

SUMMARY PRODUCT CHARACTERISTICS

1. Name of the medicinal product

Tamsu 0.4mg Tablets

2. Qualitative and quantitative composition

Each prolonged release capsule contains

400 micrograms of tamsulosin hydrochloride.

For the full list of excipients, see section 6.1.

3. Pharmaceutical form

Prolonged release capsule

Brown /Orange size “2”capsules imprinted with " R" on cap and “TSN400” on body in black. The capsules contain white to off-white granules.

4. Clinical particulars

4.1 Therapeutic indications

Lower urinary tract symptoms (LUTS) associated with Benign Prostatic Hyperplasia (BPH).

4.2 Posology and method of administration

Posology

Oral use.

One capsule daily, to be taken after breakfast or the first meal of the day.

The capsule must be swallowed whole and should not be crunched or chewed, as this interferes with the modified release of the active ingredient.

Use in renal impairment

No dose adjustment is warranted in renal impairment.

Use in hepatic impairment

No dose adjustment is warranted in patients with mild to moderate hepatic insufficiency (see also 4.3).

Paediatric population

There is no relevant indication for use of this medicine product in children.

The safety and efficacy of tamsulosin in children < 18 years have not been established. Currently available data are described in section 5.1.

4.3 Contraindications

- Hypersensitivity to the active substance, including drug-induced angioedema, or to any of the excipients listed in section 6.1.
- A history of orthostatic hypotension.

- Severe hepatic insufficiency.

4.4 Special warnings and precautions for use

As with other α 1-adrenoceptors antagonists, a reduction in blood pressure can occur in individual cases during treatment with tamsulosin, as a result of which, rarely, syncope can occur. At the first signs of orthostatic hypotension (dizziness, weakness), the patient should sit or lie down until the symptoms have disappeared.

Before therapy with tamsulosin is initiated, the patient should be examined in order to exclude the presence of other conditions, which can cause the same symptoms as benign prostatic hyperplasia. Digital rectal examination and, when necessary, determination of prostate specific antigen (PSA) should be performed before treatment and at regular intervals afterwards.

The treatment of patients with severe renal impairment (creatinine clearance of < 10 ml/min) should be approached with caution, as these patients have not been studied.

The 'Intraoperative Floppy Iris Syndrome' (IFIS, a variant of small pupil syndrome) has been observed during cataract and glaucoma surgery in some patients on or previously treated with tamsulosin hydrochloride. IFIS may increase the risk of eye complications during and after the operation.

Discontinuing tamsulosin hydrochloride 1-2 weeks prior to cataract or glaucoma surgery is anecdotally considered helpful, but the benefit of treatment discontinuation has not yet been established. IFIS has also been reported in patients who had discontinued tamsulosin for a longer period prior to cataract or glaucoma surgery. The initiation of therapy with tamsulosin hydrochloride in patients for whom cataract or glaucoma surgery is scheduled is not recommended.

During pre-operative assessment, surgeons and ophthalmic teams should consider whether patients scheduled for cataract or glaucoma surgery are being or have been treated with tamsulosin in order to ensure that appropriate measures will be in place to manage the IFIS during surgery.

Tamsulosin hydrochloride should not be given in combination with strong inhibitors of CYP3A4 (e.g. ketoconazole) in patients with poor metaboliser CYP2D6 phenotype.

Tamsulosin hydrochloride should be used with caution in combination with strong (e.g. ketoconazole) and moderate (e.g. erythromycin) inhibitors of CYP3A4 (see section 4.5).

Allergic reactions to the presence of colouring agents azorubine (E122), ponceau 4R (E124) and sunset yellow (E110) may occur.

Other ingredients

This medicinal product contains less than 1 mmol (23 mg) of sodium per capsule, which means it is nearly "sodium-free."

4.5 Interaction with other medicinal products and other forms of interaction

Interaction studies have only been performed in adults

No interactions have been seen when tamsulosin hydrochloride was given concomitantly with either atenolol, enalapril or theophylline.

Concomitant cimetidine brings about a rise in plasma levels of tamsulosin, whereas furosemide a fall, but as levels remain within the normal range posology need not be adjusted.

In vitro, neither diazepam nor propranolol, trichlormethiazide, chlormadinon, amitriptyline, diclofenac, glibenclamide, simvastatin and warfarin change the free fraction of tamsulosin in human plasma. Neither does tamsulosin change the free fractions of diazepam, propranolol, trichlormethiazide and chlormadinon.

Diclofenac and warfarin, however, may increase the elimination rate of tamsulosin.

Concomitant administration of tamsulosin hydrochloride with strong inhibitors of CYP3A4 may lead to increased exposure to tamsulosin hydrochloride. Concomitant administration with ketoconazole (a known strong CYP3A4 inhibitor) resulted in an increase in AUC and C_{max} of tamsulosin hydrochloride by a factor of 2.8 and 2.2, respectively.

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Concomitant administration of tamsulosin hydrochloride with paroxetine, a strong inhibitor of CYP2D6, resulted in a C_{max} and AUC of tamsulosin that had increased by a factor of 1.3 and 1.6, respectively, but these increases are not considered clinically relevant.

There is a theoretical risk of enhanced hypotensive effect when given concurrently with drugs which may reduce blood pressure, including anaesthetic agents and other α_1 -adrenoceptor antagonists.

4.6 Fertility, pregnancy and lactation

Tamsulosin is not indicated for use in women.

Ejaculation disorders have been observed in short and long term clinical studies with tamsulosin. Events of ejaculation disorder, retrograde ejaculation and ejaculation failure have been reported in the post authorization phase.

4.7 Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been performed. However, patients should be aware of the fact that blurred vision, dizziness and syncope can occur.

4.8 Undesirable effects

The adverse reactions are described by frequency and system organ class (SOC) in the table below.

System Organ Class	Common > 1/100, < 1/10	Uncommon >1/1.000, < 1/100	Rare > 1/10.000, < 1/1.000	Very rare < 1/10.000	Not known
Nervous system disorders	Dizziness (1.3%)	Headache	Syncope		
Eye disorders					Vision blurred*, visual impairment*
Cardiac disorders		Palpitations			
Vascular disorders		orthostatic hypotension			
Respiratory, thoracic and mediastinal disorders		Rhinitis			Epistaxis*
Gastrointestinal disorders		Constipation, diarrhoea, nausea vomiting			Dry mouth*
Skin and subcutaneous tissue disorders		rash, pruritus and urticaria	angioedema	Stevens-Johnson syndrome	Erythema multiforme*, Dermatitis exfoliative*
Reproductive system and breast disorders	Ejaculation disorders Retrograde ejaculation, Ejaculation failure			priapism	

General disorders and administration site conditions		Asthenia			
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*observed post-marketing

During cataract and glaucoma surgery a small pupil situation, known as Intraoperative Floppy Iris Syndrome (IFIS), has been associated with therapy of tamsulosin during post-marketing surveillance (see also section 4.4).

Post-marketing experience: In addition to the adverse events listed above, atrial fibrillation, arrhythmia, tachycardia and dyspnoea have been reported in association with tamsulosin use. Because these spontaneously reported events are from the worldwide post marketing experience, the frequency of events and the role of tamsulosin in their causation cannot be reliably determined.

Reporting of suspected adverse reactions: Healthcare professionals are asked to report any suspected adverse reactions via pharmacy and poisons board, Pharmacovigilance Electronic Reporting System (PvERS)

<https://pv.pharmacyboardkenya.org>

4.9 Overdose

Symptoms

Overdosage with tamsulosin hydrochloride can potentially result in severe hypotensive effects, dizziness and malaise. Severe hypotensive effects have been observed at different levels of overdosing.

Treatment

In case of acute hypotension occurring after overdosage cardiovascular support should be given.

Blood pressure can be restored and heart rate can be brought back to normal by lying the patient down. If this does not help then volume expanders and, when necessary, vasopressors could be employed.

Renal function should be monitored and general supportive measures applied. Dialysis is unlikely to be of help as tamsulosin is very highly bound to plasma proteins.

Measures, such as emesis, can be taken to impede absorption.

When large quantities are involved, gastric lavage can be applied and activated charcoal and an osmotic laxative, such as sodium sulphate, can be administered.

5. Pharmacological properties

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: **Alpha-adrenoreceptor antagonists.**

ATC code: G04C A02.

Preparations for the exclusive treatment of prostatic disease.

Mechanism of action:

Tamsulosin binds selectively and competitively to postsynaptic α_1 -adrenoceptors, in particular to the subtypes α_{1A} and α_{1D} . It brings about relaxation of prostatic and urethral smooth muscle.

Pharmacodynamic effects:

Tamsulosin increases the maximum urinary flow rate. It relieves obstruction by relaxing the smooth muscle in the prostate and urethra thereby improving voiding symptoms.

It also improves the storage symptoms in which bladder instability plays an important role.

These effects on storage and voiding symptoms are maintained during long-term therapy. The need for surgery or catheterization is significantly delayed.

α_1 -adrenoceptors antagonists can reduce blood pressure by lowering peripheral resistance.

No reduction in blood pressure of any clinical significance was observed during studies with tamsulosin.

Paediatric population

A double-blind, randomized, placebo-controlled, dose ranging study was performed in children with neuropathic bladder. A total of 161 children (with an age of 2 to 16 years) were randomized and treated at 1 of 3 dose levels of tamsulosin (low [0.001 to 0.002 mg/kg], medium [0.002 to 0.004 mg/kg], and high [0.004 to 0.008 mg/kg]), or placebo. The primary endpoint was number of patients who decreased their detrusor leak point pressure (LPP) to <40 cm H₂O based upon two evaluations on the same day. Secondary endpoints were: Actual and percent change from baseline in detrusor leak point pressure, improvement or stabilization of hydronephrosis and hydroureter and change in urine volumes obtained by catheterisation and number of times wet at time of catheterisation as recorded in catheterisation diaries. No statistically significant difference was found between the placebo group and any of the 3 tamsulosin dose groups for either the primary or any secondary endpoints. No dose response was observed for any dose level.

5.2 Pharmacokinetic properties

Absorption

Tamsulosin hydrochloride is absorbed from the intestine and is almost completely bioavailable.

Absorption of tamsulosin hydrochloride is reduced by a recent meal. Uniformity of absorption can be promoted by the patient always taking Tamsulosin Ranbaxy 0.4 mg Prolonged release capsules after the same meal.

Tamsulosin shows linear kinetics.

After a single dose of tamsulosin in the fed state, plasma levels of tamsulosin peak at around 6 hours and, in the steady state, which is reached by day 5 of multiple dosing, C_{max} in patients is about two thirds higher than that reached after a single dose.

Although this was seen in the older patients, the same finding would also be expected in young ones.

There is a considerable inter-patient variation in plasma levels, both after single and multiple dosing.

Distribution

In man, tamsulosin is about 99% bound to plasma proteins. The volume of distribution is small (about 0.2 l/kg).

Biotransformation

Tamsulosin has a low first pass effect, being metabolised slowly. Most tamsulosin is present in plasma in the form of unchanged active substance. It is metabolized in the liver.

In rats, hardly any induction of microsomal liver enzymes was seen to be caused by tamsulosin.

In vitro results suggest that CYP3A4 and also CYP2D6 are involved in metabolism, with possible minor contributions to tamsulosin hydrochloride metabolism by other CYP isozymes. Inhibition of CYP3A4 and CYP2D6 drug metabolizing enzymes may lead to increased exposure to tamsulosin hydrochloride (see section 4.4 and 4.5).

None of the metabolites are more active than the original compound.

No dose adjustment is warranted in patients with mild to moderate hepatic insufficiency (see section 4.3).

Elimination

Tamsulosin and its metabolites are mainly excreted in the urine with about 9% of a dose being present in the form of unchanged active substance.

After a single dose of tamsulosin in the fed state, and in the steady state in patients, elimination half-lives of about 10 and 13 hours, respectively, have been measured.

No dose adjustment is necessary in patients with renal impairment.

5.3 Preclinical safety data

Single and repeat dose toxicity studies were performed in mice, rats and dogs.

In addition, reproduction toxicity in rats, carcinogenicity in mice and rats, and *in vivo* and *in vitro* genotoxicity were examined.

The general toxicity profile, as seen with high doses of tamsulosin, is consistent with the known pharmacological actions of the α_1 -adrenoceptors antagonists.

At very high dose levels, the ECG was altered in dogs. This response is considered to be not clinically relevant. Tamsulosin showed no relevant genotoxic properties.

Increased incidence of proliferative changes of mammary glands of female rats and mice have been reported. These findings, which are probably mediated by hyperprolactinaemia and only occurred at high dose levels, are regarded as irrelevant.

6. Pharmaceutical particulars

6.1 List of excipients

Capsule contents:

Cellulose microcrystalline PH101

Magnesium stearate

Methacrylic acid-ethyl acrylate copolymer (1:1) dispersion

Sodium hydroxide

Triacetin

Titanium dioxide (E171)

Purified talc.

Capsule body:

Gelatine

Sunset yellow

Ponceau 4R (E124)

Quinoline yellow (E104)

Brilliant blue (E133)

Titanium dioxide (E171).

Cap composition:

Gelatine

Yellow iron oxide (E172)

Brilliant blue (E133)

Azorubine (E122)

Titanium dioxide (E171).

Printing ink:

Shellac

Black Iron oxide (E172)

Potassium Hydroxide

6.2 Incompatibilities

Not applicable

6.3 Shelf life

3 years

6.4 Special precautions for storage

This medicinal product does not require any special storage conditions.

6.5 Nature and contents of container

PVC/PVdC/Alu blisters.

Packs of 1, 2, 4, 7, 10, 14, 20, 28, 30, 50, 56, 60, 90, 98, 100 or 200 prolonged release capsules.

Not all packs sizes may be marketed.

6.6 Special precautions for disposal and other handling

No special requirements.

7. Marketing authorisation holder

Sai Pharmaceuticals Limited

Whitefield Edge, at the junction of James Gichuru Road

Ole Nguruone Road in Lavington, Nairobi, Kenya

Landline: +254 20 4454301 / 2

Mobile: +254 721 243 322

Email: info@saipharm.com

Postal Address: P.O. Box 66551, Nairobi, 00800, Kenya

Official Website: saipharm.com

8. Marketing authorisation number(s)

H2022/CTD5481/5729ER

9. Date of first authorisation/renewal of the authorisation

04/11/2010

10. Date of revision of the text

31st August 2026