

NEW ZEALAND DATASHEET

Pantoprazole Sandoz

Pantoprazole Sodium Sesquihydrate Ph Eur, enteric coated tablets, 20 mg and 40 mg (as pantoprazole)

Presentation

20 mg

Yellow, oval shaped, gastro-resistant film coated tablets, approximately 8.9 by 4.6 mm. Imprinted **20** in black ink on one face. Each tablet contains Pantoprazole Sodium Sesquihydrate Ph Eur 22.55 mg equivalent to pantoprazole 20 mg.

40 mg

Yellow, oval shaped, gastro-resistant film coated tablets, approximately 11.7 by 6.0 mm. Imprinted **40** in black ink on one face. Each tablet contains Pantoprazole Sodium Sesquihydrate Ph Eur 45.10 mg equivalent to pantoprazole 40 mg.

Uses

Actions

Pharmacotherapeutic group

A02BC02 – Proton pump inhibitors.

Mechanism of action

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.

Pharmacodynamic effects

Pantoprazole is converted to its active form in the acidic canaliculi of the parietal cells when it inhibits the H⁺, K⁺-ATPase enzyme, i.e. the final stage in the production of hydrochloric acid in the stomach. The inhibition is dose-dependent and affects both basal and stimulated acid secretion.

Onset and duration of action

In most patients, freedom from symptoms is achieved in 2 weeks. As with other proton pump inhibitors and H₂ receptor antagonists, 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 (e.g. 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 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 can be ruled out for humans for a one year treatment period.

An influence of a long-term treatment with pantoprazole exceeding one year cannot be completely ruled out on endocrine parameters of the thyroid and liver enzymes according to results in animal studies.

Pharmacokinetics

Pharmacokinetics do not vary after single or repeated administration. In the dose range of 10 to 80 mg, the plasma kinetics of pantoprazole are virtually linear after both oral and intravenous administration.

Absorption

Pantoprazole is rapidly and completely absorbed after oral administration. The maximal plasma concentration is achieved even after a single oral dose. On average at about 2.0 h to 2.5 h p.a. maximum plasma levels of about 1 to 1.5 mcg/ml following a 20 mg dose and 2 to 3 mcg/ml following a 40 mg dose are achieved, and these values remain constant after multiple administration.

The absolute bioavailability from an oral dose was found to be about 77%. Concomitant intake of food had no influence on AUC, maximum plasma concentration and therefore bioavailability. Only the variability of the lag-time will be increased by concomitant food intake.

Distribution

The volume of distribution is about 0.15 l/kg and about 98% is bound to plasma proteins.

Biotransformation

Pantoprazole is almost exclusively metabolised in the liver. Renal elimination represents the major route of excretion (about 80%) for the metabolites of pantoprazole, followed by biliary excretion. The main metabolite in both the plasma and urine is the desmethylpantoprazole sulphate conjugate. The half-life of the main metabolite (about 1.5 h) is not much longer than that of pantoprazole.

Elimination

The terminal half-life is about 1 h and the clearance is about 0.1 l/h/kg. There were a few cases of subjects with delayed elimination. As pantoprazole specifically binds 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).

Special patient groups

Renal impairment

No dose reduction is necessary when pantoprazole is administered to patients with restricted kidney function (including dialysis patients). As with healthy subjects, the half-life of pantoprazole is short. Only very small amounts of pantoprazole can be dialysed. Although the main metabolite has a moderately delayed half-life (2 to 3 h), excretion is still rapid and thus accumulation does not occur.

Liver disease

For patients presenting liver cirrhosis (classes A and B according to Child) the half-life values increased, to between 3 to 6 h following a 20 mg dose and 7 to 9 h following a 40 mg dose, and the AUC values increased by a factor of 3 to 5 following a 20 mg dose and between 5 to 7 following a 40 mg dose. However, the maximum plasma concentration only increased slightly, by a factor of 1.3 following a 20 mg dose and 1.5 following a 40 mg dose, compared with healthy subjects.

Elderly patients

A slight increase in AUC and C_{max} in elderly volunteers compared with younger counterparts is also not clinically relevant.

Indications

For the symptomatic improvement and healing of gastrointestinal diseases which require a reduction in acid secretion: duodenal ulcer (DU); gastric ulcer; gastro-oesophageal reflux disease (GORD) - for

the treatment of mild reflux disease and associated symptoms (e.g. heartburn, acid regurgitation, pain on swallowing) and reflux oesophagitis; Zollinger-Ellison Syndrome.

Eradication of *Helicobacter pylori* (hereinafter referred to as *H. pylori*) in combination with clarithromycin and amoxicillin, or clarithromycin and metronidazole, or amoxicillin and metronidazole, (refer to [Dosage and Administration](#)), in cases of duodenal ulcer and gastric ulcer with the objective of reducing the recurrence of duodenal and gastric ulcers caused by this microorganism.

The NIH have recommended that regimens to eradicate *H. pylori* in patients with peptic ulcer disease (PUD) should contain both anti-secretory agents and anti-microbial agents (to which *H. pylori* has been demonstrated to be sensitive *in vivo*). A trial by Bardhan in patients with gastritis, florid duodenal ulcer or history of duodenal ulcer, has demonstrated that pantoprazole 40 mg twice daily in the combination with tinidazole 500 mg twice daily and clarithromycin 250 mg twice daily for 10 days is effective in eradicating *H. pylori* in 86% of cases. Following combination therapy, the DU healing rate was 100% after 1 month.

Prevention of gastroduodenal ulcers induced by non-selective non-steroidal anti-inflammatory drugs (NSAIDs) in patients at risk with a need for continuous NSAID treatment.

Maintenance

Pantoprazole is indicated for maintenance treatment of reflux oesophagitis, duodenal ulcer, gastric ulcer and Zollinger-Ellison syndrome. Prolonged treatment should be considered: in patients who have recurrent peptic ulceration where the pathogenesis of the ulcer is not related to *H. pylori* infection; or where repeated eradication therapy is unsuccessful; or who have a past history of perforation or bleeding from an ulcer.

Dosage and administration

Dosage

***H. pylori* eradication**

In *H. pylori* positive patients with gastric and duodenal ulcers, eradication of the germ by a combination therapy should be achieved. One of the following combinations of pantoprazole with antibiotics is effective:

pantoprazole 40 mg twice daily plus amoxicillin 1000 mg twice daily plus clarithromycin 500 mg twice daily;

pantoprazole 40 mg twice daily plus metronidazole 500 mg twice daily plus clarithromycin 500 mg twice daily;

pantoprazole 40 mg twice daily plus amoxicillin 1000 mg twice daily plus metronidazole 500 mg twice daily.

In the case of combination therapy the datasheets of the respective drugs should be observed.

Combination therapy involving metronidazole must only be used if the other combination partners are contraindicated, since damage to human germ cells by metronidazole cannot be excluded and animal studies revealed an increased incidence of certain tumours.

General instructions

For eradication of *H. pylori*, convenient dosing could be at breakfast and dinner times. The combination therapy is implemented for 7 days. If, to ensure healing of the ulcers, further treatment with pantoprazole is indicated, the dosage recommendations for duodenal and gastric ulcers should be considered.

If combination therapy is not an option, e.g. if the patient has tested negative for *H. pylori*, the following dosage guidelines apply for pantoprazole monotherapy:

Duodenal ulcer

The recommended oral dosage is pantoprazole 40 mg per day. A duodenal ulcer generally heals within 2 weeks. If a 2 week period of treatment is not sufficient, healing will be achieved in almost all cases within a further 2 weeks.

Gastric ulcer

The recommended oral dosage is pantoprazole 40 mg per day. A 4 week period is usually required for the treatment of gastric ulcers. If this is not sufficient, healing will usually be achieved within a further 4 weeks.

GORD

For mild reflux disease and the associated symptoms, the recommended dosage is pantoprazole 20 mg per day. Symptom relief is generally accomplished within 2 to 4 weeks. If symptom control has not been achieved after four weeks treatment with pantoprazole 20 mg tablets daily, further investigation is recommended.

For treatment of reflux oesophagitis, the recommended oral dosage is pantoprazole 40 mg per day. A 4 week period is usually required for treatment of reflux oesophagitis, however if this is not sufficient, healing will usually be achieved within a further 4 weeks.

Zollinger-Ellison Syndrome

The recommended oral dosage is pantoprazole 40 mg per day.

Prevention of gastroduodenal ulcers induced by non-selective non-steroidal anti-inflammatory drugs (NSAIDs) in patients at risk with a need for continuous NSAID treatment.

The recommended oral dosage is pantoprazole 20 mg per day.

Maintenance*Duodenal and gastric ulcer, and Zollinger-Ellison Syndrome*

For long-term management, a maintenance dose of pantoprazole 40 mg per day is recommended.

Reflux oesophagitis

A maintenance dose of pantoprazole 20 mg per day is recommended, increasing to 40 mg per day if relapse occurs. After healing of the relapse the dosage can be reduced again to pantoprazole 20 mg.

Experience with long-term administration in man over several years is available in a limited number of patients. Therefore, long-term treatment exceeding 1 year may be considered after careful evaluation of the risk-benefit ratio. Patients should then be kept under regular surveillance.

Use in children

There are no data currently available on the use of pantoprazole in children.

Use in the elderly

The daily dose of 20 mg or 40 mg can be given. An exception is combination therapy for eradication of *H. pylori*, where also elderly patients should receive the usual pantoprazole dose (2 x 40 mg/day) during 1 week treatment.

Impaired renal function

The daily dose of 20 mg or 40 mg can be given.

Impaired liver function

In patients with severe liver impairment the dose has to be reduced to pantoprazole 20 mg per day.

Administration

Pantoprazole Sandoz gastro-resistant tablets should not be chewed or crushed, and should be

swallowed whole with some liquid.

Contraindications

Hypersensitivity to pantoprazole or any of the ingredients of Pantoprazole Sandoz or of the combination medicines.

Pantoprazole must not be used in combination treatment for eradication of *H. pylori* in patients with moderate to severe hepatic or renal dysfunction since currently no data are available on the efficacy and safety of pantoprazole in combination treatment of these patients.

Pantoprazole, like other proton pump inhibitors, should not be co-administered with atazanavir (refer to [Interactions](#)).

Warnings and precautions

In patients with severe liver impairment the liver enzymes should be monitored regularly during treatment with pantoprazole, particularly on long-term use. In the case of elevated liver enzymes, pantoprazole should be discontinued.

In the presence of any alarm symptom (e.g. significant unintentional weight loss, recurrent vomiting, dysphagia, haematemesis, anaemia or melaena) and when gastric ulcer is suspected or present, malignancy should be excluded, as treatment with pantoprazole may alleviate symptoms and delay diagnosis. Further investigation is to be considered if symptoms persist despite adequate treatment.

The use of pantoprazole 20 mg for prevention of gastroduodenal ulcers induced by non-selective non-steroidal anti-inflammatory drugs (NSAIDs) should be restricted to patients who require continued NSAID treatment and have an increased risk to develop gastrointestinal complications. The increased risk should be assessed according to individual risk factors, e.g. high age (>65 years), history of gastric or duodenal ulcer or upper gastrointestinal bleeding.

Generally, daily treatment with any acid-blocking medicines over a long time (e.g. longer than 3 years) may lead to malabsorption of cyanocobalamin caused by hypo- or achlorhydria. Rare cases of cyanocobalamin deficiency under acid-blocking therapy have been reported in the literature. This should be considered if respective clinical symptoms are observed.

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

In long-term treatment, especially when exceeding a treatment period of one year, patients should be kept under regular surveillance.

Patients being treated for mild reflux disease and associated symptoms with pantoprazole 20 mg, who do not respond after 4 weeks, should be investigated.

In the case of combination therapy the datasheets of the respective medicines should be observed.

Pregnancy and lactation

Use in pregnancy

Assigned Category B3 by the Australian Drug Evaluation Committee. This category includes medicines which have been taken by only a limited number of pregnant women and women of childbearing age, without an increase in the frequency of malformation or other direct or indirect harmful effects on the human foetus having been observed. Studies in animals have shown evidence of an increased occurrence of foetal damage, the significance of which is considered uncertain in humans.

Clinical experience in pregnant women is limited. In animal reproduction studies, signs of slight

foetotoxicity were observed at doses above 5 mg/kg. Pantoprazole should only be used when the benefit to the mother is considered greater than the potential risk to the foetus or baby.

Use in lactation

There is no information on the excretion of pantoprazole into human breast milk.

Effects on ability to drive and use machines

This medicine is presumed to be safe or unlikely to produce an effect.

Other

Preclinical safety data

Preclinical data reveal no special hazard to humans based on conventional studies of safety pharmacology, repeated dose toxicity and genotoxicity.

Carcinogenesis, mutagenesis, impairment of fertility

In a 2 year carcinogenicity study (corresponding to lifetime treatment) in rats, neuroendocrine neoplasms were found. In addition, squamous cell papillomas were found in the forestomach of rats in one study. The mechanism leading to the formation of gastric carcinoids by substituted benzimidazoles has been carefully investigated and allows the conclusion that it is a secondary reaction to the massively elevated serum gastrin levels occurring in the rat during chronic treatment.

In the two year studies an increased number of liver tumours was observed in rats and in female mice and was interpreted as being due to high metabolic conversion of pantoprazole in the liver. From mutagenicity studies, cell transformation tests and a DNA binding study it is concluded that pantoprazole has no genotoxic potential.

A slight increase of neoplastic changes of the thyroid was observed in the group of rats receiving the highest dose. The occurrence of these neoplasms is associated with the pantoprazole-induced changes in the breakdown of thyroxine in the rat liver. As the therapeutic dose in man is low, no side effects on the thyroid glands are expected.

Investigations revealed no evidence of impaired fertility or teratogenic effects. Penetration of the placenta was investigated in the rat and was found to increase with advanced gestation. As a result, concentration of pantoprazole in the foetus is increased shortly before birth.

Adverse effects

Adverse reactions are ranked, firstly in descending order of frequency then systemically in alphabetical order, using the following convention.

Common (from 1 in 100 to 1 in 10)

Gastrointestinal disorders

Gastrointestinal complaints such as upper abdominal pain, diarrhoea, constipation or flatulence.

Nervous system disorders

Headache.

Uncommon (from 1 in 1000 to 1 in 100)

Gastrointestinal disorders

Nausea, vomiting.

Nervous system disorders

Dizziness, disturbances in vision (blurred vision).

Skin and subcutaneous tissue disorders

Allergic reactions such as pruritus and skin rash.

Rare (from 1 in 10,000 to 1 in 1000)**Gastrointestinal disorders**

Dry mouth.

Musculoskeletal, connective tissue and bone disorders

Arthralgia.

Psychiatric disorders

Depression, hallucination, disorientation and confusion, especially in pre-disposed patients, as well as the aggravation of these symptoms in case of pre-existence.

Very rare (less than 1 in 10,000)**Blood and lymphatic system disorders**

Leukopenia, thrombocytopenia.

General disorders and administration site conditions

Peripheral oedema.

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, gamma-GT), elevated triglycerides, increased body temperature.

Musculoskeletal, connective tissue and bone disorders

Myalgia.

Renal and urinary disorders

Interstitial nephritis.

Skin and subcutaneous tissue disorders

Urticaria; angioedema; severe skin reactions such as Stevens-Johnson Syndrome, erythema multiforme, Lyell-Syndrome; photosensitivity.

Interactions

Medicines and other pharmacologically active substances

Pantoprazole may reduce or increase the absorption of drugs whose bioavailability is pH-dependent (e.g. ketoconazole).

Pantoprazole is metabolised in the liver via the cytochrome P450 enzyme system. An interaction of

pantoprazole with other drugs or compounds which are metabolised 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, antipyrine, metoprolol, naproxen, nifedipine, phenytoin, piroxicam, theophylline, and an oral contraceptive.

Although no interaction during concomitant administration of phenprocoumon or warfarin has been observed in clinical pharmacokinetic studies, a few isolated cases of changes in international normalised ratio (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.

It has been reported that co-administration of atazanavir 300 mg/ritonavir 100 mg with omeprazole 40 mg once daily or atazanavir 400 mg with lansoprazole, as a 60 mg single dose, to healthy volunteers resulted in substantial reduction in the bioavailability of atazanavir. The absorption of atazanavir is pH dependent. Therefore, proton pump inhibitors, including pantoprazole, should not be co-administered with atazanavir (refer to [Contraindications](#)).

Abnormal laboratory test results

Refer to [Adverse effects](#).

Food and alcohol

None reported.

Overdosage

Signs and symptoms

There are no known symptoms of overdosage in man. Doses up to 240 mg were administered intravenously over two minutes and were well tolerated.

Management

In the case of overdosage with clinical signs of intoxication, the usual supportive measures apply. Contact the Poisons Information Centre for advice on the management of an overdose.

Pharmaceutical precautions

Instructions for use/handling

Nil.

Incompatibilities

None known.

Special precautions for storage

Store below 25°C. Store in the original package. Keep out of the reach and sight of children.

Medicine classification

Prescription Medicine.

Package quantities

Packs of 30 tablets in blister strips or HDPE bottles.

Further information

Pathological importance of *H. pylori*

H. pylori is an important aetiological factor in the pathophysiology of PUD and eradication of the infection is the single most important therapeutic intervention in patients positive for *H. pylori*.

List of excipients

Microcrystalline cellulose, crospovidone, methacrylic acid - ethyl acrylate copolymer, hydroxypropylmethylcellulose, sodium carbonate, titanium dioxide E171, hydroxypropylcellulose, triethyl citrate, calcium stearate, macrogol 400, polysorbate 80, colloidal silicon dioxide, food and drug colourings E104, E172, E124, sodium lauryl sulphate, edible printing ink.

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