Drugfield Pharmaceuticals Limited

SUMMARY OF PRODUCT CHARACTERISTICS

(SmPC)

Resoquine® Tablet
(Chloroquine Phosphate 250 mg equivalent to 150 mg Chloroquine base)

1. NAME OF THE MEDICINAL PRODUCT

Chloroquine (Chloroquine Phosphate 250 mg equivalent to 150 mg Chloroquine base) Tablet

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 250 mg Chloroquine Phosphate equivalent to 150 mg Chloroquine base For a full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

White round shape tablets

4. Clinical particulars

4.1 Therapeutic indications

a) Treatment of amoebic hepatitis and abscess.

b) Treatment of discoid and systemic lupus erythematosus.

c) Treatment of rheumatoid arthritis.

4.2 Posology and method of administration

Posology

The dosage of Chloroquine phosphate is often expressed in terms of equivalent Chloroquine base. Each 250 mg tablet of Chloroquine phosphate contains the equivalent of 150 mg Chloroquine base. In infants and children the dosage is preferably calculated by body weight.

Usual Adult Dose for Amebiasis
1 g salt (600 mg base) orally once a day for 2 days, followed by 500 mg salt (300 mg base) orally once a day for at least 2 to 3 weeks

Comments:
-Treatment is usually combined with an effective intestinal amebicide.
Use: For the treatment of extraintestinal amebiasis

Usual Adult Dose for Sarcoidosis
Study (n=43)
Intrathoracic and cutaneous: 250 mg twice a day for 4 to 17 months; a treatment course should be limited to 6 months to minimize risk of ocular damage
Study (n=23)
Pulmonary: 750 mg per day for 6 months, then tapered every 2 months to 250 mg per day Study (n=37)
Nervous system (neurosarcoidosis): 250 mg twice a day for 6 to 18 months

Method of administration

Oral route

4.3 Contraindications

Known hypersensitivity to chloroquine or any other ingredients of the formulation. Concomitant use with amiodarone. (See section 4.5)

4.4 Special warnings and precautions for use

Cases of cardiomyopathy resulting in cardiac failure, in some cases with fatal outcome, have been reported in patients treated during long term therapy at high doses with Chloroquine Monitor for signs and symptoms of cardiomyopathy and discontinue Chloroquine if cardiomyopathy develops. Chronic toxicity should be considered when conduction

Hypoglycemia

Chloroquine has been shown to cause severe hypoglycemia including loss of consciousness that could be life-threatening in patients treated with or without antidiabetic medications. Patients presenting with clinical symptoms suggestive of hypoglycemia during treatment with Chloroquine should have their blood glucose level checked and treatment reviewed as necessary.

4.5 Interaction with other medicinal products and other forms of interaction

Antacids and kaolin: Antacids and kaolin can reduce absorption of Chloroquine; an interval of at least 4 hours between intake of these agents and Chloroquine should be observed.

Cimetidine: Cimetidine can inhibit the metabolism of Chloroquine, increasing its plasma level. Concomitant use of cimetidine should be avoided.

Insulin and other antidiabetic drugs: As Chloroquine may enhance the effects of a hypoglycemic treatment, a decrease in doses of insulin or other antidiabetic drugs may be required.

Arrhythmogenic drugs: There may be an increased risk of inducing ventricular arrhythmias if Chloroquine is used concomitantly with other arrhythmogenic drugs, such as amiodarone or moxifloxacin.

Ampicillin: In a study of healthy volunteers, Chloroquine significantly reduced the bioavailability of ampicillin. An interval of at least two hours between intake of ampicillin and Chloroquine should be observed.

Cyclosporine: After introduction of Chloroquine (oral form), a sudden increase in serum cyclosporine level has been reported. Therefore, close monitoring of serum cyclosporine level is recommended and, if necessary, Chloroquine should be discontinued.

Mefloquine: Co-administration of Chloroquine and mefloquine may increase the risk of convulsions.

The blood concentrations of Chloroquine and desethylChloroquine (the major metabolite of Chloroquine, which also has antimalarial properties) were negatively associated with log antibody titers. Chloroquine taken in the dose recommended for malaria prophylaxis can reduce the antibody response to primary immunization with intradermal human diploid-cell rabies vaccine.

4.6 Pregnancy and Lactation

Pregnancy

In animal studies, embryo-fetal developmental toxicity was shown at doses ranging from 250 to 1500 mg/kg body weight; approximately 3 to 16 times the maximum recommended therapeutic dose based on a body surface area. Preclinical data showed a potential risk of genotoxicity in some test systems. In humans, at recommended doses for prophylaxis and treatment of malaria, observational studies as well as a meta-analysis, including a small number of prospective studies with Chloroquine exposure during pregnancy, have shown no increase in the rate of birth defects or spontaneous abortions. The individual benefit-risk balance should be reviewed before prescribing Chloroquine in pregnant women..

Breast-feeding

Although chloroquine is excreted in breast milk, the amount is too small to be harmful when used for malaria prophylaxis but as a consequence is insufficient to confer any benefit on the infant. Separate chemoprophylaxis for the infant is required. However, when long-term high doses are used for rheumatoid disease, breast feeding is not recommended.

4.7 Effects on ability to drive and use machines

Defects in visual accommodation may occur on first taking Chloroquine and patients should be warned regarding driving or operating machinery.

4.8 Undesirable effects

The following adverse reactions have been identified during post-approval use of Chloroquine or other 4-aminoqunoline compounds. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Immune system disorders: Urticaria, anaphylactic reaction including angioedema.

Ear and labyrinth disorders: Nerve type deafness; tinnitus, reduced hearing in patients with preexisting auditory damage.

Musculoskeletal and connective tissue-disorders: Sensorimotor disorders, skeletal muscle myopathy or neuromyopathy leading to progressive weakness and atrophy of proximal muscle groups, depression of tendon reflexes and abnormal nerve conduction.

Gastrointestinal disorders: Hepatitis, increased liver enzymes, anorexia, nausea, vomiting, diarrhea, abdominal cramps.

Skin and subcutaneous tissue disorders: Erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis, exfoliative dermatitis. Pleomorphic skin eruptions, skin and mucosal pigmentary changes; lichen planus-like eruptions, pruritus,; drug rash with eosinophilia and systemic symptoms (DRESS syndrome); photosensitivity and hair loss and bleaching of hair pigment.

Cardiac disorders: Hypotension, electrocardiographic changes (particularly, inversion or depression of the T-wave with widening of the QRS complex), and cardiomyopathy (which may result in cardiac failure and in some cases a fatal outcome).

Cardiac arrhythmias, conduction disorders such as bundle branch block / atrio-ventricular block, QT interval prolongation, torsade de pointes, ventricular tachycardia and ventricular fibrillation have been reported with therapeutic doses of Chloroquine as well as with overdose.

4.9 Overdose

Chloroquine is very rapidly and completely absorbed after ingestion. Toxic doses of Chloroquine can be fatal. As little as 1 g may be fatal in children. Toxic symptoms can occur within minutes. The symptoms of overdosage may include nausea, vomiting, headache, drowsiness, visual disturbances, cardiovascular collapse, convulsions, hypokalemia, rhythm and conduction disorders including QT prolongation, torsades de pointes, ventricular tachycardia and ventricular fibrillation, followed by sudden potentially fatal respiratory and cardiac arrest. Immediate medical attention is required, as these effects may appear shortly after the overdose.
Treatment: Treatment is symptomatic and must be prompt with immediate evacuation of the stomach by emesis or gastric lavage followed by treatment with activated charcoal. Chloroquine overdose is a life-threatening emergency and should be managed with cardio-respiratory and hemodynamic support, monitoring of potassium along with management of arrhythmias and convulsions, as necessary. A patient who survives the acute phase and is asymptomatic should be closely observed until all clinical features of toxicity resolve.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamics properties

Pharmacotherapeutic group: Antiprotozoals, Antimalarials
ATC code: P01BA01

Mechanism of Action: Chloroquine, a 4-aminoquinoline, is an anti-protozoal agent. The precise mechanism by which Chloroquine exhibits activity is not known. Chloroquine, may exert its effect against Plasmodium species by concentrating in the acid vesicles of the parasite and by inhibiting polymerization of heme. It can also inhibit certain enzymes by its interaction with DNA. In vitro studies with Chloroquine demonstrated that it is active against the trophozoites of Entamoeba histolytica.

5.2 Pharmacokinetic properties

Studies in volunteers using single doses of chloroquine phosphate equivalent to 300mg base have found peak plasma levels to be achieved within one to six hours. These levels are in the region of 54 - 102microgram/litre, the concentration in whole blood being some 4 to 10 times higher. Following a single dose, chloroquine may be detected in plasma for more than four weeks. Mean bioavailability from tablets of chloroquine phosphate is 89%. Chloroquine is widely distributed in body tissues such as the eyes, kidneys, liver, and lungs where retention is prolonged. The elimination of chloroquine is slow, with a multi exponential decline in plasma concentration. The initial distribution phase has a half-life of 2-6 days while the terminal elimination phase is 10-60 days. Approximately 50-70% of chloroquine in plasma is bound to the plasma proteins.

The principal metabolite is monodesethylchloroquine, which reaches a peak concentration of 10-20 microgram/litre within a few hours. Mean urinary recovery, within 3-13 weeks, is approximately 50% of the administered dose, most being unchanged drug and the remainder as metabolite. Chloroquine may be detected in urine for several months.

5.3 Preclinical safety data

Chloroquine has been widely used for many years in clinical practice. There is no animal data which adds significant information relevant to the prescriber, to that covered elsewhere in this document.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Chloroquine Phosphate
Lactose Monohydrate
Corn Starch
Corn Starch (for Paste)
Methyl Paraben
Propyl Paraben
Polyvinyl Pyrrolidone (K-30)
Aerosil 200

6.2 Incompatibilities

None have been reported or are known

6.3 Shelf life

48 Months

6.4 Special precautions for storage

Store below 30°C. Protect from light and moisture.

6.5 Nature and contents of container and special equipment for use, administration or implantation

Chloroquine tablet is presented in a blister of 10 x 10 tablets packed in a hardboard carton with leaflet enclosed.

6.6 Special precautions for disposal and other handling

No special requirements.

7. APPLICANT/MANUFACTURER

Drugfield Pharmaceuticals Limited
Lynson Chemical Avenue Km38,
Lagos-Abeokuta Expressway
Sango-Otta, Ogun State, Nigeria
Tel: +2348033513989
Email:Info@drugfieldpharma.com