

Zomorph 100mg capsules

Summary of Product Characteristics Updated 26-Jan-2024 | Ethypharm UK Ltd

1. Name of the medicinal product

ZOMORPH 10mg, 30mg, 60mg, 100mg, 200mg capsules

2. Qualitative and quantitative composition

- Morphine sulfate BP 10mg
- Morphine sulfate BP 30mg
- Morphine sulfate BP 60mg
- Morphine sulfate BP 100mg
- Morphine sulfate BP 200mg

Excipients with known effect:

Each 10mg capsule contains:

Sucrose (10.62 mg/capsule)

Each 30mg capsule contains:

Sucrose (31.85 mg/capsule)

Each 60mg capsule contains:

Sucrose (63.69 mg/capsule) and a small amount (<1 mg/capsule) of sunset yellow (E110)

Each 100mg capsule contains:

Sucrose (106.16 mg/capsule)

Each 200mg capsule contains:

Sucrose (212.32 mg/capsule)

For the full list of excipients, see section 6.1.

3. Pharmaceutical form

Prolonged release capsule, hard.

4. Clinical particulars

4.1 Therapeutic indications

Severe chronic pain and/or pain resistant to other analgesics, in particular pain associated with cancer.

4.2 Posology and method of administration

Treatment goals and discontinuation

Before initiating treatment with Zomorph capsules, a treatment strategy including treatment duration and treatment goals, and a plan for end of the treatment, should be agreed together with the patient, in accordance with pain management guidelines. During treatment, there should be frequent contact between the physician and the patient to evaluate the need for continued treatment, consider discontinuation and to adjust dosages if needed. When a patient no longer requires therapy with Zomorph capsules, it may be advisable to taper the dose gradually to prevent symptoms of withdrawal. In absence of adequate pain control, the possibility of hyperalgesia, tolerance and progression of underlying disease should be considered (see section 4.4).

Posology

ZOMORPH capsules should be used at 12-hourly intervals. The dosage is dependent upon the severity of the pain, the patient's age and previous history of analgesic requirements.

Adults: Recommended dosage is one capsule twice daily, at 12-hourly intervals. A patient presenting with severe pain, uncontrolled by weaker opioids should normally be started on 30 mg 12 hourly.

Elderly: As with all narcotics, a reduction in dosage may be advisable in the elderly, as appropriate.

Duration of treatment

Zomorph capsules should not be used longer than necessary.

Increasing severity of pain will require an increased dosage of the capsules by prescribing the 10mg, 30mg, 60mg, 100mg and 200mg capsules in various combinations or alone to obtain the desired relief. Higher doses should be made, where possible in 30-50% increments as required. The correct dosage for any individual patient is that which is sufficient to control pain with no, or tolerable, side effects for a full 12 hours. It is recommended that the 200 mg strength is reserved for patients who have already been titrated to a stable analgesic dose using lower strengths of morphine or other opioid preparations.

Patients previously treated with immediate-release oral morphine should receive the same daily dose of sustained-release capsules, but in two divided doses at 12-hourly intervals.

Patients receiving Zomorph capsules in place of parenteral morphine should be given a sufficiently increased dosage to compensate for any reduction of the analgesic effect associated with oral administration. Usually such increased requirement is of the order of 100%. In such patients, individual dose adjustments are required.

Paediatric population:

For children with severe cancer pain, a starting dose in the range of 0.2 to 0.8 mg morphine per kg bodyweight 12 hourly is recommended. Doses should then be titrated as for adults.

Method of administration

Route of administration: oral.

The capsules should not be chewed and should normally be swallowed whole. The administration of broken, chewed or crushed capsules or granules may lead to a rapid release and absorption of a potentially fatal dose of morphine (see section 4.9.).

For patients who cannot swallow the capsules, their contents can be administered directly in semi-solid food (puree, jam, yoghurt) or via gastric or gastrostomy tubes of a diameter of more than 16 F.G. with an open distal end or lateral pores. It is sufficient to rinse the tube with 30ml to 50ml of water.

4.3 Contraindications

Zomorph capsules are contraindicated in patients with:

- Hypersensitivity to the active substance or to any of the excipients listed in section 6.1
- Severe chronic obstructive pulmonary disease
- Severe bronchial asthma
- Severe respiratory depression with hypoxia and/or hypercapnia
- Paralytic ileus
- 'Acute abdomen'
- Delayed gastric emptying
- Acute hepatic disease
- Head injury with raised intracranial pressure
- Concurrent treatment with MAO (MAO = monoamine oxidase) inhibitors or within two weeks of discontinuation of their use
- Children under six years of age.

Not recommended for pre-operative use or for the first 24 hours post-operatively.

4.4 Special warnings and precautions for use

Zomorph capsules should be administered with caution in patients with:

- Impaired respiratory function
- Respiratory depression (see below)
- Severe cor pulmonale
- Sleep apnoea
- CNS depressants co-administration (see below and section 4.5)
- Tolerance, physical dependence and withdrawal (see below)
- Psychological dependence [addiction], abuse profile and history of substance and/or alcohol abuse (see below)

- Acute alcoholism
- Delirium tremens
- Head injury, intracranial lesions or increased intracranial pressure, reduced level of consciousness of uncertain origin
- Hypotension with hypovolemia
- Hypothyroidism
- Adrenocortical insufficiency
- Convulsive disorders
- Biliary tract disorders
- Pancreatitis
- Prostatic hypertrophy
- Inflammatory bowel disorders
- Severely impaired renal function
- Severely impaired hepatic function
- Constipation

As with all narcotics a reduction in dosage may be advisable in the elderly.

Should paralytic ileus be suspected or occur during use, Zomorph capsules should be discontinued immediately.

Morphine may lower the seizure threshold in patients with a history of epilepsy.

Respiratory depression

The major risk of opioid excess is respiratory depression.

Sleep-related breathing disorders

Opioids can cause sleep-related breathing disorders including central sleep apnoea (CSA) and sleep-related hypoxemia. Opioid use increase the risk of CSA in a dose-dependent manner in some patients. Opioids may also cause worsening of pre-existing sleep apnoea (see section 4.8). In patients who present with CSA, consider decreasing the total opioid dosage.

Risk from concomitant use of sedative medicines such as benzodiazepines or related drugs

Concomitant use of Zomorph capsules and sedative medicines such as benzodiazepines or related drugs may result in sedation, respiratory depression, coma and death. Because of these risks, concomitant prescribing with these sedative medicines should be reserved for patients for whom alternative treatment options are not possible.

If a decision is made to prescribe Zomorph capsules concomitantly with sedative medicines, the lowest effective dose should be used, and the duration of treatment should be as short as possible (see also general dose recommendation in section 4.2).

The patients should be followed closely for signs and symptoms of respiratory depression and sedation. In this respect, it is strongly recommended to inform patients and their caregivers to be aware of these symptoms (see section 4.5).

Severe cutaneous adverse reactions (SCARs)

Acute generalized exanthematous pustulosis (AGEP), which can be life-threatening or fatal, has been reported in association with morphine treatment. Most of these reactions occurred within the first 10 days of treatment. Patients should be informed about the signs and symptoms of AGEP and advised to seek medical care if they experience such symptoms.

If signs and symptoms suggestive of these skin reactions appear, morphine should be withdrawn and an alternative treatment considered.

Acute chest syndrome (ACS) in patients with sickle cell disease (SCD)

Due to a possible association between ACS and morphine use in SCD patients treated with morphine during a vaso-occlusive crisis, close monitoring for ACS symptoms is warranted.

Patients about to undergo additional pain relieving procedures (e.g. surgery, plexus blockade) should not receive Zomorph capsules for 24 hours prior to the intervention. If further treatment with Zomorph capsules is then indicated, the dosage should be adjusted to the new post-operative requirement.

Zomorph capsules should be used with caution post-operatively, and following abdominal surgery as morphine impairs intestinal motility and should not be used until the physician is assured of normal bowel function.

Opioid Use Disorder (abuse and dependence)

Tolerance and physical and/or psychological dependence may develop upon repeated administration of opioids such as Zomorph capsules.

Repeated use of Zomorph capsules can lead to Opioid Use Disorder (OUD). **A higher dose and longer duration of opioid treatment**, can increase the risk of developing OUD. Abuse or intentional misuse of Zomorph capsules may result in overdose and/or death. The risk of developing OUD is increased in patients with a personal or a family history (parents or siblings) of substance use disorders (including alcohol use disorder), in current tobacco users or in patients with a personal history of other mental health disorders (eg. major depression, anxiety and personality disorders).

Before initiating treatment with Zomorph capsules and during the treatment, treatment goals and a discontinuation plan should be agreed with the patient (see section 4.2). Before and during treatment the patient should also be informed about the risks and signs of OUD. If these signs occur, patients should be advised to contact their physician.

Patients will require monitoring for signs of drug-seeking behavior (e.g. too early requests for refills). This includes the review of concomitant opioids and psycho-active drugs (like benzodiazepines). For patients with signs and symptoms of OUD, consultation with an addiction specialist should be considered.

Drug withdrawal syndrome

Prior to starting treatment with any opioids, a discussion should be held with patients to put in place a withdrawal strategy for ending treatment with morphine.

Drug withdrawal syndrome may occur upon abrupt cessation of therapy or dose reduction. When a patient no longer requires therapy, it is advisable to taper the dose gradually to minimise symptoms of withdrawal. Tapering from a high dose may take weeks to months.

The opioid drug withdrawal syndrome is characterised by some or all of the following: restlessness, lacrimation, rhinorrhoea, yawning, perspiration, chills, myalgia, mydriasis and palpitations. Other symptoms may also develop including irritability, agitation, anxiety, hyperkinesia, tremor, weakness, insomnia, anorexia, abdominal cramps, nausea, vomiting, diarrhoea, increased blood pressure, increased respiratory rate or heart rate.

If women take this drug during pregnancy, there is a risk that their newborn infants will experience neonatal withdrawal syndrome.

Hyperalgesia

Hyperalgesia may be diagnosed if the patient on long-term opioid therapy presents with increased pain. This might be qualitatively and anatomically distinct from pain related to disease progression or to breakthrough pain resulting from development of opioid tolerance. Pain associated with hyperalgesia tends to be more diffuse than the pre-existing pain and less defined in quality. Symptoms of hyperalgesia may resolve with a reduction of opioid dose or a change in opioid.

Adrenal insufficiency

Opioid analgesics may cause reversible adrenal insufficiency requiring monitoring and glucocorticoid replacement therapy. Symptoms of adrenal insufficiency may include e.g. nausea, vomiting, loss of appetite, fatigue, weakness, dizziness, or low blood pressure.

Hepatobiliary disorders

Morphine may cause dysfunction and spasm of the sphincter of Oddi, thus raising intrabiliary pressure and increasing the risk of biliary tract symptoms and pancreatitis.

Decreased Sex Hormones and increased prolactin

Some changes that can be seen with long-term use of opioid analgesics include an increase in serum prolactin, and decreases in plasma cortisol and testosterone in association with inappropriately low or normal ACTH, LH or FSH levels. Some premenopausal women may have low oestrogen levels. Clinical symptoms include decreased libido, impotence or amenorrhea which may be manifested from these hormonal changes.

Plasma concentrations of morphine may be reduced by rifampicin. The analgesic effect of morphine should be monitored and doses of morphine adjusted during and after treatment with rifampicin (see section 4.5).

Oral P2Y₁₂ inhibitor antiplatelet therapy

Within the first day of concomitant P2Y₁₂ inhibitor and morphine treatment, reduced efficacy of P2Y₁₂ inhibitor treatment has been observed (see section 4.5).

The prolonged release capsules should not be chewed and should normally be swallowed whole. The administration of broken, chewed or crushed capsules or granules may lead to a rapid release and absorption of a potentially fatal dose of morphine (see section 4.9.).

Abuse of oral dosage forms by parenteral administration can be expected to result in serious adverse events, which may be fatal.

Concomitant use of alcohol and Zomorph capsules may increase the undesirable effects of Zomorph capsules; concomitant use should be avoided.

It is not possible to ensure bio-equivalence between different brands of prolonged release morphine products. Therefore, it should be emphasised that patients, once titrated to an effective dose, should not be changed from Zomorph capsules to other slow, sustained or prolonged release morphine or other potent narcotic analgesic preparations without retitration and clinical assessment.

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

[60 mg strength only] This medicinal product contains sunset yellow (E110) which may cause allergic reactions.

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

4.5 Interaction with other medicinal products and other forms of interaction

Morphine should be used with caution in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics (including benzodiazepines), general anaesthetics (including barbiturates), antipsychotics (including phenothiazines), **antidepressants**, other tranquilisers, muscle relaxants, antihypertensives, antiepileptics (**including gabapentin or pregabalin**), centrally acting anti-emetics and alcohol. Interactive effects resulting in respiratory depression, hypotension, profound sedation, or coma may result if these drugs are taken in combination with the usual doses of morphine.

Morphine sulfate should not be co-administered with monoamine oxidase inhibitors or within two weeks of such therapy (see section 4.3).

Alcohol may enhance the pharmacodynamic effects of Zomorph capsules; concomitant use should be avoided.

Medicinal products that block the action of acetylcholine, for example antihistamines, anti-parkinsons and antiemetics, may interact with morphine sulfate to potentiate anticholinergic adverse events.

Cimetidine inhibits the metabolism of morphine sulfate.

Plasma concentrations of morphine sulfate may be reduced by rifampicin (see section 4.4).

A delayed and decreased exposure to oral P2Y12 inhibitor antiplatelet therapy has been observed in patients with acute coronary syndrome treated with morphine. This interaction may be related to reduced gastrointestinal motility and apply to other opioids. The clinical relevance is unknown, but data indicate the potential for reduced P2Y12 inhibitor efficacy in patients co-administered morphine and a P2Y12 inhibitor (see section 4.4). In patients with acute coronary syndrome, in whom morphine cannot be withheld and fast P2Y12 inhibition is deemed crucial, the use of a parenteral P2Y12 inhibitor may be considered.

Although there are no pharmacokinetic data available for concomitant use of ritonavir with morphine sulfate, ritonavir induces the hepatic enzymes responsible for the glucuronidation of morphine sulfate, and may possibly decrease plasma concentrations of morphine sulfate.

4.6 Fertility, pregnancy and lactation

Pregnancy

Since this product rapidly crosses the placental barrier, its use is not recommended during pregnancy and labour. Regular use during pregnancy may cause drug dependence in the foetus, leading to withdrawal symptoms in the neonate.

If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available.

Administration during labour may depress respiration in the neonate and an antidote for the child should be readily available.

Newborns whose mothers received opioid analgesics during pregnancy should be monitored for signs of neonatal withdrawal (abstinence) syndrome in the newborn infant characterised by: convulsions, irritability, vomiting, increased mortality. Treatment may include an opioid and supportive care. As with all drugs, it is not advisable to administer morphine during pregnancy.

Breast feeding

Administration to nursing mothers is not recommended as morphine may be secreted in breast milk and may cause respiratory depression in the infant.

Fertility

Animal studies have shown that morphine may reduce fertility (see section 5.3.).

4.7 Effects on ability to drive and use machines

Morphine may modify the patient's reactions to a varying extent depending on the dosage and susceptibility. If affected, patients should not drive or operate machinery.

This medicine can impair cognitive function and can affect a patient's ability to drive safely. This class of medicine is in the list of drugs included in regulations under 5a of the Road Traffic Act 1988.

When prescribing this medicine, patients should be told:

- The medicine is likely to affect your ability to drive.
- Do not drive until you know how the medicine affects you.
- It is an offence to drive while you have this medicine in your body over a specified limit unless you have a defence (called the 'statutory defence').
- This defence applies when:
 - The medicine has been prescribed to treat a medical or dental problem; and
 - You have taken it according to the instructions given by the prescriber and in the information provided with the medicine.
- Please note that it is still an offence to drive if you are unfit because of the medicine (i.e. your ability to drive is being affected)."

Details regarding a new driving offence concerning driving after drugs have been taken in the UK may be found here: <https://www.gov.uk/drug-driving-law>.

4.8 Undesirable effects

The most common side effects at usual doses are nausea, vomiting, constipation, and drowsiness. With chronic therapy, nausea and vomiting are unusual with Zomorph capsules but should they occur the capsules can be readily combined with an anti-emetic if required. Constipation may be treated with appropriate laxatives.

The following frequencies are the basis for assessing undesirable effects:

Very common ($\geq 1/10$)

Common ($\geq 1/100$ to $< 1/10$),

Uncommon ($\geq 1/1,000$ to $< 1/100$)

Rare ($\geq 1/10,000$ to $< 1/1,000$)

Very rare ($< 1/10,000$)

Not known (cannot be estimated from available data).

System organ class	Very common ($\geq 1/10$)	Common ($\geq 1/100$ to $< 1/10$)	Uncommon ($\geq 1/1000$ to $< 1/100$)	Not known
<i>Immune system disorders</i>			Hypersensitivity	Anaphylactic reaction
<i>Psychiatric disorders</i>		Confusion Insomnia	Mood altered Agitation Euphoria Hallucinations	Drug dependence (see section 4.4) Dysphoria Thinking disturbances
<i>Nervous system disorders</i>		Somnolence Headache Hyperhidrosis Dizziness Involuntary muscle contractions	Convulsions Hypertonia Myoclonus Paraesthesia Syncope	Allodynia, Hyperalgesia (see section 4.4)

<i>Eyes disorders</i>			Visual impairment	Miosis
<i>Ear and labyrinth disorders</i>			Vertigo	
<i>Cardiac disorders</i>			Palpitations	Bradycardia Tachycardia
<i>Vascular disorders</i>			Facial flushing Hypotension	Hypertension
<i>Respiratory, thoracic and mediastinal disorders</i>			Respiratory depression Bronchospasm Pulmonary oedema	Cough decreased Central sleep apnoea syndrome
<i>Gastrointestinal disorders</i>	Nausea Constipation	Vomiting Dry mouth Abdominal pain	Dyspepsia Ileus Taste perversion	Pancreatitis
<i>Metabolism and nutrition disorders</i>		Anorexia		
<i>Hepatobiliary disorders</i>				Biliary pain Exacerbation of pancreatitis Spasm of sphincter of Oddi
<i>Skin and subcutaneous tissue disorders</i>		Pruritus Rash	Urticaria	Acute generalised exanthematous pustulosis (AGEP)
<i>Renal and urinary disorders</i>			Urinary retention	Ureteric spasm
<i>Reproductive system and breast disorders</i>				Amenorrhoea Decreased libido Erectile dysfunction
<i>General disorders and administration site conditions</i>		Asthenia Fatigue Malaise	Peripheral oedema Drug withdrawal syndrome	Drug tolerance Drug withdrawal (abstinence) syndrome neonatal
<i>Investigations</i>			Increased hepatic enzymes	

Drug dependence

Use of opioid analgesics may be associated with the development of physical and/or psychological dependence or tolerance, which may appear after administration of therapeutic doses for periods of 1 to 2 weeks. Some cases of dependence have been observed after only 2 to 3 days. The risk of drug dependence may vary depending on a patient's individual risk factors, dosage, and duration of opioid treatment (see section 4.4).

Withdrawal (abstinence) syndrome

An abstinence syndrome may be precipitated when opioid administration is suddenly discontinued or opioid antagonists administered, or can sometimes be experienced between doses. It may occur a few hours after withdrawal and is maximal between the 36th and 72nd hours. For management, see section 4.4.

Physiological withdrawal symptoms include: Body aches, tremors, restless legs syndrome, diarrhoea, abdominal colic, nausea, flu-like symptoms, tachycardia and mydriasis. Psychological symptoms include dysphoric mood, anxiety and

irritability. In drug dependence, “drug craving” is often involved.

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 Yellow Card Scheme at: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

4.9 Overdose

Signs of morphine toxicity and overdose are extreme miosis (pin-point pupils), skeletal muscle flaccidity, bradycardia, hypotension, hypothermia, respiratory depression, pneumonia aspiration, somnolence and central nervous system depression which can progress to stupor or coma. Death may occur from respiratory failure.

Circulatory failure and deepening coma may occur in more severe cases.

Overdose can result in death. Rhabdomyolysis progressing to renal failure has been reported in opioid overdose.

Crushing and taking the contents of a prolonged release dosage form may lead to the release of morphine in an immediate fashion; this might result in a fatal overdose.

Patients should be informed of the signs and symptoms of overdose and to ensure that family and friends are also aware of these signs and to seek immediate medical help if they occur.

Treatment of morphine overdose

Primary attention should be given to the establishment of a patent airway and institution of assisted or controlled ventilation.

Oral activated charcoal (50g for adults, 1 g/kg for children) may be considered if a substantial amount has been ingested within one hour, provided the airway can be protected.

The pure opioid antagonists are specific antidotes against the effects of opioid overdose. Other supportive measures should be employed as needed.

In the case of massive overdose, administer naloxone 0.4mg – 2mg intravenously. Repeat at 2-3 minute intervals as necessary, or by an infusion of 2 mg in 500 ml of normal saline or 5% dextrose (0.004 mg/ml).

The infusion should be run at a rate related to the previous bolus doses administered and should be in accordance with the patient's response. However, because the duration of action of naloxone is relatively short, the patient must be carefully monitored until spontaneous respiration is reliably re-established. Zomorph capsules will continue to release and add to the morphine load for up to 12 hours after administration and the management of morphine overdose should be modified accordingly.

For less severe overdose, administer naloxone 0.2 mg intravenously followed by increments of 0.1 mg every 2 minutes if required.

Naloxone should not be administered in the absence of clinically significant respiratory or circulatory depression secondary to morphine overdose.

Naloxone should be administered cautiously to persons who are known, or suspected, to be physically dependent on morphine. In such cases, an abrupt or complete reversal of opioid effects may precipitate an acute withdrawal syndrome.

5. Pharmacological properties

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: natural opium alkaloid

ATC code: N02AA01

Morphine acts as an agonist at opiate receptors in the CNS particularly Mu and to a lesser extent Kappa receptors. Mu receptors are thought to mediate supraspinal analgesia, respiratory depression and euphoria, and Kappa receptors, spinal analgesia, miosis and sedation.

Central Nervous System

The principal actions of therapeutic value of morphine are analgesia and sedation (i.e., sleepiness and anxiolysis). Morphine produces respiratory depression by direct action on brain stem respiratory centres.

Morphine depresses the cough reflex by direct effect on the cough centre in the medulla. Antitussive effects may occur with doses lower than those usually required for analgesia. Morphine causes miosis, even in total darkness. Pinpoint pupils are a sign of narcotic overdose but are not pathognomonic (e.g., pontine lesions of haemorrhagic or ischaemic origin may produce similar findings). Marked mydriasis rather than miosis may be seen with hypoxia in the setting of morphine overdose.

Gastrointestinal Tract and Other Smooth Muscle

Morphine causes a reduction in motility associated with an increase in smooth muscle tone in the antrum of the stomach and duodenum. Digestion of food in the small intestine is delayed and propulsive contractions are decreased. Propulsive peristaltic waves in the colon are decreased, while tone is increased to the point of spasm resulting in constipation. Morphine generally increases smooth muscle tone, especially the sphincters of the gastrointestinal and biliary tracts. Morphine may produce spasm of the sphincter of Oddi, thus raising intrabiliary pressure.

Cardiovascular System

Morphine may produce release of histamine with or without associated peripheral vasodilation. Manifestations of histamine release and/or peripheral vasodilation may include pruritus, flushing, red eyes, sweating, and/or orthostatic hypotension.

Endocrine System

Opioids may affect the hypothalamic pituitary adrenal and hypothalamic pituitary gonadal system resulting in adrenal insufficiency or hypogonadism respectively (see

section 4.4).

Other Pharmacological Effects

In vitro and animal studies indicate various effects of natural opioids, such as morphine, on components of the immune system; the clinical significance of these findings is unknown.

5.2 Pharmacokinetic properties

Absorption

This is a sustained-release form, which makes twice-daily oral administration possible. Morphine is immediately absorbed from the digestive tract following oral administration. The maximum serum concentrations of morphine are obtained in 2 to 4 hours.

Distribution

The percentage of binding to plasma proteins after absorption is low (about 34%). There is no clearly defined correlation between the plasma concentration of morphine and the analgesic effect.

Metabolism

A considerable quantity of morphine is metabolised by the liver to glucuronides, which undergo enterohepatic recirculation.

Indeed, Morphine is subject to a significant first-pass effect which results in a lower bioavailability when compared to an equivalent intravenous dose.

The major metabolic transformation of morphine is glucuronidation to morphine 3- glucuronide and morphine-6-glucuronide which then undergo renal excretion. These metabolites are excreted in bile and may be subject to hydrolysis and subsequent reabsorption

Excretion

The product is eliminated essentially in the urine, by glomerular filtration, mainly as glucuronides. A small amount (less than 10%) is eliminated in the faeces.

5.3 Preclinical safety data

In male rats, reduced fertility and chromosomal damage in gametes have been reported.

6. Pharmaceutical particulars

6.1 List of excipients

Sugar spheres containing (sucrose and maize starch), polyethylene glycol 4000, ethyl-cellulose, cetyl alcohol, sodium lauryl sulphate, dibutyl sebacate, talc, gelatin, iron oxide ink (E172), titanium dioxide (E171) (for the 10mg, 30mg, 60mg and 100mg strengths), quinoline yellow (E104) (only for the 10mg strength), erythrosine (E127) (only for the 30mg strength), sunset yellow (E 110) (only for the 60mg strength).

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

36 months.

6.4 Special precautions for storage

Store below 25° C in a dry place protected from heat.

6.5 Nature and contents of container

Blister packs (aluminium/PVC).

Boxes of 14, 30 and 60 capsules.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

Not applicable.

7. Marketing authorisation holder

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France

8. Marketing authorisation number(s)

10mg: PL 06934/0182

30mg: PL 06934/0183

60mg: PL 06934/0184

100mg: PL 06934/0185

200mg: PL 06934/0186

9. Date of first authorisation/renewal of the authorisation

16 July 2010 (10mg, 30mg)

17 July 2010 (60mg, 100mg & 200mg)

10. Date of revision of the text

15th December 2023

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