

SUMMARY PRODUCT CHARACTERISTICS

1. Name of the medicinal product

Proprietary name: FLAMACOR MR

International Non-proprietary Name (INN): Diclofenac Potassium, Paracetamol and Chlorzoxazone tablets

2. Qualitative and quantitative composition

Each film coated tablet contains:

Diclofenac Potassium BP	50 mg
Paracetamol BP	325 mg
Chlorzoxazone USP	250 mg
Excipients	q.s

Colour: Titanium Dioxide

3. Pharmaceutical form

Oral Dosage form: Oral Filmcoated Tablets

White coloured, oblong shaped, film coated tablets having breakline on one side and plain on other side.

4. Clinical particulars

4.1 Therapeutic indications

FLAMACOR MR tablet is indicated for the relief of pain and muscle spasm associated with acute, painful musculoskeletal conditions, provides effective relief from headache, toothache, period pains, rheumatic pain, back ache, arthritic pain, sprains, strains, soft tissue injuries, gout, frozen shoulder, tendon pain and muscular pain.

4.2 Posology and method of administration

For oral administration.

Adults:

One tablet 2-3 times a day or as directed by the physician. To be taken whole with liquid, preferably with or after food.

Undesirable effects may be minimised by using the lowest effective dose for the shortest duration necessary to control symptoms

Special populations

Paediatric population: This medicine is not suitable for children.

Elderly: The elderly are at increased risk of the serious consequences of adverse reactions. If an FLAMACOR MR 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.

Renal impairment: Flamacor MR is contraindicated in patients with severe renal impairment. 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.

Hepatic impairment: Flamacor MR is contraindicated in patients with severe hepatic impairment. 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.

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 or perforation (two or more distinct episodes of proven ulceration or bleeding).
- Last trimester of pregnancy
- Severe hepatic, renal or cardiac failure.
- Like other non-steroidal anti-inflammatory drugs (NSAIDs), diclofenac is also contraindicated in patients in whom attacks of asthma, angioedema, urticaria, or acute rhinitis are precipitated by ibuprofen, acetylsalicylic acid or other NSAIDs.
- Established congestive heart failure (NYHA-II-IV), ischemic heart disease, peripheral arterial disease and/or cerebrovascular disease.

4.4 Special warnings and precautions for use Diclofenac :

General

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).

The concomitant use of diclofenac with systemic 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 (see section 4.5).

Caution is indicated in the elderly on basic medical grounds. In particular, it is recommended that the lowest effective dose be used in frail elderly patients or those with a low body weight. As with other NSAIDs, allergic reactions, including anaphylactic/anaphylactoid reactions, can also occur without earlier exposure to the drug.

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

This medicine contains lactose and therefore is not recommended for patients with rare hereditary problems of galactose intolerance, severe lactase deficiency or glucose-galactose malabsorption.

Gastrointestinal effects

Gastrointestinal bleeding (haematemesis, melaena), ulceration or perforation, which can be fatal has 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 (GI) events. They generally have more serious consequences in the elderly. If gastrointestinal bleeding or ulceration occurs in patients receiving diclofenac, the medicinal product should be withdrawn.

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 aspirin, or other medicinal products likely to increase gastrointestinal risk.

Caution is recommended in patients receiving concomitant medications which could increase the risk of ulceration or bleeding, such as systemic corticosteroids, anticoagulants such as warfarin, anti-platelet agents such as aspirin or selective serotonin-reuptake inhibitors.

Close medical surveillance and caution should also be exercised in patients with ulcerative colitis or Crohn's disease, as their condition may be exacerbated.

Hepatic effects

Close medical surveillance is required when prescribing diclofenac 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 diclofenac, regular monitoring of hepatic function is indicated as a precautionary measure. If abnormal liver function tests persist or worsen, clinical signs or symptoms consistent with liver disease develop, or if other manifestations occur (e.g. eosinophilia, rash), diclofenac should be discontinued. Hepatitis may occur with use of diclofenac without prodromal symptoms.

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, 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. 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 and toxic epidermal necrolysis, have been reported very rarely in association with the use of NSAIDs, including diclofenac (see section 4.8). Patients appear to be at highest risk for 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. Diclofenac Potassium tablets should be discontinued at the first appearance of skin rash, mucosal lesions or any other signs of hypersensitivity.

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 and epidemiological data suggest that use of diclofenac, particularly at high dose (150mg 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 uncontrolled hypertension, congestive heart failure, established ischaemic heart disease, peripheral arterial disease, and/or cerebrovascular disease should only be treated with diclofenac after careful consideration. Similar consideration should be made before initiating longer-term treatment of patients with risk factors for cardiovascular disease (e.g. hypertension, hyperlipidaemia, diabetes mellitus and smoking).

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.

Haematological effects

During prolonged treatment with diclofenac, as with other NSAIDs, monitoring of the blood count is recommended.

Like other NSAIDs, diclofenac may temporarily inhibit platelet aggregation. Patients with defects of haemostasis, bleeding diathesis or haematological abnormalities 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.

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.

Paracetamol :

Care is advised in the administration of paracetamol to patients with severe renal or severe hepatic impairment. The hazards of overdose are greater in those with non-cirrhotic alcoholic liver disease.

Patients should be advised that paracetamol may cause severe skin reactions. If a skin reaction such as skin reddening, blisters, or rash occurs, they should stop use and seek medical assistance right away.

Chlorzoxazone

Serious (including fatal) hepatocellular toxicity has been reported rarely in patients receiving chlorzoxazone. The mechanism is unknown but appears to be idiosyncratic and unpredictable. Factors predisposing patients to this rare event are not known. Patients should

be instructed to report early signs and/or symptoms of hepatotoxicity such as fever, rash, anorexia, nausea, vomiting, fatigue, right upper quadrant pain, dark urine, or jaundice.

Chlorzoxazone should be discontinued immediately and a physician consulted if any of these signs or symptoms develop.

Chlorzoxazone use should also be discontinued if a patient develops abnormal liver enzymes (e.g., AST, ALT, alkaline phosphatase and bilirubin).

The concomitant use of alcohol or other central nervous system depressants may have an additive effect.

4.5 Interaction with other medicinal products and other forms of interaction

Concomitant administration of FLAMACOR MR should be avoided with barbiturates, carbamazepine, hydantoins, rifampicin, sulfapyrazone, methotrexate, cyclosporine, lithium and warfarin.

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 Anti-hypertensive 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 via inhibition of vasodilatory prostaglandin synthesis. 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.

Drugs known to cause hyperkalemia: Concomitant treatment with potassium-sparing drugs may be associated with increased serum potassium levels, which should therefore be monitored frequently.

Other NSAIDs including cyclo-oxygenase-2selective inhibitors and corticosteroids: Concomitant administration of diclofenac and other systemic NSAIDs or corticosteroids may increase the risk of gastrointestinal bleeding or ulceration. Avoid concomitant use of two or more NSAIDs.

Anticoagulants and anti-platelet agents: Caution is recommended since concomitant administration could increase the risk of bleeding (see section 4.4). Although clinical investigations do not appear to indicate that diclofenac affects the action of anticoagulants, there are reports of an increased risk of haemorrhage in patients receiving diclofenac and anticoagulants concomitantly. Close monitoring of such patients is therefore recommended. As with other NSAIDs, diclofenac in high dose can reversibly inhibit platelet aggregation.

Selective serotonin reuptake inhibitors (SSRIs): Concomitant administration of systemic NSAIDs, including diclofenac, and SSRIs may increase the risk of gastrointestinal bleeding.

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.

Ciclosporin: Diclofenac, like other NSAIDs, may increase the risk of 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.

Mifepristone: NSAIDs should not be used for 8-12 days after mifepristone administration as NSAIDs can reduce the effect of mifepristone.

Quinolone antimicrobials: There have been isolated reports of convulsions which may have been due to concomitant use of quinolones and NSAIDs. This may occur in patients with or without a previous history of epilepsy or convulsions. Therefore, caution should be exercised when considering the use of a quinolone in patients who are already receiving an NSAID.

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

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.

Potent CYP2C9 inhibitors : “Caution is recommended when co-prescribing diclofenac with potent CYP2C9 inhibitors (such as sulfinpyrazone and voriconazole), which could result in a significant increase in peak plasma concentration and exposure to diclofenac due to inhibition of diclofenac metabolism.

Tacrolimus: Possible increased risk of nephrotoxicity when NSAIDs are given with tacrolimus. This might be mediated through renal antiprostaglandin effects of both NSAID and calcineurin.

Cardiac glycosides: Concomitant use of cardiac glycosides and NSAIDs in patients may exacerbate cardiac failure, reduce GFR and increase plasma glycoside levels.

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.

Metoclopramide and Domperidone: The absorption of paracetamol is increased by metoclopramide and domperidone. However, concurrent use need not be avoided.

Chloramphenicol: Increased plasma concentration of chloramphenicol.

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. During the first and second trimester of pregnancy, diclofenac Potassium tablets 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.

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

- cardiopulmonary toxicity (with premature closure of the ductus arteriosus and pulmonary hypertension);
- renal dysfunction, which may progress to renal failure with oligo-hydroamniosis;

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 Potassium tablets are contraindicated during the third trimester of pregnancy.

Lactation:

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

Fertility

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

4.7 Effects on ability to drive and use machines

Patients experiencing visual disturbances, dizziness, vertigo, somnolence central nervous system disturbances, drowsiness or fatigue while taking diclofenac, should refrain from driving or operate machinery.

4.8 Undesirable effects

Adverse reactions (Table 1) are ranked under heading of frequency, the most frequent first, using the following convention: very common: ($>1/10$); common ($\geq 1/100$, $<1/10$); uncommon ($\geq 1/1,000$, $<1/100$); rare ($\geq 1/10,000$, $<1/1,000$); very rare ($<1/10,000$); Not known: cannot be estimated from the available data.

The following undesirable effects include those reported with either short-term or long-term use.

Table 1

Blood and lymphatic system disorders	
Very rare	Thrombocytopenia, leucopenia, anaemia (including haemolytic and aplastic anaemia), agranulocytosis.
Immune system disorders	
Rare	Hypersensitivity, anaphylactic and anaphylactoid reactions (including hypotension and shock).
Very rare	Angioneurotic oedema (including face oedema).
Psychiatric disorders	
Very rare	Disorientation, depression, insomnia, nightmare, irritability, psychotic disorder.
Nervous system disorders	
Common	Headache, dizziness.
Rare	Somnolence, tiredness.
Very rare	Paraesthesia, memory impairment, convulsion, anxiety, tremor,
Unknown	aseptic meningitis, taste disturbances, cerebrovascular accident. Confusion, hallucinations, disturbances of sensation, malaise.
Eye disorders	
Very rare	Visual disturbance, vision blurred, diplopia.
Unknown	Optic neuritis.
Ear and labyrinth disorders	
Common	Vertigo.
Very rare	Tinnitus, hearing impaired.
Cardiac disorders	
Very rare	Palpitations, chest pain, cardiac failure, myocardial infarction.
Vascular disorders	
Very rare	Hypertension, hypotension, vasculitis.
Respiratory, thoracic and mediastinal disorders	

Rare	Asthma (including dyspnoea).
Very rare	Pneumonitis.
Gastrointestinal disorders	
Common	Nausea, vomiting, diarrhoea, dyspepsia, abdominal pain, flatulence, anorexia.
Rare	Gastritis, gastrointestinal haemorrhage, haematemesis, diarrhoea haemorrhagic, melaena, gastrointestinal ulcer with or without bleeding or perforation (sometimes fatal particularly in the elderly).
Very rare	
Not known	
	Colitis (including haemorrhagic colitis and exacerbation of ulcerative colitis or Crohn's disease), constipation, stomatitis (including ulcerative stomatitis), glossitis, oesophageal disorder, diaphragm-like intestinal strictures, pancreatitis.
	Ischaemic colitis
Hepatobiliary disorders	
Common	Transaminases increased.
Rare	Hepatitis, jaundice, liver disorder.
Very rare	Fulminant hepatitis, hepatic necrosis, hepatic failure.
Skin and subcutaneous tissue disorders	
Common	Rash.
Rare	Urticaria.
Very rare	Bullous eruptions, eczema, erythema, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis (Lyell's syndrome), dermatitis exfoliative, loss of hair, photosensitivity reaction, purpura, allergic purpura, pruritus.
Renal and urinary disorders	
Very rare	Acute renal failure, haematuria, proteinuria, nephrotic syndrome, interstitial nephritis, renal papillary necrosis.
General disorders and administration site conditions	
Rare	Oedema
Reproductive system and breast disorders	
Very rare	Impotence

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 dose (150 mg daily) and in long term treatment

Paracetamol

Adverse effects of paracetamol are rare. Very rare cases of serious skin reactions have been reported. There have been reports of blood dyscrasias including thrombocytopenia purpura, methaemoglobinaemia and agranulocytosis, but these were not necessarily causality related to paracetamol.

Chlorzoxazone

Occasional patients may develop gastrointestinal disturbances. It is possible in rare instances that chlorzoxazone may have been associated with gastrointestinal bleeding. Drowsiness, dizziness, lightheadedness, malaise, or overstimulation may be noted by an occasional patient. Rarely, allergic-type skin rashes, petechiae, or ecchymoses may develop during treatment. Angioneurotic edema or anaphylactic reactions are extremely rare. There is no evidence that the drug will cause renal damage. Rarely, a patient may note discoloration of the urine resulting from a phenolic metabolite of chlorzoxazone. This finding is of no known clinical significance.

Reporting of suspected adverse reactions

Healthcare professionals are requested to report any suspected adverse reactions via pharmacy and poisons board, Pharmacovigilance Electronic Reporting System (PvERS) <https://pv.pharmacyboardkenya.org>

4.9 Overdose Diclofenac Symptoms :

There is no typical clinical picture resulting from diclofenac over dosage. Over dosage can cause symptoms such as headache, nausea, vomiting, epigastric pain, gastrointestinal haemorrhage, diarrhoea, dizziness, disorientation, excitation, coma, drowsiness, tinnitus, fainting 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 haemo-perfusion are probably of no help in eliminating 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.

Paracetamol

Liver damage is possible in adults who have taken 10 g or more of paracetamol. Ingestion of 5g or more of paracetamol may lead to liver damage if the patient has risk factors (see below).

Risk factors:

If the patient

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

Symptoms:

Symptoms of paracetamol over dosage in the first 24 hours are pallor, nausea, vomiting, anorexia and abdominal pain. Liver damage may become apparent 12 to 48 hours after ingestion. Abnormalities of glucose metabolism and metabolic acidosis may occur. In severe poisoning, hepatic failure may progress to encephalopathy, haemorrhage, hypoglycaemia, cerebral oedema, and death. Acute renal failure with acute tubular necrosis, strongly suggested

by loin pain, haematuria and proteinuria, may develop even in the absence of severe liver damage. Cardiac arrhythmias and pancreatitis have been reported.

Management:

Immediate treatment is essential in the management of paracetamol overdose.

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

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

Chlorzoxazone**Symptoms:**

Initially, gastrointestinal disturbances such as nausea, vomiting, or diarrhea together with drowsiness, dizziness, light-headedness or headache may occur. Early in the course there may be malaise or sluggishness followed by marked loss of muscle tone making voluntary movement impossible. The deep tendon reflexes may be decreased or absent. The sensorium remains intact, and there is no peripheral loss of sensation. Respiratory depression may occur with rapid, irregular respiration and intercostal substernal retraction. The blood pressure is lowered, but shock has not been observed.

Treatment:

Gastric lavage or induction of emesis should be carried out, followed by administration of activated charcoal. Thereafter, treatment is entirely supportive. If respirations are depressed, oxygen and artificial respiration should be employed and a patent airway assured by use of an oropharyngeal airway or endotracheal tube. Hypotension may be counteracted by use of dextran, plasma, concentrated albumin or a vasopressor agent such as norepinephrine. Cholinergic drugs or analeptic drugs are of no value and should not be used.

5. Pharmacological properties**5.1 Pharmacodynamic properties Diclofenac**

Diclofenac Potassium is a non-steroidal anti-inflammatory agent which has analgesic and antipyretic properties. It is a prostaglandin synthesis (cyclo-oxygenase) inhibitor.

Paracetamol

Paracetamol is an analgesic and antipyretic.

Chlorzoxazone

Chlorzoxazone is a centrally acting agent for painful musculoskeletal conditions. Data available from animal experiments as well as human study indicate that chlorzoxazone acts primarily at the level of the spinal cord and subcortical areas of the brain where it inhibits multisynaptic reflex arcs involved in producing and maintaining skeletal muscle spasm of varied etiology. The clinical result is a reduction of the skeletal muscle spasm with relief of pain and increased mobility of the involved muscles.

5.2 Pharmacokinetic properties Diclofenac

Following ingestion, diclofenac Potassium is completely absorbed from the intestinal tract but undergoes first pass metabolism and peak plasma concentrations occur in about 2 to 4 hours; at therapeutic concentrations it is more than 99% bound to plasma proteins. Diclofenac is almost entirely metabolised in the liver and the terminal plasma half-life is about 1-2 hours, with metabolic excretion mainly via the kidneys and also in the bile.

Paracetamol

Paracetamol is readily absorbed from the gastrointestinal tract. It is metabolised in the liver and excreted in the urine, mainly as glucuronide and sulphate conjugates.

Chlorzoxazone

Blood levels of chlorzoxazone can be detected in people during the first 30 minutes and peak levels may be reached, in the majority of the subjects, in about 1 to 2 hours after oral administration of chlorzoxazone. Chlorzoxazone is rapidly metabolized and is excreted in the urine, primarily in a conjugated form as the glucuronide. Less than one percent of a dose of chlorzoxazone is excreted unchanged in the urine in 24 hours.

5.3 Preclinical safety data

Not Available

6. Pharmaceutical particulars

6.1 List of excipients

Maize Starch

Lactose

Microcrystalline Cellulose

Maize Starch

Purified Talc

Magnesium Stearate

Crosscarmellose Sodium

Colloidal Silica Dioxide

Kyron-T 314

Isopropyl Alcohol

Methylene Dichloride

Titanium Dioxide

6.2 Incompatibilities

None known.

6.3 Shelf life

36 Months

6.4 Special precautions for storage

This medicinal product does not require any special storage conditions.

6.5 Nature and contents of container

Aluminium – Aluminium Blister Pack

10 Tablets are blister packed with Aluminium – Aluminium foil; such 3 blister is packed in one carton box along with package leaflet.

Pack size: 3 x 10 Tablets in one carton box along with packing leaflet.

6.6 Special precautions for disposal and other handling

No special requirements for disposal.

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. Marketing Authorization Holder and Manufacturing Site Addresses

Marketing Authorization Signature

Healthcare Limited.

The Eco green Business Center (Tilisi)

Off A104 Nairobi -Nakuru Highway Ngecha Chunga Mali Road

P.O. Box 66172-00800, Nairobi.

Manufacturing Site

TNS PHARMA PVT LTD

(A Subsidiary of Trident Lifeline Limited)

Plot No. 4232, Road No. 42, Sachin GIDC, Surat-394230, Gujarat, India.

8. Marketing Authorization Number

CTD13545

9. Date of First Registration

06.05.2026

10. Date of revision of the text

06.05.2026