

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

ATENGOOD 100

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains Atenolol 100mg.

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Tablet

Circular, white, flat tablet scored on one side

4.1 Therapeutic Indications

1. The management of hypertension
2. The management of angina pectoris
3. The management of cardiac arrhythmias
4. Myocardial infarction: Early intervention in the acute phase and long-term prophylaxis after recovery from myocardial infarction.

4.2 Posology and method of administration

Posology

The dose must always be adjusted to individual requirements of the patients, with the lowest possible starting dosage. The following are guidelines:

Adults

ts

Hypertension:

One tablet daily. Most patients respond to 100 mg daily given orally as a single dose. Some patients, however, will respond to 50 mg given as a single daily dose. The effect will be fully established after one to two weeks. A further reduction in blood

pressure may be achieved by combining Atenolol with other antihypertensive agents. For example, co-administration of Atenolol with a diuretic, as in tenoretic, provides a highly effective and convenient antihypertensive therapy.

Angina:

Most patients with angina pectoris will respond to 100 mg given orally once daily or 50 mg given twice daily. It is unlikely that additional benefit will be gained by increasing the dose.

Cardiac arrhythmias

A suitable initial dose of atenolol tablets is 2.5 mg (5 ml) injected intravenously over a 2.5 minute period (i.e. 1 mg/minute). (See also prescribing information for atenolol Injection.) This may be repeated at 5 minutes intervals, until a response is observed up to a maximum dosage of 10 mg. If atenolol is given by infusion, 0.15 mg/kg bodyweight may be administered over a 20 minute period. If required, the injection or infusion may be repeated every 12 hours. Having controlled the arrhythmias with intravenous atenolol a suitable maintenance dosage is 50mg - 100mg daily, given as a single dose.

Myocardial infarction:

For patients suitable for treatment with intravenous beta-blockade and presenting within 12 hours of the onset of chest pain, atenolol 5–10 mg should be given by slow intravenous injection (1 mg/minute) followed by atenolol 50 mg orally about 15 minutes later, provided that no untoward effects have occurred from the intravenous dose. This should be followed by a further 50 mg orally 12 hours after the intravenous dose and then 12 hours later by 100 mg to be given once daily for up to ten days. If bradycardia and/or hypotension requiring treatment, or any other untoward effects occur, Atenolol should be discontinued.

Renal failure:

Atenolol is excreted via the kidneys, the dosage adjustment should be considered in patients with severe impairment of renal function.

No significant accumulation of atenolol occurs in patients who have a creatinine clearance greater than 35 ml/min/1.73 m² (normal range is 100–150 ml/min/1.73 m²).

For patients with a creatinine clearance of 15–35 ml/min/1.73 m² (equivalent to serum creatinine of 300– 600 micromol/litre), the oral dose should be 50mg daily and the intravenous dose should be 10 mg once every two days.

For patients with a creatinine clearance of less than 15 ml/min/1.73 m² (equivalent to serum creatinine of greater than 600 micromol/litre), the oral dose should be 25 mg daily or 50 mg on alternate days and the intravenous dose should be 10 mg once every four days.

Patients on haemodialysis should be given 50 mg atenolol orally after each dialysis. Because of the possibility of marked falls in blood pressure, this should be carried out under hospital supervision.

Elderly

Dosage requirements may be reduced, especially in patients with impaired renal function.

Paediatric population

There is no paediatric experience with atenolol and for this reason it is not recommended for use in children.

Method of administration For oral administration.

4.3 Contraindications

Atenolol tablets, as with other beta-blockers, should not be used in patients with any of the following:

- Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.
- second-degree or third-degree heart block.
- bradycardia (<45 bpm).
- Uncontrolled heart failure.
- cardiogenic shock.
- sick sinus syndrome.
- untreated phaeochromocytoma.
- severe peripheral arterial circulatory disturbances.
- metabolic acidosis.
- hypotension.

4.4 Special warnings and precautions for use

Atenolol with other beta-blockers:

Sudden withdrawal of Beta-adrenoceptor blocking agents in patients with ischaemic heart disease may result in the appearance of angina attacks of increased frequency or severity or deterioration in cardiac state. Atenolol therapy must not be withdrawn abruptly. The dosage should be reduced gradually

over a period of 7–14 days, to facilitate a reduction in beta blockers dosage and patients should be monitored during withdrawal especially those with ischaemic heart disease.

Anaesthesia:

If a beta-blocker is withdrawn prior to surgery it should be discontinued for at least 24 hours. The risk-benefit assessment of stopping beta-blockade should be made for each patient. If treatment is continued, an anaesthetic with little negative inotropic activity should be selected to minimize the risk of myocardial depression. The patient may be protected against vagal reactions by intravenous administration of atropine.

Although contraindicated in uncontrolled heart failure (see section 4.3), atenolol may be used in patients whose signs of heart failure have been controlled. Caution must be exercised in patients whose cardiac reserve is poor.

Beta-blockers may increase both the sensitivity towards allergens and the seriousness to patients with a history of anaphylactic reactions. Such patients may be unresponsive to the usual doses of adrenaline (epinephrine) used to treat the allergic reactions.

Atenolol may increase the number and duration of angina attacks in patients with Prinzmetal's angina due to unopposed alpha receptor mediated coronary artery vasoconstriction. Atenolol is a beta₁ selective beta adrenoceptor blocking drug; consequently its use may be considered although utmost caution must be exercised.

Although contraindicated in severe peripheral arterial circulatory disturbances (see section 4.3), atenolol may also aggravate less severe peripheral arterial circulatory disturbances.

Due to atenolol's negative effect on conduction time, caution must be exercised if it is given to patients with first degree heart block.

May mask the symptoms of hypoglycaemia, in particular tachycardia. Beta-blockers could further increase the risk of severe hypoglycaemia when used concurrently with sulfonylureas. Diabetic patients should be advised to carefully monitor blood glucose levels. (see Section 4.5).

The signs of thyrotoxicosis may be masked by

atenolol treatment.

May cause a hypersensitivity reaction including angioedema and urticaria.

Will reduce heart rate as a result of its pharmacological action. In the rare instances where a treated patient develops symptoms which may be attributable to a slow heart rate and the pulse drops to less than 50-55 bpm at rest, the dose should be reduced.

Should be used with caution in the elderly, starting with a lower dose (see section 4.2).

Since atenolol is excreted via the kidneys, the dosage should be reduced in patients with a creatinine clearance of less than 35 ml/minute/1.73 m².

Although cardioselective (beta₁) beta-blockers may have less effect on lung function than non-selective beta-blockers, as with all beta-blockers, these should be avoided in patients with reversible obstructive airways disease, unless there are compelling clinical reasons for their use. Where such reasons exist, Atenolol may be used with caution. Occasionally, some increase in airways resistance may occur in asthmatic patients however, and this may usually be reversed by commonly used dosage of bronchodilators such as salbutamol or isoprenaline. The label and patient information leaflet for this product state the following warning: "If you have ever had asthma or wheezing, you should not take this medicine unless you have discussed these symptoms with the prescribing doctor".

As with other beta-blockers, in patients with a phaeochromocytoma, an alpha-blocker should be given concomitantly.

4.5 Interaction with other medicinal products and other forms of interaction

Anaesthetics, General:

Caution should be exercised when using anaesthetic agents with atenolol. The anaesthetist should be informed and the choice of anaesthetic should be an agent with as little negative inotropic activity as possible. Use of beta-blockers with anaesthetic drugs may result in attenuation of the reflex tachycardia and increase the risk of hypotension. Anaesthetic agents causing myocardial depression are best avoided (see section 4.4).

Anti-arrhythmic

s:

. Class I anti-arrhythmic drugs (e.g. disopyramide) and amiodarone may have a potentiating effect on atrial-conduction time and induce negative inotropic effect.

Antidiabeti

cs:

Concomitant use with insulin and oral antidiabetic drugs may lead to the intensification of the blood sugar lowering effects of these drugs. The concomitant use of beta-blockers with sulfonylureas could increase the risk of severe hypoglycaemia. Symptoms of hypoglycaemia, particularly tachycardia, may be masked (see sections 4.4).

Calcium-channel

blockers:

Combined use of beta-blockers and calcium channel blockers with negative inotropic effects, e.g. verapamil and diltiazem, can lead to an exaggeration of these effects particularly in patients with impaired ventricular function and/or sinoatrial or atrioventricular conduction abnormalities. This may result in severe hypotension, bradycardia and cardiac failure. Neither the beta-blocker nor the calcium channel blocker should be administered intravenously within 48 hours of discontinuing the other.

Concomitant therapy with dihydropyridines, e.g. nifedipine, may increase the risk of hypotension, and cardiac failure may occur in patients with latent cardiac insufficiency.

Cloni

di ne:

Beta-blockers may exacerbate the rebound hypertension which can follow the withdrawal of clonidine. If the two drugs are co-administered, the beta-blocker should be withdrawn several days before discontinuing clonidine. If replacing clonidine by beta-blocker therapy, the introduction of beta-blockers should be delayed for several days after clonidine administration has stopped (See also prescribing information for clonidine.).

Digo

x in:

Digitalis glycosides, in association with beta-blockers, may increase atrioventricular conduction time.

NSAIDs:

Concomitant use of prostaglandin synthetase-inhibiting drugs, e.g. ibuprofen and indomethacin, may decrease the hypotensive

effects of beta-blockers.

Sympathomimetics:

Concomitant use of sympathomimetic agents, e.g. adrenaline (epinephrine), may counteract the effect of beta-blockers.

4.6 Fertility, Pregnancy and lactation

Caution should be exercised when atenolol is administered during pregnancy or to a woman who is breast-feeding.

Pregnancy:

Atenolol crosses the placental barrier and appears in the cord blood. No studies have been performed on the use of atenolol in the first trimester and the possibility of foetal injury cannot be excluded. Atenolol has been used under close supervision for the treatment of hypertension in the third trimester.

Administration of atenolol to pregnant women in the management of mild to moderate hypertension has been associated with intra-uterine growth retardation.

The use of atenolol in women who are, or may become, pregnant requires that the anticipated benefit be weighed against the possible risks, particularly in the first and second trimesters, since beta-blockers, in general, have been associated with a decrease in placental perfusion which may result in growth retardation, intra-uterine deaths, abortion, immature and premature deliveries.

Breast-feeding:

There is significant accumulation of atenolol in breast milk.

Neonates born to mothers who are receiving atenolol at parturition or breast-feeding may be at risk of hypoglycaemia and bradycardia.

4.7 Effects on ability to drive and use machines

Atenolol has no or negligible influence on the ability to drive and use machines. However, it should be taken into account that occasionally dizziness or fatigue may occur.

4.8 Undesirable effects

Atenolol is well-tolerated. In clinical studies, the undesired events reported are usually attributable to the pharmacological actions of atenolol.

The following undesired events, listed by body system, have been reported 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 ($< 1/10,000$); including isolated reports not known (cannot be estimated from the available data).

System Organ Class	Frequency	Undesirable Effect
Blood and lymphatic system disorders	Rare	Purpura, thrombocytopenia
Psychiatric disorders	Uncommon	Sleep disturbances of the type noted with other beta-blockers
	Rare	Mood changes, nightmares, confusion, psychoses and hallucinations
	Not known	Depression
Nervous system disorders	Rare	Dizziness, headache, paraesthesia
Eye disorders	Rare	Dry eyes, visual disturbances
Cardiac disorders	Common	Bradycardia
	Rare	Heart failure deterioration, precipitation of heart block
Vascular disorders	Common	Cold extremities
	Rare	Postural hypotension which may be associated with syncope, intermittent claudication may be increased if already present, in susceptible patients Raynaud's phenomenon
Respiratory, thoracic and mediastinal	Rare	Bronchospasm may occur in patients with

System Organ Class	Frequency	Undesirable Effect
disorders		bronchial asthma or a history of asthmatic complaints
Gastrointestinal disorders	Common	Gastrointestinal disturbances
	Rare	Dry mouth
Hepatobiliary disorders	Uncommon	Elevations of transaminase levels
	Rare	Hepatic toxicity including intrahepatic cholestasis
Skin and subcutaneous tissue disorders	Rare	Alopecia, psoriasiform skin reactions, exacerbation of psoriasis, skin rashes
	Not known	Hypersensitivity reactions, including angioedema and urticaria
Musculoskeletal and connective tissue disorders	Not known	Lupus-like syndrome
Reproductive system and breast disorders	Rare	Impotence
General disorders and administration site conditions	Common	Fatigue
Investigations	Very rare	An increase in ANA (Antinuclear Antibodies) has been observed, however the clinical relevance of this is not clear

Discontinuation of atenolol should be considered if, according to clinical judgment, the well-being of the patient is adversely affected by any of the above reactions. Cessation of therapy with a beta-blocker should be gradual.

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 Website: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

4.9 Overdose

The symptoms of overdosage may include bradycardia, hypotension, acute cardiac insufficiency and bronchospasm.

Management:

Close supervision; treatment in an intensive care ward; the use of gastric lavage; activated charcoal and a laxative to prevent absorption of any drug still present in the gastrointestinal tract; and the use of plasma or plasma substitutes to treat hypotension and shock. The uses of haemodialysis or haemoperfusion may be considered.

Excessive bradycardia can be countered with atropine 1–2 mg intravenously and/or a cardiac pacemaker. If necessary, this may be followed by a bolus dose of glucagon 10 mg intravenously. If required, this may be repeated or followed by an intravenous infusion of glucagon 1–10 mg/hour depending on response. If no response to glucagon occurs or if glucagon is unavailable, a beta-adrenoceptor stimulant such as dobutamine 2.5 to 10 micrograms/kg/minute by intravenous infusion may be given. Dobutamine, because of its positive inotropic effect could also be used to treat hypotension and acute cardiac insufficiency.

It is likely that these doses would be inadequate to reverse the cardiac effects of beta-blocker blockade if a large overdose has been taken. The dose of dobutamine should therefore be increased if necessary to achieve the required response according to the clinical condition of the patient.

Bronchospasm can usually be reversed by bronchodilators.

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Beta blocking agents, plain selective, ATC code: C07A B03.

Mechanism of action

Atenolol is a beta-blocker which is beta₁-selective, (i.e. acts preferentially on beta₁-adrenergic receptors in the heart). Selectivity decreases with increasing dose.

Atenolol is without intrinsic sympathomimetic and membrane-stabilising activities and as with other beta-blockers, has negative

inotropic effects (and is therefore contraindicated in uncontrolled heart failure).

As with other beta-blockers, the mode of action of atenolol in the treatment of hypertension is unclear.

It is probably the action of atenolol in reducing cardiac rate and contractility which makes it effective in eliminating or reducing the symptoms of patients with angina.

It is unlikely that any additional ancillary properties possessed by S (-) atenolol, in comparison with the racemic mixture, will give rise to different therapeutic effects.

Clinical efficacy and safety

Atenolol is effective and well tolerated in most ethnic populations although the response may be less in black patients.

Atenolol is effective for at least 24 hours after a single oral dose. The drug facilitates compliance by its acceptability to patients and simplicity of dosing. The narrow dose range and early patient response ensure that the effect of the drug in individual patients is quickly demonstrated. Atenolol is compatible with diuretics, other hypotensive agents and antianginals (see section 4.5). Since it acts preferentially on beta-receptors in the heart, Atenolol may, with care, be used successfully in the treatment of patients with respiratory disease, who cannot tolerate non-selective betablockers.

Early intervention with Atenolol in acute myocardial infarction reduces infarct size and decreases morbidity and mortality. Fewer patients with a threatened infarction progress to frank infarction; the incidence of ventricular arrhythmias is decreased and marked pain relief may result in reduced need of opiate analgesics. Early mortality is decreased. Atenolol is an additional treatment to standard coronary care.

5.2 Pharmacokinetic properties

Absorption

Absorption of atenolol following oral dosing is consistent but incomplete (approximately 40–50%) with peak plasma concentrations occurring 2–4 hours after dosing. The atenolol blood levels are consistent and subject to little variability. There is no significant hepatic metabolism of atenolol and more than 90% of that absorbed reaches the systemic circulation unaltered.

Distribution

Atenolol penetrates tissues poorly due to its low lipid solubility and its concentration in brain tissue is low. Plasma protein binding is low (approximately 3%).

Elimination

The plasma half-life is about 6 hours but this may rise in severe

renal impairment since the kidney is the major route of elimination.

5.3 Preclinical safety data

Atenolol is a drug on which extensive clinical experience has been obtained. Relevant information for the prescriber is provided elsewhere in the prescribing information.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

	Lactose	BP
2	Microcrystalline Cellulose	BP
3	Maize starch	BP
4	Sodium benzoate	BP
5	Povidone K-30	BP
6	Cross povidone	
7	Talcum	BP
8	Magnesium stearate	
9	Aerosil	BP
10	Purified water	IH

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

3 years.

6.4 Special precautions for storage

Do not store above 30°C.

Keep the container tightly closed (bottles & tablet containers). Store in the original package (blisters).

6.5 Nature and contents of container

10 tablets are packed in one Alu-Alu blister such 3 blisters are packed in a carton with insert.

6.6 Special precautions for disposal

No special requirements.

7. MARKETING AUTHORISATION HOLDER

ZAIN PHARMA LIMITED

Plot No: 209/13741, Colchester Park,
Go-Down No.1, 2, 3, Off Mombasa Road,
Behind Nice And Lovely House,
P.O. Box: 100167-00101, Nairobi, Kenya

8 MARKETING AUTHORISATION NUMBER(S)

H2025/CTD11588/25353

**9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE
AUTHORISATION**

2025 May 01

10 DATE OF REVISION OF THE TEXT

2025 May 01