

1.4 PRODUCT INFORMATION.

1.4.1 Prescribing Information

1. Name of the medicinal product

Totomol Suspension.

2. Qualitative and quantitative composition

Each 5mL contains: Paracetamol BP 120.0mg.

3. Pharmaceutical Form

Suspension for oral use.

Pink, viscous, homogenous suspension, packed in 60mL/100mL amber PET/glass bottles and contained in a unit a box along with literature insert.

4. Clinical particulars

4.1 Therapeutic indications

Totomol® suspension is indicated in conditions where analgesic and antipyretic effects are desired. It is used in the management of mild to moderate pain such as headache, myalgia (muscular pain) and dental pain.

The preparation is of value in the reduction of temperature in the treatment of minor febrile conditions, such as colds or influenza and in the symptomatic treatment of local redness, swelling, pain and fever which may occur after immunization in children.

4.2 Posology and method of administration

Totomol® suspension is administered by oral route.

Posology:

It is important to shake the bottle for at least 10 seconds before use.

For the relief of fever after vaccinations at 2, 3 and 4 months:

One 2.5mL spoonful (small end). This is may be given up to 4 times a day starting at the time of vaccination. Do not give more than 4 doses in any 24hour period. Leave at least 4 hours between doses. If your baby still needs this medicine two days after receiving the vaccine talk to your doctor or pharmacist.

Age: 2-3 months	Dose
Pain and other causes of fever - if your baby weighs over 4 kg and was born after 37 weeks	One 2.5 mL spoonful (small end). If necessary, after 4-6 hours, give a second 2.5 mL dose.
<ul style="list-style-type: none">Do not give to babies less than 2 months of ageLeave at least 4 hours between dosesDo not give more than 2 doses. This is to ensure that fever that may be due to a serious infection is quickly diagnosed. If your child is still feverish after two doses, talk to your doctor or pharmacist.	

Child's age	How much	How often (in 24 hours)
3-6 months	One 2.5mL spoonful (small end).	4 times.
6-24 months	One 5mL spoonful (large end).	4 times.
2-4 years	One 5.0mL spoonful (large end) and one 2.5mL spoonful (small end).	4 times.
4-8 years	Two 5mL spoonfuls (large end).	4 times.
8-10 years	Three 5mL spoonfuls (large end).	4 times.
10-12 years	Four 5ml spoonfuls (large end).	4 times.
<ul style="list-style-type: none">Do not give more than 4 doses in any 24hour periodLeave at least 4 hours between dosesDo not give this medicine to your child for more than 3 days without speaking to your doctor or pharmacist.		

4.3 Contraindications

Hypersensitivity to paracetamol or to any of the excipients listed in section 6.1.

Patients with severe hepatic dysfunction.

4.4 Special warnings and precautions for use

Care is advised in the administration of paracetamol to patients with severe renal or severe hepatic impairment. The hazards of overdose are greater in those with non-cirrhotic alcoholic liver disease. Chronic alcohol users should consult a doctor before use.

Caution is advised if paracetamol is administered concomitantly with flucloxacillin due to increased risk of high anion gap metabolic acidosis (HAGMA), particularly in patients with severe renal impairment, sepsis, malnutrition and other sources of

glutathione deficiency (e. g. chronic alcoholism), as well as those using maximum daily doses of paracetamol. Close monitoring, including measurement of urinary 5-oxoproline, is recommended.

Patients should be informed about the signs of serious skin reactions and use of the drug should be discontinued at the first appearance of skin rash or any other sign of hypersensitivity.

Do not give with any other paracetamol-containing products.

Do not give to babies less than 2 months of age.

For infants 2-3 months no more than 2 doses should be given.

Do not give more than 4 doses in any 24hour period.

Leave at least 4 hours between doses.

Do not give this medicine to your child for more than 3 days without speaking to your doctor or pharmacist.

As with all medicines, if your child is currently taking any medicine consult your doctor or pharmacist before taking this product.

Immediate medical advice should be sought in the event of an overdose, even if the child seems well, because of the risk of delayed serious liver damage.

4.5 Interaction with other medicinal products and other forms of interaction

The hepatotoxicity of Paracetamol, particularly after overdose, may be increased by drugs which induce liver microsomal enzymes such as carbamazepine, barbiturates (e. g. phenobarbital), fosphenytoin, phenytoin, primidone, tricyclic antidepressants, and alcohol.

Chronic alcohol intake can increase the hepatotoxicity of paracetamol overdose and may have contributed to the acute pancreatitis reported in one patient who had taken an overdose of paracetamol. Acute alcohol intake may diminish an individual's ability to metabolise large doses of paracetamol, the plasma half-life of which can be prolonged.

The speed of absorption of paracetamol may be increased by metoclopramide or domperidone and absorption reduced by colestyramine.

The anticoagulant effect of warfarin and other coumarins may be enhanced by prolonged regular use of paracetamol with increased risk of bleeding; occasional doses have no significant effect.

Antivirals: Regular use of Paracetamol possibly reduces metabolism of Zidovudine (increased risk of neutropenia).

The use of drugs that induce hepatic microsomal enzymes such as anticonvulsants and oral contraceptives may increase the extent of metabolism of paracetamol resulting in reduced plasma concentrations of the drug and a faster elimination rate.

Caution should be taken when paracetamol is used concomitantly with flucloxacillin as concurrent intake has been associated with high anion gap metabolic acidosis, especially in patients with risks factors.

4.6 Fertility, pregnancy and lactation

Fertility: There is no information relating to the effects of this medicine on fertility.

Pregnancy: A large amount of data on pregnant women indicate neither malformative, nor feto/neonatal toxicity. Epidemiological studies on neurodevelopment in children exposed to paracetamol in utero show inconclusive results. If clinically needed, paracetamol can be used during pregnancy however it should be used at the lowest effective dose for the shortest possible time and at the lowest possible frequency.

When given to the mother in therapeutic doses (1 g single dose), paracetamol crosses the placenta into foetal circulation as early as 30 minutes after ingestion and is metabolised in the foetus by conjugation with sulfate and increasingly with glutathione.

Breast-feeding: Paracetamol is excreted in breast milk but not in clinically significant quantities. Available published data do not contraindicate breast feeding.

4.7 Effects on ability to drive and use machines

None.

4.8 Undesirable effects

Adverse drug reactions (ADRs) identified during clinical trials and post marketing experience with paracetamol are listed below by System Organ Class (SOC)

The frequencies are defined according to the following convention:

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).

ADRs are presented by frequency category based on 1) incidence in adequately designed clinical trials or epidemiology studies, if available or 2) when incidence is unavailable, frequency category is listed as Not known.

System Organ Class (SOC)	Frequency	Adverse Drug Reaction (Preferred Term)
Blood and lymphatic system disorders	Not known	Blood disorder (including thrombocytopenia and agranulocytosis) ¹
Immune System Disorders	Very rare Very rare	Anaphylactic reaction. Hypersensitivity.
Hepatobiliary disorders	Not known	Liver injury ² .
Skin and Subcutaneous Tissue disorders	Very rare Not known Not known Not known	Rash. Fixed eruption. Rash pruritic. Urticaria.
Renal and urinary disorders	Uncommon Not known	Nephropathy toxic. Renal papillary necrosis ³ .
Investigations	Not known	Transaminases increased ⁴ .

¹Reported following paracetamol use, but not necessarily causally related to the drug.

²Chronic hepatic necrosis has been reported in a patient who took daily therapeutic doses of paracetamol for about a year.

³Reported after prolonged administration.

⁴Low level transaminase elevations may occur in some patients taking therapeutic doses of paracetamol; these elevations are not accompanied with liver failure and usually resolve with continued therapy or discontinuation of paracetamol.

Chronic hepatic necrosis has been reported in a patient who took daily therapeutic doses of paracetamol for about a year and liver damage has been reported after daily ingestion of excessive amounts for shorter periods. A review of a group of patients with chronic active hepatitis failed to reveal differences in the abnormalities of liver function in those who were long-term users of paracetamol nor was the control of the disease improved after paracetamol withdrawal.

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 recommended channels.

4.9 Overdose

Liver damage is possible in adults and adolescents (≥ 12 years of age) who have taken 7.5g or more of paracetamol. It is considered that excess quantities of a toxic metabolite (usually adequately detoxified by glutathione when normal doses of paracetamol are ingested) become irreversibly bound to liver tissue. Ingestion of 5g or more of paracetamol may lead to liver damage if the patient has risk factors (see below).

Risk factors:

If the patient

- Is on long term treatment with carbamazepine, phenobarbital, phenytoin, primidone, rifampicin, St John's Wort or other drugs that induce liver enzymes.
- Regularly consumes ethanol in excess of recommended amounts or
- Is likely to be glutathione depleted e. g. eating disorders, cystic fibrosis, HIV infection, starvation, cachexia.

Symptoms:

Symptoms of paracetamol overdose in the first 24 hours are pallor, nausea, hyperhidrosis, malaise, vomiting, anorexia and abdominal pain. Liver damage may become apparent 12 to 48 hours after ingestion. This may include hepatomegaly, liver tenderness, jaundice, acute hepatic failure and hepatic necrosis.

Abnormalities of glucose metabolism and metabolic acidosis may occur. Blood bilirubin, hepatic enzymes, INR, prothrombin time, blood phosphate and blood lactate may be increased.

In severe poisoning, hepatic failure may progress to encephalopathy, haemorrhage, hypoglycaemia, cerebral oedema, and death. Acute renal failure with acute tubular necrosis, strongly suggested by loin pain, haematuria and proteinuria may develop even in the absence of severe liver damage. Cardiac arrhythmias and pancreatitis have been reported.

Haemolytic anaemia (in patients with glucose-6-phosphate dehydrogenase [G6PD] deficiency): Haemolysis has been reported in patients with G6PD deficiency, with use of paracetamol in overdose.

Management:

Immediate treatment is essential in the management of paracetamol overdose. Despite a lack of significant early symptoms, patients should be referred to hospital urgently for immediate medical attention. Symptoms may be limited to nausea or vomiting and may not reflect the severity of overdose or the risk of organ damage. Management should be in accordance with established treatment guidelines.

Treatment with activated charcoal should be considered if the overdose has been taken within 1 hour. Plasma paracetamol concentration should be measured at 4 hours or later after ingestion (earlier concentrations are unreliable). Treatment with N-acetylcysteine may be used up to 24 hours after ingestion of paracetamol, however, the maximum protective effect is obtained up to 8 hours post-ingestion. The effectiveness of the antidote declines sharply after this time. If required, the patient should be given intravenous N-acetylcysteine in line with the established dosage schedule. If vomiting is not a problem, oral methionine may be a suitable alternative for remote areas, outside hospital. Management of patients who present with serious hepatic dysfunction beyond 24h from ingestion should be discussed with the NPIS or a liver unit.

5. Pharmacological properties

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: **Other Analgesics and Antipyretics (Anilides)**. ATC code: **N02 BE01**.

The mechanism of analgesic action has not been fully determined. Paracetamol may act predominantly by inhibiting prostaglandin synthesis in the central nervous system (CNS) and, to a lesser extent, through a peripheral action by blocking pain impulse generation. The peripheral action may also be due to inhibition of prostaglandin synthesis or to inhibition of the synthesis or actions of other substances that sensitise pain receptors to mechanical or chemical stimulation.

Paracetamol probably produces antipyresis by acting centrally on the hypothalamic heat regulating centre to produce peripheral vasodilation resulting in increased blood flow through the skin, sweating and heat loss. The central action probably involves inhibition of prostaglandin synthesis in the hypothalamus.

5.2 Pharmacokinetic properties

Oral absorption is rapid and almost complete, it may be decreased if Paracetamol is taken following a high carbohydrate meal.

There is no significant protein binding with doses producing plasma concentrations of below 60mcg (μg)/ml, but may reach moderate levels with high or toxic doses.

Approximately 90 - 95% of a dose is metabolised in the liver, primarily by conjugation with glucuronic acid, sulphuric acid and cysteine. An intermediate metabolite, which may accumulate in overdosage after primary metabolic pathways become saturated, is hepatotoxic and possibly nephrotoxic.

Half-life is 1 to 4 hours; does not change with renal failure but may be prolonged in acute overdosage, in some forms of hepatic disease, in the elderly, and in the neonate; may be somewhat shortened in children.

Time to peak concentration, 0.5 - 2 hours; peak plasma concentrations, 5 - 20mcg (μg)/ml (with doses up to 650mg); time to peak effect, 1- 3 hours; duration of action, 3- 4 hours.

Elimination is by the renal route, as metabolites, primarily conjugates, 3% of a dose may be excreted unchanged.

Peak concentration of 10 - 15mcg(μg)/ml have been measured in breast milk, 1 - 2 hours following maternal ingestion of a single 650mg dose. Half-life in breast milk is 1.35 - 3.5 hours.

5.3 Preclinical safety data

Conventional studies using the currently accepted standards for the evaluation of toxicity to reproduction and development are not available.

6. Pharmaceutical particulars

6.1 List of excipients

- Xanthan Gum 200 Mesh.
- Sodium Methyl Paraben.
- Sodium Propyl Paraben.
- Citric acid.
- Sodium saccharin.
- Sodium Benzoate.
- Glycerin.
- Polysorbate 80 (Tween 80).
- Sodium Carboxymethyl Cellulose (Blanose).
- Strawberry Essence Liquid.
- Erythrosine Soluble colour.
- Colloidal Silicon Dioxide (Aerosil 200).
- Purified water.

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

30 months from the date of manufacture.

6.4 Special precautions for storage

Store in a dry place below 30°C.

Protect from light.

Keep all medicines out of reach of children.

6.5 Nature and contents of container

Filled in 60mL or 100mL amber PET/glass bottles, packed in unit boxes along with literature insert.

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. Marketing Authorization Holder and Manufacturing Site Addresses.**Marketing Authorization Holder**

Company Name: LABORATORY & ALLIED LIMITED.

Address: Plot No. 209/10349, Opposite Sameer Business Park, Next to Libra House, Mombasa Road,
P.O. Box 42875 GPO 00100, Nairobi,

Country: Kenya.

Telephone: +254 20 8040306

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Manufacturing Site Address:

Company Name: LABORATORY & ALLIED LIMITED.

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P.O. Box 42875 GPO 00100, Nairobi,

Country: Kenya.

Telephone: +254 20 8040306.

Telefax: +254 20 8040309.

E-Mail: info@laballied.com

8. Marketing Authorization Number:

Kenya: H2006/116.

9. Date of first Registration/ Renewal of the Registration:

Date of first authorization: 6th March 2006.

Date of latest renewal: Retained Annually.

10. Date of revision of the text:

February 2024.

11. DOSIMETRY (IF APPLICABLE)

Not Applicable.

12. INSTRUCTIONS FOR PREPARATION OF RADIOPHARMACEUTICALS (IF APPLICABLE)

Not Applicable.