# SUMMARY OF PRODUCT CHARACTERISTICS

## 1. NAME OF THE MEDICINAL PRODUCT

Areston 50mg film-coated tablets

## 2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 50mg diclofenac potassium.

For the full list of excipients, see section 6.1.

## 3. PHARMACEUTICAL FORM

Film-coated tablet.

Areston tablets are white, round, convex, for oral administration.

## 4. CLINICAL PARTICULARS

### 4.1 Therapeutic indications

- Rheumatoid arthritis.
- Osteoarthrosis.
- Low back pain.
- Migraine attacks.
- Acute musculo-skeletal disorders and trauma such as periarthritis (especially frozen shoulder), tendinitis, tenosynovitis, bursitis, sprains, strains and dislocations; relief of pain in fractures.
- Ankylosing spondylitis.
- Acute gout.
- Control of pain and inflammation in orthopaedic, dental and other minor surgery.
- Pyrophosphate arthropathy and associated disorders.

### 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).

Posology

*Adults*

The recommended daily dose is 100-150 mg in two or three divided doses.

For milder cases, 75-100 mg daily in two or three divided doses is usually sufficient.

In migraine an initial dose of 50 mg should be taken at the first signs of an impending attack. In cases where relief 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 4-6 hours, not exceeding a total dose of 200 mg per day.

*Paediatric population*

*Children*

For children over 14 years of age, the recommended daily dose is 75-100mg in two or three divided doses.

Areston is not recommended for children under 14 years of age. The use of diclofenac potassium in migraine attacks has not been established in children.

*Elderly*

Although the pharmacokinetics of diclofenac potassium are not impaired to any clinically relevant extent in elderly patients, nonsteroidal anti-inflammatory drugs should be used with particular caution in such patients who generally are more prone to adverse reactions. In particular it is recommended that the lowest effective dosage be used in frail elderly patients or those with a low body weight (also see section 4.4) and the patient should be monitored for GI bleeding during NSAID therapy.

*Renal impairment*

No adjustment of the starting dose is required for renally impaired patients (see section 4.4).

*Hepatic impairment*

No adjustment of the starting dose is required for hepatically impaired patients (see section 4.4).

Method of administration

For oral administration.

The tablets should be swallowed whole with liquid, preferably before meals, and must not be chewed or divided.

## 4.3 Contraindications

- Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.
- Active, gastric or intestinal ulcer, bleeding or perforation.
- History of gastrointestinal bleeding or perforation, relating to previous NSAID 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).
- Severe hepatic, renal or cardiac failure (see section 4.4).
- 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 nonsteroidal anti-inflammatory drugs.
- 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

**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 (see section 4.2).

As with other nonsteroidal anti-inflammatory drugs including diclofenac, allergic reactions, including anaphylactic/anaphylactoid reactions, can also occur without earlier exposure to the drug (see section 4.8).

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

**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 GI events. They generally have more serious consequences in the elderly. If gastrointestinal bleeding or ulceration occurs in patients receiving diclofenac, the drug should be withdrawn.

As with all NSAIDs, including diclofenac close medical surveillance is imperative and particular caution should be excised when prescribing diclofenac in patients with symptoms indicative of gastrointestinal disorders, or with a history suggestive of gastric or intestinal ulceration, bleeding or perforation (see section 4.8). The risk of GI bleeding, ulceration or perforation is higher with increasing NSAID doses including diclofenac, in patients with a history of ulcer, particularly if complicated with haemorrhage or perforation.

The elderly have increased frequency of adverse reactions to NSAIDs especially gastro intestinal bleeding and perforation which may be fatal (see section 4.2).
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. misoprostol or proton pump inhibitors) should be considered for these patients, and also for patients requiring concomitant use of medicinal products containing low dose acetylsalicylic acid (ASA/aspirin or medicinal products likely to increase gastrointestinal risk (see section 4.5).
Patients with a history of GI toxicity, particularly when elderly, should report any unusual abdominal symptoms (especially GI bleeding).
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, selective serotonin-reuptake inhibitors (SSRIs) or anti-platelet agents such as acetylsalicylic acid (see section 4.5).
Close medical surveillance and caution should be exercised in patients with ulcerative colitis, or with Crohn's disease as these conditions may be exacerbated (see section 4.8).

**Hepatic effects**

Close medical surveillance is required when prescribing diclofenac to patients with impairment of 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 (eosinophilia, rash), diclofenac should be discontinued.
Hepatitis may occur with diclofenac without prodromal symptoms.
Caution is called for when using diclofenac in patients with hepatic porphyria, since it may trigger an attack.

**Renal effects**

As fluid retention and oedema have been reported in association with NSAIDs 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 those patients with substantial extracellular volume depletion from any cause, e.g. before or after major surgery (see section 4.3). Monitoring of

renal function is recommended as a precautionary measure when using diclofenac in such cases. Discontinuation 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 the 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. Diclofenac should be discontinued at the first appearance of skin rash, mucosal lesions or any other signs of hypersensitivity.

**SLE and mixed connective tissue disease**

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

**Cardiovascular and cerebrovascular effects**

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.

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, including diclofenac.

Clinical trial and epidemiological data consistently point towards increased risk of arterial thrombotic events (for example myocardial infarction or stroke) associated with the use of diclofenac, particularly at high dose (150mg daily) and in long term treatment.

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.

**Haematological effects**

Use of Areston 50mg tablets are recommended only for short term treatment.

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

Diclofenac may reversibly inhibit platelet aggregation (see anticoagulants in section 4.5). 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.

Like other drugs that inhibit prostaglandin synthetase activity, diclofenac sodium and other NSAIDs can precipitate bronchospasm if administered to patients suffering from, or with a previous history of bronchial asthma.

**Female fertility**

The use of diclofenac may impair female fertility and is not recommended in women attempting to conceive. In women who may have difficulties conceiving or who are undergoing investigation of infertility, withdrawal of diclofenac should be considered (see section 4.6).

## 4.5 Interactions with other medicinal products and other forms of interactions

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

**Lithium**: If used concomitantly, diclofenac may increase 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 and 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 periodically thereafter, particularly for diuretics and ACE inhibitors due to the increased risk of nephrotoxicity (see section 4.4).

**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).

**Anticoagulants and anti-platelet agents**: Caution is recommended since concomitant administration could increase the risk of bleeding. Although clinical investigations do not appear to indicate that diclofenac has an influence on the effect of anticoagulants, there are reports of an increased risk of haemorrhage in patients receiving diclofenac and anticoagulant concomitantly (see section 4.4). Therefore, to be certain that no change in anticoagulant dosage is required, close monitoring of such patients is required. As with other nonsteroidal anti-inflammatory agents, diclofenac in a high dose can reversibly inhibit platelet aggregation.

**Other NSAIDs including cyclooxygenase-2 selective inhibitors and corticosteroids**: Co-administration of diclofenac with other systemic NSAIDs or corticosteroids may increase the risk of gastrointestinal bleeding or ulceration. Avoid concomitant use of two or more NSAIDs (see section 4.4).

**Selective serotonin reuptake inhibitors (SSRIs)**: Concomitant administration of SSRI's may increase the risk of gastrointestinal bleeding (see section 4.4).

**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 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 treatment with methotrexate, since blood concentrations of methotrexate may rise and the toxicity of this substance be increase. Cases of serious toxicity have been reported when methotrexate and NSAIDs, including diclofenac are given within 24 hours of each other. This interaction is mediated through accumulation of methotrexate resulting from impairment of renal excretion in the presence of the NSAID.

**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.

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

**Quinolone antibacterials**: Convulsions may occur due to an interaction between 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.

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

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

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

### 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 or 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 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 organogenetic period. If diclofenac is used by a woman attempting to conceive, or during the 1st 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 the 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.

Breast-feeding

Like other NSAIDs, diclofenac passes into breast milk in small amounts. Therefore, diclofenac should not be administered during breast feeding in order to avoid undesirable effects in the infant (see section 5.2).

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 may have difficulties conceiving or who are undergoing investigation of infertility, withdrawal of diclofenac should be considered (see also section 4.4 regarding female fertility).

### 4.7 Effects on ability to drive and use machines

Patients who experience visual disturbances, dizziness, vertigo, somnolence, central nervous system disturbances, drowsiness or fatigue while taking NSAIDs should refrain from driving or operating machinery.

### 4.8 Undesirable effects

Adverse reactions are ranked under the heading of frequency, the most frequent first, using the following convention: very common: (>1/10); common (≥1/100, <1/10); uncommon (≥1/1,000,

<1/100); rare (≥1/10,000, <1/1000); very rare (<1/10,000); not known (cannot be estimated from available data).

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

| | |
|---|---|
| **Blood and lymphatic system disorders** | |
| Very rare | Thrombocytopenia, leucopoenia, 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, aseptic meningitis, taste disturbances, cerebrovascular accident. |
| Not known | Confusion, hallucinations, disturbances of sensation, malaise. |
| **Eye disorders** | |
| Very rare | Visual disturbance, vision blurred, diplopia. |
| Not known | 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 | 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. |
| Not known | 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 (150mg daily) and in long term treatment (see section 4.3 and 4.4).

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 national reporting system:
ADR Reporting Website: www.medicinesauthority.gov.mt/adrportal

### 4.9 Overdose

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 bleeding, diarrhoea, dizziness, disorientation, excitation, coma, drowsiness, tinnitus, fainting, or convulsions. In the case of significant poisoning acute renal failure and liver damage are possible.

Treatment

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 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: Antiinflammatory and antirheumatic products, Nonsteroids; ATC code: M01AB05.

Mechanism of action

Areston contains the potassium salt of diclofenac, a nonsteroidal compound with pronounced and clinically demonstrable analgesic, anti-inflammatory and anti-pyretic properties.

Diclofenac is a potent inhibitor of prostaglandin bio-synthesis and modulator of arachidonic acid release and uptake.

Diclofenac potassium tablets have a rapid onset of action and are therefore suitable for the treatment of acute episodes of pain and inflammation.

In migraine attacks diclofenac has been shown to be effective in relieving the headache and in improving the accompanying symptom of nausea.

Diclofenac in vitro does not suppress proteoglycan biosynthesis in cartilage at concentrations equivalent to the concentrations reached in human beings.

## 5.2 Pharmacokinetic properties

Absorption

Diclofenac is rapidly and completely absorbed from sugar-coated tablets. Food intake does not affect absorption.

Peak plasma concentration after one 50 mg sugar-coated tablet was 3.9 µmol/l after 20-60 minutes. The plasma concentrations show a linear relationship to the size of the dose.

Diclofenac undergoes first-pass metabolism and is extensively metabolised.

Distribution

Diclofenac is highly bound to plasma proteins (99.7%), chiefly albumin (99.4%).

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 (see section 4.6).

Biotransformation

The biotransformation of diclofenac involves partly glucuronidation of the intact molecule but mainly single and multiple hydroxylation followed by glucuronidation.

*Characteristics in patients:*

The age of the patient has no influence on the absorption, metabolism, or excretion of diclofenac.

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 <10 ml/min the theoretical steady-state plasma levels of metabolites are about four times higher than in normal subjects. However, the metabolites are ultimately cleared through the bile.

In the presence of impaired hepatic function (chronic hepatitis, non-decompensated cirrhosis) the kinetics and metabolism are the same as for patients without liver disease.

Elimination

The total systemic clearance of diclofenac in plasma is 263 ± 56 ml/min (mean ± SD).

The terminal half-life in plasma is 1-2 hours.

Repeated oral administration of diclofenac for 8 days in daily doses of 50 mg tid does not lead to accumulation of diclofenac in the plasma.

Approx. 60% of the dose administered is excreted in the urine in the form of metabolites, and less than 1% as unchanged substance. The remainder of the dose is eliminated as metabolites through the bile in the faeces.

### 5.3 Preclinical safety data

Relevant information on the safety of Areston is included in other sections of the Summary of Product Characteristics.

## 6. PHARMACEUTICAL PARTICULARS

### 6.1 List of excipients

**Core**

- Colloidal anhydrous silica,
- starch maize,
- sodium starch glycolate,
- povidone,
- tricalcium phosphate,
- magnesium stearate.

**Film-coating**

- polyethylene glycol 6000,
- talc and
- OPADRY WHITE Y-1-7000 (composed of: hydroxypropyl methyl cellulose, polyethylene glycol 400, titanium dioxide (E171)).

### 6.2 Incompatibilities

None

### 6.3 Shelf life

24 months

### 6.4 Special precautions for storage

Store below 25ºC in the original package, in order to protect from light.

### 6.5 Nature and contents of the container

PVC-Al blisters. Boxes of 20 tablets

### 6.6 Special precautions for disposal and other handling

No special requirements.

## 7. MARKETING AUTHORISATION HOLDER

MEDOCHEMIE LTD, 1-10 Constantinoupoleos street, 3011 Limassol, Cyprus

## 8. MARKETING AUTHORISATION NUMBER

MA032/00801

## 9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 11th April 2007

Renewal of authorisation: 3rd November 2011

## 10. DATE OF REVISION OF THE TEXT

11/2018