

SUMMARY OF PRODUCT CHARACTERISTICS

1. Name of the medicinal product

Esomeprazole 20 mg tablets

CP-Esomeprazole 20

2. Qualitative and quantitative composition

Each tablet contains 20 mg of esomeprazole (as esomeprazole magnesium dihydrate).

Excipient with known effect

Each tablet also contains 35 mg of lactose (see section 4.4).

For the full list of excipients, see section 6.1.

3. Pharmaceutical form

Tablet.

Brown-coloured, circular, biconvex, enteric-coated tablet plain on both sides with a diameter of 7.14 mm.

4. Clinical particulars

4.1 Therapeutic indications

Adults

1. *Gastroesophageal Reflux Disease (GERD).*
 - Treatment of erosive reflux oesophagitis.
 - Long-term management of patients with healed oesophagitis to prevent relapse.
 - Symptomatic treatment of gastroesophageal reflux disease (GERD).
2. *In combination with appropriate antibacterial therapeutic regimens for the eradication of *Helicobacter pylori*.*
 - Healing of *Helicobacter pylori*-associated duodenal ulcer.
 - Prevention of relapse of peptic ulcers in patients with *Helicobacter pylori*-associated ulcers.
3. *Patients requiring continued NSAID therapy.*
 - healing of gastric ulcers associated with NSAID therapy.
 - Prevention of gastric and duodenal ulcers associated with NSAID therapy, in patients at risk.
4. *Treatment of Zollinger Ellison Syndrome.*

Adolescents (from the age of 12 years)

1. *Gastroesophageal Reflux Disease (GERD).*
 - Treatment of erosive reflux esophagitis.
 - Long-term management of patients with healed esophagitis to prevent relapse.
 - Symptomatic treatment of gastroesophageal reflux disease (GERD).
2. *In combination with antibiotics in the treatment of duodenal ulcers caused by *Helicobacter pylori*.*

4.2 Posology and method of administration

Adults

1. *Gastroesophageal Reflux Disease (GERD)*

- Treatment of erosive reflux esophagitis

40 mg once daily for 4 weeks.

An additional 4 weeks of treatment is recommended for patients in whom esophagitis has not healed or who have persistent symptoms.

Prolonged treatment after i.v. induced prevention of rebleeding of peptic ulcers.

40 mg once daily for 4 weeks after i.v. induced prevention of rebleeding of peptic ulcers.

- Long-term management of patients with healed esophagitis to prevent relapse

20 mg once daily

- Symptomatic treatment of gastroesophageal reflux disease (GERD)

20 mg once daily in patients without esophagitis. If symptom control has not been achieved after 4 weeks, the patient should be further investigated. Once symptoms have resolved, subsequent symptom control can be achieved using 20 mg once daily. An on-demand regimen of taking 20 mg once daily, when needed, can be used. In NSAID-treated patients at risk of developing gastric and duodenal ulcers, subsequent symptom control using an on-demand regimen is not recommended.

2. *In combination with appropriate antibacterial therapeutic regimens for the eradication of *Helicobacter pylori**

- Healing of *Helicobacter pylori*-associated duodenal ulcer

- Prevention of relapse of peptic ulcers in patients with *Helicobacter pylori*-associated ulcers

3. *Patients requiring continued NSAID therapy*

- Healing of gastric ulcers associated with NSAID therapy

The usual dose is 20 mg once daily. The treatment duration is 4-8 weeks.

- Prevention of gastric and duodenal ulcers associated with NSAID therapy in patients at risk

20 mg once daily.

Special Populations

Renal impairment

Dose adjustment is not required in patients with impaired renal function. Due to limited experience in patients with severe renal insufficiency, such patients should be treated with caution.

Hepatic impairment

Dose adjustment is not required in patients with mild to moderate liver impairment. For patients with severe liver impairment, a maximum dose of 20 mg esomeprazole should not be exceeded.

Elderly

Dose adjustment is not required in the elderly.

Paediatric population

Adolescents from the age of 12 years

Gastroesophageal Reflux Disease (GERD)

- Treatment of erosive reflux esophagitis

40 mg once daily for 4 weeks. An additional 4-week treatment is recommended for patients in whom esophagitis has not healed or who have persistent symptoms.

- Long-term management of patients with healed esophagitis to prevent relapse

20 mg once daily.

- symptomatic treatment of gastroesophageal reflux disease (GERD)

20 mg once daily in patients without esophagitis. If symptom control has not been achieved after 4 weeks, the patient should be further investigated. Once symptoms have resolved, subsequent symptom control can be achieved using 20 mg once daily.

Treatment of duodenal ulcer caused by Helicobacter pylori

When selecting appropriate combination therapy, consideration should be given to official national, regional and local guidance regarding bacterial resistance, duration of treatment (most commonly 7 days but sometimes up to 14 days), and appropriate use of antibacterial agents. The treatment should be supervised by a specialist. The posology recommendation is:

30 to 40 kg - (Combination with two antibiotics) esomeprazole 20 mg, amoxicillin 750 mg and clarithromycin 7.5 mg/ kg body weight are all administered together twice daily for one week.

>40 kg - (Combination with two antibiotics) esomeprazole 20 mg, amoxicillin 1 g and clarithromycin 500 mg are all administered together twice daily for one week.

Method of administration

The tablets should be swallowed whole with liquid. The tablets should not be chewed or crushed. For patients who have difficulty swallowing, the tablets can also be dispersed in half a glass of non-carbonated water. No other liquids should be used as the enteric coating may be dissolved. Stir until the tablets disintegrate and drink the liquid with the tablets immediately or within 30 minutes. Rinse the glass with half a glass of water and drink.

For patients who cannot swallow, the tablets can be dispersed in non-carbonated water and administered through a gastric tube. The appropriateness of the selected syringe and tube must be carefully tested.

4.3 Contraindications

Hypersensitivity to the active substance, to substituted benzimidazoles or any of the excipients. Esomeprazole should not be used concomitantly with nelfinavir.

4.4 Special warnings and precautions for use

In the presence of any alarm symptom (e.g., significant unintentional weight loss, recurrent vomiting, dysphagia, haematemesis or melaena) and when gastric ulcer is suspected or present, malignancy should be excluded, as treatment with esomeprazole may alleviate symptoms and delay diagnosis.

Long term use

Patients on long-term treatment (particularly those treated for more than a year) should be kept under regular surveillance.

On-demand treatment

Patients on on-demand treatment should be instructed to contact their physician if their symptoms change in character.

Helicobacter pylori eradication

When prescribing esomeprazole for eradication of *Helicobacter pylori* possible drug interactions for all components in the triple therapy should be considered. Clarithromycin is a potent inhibitor of CYP3A4 and hence contraindications and interactions for clarithromycin should be considered when the triple therapy is used in patients concurrently taking other drugs metabolised via CYP3A4 such as cisapride.

Gastrointestinal infections

Treatment with proton pump inhibitors may lead to a slightly increased risk of gastrointestinal infections such as salmonella and campylobacter.

Absorption of vitamin B12

Esomeprazole, like all acid-blocking medicines, may reduce the absorption of vitamin B12 (cyanocobalamin) due to hypo- or achlorhydria. This should be considered in patients with reduced body stores or risk factors for reduced vitamin B12 absorption on long-term therapy.

Hypomagnesaemia

Severe hypomagnesaemia has been reported in patients treated with proton pump inhibitors (PPIs) like esomeprazole for at least three months, and in most cases for a year. Serious manifestations of hypomagnesaemia such as fatigue, tetany, delirium, convulsions, dizziness and ventricular arrhythmia can occur but they may begin insidiously and be overlooked. In most affected patients, hypomagnesaemia improved after magnesium replacement and discontinuation of the PPI. For patients expected to be on prolonged treatment or who take PPIs with digoxin or drugs that may cause hypomagnesaemia (e.g., diuretics), healthcare professionals should consider measuring magnesium levels before starting PPI treatment and periodically during treatment.

Risk of fracture

Proton pump inhibitors, especially if used in high doses and over long durations (> 1 year), may modestly increase the risk of hip, wrist and spine fracture, predominantly in the elderly or presence of other recognised risk factors. Observational studies suggest that proton pump inhibitors may increase the overall risk of fracture by 10–40 %. Some of this increase may be due to other risk factors. Patients at risk of osteoporosis should receive care according to current clinical guidelines and they should have an adequate intake of vitamin D and calcium.

Subacute cutaneous lupus erythematosus (SCLE)

Proton pump inhibitors are associated with very infrequent cases of SCLE. If lesions occur, especially in sun-exposed areas of the skin, and if accompanied by arthralgia, the patient should seek medical help promptly and the health care professional should consider stopping Esomeprazole. SCLE after previous treatment with a proton pump inhibitor may increase the risk of SCLE with

other proton pump inhibitors.

Combination with other medicinal products

Co-administration of esomeprazole with atazanavir is not recommended. If the combination of atazanavir with a proton pump inhibitor is judged unavoidable, close clinical monitoring is recommended in combination with an increase in the dose of atazanavir to 400mg with 100mg of ritonavir; esomeprazole 20mg should not be exceeded.

Esomeprazole is a CYP2C19 inhibitor. When starting or ending treatment with esomeprazole, the potential for interactions with drugs metabolised through CYP2C19 should be considered. An interaction is observed between clopidogrel and esomeprazole. The clinical relevance of this interaction is uncertain. As a precaution, concomitant use of esomeprazole and clopidogrel should be discouraged.

When prescribing esomeprazole for on-demand therapy, the implications for interactions with other pharmaceuticals, due to fluctuating plasma concentrations of esomeprazole should be considered.

Interference with laboratory tests

Increased Chromogranin A (CgA) levels may interfere with investigations for neuroendocrine tumours. To avoid this interference, esomeprazole treatment should be stopped for at least five days before CgA measurements.

Excipients

CP-Esomeprazole contains lactose. Patients with rare hereditary problems of galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine.

4.5 Interaction with other medicinal products and other forms of interaction

4.5.1 Effects of esomeprazole on the pharmacokinetics of other drugs

Protease inhibitors

Omeprazole has been reported to interact with some protease inhibitors. The clinical importance and the mechanisms behind these reported interactions are not always known. Increased gastric pH during omeprazole treatment may change the absorption of the protease inhibitors. Other possible interaction mechanisms are via inhibition of CYP 2C19.

For atazanavir and nelfinavir, decreased serum levels have been reported when given together with omeprazole and concomitant administration is not recommended. Co-administration of omeprazole (40 mg once daily) with atazanavir 300 mg/ritonavir 100 mg to healthy volunteers resulted in a substantial reduction in atazanavir exposure (approximately 75% decrease in AUC, C_{max} and C_{min}). Increasing the atazanavir dose to 400 mg did not compensate for the impact of omeprazole on atazanavir exposure. The co-administration of omeprazole (20 mg QD) with atazanavir 400 mg/ritonavir 100 mg to healthy volunteers resulted in a decrease of approximately 30% in the atazanavir exposure as compared with the exposure observed with atazanavir 300 mg/ritonavir 100 mg QD without omeprazole 20 mg QD. Co-administration of omeprazole (40 mg QD), reduced mean nelfinavir AUC, C_{max} and C_{min} by 36-39 % and mean AUC, C_{max} and C_{min} for the pharmacologically active metabolite M8 was reduced by 75-92%. Due to the similar

pharmacodynamic effects and pharmacokinetic properties of omeprazole and esomeprazole, concomitant administration with esomeprazole and atazanavir is not recommended and concomitant administration with esomeprazole and nelfinavir is contraindicated.

For saquinavir (with concomitant ritonavir), increased serum levels (80-100%) have been reported during concomitant omeprazole treatment (40 mg QD). Treatment with omeprazole 20 mg QD did not affect the exposure of darunavir (with concomitant ritonavir) and amprenavir (with concomitant ritonavir). Treatment with esomeprazole 20 mg QD did not affect the exposure of amprenavir (with and without concomitant ritonavir). Treatment with omeprazole 40 mg QD did not affect the exposure of lopinavir (with concomitant ritonavir).

Methotrexate

When given together with PPIs, methotrexate levels have been reported to increase in some patients. In high-dose methotrexate administration, a temporary withdrawal of esomeprazole may need to be considered.

Tacrolimus

Concomitant administration of esomeprazole has been reported to increase the serum levels of tacrolimus. A reinforced monitoring of tacrolimus concentrations as well as renal function (creatinine clearance) should be performed and the dosage of tacrolimus adjusted if needed.

Medicinal products with pH-dependent absorption

Gastric acid suppression during treatment with esomeprazole and other PPIs might decrease or increase the absorption of medicinal products with a gastric pH-dependent absorption. As with other medicinal products that decrease intragastric acidity, the absorption of medicinal products such as ketoconazole, itraconazole and erlotinib can decrease and the absorption of digoxin can increase during treatment with esomeprazole. Concomitant treatment with omeprazole (20 mg daily) and digoxin in healthy subjects increased the bioavailability of digoxin by 10 % (up to 30 % in two out of ten subjects). Digoxin toxicity has been rarely reported. However, caution should be exercised when esomeprazole is given at high doses in elderly patients. Therapeutic drug monitoring of digoxin should then be reinforced.

Medicinal products metabolised by CYP2C19

Esomeprazole inhibits CYP2C19, the major esomeprazole metabolising enzyme. Thus, when esomeprazole is combined with drugs metabolised by CYP2C19, such as diazepam, citalopram, imipramine, clomipramine, phenytoin etc., the plasma concentrations of these drugs may be increased and dose reduction could be needed. This should be considered especially when prescribing esomeprazole for on-demand therapy.

Diazepam

Concomitant administration of 30 mg esomeprazole resulted in a 45% decrease in clearance of the CYP2C19 substrate diazepam.

Phenytoin

Concomitant administration of 40 mg esomeprazole resulted in a 13% increase in trough plasma levels of phenytoin in epileptic patients. It is recommended to monitor the plasma concentrations of phenytoin when treatment with esomeprazole is introduced or withdrawn.

Voriconazole

Omeprazole (40 mg once daily) increased voriconazole (a CYP2C19 substrate) C_{max} and AUC by 15% and 41%, respectively.

Cilostazol

Omeprazole as well as esomeprazole act as inhibitors of CYP2C19. Omeprazole, given in doses of 40 mg to healthy subjects in a cross-over study, increased C_{max} and AUC for cilostazol by 18% and 26% respectively, and one of its active metabolites by 29% and 69% respectively. In healthy volunteers, concomitant administration of 40 mg esomeprazole resulted in a 32% increase in area under the plasma concentration-time curve (AUC) and a 31% prolongation of elimination half-life ($t_{1/2}$) but no significant increase in peak plasma levels of cilostazol. The slightly prolonged QTc interval observed after administration of cilostazol alone was not further prolonged when cilostazol was given in combination with esomeprazole.

Warfarin

Concomitant administration of 40 mg esomeprazole to warfarin-treated patients in a clinical trial showed that coagulation times were within the accepted range. However, post-marketing, a few isolated cases of elevated INR of clinical significance have been reported during concomitant treatment. Monitoring is recommended when initiating and ending concomitant esomeprazole treatment during treatment with warfarin or other coumarin derivatives.

Clopidogrel

Results from studies in healthy subjects have shown a pharmacokinetic (PK)/ pharmacodynamic (PD) interaction between clopidogrel (300 mg loading dose/75 mg daily maintenance dose) and esomeprazole (40 mg p.o.daily) resulting in decreased exposure to the active metabolite of clopidogrel by an average of 40 % and resulting in decreased maximum inhibition of (ADP induced) platelet aggregation by an average of 14 %.

When clopidogrel was given together with a fixed dose combination of esomeprazole 20 mg + ASA 81 mg compared to clopidogrel alone in a study in healthy subjects there was a decreased exposure by almost 40 % of the active metabolite of clopidogrel. However, the maximum levels of inhibition of (ADP induced) platelet aggregation in these subjects were the same in the clopidogrel and the clopidogrel + the combined (esomeprazole + ASA) product groups.

Inconsistent data on the clinical implications of this PK/PD interaction of esomeprazole in terms of major cardiovascular events have been reported from both observational and clinical studies. As a precaution, concomitant use of clopidogrel should be discouraged.

4.5.2 Investigated medicinal products with no clinically relevant interaction

Amoxicillin and quinidine

Esomeprazole has been shown to have no clinically relevant effects on the pharmacokinetics of amoxicillin or quinidine.

Naproxen or rofecoxib

Studies evaluating concomitant administration of esomeprazole and either naproxen or rofecoxib did not identify any clinically relevant pharmacokinetic interactions during short-term studies.

4.5.3 Effects of other medicinal products on the pharmacokinetics of esomeprazole

Medicinal products which inhibit CYP2C19 and/or CYP3A4

Esomeprazole is metabolised by CYP2C19 and CYP3A4. Concomitant administration of esomeprazole and a CYP3A4 inhibitor, clarithromycin (500 mg b.i.d.), resulted in a doubling of the exposure (AUC) to esomeprazole. Concomitant administration of esomeprazole and a combined inhibitor of CYP2C19 and CYP3A4 may result in more than doubling of the esomeprazole exposure. The CYP2C19 and CYP3A4 inhibitor voriconazole increased omeprazole AUC by 280%. A dose adjustment of esomeprazole is not regularly required in either of these situations. However, dose adjustment should be considered in patients with severe hepatic impairment and if long-term treatment is indicated.

Medicinal products which induce CYP2C19 and/or CYP3A4

Drugs known to induce CYP2C19 or CYP3A4 or both (such as rifampicin and St John's wort) may lead to decreased esomeprazole serum levels by increasing the esomeprazole metabolism.

4.5.4 Paediatric population

Interaction studies have only been performed in adults.

4.6 Pregnancy and lactation

Pregnancy

Clinical data on exposed pregnancies with esomeprazole are insufficient. With the racemic mixture, omeprazole, data on a larger number of exposed pregnancies from epidemiological studies indicate no malformative nor foetotoxic effect. Animal studies with esomeprazole do not indicate direct or indirect harmful effects concerning embryonal/fetal development. Animal studies with the racemic mixture do not indicate direct or indirect harmful effects concerning pregnancy, parturition or postnatal development. Caution should be exercised when prescribing to pregnant women.

A moderate amount of data on pregnant women (between 300-1000 pregnancy outcomes) indicates no malformative or foeto/neonatal toxicity of esomeprazole.

Animal studies do not indicate direct or indirect harmful effects concerning reproductive toxicity.

Breastfeeding

It is not known whether esomeprazole is excreted in human breast milk. There is insufficient information on the effects of esomeprazole in newborns/infants. Esomeprazole should not be used during breastfeeding.

Fertility

Animal studies with the racemic mixture omeprazole, given by oral administration do not indicate effects concerning fertility.

4.7 Effects on the ability to drive and use machines

Esomeprazole has a minor influence on the ability to drive or use machines. Adverse reactions such as dizziness (uncommon) and blurred vision (rare) have been reported. If affected patients should

not drive or use machines.

4.8 Undesirable effects

Summary of the safety profile

Headache, abdominal pain, diarrhoea and nausea are among the adverse reactions that have been most commonly reported in clinical trials (and also from post-marketing use). In addition, the safety profile is similar for different formulations, treatment indications, age groups and patient populations. No dose-related adverse reactions have been identified.

Tabulated list of adverse reactions

The following adverse drug reactions have been identified or suspected in the clinical trials programme for esomeprazole and post-marketing. None was found to be dose-related. The reactions are classified according to frequency (very common $\geq 1/10$; common $\geq 1/100$ to $< 1/10$; uncommon $\geq 1/1,000$ to $< 1/100$; rare $\geq 1/10,000$ to $< 1/1,000$; very rare $< 1/10,000$; not known (cannot be estimated from the available data)).

System Organ Class	Frequency	Undesirable Effect
Blood and lymphatic system disorders	Rare	Leukopenia, thrombocytopenia
	Very rare	Agranulocytosis, pancytopenia
Immune system disorders	Rare	Hypersensitivity reactions e.g., fever, angioedema and anaphylactic reaction/shock
Metabolism and nutrition disorders	Uncommon	Peripheral oedema
	Rare	Hyponatraemia
	Not known	Hypomagnesaemia: severe hypomagnesaemia can correlate with hypocalcaemia. Hypomagnesaemia may also be associated with hypokalaemia
Psychiatric disorders	Uncommon	Insomnia
	Rare	Agitation, confusion, depression
	Very rare	Aggression, hallucinations
Nervous system disorders	Common	Headache
	Uncommon	Dizziness, paraesthesia, somnolence
	Rare	Taste disturbance

Eye disorders	Rare	Blurred vision
Ear and labyrinth disorders	Uncommon	Vertigo
Respiratory, thoracic and mediastinal disorders	Rare	Bronchospasm
Gastrointestinal disorders	Common	Abdominal pain, constipation, diarrhoea, flatulence, nausea/vomiting
	Uncommon	Dry mouth
	Rare	Stomatitis, gastrointestinal candidiasis
	Not known	Microscopic colitis
Hepatobiliary disorders	Uncommon	Increased liver enzymes
	Rare	Hepatitis with or without jaundice
	Very rare	Hepatic failure, encephalopathy in patients with pre-existing liver disease
Skin and subcutaneous tissue disorders	Uncommon	Dermatitis, pruritus, rash, urticaria
	Rare	Alopecia, photosensitivity
	Very rare	Erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis (TEN)
	Not known	Subacute cutaneous lupus erythematosus
Musculoskeletal and connective tissue disorders	Uncommon	Fracture of the hip, wrist or spine
	Rare	Arthralgia, myalgia
	Very rare	Muscular weakness
Renal and urinary disorders	Very rare	Interstitial nephritis, in some patients renal failure has been reported concomitantly

Reproductive system and breast disorders	Very rare	Gynaecomastia
General disorders and administration site conditions	Rare	Malaise, increased sweating

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the e-PV desktop applications (https://drive.google.com/file/d/16hwTz0587ZWtSWadbBAMwQPOD_KSExZP/view) or search for e-PV Mobile applications on the Google Play or Apple App Store.

4.9 Overdose

There have been no reports of serious deleterious effects from overdose. There is very limited experience to date with deliberate overdose. The symptoms described in connection with 280 mg were gastrointestinal symptoms and weakness. Single doses of 80 mg esomeprazole were uneventful. No specific antidote is known. Esomeprazole is extensively plasma protein-bound and is, therefore, not readily dialyzable. As in any case of overdose, treatment should be symptomatic and general supportive measures should be utilised.

5. Pharmacological properties

5.1 Pharmacodynamic properties

Pharmacological classification: 16.7 Gastric/peptic ulcer medicines.

Esomeprazole is the S-isomer of omeprazole and reduces gastric acid secretion through a specific targeted mechanism of action. It is a specific inhibitor of the acid pump in the parietal cell. Both the R- and S-isomers of omeprazole have similar pharmacodynamic activity.

Mechanism of action

Esomeprazole is a weak base and is concentrated and converted to the active form in the highly acidic environment of the secretory canaliculi of the parietal cell, where it inhibits the enzyme H⁺K⁺-ATPase – the acid pump and inhibits both basal and stimulated acid secretion.

Pharmacodynamic properties

After oral dosing with esomeprazole 20 mg and 40 mg the onset of effect occurs within one hour. After repeated administration with 20 mg esomeprazole once daily for five days, mean peak acid output after pentagastrin stimulation decreased 90% when measured 6-7 hours after dosing on day five.

After five days of oral dosing with 20 mg and 40 mg of esomeprazole, intragastric pH above 4 was maintained for a mean time of 13 hours and 17 hours, respectively over 24 hours in symptomatic GERD patients. The proportion of patients maintaining an intragastric pH above 4 for at least 8, 12 and 16 hours respectively were for esomeprazole 20 mg 76%, 54% and 24%. Corresponding proportions for esomeprazole 40 mg were 97%, 92% and 56%. Using AUC as a surrogate parameter

for plasma concentration, a relationship between inhibition of acid secretion and exposure has been shown. Healing of reflux esophagitis with esomeprazole 40 mg occurs in approximately 78% of patients after four weeks and in 93% after eight weeks.

One week of treatment with esomeprazole 20 mg b.i.d. and appropriate antibiotics, results in successful eradication of *H.pylori* in approximately 90% of patients. After eradication treatment for one week, there is no need for subsequent monotherapy with antisecretory drugs for effective ulcer healing and symptom resolution in uncomplicated duodenal ulcers.

During treatment with antisecretory medicinal products serum gastrin increases in response to the decreased acid secretion. Chromogranin A (CgA) increases due to decreased gastric acidity. The increased CgA level may interfere with investigations for neuroendocrine tumours. Literature reports indicate that proton pump inhibitor treatment should be stopped at least 5 days before CgA measurement. If CgA and gastrin levels have not normalized after 5 days, measurements should be repeated 14 days after cessation of esomeprazole treatment. An increased number of ECL cells possibly related to the increased serum gastrin levels, have been observed in both children and adults during long-term treatment with esomeprazole. The findings are considered to be of no clinical significance.

During long-term treatment with antisecretory drugs gastric glandular cysts have been reported to occur at a somewhat increased frequency. These changes are a physiological consequence of pronounced inhibition of acid secretion, are benign and appear to be reversible. Decreased gastric acidity due to any means including proton pump inhibitors, increases gastric counts of bacteria normally present in the gastrointestinal tract. Treatment with proton pump inhibitors may lead to a slightly increased risk of gastrointestinal infections such as salmonella and campylobacter and, in hospitalised patients, possibly also clostridium difficile.

Clinical efficacy

In two studies with ranitidine as an active comparator, esomeprazole showed a better effect in the healing of gastric ulcers in patients using NSAIDs, including COX-2 selective NSAIDs.

In two studies with placebo as a comparator, esomeprazole showed a better effect in the prevention of gastric and duodenal ulcers in patients using NSAIDs (aged >60 and/or with previous ulcers), including COX-2 selective NSAIDs.

Paediatric population

In a study of paediatric GERD patients (<1 to 17 years of age) receiving long-term PPI treatment, 61% of the children developed minor degrees of ECL cell hyperplasia with no known clinical significance and with no development of atrophic gastritis or carcinoid tumours.

5.2 Pharmacokinetic properties

Absorption

Esomeprazole is acid labile and is administered orally as gastro-resistant granules. *In vivo*, conversion to the R-isomer is negligible. Absorption of esomeprazole is rapid, with peak plasma levels occurring approximately 1-2 hours after dose. The absolute bioavailability is 64% after a single dose of 40 mg and increases to 89% after repeated once-daily administration. For 20 mg esomeprazole, the corresponding values are 50% and 68% respectively. Food intake both delays and

decreases the absorption of esomeprazole although this has no significant influence on the effect of esomeprazole on intragastric acidity.

Distribution

The apparent volume of distribution at steady state in healthy subjects is approximately 0.22 l/kg body weight. Esomeprazole is 97% plasma protein bound.

Biotransformation

Esomeprazole is completely metabolised by the cytochrome P450 system (CYP). The major part of the metabolism of esomeprazole is dependent on the polymorphic CYP2C19, responsible for the formation of the hydroxy- and desmethyl metabolites of esomeprazole. The remaining part is dependent on another specific isoform, CYP3A4, responsible for the formation of esomeprazole sulphone, the main metabolite in plasma.

Elimination

The parameters below reflect mainly the pharmacokinetics in individuals with a functional CYP2C19 enzyme and extensive metabolisers. Total plasma clearance is about 17 l/h after a single dose and about 9 l/h after repeated administration. The plasma elimination half-life is about 1.3 hours after repeated once-daily dosing. Esomeprazole is eliminated from plasma between doses with no tendency for accumulation during once-daily administration.

The major metabolites of esomeprazole do not affect gastric acid secretion. Almost 80% of an oral dose of esomeprazole is excreted as metabolites in the urine, the remainder in the faeces. Less than 1% of the parent drug is found in urine.

Linearity/non-linearity

The pharmacokinetics of esomeprazole have been studied in doses up to 40 mg b.i.d. The area under the plasma concentration-time curve increases with repeated administration of esomeprazole. This increase is dose-dependent and results in a more than dose-proportional increase in AUC after repeated administration. This time- and dose-dependency is due to a decrease of first-pass metabolism and systemic clearance probably caused by an inhibition of the CYP2C19 enzyme by esomeprazole and/or its sulphone metabolite.

Special patient populations

Poor metabolisers

Approximately 2.9±1.5% of the population lack a functional CYP2C19 enzyme and are called poor metabolisers. In these individuals, the metabolism of esomeprazole is probably mainly catalysed by CYP3A4. After repeated once-daily administration of 40 mg esomeprazole, the mean area under the plasma concentration-time curve was approximately 100% higher in poor metabolisers than in subjects having a functional CYP2C19 enzyme (extensive metabolisers). Mean peak plasma concentrations were increased by about 60%. These findings have no implications for the posology of esomeprazole.

Gender

Following a single dose of 40 mg esomeprazole the mean area under the plasma concentration-time curve is approximately 30 % higher in females than in males. No gender difference is seen after

repeated once-daily administration. These findings have no implications for the posology of esomeprazole.

Hepatic impairment

The metabolism of esomeprazole in patients with mild to moderate liver dysfunction may be impaired. The metabolic rate is decreased in patients with severe liver dysfunction resulting in a doubling of the area under the plasma concentration-time curve of esomeprazole. Therefore, a maximum of 20 mg should not be exceeded in patients with severe dysfunction. Esomeprazole or its major metabolites do not show any tendency to accumulate with once-daily dosing.

Renal impairment

No studies have been performed in patients with decreased renal function. Since the kidney is responsible for the excretion of the metabolites of esomeprazole but not for the elimination of the parent compound, the metabolism of esomeprazole is not expected to change in patients with impaired renal function.

Older people

The metabolism of esomeprazole is not significantly changed in elderly subjects (71-80 years of age).

Paediatric population

Adolescents 12-18 years

Following repeated dose administration of 20 mg and 40 mg esomeprazole, the total exposure (AUC) and the time to reach maximum plasma drug concentration (T_{max}) in 12- to 18-year-olds was similar to that in adults for both esomeprazole doses.

5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, genotoxicity, carcinogenic potential and toxicity to reproduction and development. Adverse reactions not observed in clinical studies but seen in animals at exposure levels similar to clinical exposure levels and with possible relevance to clinical use were as follows: carcinogenicity studies in the rat with the racemic mixture showed gastric ECL-cell hyperplasia and carcinoids. These gastric effects in the rat are the result of sustained, pronounced hypergastrinaemia secondary to reduced production of gastric acid and are observed after long-term treatment in the rat with inhibitors of gastric acid secretion.

6. Pharmaceutical particulars

6.1 List of excipients

Pregelatinised starch

Lactose

Stearic acid

Anhydrous disodium hydrogen phosphate

Crospovidone

Magnesium stearate

Isopropyl alcohol

Methylene chloride

Instacoat sol IC-S-1643 transparent
Instacoat brown

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

18 months.

6.4 Special precautions for storage

Store below 30°C.

6.5 Nature and contents of the container

The tablets are packed in Alu-Alu blister packs.

Pack size: 3 x 10 tablets.

6.6 Special precautions for disposal and other handling

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. APPLICANT

Cospharm Investments (Pty) Limited
ERF 492 Dante Street
Prosperita
Windhoek
Namibia

8. MANUFACTURER

Acme Formulation Pvt. Limited
Ropar Road, Nalagarh
Distt. Solan
Himachal Pradesh – 174101
India

9. REGISTRATION DETAILS

Zimbabwe registration number: 2023/16.7/6424
Zimbabwe category for distribution: Pharmacist Initiated Medicines (P.I.M.)

10. DATE OF REVISION OF TEXT

September 2023