

NEW ZEALAND DATASHEET

Sotahexal

Sotalol Hydrochloride BP, tablets, 80 mg and 160 mg

Presentation

80 mg

White, 7 mm round, plain, uncoated tablets with one side convex and the other side scored. Each tablet contains sotalol hydrochloride 80 mg.

160 mg

White, 9 mm round, plain, uncoated biconvex tablets, scored on one side. Each tablet contains sotalol hydrochloride 160 mg.

Uses

Actions

Pharmacotherapeutic group

C07AA07 - Beta blocking agents, non-selective, sotalol.

Mechanism of action

Sotalol is a non-selective beta-adrenergic receptor blocker without sympathomimetic activity or membrane stabilising activity.

Pharmacodynamic effects

Sotalol causes a decrease in heart rate and a limited reduction in the force of contraction of the heart. There is a reduction in cardiac work and in myocardial oxygen demand. Sotalol does not decrease blood pressure in normotensive subjects.

Sotalol also possesses class III antiarrhythmic activity. Sotalol has no known effect on the upstroke velocity of the action potential and therefore no known effect on the depolarisation phase. Its major effects are prolongation of the atrial, ventricular and accessory pathway effective refractory periods. The effect on the ventricular myocardium may be reflected by a lengthening of the QTc (QT interval corrected for heart rate) on electrocardiographic recordings.

Like most other beta-blockers, sotalol inhibits renin release. This suppressive effect is significant both at rest and during exercise.

Pharmacokinetics

Absorption

Sotalol is well absorbed from the gastrointestinal tract. Peak plasma concentrations of 1.4 to 1.7 mg/l are reached at 2 to 3 hours after a 160 mg oral dose. The absolute bioavailability on oral administration is close to 100%. The bioavailability is decreased when sotalol is administered with food, especially milk.

Distribution

Total apparent volume of distribution of sotalol ranges from 1.6 to 2.4 l/kg. The volume of distribution at steady state is approximately halved in the elderly. Sotalol does not bind to plasma proteins and

does not significantly cross the blood-brain barrier. However, it is excreted in breast milk and may diffuse across the placental barrier.

Biotransformation

Sotalol is not metabolised by the liver and does not undergo biotransformation (no first-pass effect). There is a positive correlation between sotalol dose and plasma concentration.

Elimination

Sotalol is excreted by glomerular filtration and to a small degree by tubular secretion. After oral administration, about 75% of the dose is excreted in the urine within 72 hours as unchanged sotalol. Less than 10% is excreted in the faeces. The mean elimination half-life of sotalol is 12.7+/-1.6 (SE) hours.

Special patient considerations

As sotalol is primarily excreted by the kidneys, dosage adjustment is necessary in patients with moderate renal impairment. Severe renal impairment (creatinine clearance < 10 ml/minute) is a contraindication.

Indications

Prevention and treatment of supraventricular and ventricular arrhythmias.

Dosage and administration

Sotalol is administered orally for the prevention and treatment of arrhythmias. As with other antiarrhythmic agents, sotalol should be initiated and doses increased in a facility capable of monitoring and assessing cardiac rhythm. The dosage must be individualised for each patient on the basis of therapeutic response and tolerance. Proarrhythmic events can occur not only at initiation of therapy, but also with each upward dosage adjustment.

Sotahexal should be taken preferably 1 to 2 hours before meals.

Oral dosage of sotalol should be adjusted gradually allowing 2 to 3 days between dosing increments in order to attain steady-state, and to allow monitoring of QT intervals. Graded dose adjustment will help prevent the use of doses which are higher than necessary to control the arrhythmia. The recommended initial oral dosing schedule is 160 mg/daily, given in two divided doses at approximately 12 hour intervals. This dose may be increased, if necessary, after appropriate evaluation to 240 or 320 mg/day. In most patients, a therapeutic response is obtained at a total daily dose of 160 to 320 mg/day, given in 2 divided doses. Some patients with life-threatening refractory ventricular arrhythmias may require doses as high as 480 to 640 mg/day; however, these doses should only be prescribed when the potential benefit outweighs the increased risk of adverse events particularly proarrhythmias.

Because of long elimination half-life of sotalol, dosing on more than a twice daily regimen is not usually necessary.

For high risk patients such as patients with acute myocardial infarction careful monitoring for haemodynamic or electrocardiographic changes is recommended.

Impaired renal function

As sotalol is primarily excreted by the kidneys, a dosage adjustment should be made.

Contraindications

Bronchospasm (e.g. bronchial asthma or chronic obstructive airway disease).

Allergic disorders (including allergic rhinitis) which may suggest a predisposition to bronchospasm.

Right ventricular failure secondary to pulmonary hypertension.

Significant right ventricular hypertrophy.

Sinus bradycardia (less than 45 to 50 beats/minute).

Second and third degree atrioventricular block or sick sinus syndrome unless a functioning pacemaker is present.

Shock (including cardiogenic and hypovolaemic shock).

Uncontrolled congestive heart failure.

Severe renal impairment (creatinine clearance < 10 ml/minute).

Congenital or acquired long QT syndromes.

Known hypersensitivity to sotalol or to any of the inactive ingredients listed in [Further information](#).

Anaesthesia that produces myocardial depression.

Warnings and precautions

Warnings

No antiarrhythmic drug has been shown to reduce the incidence of sudden death in patients with supraventricular or asymptomatic ventricular arrhythmias. Since most antiarrhythmic drugs have the potential to cause arrhythmias or increase the incidence of sudden death, physicians should carefully consider the risks and benefits of antiarrhythmic therapy in these patients.

Proarrhythmia

Post-marketing experience

The most dangerous adverse effect of antiarrhythmic drugs is the aggravation of pre-existing arrhythmias or the provocation of new arrhythmias. The drugs that prolong the QT interval may cause torsades de pointes, a polymorphic ventricular tachycardia associated with prolongation of the QT interval. Experience to date indicates that the risk of torsades de pointes is associated with the prolongation of the QT interval, reduction in heart rate, reduction in serum potassium and magnesium (e.g. as a consequence of diuretic use), high plasma drug concentrations (e.g. as a consequence of overdose or renal insufficiency), and with the concomitant use of sotalol and other medication such as antidepressants and class I antiarrhythmics which have been associated with torsades de pointes. Females appear to be at an increased risk of developing torsades de pointes. ECG monitoring immediately prior to or following the episodes usually reveals a significantly prolonged QT interval and a significantly prolonged QTc interval. In clinical trials, sotalol generally has not been initiated in patients whose pretreatment QTc interval exceeded 450 milliseconds. Sotalol should be titrated very cautiously in patients with prolonged QT intervals. Torsades de pointes is dose dependent, usually occurs early after initiating therapy or escalation of the dose, and terminates spontaneously in the majority of patients. Although most episodes of torsades de pointes are self-limited or associated with symptoms (e.g. syncope), they can progress to ventricular fibrillation.

Clinical studies for arrhythmia

During clinical trials, 4.3% of 3,257 patients with arrhythmias experienced a new or worsened ventricular arrhythmia, including sustained ventricular tachycardia (approximately 1%) and torsades de pointes (2.4%). In addition, in approximately 1% of patients, deaths were considered possibly drug related. In patients with other, less serious, ventricular arrhythmias and supraventricular arrhythmias, the incidence of torsades de pointes was 1 and 1.4% respectively. Serious proarrhythmias including torsades de pointes were dose related as indicated below.

Percentage incidence of serious proarrhythmias* by dose for patients with sustained ventricular tachycardia or ventricular fibrillation

Daily dose (mg)	Incidence of serious proarrhythmias	Number of patients
1 - 80	0	(0/72)
81 - 160	0.5%	(4/838)
161 - 320	1.8%	(17/960)
321 - 480	4.5%	(21/471)
481 - 640	4.6%	(15/327)
> 640	6.8%	(7/103)

*Torsades de pointes or new sustained ventricular tachycardia or ventricular fibrillation

Other risk factors for torsades de pointes were excessive prolongation of the QTc and history of cardiomegaly or congestive heart failure. Patients with sustained ventricular tachycardia and a history of congestive heart failure have the highest risk of serious proarrhythmia at approximately 7%. Proarrhythmic events must be anticipated not only on initiating therapy but with every upward dose adjustment; events tend to occur within seven days of initiating therapy or with an increase in dose. Initiating therapy at 80 mg twice daily with gradual upward dose titration thereafter reduces the risk of proarrhythmic events (refer to [Dosage and administration](#)). Sotalol should be used with caution if the QTc interval is greater than 500 milliseconds on therapy, and serious consideration should be given to reducing the dose or discontinuing therapy when the QT interval exceeds 550 milliseconds. Due to the multiple risk factors associated with torsades de pointes, however, caution should be exercised regardless of the QTc interval.

Electrocardiographic monitoring

Regular electrocardiographic monitoring should therefore be carried out during sotalol therapy to monitor the QT interval prolongation described above. Excessive prolongation of the QT interval by >550 milliseconds can be a sign of toxicity and should be avoided. Sinus bradycardia (heart rate < 50 beats/minute) occurred at a frequency of 13% in arrhythmia patients receiving sotalol in clinical trials. Bradycardia itself increases the risk of torsades de pointes. Sinus pause, sinus arrest and sinus node dysfunction occur in less than 1% of patients. The incidence of second or third degree atrioventricular block is approximately 1%.

Cardiac failure

Beta-blockade depresses myocardial contractility and may precipitate cardiac failure in some patients with a history of cardiac failure, chronic myocardial insufficiency or unsuspected cardiomyopathy. In patients without a history of cardiac failure, continuing depression of the myocardium may lead to cardiac failure. If cardiac failure persists sotalol treatment should be discontinued (refer to [Abrupt withdrawal](#)).

Caution is advised when initiating therapy in patients with left ventricular dysfunction controlled by therapy (i.e. ACE inhibitors, diuretics, digitalis, etc.); a low initial dose and careful dose titration is appropriate.

Note: Although congestive heart failure has been considered to be a contraindication to the use of beta-blockers, there is growing literature on the experimental use of beta-adrenergic blocking drugs in heart failure. As further trials are needed to identify which patients are most likely to respond to which drugs, beta-blockers should not normally be prescribed for heart failure outside specialist centres.

Recent myocardial infarction

In post-infarction patients with impaired left ventricular function, the risk versus benefit of sotalol administration must be considered. Careful monitoring and dose titration are critical during initiation and follow-up of therapy. The adverse results of clinical trials involving antiarrhythmic drugs (i.e. apparent increase in mortality) suggest that sotalol should be avoided in patients with left ventricular ejection fractions 40% or less without serious ventricular arrhythmias.

In a large controlled trial in patients with a recent myocardial infarction without heart failure, who did not necessarily have ventricular arrhythmias, oral sotalol hydrochloride treatment was associated with a non-statistically significant risk reduction in mortality compared to the placebo group (18%). In this post-infarction study using a fixed dose of 320 mg once daily and in a second small randomised trial in high risk post-infarction patients with left ventricular ejection fractions 40% or less treated with high doses (640 mg/day), there were suggestions of an excess of early sudden deaths.

Abrupt withdrawal

Care should be taken if beta-blockers have to be discontinued abruptly in patients with coronary artery disease. Severe exacerbation of angina and precipitation of myocardial infarction and ventricular arrhythmias have occurred following abrupt discontinuation of beta-blockade in patients with ischaemic heart disease. Therefore it is recommended that the dosage be reduced gradually over a period of 8 to 14 days during which time the patient's progress should be assessed. Sotalol should be temporarily reinstated if the angina worsens.

If the drug must be withdrawn abruptly in these patients, close observation is required since latent coronary insufficiency may be unmasked. In the peri-operative period, sotalol should not be withdrawn unless indicated.

Concomitant therapy with calcium channel blocking drugs

Concurrent administration of beta-blocking agents and calcium channel blockers has resulted in hypotension, bradycardia, conduction defects and cardiac failure. beta-blockers should be avoided in combination with cardiodepressant calcium channel blockers because of the additive effect on atrioventricular conduction and ventricular function.

Peripheral circulation

Beta-blockade may impair the peripheral circulation and exacerbate the symptoms of peripheral vascular disease.

Antiarrhythmic drugs

Interactions have been reported during concomitant beta-blocker therapy with the class IA agents disopyramide and, less frequently, quinidine; the class IB agents tocainide, mexiletine and lignocaine; the class IC agents flecainide and propafenone; the class III agent amiodarone; and the class IV antiarrhythmic agents. Concomitant use of sotalol with these agents, and with other beta-blocking drugs, is not recommended.

Prinzmetal angina

There is a risk of exacerbating coronary artery spasm if patients with Prinzmetal or variant angina are treated with a beta-blocker. If this treatment is essential, it should only be undertaken in a coronary or intensive care unit.

Euthyroid hyperthyroxinaemia

The effects of beta-blockers on thyroid hormone metabolism may result in elevation of serum free thyroxine (T4) levels. In the absence of any signs or symptoms of hyperthyroidism, additional investigation is necessary before a diagnosis of thyrotoxicosis can be made.

Anaphylaxis

Patients with a history of anaphylactic reaction to a variety of allergens may have more severe reaction on repeated challenge while taking beta-blockers. Such patients may be unresponsive to the usual doses of adrenaline used to treat the allergic reaction.

Precautions

Anaesthesia and the perioperative period

Beta-blockade may have beneficial effects in decreasing the incidence of arrhythmias and myocardial ischaemia during anaesthesia and the postoperative period. It is currently recommended that maintenance beta-blockade be continued perioperatively. The anaesthetist must be made aware of

beta-blockade because of the potential for interactions with other drugs, resulting in severe bradyarrhythmias and hypotension, the decreased reflex ability to compensate for blood loss, hypovolaemia and regional sympathetic blockade, and the increased propensity for vagal induced bradycardia. Incidents of protracted severe hypotension or difficulty restoring normal cardiac rhythm during anaesthesia have been reported.

Modern inhalational anaesthetic agents are generally well tolerated, although older agents (ether, cyclopropane, methoxyflurane, trichlorethylene) were sometimes associated with severe circulatory depression in the presence of beta-blockade.

Diabetes

Beta-blockers affect glucose metabolism and may mask some important premonitory signs of acute hypoglycaemia, such as tachycardia.

In patients with insulin or non-insulin dependent diabetes (especially labile diabetes) or with a history of spontaneous hypoglycaemia, beta-blockade may result in the loss of diabetic control and delayed recovery from hypoglycaemia. The dose of insulin or oral hypoglycaemic agent may need to be adjusted.

Other metabolic effects

Beta-adrenoreceptors are involved in the regulation of lipid as well as carbohydrate metabolism. Some drugs affect the lipid profile adversely although the long-term clinical significance of this change is unknown and the effect appears to be less for drugs with intrinsic sympathomimetic activity.

Impaired renal function

In patients with severe renal disease, haemodynamic changes following beta-blockade may further impair renal function. Beta-blockers which are excreted mainly by the kidney may require dose adjustment in patients with renal impairment. Sotalol excretion is reduced in patients with renal impairment. Dosage should therefore be adjusted accordingly. Sotalol is contraindicated in patients with severe renal impairment (creatinine clearance < 10 ml/minute).

Use of catecholamine depleting agents

Concomitant use of drugs such as reserpine and guanethidine requires careful monitoring since the added effect of a beta-blocker may produce an excessive reduction of the resting sympathetic nervous tone.

Clonidine

Concurrent use of beta-blockers and clonidine should be avoided because of the risk of adverse interaction and severe withdrawal symptoms. If administered concomitantly, clonidine should not be discontinued until several days after the withdrawal of the beta-blocker.

Phaeochromocytoma

In patients with this condition, an alpha-blocking drug (e.g. phentolamine or phenoxybenzamine) should be administered before the beta-blocker to avoid exacerbation of hypertension.

Eye and skin reactions

Various skin rashes and conjunctival xerosis have been reported with beta-blocking agents. Cross reactions may occur between beta-blockers, therefore substitutions within the group may not necessarily preclude occurrence of symptoms.

Allergic conditions

Allergic reactions may be exaggerated by beta-blockade (e.g. allergic rhinitis during the pollen season and allergic reactions to bee and wasp stings). Beta-blockers should be avoided if there is a risk of bronchospasm.

Hyperthyroidism

Because beta-blockers may mask the clinical signs of developing or continuing hyperthyroidism,

resulting in symptomatic improvement without any change in thyroid status, special care should be exercised in hyperthyroid patients who are also receiving beta-blockers.

Abrupt withdrawal of beta-blockade in hyperthyroid patients may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm, and should be avoided in these patients.

Electrolyte disturbances

Prior to starting treatment with sotalol, serum electrolytes should be obtained and any electrolyte imbalance corrected. Hypokalaemia and hypomagnesaemia can exaggerate the degree of QT prolongation, and increase the potential for torsades de pointes. Throughout treatment, it is important to monitor electrolyte balance at regular intervals and correct any imbalance. When significant diarrhoea or other intercurrent illness associated with electrolyte losses occurs during treatment with sotalol, patients should be instructed to contact their physician so that they can be closely monitored with frequent checks of plasma electrolytes and receive replacement therapy as appropriate (refer to Warnings - Proarrhythmia).

Excessive bradycardia

If excessive bradycardia occurs alone or with hypotension, atropine 0.5 to 2.0 mg should be given intravenously and immediately followed, if necessary, by a beta-receptor stimulating agent such as isoprenaline (refer to Overdosage - Management). Patients experiencing this effect on initial administration of sotalol should be removed temporarily from therapy. Sotalol may be later reintroduced at a lower dosage level.

A reduction in dosage by 80 or 160 mg/day may be advisable to alleviate symptoms of weakness and dizziness in cases where the blood pressure continues to fall after a month or two of sotalol administration.

Psoriasis

Beta-blocking drugs have been reported rarely to exacerbate the symptoms of psoriasis vulgaris.

Paediatric use

The safety and effectiveness of sotalol in children under 18 has not been established.

Lactose intolerance

Since this medicinal product contains lactose, patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine.

Pregnancy and lactation

Use in pregnancy

Assigned Category C by the Australian Drug Evaluation Committee. This category includes medicines which, owing to their pharmacological effects, have caused or may be suspected of causing, harmful effects on the human foetus or neonate without causing malformations. These effects may be reversible. Accompanying texts should be consulted for further details.

Beta-blockers may cause pharmacological effects such as bradycardia in the foetus and newborn infant. During the late stages of pregnancy these drugs should only be given after weighing the needs of the mother against the risk to the foetus. Sotalol has been shown to diffuse across the placental barrier and cause bradycardia in the newborn infant.

Use in lactation

Sotalol is actively excreted in breast milk (milk: plasma ratio = 5.4:1) and therefore should not be administered to breastfeeding mothers.

Effects on ability to drive and use machines

This medicine is likely to produce minor or moderate adverse effects.

Adverse effects

Sotalol is well tolerated in the majority of patients, with the most frequent adverse events arising from its beta-blockade properties. Adverse reactions are usually transient in nature and rarely necessitate interruption of or withdrawal from treatment. These include dyspnoea, fatigue, dizziness, headache, fever, excessive bradycardia and/or hypotension. If they do occur, these side effects usually disappear when the dosage is reduced. The most significant adverse events, however, are those due to proarrhythmia, including torsades de pointes.

In clinical trials, 3256 patients with cardiac arrhythmias (1,363 with sustained ventricular tachycardia) received oral sotalol, of whom 2,451 received the drug for at least two weeks. The most significant adverse events were torsades de pointes and other serious new ventricular arrhythmias (refer to [Warnings and precautions - Proarrhythmia](#)), which occurred at the following rates.

Percentage incidence of torsades de pointes and sustained ventricular tachycardia/fibrillation

Adverse event	Patient population		
	VT/VF (n=1,363)	NSWVT/PVC (n=946)	SVA (n=947)
Torsades de pointes	4.1%	1.0%	1.4%
Sustained VT/VF	1.2%	0.7%	0.3%

VT = ventricular tachycardia

VR = ventricular fibrillation

NSVT = nonsustained ventricular tachycardia

PVC = premature ventricular contraction

SVA = supraventricular arrhythmia

Overall, discontinuation because of unacceptable adverse events was necessary in 18% of all patients in cardiac arrhythmia trials. The most common adverse events leading to discontinuation of sotalol were fatigue 4%, bradycardia < 50 beats/minute 3%, dyspnoea 3%, proarrhythmia 2%, asthenia 2% and dizziness 2%.

More common reactions (> 1%)

Biochemical abnormalities

Changes in plasma lipid concentrations (refer to [Warnings and precautions - Other metabolic effects](#)).

Cardiovascular

Ventricular tachyarrhythmias, torsades de pointes, chest pain, bradycardia, hypotension, cold extremities, dyspnoea, palpitations, oedema, ECG abnormalities, proarrhythmia, syncope, heart failure, presyncope. Hypotension and bradycardia are more frequent after intravenous administration.

Dermatological

Rash.

Gastrointestinal

Diarrhoea, nausea/vomiting, flatulence, dyspepsia, abdominal pain.

General

Headache, tiredness, fever.

Musculoskeletal

Cramps.

Nervous system

Dizziness, drowsiness, lethargy, weakness, vertigo. Lightheadedness, headache, sleep disturbances, depression, paraesthesia, mood changes, anxiety.

Special Senses

Visual disturbances (including eye irritation, deterioration of eyesight, blurred vision, photophobia), taste abnormalities, hearing disturbances.

Genitourinary

Sexual dysfunction.

Respiratory

Shortness of breath.

Less common reactions (<1%)

Biochemical abnormalities

Changes in antinuclear factor (ANF) titres have been reported but the clinical significance of this is not clear.

Cardiovascular

Congestive heart failure, prolonged QT interval. Increased ventricular ectopic beat frequency, cardiogenic shock and first degree atrioventricular block have been observed after intravenous administration.

Dermatological

Cutaneous thickening, pruritus.

Psychiatric

Unusual dreams.

Others

Retroperitoneal fibrosis, facial atrophy.

Severe or life-threatening reactions

Myocardial insufficiency may require treatment with digitalis and diuretics. Bradycardia may respond to atropine (see Precautions, Excessive bradycardia). Bronchospasm may be reversed with a beta₂-stimulant. Hypotension, if severe, may require use of a vasopressor. Cardiac infarction following too abrupt a withdrawal of the beta-blocker from patients with ischaemic heart disease can be avoided by gradual reduction of dose. Temporary overdrive pacing is suggested as treatment of ventricular arrhythmias in association with prolonged QT interval.

Interactions

Medicines and other pharmacologically active substances

Insulin and oral hypoglycaemics

Beta-blocking drugs may prolong the hypoglycaemic action of these drugs especially in conditions where glucose mobilisation may be compromised, e.g. labile diabetes, diabetic ketoacidosis and

fasting diabetic patients. Symptoms of hypoglycaemia may be masked by sotalol. Hyperglycaemia may occur and the dosage of antidiabetic drugs may require adjustment (refer to Warnings and precautions - Diabetes).

Anaesthetics

Agents such as ether, chloroform and cyclopropane are contraindicated with sotalol (refer to Warnings and precautions - Anaesthesia and the perioperative period).

Beta2-receptor stimulants

Beta-agonists such as salbutamol, terbutaline and isoprenaline may have to be administered in increased dosages when used concomitantly with sotalol.

Calcium channel blocking drugs

Concurrent administration of beta-blocking agents and calcium channel blockers has resulted in hypotension, bradycardia, conduction defects and cardiac failure. Beta-blockers should be avoided in combination with cardiodepressant calcium channel blockers because of the additive effects on atrioventricular conduction and ventricular function (refer to Warnings and precautions - Concomitant therapy with calcium antagonists.)

Catecholamine depleting agents

Concomitant use of catecholamine depleting drugs such as reserpine and guanethidine, with a beta-blocker may produce an excessive reduction of resting sympathetic nervous tone. Patients should be closely monitored for evidence of hypotension and/or marked bradycardia which may produce syncope.

Clonidine

Beta-blocking drugs may potentiate the rebound hypertension sometimes observed after discontinuation of clonidine treatment. Therefore, the beta-blocker should be discontinued slowly over several days before the gradual withdrawal of clonidine.

An antagonistic effect between clonidine and sotalol has been observed. Concurrent administration of clonidine and sotalol has caused increased blood pressure compared with clonidine or sotalol alone. The combination of beta-adrenoreceptor antagonists and clonidine should be avoided (refer to Warnings and precautions - Clonidine).

Drugs prolonging the QT interval

Drugs known to prolong the QT interval and/or to be associated with atypical ventricular tachycardia (AVT, torsades de pointes), especially quinidine, disopyramide, tricyclic antidepressants, terfenadine, astemizole, and certain quinolone antibiotics should be avoided (refer to Warnings and precautions - Proarrhythmia).

Antiarrhythmic agents

Interactions have been reported during concomitant beta-blocker therapy with: Class IA agents disopyramide and less frequently, quinidine; Class IB agents tocainide, mexiletine and lignocaine; Class IC agents flecainide and propafenone; the Class III agent amiodarone; the class IV antiarrhythmic agents. Concomitant use of sotalol with these agents, and with other beta-blocking drugs, is not recommended.

Potassium depleting diuretics

Hypokalaemia or hypomagnesaemia may occur, increasing the potential for torsades de pointes (refer to Warnings and precautions - Electrolyte disturbances).

Digoxin

Single and multiple doses of sotalol do not significantly affect serum digoxin levels. Proarrhythmic events were more common in sotalol treated patients also receiving digoxin, however this may be related to the presence of congestive heart failure, a known risk factor for proarrhythmia, in the patient receiving digoxin.

Abnormal laboratory test results

The presence of sotalol in the urine may result in falsely elevated levels of urinary metanephrine when measured by photometric methods. Patients suspected of having pheochromocytoma and who are treated with sotalol should have their urine screened utilising the high performance liquid chromatographic (HPLC) assay with solid phase extraction.

Food and alcohol

Alcohol

The plasma clearance of sotalol is reduced after alcohol ingestion.

Overdosage

Several cases, one fatal, of sotalol intoxication have been reported.

Signs and symptoms

Clinical features include asystole, severe bradycardia, congestive heart failure, hypotension, prolongation of QT interval, premature ventricular complexes, ventricular tachyarrhythmias, torsades de pointes, hypoglycaemia and bronchospasm.

Management

Close monitoring of the electrocardiogram in patients with suspected sotalol intoxication is recommended. Every effort should be made to promptly correct metabolic and electrolyte imbalances which might contribute to the initiation of ventricular arrhythmias.

Gastric lavage and activated charcoal should be administered when an overdose of Sotahexal tablets is suspected. Bradycardia and hypotension should be corrected prior to gastric lavage or endotracheal intubation as these procedures may increase vagal tone. Dialysis lowers the plasma sotalol concentration by approximately 20%.

Depending on the symptoms, the following therapeutic measures are suggested:

Severe bradycardia

Atropine 1 to 2 mg intravenously may be used to induce vagal blockade. If bradycardia persists, intravenous isoprenaline may be given. An appropriate regimen would be a 5 microgram bolus followed by an infusion of 0.5 to 10 microgram/minute, titrated to achieve the desired effect. In refractory cases, the use of a cardiac pacemaker should be considered.

Heart Block (second and third degree)

Transvenous cardiac pacing.

Hypotension

Severe hypotension should respond to a sympathomimetic amine, such as adrenaline or epinephrine rather than isoprenaline or noradrenaline. In refractory cases, the use of glucagon hydrochloride should be considered.

Torsades de pointes

DC cardioversion, transvenous cardiac pacing, adrenaline and/or intravenous magnesium sulphate.

Bronchospasm

A beta2-agonist and/or aminophylline.

Pharmaceutical precautions

Instructions for use/handling

Nil.

Incompatibilities

None known.

Special precautions for storage

Store at or below 25°C. Protect from light and moisture.

Medicine classification

Prescription Medicine.

Package quantities

Packs of 60 tablets in cartoned blister strips.

Further information

List of excipients

Lactose, maize starch, sodium starch glycollate, hydroxypropylcellulose, magnesium stearate, silicon dioxide.

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