1 NAME OF THE MEDICINAL PRODUCT
GP-ACETAZOLAMIDE TABLET 250MG

2 QUALITATIVE AND QUANTITATIVE COMPOSITION
Each tablet contains
Acetazolamide Ph. Eur 250mg
Excipients QS
For excipients see 5.1.

3 PHARMACEUTICAL FORM
White color, round shaped tablet with break line on one side & plain on other side. The break line only serves to facilitate breaking for ease of swallowing and does not divide the tablet into equal half-doses.

4 CLINICAL PARTICULARS
4.1 Indications
To decrease ocular aqueous humor secretion in glaucoma (chronic, simple and secondary types). Also used as an adjunct in the treatment of selected cases of epilepsy. To alkalinise the urine in selected cases of salicylate overdosage.

4.2 Contraindications
Depressed sodium and/or potassium blood levels, in renal failure, adrenal gland failure, metabolic acidosis, and some cases of hepatic cirrhosis, severe glaucoma due to peripheral anterior synechias or in hemorrhagic glaucoma. Long term use in chronic noncongestive angle closure glaucoma is contraindicated.

Studies on acetazolamide in mice and rats have consistently demonstrated embryocidal and teratogenic effects at doses in excess of 10 times the human dose. There is no evidence of these effects in humans; however, acetazolamide should not be used in pregnancy, unless the anticipated benefits outweigh these potential hazards and are not attainable in other ways.

4.3 Precautions
Increasing the dose does not increase and may often decrease the diuresis and may yet produce drowsiness and/or paresthesia.

Choroidal effusion, acute myopia and secondary angle-closure glaucoma: Sulfonamide or sulfonamide derivative drugs can cause an idiosyncratic reaction resulting in choroidal effusion with visual field defect, transient myopia and acute angle-closure glaucoma. Symptoms may include acute onset of decreased visual acuity or ocular pain and typically occur within hours to weeks of drug initiation. Untreated acute angle-closure glaucoma can lead to permanent vision loss. The primary treatment is to discontinue drug intake as rapidly as possible. Prompt medical or surgical treatments may need to be considered if the intraocular pressure remains uncontrolled. Risk factors for developing acute angle-closure glaucoma may include a history of sulfonamide or penicillin allergy.

4.4 Adverse Effects
Metabolic acidosis and hypokalemia may occur during prolonged acetazolamide therapy.

Adverse reactions common to all sulfonamide derivatives including fever, rash crystalluria, renal calculus, bone marrow depression, thrombocytopenic purpura, hemolytic anemia, leukopenia, pancytopenia, and agranulocytosis may occur. If such reactions occur, discontinue therapy and institute appropriate measures.

Untoward effects during short term therapy are said to be minimal. Those noted include paresthesias, some loss of appetite, polyuria and occasional instances of drowsiness and confusion. Other occasional adverse reactions include urticaria, melena, hematuria, glycosuria, hepatic insufficiency, flaccid paralysis and convulsions. Transient myopia has been reported. This condition invariably subsided upon the diminution or discontinuation of the medication.

Eye disorders: Choroidal effusion (frequency not known), Acute angle-closure glaucoma (frequency not known), Myopia (frequency not known)

4.5 Pregnancy and Reproduction
Problems in humans have not been documented. However, teratogenic (skeletal anomalies) and embryocidal effects have been demonstrated in rodents with high doses (for acetazolamide, more than 10 times the human dose). It has been recommended that carbonic anhydrase inhibitors not be used by women of childbearing potential or during pregnancy, especially during the first trimester unless the benefits are expected to outweigh the potential adverse effects to the fetus.

4.6 Drug interactions
Concurrent use of Adrenocorticoids or Amphotericin B or Corticotropin (especially under prolonged use) with carbonic anhydrase inhibitors may result in severe hypokalemia and should be undertaken with caution. Serum potassium concentrations and cardiac function should be monitored during concurrent use. The possibility should be considered that concurrent chronic use may increase the risk of hypocalcemia and osteoporosis because these medications increase calcium excretion.

The use of Amphetamines or Antimuscarinics (especially atropine and related compounds) or Mecamylamine or Quinidine concurrent with acetazolamide may enhance or prolong the therapeutic and/or side effects. Dosage adjustments of these medications may be necessary upon initiation of or the termination of or during the maintenance of Acetazolamide therapy.

Hypoglycemic response may be decreased during concurrent use because carbonic anhydrase inhibitors may cause hyperglycemia and glycosuria in diabetic patients. Dosage adjustments may be required.

Osteopenia induced by barbiturates (especially phenobarbital) or carbamazepine or phenytoin or other hydantoin anticonvulsants or Primidone may be enchanced. It is recommended that patients receiving concurrent therapy be monitored for early signs of osteopenia and that the carbonic anhydrase inhibitor be discontinued and appropriate treatment initiated if necessary.

Urinary alkalizers, such as carbonic anhydrase inhibitors may reduce the solubility of ciprofloxacin in the urine. Patients should be monitored for signs of crystalluria and nephrotoxicity.

Concurrent use of Digitalis glycosides with carbonic anhydrase inhibitors may enhance the possibility of digitalis toxicity associated with hypokalemia.

Diuretic effects may be enhanced when acetazolamide is used concurrent with diuretics, hypokaelmic and hyperuricemic effects of many diuretics may also be enhanced during concurrent therapy.

Urine alkalinization induced by carbonic anhydrase inhibitors may increase the half-life of ephedrine and prolong its duration of action, especially if the urine remains alkaline for several days or longer. Dosage adjustment of ephedrine may be necessary.

Carbonic anhydrase inhibitors may increase lithium excretion. Single doses of intravenous acetazolamide may be useful in the management of lithium toxicity.

Concurrent use of Mannitol or urea with carbonic anhydrase inhibitors may lead to increased reduction in intraocular pressure as well as increased diuresis.

Marked alkalinization of urine by carbonic anhydrase inhibitors may retard renal excretion of mexiletine.

Hypokalemia induced by carbonic anhydrase inhibitors may enhance the blockade of nondepolarizing neuromuscular blocking agents possibly leading to increased or prolonged

respiratory depression or paralysis (apnea). Serum potassium concentration determinations may be necessary prior to administration of nondepolarizing neuromuscular blocking agent.

The risk of Salicylate intoxication in patients receiving large doses of salicylates may be increased during concurrent therapy because metabolic acidosis induced by carbonic anhydrase inhibitors may increase penetration of salicylate into the brain. On the other hand, alkalinization of the urine results in increased salicylate excretion and decreased salicylate plasma concentrations. The increased risk of severe metabolic acidosis and salicylate toxicity must be considered if acetazolamide is used to produce forced alkaline diuresis in the treatment of salicylate overdose.

Incompatibilities: Concurrent use with mecamylamine is not recommended. Concurrent use of methenamine may be reduced because alkaline urine provided by carbonic anhydrase inhibitors inhibits methenamine conversion to formaldehyde. Concurrent use is not recommended.

4.7 Dosage
Chronic simple (open angle) glaucoma: 250mg 1 to 4 times daily. A complementary effect has been noted when acetazolamide was used with miotics or mydriatics as the case demanded.

Secondary glaucoma and preoperative treatment of some cases of acute congestive (closed angle) glaucoma: 250mg every 4 hours.

Epilepsy 8 to 30 mg/kg (375 to 1000 mg) daily in divided doses. To alkalinize the urine 250mg every 4 to 6 hours.

5 PHARMACEUTICAL PARTICULARS

5.1 List of excipients
Sodium starch glycolate,
Maize Starch,
Lactose monohydrate,
Povidone K30,
Purified water,
Anhydrous calcium hydrogen phosphate,
Magnesium Stearate

5.2 Shelf life
24 months

5.3 Special precautions for storage
Store below 30°C, in the original pack in order to protect from light.

5.4 Nature and contents of container
Blister Pack: 100 tablets packed in a blister made of Aluminium lidding foil/PVC-PE-PVDC triplex white opaque film.

6 PRODUCT REGISTRANT
Goldplus Universal Pte Ltd
103 Kallang Avenue, #06-02
Singapore 339504

7 PRODUCT REGISTRATION NUMBER(S)
SINXXXXXX

8 DATE OF REVISION OF THE TEXT
08/2023