

For the use of Registered Medical Practitioner or a Hospital or a Laboratory only



Dutasteride 0.5 mg and Tamsulosin Hydrochloride 0.4 mg Hard Capsules

Composition:

Each capsule contains	
Dutasteride	0.5 mg
Tamsulosin Hydrochloride	0.4 mg

Excipients:

Hard Capsule Shell:

Hypromellose, Carrageenan, Potassium Chloride, Titanium Dioxide (E171), Sunset Yellow (E110), Red Iron Oxide (E172)

Contents in Dutasteride Soft Capsule:

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Glycerol monocaprylocaprate , Butylhydroxytoluene (E321)

Soft Capsule Shell:

Gelatin, Glycerol, Titanium Dioxide (E171), Iron Oxide Yellow (E172), Triglycerides (medium chain), Lecithin (Soya) E-322

Tamsulosin Pellets:

Microcrystalline Cellulose, Methacrylic acid-ethyl acrylate copolymer 1:1 dispersion 30%, Magnesium stearate, Sodium hydroxide, Triacetin, Purified Talc, Titanium Dioxide (E171)

DESCRIPTION:

Dutasteride/Tamsulosin is available in Orange cap and brown body hard capsules containing white to off white pellets and one yellow soft gelatin capsule with an oily and yellowish liquid.

PHARMACOLOGY:

Mechanism of action:

Dutasteride/Tamsulosin is a combination of two drugs with complementary mechanisms of action to improve symptoms in patients with BPH: dutasteride, a dual 5α-reductase inhibitor (5-ARI) and tamsulosin hydrochloride, an antagonist of α1a-adrenoreceptors.

Dutasteride

Dutasteride inhibits the Type 1 and 2 5α-reductase isoenzymes which are responsible for the conversion of testosterone to 5α-dihydrotestosterone (DHT) and therefore causes a fall in the DHT level in the circulation and in the prostate. DHT is the main androgen responsible for hyperplasia of the glandular prostate tissue. Dutasteride reduces the size of the prostate, relieves the symptoms, improves urine flow and reduces the risk of acute urinary retention and the need for surgery.

Tamsulosin

Tamsulosin is a selective α1-adrenoreceptor blocker for the symptomatic treatment of functional symptoms of benign prostatic hyperplasia. It binds selectively and competitively to postsynaptic α1-adrenoreceptors (mainly the α1a subtype – approximately 75% of the α1-receptors in the prostate are of the α1a subtype) responsible for contraction of the smooth muscle of the prostate and urethra. Tamsulosin thereby reduces smooth muscle tension in the prostate and urethra. This increases maximum urinary flow rate and reduces urinary tract obstruction. It also improves the complex of irritative and obstructive symptoms in which bladder instability and tension of the smooth muscles of the lower urinary tract play an important role.

Effects on DHT/testosterone:

The peak effect of dutasteride in the sense of reduction of DHT is dose-dependent and occurs within 1-2 weeks. After taking dutasteride (0.5 mg/day) for one or two weeks, the mean DHT concentrations in the serum were reduced by 85% and 90% respectively.

Safety Pharmacodynamics

Adrenergic alpha-1 receptor blockers can reduce blood pressure by lowering peripheral resistance.

PHARMACOKINETICS:

Food had no effect on the AUC of tamsulosin. The bioavailability of dutasteride is not affected by concomitant intake of food.

Absorption

Dutasteride

After oral administration the peak serum concentration of dutasteride is attained within 1-3 hours. Absolute bioavailability compared with a 2-hour intravenous infusion is approx. 60%.

Tamsulosin

Tamsulosin hydrochloride is absorbed from the intestine and is almost completely available. After a single dose following a meal, tamsulosin plasma concentrations reach their peak after 6 hours. Tamsulosin hydrochloride has linear absorption kinetics, with achievement of steady state concentrations by about the fifth day of once-a-day dosing. The rate of absorption of tamsulosin hydrochloride is reduced by a recent meal. Uniformity of absorption can be promoted by the patient always taking tamsulosin hydrochloride 30 minutes after the same meal each day. Tamsulosin plasma levels exhibit considerable inter-individual variability with both single and multiple dosing.

Distribution

Dutasteride

Dutasteride has a large volume of distribution (300-500 l) and is highly plasma protein bound (> 99.5%; to albumin and α1-acid glycoprotein). The steady-state serum concentration (Css) of approx. 40 ng/ml at a dose of 0.5 mg dutasteride a day is achieved after 6 months. After 1 and 3 months the dutasteride serum levels reach 65% and about 90% respectively of the steady-state concentration. The steady-state concentration is also reached in seminal fluid after 6 months. After administration for 12 months the dutasteride concentration in seminal fluid was on average 3.4 ng/ml (range 0.4-14 ng/ml), i.e. on average 11.5% of the serum level.

Tamsulosin

The volume of distribution of tamsulosin hydrochloride is low (approx. 0.2l/kg). Tamsulosin hydrochloride is extensively bound to human plasma proteins (94% to 99%), primarily α-1 acid glycoprotein (AAG).

Metabolism

Dutasteride

Dutasteride undergoes extensive metabolism. It is mainly hydroxylated and dehydrogenated to inactive metabolites. There are 4 major metabolites and 6 subsidiary metabolites. Hydroxylation takes place in vitro via CYP3A4.

Tamsulosin

Tamsulosin hydrochloride is extensively metabolised slowly by cytochrome P450 enzymes in the liver. In vitro results indicate that CYP3A4 and CYP2D6, and to a minor extent some other CYP isoenzymes, are involved in the metabolism of tamsulosin. However, the majority is present in the plasma in the form of the unchanged active ingredient. None of the metabolites is more active or more toxic than the parent substance. The metabolites of tamsulosin hydrochloride undergo extensive conjugation to glucuronide or sulphate prior to renal excretion.

Elimination

Dutasteride

5.4% of the dose administered is excreted as unchanged dutasteride in the faeces, and the rest in the form of metabolites. Only traces of the unchanged substance (less than 0.1% of the dose) can be detected in the urine. Dutasteride clearance is low. The elimination half-life is 3-5 weeks.

Tamsulosin

Following oral administration of tamsulosin in the form of modified release capsules, the apparent elimination half life in the fed state after a single dose is approximately 10 hours and in the steady state is approximately 13 hours. Approximately 10% of the substance is excreted unchanged in urine.

Kinetics of special patient populations

No pharmacokinetic studies have been conducted with Dutasteride/Tamsulosin on special patient populations. The following statements reflect the information available on the individual components.

Elderly

Dutasteride

In the age groups >50-65 years and >70 years there were no statistically significant differences in pharmacokinetics.

Tamsulosin

Findings indicate that overall exposure is approx. 40% increased in patients aged 55-75 years compared with young males.

Renal impairment

Dutasteride

The effects of renal impairment on the pharmacokinetics of dutasteride have not been investigated. As less than 0.1% of the dose is excreted in the urine, no effect on the serum levels is to be expected.

Tamsulosin

No clinically relevant changes in the pharmacokinetics of tamsulosin were observed in patients with mild to moderate (30 ≤ CLcr < 70 mL/min/1.73m²) or moderate to severe (10 ≤ CLcr < 30 mL/min/1.73m²) renal impairment compared with subjects with normal renal function. However, patients with terminal renal disease (CLcr<10mL/min/1.73m²) have not been studied.

Hepatic impairment

Dutasteride

The effects of hepatic impairment on the pharmacokinetics of dutasteride have not been investigated.

Tamsulosin

In patients with mild to moderate hepatic dysfunction (Child-Pugh classification: Grades A and B), no clinically relevant changes in the pharmacokinetics of tamsulosin hydrochloride were observed. Tamsulosin hydrochloride has not been studied in patients with severe hepatic dysfunction (Child-Pugh C).

INDICATIONS :

Dutasteride/Tamsulosin is indicated as combination therapy for the treatment of moderate to severe symptoms of benign prostatic hyperplasia (BPH). Dutasteride/Tamsulosin reduces the risk of acute urinary retention and the need for surgery in patients with moderate to severe symptoms of BPH.

CONTRAINDICATIONS:

- patients with a history of orthostatic hypotension.
- severe hepatic impairment.
- women, patients ≤21 years old
- hypersensitivity to tamsulosin, dutasteride, other ingredients of the product or to other 5α-reductase inhibitors.

DOSAGE AND ADMINISTRATION:

Patients >21 years old (including elderly patients)

The recommended dose of Dutasteride/Tamsulosin is one capsule daily (0.5 mg / 0.4 mg). Dutasteride/Tamsulosin must always be taken with a glass of water, up to 30 minutes after a meal. It must never be taken on an empty stomach. Ideally it should be taken at the same time of the day (this means with the same meal). The capsules should be swallowed whole and not chewed or opened, as contact with the capsule contents may result in irritation of the oropharyngeal mucosa

Special dosage instructions

Elderly patients:

No age-related dose adjustment is required.

Renal impairment

There is no experience available in patients with renal impairment. Dutasteride/Tamsulosin should therefore be used with caution especially in patients with severe renal impairment (creatinine clearance <10ml/min)

Hepatic impairment

There is no experience available in patients with hepatic impairment. Dutasteride/Tamsulosin should be used with caution in patients with mild to moderate hepatic impairment. In patients with severe hepatic impairment, the use of Dutasteride/Tamsulosin is contraindicated.

Patients ≤21 years old:

Dutasteride/Tamsulosin is not indicated in patients ≤21 years old.

WARNINGS AND PRECAUTIONS:

Prior to initiating treatment with Dutasteride/Tamsulosin the patient should be examined to rule out other causes of the symptoms. Dutasteride/Tamsulosin should only be prescribed after a careful benefit/risk assessment due to the risk of adverse events from both active components, and after careful consideration of alternative treatment options (e.g. monotherapies). Patients with large residual urinary volume and/or severely impaired urine flow should be monitored carefully for acute or chronic urinary retention.

As the active principle dutasteride is absorbed through the skin, contact with leaking capsules should be avoided. In the event of contact with leaking capsules the area affected should be washed thoroughly with soap and water at once. Women should not handle crushed or broken Dutasteride/Tamsulosin capsules if they are pregnant or could become pregnant, due to the possibility of absorption of dutasteride and the possible risk to a male foetus.

Effects on prostate-specific antigen (PSA) and the detection of prostate cancers.

Before initiating treatment with Dutasteride/Tamsulosin tests to rule out prostate cancer including a digital rectal examination should be carried out. These tests should be repeated at regular intervals during the treatment. The PSA serum level is an important parameter for early detection of prostate cancer. Treatment with Dutasteride/Tamsulosin leads to an average reduction of 50% in PSA serum levels within 6 months (with great inter-individual fluctuations, standard deviation 30%). This is why PSA levels within the normal range in patients taking Dutasteride/Tamsulosin do not rule out prostate cancer. For this reason, after six months of treatment with Dutasteride/Tamsulosin, PSA levels must be assessed again and the result of this measurement used as the baseline value for future measurements. Any confirmed rise in PSA levels compared to the lowest value determined during treatment with Dutasteride/Tamsulosin may indicate the presence of prostate cancer (particularly high grade tumour) or lack of compliance and must therefore be evaluated carefully, even if values are still within the normal range for men who have not been treated with 5α-reductase inhibitors. A comparison with previous PSA values should be used to interpret the PSA value in patients treated with dutasteride. After discontinuation of the treatment the PSA levels return to baseline values within 6 months. The ratio of free to total PSA remains unchanged by Dutasteride/Tamsulosin. If the doctor uses the percentage of free PSA as a marker to detect prostate cancer, no adjustment of the value is necessary during treatment with Dutasteride/Tamsulosin.

Increased Risk of High-Grade Prostate Cancer

In men aged 50 to 75 years with a prior negative biopsy for prostate cancer and a baseline PSA between 2.5 ng/mL and 10.0 ng/mL taking AVODART in the 4-year. Reduction by Dutasteride of Prostate Cancer Events (REDUCE) trial, there was an increased incidence of Gleason score 8-10 prostate cancer compared with men taking placebo (AVODART 1.0% versus placebo 0.5%). In a 7-year placebocontrolled clinical trial with another 5-α reductase inhibitor (finasteride 5 mg, PROSCAR), similar results for Gleason score 8-10 prostate cancer were observed (finasteride 1.8% versus placebo 1.1%).

5-α reductase inhibitors may increase the risk of development of high-grade prostate cancer. Whether the effect of 5-α reductase inhibitors to reduce prostate volume, or study-related factors, impacted the results of these studies has not been established.

Prostate cancer (in particular high grade tumours)

Results of two long-term clinical studies (REDUCE dutasteride study and PCPT finasteride study) in men at increased risk of prostate cancer revealed a higher incidence of Gleason 8 - 10 prostate cancers in men treated with 5α-reductase inhibitors (dutasteride or finasteride) compared to placebo. The relationship between 5α-reductase inhibitors and higher grade prostate cancer is not clear yet. Men taking Dutasteride/Tamsulosin should be regularly evaluated for the manifestation of prostate cancer, including PSA testing.

Breast cancer in men

Data on a possible relationship between long-term therapy with dutasteride and the occurrence of breast cancer in men are currently inadequate. Prescribers should instruct their patients to promptly report any changes in their breast tissue such as lumps or nipple discharge. Currently it is not clear if there is a causal relationship between the occurrence of male breast cancer and long term use of dutasteride.

Hypotension:

During treatment with an adrenergic α-1 receptor blocker such as tamsulosin orthostatic hypotension may occur which in rare cases can result in syncope. Caution is advised in particular in patients who exhibited an excessive haemodynamic reaction during previous treatment with an α-1 receptor blocker and in patients receiving antihypertensive therapy. In theory, when tamsulosin hydrochloride is coadministered with anaesthetics, PDE5 inhibitors or other adrenergic α-1 receptor blockers, there is a risk of potentiation of hypotensive effects. Dutasteride/Tamsulosin must not therefore be used in combination with other adrenergic α-1 receptor blockers, and should only be used with caution in combination with PDE5 inhibitors. Patients beginning treatment with Dutasteride/Tamsulosin should be cautioned to sit or lie down at the first signs of orthostatic hypotension (dizziness) until the symptoms have resolved.

Cardiac failure under combined therapy with tamsulosin

Up until now there have been no grounds to suspect a causal connection between the medication and the manifestation of cardiac failure, especially since the majority of the patients affected presented predisposing illnesses such as arterial hypertonia or coronary heart disease. In some cases the symptoms of heart failure did not occur until after more than one year of treatment. Caution is advised in patients with coronary heart disease owing to the possible antihypertensive effects of tamsulosin

Intraoperative floppy iris syndrome

Intraoperative floppy iris syndrome (IFIS) has been observed during ophthalmological interventions (cataract and glaucoma surgery) in some patients treated with adrenergic α-1 receptor blockers, such as tamsulosin. IFIS is characterised by a flaccid iris, progressive intraoperative miosis despite premedication with standard mydriatics, and potential prolapse of the iris towards the incisions for phacoemulsification. IFIS may increase the risk of intraoperative and postoperative ophthalmological complications, and the surgeon should be prepared, if necessary, to adjust his surgical techniques accordingly. It is recommended that treatment with tamsulosin is not initiated in patients who are about to undergo eye surgery. However, it has not been proven that discontinuation of tamsulosin 1-2 weeks prior to the intervention is beneficial. There have been some reports on IFIS in patients who discontinued tamsulosin some time prior to the operation.

Effects on the reproductive system

The relevance of the effects of dutasteride on semen characteristics for an individual patient's fertility is not known

The effects of tamsulosin hydrochloride on sperm count or function have not been examined. In the case of combined administration of dutasteride and tamsulosin there was an increased incidence of undesirable effects in the organ system "reproductive system and breast", particularly at the start of the treatment (i.e. during the first 6-12 months) compared to therapy with dutasteride or tamsulosin alone.

Hepatic impairment

The effects of hepatic impairment on the pharmacokinetics of

dutasteride have not been investigated. As dutasteride undergoes extensive metabolism and has a half-life of 3-5 weeks, Dutasteride/Tamsulosin should be used with caution in patients with mild to moderate hepatic impairment. Since also for tamsulosin there are no data regarding severe hepatic impairment available, Dutasteride/Tamsulosin is contraindicated for severe liver impairment.

CYP3A4 inhibitors

Co-administration of tamsulosin and CYP3A4 inhibitors may increase tamsulosin exposure. In particular, there is a risk for significantly increased tamsulosin exposure in the case of CYP2D6 slow metabolisers who are being treated concurrently with potent CYP3A4 inhibitors. As polymorphism for CYP2D6 is generally unknown outside clinical studies, Dutasteride/Tamsulosin should basically not be coadministered with potent CYP3A4 inhibitors (e.g. ketoconazole, itraconazole, voriconazole, clarithromycin, indinavir, nelfinavir, ritonavir, saquinavir). Dutasteride/Tamsulosin should only be co-administered with caution with moderate CYP3A4 inhibitors (e.g. erythromycin, fluconazole, verapamil, diltiazem). This applies in particular if the patient is being concurrently treated with a potent or moderate CYP2D6 inhibitor (such as paroxetine) or if concurrent treatment is with a CYP3A4 inhibitor that also inhibits CYP2D6 (such as amiodarone, cimetidine, imatinib).

Renal impairment: The effects of renal impairment on the pharmacokinetics of tamsulosin have not been investigated in patients with creatinine clearance <10ml/min Dutasteride/Tamsulosin should therefore be used with caution in such patients. For dutasteride no pharmacokinetic data are available in patients with impaired renal function. Due to the minimal renal elimination, there is no meaningful impact expected.

Swallowing disorders: Dutasteride/Tamsulosin has not been studied in patients with swallowing disorders (e.g. stenosing oesophageal changes or neurological disorders accompanied by impaired oesophageal motility). Caution is therefore advised in such patients.

Discontinuation of Dutasteride/Tamsulosin: On discontinuing Dutasteride/Tamsulosin the prostate can go back to the size it was prior to the treatment. Patients should therefore be suitably monitored for the recurrence of symptomatic BPH.

DRUG INTERACTIONS:

There have been no drug interaction studies for Dutasteride/Tamsulosin. The following statements reflect the information available on the individual components.

Pharmacokinetic interactions

Interactions with CYP450 enzyme system

Dutasteride

Dutasteride is metabolized by CYP3A4. A reduction in clearance by concomitant administration of CYP3A4 inhibitors is regarded as clinically irrelevant in view of the wide therapeutic window. In vitro, dutasteride is not metabolised by CYP1A2, CYP2A6, CYP2D6, CYP2E1, CYP2C8, CYP2C9, CYP2C19 and CYP2B6. Dutasteride has no inhibitory effect on cytochrome P450 enzymes.

Tamsulosin

Concomitant administration of tamsulosin with CYP3A4 or CYP2D6 enzyme inhibitors may lead to increased tamsulosin exposure. Concomitant administration of ketoconazole (a potent CYP3A4 inhibitor) resulted in an increase of the Cmax and AUC of tamsulosin by a factor of 2.2 and 2.8 respectively. Concomitant administration of paroxetine (a potent CYP2D6 inhibitor) caused an increase of the Cmax and AUC of tamsulosin by a factor of 1.3 and 1.6 respectively. The effects of co-administration of both a CYP3A4 and a CYP2D6 inhibitors with tamsulosin have not been evaluated clinically, however there is a potential for significant increase in tamsulosin exposure.

Interactions with oral anticoagulants

Dutasteride

Dutasteride did not show any interaction with the plasma protein binding of warfarin, acenocoumarol or phenprocoumon in vitro.

Tamsulosin

No study has been conducted on interactions between tamsulosin hydrochloride and warfarin. Tamsulosin has no effect on the pharmacokinetics or efficacy of acenocoumarol in healthy subjects. The effect of acenocoumarol on the pharmacokinetics of tamsulosin has not been investigated. There are no interaction studies with phenprocoumon. The INR values of patients on oral anticoagulation therapy should be closely monitored for 2-3 months when starting or stopping treatment with Dutasteride/Tamsulosin.

Other pharmacokinetic interactions

Dutasteride

No clinically significant pharmacokinetic or pharmacodynamic interactions have been observed between dutasteride and tamsulosin, terazosin, warfarin, digoxin and cholestyramine. In vitro, dutasteride did not displace diazepam or phenytoin from plasma protein binding and in turn was not displaced by them either.

Tamsulosin

Concomitant administration of tamsulosin hydrochloride and furosemide produced an 11-12% reduction in the Cmax and AUC of tamsulosin hydrochloride; however these changes are clinically irrelevant and no dose adjustment is necessary. In clinical studies, tamsulosin had no effect on the pharmacokinetics of atenolol, digoxin, enalapril, nifedipine or theophylline.

Pharmacodynamic interactions

Tamsulosin

In three studies on hypertonic patients whose blood pressure was stable with atenolol, enalapril or nifedipine, tamsulosin did not have a relevant effect on blood pressure compared to placebo.

Pregnancy and lactation

Dutasteride/Tamsulosin is contraindicated in women.

No studies have been conducted with Dutasteride/Tamsulosin to investigate the effect on pregnancy and lactation. The following statements reflect the information available on the individual components.

Pregnancy:

5α-reductase inhibitors can inhibit the development of the external genitalia of male fetuses. As dutasteride is absorbed through the skin, contact (especially with leaking capsules) should be avoided during pregnancy.

It is not known whether a male fetus may be adversely affected if his mother is exposed to the semen of a patient being treated with dutasteride.

Lactation: It is not known whether dutasteride or tamsulosin are excreted in human breast milk.

Effects on ability to drive and use machines

Studies to investigate the effect of Dutasteride/Tamsulosin on the ability to perform tasks that require judgement, motor or cognitive skills have not been conducted. However, patients should be informed about the possible occurrence of symptoms related to orthostatic hypotension (such as dizziness) and visual disturbances when taking Dutasteride/Tamsulosin that could impair the ability to drive and to use machines

Undesirable effects

There have been no Phase III trials conducted with Dutasteride/Tamsulosin; however, coadministration information is available from the Avodart and Tamsulosin study, a comparison of dutasteride 0.5mg and tamsulosin 0.4mg once daily for four years as co-administration or as monotherapy.

Information on the side effect profiles of the individual components (dutasteride and tamsulosin) is also provided.

The most common undesirable effects during combined administration of dutasteride and tamsulosin related to the organ system "Reproductive system and breast".

These undesirable effects were observed more frequently with the combination therapy than with the respective monotherapies and in each case were more frequent in the first year of treatment than in the subsequent years of treatment.

The undesirable effects, which were observed either during one of the two monotherapies (in clinical trials and/or during post-marketing surveillance) or in the co-administration study, are listed below by organ system and frequency. (See the prescribing information of the single-agent preparations for any assignment of individual undesirable effects to either of the two active ingredients)

The following convention has been chosen for classification of the undesirable effects: very common (≥ 1/10), common (≥ 1/100 and <1/100), rare (≥ 1/10,000 and < 1/1000), very rare (< 1/10,000), unknown (based predominantly on spontaneous reports during post-marketing surveillance, precise frequency cannot be estimated).

Neoplasms

Unknown: Breast cancer in men

Immune system disorders

Uncommon: Rash, pruritus, urticaria

Rare: Angioedema

Very rare: Stevens-Johnson syndrome

Psychiatric disorders

Common: Decreased libido

Very rare: Depressive mood

Nervous system disorders

Common: Dizziness

Rare: Syncope

Eyes

Unknown: blurred vision, visual disturbances.

Following market launch there have also been reports of a relationship between the occurrence of what is known as Intraoperative Floppy Iris Syndrome (IFIS) during cataract and glaucoma surgery and treatment tamsulosin.

Cardiovascular disorders

Uncommon: Palpitations, orthostatic hypotension

Unknown: Tachycardia, arrhythmias (e.g. atrial fibrillation)

Respiratory disorders

Uncommon: Rhinitis

Unknown: Epistaxis, dyspnoea

Gastrointestinal disorders

Uncommon: Nausea, constipation, diarrhoea, vomiting, dry mouth

Skin and subcutaneous tissue disorders

Unknown: Exfoliative dermatitis, erythema multiforme

Reproductive system and breast disorders

Common: Impotence, ejaculation disorders (such as retrograde ejaculation), gynaecomastia, breast tenderness.

Very rare: Priapism, testicular pain and testicular swelling

Unknown: Persistent sexual dysfunction (such as impotence, ejaculation disorders and decreased libido) even after discontinuation of therapy

General disorders

Uncommon: Asthenia

OVERDOSE

No data are available with regard to overdosage with Dutasteride/Tamsulosin. The following statements reflect the information available on the individual components.

Dutasteride

Single daily doses of up to 40 mg dutasteride (equivalent to 80 times the therapeutic dose) for 7 days without any major problems as regards safety, daily doses of 5 mg for 6 months without any additional side-effects occurred compared with the recommended dose. There is no specific antidote for dutasteride. Therefore if an overdose is suspected appropriate symptomatic treatment should be initiated.

Tamsulosin

Cases of acute overdose with 5mg tamsulosin have been reported. Acute hypotension (systolic blood pressure 70 mmHg), vomiting and diarrhoea were observed in these patients. In cases of acute hypotension occurring after overdose with tamsulosin hydrochloride cardiovascular support should be given. Normalisation of blood pressure and heart rate may be accomplished by lying the patient down. If this is inadequate, volume expanders and if necessary vasopressors can then be administered. Since tamsulosin exhibits strong plasma protein binding, dialysis is unlikely to be of benefit in removing tamsulosin from the body. Vomiting may be induced to reduce absorption. If a large dose has been taken, administration of activated charcoal and osmotic laxatives may be useful.

Keep out of reach of children.

Jauhi Ubat dari Kanak Kanak

STORAGE:

Protect from light and moisture.

Store below 30°C in dry place.

SHELF LIFE: 3 years

PRESENTATION:

Dutasteride/Tamsulosin is available as alu-alu blister pack of 6 capsules.

Such 5 blisters are packed in carton



Manufactured for :

MEGA LIFSCIENCES (AUSTRALIA) PTY LTD

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Product Registration Holder in Malaysia:

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