

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Ibuprofen Tablets BP 600 mg

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 600 mg Ibuprofen

Excipient with known effect: Ibuprofen Tablets BP 600 mg contains 0.28 mg of Sunset yellow FCF Aluminium lake (E110)

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Pink, film-coated rounded oblong, biconvex tablets engraved with I600 on one face, and plain on the other face.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Ibuprofen is indicated in the treatment of rheumatoid arthritis (including juvenile rheumatoid arthritis), ankylosing spondylitis, osteoarthritis, other non-rheumatoid (seronegative) arthropathies.

In the treatment of non-articular rheumatic conditions, Ibuprofen is indicated in periarticular conditions such as frozen shoulder (capsulitis), bursitis, tendonitis, tenosynovitis and low back pain, Ibuprofen can also be used in soft-tissue injuries such as sprains and strains.

Ibuprofen is also indicated for its analgesic effect in the relief of mild to moderate pain such as dysmenorrhoea, dental and post-operative pain and for the symptomatic relief of headache including migraine headache.

4.2 Posology and method of administration

Route of administration: Oral. To be taken preferably with or after food, with plenty of fluid.

The lowest effective dose should be used for the shortest duration necessary to relieve symptoms (see section 4.4).

Adults

Initial dose: 1200 - 1800 mg daily in divided doses. Some patients can be maintained on 600 -1200 mg daily. In severe or acute conditions, it can be advantageous to increase the dosage until the acute phase is brought under control.

The dose may be increased to a maximum of 2.4 g daily in divided doses.

In Juvenile Rheumatoid Arthritis, up to 40mg/kg of body weight daily in divided doses may be taken.

Maintenance Dose: 600 - 1200 mg daily in divided doses.

Elderly

The elderly are at increased risk of the serious consequences of adverse reactions. If an NSAID is considered necessary, the lowest effective dose should be used and for the shortest possible duration. The patient should be monitored regularly for GI bleeding during NSAID therapy. If renal or hepatic function is impaired, dosage should be assessed individually.

Not suitable for children under the age of 12 years.

Undesirable effects may be minimised by using the lowest effective dose for the shortest duration necessary to control symptoms (see section 4.4).

4.3 Contraindications

Hypersensitivity to ibuprofen or to any of the excipients.

Ibuprofen should not be given to patients with conditions involving an increased tendency to bleeding.

Ibuprofen is also contraindicated in patients with a history of gastrointestinal bleeding or perforation, related to previous NSAID therapy. Ibuprofen should not be used in patients with active, or history of, recurrent peptic ulcer or gastrointestinal haemorrhage (two or more distinct episodes of proven ulceration or bleeding).

Ibuprofen should not be used in patients who have previously shown hypersensitivity reactions (e.g. asthma, rhinitis, angioedema or urticarial) in response to ibuprofen, aspirin or other non-steroidal anti-inflammatory drugs.

Ibuprofen should not be given to patients with conditions involving an increased tendency to bleeding.

Ibuprofen is contraindicated in patients with severe heart failure (NYHA Class IV), hepatic failure and renal failure (see section 4.4).

Ibuprofen is contraindicated during the last trimester of pregnancy (see section 4.6).

4.4 Special warnings and precautions for use

Undesirable effects may be minimised by using the lowest effective dose for the shortest duration necessary to control symptoms (see section 4.2 and GI and

cardiovascular risks below).

This medicine contains sunset yellow (E110) which may cause allergic reactions.

As with other NSAIDs, ibuprofen may mask the signs of infection.

The use of ibuprofen with concomitant NSAIDs, including cyclooxygenase-2 selective inhibitors, should be avoided due to the increased risk of ulceration or bleeding (see section 4.5).

The diagnosis of medication overuse headache (MOH) should be suspected in patients who have frequent or daily headaches despite (or because of) the regular use of analgesic medication. Patients with medication overuse headache should not be treated by increasing the dose of the analgesic. In such cases the use of analgesics should be discontinued.

The concomitant consumption of excessive alcohol with NSAIDs, including ibuprofen may increase the risk of adverse effects on the gastrointestinal tract, such as GI haemorrhage or the central nervous system, possibly due to an additive effect.

Caution should be exercised in patients suffering from bleeding disorders, cardiovascular disorders, and those receiving coumarin anticoagulants.

Elderly

The elderly have an increased frequency of adverse reactions to NSAIDs especially gastrointestinal bleeding and perforation which may be fatal (see section 4.2).

Paediatric population

There is a risk of renal impairment in dehydrated children and adolescents.

Respiratory disorders hypersensitivity reactions

Caution is required if administered to patients suffering from, or with a previous history of bronchial asthma, chronic rhinitis or allergic disease since NSAIDs have been reported to precipitate bronchospasm, urticaria or angioedema in such patients.

Cardiac, renal and hepatic impairment

The administration of an NSAID may cause a dose dependent reduction in prostaglandin formation and precipitate renal failure. The habitual concomitant intake of various similar painkillers further increases this risk. Patients at greatest risk of this reaction are those with impaired renal function, cardiac impairment, liver dysfunction, those taking diuretics and the elderly. For these patients, use the lowest effective dose, for the shortest possible duration and monitor renal function especially in long-term treated patients (see also section 4.3).

Ibuprofen should be given with care to patients with a history of heart failure or hypertension since oedema has been reported in association with ibuprofen administration.

Cardiovascular and cerebrovascular effects

Appropriate monitoring and advice are required for patients with a history of hypertension and/or mild to moderate congestive heart failure as fluid retention and oedema have been reported in association with NSAID therapy.

Clinical trial data suggest that use of ibuprofen, particularly at high doses (2400 mg/day) may be associated with a small increased risk of arterial thrombotic events (for example myocardial infarction or stroke). Overall, epidemiological studies do not suggest that low dose ibuprofen (e.g. ≤ 1200 mg/day) is associated with an increased risk of arterial thrombotic events.

Patients with uncontrolled hypertension, congestive heart failure (NHYA II-III), established ischaemic heart disease, peripheral arterial disease, and/or cerebrovascular disease should only be treated with ibuprofen after careful consideration and high doses (2400 mg/day) should be avoided. Careful consideration should also be exercised before initiating long-term treatment of patients with risk factors for cardiovascular events (e.g. hypertension, hyperlipidaemia, diabetes mellitus, smoking), particularly if high doses of Ibuprofen (2400 mg/day) are required.

Renal effects

Caution should be used when initiating treatment with ibuprofen in patients with considerable dehydration. There is a risk of renal impairment especially in dehydrated children, adolescents and the elderly.

As with other NSAIDs, long-term administration of ibuprofen has resulted in renal papillary necrosis and other renal pathologic changes. Renal toxicity has also been seen in patients whom renal prostaglandins have a compensatory role in the maintenance of renal perfusion. In these patients, administration of an NSAID may cause a dose-dependant reduction in prostaglandin formation and, secondarily, in renal blood flow, which may precipitate overt renal decomposition. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, those taking diuretics and ACE inhibitors and the elderly. Discontinuation of NSAID therapy is usually followed by recovery to the pre-treatment state.

Renal tubular acidosis and hypokalaemia may occur following acute overdose and in patients taking ibuprofen products over long periods at high doses (typically greater than 4 weeks), including doses exceeding the recommended daily dose.

Gastrointestinal bleeding, ulceration and perforation

GI bleeding, ulceration or perforation, which can be fatal, has been reported with all NSAIDs at any time during treatment, with or without warning symptoms or a previous history of serious GI events.

The risk of GI bleeding, ulceration or perforation is higher with increasing NSAID doses, in patients with a history of ulcer, particularly if complicated with hemorrhage or perforation (see section 4.3), and in the elderly. These patients should commence treatment on the lowest dose available. Combination therapy with protective agents (e.g. misoprostol or proton pump inhibitors) should be considered for these patients, and also for patients requiring concomitant low dose aspirin, or other drugs likely to increase gastrointestinal risk (see below and section 4.5).

Patients with a history of GI toxicity, particularly when elderly, should report any unusual abdominal symptoms (especially GI bleeding) particularly in the initial stages of treatment.

Caution should be advised in patients receiving concomitant medications which could

increase the risk of ulceration or bleeding, such as oral corticosteroids or anticoagulants such as warfarin, selective serotonin-reuptake inhibitors or antiplatelet agents such as aspirin (see section 4.5).

When GI bleeding or ulceration occurs in patients receiving ibuprofen, the treatment should be withdrawn.

NSAIDs should be given with care to patients with a history of gastrointestinal disease (ulcerative colitis, Crohn's disease) as these conditions may be exacerbated (see section 4.8).

SLE and mixed connective tissue disease

In patients with systemic lupus erythematosus (SLE) and mixed connective tissue disorders there may be an increased risk of aseptic meningitis (see below and section 4.8).

Aseptic meningitis

Aseptic meningitis has been observed on rare occasions in patients on ibuprofen therapy. Although it is probably more likely to occur in patients with systemic lupus erythematosus and related connective tissue diseases, it has been reported in patients who do not have an underlying chronic disease.

Severe skin reactions

Serious skin reactions, some of them fatal, including exfoliative dermatitis, Stevens-Johnson syndrome, and toxic epidermal necrolysis, have been reported very rarely in association with the use of NSAIDs (see section 4.8). Patients appear to be at highest risk of these reactions early in the course of therapy: the onset of the reaction occurring in the majority of cases within the first month of treatment. Acute generalised exanthematous pustulosis (AGEP) has been reported in relation to ibuprofen-containing products. Ibuprofen should be discontinued at the first appearance of signs and symptoms of severe skin reactions, such as skin rash, mucosal lesions, or any other sign of hypersensitivity.

In exceptional cases, varicella can be at the origin of serious cutaneous and soft tissues infectious complications. To date, the contributing role of NSAIDs in the worsening of these infections cannot be ruled out. Thus, it is advisable to avoid use of Ibuprofen in case of varicella.

Haematological effects

Ibuprofen, like other NSAIDs, can interfere with platelet aggregation and has been shown to prolong bleeding time in normal subjects.

Masking of symptoms of underlying infections

Ibuprofen Tablets BP 600 mg can mask symptoms of infection, which may lead to delayed initiation of appropriate treatment and thereby worsening the outcome of the infection. This has been observed in bacterial community acquired pneumonia and bacterial complications to varicella. When Ibuprofen Tablets BP 600 mg is administered for fever or pain relief in relation to infection, monitoring of infection is advised. In non-hospital settings, the patient should consult a doctor if symptoms persist or worsen.

Impaired female fertility

The use of Ibuprofen may impair female fertility and is not recommended in women attempting to conceive. In women who have difficulties conceiving or who are undergoing investigation of infertility, withdrawal of Ibuprofen should be considered.

4.5 Interaction with other medicinal products and other forms of interaction

Care should be taken in patients treated with any of the following drugs as interactions have been reported in some patients.

Anti-hypertensives, beta-blockers and diuretics: NSAIDs may reduce the effect of anti-hypertensives, such as ACE inhibitors, angiotensin-II receptors antagonists, beta-blockers and diuretics.

Other analgesics including cyclooxygenase-2 selective inhibitors: Avoid concomitant use of two or more NSAIDs, including Cox-2 inhibitors, as this may result in an increased risk of adverse effects (see section 4.4).

Aspirin (Acetylsalicylic acid): As with other products containing NSAIDs, concomitant administration of ibuprofen and aspirin is not generally recommended because of the potential of increased adverse effects.

Concurrent use of bone marrow depressants or radiation therapy with ibuprofen may increase the risk of serious haemolytic adverse effects. Concurrent use with gold compounds may increase the risk of adverse renal effects.

Ciclosporin: Increased risk of nephrotoxicity.

Tacrolimus: Possible increased risk of nephrotoxicity when NSAIDs are given with tacrolimus.

Lithium: Decreased elimination of lithium.

Cholestyramine: The concomitant administration of ibuprofen and cholestyramine may reduce the absorption of ibuprofen in the gastrointestinal tract. However, the clinical significance is unknown.

Anticoagulants: NSAIDs may enhance the effects of anticoagulants, such as warfarin (see section 4.4 Special warnings and precautions).

Diuretics: reduced diuretic effect. Diuretics can increase the risk of nephrotoxicity of NSAIDs.

Cardiac glycosides: NSAIDs may exacerbate cardiac failure, reduce GFR and increase plasma cardiac glycoside levels.

Methotrexate: NSAIDs may inhibit the tubular secretion of methotrexate and reduce clearance of methotrexate.

Mifepristone: A decrease in the efficacy of the medicinal product can theoretically occur due to the anti-prostaglandin properties of NSAIDs. Limited evidence suggests

that co-administration of NSAIDs on the day of prostaglandin administration does not adversely influence the effects of mifepristone or the prostaglandin on cervical ripening or uterine contractility and does not reduce the clinical efficacy of medicinal termination of pregnancy.

Corticosteroids: Increased risk of gastrointestinal bleeding or ulceration with NSAIDs (see section 4.4).

Quinolone antibiotics: Animal data indicate that NSAIDs can increase the risk of convulsions associated with quinolone antibiotics. Patients taking NSAIDs and quinolones may have an increased risk of developing convulsions.

Sulfonylureas: NSAIDs may potentiate the effects of sulfonylurea medications. There have been rare reports of hypoglycaemia in patients on sulfonylurea medications receiving ibuprofen.

Anti-platelet agents and selective serotonin reuptake inhibitors (SSRIs): Increased risk of gastrointestinal bleeding (see section 4.4).

Experimental data suggest that ibuprofen may competitively inhibit the effect of low dose aspirin on platelet aggregation when they are dosed concomitantly. However, the limitations of these data and the uncertainties regarding extrapolation of ex vivo data to the clinical situation imply that no firm conclusions can be made for regular ibuprofen use and no clinically relevant effect is considered to be likely for occasional ibuprofen use (see section 5.1).

Zidovudine: Increased risk of haematological toxicity when NSAIDs are given with zidovudine. There is evidence of an increased risk of haemarthroses and haematoma in HIV (+) haemophiliacs receiving concurrent treatment with zidovudine and ibuprofen.

Aminoglycosides: NSAIDs may decrease the excretion of aminoglycosides.

Herbal extracts: Ginkgo biloba may potentiate the risk of bleeding with NSAIDs.

CYP2C9 Inhibitors: Concomitant administration of ibuprofen with CYP2C9 inhibitors may increase the exposure to ibuprofen (CYP2C9 substrate). In a study with voriconazole and fluconazole (CYP2C9 inhibitors), an increased S (+)-ibuprofen exposure by approximately 80 to 100% has been shown. Reduction of the ibuprofen dose should be considered when potent CYP2C9 inhibitors are administered concomitantly, particularly when high dose ibuprofen is administered with either voriconazole or fluconazole.

4.6 Fertility, pregnancy and lactation

Pregnancy

Inhibition of prostaglandin synthesis may adversely affect the pregnancy and/or the embryo/foetal development. Data from epidemiological studies suggest an increased risk of miscarriage and of cardiac malformation and gastroschisis after use of a prostaglandin synthesis inhibitor in early pregnancy. The risk is believed to increase with dose and duration of therapy. In animals, administration of a prostaglandin synthesis inhibitor has been shown to result in increased pre- and post-implantation loss and embryo/foetal lethality. In addition, increased incidences of various malformations,

including cardiovascular, have been reported in animals given a prostaglandin synthesis inhibitor during the organogenetic period.

During the first and second trimester of pregnancy, ibuprofen should not be given unless clearly necessary. If Ibuprofen is used by a woman attempting to conceive, or during the first and second trimester of pregnancy, the dose should be kept as low and duration of treatment as short as possible.

During the third trimester of pregnancy, all prostaglandin synthesis inhibitors may expose the foetus to the following:

- Cardiopulmonary toxicity (with premature closure of the ductus arteriosus and pulmonary hypertension);
- Renal dysfunction, which may progress to renal failure with oligohydroamniosis;

At the end of pregnancy, prostaglandin synthesis inhibitors may expose the mother and the neonate to the following.

- Possible prolongation of bleeding time
- Inhibition of uterine contractions resulting in delayed or prolonged labour.

Consequently, Ibuprofen is contraindicated during the third trimester of pregnancy.

Breast-feeding

In limited studies so far available, NSAIDs can appear in breast milk in very low concentrations. NSAIDs should, if possible be avoided when breast-feeding.

See section 4.4 Special warnings and precautions for use, regarding female fertility.

4.7 Effects on ability to drive and use machines

Undesirable effects such as dizziness, drowsiness, fatigue and visual disturbances are possible after taking NSAIDs. If affected, patients should not drive or operate machinery.

4.8 Undesirable effects

Gastrointestinal disorders: The most commonly observed adverse events are gastrointestinal in nature. Peptic ulcers, perforation or GI bleeding, sometimes fatal, particularly in the elderly, may occur (see section 4.4). Nausea, vomiting, diarrhoea, flatulence, constipation, dyspepsia, abdominal pain, melaena, haematemesis, ulcerative stomatitis, gastrointestinal haemorrhage and exacerbation of colitis and Crohn's disease (see section 4.4) have been reported following administration. Gastrointestinal perforation has been rarely reported with ibuprofen use. Less frequently, gastritis, duodenal ulcer and gastric ulcer has been observed. Pancreatitis has been reported very rarely.

Immune system disorders: Hypersensitivity reactions have been reported following treatment with NSAIDs. These may consist of (a) nonspecific allergic reaction and anaphylaxis, (b) respiratory tract reactivity comprising asthma, aggravated asthma, bronchospasm or dyspnoea, or (c) assorted skin disorders, including rashes of various types, pruritus, urticaria, purpura, angioedema and more rarely, exfoliative and

bullous dermatoses (including Stevens-Johnson syndrome and toxic epidermal necrolysis and erythema multiforme).

Cardiac disorders and vascular disorders: Oedema, hypertension and cardiac failure have been reported in association with NSAID treatment.

Clinical studies suggest that use of ibuprofen, particularly at high dose (2400 mg/day) may be associated with a small increased risk of arterial thrombotic (for example myocardial infarction or stroke) (see section 4.4).

Infections and infestations: Rhinitis and aseptic meningitis (especially in patients with existing auto-immune disorders, such as systemic lupus erythematosus and mixed connective tissue disease) with symptoms of stiff neck, headache, nausea, vomiting, fever or disorientation (see section 4.4).

Exacerbation of infection-related inflammations coinciding with the use of NSAIDs has been described. If signs of an infection occur or get worse during use of Ibuprofen the patient is therefore recommended to go to a doctor without delay.

Skin and subcutaneous tissue disorders: In exceptional cases, severe skin infections and soft-tissue complications may occur during a varicella infection (see also "Infections and infestations").

The following adverse reactions possibly related to ibuprofen and displayed by MedDRA frequency convention and system organ classification. Frequency groupings are classified according to the subsequent conventions: 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 ($< 1/10,000$) and Not known (cannot be estimated from the available data).

System Organ Class	Frequency	Adverse Event
Infection and infestations	Uncommon	Rhinitis
	Rare	Meningitis aseptic (see section 4.4)
Blood and Lymphatic system disorders	Rare	Leucopenia, thrombocytopenia, neutropenia, agranulocytosis, aplastic anaemia, haemolytic anaemia
Immune system disorders	Uncommon	Hypersensitivity
	Rare	Anaphylactic reaction
Psychiatric disorders	Uncommon	Insomnia, anxiety
	Rare	Depression, confusional state
Nervous system disorders	Common	Headache, dizziness
	Uncommon	Paraesthesia, somnolence
	Rare	Optic neuritis
Eye disorders	Uncommon	Visual impairment
	Rare	Toxic optic neuropathy
Ear and labyrinth disorders	Uncommon	Hearing impaired, tinnitus, vertigo
Respiratory, thoracic and mediastinal disorders	Uncommon	Asthma, bronchospasm, dyspnoea

Gastrointestinal disorders	Common	Dyspepsia, diarrhoea, nausea, vomiting, abdominal pain, flatulence, constipation, melaena, haematemesis, gastrointestinal haemorrhage
	Uncommon	Gastritis, duodenal ulcer, gastric ulcer, mouth ulceration, gastrointestinal perforation
	Very rare	pancreatitis
	Not known	Exacerbation of colitis and Crohn's disease
Hepatobiliary disorders	Uncommon	Hepatitis, jaundice, hepatic function abnormal
	Very rare	Hepatic failure
Skin and subcutaneous tissue disorders	Common	Rash
	Uncommon	Urticaria, pruritus, purpura, angioedema,
	Very rare	Severe forms of skin reactions (e.g. Erythema multiforme, bullous reactions including Stevens-Johnson syndrome, and toxic epidermal necrolysis)
	Unknown	Drug reaction with eosinophilia and systemic symptoms (DRESS syndrome) Acute generalised exanthematous pustulosis (AGEP) Photosensitivity reactions.
Renal and urinary disorders	Uncommon	Nephrotoxicity in various forms e.g. Tubulointerstitial nephritis, nephrotic syndrome and renal failure
	Very rare	Acute renal failure
	Not Known	Ureteric Colic, Dysuria Renal tubular acidosis*
Metabolism and Nutrition Disorders	Not known	Decreased Appetite Hypokalaemia* (The reference numbers for the description of the selected Adverse reaction should be updated throughout the table)
General disorders and administration site conditions	Common	Fatigue
	Rare	Oedema
Cardiac disorders	Very rare	Cardiac failure, myocardial infarction (also see section 4.4)
Vascular disorders	Very rare	Hypertension

Description of Selected Adverse Reactions

*Renal tubular acidosis and hypokalaemia have been reported in the post-marketing setting typically following prolonged use of the ibuprofen component at higher than recommended doses.

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 yellow card scheme at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google play or Apple App Store.

Overdose

Toxicity

Signs and symptoms of toxicity have generally not been observed at doses below 100 mg/kg in children or adults. However, supportive care may be needed in some cases. Children have been observed to manifest signs and symptoms of toxicity after ingestion of 400 mg/kg or greater.

a) Symptoms

Most patients who have ingested significant amounts of ibuprofen will manifest symptoms within 4 to 6 hours.

The most frequently reported symptoms of overdose include nausea, vomiting, abdominal pain, lethargy and drowsiness. Central nervous system (CNS) effects include headache, tinnitus, dizziness, convulsion, and loss of consciousness. Nystagmus, metabolic acidosis, hypothermia, renal effects, gastrointestinal bleeding, coma, apnoea, diarrhoea and depression of the CNS and respiratory system have also been rarely reported. Disorientation, excitation, fainting and cardiovascular toxicity, including hypotension, bradycardia and tachycardia have been reported. In cases of significant overdose, renal failure and liver damage are possible. Large overdoses are generally well tolerated when no other drugs are being taken.

In serious poisoning metabolic acidosis may occur and the prothrombin time/INR may be prolonged, probably due to interference with the actions of circulating clotting factors. Acute renal failure and liver damage may occur.

Prolonged use at higher than recommended doses may result in severe hypokalaemia and renal tubular acidosis. Symptoms may include reduced level of consciousness and generalised weakness (see section 4.4 and section 4.8).

b) Therapeutic measures

Patients should be treated symptomatically as required.

Within one hour of ingestion of a potentially toxic amount, activated charcoal should be considered. Alternatively, in adults, gastric lavage should be considered within one hour of ingestion of a potentially life-threatening overdose.

Good urine output should be ensured.

Renal and liver function should be closely monitored.

Patients should be observed for at least four hours after ingestion of potentially toxic amounts.

Frequent or prolonged convulsions should be treated with intravenous diazepam. Other measures may be indicated by the patient's clinical condition.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic classification: Anti-inflammatory and anti-rheumatic products, non-steroidal, propionic acid derivatives.

ATC code: M01AE01

Ibuprofen is a propionic acid derivative with analgesic, anti-inflammatory and antipyretic activity. The drug's therapeutic effects as an NSAID is thought to result from its inhibitory effect on the enzyme cyclo-oxygenase, which results in a marked reduction in prostaglandin synthesis.

Experimental data suggest that ibuprofen may competitively inhibit the effect of low dose aspirin on platelet aggregation when they are dosed concomitantly. Some pharmacodynamics studies show that when single doses of ibuprofen 400mg were taken within 8 hours before or within 30 min after immediate release aspirin dosing (81 mg), a decreased effect of aspirin on the formation of thromboxane or platelet aggregation occurred. Although there are uncertainties regarding extrapolation of these data to the clinical situation, the possibility that regular, long-term use of ibuprofen may reduce the cardioprotective effect of low-dose acetylsalicylic acid cannot be excluded. No clinically relevant effect is considered to be likely for occasional ibuprofen use (See section 4.5).

5.2 Pharmacokinetic properties

Ibuprofen is rapidly absorbed from the gastrointestinal tract, peak serum concentrations occurring 12 hours after administration. The elimination half-life is approximately 2 hours.

Ibuprofen is metabolised in the liver to two inactive metabolites and these, together with unchanged ibuprofen, are excreted by the kidney either as such or as conjugates. Excretion by the kidney is both rapid and complete.

Ibuprofen is extensively bound to plasma proteins.

5.3 Preclinical safety data

None stated

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Colloidal silicon dioxide
Maize starch
Pregelatinised maize starch
Magnesium stearate

Sodium starch glycollate
Stearic acid
Hypromellose 5 cps
Hydroxypropylcellulose 100 cps
Macrogol 400
Titanium dioxide (E171)
Erythrosine Aluminium Lake (E127)
Sunset Yellow FCF Aluminium Lake (E110)

6.2 Incompatibilities

None known.

6.3 Shelf life

36 months

6.4 Special precautions for storage

Keep out of reach of children
Store at 25°C.
Protect from light and moisture.

6.5 Nature and contents of container

Opaque plastic containers (securitainers) made up of polypropylene tubes and snap-on polyethylene caps or Blister pack (White opaque PVC/Alu foil blisters)

6.6 Special precautions for disposal

None stated

7 MARKETING AUTHORISATION HOLDER

Relonchem Limited
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8 MARKETING AUTHORISATION NUMBER(S)

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**9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE
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10 DATE OF REVISION OF THE TEXT

05/05/2023