

For the use of a Registered Medical Practitioner only

PRESCRIBING INFORMATION

ESOZ IV

(Esomeprazole 40mg Powder for Solution for Injection or Infusion -Lyophilised Powder)

COMPOSITION

Each vial contains:

Esomeprazole Sodium equivalent to

Esomeprazole ... 40 mg

Excipients: Disodium Edetate, Sodium Hydroxide, Water for Injection

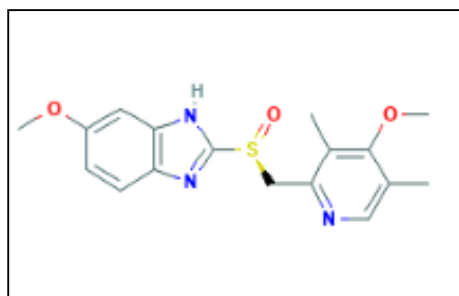
DESCRIPTION

ESOZ IV (Esomeprazole 40mg Powder for Solution for Injection or Infusion -Lyophilized Powder) is a white to off white lyophilized cake filled in 5ml colorless tubular glass vial with grey rubber stopper and grey flip off aluminum seal.

After reconstitution:

Colorless to pale yellow solution

ESOZ IV contains the active substance esomeprazole, which is the S-isomer of omeprazole, with gastric proton pump inhibitor activity. Esomeprazole is chemically described as 6-methoxy-2-[(S)-(4-methoxy-3,5-dimethylpyridin-2-yl)methylsulfinyl]-1H-benzimidazole. The molecular formula of esomeprazole is $C_{17}H_{19}N_3O_3S$ and its molecular weight is 345.4 g/mol. The structural formula of esomeprazole is presented below.



Structural Formula of Esomeprazole

PHARMACODYNAMIC AND PHARMACOKINETIC PROPERTIES

Pharmacodynamic Properties

Pharmacotherapeutic group: Proton pump inhibitor

ATC Code: A02B C05

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 5 days of oral dosing with 20 mg and 40 mg of esomeprazole, intragastric pH above 4 has been reported to be maintained for a mean time of 13 hours and 17 hours, respectively over 24 hours in symptomatic GERD patients. The effect was similar irrespective of whether esomeprazole is administered orally or intravenously.

Using AUC as a surrogate parameter for plasma concentration, a relationship between inhibition of acid secretion and exposure has been reported after oral administration of esomeprazole.

During intravenous administration of 80 mg esomeprazole as a bolus infusion over 30 minutes followed by a continuous intravenous infusion of 8 mg/h for 23.5 hours, intragastric pH above 4, and pH above 6 was maintained for a mean time of 21 hours, and 11-13 hours, respectively, over 24 hours in healthy subjects.

Therapeutic effects of acid inhibition

Healing of reflux esophagitis has been reported in approximately 78% of the patients after 4 weeks, and in 93% after 8 weeks with esomeprazole 40 mg oral treatment.

Other effects related to acid inhibition

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. Literature reports indicate that proton pump inhibitor treatment should be stopped 5 to 14 days before CgA measurement. Measurements should be repeated if levels have not normalised by this time.

An increased number of ECL cells possibly related to the increased serum gastrin levels, have been reported in both children and adults during long term treatment with orally administered esomeprazole. The findings were considered to be of no clinical significance.

During long-term oral treatment with antisecretory drugs gastric glandular cysts have been reported to occur at a somewhat increased frequency. These changes are a physiological consequence 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 has been reported. Treatment with proton pump inhibitors may lead to slightly increased risk of gastrointestinal infections such as *Salmonella* and *Campylobacter* and, in hospitalised patients, possibly also *Clostridium difficile*.

Pharmacokinetic properties

Distribution

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.

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. Total exposure (AUC) increases with repeated administration of esomeprazole. This increase is dose-dependent and results in a non-linear dose-AUC relationship after repeated administration. This time- and dose-dependency is due to a decrease of first pass metabolism and systemic clearance probably caused by 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.

Following repeated doses of 40 mg administered as intravenous injections, the mean peak plasma concentration is approx. 13.6 micromol/l. The mean peak plasma concentration after corresponding oral doses is approx. 4.6 micromol/l. A smaller increase (of approx. 30%) can be seen in the total exposure after intravenous administration compared to oral administration.

There is a dose-linear increase in total exposure following intravenous administration of esomeprazole as a 30-minute infusion (40 mg, 80 mg or 120 mg) followed by a continuous infusion (4 mg/h or 8 mg/h) over 23.5 hours.

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 drug is found in urine.

Special patient populations

Approximately 2.9±1.5% of the population lacks a functional CYP2C19 enzyme and is called poor metabolisers. In these individuals the metabolism of esomeprazole is probably mainly catalysed by CYP3A4. After repeated once-daily administration of 40 mg oral esomeprazole, the mean total exposure has been reported to be approximately 100% higher in poor metabolisers than in subjects with a functional CYP2C19 enzyme (extensive metabolisers). Mean peak plasma concentrations were increased by about 60%. Similar differences have been seen for intravenous administration of esomeprazole. These findings have no implications for the posology of esomeprazole.

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

Following a single oral dose of 40 mg esomeprazole the mean total exposure is approximately 30% higher in females than in males. No gender difference has been reported after repeated once-daily administration. Similar differences have been reported for intravenous administration of esomeprazole. These findings have no implications for the posology of esomeprazole.

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 total exposure of esomeprazole. Therefore, a maximum dose of 20 mg should not be exceeded in GERD patients with severe dysfunction. For patients with bleeding ulcers and severe liver impairment, following an initial bolus dose of 80 mg, a maximum continuous intravenous infusion dose of 4 mg/h for 71.5 hours may be sufficient. Esomeprazole or its major metabolites do not show any tendency to accumulate with once daily dosing.

No studies have been reported 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.

INDICATIONS

ESOZ IV for injection and infusion is indicated for:

- a) Gastric antisecretory treatment when the oral route is not possible, such as:
 - Gastro esophageal reflux disease in patients with esophagitis and/or severe symptoms of reflux.
 - Healing of gastric ulcers associate with NSAID therapy.
 - Prevention of gastric and duodenal ulcers associated with NSAID therapy, in patients at risk.
- b) Prevention of rebleeding following therapeutic endoscopy for acute bleeding gastric or duodenal ulcers.

DOSE AND METHOD OF ADMINISTRATION

DOSE

Gastric antisecretory treatment when the oral route is not possible

Patients who cannot take oral medication may be treated parenterally with 20-40 mg once daily. Patients with reflux oesophagitis should be treated with 40 mg once daily. Patients treated symptomatically for reflux disease should be treated with 20 mg once daily.

For healing of gastric ulcers associated with NSAID therapy the usual dose is 20 mg once daily. For prevention of gastric and duodenal ulcers associated with NSAID therapy, patients at risk should be treated with 20 mg once daily.

Usually the intravenous treatment duration is short and transfer to oral treatment should be made as soon as possible. Treatment with **ESOZ IV** can be given for up to 10 days as part of a full treatment period for the specified indications.

Prevention of rebleeding of gastric and duodenal ulcers

Following therapeutic endoscopy for acute bleeding gastric or duodenal ulcers, 80 mg should be administered as a bolus infusion over 30 minutes, followed by a continuous intravenous infusion of 8 mg/h given over 3 days (72 hours).

The parenteral treatment period should be followed by oral acid suppression therapy.

Method of Administration

Route of Administration - Intravenous

Method of Reconstitution

The reconstituted solution should be inspected visually for particulate matter and discoloration prior to administration. Only clear solution should be used. For single use only.

If the entire reconstituted content of the vial is not required, any unused solution should be discarded in accordance with local requirements.

Injection 40 mg

A solution for injection (8 mg/ml) is prepared by adding 5 ml of 0.9% sodium chloride for intravenous use to the esomeprazole 40 mg vial.

The reconstituted solution for injection is clear and colourless to very slightly yellow.

Infusion 40 mg

A solution for infusion is prepared by dissolving the content of one vial with esomeprazole 40 mg in up to 100 ml of 0.9% sodium chloride for intravenous use.

Infusion 80 mg

A solution for infusion is prepared by dissolving the contents of two vials of esomeprazole 40 mg in up to 100 ml of 0.9% sodium chloride for intravenous use.

The reconstituted solution for infusion is clear and colourless to very slightly yellow.

Method of Administration

Injection

40 mg dose

The reconstituted solution should be given as an intravenous injection over a period of at least 3 minutes.

20 mg dose

Half of the reconstituted solution should be given as an intravenous injection over a period of at least 3 minutes. Any unused solution should be discarded.

Infusion

40 mg dose

The reconstituted solution should be given as an intravenous infusion over a period of 10 to 30 minutes.

20 mg dose

Half of the reconstituted solution should be given as an intravenous infusion over a period of 10 to 30 minutes. Any unused solution should be discarded.

80 mg bolus dose

The reconstituted solution should be given as a continuous intravenous infusion over 30 minutes.

8 mg/h dose

The reconstituted solution should be given as a continuous intravenous infusion over a period of 71.5 hours.

Children and adolescents

ESOZ IV should not be used in children 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 (see “**Pharmacokinetic Properties**”).

Impaired hepatic function

GERD: Dose adjustment is not required in patients with mild to moderate liver impairment. For patients with severe liver impairment, a maximum daily dose of 20 mg **ESOZ IV** should not be exceeded (see “**Pharmacokinetic Properties**”).

Bleeding ulcers: Dose adjustment is not required in patients with mild to moderate liver impairment. For patients with severe liver impairment, following an initial bolus dose of 80 mg **ESOZ IV** for infusion, a continuous intravenous infusion dose of 4 mg/h for 71.5 hours may be sufficient (see “**Pharmacokinetic Properties**”).

Elderly

Dose adjustment is not required in the elderly.

CONTRAINDICATIONS

Hypersensitivity to the active substance esomeprazole or to other substituted benzimidazoles or to any of the excipients of this medicinal product.

Esomeprazole should not be used concomitantly with nelfinavir (see “**Interactions**”).

WARNINGS AND PRECAUTIONS

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 esomeprazole may alleviate symptoms and delay diagnosis.

Treatment with proton pump inhibitors may lead to slightly increased risk of gastrointestinal infections such as *Salmonella* and *Campylobacter* (see “**Pharmacodynamic Properties**”).

Co-administration of esomeprazole with atazanavir is not recommended (see “**Interactions**”). 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, as all acid-blocking medicines, may reduce the absorption of Vitamin B12 (cyanocobalamin) due to hypo- or achlorhydria. This should be considered in patients with reduced body stores or risk factors for reduced Vitamin B12 absorption on long-term therapy.

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 esomeprazole (see “**Interactions**”). The clinical relevance of this interaction is uncertain. As a precaution, concomitant use of esomeprazole and clopidogrel should be discouraged.

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 esomeprazole. SCLE after previous treatment with a proton pump inhibitor may increase the risk of SCLE with other proton pump inhibitors.

Hypomagnesaemia

Severe hypomagnesaemia has been reported in patients treated with PPI like esomeprazole 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. Proton pump inhibitors has been reported to 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.

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. To avoid this interference, esomeprazole treatment should be stopped for at least 5 days before CgA measurements (see section **Pharmacodynamic properties**). If CgA and gastrin levels have not returned to reference range after initial measurement, measurements should be repeated 14 days after cessation of PPI treatment.

Effects on Ability to Drive and Use Machines

ESOZ IV is not likely to affect the ability to drive or use machines.

Esomeprazole has minor influence on the ability to drive and use machines. Adverse reactions such as dizziness (uncommon) and blurred vision (uncommon) have been reported. If affected patients should not drive or use machines.

DRUG INTERACTIONS

Interaction studies have only been reported in adults.

Effects of esomeprazole on the pharmacokinetics of other drugs

Medicinal products with pH dependent absorption

Gastric acid suppression during treatment with esomeprazole and other PPIs might decrease or increase the absorption of medicinal products drugs with a gastric pH dependent absorption. As with other medicinal products that decrease the intragastric acidity, the absorption of medicinal products, such as ketoconazole, itraconazole and erlotinib and the absorption of digoxin can increase during treatment with esomeprazole. Concomitant treatment with omeprazole (20 mg daily) and digoxin in healthy subjects has been reported to increase 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 co-administration of omeprazole (20 mg qd) with atazanavir 400 mg/ritonavir 100 mg to healthy volunteers has been reported to result in a decrease of approximately 30% in the atazanavir exposure as compared with the exposure reported with atazanavir 300 mg/ritonavir 100 mg qd without omeprazole 20 mg qd. Co-administration 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 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. Concomitant oral administration of 30 mg esomeprazole has been reported to result in a 45% decrease in clearance of the CYP2C19 substrate diazepam.

Concomitant oral administration of 40 mg esomeprazole and phenytoin 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_r by 15% and 41%, respectively.

The coagulation times have been reported to be within the accepted range after concomitant oral administration of 40 mg esomeprazole to warfarin-treated patients. However, 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 oral administration of 40 mg esomeprazole and cisapride have been reported to result 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 reported after administration of cisapride alone, was not further prolonged when cisapride was given in combination with esomeprazole.

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

No clinically relevant pharmacokinetic interactions have been reported with concomitant administration of esomeprazole and either naproxen or rofecoxib..

The effect of esomeprazole on drugs metabolised by CYP2C19 may be more pronounced during this regimen, and patients should be monitored closely for adverse A decreased exposure to the active metabolite of clopidogrel by an average of 40% and resulting in decreased maximum

As a precaution concomitant use of clopidogrel should be discouraged.

Omeprazole as well as esomeprazole act as inhibitors of CYP 2C19. Omeprazole, given in doses of 40 mg to healthy subjects has been reported to increase C_{max} and AUC for cilostazol by 18% and 26% respectively, and one of its active metabolites by 29% and 69%, respectively.

Unknown mechanism

Concomitant administration of esomeprazole has been reported to increase the serum levels of tacrolimus. A reinforced monitoring of tacrolimus concentrations as well as renal function (creatinine clearance) should be performed, and dosage of tacrolimus adjusted if needed.

When given together with proton pump inhibitors, methotrexate levels have been reported to increase in some patients. In high-dose methotrexate administration a temporary withdrawal of esomeprazole may need to be considered.

Effects of other drugs on the pharmacokinetics of esomeprazole

Esomeprazole is metabolised by CYP2C19 and CYP3A4. Concomitant oral 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. 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.

UNDESIRABLE EFFECTS

The following adverse drug reactions have been reported for esomeprazole administered orally or intravenously.

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

Very Rare: Hypomagnesaemia; severe hypomagnesaemia may result in hypocalcaemia, Hypomagnesaemia may also result in hypokalaemia.

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

Uncommon: Blurred vision

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

Common: Administration site reactions*

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:- in some patients, renal failure has been reported concomitantly

Reproductive system and breast disorders

Very rare: Gynaecomastia

General disorders and administration site conditions

Rare: malaise, increased sweating

*Administration site reactions have mainly been reported with high-dose exposure over 3 days (72 hours).

Irreversible visual impairment has been reported in isolated cases of critically ill patients who have received omeprazole (the racemate) intravenous injection, especially at high doses, but no causal relationship has been established.

Other possible side effects include *Clostridium difficile* associated diarrhoea and Vitamin B12 deficiency (with unknown frequency).

PREGNANCY AND LACTATION

For esomeprazole limited data on exposed pregnancies are available. Reported animal data with esomeprazole do not indicate direct or indirect harmful effects with respect to embryonal/fetal development. Reported animal data 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 **ESOZ IV** to pregnant women.

It is not known whether esomeprazole is excreted in human breast milk. No data in lactating women have been reported. Therefore, **ESOZ IV** should not be used during breastfeeding.

OVERDOSE

There is very limited experience to date with deliberate overdose. The symptoms described in connection with an oral dose of 280 mg were gastrointestinal symptoms and weakness. Single oral doses of 80 mg esomeprazole and intravenous doses of 308 mg esomeprazole over 24 hours have been reported to be 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.

INCOMPATIBILITIES

This medicinal product should not be used with other medicinal products except those mentioned in Instruction for use and handling.

STORAGE

Do not store above 30°C. Protect from light.

Use the reconstituted solution within 12 hours when stored below 30°C.

Keep out of the reach of children.

SUPPLY

Unit vial supply along with pack inserts.

**Manufactured in India by
Sun Pharmaceutical Industries Ltd.**
Halol-Baroda Highway,
Halol-389 350, Dist – Panchmahal,
Gujarat State, India

Product Registration Holder
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