

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Dispersible Aspirin 75mg Tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Aspirin BP 75.0mg

3 PHARMACEUTICAL FORM

Tablet

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Mild to moderate pain.

4.2 Posology and method of administration

Adults: 4 tablets every four hours, or as directed by a doctor. Not more than 6 doses in 24 hours.

Elderly: There is no evidence that the dose should differ.

Children: Do not give to children under 16 years, unless specifically indicated (e.g. for Kawasaki's disease).

For oral administration.

4.3 Contraindications

Asprin is contraindicated in:

A history of, or active peptic ulceration or gout.

Children under 16

Breast feeding.

Patients with known history of other clotting disorders or on anti coagulant therapy

Asthma, urticaria, rhinitis or other evidence of hypersensitivity to aspirin or non steroidal anti-inflammatory drugs

Severe renal impairment or severe hepatic impairment

4.4 Special warnings and precautions for use

Administer with caution in the presence of allergic disease, renal or hepatic impairment, dehydration and in patients with G6PD deficiency.

There is a possible association between aspirin and Reye's Syndrome when given to children. Reye's syndrome is a very rare disease which affects the brain and liver, and can be fatal. For this reason aspirin should not be given to children under 16 years unless specifically indicated (e.g. Kawasaki's disease).

Before commencing long-term aspirin therapy for the management of cardiovascular or cerebrovascular disease patients should consult their doctor who can advise on the relative benefits versus the risks for the individual patient.

Keep all medicines out of the reach of children.

4.5 Interaction with other medicinal products and other forms of interaction

Experimental data suggest that ibuprofen may inhibit the effect of low dose aspirin on platelet aggregation when they are dosed concomitantly. However, the limitations of these data and the uncertainties regarding extrapolation of *ex vivo* data to the clinical situation imply that no firm conclusions can be made for regular ibuprofen use, and no clinically relevant effect is considered to be likely for occasional ibuprofen use (see section 5.1).

Aspirin increases the risk of bleeding when used with heparin, warfarin, phenindione (due to antiplatelet effect), clopidogrel, venlafaxine/ SSRIs antidepressants and acenocoumarol.

Antagonises the diuretic effect of spironolactone, increases the toxicity of methotrexate and acetazolamide by delaying excretion, inhibits the effect of probenecid and sulfinpyrazole.

Antacids, corticosteroids, ibuprofen and kaolin reduce the effect of aspirin.

Metoclopramide potentiates the effect of aspirin.

No interaction normally occurs between aspirin and antidiabetic drugs. However, there have been a few isolated cases of hypoglycaemia. Aspirin may increase the activity of sulfonylurea hypoglycaemic drugs.

Large doses of aspirin cause higher levels of phenytoin and valproate. However, clinical toxicity has only been reported in the latter.

NSAIDs including aspirin have been reported to reduce or abolish the hypotensive action of ACE inhibitors. The combination of an NSAID and an ACE inhibitor can increase the risk of renal impairment and hyperkalaemia.

Use of aspirin with other NSAIDs should be avoided because of the increased risk of adverse effects. Aspirin may decrease the plasma concentration of some other NSAIDs, for example, fenbufen, indometacin, and piroxicam .

Cilostazol appears not to interact to a clinically relevant extent with low -dose aspirin. Manufacturer of cilostazol recommends dose of aspirin should not exceed 80 mg daily when given with cilostazol.

Licensed product information for mifepristone advises of a theoretical risk that prostaglandin synthetase inhibition by aspirin or NSAIDs may alter the efficacy of mifepristone.

4.6 Pregnancy and lactation

Pregnancy:

The use of analgesic doses of aspirin during pregnancy, particularly during the third trimester, should be avoided. The drug may affect maternal and newborn haemostatic mechanisms, leading to an increased risk of haemorrhage. Aspirin may also delay the onset and increase the duration of labour. With high doses, there may be premature closure of the ductus arteriosus, leading possibly to persistent pulmonary hypertension. The use of low doses of aspirin, for the secondary prevention of myocardial infarction and stroke are probably not harmful.

Lactation:

Aspirin is secreted into breast milk in low concentration and should therefore be avoided during lactation because of the possible risk of Reye's Syndrome and the fact that high doses could potentially impair platelet function.

4.7 Effects on ability to drive and use machines

None stated.

4.8 Undesirable effects

Dyspepsia, nausea and vomiting. Aspirin prolongs bleeding time. Less commonly irritation of the gastrointestinal mucosa may lead to erosion, ulceration and gastrointestinal bleeding. Hypersensitivity reactions including urticaria, rhinitis and angioneurotic oedema.

Association with Reye's Syndrome in children can lead to hearing disturbances (such as tinnitus), vertigo or mental confusion.

4.9 Overdose

Salicylate poisoning is usually associated with plasma concentrations >350 mg/L (2.5mmol/L). Most adult deaths occur in patients whose concentrations exceed 700mg/L (5.1mmol/L). Single doses less than 100 mg/kg are unlikely to cause serious poisoning.

Symptoms

Common features include vomiting, dehydration, tinnitus, vertigo, deafness, sweating, warm extremities with bounding pulses, increased respiratory rate and hyperventilation. Some degree of acid-base disturbance is present in most cases.

A mixed respiratory alkalosis and metabolic acidosis with normal or high arterial pH (normal or reduced hydrogen ion concentration) is usual in adults and children over the age of four years. In children aged four years or less, a dominant metabolic acidosis with low arterial pH (raised hydrogen ion concentration) is common. Acidosis may increase salicylate transfer across the blood brain barrier.

Uncommon features include haematemesis, hyperpyrexia, hypoglycaemia, hypokalaemia, thrombocytopenia, increased INR/PTR, intravascular coagulation, renal failure and non-cardiac pulmonary oedema.

Central nervous system features including confusion, disorientation, coma and convulsions are less common in adults than in children.

Management

Give activated charcoal if an adult presents within one hour of ingestion of more than 250 mg/kg. The plasma salicylate concentration should be measured, although the severity of poisoning cannot be determined from this alone and the clinical and biochemical features must be taken into account. Elimination is increased by urinary alkalinisation, which achieved by the administration of 1.26% sodium bicarbonate. The urine pH should be monitored. Correct metabolic acidosis with intravenous 8.4% sodium bicarbonate (first check serum potassium). Forced diuresis should not be used since it does not enhance salicylate excretion and may cause pulmonary oedema.

Haemodialysis is the treatment of choice for severe poisoning and should be considered in patients with plasma salicylate concentrations >700 mg/L (5.1mmol/L), or lower concentrations associated with severe clinical or metabolic features. Patients under ten years or over 70 have increased risk of salicylate toxicity and may require dialysis at an earlier stage.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Aspirin is an inhibitor of enzyme cyclo-oxygenase which results in the inhibition of the biosynthesis of prostaglandins.

Experimental data suggest that ibuprofen may inhibit the effect of low dose aspirin on platelet aggregation when they are dosed concomitantly. In one study, when a single dose of ibuprofen 400mg was taken within 8 hours before or within 30 minutes after immediate release aspirin (81mg), a decreased effect of aspirin on the formation of thromboxane or platelet aggregation occurred. However, the limitations of these data and the uncertainties regarding extrapolation of *ex vivo* data to the clinical situation imply that no firm conclusions can be made for regular ibuprofen use, and no clinically relevant effect is considered to be likely for occasional ibuprofen use.

5.2 Pharmacokinetic properties

Absorption of non-ionised aspirin occurs in the stomach. Acetylsalicylates and salicylates are also readily absorbed from the intestine. Hydrolysis to salicylic acid occurs rapidly in the intestine and in the circulation. Salicylates are extensively bound to plasma proteins; aspirin to a lesser degree. Aspirin and salicylates are rapidly distributed to all body tissues; they appear in the milk and cross the placenta. The rate of excretion of aspirin varies as the pH rises, being greatest at pH 7.5 and above. Aspirin is also excreted as salicylic acid and as glucuronide conjugate, and as salicyluric and gentisic acid.

5.3 Preclinical safety data

Not applicable.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Starch

Sodium saccharin

Lactose

Citric acid

Calcium carbonate

Talc

Sodium lauryl sulphate.

6.2 Incompatibilities

None known.

6.3 Shelf life

3 years.

6.4 Special precautions for storage

Store in a cool dry place protected from light below 25°C.

6.5 Nature and Contents of Container

Securitainers or opaque plastic screw capped containers containing 50, 100, or 1000 tablets.

Blister packs of 24 and 28 tablets.

6.6 Special precautions for disposal

Not applicable.

7 MARKETING AUTHORISATION HOLDER

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8 MARKETING AUTHORISATION NUMBER(S)

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22 July 1999

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16/08/2010