillisers or sedatives may enhance the potential respiratory depressant effects of codeine.

Benzodiazepines

The concomitant use of alcohol and opioids increases the risk of sedation, respiratory depression, coma and death because of additive CNS depressant effect. Limit dosage and duration of concomitant use of benzodiazepines and opioids (see **PRECAUTIONS**).

Hepatotoxic drugs and liver microsomal enzyme inducers:

The risk of paracetamol toxicity may be increased in patients receiving other potentially hepatotoxic drugs or drugs that induce liver microsomal enzymes, such as anti-epileptics (such as phenobarbital, phenytoin, carbamazepine, topiramate), alcohol, barbiturates and rifampicin. The induced metabolism results in an elevated production of the hepatotoxic oxidative metabolite of paracetamol. Hepatotoxicity will occur if this metabolite exceeds the normal glutathione binding capacity.

Zidovudine:

When used concurrently with zidovudine, an increased tendency for neutropenia or hepatotoxicity may develop. Combination of Codapane Forte and zidovudine particularly chronic or multiple-dose paracetamol, should be avoided. If chronic paracetamol and zidovudine are to be given concurrently, monitor white blood count and liver function tests, especially in malnourished patients.

Antiperistaltic antidiarrhoeals (including kaolin, pectin, loperamide):

Concurrent use of these agents with codeine may increase the risk of severe constipation and CNS depression.

Monoamine Oxidase Inhibitors:

Non-selective MAOI's intensify the effects of opioid drugs which can cause anxiety, confusion, significant respiratory depression and other side effects of unpredictable severity. Severe and sometimes fatal reactions have occurred in patients concurrently administered MAO inhibitors and pethidine. Codeine should not be given to patients taking non-selective MAOI's or within 2 weeks of stopping such treatment. As it is unknown whether there is an interaction between the selective MAOI's (Reversible Inhibitors of Monoamine Oxidase A) and codeine, caution is advised with this drug combination.

Tricyclic antidepressants:

A codeine-induced respiratory depression can be potentiated by tricyclic antidepressants.

Antihypertensives:

Hypotensive effects of antihypertensive agents may be potentiated when used concurrently with codeine and lead to orthostatic hypotension.

Neuromuscular blocking agents:

Codeine may enhance the effects of neuromuscular blocking agents resulting in increased respiratory depression. Patients receiving other narcotic analgesics, antitussives, antihypertensives, antihistamines, antipsychotics, antianxiety agents or other CNS depressants (including alcohol) concomitantly with Codapane Forte may experience additive CNS depression.

ADVERSE EFFECTS

Reports of adverse reactions are rare. Although the following reactions have been reported when paracetamol and codeine have been administered:

Haematologic

Less frequent to rare	Agranulocytosis
	Anaemia
	Thrombocytopenia

Genitourinary

Less frequent to rare	Renal failure
	Uraemia
	Urinary retention or hesitance

Hypersensitive

Less frequent to rare	Skin rashes and other allergic reactions
	Histamine release (hypotension, flushing of the face, tachycardia, breathlessness)

Gastrointestinal

Common	Constipation
	Nausea
	Vomiting

Neurological

Common	Drowsiness
	Dizziness
Less frequent to rare	Euphoria, dysphoria
	At higher doses codeine may cause respiratory depression

Hepatic

Very rare	Pancreatitis
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Paracetamol has also been associated with dyspepsia, sweating, erythema, urticaria, anaphylactic shock, angioneurotic oedema, leukopenia, neutropenia and pancytopenia. Bronchospasms may be triggered in patients having a tendency of analgesic asthma. Toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome (SJS), acute generalised exanthematous pustulosis, fixed drug eruption and cytolytic hepatitis, which may lead to acute hepatic failure, have also been reported. Haemolytic anaemia in patients with underlying glucose 6-phosphate-dehydrogenase deficiency has been reported. Kounis syndrome and bronchospasm have also been reported.

Codeine can cause confusional state, dysphoria, seizure, headache, somnolence, sedation, miosis, tinnitus, dry mouth, pruritus, fatigue. Visuomotor coordination and visual acuity may be adversely affected in a dose-dependent manner at higher doses or in particular sensitive patients. Long term use also entails the risk of drug dependence.

DOSAGE AND ADMINISTRATION

Tablets are to be taken with a glass of water.

Adults

Mild to moderate pain: The initial dose is 1 tablet, repeated every 4 to 6 hours if necessary.

Severe pain: The initial dose is 2 tablets, repeated every 4 to 6 hours if necessary (maximum of 8 tablets in 24 hours).

Codapane Forte is contraindicated for use in patients who are:

- younger than 12 years.
- Aged between 12 – 18 years in whom respiratory function might be compromised, including post tonsillectomy and / or adenoidectomy for obstructive sleep apnoea. (See also **CONTRAINDICATIONS** and **PRECAUTIONS** – Paediatric Use.)

OVERDOSAGE

Elderly persons, small children, patients with liver disorders, chronic alcohol consumption or chronic malnutrition, as well as patients concomitantly treated with enzyme-inducing drugs are at an increased risk of intoxication, including fatal outcome.

Symptoms

Toxic symptoms include vomiting, abdominal pain, hypotension, sweating, central stimulation with exhilaration and convulsions in children, drowsiness, respiratory depression, cyanosis and coma. Nausea, vomiting, anorexia, pallor and abdominal pain generally appear during the first 24 hours of overdose with paracetamol. Overdose with paracetamol may cause hepatic cytolysis which can lead to hepatocellular insufficiency, gastrointestinal bleeding, metabolic acidosis, encephalopathy, coma and death. Increased levels of hepatic transaminases, lactate dehydrogenase and bilirubin with a reduction in prothrombin level can appear 12 to 48 hours after acute overdose. It can also lead to pancreatitis, acute renal failure and pancytopenia. The most serious adverse effect of acute overdose of paracetamol is a dose-dependent, potentially fatal hepatic necrosis. In adults, hepatotoxicity may occur after ingestion of a single dose of 10 to 15 g (30 tablets) of paracetamol; a dose of 25 g (50 tablets) or more is potentially fatal. Symptoms during the first two days of acute poisoning by paracetamol do not reflect the potential seriousness of the intoxication. Major manifestations of liver failure such as jaundice, hypoglycaemia and metabolic acidosis may take at least three days to develop.

In an evaluation of codeine intoxication in children, symptoms seen included: sedation, rash, miosis, vomiting, itching, ataxia and swelling of the skin. Respiratory failure may occur.

The ingestion of very high doses of codeine can cause initial excitation, anxiety, insomnia followed by drowsiness in certain cases, areflexia progressing to stupor or coma, headache, miosis, alterations in blood pressure, arrhythmias, dry mouth, hypersensitivity reactions, cold clammy skin, bradycardia, tachycardia, convulsions, gastrointestinal disorders, nausea, vomiting and respiratory depression.

Severe intoxication can lead to apnoea, circulatory collapse, cardiac arrest and death.

Treatment

Despite lack of significant early symptoms, patients should be referred to hospital urgently for immediate medical attention.

Consists primarily of management of paracetamol toxicity; naloxone is the treatment of choice for codeine intoxication. In cases of overdose, methods of reducing the absorption of ingested drug are important. Prompt administration of 50 g activated charcoal and 500 mL iced mannitol 20% by mouth may reduce absorption.

Determinations of the plasma concentration of paracetamol are recommended.

If the history suggests that 15 g paracetamol or more has been ingested, administer one of the following antidotes:

Acetylcysteine 20% I.V.

Administer 20% acetylcysteine (Parvolex, David Bull) immediately without waiting for positive urine test or plasma level results: initial dose 150 mg/kg over 15 minutes, followed by continuous infusion of 50mg/kg in 500mL 5% glucose over 4 hours and 100 mg/kg in 1L 5% glucose over 16 hours; or

Oral Methionine

2.5 g immediately followed by three further doses of 2.5 g at four hourly intervals. For a 3-year-old child, 1 g methionine 4-hourly for four doses has been used.

If more than ten hours have elapsed since the overdose was taken, the antidote may be ineffective.

In general, treatment for codeine overdose should be symptomatic: re-establish adequate respiratory exchange by ensuring a clear airway and using mechanical ventilation. When treatment for paracetamol toxicity has been initiated; naloxone 400 microgram may be administered SC, IM or IV; IV may be repeated at intervals of 2 to 3 minutes if necessary. Assisted respiration may be required.

Further measures will depend on the severity, nature and course of clinical symptoms of intoxication and should follow standard intensive care protocols.

Contact the Poisons Information Centre on 13 11 26 (Australia) for advice on management of overdose.

PRESENTATION AND STORAGE CONDITIONS

Codapane Forte : White, oblong, convex tablets debossed with “PC/F” (“PC” over breakline over “F”) on one side and “α” on the other.

Supplied in PVC/PVDC/Al blisters.

Available in pack sizes of 20 s and 50s.

Store below 25°C.

Some pack sizes may not be marketed.

NAME AND ADDRESS OF THE SPONSOR

Alphapharm Pty Limited

Level 1, 30 The Bond

30-34 Hickson Road

Millers Point NSW 2000

ABN 93 002 359 739

www.mylan.com.au

POISON SCHEDULE OF THE MEDICINE

S4 (Prescription Only Medicine)

DATE OF FIRST INCLUSION ON THE AUSTRALIAN REGISTER OF THERAPEUTIC GOODS (THE ARTG)

29/03/2005

DATE OF MOST RECENT AMENDMENT

10/08/2017

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