ESOPAM 10 mg Tablet

Each film coated tablet contains:
Escitalopram oxalate eq. to
Escitalopram 10 mg

✧ **PRODUCT DESCRIPTION:**
White, elliptical, biconvex, film coated tablet with scored on one side and plain on the other

✧ **MECHANISM OF ACTION:**
Pharmacology
Escitalopram is a selective inhibitor of serotonin (5-HT) re-uptake with high affinity for the primary binding site. It also binds to an allosteric site on the serotonin transporter, with a 1000 fold lower affinity. Escitalopram has no or low affinity for a number of receptors including 5-HT_{1A}, 5-HT_2, DA D_1 and D_2 receptors, α_1-, α_2-, β-adrenoceptors, histamine H_1, muscarine cholinergic, benzodiazepine, and opioid receptors.
The inhibition of 5-HT re-uptake is the only likely mechanism of action explaining the pharmacological and clinical effects of Escitalopram.
Pharmacokinetics
Absorption
Absorption is almost complete and independent of food intake. Mean time to maximum concentration (mean T_{max}) is 4 hours after multiple dosing. As with racemic Citalopram, the absolute bioavailability of Escitalopram is expected to be about 80%.
Distribution
The apparent volume of distribution ($V_{d,\beta}/F$) after oral administration is about 12 to 26 L/Kg. The plasma protein binding is below 80% for Escitalopram and its main metabolites.
Biotransformation
Escitalopram is metabolized in the liver to the demethylated and didemethylated metabolites. Both of these are pharmacologically active. Alternatively, the Nitrogen may be oxidized to form the N-oxide metabolite. Both parent substance and metabolites are partly excreted as glucuronides. After multiple dosing the mean concentrations of the demethyl and didemethyl metabolites are usually 28-31% and < 5%, respectively, of the Escitalopram concentration. Biotransformation of Escitalopram to the demethylated metabolite is mediated primarily by CYP2C19. Some contribution by the enzymes CYP3A4 and CYP2D6 is possible.
Elimination
The elimination half-life ($t_{½}$ β) after multiple dosing is about 30 hours and the oral plasma clearance (Cl_{oral}) is about 0.6 L/min. The major metabolites have a significantly longer half-life. Escitalopram and its major metabolites are assumed to be eliminated by both the hepatic (metabolic) and the renal routes, with the major part of the dose excreted as metabolites in the urine.
Linearity
There is linear pharmacokinetics. Steady-state plasma levels are achieved in about 1 week. Average steady-state concentrations of 50 nmol/L (range 20 to 125 nmol/L) are achieved at a daily dose of 10 mg.
Elderly patients (> 65 years)
Escitalopram appears to be eliminated more slowly in elderly patients compared to younger patients. Systemic exposure (AUC) is about 50% higher in elderly compared to young healthy volunteers.
Reduced hepatic function
In patients with mild or moderate hepatic impairment (Child-Pugh Criteria A and B), the half-life of Escitalopram was about twice as long and the exposure was about 60% higher than in subjects with normal liver function.
Reduced renal function
With racemic Citalopram, a longer half-life and a minor increase in exposure have been observed in patients with reduced kidney function (CL_{cr} 10-53 mL/min). Plasma concentrations of the metabolites have not been studied, but they may be elevated.
Polymorphism
It has been observed that poor metabolizers with respect to CYP2C19 have twice as high a plasma concentration of Escitalopram as extensive metabolizers. No significant change in exposure was observed in poor metabolizers with respect to CYP2D6.

✧ **INDICATION[2]:**
- Treatment of major depressive episodes
- Treatment of panic disorder with or without agoraphobia
- Treatment of social anxiety disorder (social phobia)
- Treatment of generalized anxiety disorder
- Treatment of obsessive-compulsive disorder

✧ **DOSAGE AND ADMINISTRATION:**
Oral
Safety of daily doses above 20 mg has not been demonstrated.
Escitalopram is administered as a single daily dose and may be taken with or without food.
Posology
Major depressive episodes
Usual dosage is 10 mg once daily. Depending on individual patient response, the dose may be increased to a maximum of 20 mg daily.
Usually 2-4 weeks are necessary to obtain antidepressant response. After the symptoms resolve, treatment for at least 6 months is required for consolidation of the response.
Panic disorder with or without agoraphobia
An initial dose of 5 mg is recommended for the first week before increasing the dose to 10 mg daily. The dose may be further increased, up to a maximum of 20 mg daily, dependent on individual patient response.
Maximum effectiveness is reached after about 3 months. The treatment lasts several months.
Social anxiety disorder
Usual dosage is 10 mg once daily. Depending on individual patient response, the dose may be increased to a maximum of 20 mg daily.
Usually 2-4 weeks are necessary to obtain symptom relief. Treatment for 3 months is recommended to consolidate response. Long-term treatment of responders for 6 months has been shown to prevent relapse and can be considered on an individual basis; treatment benefits should be re-evaluated at regular intervals.
Generalized anxiety disorder
Usual dosage is 10 mg once daily. Depending on the individual patient response, the dose may be increased to a maximum of 20 mg daily. Treatment for 3 months is recommended to consolidate response. Long-term treatment of responders for 6 months has been shown to prevent relapse and can be considered on an individual basis; treatment benefits should be re-evaluated at regular intervals.
Obsessive-Compulsive disorder (OCD)
Usual dosage is 10 mg once daily. Depending on the individual patient response, the dose may be increased to a maximum of 20 mg daily. As OCD is a chronic disease, patients should be treated for a sufficient period to ensure that they are symptom free. This period may be several months or even longer.
Elderly patients (> 65 years of age)
Initial treatment with half the usually recommended dose and a lower maximum dose should be considered.
Children and adolescents (< 18 years)
Escitalopram should not be used in the treatment of children and adolescents under the age of 18 years.
Reduced renal function
Dosage adjustment is not necessary in patients with mild or moderate renal impairment. Caution is advised in patients with severely reduced renal function (CL_{cr} less than 30 mL/min).
Reduced hepatic function
An initial dose of 5 mg daily for the first two weeks of treatment is recommended. Depending on individual patient response, the dose may be increased to 10 mg daily.
Poor metabolizers of CYP2C19
For patients who are known to be poor metabolizers with respect to CYP2C19, an initial dose of 5 mg daily during the first two weeks of treatment is recommended. Depending on individual patient response, the dose may be increased to 10 mg daily.
Discontinuation symptoms
When stopping treatment with Escitalopram the dose should be gradually reduced over a period of at least one to two weeks in order to avoid possible discontinuation symptoms.

✧ **WARNING AND PRECAUTION:**
The following precautions apply to the therapeutic class of SSRIs (Selective Serotonin Re-uptake Inhibitors):
Pediatric population[1]
Escitalopram should not be used in the treatment of pediatric population. Suicide related behaviours (suicide attempt and suicidal thoughts), and hostility (predominately aggression, oppositional behaviour and anger) can be frequently observed in pediatric population treated with antidepressants. If based on clinical need, a decision to treat is nevertheless taken; the patient should be carefully monitored for the appearance of suicidal symptoms. In addition, long-term safety data in the pediatric population concerning growth, maturation and cognitive and behavioural development are lacking.
Suicidality in children and adolescents[3]
Antidepressants increase risk of suicidal thinking and behavior (suicidality) in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders.
Anyone considering the use of an antidepressant in a child or adolescent for any clinical use must balance the risk of increase suicidality with the clinical need.
Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior.
Families and caregivers should be advised to closely observe the patient and to communicate with the prescriber.
The indication(s) approved in pediatric for the particular drug should be clearly stated/included.
Paradoxical anxiety
Some patients with panic disorder may experience increased anxiety symptoms at the beginning of treatment with antidepressants. This paradoxical reaction usually subsides within two weeks during continued treatment. A low starting dose is advised to reduce the likelihood of an anxiogenic effect.
Seizures
Escitalopram should be discontinued if a patient develops seizures for the first time, or if there is an increase in seizure frequency (in patients with a previous diagnosis of epilepsy). SSRIs should be avoided in patients with unstable epilepsy and patients with controlled epilepsy should be closely monitored.
Mania
SSRIs should be used with caution in patients with a history of mania/hypomania. SSRIs should be discontinued in any patient entering a manic phase.
Diabetes
In patients with diabetes, treatment with SSRIs may alter glycemic control (hypoglycemia or hyperglycemia). Insulin and/or oral hypoglycemic dosage may need to be adjusted.
Suicide/suicidal thoughts or clinical worsening
Depression is associated with an increased risk of suicidal thoughts, self harm and suicide (suicide-related events). This risk persists until significant remission occurs. As improvement may not occur during the first few weeks or more of treatment, patients should be closely monitored until such improvement occurs. It is general clinical experience that the risk of suicide may increase in the early stages of recovery.
Other psychiatric conditions for which Escitalopram is prescribed can also be associated with an increase risk of suicide-related events. In addition, these conditions may be co-morbid with major depressive disorder. The same precautions observed when treating patients with major depressive disorder should therefore be observed when treating patients with other psychiatric disorders.
Patients with a history of suicide-related events, or those exhibiting a significant degree of suicidal ideation prior to commencement of treatment, are known to be at greater risk of suicidal thoughts or suicide attempts, and should receive careful monitoring during treatment.
Close supervision of patients and in particular those at high risk should accompany drug therapy especially in early treatment and following dose changes. Patients (and caregiver of patients) should be alerted about the need to monitor for any clinical worsening, suicidal behavior or thoughts and unusual changes in behavior and to seek medical advice immediately if these symptoms present.
Akathisia/psychomotor restlessness
The use of SSRIs/SNRIs has been associated with the development of akathisia, characterized by a subjectively unpleasant or distressing restlessness and need to move often accompanied by an inability to sit or stand still. This is most likely to occur within the first few weeks of treatment. In patients who develop these symptoms, increasing the dose may be detrimental.
Hyponatremia
Hyponatremia, probably due to inappropriate antidiuretic hormone secretion (SIADH), has been reported rarely with the use of SSRIs and generally resolves on discontinuation of therapy. Caution should be exercised in patients at risk, such as the elderly, or patients with cirrhosis, or if used in combination with other medications which may cause hyponatremia.
Hemorrhage
Cautions is advised in patients taking SSRIs, particularly in concomitant use with oral anticoagulants, with medicinal products known to affect platelet function (e.g. atypical antipsychotics and Phenothiazines, most tricyclic antidepressants, Acetylsalicylic acid and non-steroidal anti-inflammatory medicinal products (NSAIDs), Ticlopidine and Dipyridamole) and in patients with known bleeding tendencies.
ECT (Electroconvulsive therapy)
There is limited clinical experience of concurrent administration of SSRIs and ECT, therefore caution is advisable.
Serotonin syndrome
Caution is advisable if Escitalopram is used concomitantly with medicinal products with serotogenic effects such as Sumatriptan, or other triptans, Tramadol and Trytophan.
In rare cases, serotonin syndrome has been reported in patients using SSRIs concomitantly with serotogenic medicinal products. A combination of symptoms, such as agitation, tremor, myoclonus and hyperthermia may indicate the development of this condition. If this occurs treatment with the SSRI and serotogenic medicinal product should be discontinued immediately and symptomatic treatment initiated.
St. John's wort
Concomitant use of SSRIs and herbal remedies containing St. John's wort (Hypericum perforatum) may result in an increased incidence of adverse reactions.
Discontinuation symptoms seen when stopping treatment
Discontinuation symptoms when stopping treatment are common, particularly if discontinuation is abrupt. The risk of discontinuation symptoms may be dependent on several factors including the duration and dose of therapy and the rate of dose reduction. Dizziness, sensory disturbances (including paresthesia and electric shock sensations), sleep disturbances (including insomnia and intense dreams), agitation or anxiety, nausea and/or vomiting, tremor, confusion, sweating, headache, diarrhea, palpitations, emotional instability, irritability, and visual disturbances are the most commonly reported reactions. Generally these symptoms are mild to moderate, however, in some patients they may be severe in intensity. They usually occur within the first few days of discontinuing treatment, but there have been very rare reports of such symptoms in patients who have inadvertently missed a dose.
Generally these symptoms are self-limiting and usually resolve within 2 weeks, though in some individuals they may be prolonged (2-3 months or more). It is therefore advised that Escitalopram should be gradually tapered when discontinuing treatment over a period of several weeks or months, according to the patient's need.
Sexual dysfunction[1]
Selective serotonin re-uptake inhibitors (SSRIs)/serotonin norepinephrine re-uptake inhibitors (SNRIs) may cause symptoms of sexual dysfunction (see section Side effect). There have been reports of long-lasting sexual dysfunction where the symptoms have continued despite discontinuation of SSRIs/SNRI.
Coronary heart disease
Due to limited clinical experience, caution is advised in patients with coronary heart disease.
QT interval prolongation
Escitalopram has been found to cause a dose-dependent prolongation of the QT interval. Caution is advised in patients with significant bradycardia; or in patients with recent acute myocardial infarction or uncompensated heart failure. Electrolyte disturbances such as hypokalemia and hypomagnesemia increase the risk for malignant arrhythmias and should be corrected before treatment with Escitalopram is started. If patients with stable cardiac disease are treated, an ECG review should be considered before treatment is started. If signs of cardiac arrhythmia occur during treatment with Escitalopram, the treatment should be withdrawn and an ECG should be performed.
Angle-Closure Glaucoma
SSRIs including Escitalopram may have an effect on pupil size resulting in mydriasis. This mydriatic effect has the potential to narrow the eye angle resulting in increase intraocular pressure and angle-closure glaucoma, especially in patients pre-disposed. Escitalopram should therefore be used with caution in patients with angle-closure glaucoma or history of glaucoma.

PM Specification	Product	Code No.	Dimension	Packaging Type	Thickness
	ESOPAM	IEMY 0061	W 19.5 x L 28 cm.	Wood Free Paper (กระดาษปอนด์)	60 g (0.08 mm.)

Designed by: (PDM, ASPD, PDC-M, PDC-A, PDO-M, PDO-A) | Checked by: (PDM/ASPD) | Approved by: (MD (Only Pattern and Colors))

Approved by: PLC: (Date) | LRA: (Date) | IRA: (Date) | QCC-PM: (Date) | CUSTOMER/SALES DEPT.: (Date)

Warning^
This preparation contains Sodium metabisulfite that may cause serious allergic type reactions in certain susceptible patients. Do not use if known to be hypersensitive to bisulfites.

✧ **PREGNANCY AND LACTATION:**
Pregnancy
For Escitalopram only limited clinical data are available regarding exposed pregnancies.
Escitalopram should not be used during pregnancy unless clearly necessary and only after careful consideration of the risk/benefit.
Neonates should be observed if maternal use of Escitalopram continues into the later stages of pregnancy, particularly in the third trimester. Abrupt discontinuation should be avoided if SSRIs are used during pregnancy.
The following symptoms may occur in the neonate after maternal SSRI/SNRI use in later stages of pregnancy: respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypertonia, hypotonia, hyperreflexia, tremor, jitteriness, irritability, lethargy, constant crying, somnolence, difficulty sleeping. These symptoms could be due to either serotonergic effects or discontinuation symptoms.
In a majority of instances the complications begin immediately or soon (< 24 hours) after delivery.
Epidemiological data have suggested that the use of SSRIs in pregnancy, particular in late pregnancy, may increase the risk of persistent pulmonary hypertension in the newborn (PPHN). The observed risk was approximately 5 cases per 1000 pregnancies. In the general population 1 to 2 cases of PPHN per 1000 pregnancies occur.
Breastfeeding
It is expected that Escitalopram will be excreted into human milk.
Consequently, breastfeeding is not recommended during treatment.
Fertility
Human case reports with some SSRIs have shown that an effect on sperm quality is reversible. Impact on human fertility has not been observed so far.
[3]Observational data indicate an increased risk (less than 2-fold) of postpartum hemorrhage following SSRI/SNRI exposure within the month prior to birth.

✧ **SIDE EFFECT:**
Adverse reactions are most frequent during the first or second week of treatment and usually decrease in intensity and frequency with continued treatment.
Tabulated list of adverse reactions
Adverse reactions known for Escitalopram are listed below by system organ class and frequency:

System Organ Class	Frequency	Undesirable Effect
Blood and lymphatic system disorders	Not known	Thrombocytopenia
Immune system disorders	Rare	Anaphylactic reaction
Endocrine disorders	Not known	Inappropriate ADH secretion
Metabolism and nutrition disorders	Common	Decrease appetite, increased appetite, weight increased
	Uncommon	Weight decreased
	Not known	Hyponatremia, anorexia
Psychiatric disorders	Common	Anxiety, restlessness, abnormal dreams, libido decreased Female: Anorgasmia
	Uncommon	Bruxism, agitation, nervousness, panic attack, confusional state
	Rare	Aggression, depersonalization, hallucination
	Not known	Mania, suicidal ideation, suicidal behavior
Nervous system disorders	Very common	Headache
	Common	Insomnia, somnolence, dizziness, paresthesia, tremor
	Uncommon	Taste disturbances, sleep disorder, syncope
	Rare	Serotonin syndrome
	Not known	Dyskinesia, movement disorder, convulsion, psychomotor restlessness/akathisia
Eye disorders	Uncommon	Mydriasis, visual disturbance
Ear and labyrinth disorders	Uncommon	Tinnitus
Cardiac disorders	Uncommon	Tachycardia
	Rare	Bradycardia
	Not known	Electrocardiogram QT prolonged, ventricular arrhythmia including Torsade de Pointes
Vascular disorders	Not known	Orthostatic hypotension
Respiratory, thoracic and mediastinal disorder	Common	Sinusitis, yawning
	Uncommon	Epistaxis
Gastrointestinal disorders	Very common	Nausea
	Common	Diarrhea, constipation, vomiting, dry mouth
	Uncommon	Gastrointestinal hemorrhages (including rectal hemorrhages)
Hepatobiliary disorders	Not known	Hepatitis, liver function tests abnormal
Skin and subcutaneous tissue disorders	Common	Sweating increased
	Uncommon	Urticaria, alopecia, rash, pruritus
	Not known	Ecchymosis, angioedemas
Musculoskeletal and connective tissue disorders	Common	Arthralgia, myalgia
Renal and urinary disorders	Not known	Urinary retention
Reproductive system and breast disorders	Common	Male: Ejaculation disorder, impotence
	Uncommon	Female: Metrorrhagia, menorrhagia
	Not known	Galactorrhea Male: Priapism
General disorders and administration site conditions	Common	Fatigue, pyrexia
	Uncommon	Edema

QT interval prolongation[1]
Cases of QT interval prolongation and ventricular arrhythmia including Torsade de pointes can be observed predominantly in patients of female gender with hypokalemia or with pre-existing QT interval prolongation or other cardiac diseases (see sections Contraindications, Warning and Precaution, Drug interaction, Overdose and Treatment and Pharmacology)
Class effects
Increased risk of bone fractures can be observed in patients receiving SSRIs and TCAs. The mechanism leading to this risk is unknown.
Discontinuation symptoms seen when stopping treatment
Discontinuation of SSRIs/SNRIs (particularly when abrupt) commonly leads to discontinuation symptoms. Dizziness, sensory disturbances (including paraesthesia and electric shock sensations), sleep disturbances (including insomnia and intense dreams), agitation or anxiety, nausea and/or vomiting, tremor, confusion, sweating, headache, diarrhea, palpitations, emotional instability, irritability, and visual disturbances are the most common reactions. Generally these events are mild to moderate and are self-limiting; however, in some patients they may be severe and/or prolonged. It is therefore advised that when Escitalopram treatment is no longer required, gradual discontinuation by dose tapering should be carried out (see sections Dosage and administration and Warning and Precaution).

✧ **EFFECTS ON ABILITY TO DRIVE AND USE MACHINES:**
Although Escitalopram has been shown not to affect intellectual function or psychomotor performance, any psychoactive medicinal product may impair judgment or skills. Patients should be cautioned about the potential risk of an influence on their ability to drive a car and operate machinery.

✧ **CONTRAINDICATION:**
- Hypersensitivity to the active substance or to any of the excipients
- Concomitant treatment with non-selective, irreversible monoamine oxidase inhibitors (MAO-inhibitors) is contraindicated due to the risk of serotonin syndrome with agitation, tremor, hyperthermia, etc.
- The combination of Escitalopram with reversible MAO-A inhibitors (e.g. Moclobemide) or the reversible non-selective MAO-inhibitor Linezolid is contraindicated due to the risk of onset of a serotonin syndrome.
- Escitalopram is contraindicated in patients with known QT-interval prolongation or congenital long QT syndrome.
- Escitalopram is contraindicated together with medicinal products that are known to prolong the QT-interval.

✧ **DRUG INTERACTION:**
Contraindicated combinations
Irreversible non-selective MAOIs
Cases of serious reactions have been reported in patients receiving an SSRI in combination with a non-selective, irreversible monoamine oxidase inhibitor (MAOI), and in patients who have recently discontinued SSRI treatment and have been started on such MAOI treatment. In some cases, the patient developed serotonin syndrome. Escitalopram is contraindicated in combination with non-selective, irreversible MAOIs. Escitalopram may be started 14 days after discontinuing treatment with an irreversible MAOI. At least 7 days should elapse after discontinuing Escitalopram treatment, before starting a non-selective, irreversible MAOI.
Reversible, selective MAO-A inhibitor (Moclobemide)
Due to the risk of serotonin syndrome. the combination of Escitalopram with a MAO-A inhibitor such as Moclobemide is contraindicated. If the combination proves necessary, it should be started at the minimum recommend dosage and clinical monitoring should be reinforced.
Reversible, non-selective MAO-inhibitor (Linezolid)
The antibiotic Linezolid should not be given to patients treated with Escitalopram. If combination proves necessary, it should be given with minimum dosages and under close clinical monitoring.
Irreversible, selective MAO-B inhibitor (Selegiline)
In combination of Selegiline, caution is required due to risk of developing serotonin syndrome. Selegiline doses up to 10 mg/day have been safely co-administered with racemic Citalopram.
QT interval prolongation
Co-administration of Escitalopram with medicinal products that prolong the QT interval, such as Class IA and III antiarrhythmics, antipsychotics (e.g. Phenothiazine derivatives, Pimozide, Haloperidol), tricyclic antidepressants, certain antimicrobial agents (e.g. Sparfloxacin, Moxifloxacin, Erythromycin IV, Pentamidine, anti-malarial treatment particularly Halofantrine) certain antihistamines (Astemizole, Mizolastine), is contraindicated.
Combinations requiring precautions for use
Serotonergic medicinal products
Co-administration with serotonergic medicinal products (e.g. Tramadol, Sumatriptan, and other triptans) may lead to serotonin syndrome.
Medicinal products lowering the seizure threshold
SSRIs can lower the seizure threshold. Caution is advised when concomitantly using other medicinal products capable of lowering the seizure threshold (e.g. antidepressant (tricyclics, SSRIs), neuroleptics (Phenothiazines, Thioxanthenes and Butyrophenones), Mefloquin, Bupropion and Tramadol).
Lithium, Tryptophan
There have been reports of enhanced effects when SSRIs have been given together with Lithium or Tryptophan, therefore concomitant use of SSRIs with these medicinal products should be undertaken with caution.
St. John's wort
Concomitant use of SSRIs and herbal remedies containing St. John's wort (Hypericum perforatum) may result in an increased incidence of adverse reactions.
Hemorrhage
Altered anti-coagulant effects may occur when Escitalopram is combined with oral anticoagulants. Patients receiving oral anticoagulant therapy should receive careful coagulation monitoring when Escitalopram is started or stopped. Concomitant use of NSAIDs may increase bleeding-tendency.
Alcohol
As with other psychotropic medicinal products, the combination with alcohol is not advisable.
Medicinal products inducing hypokalemia/hypomagnesemia
Caution is warranted for concomitant use of hypokalemia/hypomagnesemia inducing medicinal products as these conditions increase the risk of malignant arrhythmias.
Pharmacokinetic interaction[1]
Influence of other medicinal products on the pharmacokinetics of Escitalopram
The metabolism of Escitalopram is mainly mediated by CYP2C19. CYP3A4 and CYP2D6 may also contribute to the metabolism although to a smaller extent. The metabolism of the major metabolite S-DCT (demethylated Escitalopram) seems to be partly catalyzed by CYP2D6.
Co-administration of Escitalopram with Omeprazole 30 mg once daily (a CYP2C19 inhibitor) resulted in moderate (approximately 50%) increase in the plasma concentrations of Escitalopram.
Co-administration of Escitalopram with Cimetidine 400 mg twice daily (moderately potent general enzyme-inhibitor) will result in a moderate (approximately 70%) increase in the plasma concentrations of Escitalopram. Caution is advised when administering Escitalopram in combination with Cimetidine. Dose adjustment may be warranted.
Thus, caution should be exercised when used concomitantly with CYP2C19 inhibitors (e.g. Omeprazole, Esomeprazole, Fluconazole, Fluvoxamine, Lanzoprazole, Ticlopidine) or Cimetidine. A reduction in the dose of Escitalopram may be necessary based on monitoring of side-effects during concomitant treatment (see section Warnings and Precautions).
Effect of Escitalopram on the pharmacokinetics of other medicinal products
Escitalopram is an inhibitor of the enzyme CYP2D6. Caution is recommended when Escitalopram is co-administered with medicinal products that are mainly metabolized by this enzyme, and that have a narrow therapeutic index, e.g. Flecainide, Propafenone and Metoprolol (when used in cardiac failure), or some CNS acting medicinal products that are mainly metabolized by CYP2D6, e.g. antidepressants such as Desipramine, Clomipramine and Nortriptyline or antipsychotics like Risperidone, Thioridazine and Haloperidol. Dosage adjustment may be warranted.
Co-administration with Desipramine or Metoprolol resulted in both cases in a two-fold increase in the plasma levels of these two CYP2D6 substrates.
Escitalopram may also cause weak inhibition of CYP2C19. Caution is recommended with concomitant use of medicinal products that are metabolized by CYP2C19.

✧ **OVERDOSE AND TREATMENT:**
Toxicity
Clinical data on Escitalopram overdose are limited and many cases involve concomitant overdoses of other drugs. In the majority of cases mild or no symptoms have been reported. Fatal cases of Escitalopram overdose have rarely been reported with Escitalopram alone; the majority of cases have involved overdose with concomitant medications. Doses between 400 and 800 mg of Escitalopram alone have been taken without any severe symptoms.
Symptoms
Symptoms seen in reported overdose of Escitalopram include symptoms mainly related to the central nervous system (ranging from dizziness, tremor, and agitation to rare cases of serotonin syndrome, convulsion, and coma),the gastrointestinal system (nausea/vomiting), and the cardiovascular system (hypotension, tachycardia, QT interval prolongation, and arrhythmia) and electrolyte/fluid balance conditions (hypokalemia, hyponatremia).
Management
There is no specific antidote. Establish and maintain an airway, ensure adequate oxygenation and respiratory function. Gastric lavage and the use of activated charcoal should be considered. Gastric lavage should be carried out as soon as possible after oral ingestion. Cardiac and vital signs monitoring are recommended along with general symptomatic supportive measures.
ECG monitoring is advised in case of overdose, in patients with congestive heart failure/bradyarrhythmias, in patients using concomitant medications that prolong the QT interval, or in patients with altered metabolism, e.g. liver impairment.

✧ **STORAGE:**
Store at temperature of not more than 30°C.

✧ **DOSAGE FORM AND PACKAGING AVAILABLE:**
10 mg Tablet, Blister 4x7's

✧ **DATE OF REVISION:**
June 13, 2023

Manufactured by:
UNISON LABORATORIES CO., LTD.
39 Moo 4, Klong Udomcholjorn, Muang Chachoengsao,
Chachoengsao 24000 Thailand

C-MY/130623-05 (AR)
(www.medicines.ie, [2]DRGD_MY, [1]DCA 13/10/20, [2]DCA 09/02/20, [3]DCA 20/12/21)
IEMY 0061

PM Specification	Product	Code No.	Dimension	Packaging Type	Thickness
	ESOPAM	IEMY 0061	W 19.5 x L 28 cm.	Wood Free Paper (กระดาษปอนด์)	60 g (0.08 mm.)

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Approved by: PLC: (Date) | LRA: (Date) | IRA: (Date) | QCC-PM: (Date) | CUSTOMER/SALES DEPT.: (Date)

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14/06/23