

New Zealand Data Sheet

1 **NORADRENALINE BNM (1 mg/1 mL and 4 mg/4 mL CONCENTRATED INJECTION)**

NORADRENALINE BNM 1 mg/1 mL and 4 mg/4 mL concentrated injection.

2 **QUALITATIVE AND QUANTITATIVE COMPOSITION**

Each 1 mL ampoule contains noradrenaline (norepinephrine) 1 mg in 1 mL (1:1000), present as 2 mg of noradrenaline (norepinephrine) acid tartrate monohydrate in 1 mL.

Each 4 mL ampoule contains noradrenaline (norepinephrine) 4 mg in 4 mL (1:1000), present as 8 mg of noradrenaline (norepinephrine) acid tartrate monohydrate in 4 mL.

Excipient(s) with known effect:

Each ampoule also contains the excipients sodium chloride 8.4 mg/mL for tonicity.

For the full list of excipients, see section 6.1.

3 **PHARMACEUTICAL FORM**

Noradrenaline BNM is a sterile noradrenaline (norepinephrine) concentrated solution for injection available in ampoules.

The solution has a pH of 3.0 to 4.5.

4 **CLINICAL PARTICULARS**

4.1 **Therapeutic indications**

For the restoration of blood pressure in certain acute hypotensive states (e.g. phaeochromocytomectomy, sympathectomy, poliomyelitis, spinal anaesthesia, myocardial infarction, septicaemia, blood transfusion and drug reactions).

As an adjunct in the treatment of cardiac arrest. To restore and maintain an adequate blood pressure after an effective heartbeat and ventilation have been established by other means.

4.2 Dose and method of administration

Restoration of blood pressure in acute hypotensive states

Blood volume depletion should always be corrected as fully as possible before any vasopressor is administered. When, as an emergency measure, intra-aortic pressures must be maintained to prevent cerebral or coronary artery ischaemia, noradrenaline (norepinephrine) can be administered before and concurrently with blood volume replacement.

Average dosage

Add four 1 mL ampoules (4 mL) of Noradrenaline BNM (4 mg of noradrenaline (norepinephrine)), or one 4 mL ampoule of Noradrenaline BNM (4 mg of noradrenaline (norepinephrine)), to 1,000 mL of a 5% glucose containing solution.

Each 1 mL of this dilution contains 4 micrograms of the base of noradrenaline (norepinephrine) (or 8 micrograms of the acid tartrate monohydrate).

Give this solution by intravenous infusion. Insert a plastic intravenous catheter through a suitable bore needle well advanced centrally into the vein and securely fixed with adhesive tape, avoiding, if possible, a catheter tie-in technique as this promotes stasis. An IV drip chamber or other suitable metering device is essential to permit an accurate estimation of the rate of flow in drops per minute.

After observing the response to an initial dose of 2 mL to 3 mL (from 8 micrograms to 12 micrograms of base) per minute, adjust the rate of flow to establish and maintain a low normal blood pressure (usually 80 mmHg to 100 mmHg systolic) sufficient to maintain the circulation to vital organs. In previously hypertensive patients, it is recommended that the blood pressure should be raised no higher than 40 mmHg below the pre-existing systolic pressure. The average maintenance dose ranges from 0.5 mL to 1 mL per minute (from 2 micrograms to 4 micrograms of base).

High dosage

Great individual variation occurs in the dose required to attain and maintain an adequate blood pressure. In all cases, dosage of noradrenaline (norepinephrine) should be titrated according to the response of the patient. Occasionally much larger or even enormous daily doses (as high as 68 mg base or 68 x 1 mL ampoules or 17 x 4 mL ampoules) may be necessary if the patient remains hypotensive, but occult blood volume depletion should always be suspected and corrected when present. Central venous pressure monitoring is usually helpful in detecting and treating this situation.

Fluid intake

The degree of dilution depends on clinical fluid volume requirements. If large volumes of fluid (glucose) are needed at a flow rate that would involve an excessive dose of the pressor agent per unit of time, a solution more dilute than 4 micrograms per mL should be used. On the other hand, when large volumes of fluid are clinically undesirable, a concentration greater than 4 micrograms per mL may be necessary.

Duration of therapy

The infusion should be continued until adequate blood pressure and tissue perfusion are maintained without therapy. The infusion rate of noradrenaline (norepinephrine) should then be reduced gradually, avoiding abrupt withdrawal. In some of the reported cases of vascular collapse due to acute myocardial infarction, treatment was required for up to six days.

Adjunctive treatment in cardiac arrest

Infusions of noradrenaline (norepinephrine) are usually administered intravenously during cardiac resuscitation to restore and maintain an adequate blood pressure after an effective heartbeat and ventilation have been established by other means. [Noradrenaline's (norepinephrine's) β -adrenergic stimulating action is also thought to increase the strength and effectiveness of systolic contractions once they occur.]

Average dosage

To maintain systemic blood pressure during the management of cardiac arrest, noradrenaline (norepinephrine) is used in the same manner as described under Restoration of blood pressure in acute hypotensive states above.

Special populations

Elderly

In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other therapy.

Noradrenaline (norepinephrine) infusions should not be administered into the veins in the leg in elderly patients. (see section 4.4).

Paediatric population

Safety and effectiveness in paediatric patients has not been established.

Method of administration

Noradrenaline BNM contains noradrenaline (norepinephrine) as the acid tartrate monohydrate. It is a concentrated, potent injection which must be diluted in glucose containing solutions prior to infusion. An infusion of noradrenaline (norepinephrine) should be given into a large vein (see section 4.4).

Noradrenaline BNM contains no antimicrobial preservative; to reduce microbiological hazard use as soon as practicable after preparation. If storage is necessary, hold at 2 to 8°C for not more than 24 hours. It is for single use in one patient only. Discard any residue.

Parenteral drug products should be inspected visually for particulate matter and discolouration prior to use, whenever solution and container permit.

Discoloured solutions or those containing a precipitate should not be used.

Avoid contact with iron salts, alkalis, or oxidising agents.

Diluent

Noradrenaline BNM should be diluted in five percent (5%) glucose injection or five percent (5%) glucose in saline solution. These glucose containing fluids provide protection against significant loss of potency due to oxidation. Administration in saline solution alone is not recommended. Whole blood or plasma, if indicated to increase blood volume, should be administered separately (for example, by use of a Y-tube and individual containers if given simultaneously).

4.3 Contraindications

Noradrenaline (norepinephrine) should not be given to patients who are hypotensive from blood volume deficits except as an emergency measure to maintain coronary and cerebral artery perfusion until blood volume replacement therapy can be completed. If noradrenaline (norepinephrine) is continuously administered to maintain blood pressure in the absence of blood volume replacement, the following may occur: severe peripheral and visceral vasoconstriction, decreased renal perfusion and urine output, poor systemic blood flow despite "normal" blood pressure, tissue hypoxia, and lactate acidosis.

Noradrenaline (norepinephrine) should also not be given to patients with mesenteric or peripheral vascular thrombosis (because of the risk of increasing ischaemia and extending the area of infarction) unless, in the opinion of the attending physician, the administration of noradrenaline (norepinephrine) is necessary as a lifesaving procedure.

Cyclopropane and halothane anaesthetics increase cardiac autonomic irritability and therefore seem to sensitise the myocardium to the action of intravenously administered adrenaline or noradrenaline (norepinephrine). Hence, the use of noradrenaline (norepinephrine) during cyclopropane and halothane anaesthesia is generally considered contraindicated because of the risk of producing ventricular tachycardia or fibrillation.

The same type of cardiac arrhythmias may result from the use of noradrenaline (norepinephrine) in patients with profound hypoxia or hypercarbia.

Hypersensitivity to noradrenaline or any of the excipients.

4.4 Special warnings and precautions for use**Warnings**

Noradrenaline BNM should be used with extreme caution in patients receiving monoamine oxidase (MAO) inhibitors or antidepressants of the triptyline or imipramine types because severe, prolonged hypertension may result.

Precautions

General

Avoid hypertension

Because of the potency of noradrenaline (norepinephrine) and because of varying response to pressor substances, the possibility always exists that dangerously high blood pressure may be produced with overdoses of this pressor agent. It is desirable, therefore, to record the blood pressure every two minutes from the time administration is started until the desired blood pressure is obtained, then every five minutes if administration is to be continued.

The rate of flow must be watched constantly, and the patient should never be left unattended while receiving noradrenaline (norepinephrine). Headache may be a symptom of hypertension due to overdosage.

Similar caution should be observed in patients with hypotension following myocardial infarction, in patients with Prinzmetal's variant angina, and in patients with diabetes, hypertension or hyperthyroidism.

Noradrenaline should only be administered by healthcare professionals who are familiar with its use.

Hypersensitivity

Certain patients may be hypersensitive to the effects of noradrenaline (norepinephrine), e.g. patients with hyperthyroidism (see section 4.8).

Site of infusion

Whenever possible, infusions of noradrenaline (norepinephrine) should be given into a large vein, particularly an antecubital vein because, when administered into this vein, the risk of necrosis of the overlying skin from prolonged vasoconstriction is apparently very slight. Some authors have indicated that the femoral vein is also an acceptable route of administration. A catheter tie-in technique should be avoided, if possible, since the obstruction to blood flow around the tubing may cause stasis and increased local concentration of noradrenaline (norepinephrine). Occlusive vascular diseases (for example, atherosclerosis, arteriosclerosis, diabetic endarteritis, Buerger's disease) are more likely to occur in the lower than in the upper extremity. Therefore, one should avoid the veins of the leg in elderly patients or in those suffering from such disorders. Gangrene has been reported in a lower extremity when infusions of noradrenaline (norepinephrine) were given in an ankle vein.

Extravasation

The infusion site should be checked frequently for free flow. Care should be taken to avoid extravasation of noradrenaline (norepinephrine) into the tissues, as local necrosis might ensue due to the vasoconstrictive action of the drug. Blanching along the course of the infused vein, sometimes without obvious extravasation, has been attributed to vasa vasorum constriction with increased permeability of the vein wall, permitting some leakage. This also may progress on rare occasions to superficial slough, particularly during infusion into leg veins in elderly patients or in those suffering from obliterative vascular disease. Hence, if blanching occurs, consideration should be given to changing the infusion site at intervals to allow the effects of local vasoconstriction to subside.

IMPORTANT -- Antidote for extravasation ischaemia

The antidote for extravasation ischaemia is phentolamine. To prevent sloughing and necrosis in areas in which extravasation has taken place, the area should be infiltrated as soon as possible with 10 mL to 15 mL of saline solution containing from 5 mg to 10 mg of phentolamine, an adrenergic blocking agent. A syringe with a fine hypodermic needle should be used, with the solution being infiltrated liberally throughout the area, which is easily identified by its cold, hard, and pallid appearance. Sympathetic blockade with phentolamine causes immediate and conspicuous local hyperaemic changes if the area is infiltrated within 12 hours. Therefore, phentolamine should be given as soon as possible after the extravasation is noted.

Paediatric population

Safety and effectiveness in paediatric patients has not been established.

Special populations

Elderly

Clinical studies of noradrenaline (norepinephrine) did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other therapy.

Noradrenaline (norepinephrine) infusions should not be administered into the veins in the leg in elderly patients (see Site of infusion above).

4.5 Interaction with other medicines and other forms of interaction

Cyclopropane and halothane anaesthetics increase cardiac autonomic irritability and therefore seem to sensitise the myocardium to the action of intravenously administered adrenaline or noradrenaline (norepinephrine). Hence, the use of noradrenaline (norepinephrine) during cyclopropane and halothane anaesthesia is generally considered contraindicated because of the risk of producing ventricular tachycardia or fibrillation. The same type of cardiac arrhythmias may result from the use of noradrenaline (norepinephrine) in patients with profound hypoxia or hypercarbia.

Noradrenaline (norepinephrine) should be used with extreme caution in patients receiving monoamine oxidase inhibitors (MAOI) or antidepressants of the triptyline or imipramine types, because severe, prolonged hypertension may result (see section 4.4). Linezolid, adrenergic-serotonergic drugs, or any other cardiac sensitizing agents are not recommended as severe prolonged hypertension and possible arrhythmias may result.

Guanethidine

The effects of noradrenaline may be enhanced by guanethidine.

Paediatric population

Interaction studies have only been performed in adults.

4.6 Fertility, pregnancy and lactation

Pregnancy

Category B3

Noradrenaline BNM should be given to a pregnant woman only if clearly needed.

Animal studies indicate noradrenaline (norepinephrine) may impair placental perfusion and induce foetal bradycardia. It may also exert a contractile effect on the pregnant uterus and lead to foetal asphyxia in late pregnancy. However, the clinical significance of these changes to a human foetus is unknown. These possible risks to the foetus should therefore be weighed against the potential benefit to the mother.

Breastfeeding

It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when noradrenaline (norepinephrine) is administered to a nursing woman.

Fertility

Studies have not been performed.

4.7 Effects on ability to drive and use machines

No information held by the sponsor.

4.8 Undesirable effects

The following reactions can occur:

Body as a whole

Ischaemic injury due to potent vasoconstrictor action and tissue hypoxia.

Cardiovascular system

Bradycardia, probably as a reflex of a rise in blood pressure, cardiogenic shock, arrhythmias and stress cardiomyopathy.

Peripheral ischemia, gangrene, hypertension, plasma depletion

Nervous system

Anxiety, transient headache.

Respiratory system

Respiratory difficulty, dyspnoea.

Skin and appendages

Extravasation necrosis at injection site.

Prolonged administration of any potent vasopressor may result in plasma volume depletion which should be continuously corrected by appropriate fluid and electrolyte replacement therapy. If plasma volumes are not corrected, hypotension may recur when noradrenaline (norepinephrine) is discontinued, or blood pressure may be maintained at the risk of severe peripheral and visceral vasoconstriction (e.g. decreased renal perfusion) with diminution in blood flow and tissue perfusion with subsequent tissue hypoxia and lactic acidosis and possible ischaemic injury. Gangrene of extremities has been rarely reported. Bradycardia sometimes occurs, probably as a reflex result of a rise in blood pressure.

Overdoses or conventional doses in hypersensitive persons (e.g. hyperthyroid patients) cause severe hypertension with violent headache, photophobia, stabbing retrosternal pain, pallor, intense sweating and vomiting (see section 4.9).

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**

Overdosage with noradrenaline (norepinephrine) may result in headache, severe hypertension, reflex bradycardia, marked increase in peripheral resistance, and decreased cardiac output (see section 4.8). Headache may indicate severe hypertension. Pulmonary oedema, photophobia, retrosternal pain, pallor, intense sweating and vomiting may occur. In the event of overdose, treatment with noradrenaline should be withdrawn and appropriate corrective measures initiated.

In case of overdose, immediately contact the New Zealand Poisons Information Centre for advice on 0800 764 766.

5 **PHARMACOLOGICAL PROPERTIES**

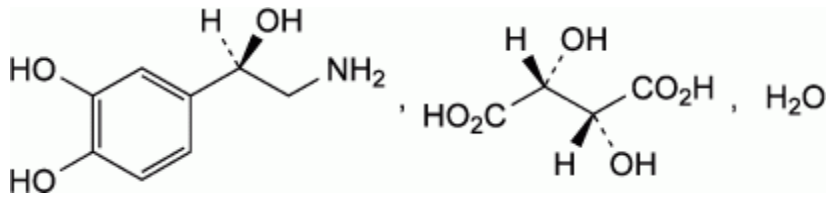
5.1 **Pharmacodynamic properties**

Pharmacotherapeutic group: Adrenergic and dopaminergic agents

ATC code: C01CA03

Chemistry information

The chemical structure for noradrenaline (norepinephrine) acid tartrate monohydrate is shown below:



Chemically, noradrenaline (norepinephrine) acid tartrate monohydrate, (1*R*)-2-Amino-1-(3,4-dihydroxyphenyl)ethanol hydrogen (2*R*,3*R*)-2,3-dihydroxybutanedioate monohydrate, is a white or almost white crystalline powder. It is freely soluble in water, and slightly soluble in ethanol (96%).

Molecular formula: C₈H₁₁NO₃,C₄H₆O₆,H₂O

Molecular weight: 337.3

CAS registry no.: 69815-49-2

Mechanism of action

Noradrenaline (sometimes referred to as norepinephrine or l-arterenol/levarterenol), a sympathomimetic amine which differs from adrenaline by the absence of a methyl group on the nitrogen atom.

Noradrenaline (norepinephrine) functions as a peripheral vasoconstrictor (α -adrenergic action) and as an inotropic stimulator of the heart and dilator of coronary arteries (β -adrenergic action).

These actions result in an increase in systemic blood pressure and coronary artery blood flow. In myocardial infarction accompanied by hypotension, noradrenaline (norepinephrine) usually increases aortic blood pressure, coronary artery blood flow, and myocardial oxygenation, thereby helping to limit the area of myocardial ischaemia and infarction. Venous return is increased and the heart tends to resume a more normal rate and rhythm than in the hypotensive state. In hypotension that persists after correction of blood volume deficits, noradrenaline (norepinephrine) helps raise the blood pressure to an optimal level and establish a more adequate circulation.

5.2 Pharmacokinetic properties

Absorption

Orally ingested noradrenaline is destroyed in the GI tract, and the drug is poorly absorbed after subcutaneous injection. After IV administration, a pressor response occurs rapidly. The drug has a short duration of action, and the pressor action stops within 1-2 minutes after the infusion is discontinued.

Distribution

Noradrenaline (norepinephrine) localises mainly in sympathetic nervous tissue. The drug crosses the placenta but not the blood-brain barrier.

Metabolism

The pharmacologic actions of noradrenaline (norepinephrine) are terminated primarily by uptake and metabolism in sympathetic nerve endings. The drug is metabolised in the liver and other tissues by a combination of reactions involving the enzymes catechol-O-methyltransferase (COMT) and monoamine oxidase (MAO).

The major metabolites are normetanephrine and 3-methoxyl-4-hydroxy mandelic acid (vanillylmandelic acid, VMA), both of which are inactive. Other inactive metabolites include 3-methoxy-4-hydroxyphenylglycol, 3,4-dihydroxymandelic acid, and 3,4-dihydroxyphenylglycol.

Elimination

Noradrenaline (norepinephrine) metabolites are excreted in urine primarily as the sulfate conjugates and, to a lesser extent, as the glucuronide conjugates. Only small quantities of noradrenaline (norepinephrine) are excreted unchanged.

5.3 Preclinical safety data

Genotoxicity and carcinogenicity studies have not been performed.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Noradrenaline BNM concentrated injection contains the following excipients: sodium chloride and water for injections.

6.2 Incompatibilities

Noradrenaline BNM infusion solutions should not be mixed with other medicines. Infusion solutions containing noradrenaline (norepinephrine) acid tartrate monohydrate have been reported to be incompatible with iron salts, alkalis and oxidising agents, barbituates, chlorphenamine maleate (chlorpheniramine maleate), chlorothiazide, nitrofurantoin, phenytoin, sodium bicarbonate, sodium iodide, streptomycin, sulfadiazine and sulfafurazole.

6.3 Shelf life

18 months.

6.4 Special precautions for storage

Store below 25°C. Do not refrigerate or freeze. Protect from light.

6.5 Nature and contents of container

Noradrenaline BNM is available as 1 mL and 4 mL single use glass ampoules (1 mg noradrenaline (norepinephrine) base/1 mL ampoule or 4 mg noradrenaline (norepinephrine) base/4 mL ampoule). Both presentations are supplied in packs of 10 ampoules per carton.

Not all presentations may be distributed in New Zealand.

6.6 Special precautions for disposal

No special requirements.

7 MEDICINE SCHEDULE

Prescription Medicine

8 SPONSOR

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9 DATE OF FIRST APPROVAL

01 December 2016

10 DATE OF REVISION OF TEXT

15 December 2020

Summary table of changes

Section changed	Summary of new information
4.3	Addition of hypersensitivity as a contraindication
4.4.	Addition of general precaution information
4.5	Addition of further interactions
4.8	Addition of some more Undesirable effects
4.9	Addition of examples of signs of overdose