NEW ZEALAND DATA SHEET

1. PRODUCT NAME
DBL™ ACETYLCYSTEINE INJECTION CONCENTRATE

2. QUALITATIVE AND QUANTITATIVE COMPOSITION
Acetylcysteine 20% w/v or 200mg in 1mL.
Each 10mL ampoule contains 2g Acetylcysteine.
For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM
Concentrate for Solution for Infusion

4. CLINICAL PARTICULARS

4.1 Therapeutic indications
N-acetylcysteine is indicated for the treatment of paracetamol overdose in patients:

- who present within 15 hours after an acute overdose with a plasma paracetamol level on or above a line joining points of 150mg/L at 4h and 20mg/L at 15h (see nomogram below). or
- who have taken more than 200mg/kg or 10g (whichever is less) of sustained release paracetamol or have one of two serum paracetamol levels taken four hours apart on or above a line joining points of 150mg/L at 4h and 20mg/L at 15h (see nomogram below). Or
- who have taken an acute overdose of paracetamol with opiates or medicines with anticholinergic effects and have one of two serum paracetamol levels taken four hours apart on or above a line joining points of 150mg/L at 4h and 20mg/L at 15h (see nomogram below). or
- where there is any doubt over the time of an acute overdose, irrespective of plasma paracetamol level or
- who present more than 15 hours after an overdose with abnormal liver biochemistry (INR >1.3 and/or ALT>150) or fulminant hepatic failure or
- who have taken a staggered overdose irrespective of plasma paracetamol level. Staggered is defined as an overdose of 200mg/kg or 10g (whichever is less) over a single 24 hour period or 150mg/kg of 6g (whichever is less) per 24 hour period for at least 48 hours.

Plasma Paracetamol nomogram
4.2 Dose and method of administration

Acetylcysteine should be administered by intravenous infusion preferably using glucose 5% as the infusion fluid. Sodium Chloride 0.9% solution may be used if Glucose 5% is not suitable.

The majority of patients should be treated with the three infusion schedule. However some patients may require prolonged treatment.

Patients who have taken very large overdoses (eg, 50g of paracetamol), co-ingested opiates or medicines with anticholinergic effects, or have taken modified release paracetamol should be assessed at the end of the normal dose schedule. Treatment should be continued until aminotransferase levels are improving, INR is 1.3 or less and there is no acidosis.

Dose in Adults

Acetylcysteine 200mg/mL Injection is infused in three intravenous infusions containing different doses. This will give a total dose of 300 milligrams/kg of Acetylcysteine infused over 21 hours.

INITIAL INFUSION: An initial dose of 150 milligrams/kg of Acetylcysteine diluted in 200 mL of 5% glucose and infused over 60 minutes.

SECOND INFUSION: 50 milligrams/kg of Acetylcysteine in 500 mL of 5% glucose over the next 4 hours.

THIRD INFUSION: 100 milligrams/kg of Acetylcysteine in 1000 mL of 5% glucose over the next 16 hours.

The dose should be calculated using the patient’s actual weight to a ceiling of 110kg for obese patients.

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<tr>
<th>Regimen</th>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
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<tr>
<td>Fluid</td>
<td>200mL 5% glucose or sodium chloride 0.9%</td>
<td>500mL 5% glucose or sodium chloride 0.9%</td>
<td>1000mL 5% glucose or sodium chloride 0.9%</td>
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### Dose in Children

Children should be treated with the same doses and regimen as adults; however the quantity of intravenous fluid used must be modified to take into account age and weight as fluid overload is a potential danger.

The full course of treatment with acetylcysteine includes three consecutive intravenous infusions.

**INITIAL INFUSION:** An initial dose of 150 milligrams/kg of Acetylcysteine given as a 50mg/mL solution at a rate of 3mL/kg/h.

**SECOND INFUSION:** 50 milligrams/kg of Acetylcysteine over the next 4 hours. Given as a 6.25mg/mL solution at a rate of 2mL/kg/h.

**THIRD INFUSION:** 100 milligrams/kg of Acetylcysteine over the next 16 hours. Given as a 6.25mg/mL solution at a rate of 1mL/kg/h.

The dose should be calculated using the patient’s actual weight. Determine the total volume of solution needed from the table.

### Preparation of the solution

Initial infusion: To prepare a 50mg/mL solution, dilute each 10mL ampoule of acetylcysteine (200mg/mL) with 30mL glucose 5% or sodium chloride 0.9% to a total volume of 40mL.

Second infusion: To prepare a 6.25mg/mL solution, dilute each 10mL ampoule of acetylcysteine (200mg/mL) with 310mL glucose 5% or sodium chloride 0.9% to give a total volume of 320mL.
Third infusion. To prepare a 6.25mg/mL solution, dilute each 10mL ampoule of acetylcysteine (200mg/mL) with 310mL glucose 5% or sodium chloride 0.9% to give a total volume of 320mL.

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For example for a child weighing 12kg, 38mL of solution is required for dose/infusion 1, 100mL for dose/infusion 2 and 200mL for dose/infusion 3. Dose 1 is infused at 38mL/h over 60 mins, dose 2 is infused at 25mL/h and dose 3 at 13mL/h.

Acetylcysteine is not compatible with rubber and some metals, particularly, iron, copper and nickel. Acetylcysteine 200mg/mL Injection can be used satisfactorily with silicone rubber and plastic.

4.3 Contraindications

There are no contraindications to the treatment of paracetamol overdose with acetylcysteine.

4.4 Special warnings and precautions for use

Management of Paracetamol Overdose

It should be noted that, after an ingestion of a potentially fatal dose of paracetamol, the patient may appear relatively well initially and may even continue normal activities for a day or two before the onset of hepatic failure.
Hepatic damage is more likely to occur with a lower dosage of paracetamol in patients who have a history of poor diet, chronic alcohol or enzyme-inducing drug ingestion (e.g. isoniazid, rifampicin, anticonvulsants including carbamazepine, phenytoin, phenobarbitone, primidone, sodium valproate).

Patients may be unreliable as to the amount ingested and the time of ingestion. Hepatic necrosis is preventable if treatment can be instituted within 10 to 12 hours of ingestion.

**Hepatic necrosis has been seen with 6 grams of paracetamol, and death with 15 grams.**

**Patient Presenting Within 15 Hours of Ingestion**

Give activated charcoal (1 – 2 grams/kg) if it is within 1 hour of paracetamol ingestion, and the patient’s conscious state is not impaired. In the event of overdose with sustained release paracetamol activated charcoal may be useful after 1 hour of ingestion.

Plasma paracetamol levels should be obtained no earlier than 4 hours after ingestion of the paracetamol overdose. Concentrations determined prior to this time are not reliable for assessing potential hepatotoxicity.

Measurements of plasma liver enzymes and bilirubin levels, and coagulation studies, should be performed as soon as possible after admission. Blood urea, electrolytes, glucose and blood gases should be obtained. The laboratory measurements are used to monitor hepatic and renal function and electrolyte balance. An ECG should also be performed.

Do not delay Acetylcysteine therapy while awaiting the results of plasma assays. Once the results become available, treatment may be discontinued if the initial concentration is below nomogram reference line.

Do not discontinue Acetylcysteine therapy if the initial level is above the reference line and subsequent levels fall below the reference line.

**Patients Presenting More Than 15 Hours after Ingestion**

Plasma paracetamol, bilirubin, AST, ALT levels and INR should be determined urgently.

Patients with INR>1.3 and/or ALT> 150 should be treated. Further advice should be sought from the New Zealand Poisons Centre.

**Anaphylactoid reactions**

Anaphylactoid hypersensitivity reactions occur with acetylcysteine, particularly with the initial loading dose. The patient should be carefully observed during this period for signs of an anaphylactoid reaction. Nausea, vomiting, flushing, skin rash, pruritus and urticaria are the most common features, but more serious anaphylactoid reactions have been reported where the patient develops angioedema, bronchospasm, respiratory distress, tachycardia and hypotension. In very rare cases these reactions have been fatal. There is some evidence that patients with a history of atopy and asthma may be at increased risk of developing an anaphylactoid reaction.

Most anaphylactoid reactions can be managed by temporarily suspending the acetylcysteine infusion, administering appropriate supportive care, antihistamines and bronchodilators and...
restarting at a lower infusion rate. Once an anaphylactoid reaction is under control, the infusion can normally be restarted at an infusion rate of 50 mg/kg over 4 hours, followed by the final 16 hour infusion (100 mg/kg over 16 hours).

In patients who have previously experienced an anaphylactoid reaction with acetylcysteine consideration should be given to pre-treatment with an IV antihistamine 15 minutes before starting the acetylcysteine infusion.

Coagulation

Changes in haemostatic parameters have been observed in association with acetylcysteine treatment, some leading to decreased prothrombin time, but most leading to a small increase in prothrombin time (INR). An isolated increase in prothrombin (INR) time up to 1.3 at the end of a 21 hour course of acetylcysteine without an elevated transaminase activity does not require further monitoring or treatment with acetylcysteine.

Fluid and electrolytes

Use with caution in children, patients requiring fluid restriction or those who weigh less than <40 kg because of the risk of fluid overload which may result in hyponatraemia and seizures which may be life threatening (see section 4.2).

Each 10mL of N-acetylcysteine for Infusion contains 322.6mg sodium. To be taken into consideration with patients on a controlled sodium diet.

Use in Renal/Hepatic Impaired Patients

Caution should be taken when administering Acetylcysteine in patients with hepatic or renal failure, since there is little data relating to the effects of Acetylcysteine in impaired renal and/or hepatic function. The decision to administer should be passed on a risk/benefit assessment for the individual subject.

In the presence of hepatic failure due to paracetamol overdose the degree of existing liver damage and the possible risk associated with the administration of Acetylcysteine should be considered.

Effects on Laboratory Tests

Acetylcysteine may cause a false-positive reaction with reagent dipstick tests for urinary ketones.

4.5 Interaction with other medicines and other forms of interaction

There are no known interactions.

4.6 Fertility, pregnancy and lactation

Fertility

see section 5.3
Pregnancy

Category B2

There was no evidence of teratogenicity in limited studies in rats and rabbits following administration of Acetylcysteine during the period of gestation at doses up to 1.2 times the maximum clinical dose, on a body surface area basis. There are no well-controlled studies in pregnant women but experience does not include any positive evidence of adverse effects to the foetus.

Lactation

There was no evidence of adverse effects in a limited study in rats following administration of acetylcysteine during late gestation and lactation at 60% of the maximum clinical dose, on a body surface area basis. It is not known whether acetylcysteine and/or its metabolites are excreted in milk. There are no data on the use of acetylcysteine in lactating women and therefore breastfeeding is not recommended during treatment.

4.7 Effects on ability to drive and use machinery

Acetylcysteine is presumed to be safe since it is unlikely to produce an effect that may impair the patient's ability to concentrate and react and therefore not constitute a risk in the ability to drive and use machines.

4.8 Undesirable effects

Intravenous administration of acetylcysteine, especially in the large doses needed to treat paracetamol overdose, may result in nausea, vomiting and other gastrointestinal symptoms.

Anaphylactoid reactions have been reported following intravenous administration of acetylcysteine. Bronchospasm may occur in conjunction with a generalized anaphylactic reaction. Other symptoms include airway obstruction (bronchospasm), angioedema, dyspnoea, hypotension, shock, tachycardia, urticaria, and injection site reaction (including rash). These reactions occur most commonly either during, or at the end of the period of the loading dose infusion, and may in fact be dose-related. Since these anaphylactic-like reactions usually occur following the loading dose, careful monitoring is recommended.

There have been rare instances of death.

The following adverse effects have been reported:

**Blood and lymphatic system disorders:** Thrombocytopenia

**Immune system disorders:** Anaphylactoid reaction

**Metabolism and nutrition disorders:** Acidosis

**Psychiatric disorders:** Anxiety

**Nervous system disorders:** Syncope, generalized seizure
Eye disorders: Blurred vision, eye pain

Cardiac disorders: Cyanosis, tachycardia, bradycardia, cardiac arrest, extrasystoles

Vascular disorders: Flushing, hypotension, hypertension, vasodilation

Respiratory, thoracic and mediastinal disorders: Dyspnoea, respiratory arrest, bronchospasm, coughing, stridor

Gastrointestinal disorders: Vomiting, nausea

Hepatobiliary disorders: Deterioration of liver function

Skin and subcutaneous tissue disorders: Angioedema, urticaria, rash (erythematous and maculopapular), sweating, oedema periorbital

Musculoskeletal and connective tissue disorders: Arthralgia

General disorders and administration site conditions: Malaise, rigors, injection site reaction, chest pain, facial pain, face oedema

Investigations: Raised temperature, changes in prothrombin time (INR) (usually increased).

Hypokalaemia and ECG changes have been noted in patients with paracetamol poisoning irrespective of the treatment given. Monitoring of plasma potassium concentration is therefore recommended.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions https://nzphvc.otago.ac.nz/reporting/.

4.9 Overdose

Symptoms

Symptoms following overdose with acetylcysteine have been similar to those of anaphylactoid reactions noted under "Adverse Effects", but they may be more severe. Hypotension appears to be especially prominent. There is also a theoretical risk of hepatic encephalopathy.

Treatment

There is no specific treatment. General supportive measures should be carried out. It has been suggested that generalised reactions to acetylcysteine can be treated with intravenous injection of an antihistamine, and infusion of acetylcysteine should be temporarily stopped but can be restarted at a slower rate without further reaction.

For advice on the management of overdose please contact the National Poisons Centre on 0800 POISON (0800 764766).
5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Mechanism of action

Paracetamol is metabolised in the liver, mainly by conjugation with glucuronide and sulphate. It is also metabolised by cytochrome P450 to form a reactive, potentially toxic metabolite. This metabolite is normally detoxified by conjugation with hepatic glutathione, to form non-toxic derivatives. In paracetamol overdosage, the glucuronide and sulphate conjugation pathways are saturated, so that more of the toxic metabolite is formed. As hepatic glutathione stores are depleted, this toxic metabolite may bind to hepatocyte proteins, leading to liver cell damage and necrosis. Acetylcysteine is a sulphydryl (SH) group donor, and may protect the liver from damage by restoring depleted hepatic-reduced glutathione levels, or by acting as an alternative substrate for conjugation with, and thus detoxification of, the toxic paracetamol metabolite.

5.2 Pharmacokinetic properties

Acetylcysteine is the N-acetyl derivative of the naturally occurring amino acid, L-cysteine, and is deacetylated in the liver to cysteine, or oxidised to other metabolites such as N-acetylcystine or N,N-diacetyl cysteine. The parent compound and metabolites may be present in the plasma either free or protein bound. Renal clearance accounts for about 30% of total body clearance. Following intravenous administration, mean terminal half lives have been calculated to be 1.95 and 5.58 hours respectively for reduced and total acetylcysteine.

5.3 Preclinical safety data

Genotoxicity

No evidence of mutagenicity was obtained in limited gene mutation assays with Acetylcysteine. The potential for Acetylcysteine to cause chromosomal damage has not been investigated.

Carcinogenicity

Carcinogenicity assays have not been performed with Acetylcysteine. In rats, no evidence of carcinogenicity was reported following 18 months of daily dietary administration of Acetylcysteine at 60% of the maximum clinical dose, on a body surface area basis.

Reproductive and developmental toxicity

There was evidence of effects on fertility in male rats given Acetylcysteine at doses up to 60% of the maximum clinical dose, on a body surface area basis. No effects were observed at doses 15% the maximum clinical dose, on a body surface area basis.
6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients
- Sodium hydroxide,
- Disodium edetate,
- Water for injections.

6.2 Incompatibilities
No data available.

6.3 Shelf life
15 months

6.4 Special precautions for storage
Store below 25°C. Protect from light.

6.5 Nature and contents of container
DBL™ Acetylcysteine Injection Concentrate is supplied in ampoules of 10mL (acetylcysteine 200 mg/mL) for intravenous administration. It is available in packs of 10 ampoules.

6.6 Special precautions for disposal
Any unused medicine or waste material should be disposed of in accordance with local requirements.

7. MEDICINE SCHEDULE
Prescription Medicine.

8. SPONSOR
Pfizer New Zealand Limited
P O Box 3998
Auckland, New Zealand
Toll Free Number: 0800 736 363
9. DATE OF FIRST APPROVAL

26 October 2006

10. DATE OF REVISION OF THE TEXT

1 February 2019

Summary table of changes

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