PEPTAZOL ENTERIC-COATED TABLET 40MG

Pantoprazole Tablet 40 mg

Enteric-coated tablets
Made In Argentina
Rx ONLY

Composition

Each enteric-coated tablet contains: PANTOPRAZOLE (as PANTOPRAZOLE SODIUM SESQUIHYDRATE) 40 mg.
Inactive Ingredients: Calcium Stearate; Povidone K 90; Crospovidone; Sodium carbonate ; Granulated Mannitol; Opadry AMB (Opadry White OY-B28920); Sureteric (Y AE-6-18107 White); Activated dimethyl polysiloxane .

Product Description

Round, biconvex, white enteric coated tablet.

Indications

In combination with 2 appropriate antibiotics for the eradication of Helicobacter pylori in patients with peptic ulcers to reduce recurrence of duodenal and gastric ulcers caused by the microorganism; duodenal and gastric ulcers; moderate and severe cases of inflammation of the esophagus (reflux esophagitis); Zollinger-Ellison syndrome and other pathological hypersecretory conditions.

Pharmacodynamics

Pantoprazole is a substituted benzimidazole which inhibits the secretion of hydrochloric acid in the stomach by specific action on the proton pumps of the parietal cells.
Pantoprazole is converted to its active form in the acidic canaliculi of the parietal cells where it inhibits the H+, K^+ATPase enzyme, i. e. the final stage in the production of hydrochloric acid in the stomach. The inhibition is dosedependent and affects both basal and stimulated acid secretion. In most patients, freedom from symptoms is achieved in 2 weeks. As with other proton pump inhibitors and H_2 receptor inhibitors, treatment with pantoprazole causes a reduced acidity in the stomach and thereby an increase in gastrin in proportion to the reduction in acidity. The increase in gastrin is reversible. Since pantoprazole binds to the enzyme distal to the cell receptor level, the substance can affect hydrochloric acid secretion independently of stimulation by other substances (acetylcholine, histamine, gastrin). The effect is the same whether the product is given orally or intravenously.
The fasting gastrin values increase under pantoprazole. On short-term use, in most cases they do not exceed the normal upper limit. During long-term treatment, gastrin levels double in most cases. An excessive increase, however, occurs only in isolated cases. As a result, a mild to moderate increase in the number of specific endocrine (ECL) cells in the stomach is observed in a minority of cases during long-term treatment (simple to adenomatoid hyperplasia). However, according to the studies conducted so far, the formation of carcinoid precursors (atypical hyperplasia) or gastric carcinoids as were found in animal experiments have not been observed in humans

Pharmacokinetics:

Pantoprazole is rapidly absorbed and the maximal plasma concentration is achieved even after one single 40 mg oral dose. On average at about 2.5 h p.a. the maximum serum concentrations of about 2-3 µg/ml are achieved, and these values remain constant after multiple administration. Volume of distribution is about 0.15 l/kg and clearance is about 0.1 l/h/kg. Terminal half - life is about 1 h. There were a few cases of subjects with delayed elimination. Because of the specific binding of pantoprazole to the proton pumps of the parietal cell the elimination half - life does not correlate with the much longer duration of action (inhibition of acid secretion). Pharmacokinetics do not vary after single or repeated administration. In the dose range of 10 to 80mg, the plasma kinetics of pantoprazole are linear after both oral and intravenous administration. Pantoprazole's serum protein binding is about 98%. The substance is almost exclusively metabolized in the liver. Renal elimination represents the major route of excretion (about 80%) for the metabolites of pantoprazole, the rest is excreted with the faeces. The main metabolite in both

the serum and urine is desmethylpantoprazole which is conjugated with sulphate. The half - life of the main metabolite (about 1.5 h) Is not much longer than that of pantoprazole.

Bioavailability
Pantoprazole is completely absorbed after oral administration. The absolute bioavailability from the tablet was found to be about 77%. Concomitant intake of food had no influence on AUC, maximum serum concentration and thus bioavailability. Only the variability of the lag - time will be increased by concomitant food intake.

Characteristics in patients/special groups of subjects
No dose reduction is requested when pantoprazole is administered to patients with restricted kidney function (incl. dialysis patients). As with healthy subjects, pantoprazole's half - life is short. Only very small amounts of pantoprazole can be dialyzed. Although the main metabolite has a moderately delayed half - life (2 - 3h), excretion is still rapid and thus accumulation does not occur.
Although for patients with liver cirrhosis (classes A and B according to Child) the half - life values increased to between 7 and 9 h and the AUC values increased by a factor of -5-7, the maximum serum concentration only increased slightly by a factor of 1.5 compared with healthy subjects.
A slight increase in AUC and Cmax in elderly volunteers compared with younger counterparts is also not clinically relevant.

Dosage and administration:
Adults and Adolescents ≥12 years:
Treatment of Moderate and Severe Reflux Esophagitis:
One Peptazol Enteric-coated Tab 40 mg/day for 4 weeks.Treatment should not exceed 8 weeks as experience with long-term use is limited. In individual cases, the dose may be doubled (increased to two 40 mg tablets daily) especially when there has been no response to other medicines.
Adults: Eradication of H. pylori in Combination with 2 Appropriate Antibiotics:
In cases of duodenal or gastric ulcer in which infection with Helicobacter pylori has been confirmed, the microorganism should be eradicated by combination treatment. Depending upon the resistance pattern, the following combinations can be recommended:
- One Peptazol Enteric-coated Tab 40 mg twice daily + Amoxicillin 1000 mg twice daily + clarithromycin 500 mg twice daily for 1 week or max. 2 weeks.
- One Peptazol Enteric-coated Tab 40 mg twice daily + Metronidazole 500 mg twice daily + Clarithromycin 500 mg twice daily for 1 week or max. 2 weeks.
- One Peptazol Enteric-coated Tab 40 mg twice daily + Amoxicillin 1000 mg twice daily + Metronidazole 500 mg twice daily for 1 week or max. 2 weeks.
If combination therapy is not an option or if the patient has been tested negative for Helicobacter pylori, the following dosage guidelines apply for Peptazol Enteric-coated Tablet monotherapy:
Duodenal and Gastric Ulcers, Reflux Oesophagitis:
One Peptazol Enteric-coated Tab 40 mg daily in most cases. In individual cases, the dose may be doubled (increased to two 40 mg tab daily) especially when there has been no response to other medicines. In patients with severe liver impairment, the dose has to be reduced to one 40 mg pantoprazole tab every other day. Furthermore, in these patients, the liver enzymes should be monitored during Peptazol therapy. In case liver enzymes rise, Peptazol Enteric-coated Tablet should be discontinued. The daily dose of 40 mg pantoprazole should not be exceeded in elderly patients or in those with impaired renal function. An exception in combination therapy for eradication of Helicobacter pylori where elderly patients should receive the usual pantoprazole dose (40 mg twice daily) during 1-week treatment.
Long-Term Management of Zollinger-Ellison Syndrome and Other Pathological Hypersecretory Conditions:
The recommended daily dose at the beginning of treatment is 80 mg (two 40 mg tab). Thereafter, the dosage can be titrated up or down as needed using measurements of gastric acid secretion to guide. Doses >80 mg daily should be divided and given twice daily. A temporary increase in dosage to >160 mg pantoprazole is possible but should not be applied longer than required for acid control.

Type and duration of Treatment:
Combination therapy for eradication of Helicobacter pylori infection usually lasts 7 days and can be extended to a maximum of 2 weeks. Further treatment with Pantoprazole 40mg is indicated to ensure complete healing of ulcers, dose recommendations for gastric and duodenal ulcers must be observed. In majority of cases, duodenal ulcer heals completely within 2 weeks. If a 2-week treatment period is not sufficient, healing will be achieved in almost all cases. Reflux esophagitis usually require 4-week course of treatment. If this should be inadequate, healing will be achieved within further 4 weeks. Treatment should not exceed 8 weeks as experience with long-term use is limited.
Treatment duration in Zollinger-Ellison syndrome and other pathological hypersecretory conditions is not limited and should be adapted according to clinical needs.
Administration:
PANTOPRAZOLE enteric coated tablets should be swallowed whole with liquid either before or during breakfast.
A dose of 40 mq daily of PANTOPRAZOLE should not be exceeded in cases of impaired liver and renal function and in elderly patients.

Contraindications:
Pantoprazole should not be used in case of known hypersensitivity to the active substance or any of the excipients of Peptazol enteric coated Tablet 40mg, or of one of the combination products.
Pantoprazole like other PPIs should not be administered with atazanavir.

Special Warnings and precautions for use:
Pantoprazole should not be used for the treatment of mild gastro-intestinal complaints such as functional dyspepsia.
Before starting the treatment, the possibility of a malignant gastric ulcer or malignance of the oesophagus should be ruled out, as treatment with pantoprazole could mask the symptoms thereof and thus could delay the diagnosis.
The diagnosis reflux oesophagitis should be confirmed via endoscopy.
In long-term treatment, especially when exceeding a treatment period of 1 year, patients should be kept under regular surveillance.
In patients with Zollinger-Ellison-Syndrome and other disorders involving pathological hypersecretion which require long term treatment, pantoprazole, like all acid inhibiting medicines, can reduce the absorption of vitamine B12 (cyanocobalamine) as a consequence of hypo or a-chloridehydry. This should be taken into consideration when accompanying clinical symptoms are manifested.

Drug Interactions:
Pantoprazole may reduce the absorption of drugs whose bioavailability is pH-dependent (e.g. ketoconazole).
Pantoprazole is metabolized in the liver via the cytochrome P450 enzyme system. An interaction of pantoprazole with other drugs or compounds which are metabolized using the same enzyme system cannot be excluded. However, no clinically significant interactions were observed in specific tests with a number of such drugs or compounds, namely carbamazepine, caffeine, diazepam, diclofenac, digoxin, ethanol, glibenclamide, metoprolol, naproxen, nifedipine, phenytoin, piroxicam, theophylline and an oral contraceptive.
Studies with other PPIs have shown a marked reduction in atazanavir exposure during concomitant PPI treatment.
Use of Pantoprazole is contraindicated during atazanavir treatment (see contraindication).
Although no interaction during concomitant administration of phenprocoumon or warfarin has been observed in clinical pharmacokinetic studies, a few isolated cases of changes in INR have been reported during concomitant treatment in the post-marketing period. Therefore, in patients being treated with coumarin anticoagulants, monitoring of prothrombin time / INR is recommended after initiation, termination or during irregular use of pantoprazole.
There were also no interactions with concomitantly administered antacids.

Pregnancy
Experience in pregnant women is very limited. Limited experience with proton pump inhibitors as a class does not indicate an increased risk for major congenital malformations. Pantoprazole should only be used when the benefit to the mother is considered greater than the potential risk to the foetus/baby.

Lactation
There is no information on the excretion of pantoprazole into human breast milk. Since potential risks to the child cannot be fully excluded, discontinuation of breastfeeding should be considered when treatment with pantoprazole is needed.

Children:
To date there has been no experience with treatment in children.

Adverse reactions

Frequency Organ system	common (>1/100, <1/10)	uncommon (>1/1,000,<1/100)	rare (<1/1,000,>1/10,000)	Very rare (<1/10,000, incl. Isolated reports)
Blood and lymphatic system				Leukopenia; Thrombocytopenia
Gastrointestinal Disorders	Upper abdominal pain; Diarrhoea; Constipation; Flatulence	Nausea / Vomiting	Dry mouth	
General disorders and administration site conditions				Peripheral edema
Hepatobiliary disorders				Severe hepatocellular damage leading to jaundice with or without hepatic failure
Immune system disorders				Anaphylactic reactions including anaphylactic shock
Investigations				Increased liver enzymes (transaminases, γ-GT); elevated triglycerides; Increased body temperature
Musculoskeletal, connective tissue disorders			Arthralgia	Myalgia
Nervous system disorders	Headache	Dizziness; Disturbances in vision (blurred vision)		
Psychiatric disorders			Depression;hallucination Disorientation;confusion, especially in predisposed patients, as well as aggravation of these symptoms in case of preexistence	

Renal and urinary disorders				Interstitial nephritis
Skin and sub-cutaneous tissue disorders		Allergic reactions such as pruritus and skin rash		Urticaria; Angioedema; Severe skin reactions such as Stevens-Johnson Syndrome, Erythema multiforme, Lyell Syndrome; Photosensitivity

Overdosage
There are no known symptoms of overdosage in man. Doses up to 240 mg i.v. were administered over 2 minutes and were well tolerated. Only very small amounts of pantoprazole can be dialyzed.
In the case of overdosage with clinical signs of intoxication, the usual rules of intoxication therapy apply.

Storage
Store below 30°C Protect from light and moisture. Keep out of reach of children.

Shelf Life
24 months from the date of manufacture

Packing
2 Alu/OPA blister strips of 15 tablets each, packed in a printed box with a package insert.

Manufactured By
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Bagó Group Company

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