108.5mm LAMINATION AREA

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Batch coding details to be post printed on-line

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Exp : xxxxxxxxxx
Batch No.: xxxxxxxxxx
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2D Barcode

DO NOT STORE ABOVE 30°C.
DO NOT REFRIGERATE
KEEP CAP TIGHTLY CLOSED
KEEP OUT OF REACH AND SIGHT OF CHILDREN
JAUHKAN UBAT DARI KANAK-KANAK
M. L. No. 220/AP/MD/96/BF/R
MAL 16025031AZ
Controlled Medicine
Ubat Terkawal
Manufactured by:
Piramal Pharma Limited
Sy.Nos. 7-70, 70/1 & 70/2,
Digwal Village, Kohir Mandal,
Sangareddy District - 502 321,
Telangana State, India.
Product Registration Holder and Imported by:
Unimed Sdn. Bhd,
53, Jalan Tembaga SD 5/2B, Bandar Sri Damansara 52200, Kuala Lumpur, Malaysia.

IN/EL/0013/21/00

250 ml

PIRAMAL SEVOFLURANE

Inhalation Anaesthetic Liquid 100% v/v

Contains Sevoflurane USP

Piramal Critical Care

Non flammable. Non explosive.

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AWN: IN/EL/0013/21/00	**Filename:** EL0013-21-00_SevoPiramal_250mL_MYS_IND_EL_02_22.cdr — **Proof#:** 1
Artist/Date: Jeremy Zaskoda 28 Feb 2022	RAG Vers.: n/a
Reason for Revision: text change per dist.	**Market:** Malaysia
Font Set & min. size: Times New Roman, Arial Narrow; 5pt.	**Material #:** 20688213
Notes:	**Superceded Mat.#:** n/a
	Rev. : n/a
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	Superceded AWN: n/a
Piramal Critical Care — Created by: **Regulatory Affairs, Global Labeling & Artwork** 268 Brodhead Rd., Bethlehem, PA 18017ph: (800) 414-1901	**Extensia Label Size:** 150 x 53mm; flat: 675 x53mm; fold: 88.5 x 53mm

Colour	
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For the use of a registered medical practitioner or a hospital or a laboratory only

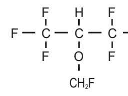
PIRAMAL SEVOFLURANE

Inhalation Anaesthetic Liquid 100% v/v

Description and Composition

Sevoflurane is a clear, colorless, volatile, non-flammable liquid.

It is 1, 1, 1, 3, 3, 3-hexafluoro-2-fluoromethoxypropane and has the following structural formula:



Some physical constants of sevoflurane are:

Relative molecular mass		200.05
Boiling point at 760mmHg		58.6°C
Refractive index n20		1.2740 - 1.2760
Specific gravity at 20°C		1.520 - 1.525
Vapour pressure	Temp°C	mmHg
	20	157
	25	197
	36	317

Partition coefficients at 37°C

Water/gas	0.36
Blood/gas	0.63-0.69
Olive Oil/gas	47.2-53.9

Mean partition coefficients at 25°C - component/gas

Conductive rubber	14.0
Butyl rubber	7.7
Polyvinylchloride	17.4
Polyethylene	1.3
Purity by gas chromatography	99.975% or better
Flammability	Not flammable

Indications

Induction and maintenance of general anaesthesia in adult and paediatric patients for inpatient and outpatient surgery.

Posology and Method of Administration

Inhalation use. Sevoflurane has to be administered either via face mask or via endotracheal tube. Sevoflurane should be administered only by persons trained in the administration of general anaesthesia. Facilities for maintenance of a patient airway, artificial ventilation, oxygen enrichment and circulatory resuscitation must be immediately available. Sevoflurane should be delivered via a vaporiser specifically calibrated for use with sevoflurane so that the concentration delivered can be accurately controlled. If the carbon dioxide absorbent may be desiccated, it must be replaced before the use of sevoflurane.

Surgical Anaesthesia:

Sevoflurane should be delivered via a vaporiser specifically calibrated for use with sevoflurane so that the concentration delivered can be accurately controlled. MAC (minimum alveolar concentration) values for sevoflurane decrease with age and with the addition of nitrous oxide. The table below indicates average MAC values for different age groups.

Table 1: MAC values for Adults and Paediatric patients according to age

Age of Patient (years)	Sevoflurane in Oxygen	Sevoflurane in 65% $N_2O/35\%\ O_2$
0 – 1 mnths*	3.3%	
1 - < 6 months	3.0%	2.0%**
6 months - < 3 years	2.8%	
3 - 12	2.5%	
25	2.6%	1.4%
40	2.1%	1.1%
60	1.7%	0.9%
80	1.4%	0.7%

* Neonates are full term gestational age. MAC in premature infants has not been determined.

** In 1 – <3 year old paediatric patients, 60% $N_2O/40\%\ O_2$ was used.

Induction:

Dosage should be individualised and titrated to the desired effect according to the patient's age and clinical status. A short acting barbiturate or other intravenous induction agent may be administered followed by inhalation of sevoflurane. Induction with sevoflurane may be achieved in oxygen or in combination with oxygen-nitrous oxide mixtures.

For induction of anaesthesia, inspired concentrations of up to 8% sevoflurane usually produces surgical anaesthesia in less than two minutes in both adults and children.

Maintenance:

Surgical levels of anaesthesia may be sustained with concentrations of 0.5 - 3% sevoflurane with or without the concomitant use of nitrous oxide.

Emergence:

Emergence times are generally short following sevoflurane anaesthesia. Therefore, patients may require early post operative pain relief.

Older People:

MAC decreases with increasing age. The average concentration of sevoflurane to achieve MAC in an 80 year old is approximately 50% of that required in a 20 year old.

Paediatric population:

Refer to Table 1 for MAC values for paediatric patients according to age.

Contra-indications:

Sevoflurane should not be used in patients with known or suspected sensitivity to sevoflurane or other halogenated anaesthetics (e.g. history of liver function disorder, fever or leucocytosis of unknown cause after anaesthesia with one of these agents).

Sevoflurane is also contraindicated in patients with known or suspected genetic susceptibility to malignant hyperthermia.

Sevoflurane is contraindicated in patients in whom general anaesthesia is contraindicated.

Warnings and Precautions:

Sevoflurane may cause respiratory depression, which may be augmented by narcotic premedication or other agents causing respiratory depression. Respiration should be supervised and if necessary, assisted.

Sevoflurane should be administered only by persons trained in the administration of general anaesthesia. Facilities for maintenance of a patient airway, artificial ventilation, oxygen enrichment and circulatory resuscitation must be immediately available.

The concentration of sevoflurane being delivered from a vaporiser must be known exactly. As volatile anaesthetics differ in their physical properties, only vaporisers specifically calibrated for sevoflurane must be used. The administration of general anaesthesia must be individualised based on the patient's response. Hypotension and respiratory depression increase as anaesthesia is deepened.

In susceptible individuals, potent inhalation anaesthetic agents may trigger a skeletal muscle hypermetabolic state leading to high oxygen demand and the clinical syndrome known as malignant hyperthermia. The clinical syndrome is signalled by hypercapnia, and may include muscle rigidity, tachycardia, tachypnoea, cyanosis, arrhythmias, and/or unstable blood pressure. Some of these nonspecific signs may also appear during light anaesthesia, acute hypoxia, hypercapnia and hypovolaemia.

In clinical trials, one case of malignant hyperthermia was reported. In addition, there have been postmarketing reports of malignant hyperthermia. Some of these reports have been fatal.

Treatment includes discontinuation of triggering agents (e.g. sevoflurane), administration of intravenous dantrolene sodium (consult prescribing information for intravenous dantrolene sodium for additional information on patient management), and application of supportive therapy. Such therapy includes vigorous efforts to restore body temperature to normal, respiratory and circulatory support as indicated, and management of electrolyte-fluid-acid-base abnormalities. Renal failure may appear later, and urine flow should be monitored and sustained if possible.

Use of inhaled anaesthetic agents has been associated with rare increases in serum potassium levels that have resulted in cardiac arrhythmias and death in paediatric patients during the postoperative period. Patients with latent as well as overt neuromuscular disease, particularly Duchenne muscular dystrophy, appear to be most vulnerable. Concomitant use of succinylcholine has been associated with most, but not all, of these cases. These patients also experienced significant elevations in serum creatine kinase levels and, in some cases, changes in urine consistent with myoglobinuria. Despite the similarity in presentation to malignant hyperthermia, none of these patients exhibited signs or symptoms of muscle rigidity or hypermetabolic state. Early and aggressive intervention to treat the hyperkalaemia and resistant arrhythmias is recommended, as is subsequent evaluation for latent neuromuscular disease.

Isolated reports of QT prolongation, very rarely associated with torsade de pointes (in exceptional cases, fatal), have been received. Caution should be exercised when administering sevoflurane to susceptible patients.

Isolated cases of ventricular arrhythmia were reported in paediatric patients with Pompe's disease.

Caution should be exercised in administering general anaesthesia, including sevoflurane, to patients with mitochondrial disorders.

Very rare cases of mild, moderate and severe post-operative hepatic dysfunction or hepatitis with or without jaundice have been reported from postmarketing experiences.

Clinical judgment should be exercised when sevoflurane is used in patients with underlying hepatic conditions or under treatment with drugs known to cause hepatic dysfunction (see Side Effects).

Patients with repeated exposures to halogenated hydrocarbons, including sevoflurane, within a relatively short interval may have an increased risk of hepatic injury.

During the maintenance of anaesthesia, increasing the concentration of sevoflurane produces dosedependent decreases in blood pressure. Excessive decrease in blood pressure may be related to depth of anaesthesia and in such instances may be corrected by decreasing the inspired concentration of sevoflurane. Particular care must be taken when selecting the dosage for patients who are hypovolemic, hypotensive, or otherwise haemodynamically compromised, e.g., due to concomitant medications.

As with all anaesthetics, maintenance of haemodynamic stability is important to avoid myocardial ischaemia in patients with coronary artery disease.

Caution should be observed when using sevoflurane during obstetric anaesthesia because the relaxant effect on the uterus could increase the risk of uterine bleeding (see Use in pregnancy and lactation).

The recovery from general anaesthesia should be assessed carefully before patients are discharged from the recovery room. Rapid emergence is generally seen so early relief of post operative pain may be required. Although recovery of consciousness following sevoflurane administration generally occurs within minutes, the impact on intellectual function for two or three days following anaesthesia has not been studied. As with other anaesthetics, small changes in moods may persist for several days following administration (see Effects on driving ability and operation of machinery). Rapid emergence in children may be associated with agitation and lack of co-operation (in about 25% of cases).

Replacement of Desiccated CO_2 Absorbents:

Rare cases of extreme heat, smoke, and/or spontaneous fire in the anaesthesia machine have been reported during sevoflurane use in conjunction with the use of desiccated CO_2 absorbent, specifically those containing potassium hydroxide (e.g Baralyme). An unusually delayed rise or unexpected decline of inspired sevoflurane concentration compared to the vaporiser setting may be associated with excessive heating of the CO_2 absorbent canister.

An exothermic reaction, enhanced sevoflurane degradation, and production of degradation products (see DESCRIPTION) can occur when the CO_2 absorbent becomes desiccated, such as after an extended period of dry gas flow through the CO_2 absorbent canisters. Sevoflurane degradants (methanol, formaldehyde, carbon monoxide, and Compounds A, B, C, and D) were observed in the respiratory circuit of an experimental anaesthesia machine using desiccated CO_2 absorbents and maximum sevoflurane concentrations (8%) for extended periods of time (≥2 hours). Concentrations of formaldehyde observed at the anaesthesia respiratory circuit (using sodium hydroxide containing absorbents) were consistent with levels known to cause mild respiratory irritation. The clinical relevance of the degradants observed under this extreme experimental model is unknown.

If a health care professional suspects that the CO_2 absorbent has become desiccated, it must be replaced before subsequent use of volatile anaesthetics (such as sevoflurane). It must be taken into account that the colour indicator does not always change after desiccation has taken place. Therefore, the lack of significant colour change should not be taken as an assurance of adequate hydration. CO_2 absorbents should be replaced routinely regardless of the state of the colour indicator.

Renal Impairment:

Because of the small number of patients with renal insufficiency (baseline serum creatinine greater than 1.5mg/dL) studied, the safety of sevoflurane administration in this group has not been fully established. Therefore, sevoflurane should be used with caution in patients with renal insufficiency.

In some studies in rats, nephrotoxicity was seen in animals exposed to levels of Compound A (pentafluoroisopropenyl fluoromethyl ether (PIFE)) in excess of those usually seen in routine clinical practice. The mechanism of this renal toxicity in rats is unknown and its relevance to man has not been established.

Neurosurgery & Neuromuscular Impairment:

In patients at risk from elevation of intra-cranial pressure, sevoflurane should be administered cautiously in conjunction with techniques to lower intra-cranial pressure (eg hyperventilation).

Seizures:

Rare cases of seizures have been reported in association with sevoflurane use.

Use of sevoflurane has been associated with seizures occurring in children and young adults as well as older adults with and without predisposing risk factors. Clinical judgment is necessary before sevoflurane is used in patients at risk of seizures. In children the depth of anaesthesia should be limited. EEG may permit the optimization of sevoflurane dose and help avoid the development of seizure activity in fragile patients (see Side Effects-Paediatric population).

Paediatric population:

The use of sevoflurane has been associated with seizures. Many have occurred in children and young adults starting from 2 months of age, most of whom had no predisposing risk factors. Clinical judgment should be exercised when using sevoflurane in patients who may be at risk for seizures (see Warnings and Precautions- Seizures).

Dystonic movements in children have been observed (see Side Effects).

Interactions:

Beta-sympathomimetic agents like isoprenaline and alpha- and beta-sympathomimetic agents like adrenaline and noradrenaline should be used with caution during Sevoflurane narcosis, due to a potential risk of ventricular arrhythmia.

Non-selective MAO-inhibitors: Risk of crisis during the operation. It is generally recommended that treatment should be stopped 2 weeks prior to surgery.

Sevoflurane may lead to marked hypotension in patients treated with calcium antagonists, in particular dihydropyridine derivates.

Caution should be exercised when calcium antagonists are used concomitantly with inhalation anesthetics due to the risk of additive negative inotropic effect.

Concomitant use of succinylcholine with inhaled anesthetic agents has been associated with rare increases in serum potassium levels that have resulted in cardiac arrhythmias and death in pediatric patients during the post-operative period.

Sevoflurane has been shown to be safe and effective when administered concurrently with a wide variety of agents commonly encountered in surgical situations such as central nervous system agents, autonomic drugs, skeletal muscle relaxants, anti-infective agents including aminoglycosides, hormones and synthetic substitutes, blood derivatives and cardiovascular drugs, including epinephrine.

Epinephrine/Adrenaline

Sevoflurane is similar to isoflurane in the sensitisation of the myocardium to the arrhythmogenic effect of exogenously administered adrenaline.

Indirect-acting sympathomimetics

There is a risk of acute hypertensive episode with the concomitant use of sevoflurane and indirectacting sympathomimetics products (amphetamines, ephedrine).

Beta blockers

Sevoflurane may increase the negative inotropic, chronotropic and dromotropic effects of beta blockers (by blocking cardiovascular compensatory mechanisms).

Verapamil

Impairment of atrioventricular conduction was observed when verapamil and sevoflurane were administered at the same time.

Inducers of CYP2E1

Medicinal products and compounds that increase the activity of cytochrome P450 isoenzyme CYP2E1, such as isoniazid and alcohol, may increase the metabolism of sevoflurane and lead to significant increases in plasma fluoride concentrations. Concomitant use of sevoflurane and isoniazid can potentiate the hepatotoxic effects of isoniazid.

St John's Wort

Severe hypotension and delayed emergence from anaesthesia with halogenated inhalational anaesthetics have been reported in patients treated long-term with St John's Wort.

Barbiturates

Sevoflurane administration is compatible with barbiturates as commonly used in surgical practice.

Benzodiazepines and Opioids

Benzodiazepines and opioids are expected to decrease the MAC of sevoflurane in the same manner as with other inhalational anaesthetics. Sevoflurane administration is compatible with benzodiazepines and opioids as commonly used in surgical practice.

Opioids such as alfentanil and sufentail, when combined with sevoflurane, may lead to a synergistic fall in heart rate, blood pressure and respiratory rate.

Nitrous Oxide

As with other halogenated volatile anaesthetics, the MAC of sevoflurane is decreased when administered in combination with nitrous oxide. The MAC equivalent is reduced approximately 50% in adult and approximately 25% in paediatric patients (see Posology and Method of Administration – Maintenance).

Neuromuscular Blocking Agents

As with other inhalational anaesthetic agents, sevoflurane affects both the intensity and duration of neuromuscular blockade by non-depolarising muscle relaxants. When used to supplement alfentanil-N_2O anaesthesia, sevoflurane potentiates neuromuscular block induced with pancuronium, vecuronium or atracurium. The dosage adjustments for these muscle relaxants when administered with sevoflurane are similar to those required with isoflurane. The effect of sevoflurane on succinylcholine and the duration of depolarising neuromuscular blockade has not been studied.

Dosage reduction of neuromuscular blocking agents during induction of anaesthesia may result in delayed onset of conditions suitable for endotracheal intubation or inadequate muscle relaxation because potentiation of neuromuscular blocking agents is observed a few minutes after the beginning of sevoflurane administration.

Among non-depolarising agents, vecuronium, pancuronium and atracurium interactions have been studied. In the absence of specific guidelines: (1) for endotracheal intubation, do not reduce the dose of non-depolarising muscle relaxants; and, (2) during maintenance of anaesthesia, the dose of nondepolarising muscle relaxants is likely to be reduced compared to that during N_2O/opioid anaesthesia.

Administration of supplemental doses of muscle relaxants should be guided by the response to nerve stimulation.

As with other agents, lesser concentrations of sevoflurane may be required following use of an intravenous anaesthetic e.g. propofol.

Significant increases in plasma fluoride concentrations have been observed following the increased activity of CYP 2E1.

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Use in fertility, pregnancy and lactation:

Pregnancy

Sevoflurane has a relaxant effect on the uterus, which can lead to increased uterine bleeding, as was reported in a study of its use during termination of pregnancy. Use during labour and delivery is limited to one small study in caesarean section.

Reproduction studies in rats and rabbits at doses up to 1 MAC have revealed no evidence of harm to the fetus due to sevoflurane. There are no adequate and well-controlled studies in pregnant women; therefore, sevoflurane should be used during pregnancy only if clearly needed.

Labour and Delivery

In a clinical trial, the safety of sevoflurane was demonstrated for mothers and infants when used for anaesthesia during caesarean section. The safety of sevoflurane in labour and vaginal delivery has not been demonstrated.

Breastfeeding

It is not known whether sevoflurane or its metabolites are excreted in human milk. Due to the absence of documented experience, women should be advised to skip breast-feeding for 48 hours after administration of sevoflurane and discard milk produced during this period.

Fertility

Reproduction studies in rats and rabbits at doses up to 1 MAC have revealed no evidence of impaired fertility due to sevoflurane.

Effects on driving ability and operation of machinery:

As with other anaesthetic agents, patients should be advised that performance of activities requiring mental alertness, such as operating a motor vehicle or hazardous machinery, may be impaired for some time after general anaesthesia (see Warnings and Precautions).

Patients should not be allowed to drive for a suitable period after sevoflurane anaesthesia.

Side Effects:

Summary of the safety profile

As with all potent inhaled anaesthetics, sevoflurane may cause dose-dependent cardio-respiratory depression. Most adverse reactions are mild to moderate in severity and transient. Nausea, vomiting and delirium are commonly observed in the post-operative period, at a similar incidence to those found with other inhalation anaesthetics. These effects are common sequelae of surgery and general anaesthesia which may be due to the inhalational anaesthetic, other agents administered intra-operatively or post-operatively and to the patient's response to the surgical procedure.

The most commonly reported adverse reactions were as follows:

In adult patients: hypotension, nausea and vomiting;

In elderly patients: bradycardia, hypotension and nausea; andIn paediatric patients: agitation, cough, vomiting and nausea.

Tabulated summary of adverse reactions

All adverse reactions, at least possibly related to sevofl urane from clinical trials and post-marketing experience, are presented in the following table by MedDRA System Organ Class, Preferred Term and frequency. The following frequency categories are used: Very common (>1/10); common (>1/100, <1/10); uncommon (>1/1,000, <1/100); rare (>1/10,000, <1/1,000); very rare (<1/10,000) including isolated reports. Post-marketing adverse reactions are reported voluntarily from a population with an unknown rate of exposure. Therefore it is not possible to estimate the true incidence of adverse events and the frequency is "unknown". The type, severity and frequency of adverse reactions in sevofl urane patients in clinical trials were comparable to adverse reactions in reference drug patients.

Adverse Reaction Data Derived From Clinical Trials and Post-marketing Experience

Summary of Most Frequent Adverse Drug Reactions in Sevoflurane Clinical Trials and Post-marketing Experience

System Organ Class	Frequency	Adverse Reactions
Immune system disorders	Unknown	Anaphylactic reaction[1] Anaphylactoid reaction Hypersensitivity[1]
Blood and lymphatic system disorders	Uncommon	Leukopenia Leukocytosis
Psychiatric disorders	Very Common	Agitation
	Uncommon	Confusional state
Nervous system disorders	Common	Somnolence Dizziness Headache
	Unknown	Convulsion 2, 3 Dystonia
Cardiac disorders	Very Common	Bradycardia
	Common	Tachycardia
	Uncommon	Atrioventricular block Atrioventricular block complete Atrial fibrillation Arrythmia Ventricular extrasystoles Supraventricular extrasystoles Extrasystoles
	Unknown	Cardiac arrest[4] QT prolongation associated with Torsade
Vascular disorders	Very Common	Hypotension
	Common	Hypertension
Respiratory, thoracic and mediastinal disorders	Very Common	Cough
	Common	Respiratory disorder Laryngospasm
	Uncommon	Apnoea Hypoxia Asthma
	Unknown	Bronchospasm Dyspnoea[1] Wheezing[1] Pulmonary oedema
Gastrointestinal disorders	Very Common	Nausea Vomiting
	Common	Salivary hypersecretion
Renal and urinary disorders	Uncommon	Urinary retention Glycosuria
	Unknown	Renal failure acute
Hepato-biliary disorders	Unknown	Hepatitis 1, 2 Hepatic failure 1, 2 Hepatic necrosis 1, 2
Skin and subcutaneous tissue disorders	Unknown	Dermatitis contact[1] Pruritus Rash[1] Swelling face[1] Urticaria
Musculoskeleta and connective tissue disorders	Unknown	Muscle twitchingl
General disorders and administration site conditions	Common	Chills Pyrexia Hypothermia
	Unknown	Chest discomfort[1] Hyperthermia malignant 1, 2
Investigations	Common	Blood glucose abnormal Liver function test abnormal[5] White blood cell count abnormal Aspartate aminotransferase increased Blood fluoride increased[6]
	Uncommon	Alanine aminotransferase increased Blood creatinine increased Blood lactate dehydrogenase increased
Injury, poisoning and procedural complications	Common	Hypothermia

[1] See section Side Effects – Description of selected adverse reactions.

[2] See section Warnings and Precautions.

[3] See section Side Effects – Paediatric population.

[4] There have been very rare postmarketing reports of cardiac arrest in the setting of sevoflurane use.

[5] Occasional cases of transient changes in hepatic function tests were reported with sevoflurane and reference agents.

[6] Transient increases in serum inorganic fluoride levels may occur during and after sevoflurane anaesthesia. See Description of selected adverse reactions below.

Description of selected adverse reactions

Transient increases in serum inorganic fluoride levels may occur during and after sevoflurane anaesthesia. Concentrations of inorganic fluoride generally peak within two hours of the end of sevoflurane anaesthesia and return within 48 hours to pre-operative levels. In clinical trials, elevated fluoride concentrations were not associated with impairment of renal function.

Rare reports of post-operative hepatitis exist. In addition, there have been rare post-marketing reports of hepatic failure and hepatic necrosis associated with the use of potent volatile anaesthetic agents, including sevoflurane. However, the actual incidence and relationship of sevoflurane to these events cannot be established with certainty (see Warnings and Precautions).

Rare reports of hypersensitivity (including contact dermatitis, rash, dyspnoea, wheezing, chest discomfort, swelling face, or anaphylactic reaction) have been received, particularly in association with long-term occupational exposure to inhaled anaesthetic agents, including sevoflurane.

In susceptible individuals, potent inhalation anaesthetic agents may trigger a skeletal muscle hypermetabolic state leading to high oxygen demand and the clinical syndrome known as malignant hyperthermia (see **Warnings and Precautions**).

Paediatric population

The use of sevoflurane has been associated with seizures. Many of these have occurred in children and young adults starting from 2 months of age, most of whom had no predisposing risk factors. Clinical judgment should be exercised when using sevoflurane in patients who may be at risk for seizures (see **Warnings and Precautions**).

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 direct via:

Overdosage: In the event of overdosage, the following action should be taken: Stop drug administration, establish a clear airway and initiate assisted or controlled ventilation with pure oxygen and maintain adequate cardiovascular function.

Clinical pharmacology

Pharmacodynamics

The low solubility of sevoflurane in blood should result in alveolar concentrations which rapidly increase upon induction and rapidly decrease upon cessation of the inhaled agent.

Pharmacokinetics

Absorption & Distribution:

In humans <5% of the absorbed sevoflurane is metabolised. The rapid and extensive pulmonary elimination of sevoflurane minimises the amount of anaesthetic available for metabolism.

Metabolism:

Sevoflurane is defluorinated via cytochrome p450 (CYP)2E1 resulting in the production of hexafluoroisopropanol (HFIP) with release of inorganic fluoride and carbon dioxide (or a one carbon fragment).

Elimination:

HFIP is then rapidly conjugated with glucuronic acid and excreted in the urine.

Futher information:

The metabolism of sevoflurane may be increased by known inducers of CYP2E1 (e.g. isoniazid and alcohol), but it is not inducible by barbiturates.

Transient increases in serum inorganic fluoride levels may occur during and after sevoflurane anaesthesia.

Generally, concentrations of inorganic fluoride peak within 2 hours of the end of sevoflurane anaesthesia and return within 48 hours to pre-operative levels.

Pharmaceutical precautions:

Sevoflurane is stable when stored under normal room lighting conditions. No discernible degradation of sevoflurane occurs in the presence of strong acids or heat. Sevoflurane is not corrosive to stainless steel, brass, aluminium, nickel-plated brass, chrome-plated brass or copper beryllium alloy.

Chemical degradation can occur upon exposure of inhaled anaesthetics to CO_2 absorbent within the anaesthesia machine. When used as directed with fresh absorbents, degradation of sevoflurane is minimal and degradants are undetectable or non-toxic. Sevoflurane degradation and subsequent degradant formation are enhanced by increasing absorbent temperature, desiccated CO_2 absorbent (especially potassium hydroxide-containing, e.g. BaralymeR), increased sevoflurane concentration and decreased fresh gas flow. Sevoflurane can undergo alkaline degradation by two pathways. The first results from the loss of hydrogen fluoride with the formation of pentafluoroisopropanyl fluoromethyl ether (PIFE or more commonly known as Compound A). The second pathway for degradation of sevoflurane occurs only in the presence of desiccated CO_2 absorbents and leads to the dissociation of sevoflurane into hexafluoroisopropanol (HFIP) and formaldehyde. HFIP is inactive, non-genotoxic, rapidly glucoronidated, cleared and has toxicity comparable to sevoflurane. Formaldehyde is present during normal metabolic processes. Upon exposure to a highly desiccated absorbent, formaldehyde can further degrade into methanol and formate. Formate can contribute to the formation of carbon monoxide in the presence of high temperature. Methanol can react with compound A to form the methoxy addition product Compound B. Compound B can undergo further HF elimination to form Compounds C, D and E. With highly desiccated absorbents, especially those containing potassium hydroxide (e.g BaralymeR) the formation of formaldehyde, methanol, carbon monoxide, Compound A and perhaps some of its degradants, Compounds B, C and D may occur.

How supplied :

Bottles of 250ml.

Storage Conditions :

Store below 30°C. Keep cap tightly closed.

DO NOT STORE ABOVE 30°C.
DO NOT REFRIGERATE
KEEP CAP TIGHTLY CLOSED
KEEP OUT OF REACH AND SIGHT OF CHILDREN
JAUHKAN UBAT DARI KANAK-KANAK
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Sy.Nos. 7-70, 70/1 & 70/2,
Digwal Village, Kohir Mandal,
Sangareddy District - 502 321,
Telangana State, India.
Product Registration Holder and Imported by:
Unimed Sdn. Bhd,
53, Jalan Tembaga SD 5/2B, Bandar Sri Damansara 52200, Kuala Lumpur, Malaysia.

IN/EL/0013/21/00

250 ml

PIRAMAL SEVOFLURANE

Inhalation Anaesthetic Liquid 100% v/v

Contains Sevoflurane USP

Piramal Critical Care

Non flammable.
Non explosive.

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