APPROVED
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AMMENDED
Order of the Ministry of
Healthcare of Ukraine
22.12.2023 № 2182

INSTRUCTION
for medical use

DICLOTOL®

Composition:
active ingredient: aceclofenac;
1 tablet contains aceclofenac 100 mg;
excipients: microcrystalline cellulose, croscarmellose sodium, silicon dioxide colloidal anhydrous, stearic acid, Opadry-YS-1-7027 White (hydroxypropylmethylcellulose), titanium dioxide (E 171), triacetin).

Pharmaceutical form. Coated tablets.
Basic physical and chemical properties: round biconvex tablets with white colour coating.

Pharmacotherapeutic group.
Nonsteroidal anti-inflammatory and antirheumatic drugs. Acetic acid derivatives and related substances. ATC code M01A B16.

Pharmacological properties.
Pharmacodynamics.
Aceclofenac is a non-steroidal anti-inflammatory agent with anti-inflammatory and analgesic properties. The mode of action of aceclofenac is largely based on the inhibition to prostaglandin synthesis.
Pharmacokinetics.
Absorption.
After oral administration, aceclofenac is rapidly absorbed, its bioavailability is almost 100%. Peak plasma concentrations are reached approximately 1.25 to 3.00 hours following ingestion. Eating slows down absorption, but does not affect its degree.
Distribution.
Aceclofenac is highly bound to plasma proteins (> 99.7%). Aceclofenac penetrates into the synovial fluid, where the concentration reaches about 60% of the plasma concentration. Volume of distribution is approximately 30 litres.
Elimination.
The average half-life is 4-4.3 hours. The clearance is 5 litres per hour. Approximately two-third of the administered dose is excreted in the urine, preferably in the form of conjugated hydroxymetabolites. Only 1% of a single oral dose is excreted unchanged.

Aceclofenac is likely to be metabolized by CYP2C9 to the major metabolite of 4-OH aceclofenac, whose clinical effect is insignificant. Diclofenac and 4-OH-diclofenac were found among many metabolites.
Special patient groups.
No changes in the pharmacokinetics of aceclofenac were found in elderly patients.
Patients with impaired liver function had a slower elimination of aceclofenac after a single dose of the drug. There were no differences in pharmacokinetic parameters between patients with mild and moderate liver cirrhosis and healthy volunteers in studies with repeated dose of 100 mg daily.
In patients with mild or moderate renal insufficiency, clinically significant differences in pharmacokinetics were not observed after single dose administration.

Clinical particulars.
Indications.
Symptomatic treatment of pain syndrome and inflammation in osteoarthritis, rheumatoid arthritis and ankylosing spondylitis, as well as other diseases of the musculoskeletal system, accompanied by pain (e.g., shoulder-palpation periarthritis or extra-articular rheumatism).
As an analgesic with conditions accompanied by pain (including pain in the lumbar, dental pain and primary (functional) dysmenorrhea).

Contraindications.
Aceclofenac is contraindicated:
- to patients with hypersensitivity to aceclofenac or to any excipient of the drug (see the "Composition" section);
- to patients in whom acetylsalicylic acid or other non-steroidal anti-inflammatory drugs (NSAIDs) cause asthma attacks, acute rhinitis, angioedema or urticaria, as well as patients with hypersensitivity to these drugs;
- to patients with a history of gastrointestinal bleeding or perforation of an ulcer associated with previous NSAID therapy;
- to patients with accompanying peptic ulcer or bleeding, including in the anamnesis (two or more separate proven episodes of ulcer or bleeding);
- to patients with acute bleeding or diseases accompanied by bleeding (haemophilia or blood coagulation disorders);
- to patients with congestive heart failure (functional class II–IV according to NYHA), coronary heart disease, diseases of peripheral arteries or with cerebrovascular disorders;
- to patients with cerebrovascular diseases who have suffered a stroke or have episodes of transient ischemic attacks;
- to patients with coronary heart disease who have angina or have suffered a myocardial infarction;
- for the treatment of perioperative pain during coronary artery bypass grafting (or when using an artificial blood circulation device);
- to patients with severe liver or kidney failure;
- during breastfeeding;
- in the last trimester of pregnancy;
- to patients under 18 years of age.

Interaction with other medicinal products and other forms of interaction.
Interaction studies have not been performed, except for interactions with warfarin.
Aceclofenac is metabolized by cytochrome P450 2C9 and *in vitro* data suggest that aceclofenac may be an inhibitor of this enzyme. Thus, the risk of pharmacokinetic interactions is possible when co-administered with phenytoin, cimetidine, tolbutamide, phenylbutazone, amiodarone, miconazole and sulfaphenazole. As with other NSAIDs, there is an increased risk of

pharmacokinetic interactions with other drugs that are excreted by active renal secretion, such as methotrexate and lithium. Aceclofenac is almost completely bound to plasma albumin, so it may interact with other protein-binding drugs.
Due to the lack of pharmacokinetic interaction studies with aceclofenac, the following information is based on data from other NSAIDs.
Concurrent use should be avoided:
Methotrexate. NSAIDs inhibit tubular secretion of methotrexate; in addition, a slight metabolic interaction may occur, which leads to a decrease in methotrexate clearance. Therefore, during the use of high doses of methotrexate always avoid the use of NSAIDs.
Cardiac glycosides, digoxin. NSAIDs can increase heart failure, reduce glomerular filtration rate (GFR), and inhibit renal glycoside clearance, leading to increased plasma levels of glycosides. Concomitant use should be avoided unless frequent monitoring of digoxin concentration is performed.
Lithium and digoxin preparations. Some NSAIDs inhibit the renal clearance of lithium and digoxin that leads to increased serum concentrations of both substances. Concomitant use should be avoided unless frequent monitoring of lithium and digoxin concentrations is performed.
Anticoagulants. NSAIDs inhibit platelet aggregation and damage the mucous membrane of gastrointestinal tract (GI), which can lead to increased anticoagulants and increase the risk of gastrointestinal bleeding in patients receiving anticoagulants. Concomitant use of aceclofenac and oral anticoagulants of coumarin, ticlopidine and thrombolytics and heparin should be avoided unless careful monitoring of the patient is carried out.
Quinolone antibiotics. Animal studies show that NSAIDs increase the risk of convulsions related to the use of quinolone antibiotics. Patients taking NSAIDs and quinolone antibiotics are at increased risk of developing seizures.
Antiplatelet agents and selective serotonin reuptake inhibitors (SSRIs). Concomitant use with NSAIDs increases the risk of gastrointestinal bleeding (see section "Special warnings and precautions for use").
Combinations requiring dose selection and precautionary use:
Methotrexate. Possible interaction of NSAIDs and methotrexate should be considered, even with low dose methotrexate, especially in patients with impaired renal function. With simultaneous use, indicators of kidney function should be monitored. Caution is required, if NSAIDs and methotrexate was taken within 24 hours, as the concentration of methotrexate may increase that will increase the toxicity of this medicinal product.
Cyclosporine, tacrolimus. A simultaneous administration of NSAIDs with cyclosporine or tacrolimus, the risk of increased nephrotoxicity by reducing renal formation of prostacyclin should be taken into consideration. Therefore, during simultaneous administration, the kidney function should be carefully controlled.
Other analgesics, NSAIDs, including selective cyclooxygenase-2 inhibitors. The simultaneous use of two or more NSAIDs (including acetylsalicylic acid) should be avoided as this increases the incidence of adverse events (see section "Special warnings and precautions for use").
Mifepristone. NSAIDs should not be taken for 8–12 days after receiving mifepristone as they may reduce the effect of mifepristone.
Corticosteroids. The risk of ulceration or gastrointestinal bleeding increases (see section "Special warnings and precautions for use").
Diuretics. Aceclofenac, like other NSAIDs, can suppress the activity of diuretics, may reduce the diuretic effect of furosemide and bumetanide and the antihypertensive effect of thiazides. Simultaneous use with potassium-sparing diuretics can lead to increased potassium content; therefore, serum potassium content should be monitored regularly.
Aceclofenac did not affect blood pressure control when used with benzofluazide, although interactions with other diuretics cannot be excluded.
Antihypertensive medicinal products. NSAIDs can also reduce the effect of antihypertensive medicinal products. Simultaneous administration of ACE inhibitors or angiotensin II receptor

antagonists and NSAIDs may impair renal function. The risk of acute renal failure, which is usually reversible, is increased in some patients with impaired renal function, for example, elderly or dehydrated patients. Therefore, caution should be exercised when administering NSAIDs, especially to elderly patients. Patients should consume the required amount of fluid and be supervised (renal function monitoring at the beginning of concomitant use and periodically during treatment).
Hypoglycaemic agents. Clinical studies show that diclofenac can be used together with oral hypoglycaemic agents without affecting their clinical effect. However, there is separate reports on hypoglycaemic and hyperglycaemic effects of the medicinal product. Thus, during administration of aceclofenac doses of medicinal products that may cause hypoglycaemia should be corrected.
Zidovudine. With simultaneous administration of NSAIDs and zidovudine, haematological toxicity risk increases. There is evidence of an increased risk of hemarthrosis and hematoma in HIV (+) patients with haemophilia receiving zidovudine and ibuprofen.

Special warnings and precautions for use.
The simultaneous use of aceclofenac and NSAIDs, including selective cyclooxygenase-2 inhibitors, should be avoided.
Undesirable effects can be minimized by lower use for a short time of effective dose for symptom control (see section "Administration details and dosage" and the risks associated with the gastrointestinal tract and the cardiovascular system see below).
Effects on the gastrointestinal tract (GIT)
Gastrointestinal bleeding, ulceration, or perforation of the gastrointestinal tract with a fatal outcome were observed with all NSAIDs during any treatment period, both with and without dangerous symptoms, regardless of the history of serious gastrointestinal pathology.
The risk of bleeding, ulceration, and gastrointestinal perforation increases with increase of NSAID doses in patients with a history of ulcer, especially if accompanied by hemorrhage or perforation (see section "Contraindications") and elderly patients. These patients should receive the lowest effective dose of the medicinal product. They need combination therapy with use of protective medicinal products (e.g., misoprostol or proton pump inhibitors), similar therapy is required for patients who use low doses of acetylsalicylic acid (aspirin) or other medicinal products that have a negative effect on the gastrointestinal tract (see section "Interaction with other medicinal products and other types of interactions").
Gastrointestinal patients, including elderly patients, should report any unusual symptoms associated with GIT (especially gastrointestinal bleeding), including at the initial stage of treatment. Particular caution should be followed in patients receiving concomitant medicinal products that increase the risk of bleeding or ulcers, such as systemic corticosteroids, anticoagulants (e.g., warfarin), selective inhibitors of serotonin reuptake or antiplatelet agents (such as acetylsalicylic acid) (see section "Interaction with other medicinal products and other types of interaction").
If bleeding or gastrointestinal ulcers occur in patients receiving aceclofenac, treatment should be discontinued.
Cardiovascular and cerebrovascular effects.
Patients with hypertension and/or mild or moderate congestive heart failure require appropriate monitoring and special instructions as reported fluid retention in the body and oedema associated with NSAIDs. Clinical studies and epidemiological data suggest that some NSAIDs (especially when administered high doses and prolonged use) slightly increase the risk of arterial thrombotic events (such as myocardial infarction or stroke).
Patients with congestive heart failure (NYHA functional class I) with factors of risk for the cardiovascular system (e.g., hypertension, hyperlipidemia, diabetes and smoking) should be used with caution when taking aceclofenac. As the adverse effect on the cardiovascular system increases with increasing dose and duration of treatment, the minimum effective daily dose

should be used throughout the shortest period of treatment. The need for further symptomatic treatment of the patient and the effectiveness of therapy should be reviewed periodically.
Aceclofenac should be used with caution and close medical attention in patients with history of cerebrovascular hemorrhage.
Aceclofenac should be used with caution and under close medical supervision in patients with the following conditions (as there is a risk of exacerbation of the disease) (see "Adverse reactions"):
– symptoms indicating the presence of gastrointestinal tract disease, including its upper and lower respiratory tract;
– history of ulceration, bleeding or perforation of the gastrointestinal tract;
– ulcerative colitis;
– Crohn's disease;
– bleeding tendency, systemic lupus erythematosus (SLE), porphyria and disorders of hematopoiesis and hemostasis.
Impact on the liver and kidneys.
Administration of NSAIDs can cause dose-dependent reduction in prostaglandin and sudden renal failure. The importance of prostaglandins in providing renal blood flow should be considered when administering the medicinal product to patients with cardiac, renal, or liver disorders, patients on diuretic, patients after surgery, and elderly patients.
Caution should be followed when administering the medicinal product to patients with liver or kidney disorders of mild or moderate degree, as well as to patients with other conditions that is accompanied by fluid retention in the body. In these patients, use of NSAIDs can lead to impaired renal function and fluid retention. Caution should also be followed when administering aceclofenac to patients receiving diuretics or those at increased risk of hypovolemia. A minimal effective dose and regular medical monitoring of renal function are required. Adverse effects from kidney usually disappear after discontinuation of aceclofenac.
Aceclofenac should be discontinued if abnormalities in liver function persist or worsen, clinical symptoms of liver disease develops, or other manifestations (eosinophilia, rash) occurs. Hepatitis can develop without prodromal symptoms. Use of NSAIDs in patients with hepatic porphyria can trigger an attack.
Systemic lupus erythematosus (SLE) and mixed connective tissue disease.
Patients with systemic lupus erythematosus and mixed connective tissue diseases are at increased risk of development of aseptic meningitis (see section "Adverse reactions").
Hypersensitivity and skin reactions
Like other NSAIDs, aceclofenac can cause allergic reactions, including anaphylactic/anaphylactoid reactions, even if the medicinal product is taken for the first time. Severe skin reactions (some of which can be fatal), including exfoliative dermatitis, Stevens-Johnson syndrome, and toxic epidermal necrolysis, have been reported very rare after receiving NSAIDs (see "Adverse reactions"). The highest risk of these reactions in patients is observed at the beginning of administration of the medicinal product, and the development of these undesirable reactions is observed mainly during the first month of administration of the medicinal product. Aceclofenac should be discontinued if skin rashes, damage to the oral mucosa or other signs of hypersensitivity occurs.
In special cases, chicken pox can cause complications: serious skin and soft tissue infections. The role of NSAIDs in worsening the course of these infections cannot be ruled out at this time. Therefore, administration of aceclofenac with chicken pox should be avoided.
Hematological disorders.
Aceclofenac may cause reversible inhibition of platelet aggregation (see section "Interactions with other medicinal products and other types of interactions").
Respiratory system disorders.
Caution should be followed when administering the medicinal product to patients with bronchial asthma, including in anamnesis, as NSAIDs may provoke the development of sudden bronchospasm in such patients.

Elderly patients.
Caution should be followed when administering the medicinal product to elderly patients (65 years of age and older) as they are more likely to experience side effects (especially bleeding, gastrointestinal perforation) when receiving NSAIDs. Complications can be fatal. Also, elderly patients are more likely to suffer from kidney, liver or cardiovascular disease.
Long-term use.
All patients using non-steroidal anti-inflammatory drugs for a long time should be under careful medical monitoring (general blood test, functional liver and kidney tests).
Excipients.
This medicinal product contains less than 1 mmol (23 mg)/sodium dose, ie substantially free of sodium.

Use during pregnancy or breastfeeding.
Pregnancy.
There is no information on the use of aceclofenac during pregnancy.
Inhibition of prostaglandin synthesis may adversely affect the pregnancy and/or the embryo/fetal development.
Data from epidemiological studies suggest an increased risk of miscarriage, cardiac malformation or gastroschisis after use of 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.
Starting from the 20th week of pregnancy, the use of aceclofenac can cause oligohydramnios due to foetal kidney dysfunction. This disorder may occur soon after starting treatment and is usually reversible after treatment discontinuation. In addition, there are reports of narrowing of the ductus arteriosus after treatment in the second trimester of pregnancy, which in most cases disappeared after treatment was discontinued. Therefore, during the first and second trimesters of pregnancy, Diclotol® should not be prescribed, except in cases of extreme necessity. If aceclofenac is used by a woman trying to conceive or during the first or second trimester of pregnancy, the dose should be as low as possible and the duration of treatment should be as short as possible.
Antepartum monitoring for oligohydramnios and ductus arteriosus after exposure to aceclofenac for several days beginning at 20 weeks' gestation may be appropriate. Diclotol® should be discontinued if oligohydramnios or ductus arteriosus narrowing is detected.
During the third trimester of pregnancy, all prostaglandin synthesis inhibitors:
- can affect the foetus, having cardiopulmonary toxicity (premature narrowing/closure of the ductus arteriosus and pulmonary hypertension);
- may affect the foetus, causing renal dysfunction which may progress to renal failure with oligohydramnios (see above).

In a woman at the end of pregnancy and a newborn, the drug can affect the duration of bleeding due to the anti-aggregation effect, which can develop even after the use of very low doses;
the drug can inhibit uterine contractions, leading to delayed labour or prolonged labour.
Consequently, aceclofenac is contraindicated during the third trimester of pregnancy (see sections "Contraindications" and "Special warnings and precautions for use").
Breastfeeding.
There is no information on the penetration of aceclofenac into breast milk. However, there was no significant penetration of radiolabeled (C14) aceclofenac into the milk of rats.

Like other NSAIDs, aceclofenac penetrates into breast milk in a small amount, so the drug is contraindicated for use by women during breastfeeding in order to avoid undesirable effects on the baby.
Fertility.
Aceclofenac, like other cyclooxygenase/prostaglandin inhibitors, may reduce fertility and is therefore not recommended in women planning a pregnancy. Aceclofenac should be discontinued in women who have difficulty conceiving or are undergoing fertility testing.

Ability to influence the speed of reaction when driving a car or other machinery.
Patients who experience symptoms such as weakness, dizziness, drowsiness, vertigo, or other symptoms of the central nervous system should not drive motor vehicles or use other dangerous mechanisms when receiving NSAIDs.

Administration details and dosage.
Diclotol® coated tablets are intended for oral administration and should be washed at least ½ cup liquids. It is desirable to take Diclotol® with food. Simultaneous consumption with food slows the rate of absorption of the active substance, but does not reduce the degree of absorption from the gastrointestinal tract. Undesirable effects can be minimized if the duration of the drug is the smallest necessary to control the symptoms (see section "Special warnings and precautions for use").
Adults. The maximum recommended dose is 200 mg per day for two doses of 100 mg (1 tablet in the morning and 1 tablet in the evening).
Elderly patients. Such patients should be taken to monitor the condition of, as they are more likely to experience impaired kidney function, liver function, cardiovascular disorders, and they are more likely to receive concomitant therapy with other diseases, which increases the risk of serious adverse reactions. If necessary, the use of NSAIDs should be used in minimal doses and for the shortest possible time. As a rule, no dose reduction is required. Careful observation of patients for the timely detection of gastrointestinal bleeding against the background of NSAID therapy, as well as the recommendations described in the section "Special warnings and precautions for use".
Hepatic insufficiency. Aceclofenac dose should be reduced for patients with mild or moderate hepatic impairment. The recommended starting dose is 100 mg per day (see section "Special warnings and precautions for use").
Renal insufficiency. There is no information that patients with mild renal insufficiency require a dose adjustment of aceclofenac, but these patients should be following caution when using the medicinal product (see section "Special warnings and precautions for use").

Children.
There are no clinical data on the use of aceclofenac, therefore this drug is contraindicated for use in this age group.

Overdose.
There are no data on aceclofenac overdose in humans.
Possible symptoms
Headache, nausea, vomiting, epigastric pain, dizziness, drowsiness, gastrointestinal irritation, gastrointestinal bleeding, diarrhea, disorientation, agitation, coma, tinnitus, hypotension, respiratory depression, loss of consciousness, convulsions. In cases of significant poisoning acute renal failure and liver damage are possible.
Treatment
Treatment of acute NSAID poisoning consists of the use of antacids (if necessary) and other supportive symptomatic therapy for complications such as arterial hypotension, renal failure, cramps, irritation of the gastrointestinal mucosa, and respiratory depression.

Treatment of acute poisoning with aceclofenac ingestion is to prevent absorption of the medicinal product by gastric lavage and the use of activated charcoal (repeated doses) as soon as possible after overdose. Forced diuresis, dialysis, or hemoperfusion may not be effective enough for NSAID's elimination due to high-grade protein binding of NSAIDs and extensive metabolism.
However, it is necessary to ensure good urination.
It is necessary to carefully monitor the function of the kidneys and liver.
The patient should be observed for at least four hours after ingestion of a potentially toxic amount of the drug.
In case of frequent or prolonged convulsions, intravenous diazepam should be used. Other measures may be indicated depending on the clinical condition of the patient.

Adverse reactions.
Gastrointestinal disorders. The most commonly-observed adverse reactions are gastrointestinal in nature. Peptic ulcers, perforation or GI bleeding, sometimes fatal, particularly in the elderly, may occur (see section "Special warnings and precautions for use"). Nausea, vomiting, diarrhoea, flatulence, constipation, dyspepsia, abdominal pain, melaena, haematemesis, ulcerative stomatitis, exacerbation of colitis and Crohn's disease (See section "Special warnings and precautions for use") have been reported following administration of NSAIDs. Less frequently, gastritis has been observed.
Hypersensitivity and skin reactions. The use of NSAIDs may develop non-specific allergic reactions, manifested in the form of anaphylactic reactions, respiratory tract reactivity comprising asthma, aggravated asthma, bronchospasm or dyspnea, various skin reactions, including rashes of various types, itching, urticaria, purpura, angioedema, less often – exfoliative and bullous dermatitis (including epidermal necrolysis and erythema multiforme).
Neurological disorders and disorders of the senses. Optic neuritis, cases of aseptic meningitis (especially in patients with autoimmune disorders such as SLE, mixed connective tissue disease) with symptoms such as numbness (stiffness) of the neck muscles, fever, disorientation, confusion, hallucinations, malaise.
Haematological disorders: agranulocytosis, aplastic anaemia.
Clinical studies and epidemiological data show that some NSAIDs (especially at high doses and with long-term use) increase the risk of arterial thrombotic events (e.g. myocardial infarction or stroke) (see section "Special warnings and precautions for use").
The table below shows adverse reactions reported in clinical trials, as well as with Diclotol®, are grouped by organ system and frequency: very common (≥1/10); common (≥1/100, <1/10); uncommon (≥1/1000, <1/100); rare (≥1/10000, <1/1000); very rare (<1/10000).

MedDRa SOC	Common >1/100, <1/10	Uncommon >1/1000, <1/100	Rare >1/10000, <1/1000	Very rare/ individual cases <1/10000
Blood and lymphatic system disorders			Anaemia	Bone marrow depression, granulocytopenia, thrombocytopenia, neutropenia, haemolytic anaemia
Immune system disorders			Anaphylactic reaction (including shock), hypersensitivity	
Metabolism and nutrition disorders				Hyperkalaemia

Psychiatric disorders				Depression, abnormal dreams, insomnia
Nervous system disorders	Dizziness			Paraesthesia, tremor, somnolence, headache, dysgeusia (abnormal taste)
Eye disorders			Visual disturbance	
Ear and labyrinth disorders				Vertigo, tinnitus
Cardiac disorders			Cardiac failure	Palpitations
Vascular disorders			Hypertension, worsening of hypertension	Flushing, hot flush, vasculitis
Respiratory, thoracic and mediastinal disorders			Dyspnoea	Bronchospasm, stridor
Gastrointestinal disorders	Dyspepsia, abdominal pain, nausea, diarrhoea	Flatulence, gastritis, constipation, vomiting, mouth ulceration	Melaena, gastrointestinal ulcers, hemorrhagic diarrhea, gastrointestinal hemorrhage	Stomatitis, bloody vomiting, intestinal perforations, gastrointestinal bleeding, exacerbation of Crohn's disease and ulcerative colitis, pancreatitis
Hepatobiliary disorders	Hepatic enzyme increased			Hepatic injury (including hepatitis), blood alkaline phosphatase increased, jaundice
Skin and subcutaneous tissue disorders		Itching, rash, dermatitis, urticaria	Angioneurotic oedema	Purpura, eczema, severe skin and mucous membrane reactions (including Stevens-Johnson syndrome and toxic epidermal necrolysis)
Renal and urinary disorders		Increase in concentration of urea in blood, increase in content of creatinine in blood		Nephrotic syndrome, renal failure
General disorders and administration site conditions				Oedema, fatigue, muscle cramps (in the legs)
Investigations				Weight gain

Other undesirable reactions observed with NSAIDs.
Very rare (<1/10000):
Renal and urinary tract disorders: interstitial nephritis.
Skin and subcutaneous tissue disorders: bullous reactions, including Stevens-Johnson syndrome and toxic epidermal necrolysis (very rare), photosensitization.
In particular cases, severe skin and soft tissue infections were observed with NSAIDs during chickenpox disease (see also "Special warnings and precautions for use" and "Interaction with other medicinal products and other types of interactions").
Reported suspected adverse reactions.
The reporting of adverse reactions after the registration of the medicinal product is of great importance. This makes it possible to monitor the benefit/risk ratio when using this medicinal product. Medical and pharmaceutical workers, as well as patients or their legal representatives should be notified of all cases of suspected adverse reactions and lack of efficacy of the medicinal product through the Automated Pharmacovigilance Information System at the link: https://aisf.dec.gov.ua.

Shelf life.
3 years.

Storage conditions.
Store in original packing at temperature below 25 °C.
Keep out of reach of children.

Package.
10 tablets in a blister, 3 or 10 blisters in a carton package.
14 tablets in a blister, 2 blisters in a carton package.

Conditions of supply.
By prescription.

Manufacturer.
KUSUM HEALTHCARE PVT LTD.

Location of manufacturer and its address of business activity.
Plot No. M-3, Indore Special Economic Zone, Phase-II, Pithampur, Distt. Dhar, Madhya Pradesh, Pin 454774, India.

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