

HEPARINE MEDIS

Heparin sodium 25000UI

Solution for injection

1. NAME OF THE MEDICINAL PRODUCT

Heparine Médís, solution for injection.

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Heparin sodium 25,000 I.U. /ml

For excipients, see 6.1.

3. PHARMACEUTICAL FORM

Solution for injection.

4. CLINICAL PARTICULARS

4.1. Therapeutic indications

- Prophylaxis and threatement of thromboembolic diseases (phlebitis and thrombophlebites and embolisms).
- As an adjuvant to early treatment of myocardial infarction.
- Heparinization of blood in extracorporeal circulation or during dialysis.

4.2 Posology and method of administration

Method of administration

By continuous intravenous infusion in 5% glucose or 0.9% sodium chloride or by intermittent intravenous injection, or by subcutaneous injection.

The intravenous injection volume of Heparine Medis 25000 IU/5ml should not exceed 15ml. As the effects of heparin are short-lived, administration by intravenous infusion or subcutaneous injection is preferable to intermittent intravenous injections. Posology

Prophylaxis of deep vein thrombosis and pulmonary embolism

Adults:

2 hours pre- 5,000 units subcutaneously
operatively:

followed by: 5,000 units subcutaneously every 8-12 hours, for 7-
10 days or until the patient is fully ambulant.

No laboratory monitoring should be necessary during low dose heparin prophylaxis. If monitoring is considered desirable, anti-Xa assays should be used as the activated partial thromboplastin time (APTT) is not significantly prolonged.

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Elderly:

Dosage reduction and monitoring of APTT may be advisable.

Paediatric population: No dosage recommendations.

Treatment of deep vein thrombosis and pulmonary embolism:

Adults:

Loading dose: 5,000 units intravenously (10,000 units may be required in severe pulmonary embolism)

Maintenance: 1,000-2,000 units/hour by intravenous infusion, or 10,000-20,000 units 12 hourly subcutaneously, or 5,000-10,000 units 4-hourly by intravenous injection.

Elderly:

Dosage reduction may be advisable.

Children and small adults:

Loading dose: 50 units/kg intravenously

Maintenance: 15-25 units/kg/hour by intravenous infusion, or 250 units/kg 12 hourly subcutaneously, or 100 units/kg 4-hourly by intravenous injection.

Treatment of unstable angina pectoris and acute peripheral arterial occlusion:

Adults:

Loading dose: 5,000 units intravenously

Maintenance: 1,000-2,000 units/hour by intravenous infusion, or 5,000-10,000 units 4-hourly by intravenous injection.

Elderly:

Dosage reduction may be advisable.

Children and small adults:

Loading dose: 50 units/kg intravenously

Maintenance: 15-25 units/kg/hour by intravenous infusion, or 100 units/kg 4-hourly by intravenous injection.

Daily laboratory monitoring (ideally at the same time each day, starting 4-6 hours after initiation of treatment) is essential during full-dose heparin treatment, with adjustment of dosage to maintain an APTT value 1.5-2.5 x midpoint of normal range or control value.

Prophylaxis of mural thrombosis following myocardial infarction

Adults:

12,500 units 12 hourly subcutaneously for at least 10 days.

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Elderly:

Dosage reduction may be advisable

In extracorporeal circulation and haemodialysis

Adults:

Cardiopulmonary bypass:

Initially 300 units/kg intravenously, adjusted thereafter to maintain the activated clotting time (ACT) in the range 400-500 seconds.

Haemodialysis and haemofiltration: Initially 1,000-5,000 units,

Maintenance: 1,000-2,000 units/hour, adjusted to maintain clotting time >40 minutes.

Heparin resistance

Patients with altered heparin responsiveness or heparin resistance may require disproportionately higher doses of heparin to achieve the desired effect. Also refer to section 4.4, Special warnings and precautions for use.

4.3 Contraindications

Hypersensitivity to the active substance(s) or to any of the excipients listed in section 6.1.

Current (or history of) heparin-induced thrombocytopenia. Generalised or local haemorrhagic tendency.

An epidural anaesthesia during birth in pregnant women treated with heparin is contraindicated.

Regional anaesthesia in elective surgical procedures is contra-indicated because the use of heparin may be very rarely associated with epidural or spinal haematoma resulting in prolonged or permanent paralysis.

4.4 Special warnings and precautions for use

Heparin should be used with caution in patients with hypersensitivity to low molecular weight heparin.

Care should be taken when heparin is administered to patients with increased risk of bleeding complications, hypertension, renal or hepatic insufficiency.

Heparin can suppress adrenal secretion of aldosterone leading to hyperkalaemia, particularly in patients such as those with diabetes mellitus, chronic renal failure, pre-existing metabolic acidosis, a raised plasma potassium or taking potassium sparing drugs. The risk of hyperkalaemia appears to increase with duration of therapy but is usually reversible. Plasma potassium should be measured in patients at risk before starting heparin therapy and monitored regularly thereafter particularly if treatment is prolonged beyond about 7 days.

Drugs affecting platelet function or the coagulation system should in general not be given concomitantly with heparin (see Section 4.5).

In patients undergoing peri-dural or spinal anaesthesia or spinal puncture, the prophylactic use of heparin may be very rarely associated with epidural or spinal haematoma resulting in

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prolonged or permanent paralysis. The risk is increased by the use of a peri-dural or spinal catheter for anaesthesia, by the concomitant use of drugs affecting haemostasis such as non-steroidal anti-inflammatory drugs, platelet inhibitors or anticoagulants and by traumatic or repeated puncture. In decision making on the interval between the last administration of heparin at prophylactic doses and the placement or removal of a peri-dural or spinal catheter, the product characteristics and the patient profile should be taken into account. Subsequent dose should not take place before at least four hours have elapsed. Re-administration should be delayed until the surgical procedure is completed.

Should a physician decide to administer anti-coagulation in the context of peridural or spinal anaesthesia, extreme vigilance and frequent monitoring must be exercised to detect any signs and symptoms of neurologic impairment, such as back pain, sensory and motor deficits and bowel or bladder dysfunction. Patients should be instructed to inform immediately a nurse or a clinician if they experience any of these.

Heparin should not be administered by intramuscular injection due to the risk of haematoma.

Due to increased bleeding risk, care should be taken when giving concomitant intramuscular injections, lumbar puncture and similar procedures.

As there is a risk of antibody-mediated heparin-induced thrombocytopenia, platelet counts should be measured in patients receiving heparin treatment for longer than 5 days and the treatment should be stopped immediately in those who develop thrombocytopenia.

Heparin induced thrombocytopenia and heparin induced thrombocytopenia with thrombosis can occur up to several weeks after discontinuation of heparin therapy. Patients presenting with thrombocytopenia or thrombosis after discontinuation of heparin should be evaluated for heparin induced thrombocytopenia and heparin induced thrombocytopenia with thrombosis.

Heparine Medis 25000 IU/5ml contains chlorocresol as preservative. Caution should be used if prescribing Heparine Medis 25000 IU/5ml to susceptible patients. Chlorocresol may cause allergic reactions.

4.5 Interaction with other medicinal products and other forms of interaction

Heparin may prolong the one stage prothrombin time. Accordingly, when Heparin is given with dicoumarol or warfarin sodium, a period of at least 5 hours after the last intravenous dose of heparin should elapse before blood is drawn, if a valid prothrombin time is to be obtained.

The anticoagulant effect of heparin may be enhanced by concomitant medication with other drugs affecting platelet function or the coagulation system, e.g. platelet aggregation inhibitors, thrombolytic agents, salicylates, non-steroidal anti-inflammatory drugs, vitamin K antagonists, dextrans, activated protein C. Where such combination cannot be avoided, careful clinical and biological monitoring is required.

Combined use with ACE inhibitors or angiotensin II antagonists may increase the risk of hyperkalaemia.

4.6 Fertility, pregnancy and lactation

The use of heparin in women with abortus imminens is contraindicated (see Section 4.3). Heparin does not cross the placental barrier and is not excreted in breast milk.

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4.7 Effects on ability to drive and use machines

None stated.

4.8 Undesirable effects

The following adverse reactions have been observed and reported during treatment with Heparin Sodium with the following frequencies: 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 available data).

Adverse Drug Reactions

System (SOC)	Organ Class	MedDRA Preferred Term	Frequency
Vascular disorders		Haemorrhage	Not known
		Epistaxis	Not known
		Contusion	Not known
Blood and lymphatic system disorders		Thrombocytopenia	Not known
Renal and urinary disorders		Haematuria	Not known
Endocrine disorders		Adrenal insufficiency	Not known
		Hypoadosteronism	Not known
Skin and subcutaneous tissue disorders		Alopecia	Not known
		Skin necrosis	Not known
Musculoskeletal, connective tissue and bone disorders		Osteoporosis	Not known
Immune disorders	system	Hypersensitivity	Not known
Metabolism and nutrition disorders		Rebound hyperlipidaemia	Not known
		Hyperkalaemia	Not known
		Hypokalaemia	Not known
Reproductive system and breast disorders		Priapism	Not known
General disorders and administration site conditions		Injection site reaction	Not known
Investigations		Alanine aminotransferase increased; Aspartate	Not known

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	aminotransferase increased	
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Erythematous nodules, or infiltrated and sometimes eczema-like plaques, at the site of subcutaneous injections are common, occurring 3-21 days after starting heparin treatment.

Haemorrhage:

Haemorrhage is the chief complication that may result from heparin therapy. An overly prolonged clotting time or minor bleeding during therapy can usually be controlled by withdrawing the drug. It should be appreciated that gastrointestinal or urinary tract bleeding during anticoagulant therapy may indicate the presence of an underlying occult lesion. Bleeding can occur at any site but certain specific haemorrhage complications may be difficult to detect.

Adrenal haemorrhage, with resultant acute adrenal insufficiency, has occurred during anticoagulant therapy. Therefore, such treatment should be discontinued in patients who develop signs and symptoms of acute adrenal haemorrhage and insufficiency. Initiation of corrective therapy should not depend on laboratory confirmation of the diagnosis, since any delay in an acute situation may result in the patient's death.

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 National pharmacovigilance system.

4.9 Overdose

Bleeding is the main sign of overdose with heparin.

As heparin is eliminated quickly, a discontinuation of treatment is sufficient in case of minor haemorrhages. In case of severe haemorrhages heparin may be neutralised with protamine sulphate injected slowly intravenously. One mg of protamine sulphate neutralises approximately 100 IU of heparin. Nevertheless, the required protamine sulphate dose varies according to the time of heparin administration and the dose administered.

It is important to avoid overdosage of protamine sulphate because protamine itself has anticoagulant properties. A single dose of protamine sulphate should never exceed 50 mg. Intravenous injection of protamine may cause a sudden fall in blood pressure, bradycardia, dyspnoea and transitory flushing, but these may be avoided or diminished by slow and careful administration.

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5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antithrombotic agents, ATC code: B01AB01

Heparin prevents the coagulation of blood in-vivo and in-vitro. It potentiates the inhibition of several activated coagulation factors, including thrombin and factor X.

5.2 Pharmacokinetic properties

Absorption

Heparin is not absorbed from the gastrointestinal tract. Heparin is administered by injection.

Distribution

Heparin binds extensively to plasma proteins.

Elimination

Heparin and its metabolites are excreted in the urine.

The half-life of heparin depends on the dose administered, the route of administration and is subject to wide inter- and intra-individual variation.

5.3 Preclinical safety data

There are no pre-clinical data of relevance to the prescriber which are additional to that already included in other sections.

6. PHARMACEUTICAL PARTICULARS

6.1. List of Excipients

Chlorocresol
Water for injection

6.2. Incompatibilities

In the absence of compatibility studies, this medicinal product must not be mixed with other medicinal products.

6.3. Shelf-life

36 months

6.4. Special precautions for storage

Store at a temperature not exceeding 25°C.

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6.5. Nature and content of container

Glass (Type 1) vial containing 5 ml. Carton containing 10 vials.

6.6. Special precautions for disposal

Each vial should be restricted to use in a single patient.

7. MARKETING AUTHORISATION HOLDER

Les Laboratoires « MédiS »; Route de Tunis km 7 – BP 206 – 8000 Nabeul, Tunisie.

8. MARKETING AUTHORISATION NUMBER

923 318 1

9. DATE OF FIRST AUTHORISATION / RENEWAL OF THE AUTHORISATION

DATE OF FIRST AUTHORISATION: 19/06/2002

RENEWAL OF THE AUTHORISATION: 30/11/2012; 30/11/2017

DATE OF REVISION OF THE TEXT: 11/2017.