Summary of Product Characteristics for Pharmaceutical Products

1. NAME OF THE MEDICINAL PRODUCT

Cataflam 50mg Coated Tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 50mg diclofenac potassium.
Each tablet also contains 67 mg sucrose.

For a full list of excipients, see Section 6.1.

3. PHARMACEUTICAL FORM

Coated tablet (Tablet).

Circular, biconvex, reddish-brown sugar-coated tablet approximately 8.8mm diameter

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Short-term treatment of all grades of pain and inflammation in the following acute conditions:

- Post-traumatic pain, inflammation and swelling, e.g. due to sprains.
- acute musculo-skeletal disorders such as periarthritis (for example frozen shoulder), tendonitis, tenosynovitis, bursitis
- Post-operative pain, inflammation and swelling, e.g. following dental or orthopaedic surgery.
- Painful and/or inflammatory conditions in gynaecology, e.g. primary dysmenorrhoea or adnexitis and associated menorrhagia.
- Migraine attacks.
- Acute gout
- Painful syndromes of the vertebral column.
- Non-articular rheumatism.
- As an adjuvant in severe painful inflammatory infections of the ear, nose or throat, e.g. pharyngotonsillitis, otitis. In keeping with general therapeutic principles, the underlying disease should be treated with basic therapy, as appropriate. Fever alone is not an indication.

4.2 Posology and method of administration

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

The tablets should be swallowed whole with liquid, preferably before meals,

and must not be divided or chewed.

Adults

The recommended initial daily dose is 100 to 150 mg. In milder cases, 75 to 100 mg daily is usually sufficient.

The total daily dose should generally be divided in 2 to 3 doses.
In primary dysmenorrhea, the daily dose should be individually adjusted and is generally 50 to 150 mg. A dose of 50 to 100 mg should be given initially and, if necessary, increased over the course of several menstrual cycles up to a maximum of 200 mg/day. Treatment should be started on appearance of the first symptoms and, depending on the symptomatology, continued for a few days.

In migraine, an initial dose of 50 mg should be taken at the first signs of an impending attack. In cases where pain relief within 2 hours after the first dose is not sufficient, a further dose of 50 mg may be taken. If needed, further doses of 50 mg may be taken at intervals of 4 to 6 hours, not exceeding a total dose of 200 mg per day.

Children and adolescents:
Cataflam tablets are not recommended for use in children and adolescents below 14 years of age; other forms of diclofenac such as oral drops or suppositories could be used in these patients. For adolescents aged 14 years and over, a daily dose of 75 to 100 mg is usually sufficient. The total daily dose should generally be divided in 2 to 3 doses. The maximum daily dose of 150 mg should not be exceeded the use of Cataflam (all forms) in migraine attacks has not been established in children and adolescents.

Older people (Patients aged 65 or above)
Although the pharmacokinetics of Cataflam are not impaired to any clinically relevant extent in elderly patients, non-steroidal anti-inflammatory drugs should be used with particular caution in frail elderly patients or those with a low body weight. In particular, it is recommended that the lowest effective dosage be used in these patients (see section 4.4). Treatment should be reviewed at regular intervals and discontinued if no benefit is seen or if intolerance occurs

Renal impairment
Diclofenac is contraindicated in patients with severe renal impairment (see section 4.3). No specific studies have been carried out in patients with renal impairment; therefore, no specific dose adjustment recommendations can be made. Caution is advised when administering diclofenac to patients with mild to moderate renal impairment (see section 4.3 and 4.4).

Hepatic impairment
Diclofenac is contraindicated in patients with severe hepatic impairment (see section 4.3). No specific studies have been carried out in patients with hepatic impairment; therefore, no specific dose adjustment recommendations can be made. Caution is advised when administering diclofenac to patients with mild to moderate hepatic impairment (see section 4.3 and 4.4).

4.3 Contraindications

- Known hypersensitivity to the active substance or to any of the excipients.
- Active gastric or intestinal ulcer, bleeding or perforation
- History of gastrointestinal bleeding or perforation, related to previous NSAIDs therapy. Active or history of recurrent peptic ulcer/ haemorrhage (two or more distinct episodes of proven ulceration or bleeding).
- Last trimester of pregnancy (see section 4.6 Pregnancy and lactation).
- Hepatic failure
- Chronic Kidney Disease Grade 5 (GFR <15ml/min/1.73m^2)
- Established congestive heart failure (NYHA II-IV), ischemic heart disease, peripheral arterial disease and/or cerebrovascular disease.
- Like other non-steroidal anti-inflammatory drugs (NSAIDs), Cataflam is also contraindicated in patients in whom the use of acetylsalicylic acid or other NSAIDs can precipitate asthma, angioedema, urticaria, or acute rhinitis (i.e. NSAID-induced cross-reactivity reactions) (see Section 4.4 Special warnings and special precautions for use and Section 4.8 Undesirable Effects).

4.4 Special warnings and precautions for use

General

Undesirable effects may be minimised by using the lowest effective dose for the shortest possible duration necessary to control symptoms (see section 4.2 Posology and GI and cardiovascular risks below).

The use of Cataflam with concomitant NSAIDs including cyclooxygenase-2 selective inhibitors, should be avoided due to the absence of any evidence demonstrating synergistic benefits and the potential for additive undesirable effects.

Caution is indicated in the elderly on basic medical grounds especially used in frail elderly patients or those with a low body weight.

Like other NSAIDs, Cataflam may mask the signs and symptoms of infection due to its pharmacodynamic properties.

The use of diclofenac potassium 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 diclofenac potassium should be considered.

Gastrointestinal effects

Gastrointestinal bleeding or ulceration or perforation, which can be fatal, have been reported with all NSAIDs, including diclofenac, and may occur at any time during treatment, with or without warning symptoms or a previous history of serious gastrointestinal events. The elderly have an increased frequency of adverse reactions to NSAIDs especially gastrointestinal bleeding and perforation which may be fatal (see section 4.2 Posology and method of administration) When gastrointestinal bleeding or ulceration occur in patients receiving Cataflam, the medicinal product should be withdrawn

As with all NSAIDs, including diclofenac, close medical surveillance is imperative and particular caution should be exercised when prescribing Cataflam in patients with symptoms indicative of gastrointestinal (GI) disorders or with a history suggestive of gastric or intestinal ulceration,

bleeding or perforation (see section 4.8 Undesirable effects). 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 haemorrhage or perforation (see 4.3 Contra-indications) The elderly have an increased frequency of adverse reactions to NSAIDs especially gastrointestinal bleeding and perforation which may be fatal.

To reduce the risk of GI toxicity in patients with a history of ulcer, particularly if complicated with haemorrhage or perforation, and in the elderly, the treatment should be initiated and maintained at the lowest effective dose.

Combination therapy with protective agents (e.g. proton pump inhibitors or misoprostol) should be considered for these patients, and also for patients requiring concomitant use of medicinal products containing low-dose acetylsalicylic acid (ASA)/aspirin or other medicinal products likely to increase gastrointestinal risk (see below and section 4.5 Interactions with other medicinal products and other forms of interaction) .

Patients with a history of GI toxicity, particularly the elderly, should report any unusual abdominal symptoms (especially GI bleeding) particularly in the early stages of treatment. Caution is recommended in patients receiving concomitant medications which could increase the risk of ulceration or bleeding, such as oral corticosteroids, anticoagulants such as warfarin, anti-platelet agents such as aspirin or selective serotonin-reuptake inhibitors (see section 4.5 Interaction with other medicinal products and other forms of interaction).
Close medical surveillance and caution should also be exercised inpatients with ulcerative colitis or Crohn's disease), as their condition may be exacerbated (see section 4.8 Undesirable effects).

NSAIDs, including diclofenac, may be associated with increased risk of gastro-intestinal anastomotic leak. Close medical surveillance and caution are recommended when using diclofenac after gastro-intestinal surgery.

Cardiovascular and cerebrovascular effects

Appropriate monitoring and advice are required for patients with a history of hypertension and/or congestive heart failure (NYHA-1) as fluid retention and oedema have been reported in association with NSAID therapy.

Clinical trial and epidemiological data suggest that the use of diclofenac, particularly at high doses (150 mg daily) and in long term treatment may be associated with a small increased risk of arterial thrombotic events (for example myocardial infarction or stroke).
Patients with congestive heart failure (NYHA-1) and patients with significant risk factors for cardiovascular events (e.g. hypertension, hyperlipidaemia, diabetes mellitus, smoking) should only be treated with diclofenac after careful consideration. As the cardiovascular risks of diclofenac may increase with dose and duration of exposure, the shortest duration possible and the lowest effective daily dose should be used. The patient's need for symptomatic relief and response to therapy should be re-evaluated periodically.

Patients should remain alert for the signs and symptoms of serious arteriothrombotic events (e.g. chest pain, shortness of breath, weakness, slurring of speech), which can occur without warnings. Patients should be instructed to see a physician immediately in case of such an event.

Hepatic effects

Close medical surveillance is required when prescribing Cataflam to patients with impaired hepatic function as their condition may be exacerbated.

As with other NSAIDs, including diclofenac, values of one or more liver enzymes may increase. During prolonged treatment with Cataflam, regular monitoring of hepatic function is indicated as a precautionary measure. If abnormal liver function tests persist or worsen, if clinical signs or symptoms consistent with liver disease develop, or if other manifestations occur (e.g. eosinophilia, rash etc), Cataflam should be discontinued. Hepatitis may occur with use of diclofenac without prodromal symptoms.

Caution is called for when using Cataflam in patients with hepatic porphyria, since it may trigger an attack.

Renal effects

As fluid retention and oedema have been reported in association with NSAID therapy, including diclofenac, particular caution is called for in patients with impaired cardiac or renal function , history of hypertension in the elderly, patients receiving concomitant treatment with diuretics or medicinal products that can significantly impact renal function, and in those patients with substantial extracellular volume depletion from any cause, e.g. before or after major surgery (see section 4.3 Contraindications). Monitoring of renal function is recommended as a precautionary measure when using diclofenac in such cases. Discontinuation of therapy is usually followed by recovery to the pre-treatment state.

Skin Effects

Serious skin reactions, some of them fatal, including exfoliative dermatitis, Stevens-Johnson syndrome, toxic epidermal necrolysis, and generalised bullous fixed drug eruption have been reported very rarely in association with the use of diclofenac (see section 4.8 Undesirable effects). 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. Cataflam should be discontinued at the first appearance of skin rash, mucosal lesions or any other sign of hypersensitivity.

As with other NSAIDs, allergic reactions, including anaphylactic/anaphylactoid reactions, can also occur in rare cases with diclofenac without earlier exposure to the drug. Hypersensitivity reactions can also progress to Kounis syndrome, a serious allergic reaction that can result in myocardial infarction. Presenting symptoms of such reactions can include chest pain occurring in association with an allergic reaction to diclofenac.

Haematological effects

Use of Cataflam is recommended only for short-term treatment. If, however, Cataflam is used for a prolonged period, monitoring of the blood count is recommended, as with other NSAIDs.

Like other NSAIDs, Cataflam may temporarily inhibit platelet aggregation. Patients with defects of haemostasis should be carefully monitored.

Pre-existing asthma

In patients with asthma, seasonal allergic rhinitis, swelling of the nasal

mucosa (i.e. nasal polyps), chronic obstructive pulmonary diseases or chronic infections of the respiratory tract (especially if linked to allergic rhinitis-like symptoms), reactions on NSAIDs like asthma exacerbations (so-called intolerance to analgesics/analgesics-asthma), Quincke's oedema or urticaria are more frequent than in other patients. Therefore, special precaution is recommended in such patients (readiness for emergency). This is applicable as well for patients who are allergic to other substances, e.g. with skin reactions, pruritus or urticaria.

Sucrose

Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine .

This medicine contains less than 1 mmol sodium (23 mg) per tablet, that is to say essentially "sodium-free".

4.5 Interaction with other medicinal products and other forms of interactions

The following interactions include those observed with Cataflam sugar-coated tablets and/or other pharmaceutical forms of diclofenac.

CYP2C9 inhibitors: Caution is recommended when co-prescribing diclofenac with CYP2C9 inhibitors (such as voriconazole), which could result in a significant increase in peak plasma concentrations and exposure to diclofenac
CYP2C9 inducers: Caution is recommended when co-prescribing diclofenac with CYP2C9 inducers (such as rifampicin), which could result in a significant decrease in plasma concentration and exposure to diclofenac.

Lithium: If used concomitantly, diclofenac may raise plasma concentrations of lithium Monitoring of the serum lithium level is recommended

Digoxin: If used concomitantly, diclofenac may raise plasma concentrations of digoxin. Monitoring of the serum digoxin level is recommended.

Diuretics and antihypertensive agents: Like other NSAIDs, concomitant use of diclofenac with diuretics or antihypertensive agents (e.g. beta-blockers, angiotensin converting enzyme (ACE) inhibitors) may cause a decrease in their antihypertensive effect. Therefore, the combination should be administered with caution and patients, especially the elderly, should have their blood pressure periodically monitored. Patients should be adequately hydrated and consideration should be given to monitoring of renal function after initiation of concomitant therapy and periodically thereafter, particularly for diuretics and ACE inhibitors due to the increased risk of nephrotoxicity. (see section 4.4 Special warnings and precautions for use).

Ciclosporin: Diclofenac, like other NSAIDs, may increase the nephrotoxicity of ciclosporin due to the effect on renal prostaglandins. Therefore, it should be given at doses lower than those that would be used in patients not receiving ciclosporin.

Drugs known to cause hyperkalemia: Concomitant treatment with potassium-sparing diuretics, ciclosporin, tacrolimus or trimethoprim may be associated with increased serum potassium levels, which should therefore be monitored frequently (see section 4.4 Special warnings and precautions for use).

***Quinolone antibacterials*:** There have been isolated reports of convulsions which may have been due to concomitant use of quinolones and NSAIDs.

Anticipated Interactions to be considered

Other NSAIDs and corticosteroids: Concomitant administration of diclofenac and other systemic NSAIDs or corticosteroids may increase the risk of gastrointestinal ulceration or bleeding (see section 4.4 Special warnings and precautions for use)

Anticoagulants and anti-platelet agents: Caution is recommended since concomitant administration could increase the risk of gastrointestinal bleeding (see section 4.4 Special warnings and special precautions for use). Although clinical investigations do not appear to indicate that diclofenac affects the action of anticoagulants, NSAIDs may enhance the effects of anti-coagulants, such as warfarin (see section 4.4.). There are also reports of an increased risk of haemorrhage in patients receiving diclofenac and anticoagulants concomitantly. Close monitoring of such patients is therefore recommended.

Selective serotonin reuptake inhibitors (SSRIs): Concomitant administration of systemic NSAIDs, including diclofenac, and SSRIs may increase the risk of gastrointestinal bleeding (see section 4.4 Special warnings and precautions for use)

Antidiabetics: Clinical studies have shown that diclofenac can be given together with oral antidiabetic agents without influencing their clinical effect. However, there have been isolated reports of both hypoglycaemic and hyperglycaemic effects necessitating changes in the dosage of the antidiabetic agents during treatment with diclofenac. For this reason, monitoring of the blood glucose level is recommended as a precautionary measure during concomitant therapy.

Methotrexate: Diclofenac can inhibit the tubular renal clearance of methotrexate hereby increasing methotrexate levels. Caution is recommended when NSAIDs, including diclofenac, are administered less than 24 hours before or after treatment with methotrexate, since blood concentrations of methotrexate may rise and the toxicity of this substance be increased

Colestipol and cholestyramine: These agents can induce a delay or decrease in absorption of diclofenac. Therefore, it is recommended to administer diclofenac at least one hour before or 4 to 6 hours after administration of colestipol/ cholestyramine.

Phenytoin: When using phenytoin concomitantly with diclofenac, monitoring of phenytoin plasma concentrations is recommended due to an expected increase in exposure to phenytoin

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 absolute risk for cardiovascular malformation was increased from less than 1%, up to approximately 1.5 %.

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.
From the 20th week of pregnancy onward, diclofenac may cause oligohydramnios resulting from foetal renal dysfunction. This may occur shortly after treatment initiation and is usually reversible upon discontinuation. In addition, there have been reports of ductus arteriosus constriction following treatment in the second trimester, most of which resolved after treatment cessation. Therefore, during the first and second trimester of pregnancy, diclofenac should not be given unless clearly necessary. If diclofenac 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. Antenatal monitoring for oligohydramnios and ductus arteriosus constriction should be considered after exposure to diclofenac for several days from gestational week 20 onward. Diclofenac should be discontinued if oligohydramnios or ductus arteriosus constriction are found.
During the third trimester of pregnancy, all prostaglandin synthesis inhibitors may expose the foetus to:

- cardiopulmonary toxicity (premature constriction/closure of the ductus arteriosus and pulmonary hypertension);
- renal dysfunction (see above)

the mother and the neonate, at the end of pregnancy, to:

- possible prolongation of bleeding time, an anti-aggregating effect which may occur even at very low doses.
- inhibition of uterine contractions resulting in delayed or prolonged labour. Consequently, diclofenac is contraindicated during the third trimester of pregnancy.

Lactation

Like other NSAIDs, diclofenac passes into the breast milk in small amounts. Therefore, Cataflam should not be administered during breast feeding in order to avoid undesirable effects in the infant.

Fertility

As with other NSAIDs, the use of Cataflam 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 Cataflam should be considered.

4.7 Effects on ability to drive and use machines

Patients who experience dizziness, vertigo, somnolence or other central nervous system disturbances, including visual disturbances, while taking NSAIDs should refrain from driving or using machines.

4.8 Undesirable effects

Adverse drug reactions from clinical trials and/or spontaneous or literature

cases (Table 1) are listed by MedRA system order class. Within each system organ class, the adverse drug reactions are ranked by frequency, with the most frequent reactions first. Within each frequency grouping, adverse drug reactions are presented in order of decreasing seriousness. In addition, the corresponding frequency category for each adverse drug reaction is based on using the following convention: (CIOMS III): very common (>1/10); common (≥ 1/100, < 1/10); uncommon (≥ 1/1,000, < 1/100); rare (≥ 1/10,000, < 1/1,000); very rare (<1/10,000).
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 Special warnings and precautions for use). Nausea, vomiting, diarrhoea, flatulence, constipation, dyspepsia, abdominal pain, melaena, haematemesis, ulcerative stomatitis, exacerbation of coilitis and Crohn's disease (see section 4.4 Special warnings and precautions for use) have been reported following administration. Less frequently, gastritis has been observed.

The following table of undesirable effects include those reported with Cataflam sugar-coated tablets and/or other pharmaceutical forms of diclofenac, with either short-term or long-term use.

Table 1

System organ class	**Frequency**	**Adverse reaction**
Blood and lymphatic system disorders	Very rare	Thrombocytopenia, leucopenia, anemia (including haemolytic anemia and aplastic anaemia), agranulocytosis.
Immune system disorders	Rare	Hypersensitivity, anaphylactic and anaphylactoid reactions (including hypotension and shock).
	Very rare	Angioedema (including face oedema)
Psychiatric disorders	Very rare	Disorientation, depression, insomnia, nightmare, irritability, psychotic disorder.
Nervous system disorders	Common	Headache, dizziness.
	Rare	Somnolence
	Very rare	Paresthesia, memory impairment, convulsions, anxiety, tremor, meningitis aseptic, dysgeusia, cerebrovascular accident.
Eye disorders	Very rare	Visual impairment, (blurred vision, diplopia).
Ear and labyrinth disorders	Common	Vertigo.
	Very rare	Tinnitus, hearing impaired.
Cardiac disorders	Uncommon*	Myocardial infarction, cardiac failure, palpitations, chest pain
	Frequency Not Known	Kounis syndrome
Vascular disorders	Very rare	Hypertension, vasculitis.
Respiratory, thoracic and mediastinal disorders	Rare	Asthma/bronchospasm (including dyspnoea).
	Very Rare	Pneumonitis.
Gastrointestinal disorders	Common	Nausea, vomiting, diarrhea, dyspepsia, abdominal pain, flatulence, decreased appetite.

	Rare	Gastritis, gastrointestinal hemorrhage, hematemesis, diarrhea, hemorrhagic melaena, gastrointestinal ulcer (with or without bleeding or perforation).
	Very rare	Colitis (including hemorrhagic colitis and exacerbation of ulcerative colitis or Crohn's disease), constipation, stomatitis (including ulcerative stomatitis), glossitis, oesophageal disorder, diaphragm-like intestinal strictures, pancreatitis.
	Not known	Ischemic colitis
Hepatobiliary disorders	Common	Transaminases increased.
	Rare	Hepatitis with or without jaundice, liver disorder.
	Very rare	Hepatitis fulminant, hepatic necrosis, hepatic failure.
Skin and subcutaneous tissue disorders	Common	Rashes
	Rare	Urticaria
	Very rare	Dermatitis bullous, eczema, erythema, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis (Lyell's syndrome), dermatitis exfoliative, alopecia, photosensitivity reaction, purpura, allergic purpura, Henoch-Schonlein purpura, pruritus.
	Not known	Fixed drug eruptions, generalised bullous fixed drug eruption
Renal and urinary disorders	Very rare	Acute kidney injury (acute renal failure), hematuria, proteinuria, nephritic syndrome, tubulointerstitial nephritis, renal papillary necrosis.
General disorders and administration site conditions	Rare	Edema
* The frequency reflects data from long-term treatment with a high dose (150 mg/day).		

Clinical trial and epidemiological data consistently point towards an increased risk of arterial thrombotic events (for example myocardial infarction or stroke) associated with the use of diclofenac, particularly at high doses (150 mg daily) and in long term treatment (see section 4.3 and 4.4 for Contraindications and Special warnings and special precautions for use).

Oedema, hypertension and cardiac failure have been reported in association with NSAID treatment.

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 HPRA Pharmacovigilance Website: www.hpra.ie.

4.9 Over

dose

Symptom

There is no typical clinical picture resulting from diclofenac overdosage. Overdosage can cause
symptoms such as vomiting, gastrointestinal haemorrhage, diarrhoea,

dizziness, tinnitus or convulsions. In the event of significant poisoning, acute renal failure and liver damage are possible

Therapeutic measures

Management of acute poisoning with NSAIDs, including diclofenac, essentially consists of supportive measures and symptomatic treatment. Supportive measures and symptomatic treatment should be given for complications such as hypotension, renal failure, convulsions, gastrointestinal disorder, and respiratory depression.

Special measures such as forced diuresis, dialysis or haemoperfusion are probably unlikely to be helpful in accelerating the elimination of NSAIDs, including diclofenac, due to the high protein binding and extensive metabolism

Activated charcoal may be considered after ingestion of a potentially toxic overdose, and gastric decontamination (e.g. vomiting, gastric lavage) after ingestion of a potentially life-threatening overdose

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Anti-inflammatory and antirheumatic products, non-steroids, acetic acid derivatives and related substances (ATC code: M01A B05).

Mechanism of action

Cataflam contains the potassium salt of diclofenac, a non-steroidal compound with pronounced analgesic, anti-inflammatory and antipyretic properties. Inhibition of prostaglandin biosynthesis, which has been demonstrated in experiments, is considered to be fundamental to its mechanism of action. Prostaglandins play a major role in causing inflammation, pain and fever.

Cataflam tablets have a rapid onset of action which makes them particularly suitable for the treatment of acute painful and inflammatory conditions.

Diclofenac potassium *in vitro* does not suppress proteoglycan biosynthesis in cartilage at concentrations equivalent to those reached in humans.

Pharmacodynamic effects

Cataflam has been found to exert a pronounced analgesic effect in moderate and severe pain. In the presence of inflammation, e.g. due to trauma or following surgical interventions, it rapidly relieves both spontaneous pain and pain on movement and diminishes inflammatory swelling and wound oedema

Clinical studies have also revealed that in primary dysmenorrhoea the active substance is capable of relieving the pain and reducing the extent of bleeding

In migraine attacks Cataflam has been shown to be effective in relieving the headache and in improving the accompanying symptoms of nausea and vomiting.

There is limited clinical trial experience of the use of diclofenac in Juvenile Rheumatoid Arthritis (JRA)/Juvenile Idiopathic Arthritis (JIA) paediatric

patients. In a randomized, double-blind, 2-week, parallel group study in children aged 3-15 years with JRA/JIA, the efficacy and safety of daily 2-3 mg/kg BW diclofenac was compared with acetylsalicylic acid (ASS, 50-100 mg/kg BW/d) and placebo – 15 patients in each group. In the global evaluation, 11 of 15 diclofenac patients, 6 of 12 aspirin and 4 of 15 placebo patients showed improvement with the difference being statistically significant ($p < 0.05$). The number of tender joints decreased with diclofenac and ASS but increased with placebo. In a second randomized, double-blind, 6-week, parallel group study in children aged 4-15 years with JRA/JIA, the efficacy of diclofenac (daily dose 2-3 mg/kg BW, n=22) was comparable with that of indomethacin (daily dose 2-3mg/kg BW, n=23).

5.2 Pharmacokinetic properties

Absorption:
Diclofenac is rapidly and completely absorbed from diclofenac potassium tablets. The absorption sets in immediately after administration and the same amount is absorbed as from an equivalent dose of diclofenac sodium gastro-resistant tablets. Mean peak plasma concentrations of 3.8micromol/L are attained after 20 - 60 minutes after ingestion of one tablet of 50mg. Ingestion together with food has no influence on the amount of diclofenac absorbed although onset and rate of absorption may be slightly delayed.

Since about half of diclofenac is metabolized during its first passage through the liver (first pass effect), the area under the concentration curve (AUC) is about half as large following oral or rectal administration as it is following a parenteral dose of equal size.

The amount absorbed is in linear proportion to the size of the dose.

Pharmacokinetic behaviour does not change after repeated administration. No accumulation occurs provided the recommended dosage intervals are observed.

Distribution:
The active substance is 99.7% protein bound, mainly to albumin (99.4%).

Diclofenac enters the synovial fluid, where maximum concentrations are measured 2-4 hours after peak plasma values have been attained. The apparent half-life for elimination from the synovial fluid is 3-6 hours. Two hours after reaching the peak plasma values, concentrations of the active substance

are already higher in the synovial fluid than they are in the plasma, and remain higher for up to 12 hours.

Diclofenac was detected in a low concentration (100 ng/mL) in breast milk in one nursing mother. The estimated amount ingested by an infant consuming breast milk is equivalent to a 0.03 mg/kg/day dose.

Biotransformation/Metabolism:
Biotransformation of diclofenac takes place partly by glucuronidation of the intact molecule, but mainly by single and multiple hydroxylation and methoxylation, resulting in several phenolic metabolites, most of which are converted to glucuronide conjugates. Two phenolic metabolites are biologically active, but to a much lesser extent than diclofenac.

Elimination:
Total systemic clearance of diclofenac in plasma is 263 □ 56mL/min (mean value □ SD). The terminal half-life in plasma is 1-2 hours. Four of the metabolites, including the two active ones, also have short plasma half-lives of 1-3 hours.

About 60% of the administered dose is excreted in the urine as the glucuronide conjugate of the intact molecule and as metabolites, most of which are also converted to glucuronide conjugates. Less than 1% is excreted as unchanged substance. The rest of the dose is eliminated as metabolites through the bile in the faeces.

Special Populations:

No relevant age-dependent differences in the drug's absorption, metabolism, or excretion have been observed.

Patients with renal impairment: In patients suffering from renal impairment, no accumulation of the unchanged active substance can be inferred from the single-dose kinetics when applying the usual dosage schedule. At a creatinine clearance of <10mL/min, the calculated steady-state plasma levels of the hydroxy metabolites are about 4 times higher than in normal subjects. However, the metabolites are ultimately cleared through the bile.

Patients with hepatic disease: In patients with chronic hepatitis or non-decompensated cirrhosis, the kinetics and metabolism of diclofenac are the same as in patients without liver disease.

5.3 Preclinical safety data

Preclinical data from acute and repeated dose toxicity studies, as well as from genotoxicity, mutagenicity, and carcinogenicity studies with diclofenac revealed no specific hazard for humans at the intended therapeutic doses. In standard preclinical animal studies, there was no evidence that diclofenac had a teratogenic potential in mice, rats or rabbits.

Diclofenac had no influence on the fertility of parent animals in rats. Except for minimal fetal effects at maternally toxic doses the prenatal, perinatal and postnatal development of the offspring was not affected.

Administration of NSAIDs (including diclofenac) inhibited ovulation in the

rabbit and implantation and placentation in the rat, and led to premature closure of the ductus arteriosus in the pregnant rat. Maternally toxic doses of diclofenac were associated with dystocia, prolonged gestation, decreased fetal survival, and intrauterine growth retardation in rats. The slight effects of diclofenac on reproduction parameters and delivery as well as constriction of the ductus arteriosus in utero are pharmacologic consequences of this class of prostaglandin synthesis inhibitors (see sections 4.3 Contraindications and 4.6 Fertility, pregnancy and lactation)

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Core:
Colloidal anhydrous
silica, Calcium
phosphate,
Magnesium
stearate, Maize
starch,
Povidone K30
Sodium starch glycolate Type A

Coating and Polish:
Microcrystalline
cellulose Macrogol
8000 Crystalline
sucrose Povidone
Dispersed Red (which consists of titanium dioxide E171 and red
iron oxide E172). Talc

6.2 Incompatibilities

Not applicable.

6.3 Shelf Life

3 years.

6.4 Special precautions for storage

Do not store above 30□C. Store in the original pack**age**.

6.5 Nature and contents of container

PVC/PE/PVDC film on aluminium foil blister strips,
10 tablets/strip. Pack sizes: 10 (sample pack), 20 or
30 tablets.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal of a used medicinal product or waste materials derived from such medicinal product and other handling of the product.

No special requirements.

7. MARKETING AUTHORISATION HOLDER

Novartis Pharma Services Inc

8. MARKETING AUTHORISATION NUMBER

PA0896/004/001

H2011/7350

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 13th March 1995

2026 May 11

10. DATE OF REVISION OF THE TEXT

01/2026