

1.3.1	Esomeprazole
SPC, Labeling and Package Leaflet	MY

Emanera 20 mg gastro-resistant capsules, hard

Emanera 40 mg gastro-resistant capsules, hard

COMPOSITION

Each gastro-resistant capsule, hard, contains 20 mg esomeprazole (as esomeprazole magnesium dihydrate).

Each gastro-resistant capsule, hard, contains 40 mg esomeprazole (as esomeprazole magnesium dihydrate).

Excipient with known effect:

	20 mg gastro-resistant capsule, hard	40 mg gastro-resistant capsule, hard
sucrose	28.46–32.56 mg	56.93–65.11 mg

PRODUCT DESCRIPTION

20 mg: the body and the cap are slightly pink; the capsules are filled with white to almost white pellets. Capsule size no. 3.

40 mg: the body and the cap are off-pink; the capsules are filled with white to almost white pellets. Capsule size no. 1.

THERAPEUTIC INDICATIONS

Emanera capsules are indicated for:

Gastroesophageal Reflux Disease (GERD)

- treatment of erosive reflux esophagitis
- long-term management of patients with healed esophagitis to prevent relapse
- symptomatic treatment of gastroesophageal reflux disease (GERD)

In combination with appropriate antibacterial therapeutic regimens for the eradication of *Helicobacter pylori* and

- healing of *Helicobacter pylori* associated duodenal ulcer and
- prevention of relapse of peptic ulcers in patients with *Helicobacter pylori* associated ulcers

Patients requiring continued NSAID therapy

- Healing of gastric ulcers associated with NSAID therapy.
- Prevention of gastric and duodenal ulcers associated with NSAID therapy, in patients at risk.

Prolonged treatment after IV induced prevention of rebleeding of peptic ulcers.

Treatment of Zollinger Ellison Syndrome

POSODOLOGY AND METHOD OF ADMINISTRATION

The capsules should be swallowed whole with some water. The capsules should not be chewed or crushed.

For patients who have difficulty in swallowing, the capsules can also be opened and the pellets mixed in half a glass of non-carbonated water. No other liquids should be used as the enteric coating may be

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dissolved. Drink the water with the pellets immediately or within 30 minutes. Rinse the glass with half a glass of water and drink. The pellets must not be chewed or crushed.

For patients who cannot swallow, the capsules can be opened and pellets mixed in non-carbonated water and administered through a gastric tube. It is important that the appropriateness of the selected syringe and tube is carefully tested before use.

Administration through gastric tube (≥ 16 French size)

1. Open the capsule and empty the pellets into an appropriate syringe and fill the syringe with approximately 25 ml water and approximately 5 ml air. A syringe with a catheter tip that fits a gastric tube should be used (syringe size 50 ml or larger). For some tubes, dispersion in 50 ml water is needed to prevent the pellets from clogging the tube.
2. Immediately shake the syringe to evenly distribute the granules throughout the suspension.
3. Hold the syringe with the tip up and check that the tip has not clogged.
4. Attach the syringe to the tube whilst maintaining the above position.
5. Shake the syringe and position it with the tip pointing down. Immediately inject 5 – 10 ml into the tube. Invert the syringe after injection and shake (the syringe must be held with the tip pointing up to avoid clogging of the tip).
6. Turn the syringe with the tip down and immediately inject another 5 – 10 ml into the tube. Repeat this procedure until the syringe is empty.
7. Fill the syringe with 25 ml of water and 5 ml of air and repeat step 5 if necessary to wash down any sediment left in the syringe. For some tubes, 50 ml water is needed.

The pellets become slightly sticky in the suspension and therefore it is very important that the administration procedure is done as fast as possible. Vigorous shaking and the use of a big enough gastric tube prevent the pellets from clogging the tip of the syringe and the tube.

Adults and adolescents from the age of 12 years:

Gastroesophageal Reflux Disease (GERD)

- *treatment of erosive reflux esophagitis*
40 mg once daily for 4 weeks.
An additional 4 weeks treatment is recommended for patients in whom esophagitis has not healed or who have persistent symptoms.
- *long-term management of patients with healed esophagitis to prevent relapse*
20 mg once daily.
- *symptomatic treatment of gastroesophageal reflux disease (GERD)*
20 mg once daily in patients without esophagitis. If symptom control has not been achieved after 4 weeks, the patient should be further investigated. Once symptoms have resolved, subsequent symptom control can be achieved using 20 mg once daily. In adults, an on demand regimen taking 20 mg once daily, when needed, can be used. In NSAID treated patients at risk of developing gastric and duodenal ulcers, subsequent symptom control using an on demand regimen is not recommended.

Adults:

In combination with appropriate antibacterial therapeutic regimens for the eradication of *Helicobacter pylori* and

- *healing of Helicobacter pylori associated duodenal ulcer and*
- *prevention of relapse of peptic ulcers in patients with Helicobacter pylori associated ulcers.*
20 mg Emanera with 1 g amoxicillin and 500 mg clarithromycin, all twice daily for 7 days.

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Patients requiring continued NSAID therapy

- *Healing of gastric ulcers associated with NSAID therapy*
The usual dose is 20 mg once daily. The treatment duration is 4-8 weeks.
- *Prevention of gastric and duodenal ulcers associated with NSAID therapy in patients at risk*
20 mg once daily.

Prolonged treatment after IV induced prevention of rebleeding of peptic ulcers

40 mg once daily for 4 weeks after IV induced prevention of rebleeding of peptic ulcers.

Treatment of Zollinger Ellison Syndrome

The recommended initial dosage is Emanera 40 mg twice daily. The dosage should then be individually adjusted and treatment continued as long as clinically indicated. Based on the clinical data available, the majority of patients can be controlled on doses between 80 to 160 mg esomeprazole daily. With doses above 80 mg daily, the dose should be divided and given twice daily.

Children below the age of 12 years

Emanera should not be used in children younger than 12 years since no data is available.

Impaired renal function

Dose adjustment is not required in patients with impaired renal function. Due to limited experience in patients with severe renal insufficiency, such patients should be treated with caution

Impaired hepatic function

Dose adjustment is not required in patients with mild to moderate liver impairment. For patients with severe liver impairment, a maximum dose of 20 mg Emanera should not be exceeded

Elderly

Dose adjustment is not required in the elderly.

Do not eat the desiccant capsule provided in the container.

CONTRAINDICATIONS

Known hypersensitivity to esomeprazole, substituted benzimidazoles or any of the excipients.

Esomeprazole like other PPIs should not be administered with nelfinavir

SPECIAL WARNINGS AND PRECAUTIONS FOR USE

In the presence of any alarm symptom (e.g. significant unintentional weight loss, recurrent vomiting, dysphagia, haematemesis or melaena) and when gastric ulcer is suspected or present, malignancy should be excluded, as treatment with Emanera may alleviate symptoms and delay diagnosis.

Regular Surveillance

Patients on proton pump inhibitor treatment (particularly those treated for long term) should be kept under regular surveillance.

Subacute Cutaneous Lupus Erythematosus (SCLE)

Proton pump inhibitors are associated with very infrequent cases of subacute cutaneous lupus erythematosus (SCLE). If lesions occur, especially in sun-exposed areas of the skin, and if accompanied by arthralgia, the patient should seek medical help promptly and the health care professional should consider stopping Emanera. SCLE after previous treatment with a proton pump

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inhibitor may increase the risk of SCLF with other proton pump inhibitors.

Hypomagnesaemia

Severe hypomagnesaemia has been reported in patients treated with PPI like Emanera for at least three months, and in most cases for a year. Serious manifestations of hypomagnesaemia such as fatigue, tetany, delirium, convulsions, dizziness and ventricular arrhythmia can occur but they may begin insidiously and be overlooked. In most affected patients, hypomagnesaemia improved after magnesium replacement and discontinuation of the PPI.

For patients expected to be on prolonged treatment or who take PPI with digoxin or drugs that may cause hypomagnesaemia (e.g., diuretics), health care professionals should consider measuring magnesium levels before starting PPI treatment and periodically during treatment.

Fracture

Proton pump inhibitors, especially if used in high doses and over long durations (>1 year), may modestly increase the risk of hip, wrist and spine fracture, predominantly in the elderly or in presence of other recognised risk factors. Observational studies suggest that proton pump inhibitors may increase the overall risk of fracture by 10–40%. Some of this increase may be due to other risk factors. Patients at risk of osteoporosis should receive care according to current clinical guidelines and they should have an adequate intake of vitamin D and calcium.

Clostridium Difficile Diarrhea

Published observational studies suggest that PPI therapy may be associated with an increased risk of Clostridium difficile associated diarrhea, especially in hospitalized patients. This diagnosis should be considered for diarrhea that does not improve. Patients should use the lowest dose and shortest duration of PPI therapy appropriate to the condition being treated.

Treatment with proton pump inhibitors may lead to slightly increased risk of gastrointestinal infections such as *Salmonella* and *Campylobacter*.

Vitamin B12 Deficiency

Daily treatment with any acid-suppressing medications over a long period of time (e.g., longer than 3 years) may lead to malabsorption of cyanocobalamin (vitamin B12) caused by hypo- or achlorhydria. Rare reports of cyanocobalamin deficiency occurring with acid-suppressing therapy have been reported in the literature. This diagnosis should be considered if clinical symptoms consistent with cyanocobalamin deficiency are observed.

Interference with laboratory tests

Increased Chromogranin A (CgA) level may interfere with investigations for neuroendocrine tumours. If the patient(s) are due to have a test on Chromogranin A level, [product name] treatment should be stopped for at least 5 days before CgA measurements to avoid this interference. If CgA and gastrin levels have not returned to reference range after initial measurement, measurements should be repeated 14 days after cessation of proton pump inhibitor treatment.

Patients on on-demand treatment should be instructed to contact their physician if their symptoms change in character. When prescribing esomeprazole for on demand therapy, the implications for interactions with other pharmaceuticals, due to fluctuating plasma concentrations of esomeprazole should be considered

When prescribing esomeprazole for eradication of *Helicobacter pylori* possible active substance interactions for all components in the triple therapy should be considered. Clarithromycin is a potent inhibitor of CYP3A4 and hence contraindications and interactions for clarithromycin should be

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considered when the triple therapy is used in patients concurrently taking other medicinal products metabolised via CYP3A4 such as cisapride.

Co-administration of esomeprazole with atazanavir is not recommended. If the combination of atazanavir with a proton pump inhibitor is judged unavoidable, close clinical monitoring is recommended in combination with an increase in the dose of atazanavir to 400 mg with 100 mg of ritonavir; esomeprazole 20 mg should not be exceeded.

Esomeprazole is a CYP2C19 inhibitor. When starting or ending treatment with esomeprazole, the potential for interactions with drugs metabolised through CYP2C19 should be considered. An interaction is observed between clopidogrel and omeprazole. The clinical relevance of this interaction is uncertain. As a precaution, concomitant use of esomeprazole and clopidogrel should be discouraged.

Special information about some of the ingredients

Emanera contains sucrose. Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine.

INTERACTION WITH OTHER MEDICINAL PRODUCTS AND OTHER FORMS OF INTERACTION

Effects of esomeprazole on the pharmacokinetics of other drugs

Medicinal products with pH dependent absorption

The decreased intragastric acidity during treatment with esomeprazole, might increase or decrease the absorption of drugs if the mechanism of absorption is influenced by gastric acidity. In common with the use of other inhibitors of acid secretion or antacids, the absorption of ketoconazole and itraconazole can decrease and the absorption of digoxin can increase during treatment with esomeprazole. Concomitant treatment with omeprazole (20 mg daily) and digoxin in healthy subjects increased the bioavailability of digoxin by 10% (up to 30% in two out of ten subjects). Digoxin toxicity has been rarely reported. However, caution should be exercised when esomeprazole is given at high doses in elderly patients. Therapeutic drug monitoring of digoxin should then be reinforced.

Omeprazole has been reported to interact with some protease inhibitors.

The clinical importance and the mechanisms behind these reported interactions are not always known. Increased gastric pH during omeprazole treatment may change the absorption of the protease inhibitors. Other possible interaction mechanisms are via inhibition of CYP 2C19. For atazanavir and nelfinavir, decreased serum levels have been reported when given together with omeprazole and concomitant administration is not recommended. Co-administration of omeprazole (40 mg once daily) with atazanavir 300 mg/ritonavir 100 mg to healthy volunteers resulted in a substantial reduction in atazanavir exposure (approximately 75% decrease in AUC, C_{max} and C_{min}). Increasing the atazanavir dose to 400 mg did not compensate for the impact of omeprazole on atazanavir exposure. The coadministration of omeprazole (20 mg qd) with atazanavir 400 mg/ritonavir 100 mg to healthy volunteers resulted in a decrease of approximately 30% in the atazanavir exposure as compared with the exposure observed with atazanavir 300 mg/ritonavir 100 mg qd without omeprazole 20 mg qd. Coadministration of omeprazole (40 mg qd) reduced mean nelfinavir AUC, C_{max} and C_{min} by 36–39% and mean AUC, C_{max} and C_{min} for the pharmacologically active metabolite M8 was reduced by 75-92%. For saquinavir (with concomitant ritonavir), increased serum levels (80-100%) have been reported during concomitant omeprazole treatment (40 mg qd). Treatment with omeprazole 20 mg qd had no effect on the exposure of darunavir (with concomitant ritonavir) and amprenavir (with concomitant ritonavir). Treatment with esomeprazole 20 mg qd had no effect on the exposure of amprenavir (with and without concomitant ritonavir). Treatment with omeprazole 40 mg qd had no effect on the exposure of lopinavir (with concomitant ritonavir). Due to the similar pharmacodynamic effects and pharmacokinetic properties of omeprazole and esomeprazole, concomitant administration

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with esomeprazole and atazanavir is not recommended and concomitant administration with esomeprazole and nelfinavir is contraindicated.

Drugs metabolised by CYP2C19

Esomeprazole inhibits CYP2C19, the major esomeprazole metabolising enzyme. Thus, when esomeprazole is combined with drugs metabolised by CYP2C19, such as diazepam, citalopram, imipramine, clomipramine, phenytoin etc., the plasma concentrations of these drugs may be increased and a dose reduction could be needed. This should be considered especially when prescribing esomeprazole for on demand therapy. Concomitant administration of 30 mg esomeprazole resulted in a 45% decrease in clearance of the CYP2C19 substrate diazepam. Concomitant administration of 40 mg esomeprazole resulted in a 13% increase in trough plasma levels of phenytoin in epileptic patients. It is recommended to monitor the plasma concentrations of phenytoin when treatment with esomeprazole is introduced or withdrawn. Omeprazole (40 mg once daily) increased voriconazole (a CYP2C19 substrate) C_{max} and AUC_{τ} by 15% and 41%, respectively.

Concomitant administration of 40 mg esomeprazole to warfarin-treated patients in a clinical trial showed that coagulation times were within the accepted range. However, post-marketing, a few isolated cases of elevated INR of clinical significance have been reported during concomitant treatment. Monitoring is recommended when initiating and ending concomitant esomeprazole treatment during treatment with warfarin or other coumarine derivatives.

In healthy volunteers, concomitant administration of 40 mg esomeprazole resulted in a 32% increase in area under the plasma concentration-time curve (AUC) and a 31% prolongation of elimination half-life ($t_{1/2}$) but no significant increase in peak plasma levels of cisapride. The slightly prolonged QTc interval observed after administration of cisapride alone, was not further prolonged when cisapride was given in combination with esomeprazole

Esomeprazole has been shown to have no clinically relevant effects on the pharmacokinetics of amoxicillin, quinidine.

No in vivo interaction studies have been performed with the high dose iv regimen (80mg+8mg/h). The effect of esomeprazole on drugs metabolised by CYP2C19 may be more pronounced during this regimen, and patients should be monitored closely for adverse effects, during the 3-day i.v. treatment.

Studies evaluating concomitant administration of esomeprazole and either naproxen or rofecoxib did not identify any clinically relevant pharmacokinetic interactions during short-term studies.

In a crossover clinical study, clopidogrel (300 mg loading dose followed by 75 mg/day) alone and with omeprazole (80 mg at the same time as clopidogrel) were administered for 5 days. The exposure to the active metabolite of clopidogrel was decreased by 46% (Day 1) and 42% (Day 5) when clopidogrel and omeprazole were administered together. Mean inhibition of platelet aggregation (IPA) was diminished by 47% (24 hours) and 30% (Day 5) when clopidogrel and omeprazole were administered together. In another study it was shown that administering clopidogrel and omeprazole at different times did not prevent their interaction that is likely to be driven by the inhibitory effect of omeprazole on CYP2C19. Inconsistent data on the clinical implications of this PK/PD interaction in terms of major cardiovascular events have been reported from observational and clinical studies.

Effects of other drugs on the pharmacokinetics of esomeprazole

Esomeprazole is metabolised by CYP2C19 and CYP3A4. Concomitant administration of esomeprazole and a CYP3A4 inhibitor, clarithromycin (500 mg b.i.d.), resulted in a doubling of the exposure (AUC) to esomeprazole. Concomitant administration of esomeprazole and a combined inhibitor of CYP2C19 and CYP 3A4 may result in more than doubling of the esomeprazole exposure.

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The CYP2C19 and CYP3A4 inhibitor voriconazole increased omeprazole AUC_τ by 280%. A dose adjustment of esomeprazole is not regularly required in either of these situations. However, dose adjustment should be considered in patients with severe hepatic impairment and if long-term treatment is indicated.

Drugs known to induce CYP2C19 or CYP3A4 or both (such as rifampicin and St. John's wort) may lead to decreased esomeprazole serum levels by increasing the esomeprazole metabolism.

PREGNANCY AND LACTATION

For esomeprazole, clinical data on exposed pregnancies are insufficient. With the racemic mixture, omeprazole, data on a larger number of exposed pregnancies from epidemiological studies indicate no malformative nor foetotoxic effect. Animal studies with esomeprazole do not indicate direct or indirect harmful effects with respect to embryonal/fetal development. Animal studies with the racemic mixture do not indicate direct or indirect harmful effects with respect to pregnancy, parturition or postnatal development. Caution should be exercised when prescribing to pregnant women.

It is not known whether esomeprazole is excreted in human breast milk. No studies in lactating women have been performed. Therefore Emanera should not be used during breast-feeding.

EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

Emanera has no influence on the ability to drive and use machines.

UNDESIRABLE EFFECTS

The following adverse drug reactions have been identified or suspected in the clinical trials programme for esomeprazole and post-marketing. None was found to be dose-related.

Blood and lymphatic system disorders

Rare: Leukopenia, thrombocytopenia

Very rare: Agranulocytosis, pancytopenia

Immune system disorders

Rare: Hypersensitivity reactions e.g. fever, angioedema and anaphylactic reaction/shock

Metabolism and nutrition disorders

Uncommon: Peripheral oedema

Rare: Hyponatraemia

Not known: Hypomagnesaemia; severe hypomagnesaemia can correlate with hypocalcaemia, vitamin B12 deficiency

Psychiatric disorders

Uncommon: Insomnia

Rare: Agitation, confusion, depression

Very rare: Aggression, hallucinations

Nervous system disorders

Common: Headache

Uncommon: Dizziness, paraesthesia, somnolence

Rare: Taste disturbance

Eye disorders

Rare: Blurred vision

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Ear and labyrinth disorders

Uncommon: Vertigo

Respiratory, thoracic and mediastinal disorders

Rare: Bronchospasm

Gastrointestinal disorders

Common: Abdominal pain, constipation, diarrhoea, flatulence, nausea/vomiting, Fundic gland polyps (benign)

Uncommon: Dry mouth

Rare: Stomatitis, gastrointestinal candidiasis

Not known: Microscopic colitis

Hepatobiliary disorders

Uncommon: Increased liver enzymes

Rare: Hepatitis with or without jaundice

Very rare: Hepatic failure, encephalopathy in patients with pre-existing liver disease

Skin and subcutaneous tissue disorders

Uncommon: Dermatitis, pruritus, rash, urticaria

Rare: Alopecia, photosensitivity

Very rare: Erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis (TEN)

Not known: Subacute cutaneous lupus erythematosus (SCLE)

Musculoskeletal, connective tissue and bone disorders

Uncommon: Fracture of the hip, wrist or spine

Rare: Arthralgia, myalgia

Very rare: Muscular weakness

Renal and urinary disorders

Very rare: Interstitial nephritis

Reproductive system and breast disorders

Very rare: Gynaecomastia

General disorders and administration site conditions

Rare: Malaise, increased sweating

Infections and infestations

Not known: *Clostridium difficile* associated diarrhea

OVERDOSE

There is very limited experience to date with deliberate overdose. The symptoms described in connection with 280 mg were gastrointestinal symptoms and weakness. Single doses of 80 mg esomeprazole were uneventful. No specific antidote is known. Esomeprazole is extensively plasma protein bound and is therefore not readily dialyzable. As in any case of overdose, treatment should be symptomatic and general supportive measures should be utilised.

PHARMACODYNAMIC PROPERTIES

Pharmacotherapeutic group: proton pump inhibitors

ATC Code: A02B C05

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Esomeprazole is the S-isomer of omeprazole and reduces gastric acid secretion through a specific targeted mechanism of action. It is a specific inhibitor of the acid pump in the parietal cell. Both the R- and S-isomer of omeprazole have similar pharmacodynamic activity.

Site and mechanism of action

Esomeprazole is a weak base and is concentrated and converted to the active form in the highly acidic environment of the secretory canaliculi of the parietal cell, where it inhibits the enzyme $H^+K^+-ATPase$ – the acid pump and inhibits both basal and stimulated acid secretion.

Effect on gastric acid secretion

After oral dosing with esomeprazole 20 mg and 40 mg the onset of effect occurs within one hour. After repeated administration with 20 mg esomeprazole once daily for five days, mean peak acid output after pentagastrin stimulation is decreased 90% when measured 6-7 hours after dosing on day five.

After five days of oral dosing with 20 mg and 40 mg of esomeprazole, intragastric pH above 4 was maintained for a mean time of 13 hours and 17 hours, respectively over 24 hours in symptomatic GERD patients. The proportion of patients maintaining an intragastric pH above 4 for at least 8, 12 and 16 hours respectively were for esomeprazole 20 mg 76%, 54% and 24%. Corresponding proportions for esomeprazole 40 mg were 97%, 92% and 56%.

Using AUC as a surrogate parameter for plasma concentration, a relationship between inhibition of acid secretion and exposure has been shown.

Therapeutic effects of acid inhibition

Healing of reflux esophagitis with esomeprazole 40 mg occurs in approximately 78% of patients after four weeks, and in 93% after eight weeks.

One week treatment with esomeprazole 20 mg b.i.d. and appropriate antibiotics, results in successful eradication of *H. pylori* in approximately 90% of patients.

After eradication treatment for one week there is no need for subsequent monotherapy with antisecretory active substances for effective ulcer healing and symptom resolution in uncomplicated duodenal ulcers.

Other effects related to acid inhibition

During treatment with antisecretory active substances serum gastrin increases in response to the decreased acid secretion.

During treatment with antisecretory medicinal products, serum gastrin increases in response to the decreased acid secretion. Also CgA increases due to decreased gastric acidity. The increased CgA level may interfere with investigations for neuroendocrine tumours.

Available published evidence suggests that proton pump inhibitors should be discontinued between 5 days and 2 weeks prior to CgA measurements. This is to allow CgA levels that might be spuriously elevated following PPI treatment to return to reference range.

An increased number of ECL cells (enterochromaffin-like cells), possibly related to the increased serum gastrin levels, have been observed in some patients during long term treatment with esomeprazole.

During long-term treatment with antisecretory active substances gastric glandular cysts have been reported to occur at a somewhat increased frequency. These changes are a physiological consequence

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of pronounced inhibition of acid secretion, are benign and appear to be reversible.

Decreased gastric acidity due to any means including proton pump inhibitors, increases gastric counts of bacteria normally present in the gastrointestinal tract. Treatment with proton pump inhibitors may lead to slightly increased risk of gastrointestinal infections such as *Salmonella* and *Campylobacter*.

PHARMACOKINETIC PROPERTIES

Absorption and distribution

Esomeprazole is acid labile and is administered orally as enteric-coated granules. *In vivo* conversion to the R-isomer is negligible. Absorption of esomeprazole is rapid, with peak plasma levels occurring approximately 1-2 hours after dose. The absolute bioavailability is 64% after a single dose of 40 mg and increases to 89% after repeated once-daily administration. For 20 mg esomeprazole the corresponding values are 50% and 68% respectively. The apparent volume of distribution at steady state in healthy subjects is approximately 0.22 l/kg body weight. Esomeprazole is 97% plasma protein bound.

Food intake both delays and decreases the absorption of esomeprazole although this has no significant influence on the effect of esomeprazole on intragastric acidity.

Metabolism and excretion

Esomeprazole is completely metabolised by the cytochrome P450 system (CYP). The major part of the metabolism of esomeprazole is dependent on the polymorphic CYP2C19, responsible for the formation of the hydroxy- and desmethyl metabolites of esomeprazole. The remaining part is dependent on another specific isoform, CYP3A4, responsible for the formation of esomeprazole sulphone, the main metabolite in plasma.

The parameters below reflect mainly the pharmacokinetics in individuals with a functional CYP2C19 enzyme, extensive metabolisers.

Total plasma clearance is about 17 l/h after a single dose and about 9 l/h after repeated administration. The plasma elimination half-life is about 1.3 hours after repeated once-daily dosing. The pharmacokinetics of esomeprazole has been studied in doses up to 40 mg b.i.d. The area under the plasma concentration-time curve increases with repeated administration of esomeprazole. This increase is dose-dependent and results in a more than dose proportional increase in AUC after repeated administration. This time - and dose-dependency is due to a decrease of first pass metabolism and systemic clearance probably caused by an inhibition of the CYP2C19 enzyme by esomeprazole and/or its sulphone metabolite. Esomeprazole is completely eliminated from plasma between doses with no tendency for accumulation during once-daily administration.

The major metabolites of esomeprazole have no effect on gastric acid secretion. Almost 80% of an oral dose of esomeprazole is excreted as metabolites in the urine, the remainder in the faeces. Less than 1% of the parent compound is found in urine.

Special patient populations

Approximately 2.9 ± 1.5% of the population lack a functional CYP2C19 enzyme and are called poor metabolisers. In these individuals the metabolism of esomeprazole is probably mainly catalysed by CYP3A4. After repeated once-daily administration of 40 mg esomeprazole, the mean area under the plasma concentration-time curve was approximately 100% higher in poor metabolisers than in subjects having a functional CYP2C19 enzyme (extensive metabolisers). Mean peak plasma concentrations were increased by about 60%.

These findings have no implications for the posology of esomeprazole.

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The metabolism of esomeprazole is not significantly changed in elderly subjects (71-80 years of age).

Following a single dose of 40 mg esomeprazole the mean area under the plasma concentration-time curve is approximately 30% higher in females than in males. No gender difference is seen after repeated once-daily administration. These findings have no implications for the posology of esomeprazole.

Impaired organ function

The metabolism of esomeprazole in patients with mild to moderate liver dysfunction may be impaired. The metabolic rate is decreased in patients with severe liver dysfunction resulting in a doubling of the area under the plasma concentration-time curve of esomeprazole. Therefore, a maximum of 20 mg should not be exceeded in patients with severe dysfunction. Esomeprazole or its major metabolites do not show any tendency to accumulate with once-daily dosing.

No studies have been performed in patients with decreased renal function. Since the kidney is responsible for the excretion of the metabolites of esomeprazole but not for the elimination of the parent compound, the metabolism of esomeprazole is not expected to be changed in patients with impaired renal function.

Paediatric

Adolescents 12-18 years:

Following repeated dose administration of 20 mg and 40 mg esomeprazole, the total exposure (AUC) and the time to reach maximum plasma concentration (t_{max}) in 12 to 18 year-olds was similar to that in adults for both esomeprazole doses.

PRECLINICAL SAFETY DATA

Preclinical bridging studies reveal no particular hazard for humans based on conventional studies of repeated dose toxicity, genotoxicity, and toxicity to reproduction. Carcinogenicity studies in the rat with the racemic mixture have shown gastric ECL-cell hyperplasia and carcinoids. These gastric effects in the rat are the result of sustained, pronounced hypergastrinaemia secondary to reduced production of gastric acid and are observed after long-term treatment in the rat with inhibitors of gastric acid secretion.

SPECIAL PRECAUTIONS FOR STORAGE

Do not store above 30°C.

Store in the original package in order to protect from moisture.

DOSAGE FORM & PACKAGING AVAILABLE

Blister packs: 14 and 28 gastro-resistant capsules, hard, in a box.

Not all pack sizes may be marketed.

PRODUCT REGISTRATION HOLDER

PAHANG PHARMACY SDN. BHD., Lot 5979, Jalan Teratai, 5 ½ Miles, Off Jalan Meru, 41050 Klang, Selangor, Malaysia

NAME AND ADDRESS OF THE MANUFACTURER

KRKA, d.d., Novo mesto

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DATE OF REVISION OF THE TEXT

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