EFCORLIN® SOLUBLE

Hydrocortisone Sodium Succinate injection IP 100 mg

QUALITATIVE AND QUANTITATIVE COMPOSITION

Each vial contains:
Hydrocortisone Sodium Succinate 134 mg (equivalent to 100 mg Hydrocortisone).

PHARMACEUTICAL FORM

Lyophilised Injection.

CLINICAL PARTICULARS

Therapeutic Indications

Anti-inflammatory agent.

EFCORLIN SOLUBLE is indicated for any condition in which rapid and intense corticosteroid effect is required such as:

1. Endocrine disorders - Primary or secondary adrenocortical insufficiency.
2. Collagen diseases - Systemic lupus erythematosus.
3. Dermatological diseases - Severe erythema multiforme (Stevens-Johnson syndrome).
4. Allergic states - Bronchial asthma, anaphylactic reactions.
7. Medical emergencies - EFCORLIN SOLUBLE is indicated in the treatment of shock secondary to adrenocortical insufficiency or shock unresponsive to conventional therapy when adrenocortical insufficiency may be present.
Posology and Method of Administration

_EFCORLIN SOLUBLE_ may be administered by intravenous injection, by intravenous infusion, or by intramuscular injection, the preferred method for initial emergency use being intravenous injection. Following the initial emergency period, consideration should be given to employing a longer-acting injectable preparation or an oral preparation.

Dosage usually ranges from 100 mg to 500 mg depending on the severity of the condition, administered by intravenous injection over a period of one to ten minutes. This dose may be repeated at intervals of 2, 4 or 6 hours as indicated by the patient's response and clinical condition.

In general high-dose corticosteroid therapy should be continued only until the patient's condition has stabilised - usually not beyond 48 to 72 hours. If hydrocortisone therapy must be continued beyond 48 to 72 hours hypernatraemia may occur, therefore it may be preferable to replace _EFCORLIN SOLUBLE_ with a corticosteroid such as methylprednisolone sodium succinate as little or no sodium retention occurs. Although adverse effects associated with high dose, short-term corticoid therapy are uncommon, peptic ulceration may occur. Prophylactic antacid therapy may be indicated.

Patients subjected to severe stress following corticoid therapy should be observed closely for signs and symptoms of adrenocortical insufficiency.

Corticosteroid therapy is an adjunct to, and not a replacement for, conventional therapy.

In patients with liver disease, there may be an increased effect (see Special Warnings and Special Precautions for Use) and reduced dosing may be considered.

_Elderly patients_

_EFCORLIN SOLUBLE_ is primarily used in acute short-term conditions. There is no information to suggest that a change in dosage is warranted in the elderly. However, treatment of elderly patients should be planned bearing in mind the more serious consequences of the common side-effects of corticosteroids in old age and close clinical supervision is required (see Special Warnings and Special Precautions for Use).

_Paediatric population_

While the dose may be reduced for infants and children, it is governed more by the severity of the condition and response of the patient than by age or body weight but should not be less than 25 mg daily (see Special Warnings and Special Precautions for Use).
**Preparation of solutions**

For intravenous or intramuscular injection prepare the solution aseptically by adding not more than 2 ml of sterile water for intravenous or intramuscular injections. The prepared solution should be used only if it is clear. The solution should be used immediately after preparation.

For intravenous infusion, first prepare the solution by adding not more than 2 ml of Sterile Water for Injections to the vial; this solution may then be added to 100 ml - 1000 ml (but not less than 100 ml) of 5% dextrose in water (or isotonic saline solution or 5% dextrose in isotonic saline solution if patient is not on sodium restriction).

When reconstituted as directed the pH of the solution will range from 7.0 to 8.0.

**Contraindications**

**EFCORLIN SOLUBLE** is contraindicated where there is known hypersensitivity to the active substance or any of the excipients in section *List of Excipients* and in systemic fungal infection unless specific anti-infective therapy is employed.

Administration of live or live attenuated vaccines is contraindicated in patients receiving immunosuppressive doses of corticosteroids.

**Special Warnings and Special Precautions for Use**

**Warnings and precautions**

1. Undesirable effects may be minimised by using the lowest effective dose for the minimum period. Frequent patient review is required to appropriately titrate the dose against disease activity (see *Posology and Method of Administration*).

2. Adrenal cortical atrophy develops during prolonged therapy and may persist for months after stopping treatment. In patients who have received more than physiological doses of systemic corticosteroids (approximately 30 mg hydrocortisone) for greater than 3 weeks, withdrawal should not be abrupt. How dose reduction should be carried out depends largely on whether the disease is likely to relapse as the dose of systemic corticosteroids is reduced. Clinical assessment of disease activity may be needed during withdrawal. If the disease is unlikely to relapse on withdrawal of systemic corticosteroids, but there is uncertainty about Hypothalamic–pituitary–adrenal (HPA) axis suppression, the dose of systemic corticosteroid may be reduced rapidly to physiological doses. Once a daily dose of 30
mg hydrocortisone is reached, dose reduction should be slower to allow the HPA-axis to recover.

Abrupt withdrawal of systemic corticosteroid treatment, which has continued up to 3 weeks is appropriate if it considered that the disease is unlikely to relapse. Abrupt withdrawal of doses up to 160 mg hydrocortisone for 3 weeks is unlikely to lead to clinically relevant HPA-axis suppression, in the majority of patients. In the following patient groups, gradual withdrawal of systemic corticosteroid therapy should be considered even after courses lasting 3 weeks or less:

- Patients who have had repeated courses of systemic corticosteroids, particularly if taken for greater than 3 weeks.
- When a short course has been prescribed within one year of cessation of long-term therapy (months or years).
- Patients who may have reasons for adrenocortical insufficiency other than exogenous corticosteroid therapy.
- Patients receiving doses of systemic corticosteroid greater than 160 mg hydrocortisone.
- Patients repeatedly taking doses in the evening.

3. Patients should carry 'Steroid Treatment' cards which give clear guidance on the precautions to be taken to minimise risk and which provide details of prescriber, drug, dosage and the duration of treatment.

4. Corticosteroids may mask some signs of infection, and new infections may appear during their use. Suppression of the inflammatory response and immune function increases the susceptibility to fungal, viral and bacterial infections and their severity. The clinical presentation may often be atypical and may reach an advanced stage before being recognised.

5. Chickenpox is of serious concern since this normally minor illness may be fatal in immunosuppressed patients. Patients (or parents of children) without a definite history of chickenpox should be advised to avoid close personal contact with chickenpox or herpes zoster and if exposed they should seek urgent medical attention. Passive immunization with varicella/zoster immunoglobulin (VZIG) is needed by exposed non-immune patients who are receiving systemic corticosteroids or who have used them within the previous 3 months; this should be given within 10 days of exposure to chickenpox. If a diagnosis of chickenpox is confirmed, the illness warrants specialist care and urgent treatment. Corticosteroids should not be stopped and the dose may need to be increased.
6. Exposure to measles should be avoided. Medical advice should be sought immediately if exposure occurs. Prophylaxis with normal intramuscular immunoglobulin may be needed.

7. Live vaccines should not be given to individuals with impaired immune responsiveness. The antibody response to other vaccines may be diminished.

8. The use of *EFCORLIN SOLUBLE* in active tuberculosis should be restricted to those cases of fulminating or disseminated tuberculosis in which the corticosteroid is used for the management of the disease in conjunction with appropriate antituberculosis regimen. If corticosteroids are indicated in patients with latent tuberculosis or tuberculin reactivity, close observation is necessary as reactivation of the disease may occur. During prolonged corticosteroid therapy, these patients should receive chemoprophylaxis.

9. Rarely anaphylactoid reactions have been reported following parenteral hydrocortisone therapy. Physicians using the drug should be prepared to deal with such a possibility. Appropriate precautionary measures should be taken prior to administration, especially when the patient has a history of drug allergy.

10. Care should be taken for patients receiving cardioactive drugs such as digoxin because of steroid induced electrolyte disturbance/potassium loss (see Undesirable Effects).

11. Hydrocortisone may have an increased effect in patients with liver diseases since the metabolism and elimination of hydrocortisone is significantly decreased in these patients.

12. Corticosteroid therapy has been associated with central serous chorioretinopathy, which may lead to retinal detachment.

13. There have been reports of epidural lipomatosis in patients taking corticosteroids, typically with long-term use at high doses.

14. Thrombosis including venous thromboembolism has been reported to occur with corticosteroids. As a result corticosteroids should be used with caution in patients who have or may be predisposed to thromboembolic disorders.

*Special precautions*

Particular care is required when considering the use of systemic corticosteroids in patients with the following conditions and frequent patient monitoring is necessary.
1. Osteoporosis (post-menopausal females are particularly at risk).

2. Hypertension or congestive heart failure.

3. Existing or previous history of severe affective disorders (especially previous steroid psychosis).

4. Diabetes mellitus (or a family history of diabetes).

5. History of tuberculosis.

6. Glaucoma (or a family history of glaucoma).

7. Previous corticosteroid-induced myopathy.

8. Liver failure or cirrhosis.

9. Renal insufficiency.

10. Epilepsy.

11. Peptic ulceration.

12. Fresh intestinal anastomoses.

13. Predisposition to thrombophlebitis.

14. Abscess or other pyogenic infections.

15. Ulcerative colitis.


17. Myasthenia gravis.

18. Ocular herpes simplex, for fear of corneal perforation.

19. Hypothyroidism.

20. Recent myocardial infarction (myocardial rupture has been reported).

21. Kaposi's sarcoma has been reported to occur in patients receiving corticosteroid therapy. Discontinuation of corticosteroids may result in clinical remission.
22. Pheochromocytoma crisis, which can be fatal, has been reported after administration of systemic corticosteroids. Corticosteroids should only be administered to patients with suspected or identified pheochromocytoma after an appropriate risk/benefit evaluation.

23. Hydrocortisone can cause elevation of blood pressure, salt and water retention and increased excretion of potassium. Dietary salt restriction and potassium supplementation may be necessary. All corticosteroids increase calcium excretion.

24. Patients and/or carers should be warned that potentially severe psychiatric adverse reactions may occur with systemic steroids (see Undesirable Effects). Symptoms typically emerge within a few days or weeks of starting treatment. Risks may be higher with high doses/systemic exposure (see Interaction with Other Medicaments and Other Forms of Interaction), although dose levels do not allow prediction of the onset, type, severity or duration of reactions. Most reactions recover after either dose reduction or withdrawal, although specific treatment may be necessary. Patients/carers should be encouraged to seek medical advice if worrying psychological symptoms develop, especially if depressed mood or suicidal ideation is suspected. Patients/carers should be alert to possible psychiatric disturbances that may occur either during or immediately after dose tapering/withdrawal of systemic steroids, although such reactions have been reported infrequently.

Particular care is required when considering the use of systemic corticosteroids in patients with existing or previous history of severe affective disorders in themselves or in their first degree relatives. These would include depressive or manic-depressive illness and previous steroid psychosis.

Paediatric population

Corticosteroids cause growth retardation in infancy, childhood and adolescence, which may be irreversible. Treatment should be limited to the minimum dosage for the shortest possible time. The use of steroids should be restricted to the most serious indications.

Use in the elderly

The common adverse effects of systemic corticosteroids may be associated with more serious consequences in old age, especially osteoporosis, hypertension, hypokalaemia, diabetes, susceptibility to infection and thinning of the skin. Close clinical supervision is required to avoid life-threatening reactions.

Systemic corticosteroids are not indicated for, and therefore should not be used to treat traumatic brain injury or stroke because it is unlikely to be of benefit and may even be
harmful. For traumatic brain injury a multicenter study revealed an increased mortality at 2 weeks and 6 months after injury in patients administered methylprednisolone sodium succinate compared to placebo. A casual association with methylprednisolone sodium succinate treatment has not been established.

**Interaction with Other Medicaments and Other Forms of Interaction**

1. Convulsions have been reported with concurrent use of corticosteroids and ciclosporin. Since concurrent administration of these agents results in a mutual inhibition of metabolism, it is possible that convulsions and other adverse effects associated with the individual use of either drug may be more apt to occur.

2. Drugs that induce hepatic enzymes, such as rifampicin, rifabutin, carbamazepine, phenobarbitone, phenytoin, primidone, and aminogluthethimide enhance the metabolism of corticosteroids and its therapeutic effects may be reduced.

3. Drugs which inhibit the CYP3A4 enzyme, such as cimetidine, erythromycin, ketoconazole, itraconazole, diltiazem and mibefradil, may decrease the rate of metabolism of corticosteroids and hence increase the serum concentration.

4. Steroids may reduce the effects of anticholinesterases in myasthenia gravis. The desired effects of hypoglycaemic agents (including insulin), anti-hypertensives and diuretics are antagonised by corticosteroids, and the hypokalaemic effects of acetazolamide, loop diuretics, thiazide diuretics and carbenoxolone are enhanced.

5. The efficacy of coumarin anticoagulants may be enhanced by concurrent corticosteroid therapy and close monitoring of the INR or prothrombin time is required to avoid spontaneous bleeding.

6. The renal clearance of salicylates is increased by corticosteroids and steroid withdrawal may result in salicylate intoxication. Salicylates and non-steroidal anti-inflammatory agents should be used cautiously in conjunction with corticosteroids in hypothyrombinaemia.

7. Steroids have been reported to interact with neuromuscular blocking agents such as pancuronium with partial reversal of the neuromuscular block.

**Pregnancy and Lactation**

**Pregnancy**

The ability of corticosteroids to cross the placenta varies between individual drugs, however, hydrocortisone readily crosses the placenta.
Administration of corticosteroids to pregnant animals can cause abnormalities of foetal development including cleft palate, intra-uterine growth retardation and affects on brain growth and development. There is no evidence that corticosteroids result in an increased incidence of congenital abnormalities, such as cleft palate in man, however, when administered for long periods or repeatedly during pregnancy, corticosteroids may increase the risk of intrauterine growth retardation. Hypoadrenalism may, in theory, occur in the neonate following prenatal exposure to corticosteroids but usually resolves spontaneously following birth and is rarely clinically important. As with all drugs, corticosteroids should only be prescribed when the benefits to the mother and child outweigh the risks. When corticosteroids are essential, however, patients with normal pregnancies may be treated as though they were in the non-gravid state.

**Lactation**

Corticosteroids are excreted in breast milk, although no data are available for hydrocortisone. Doses up to 160 mg daily of hydrocortisone are unlikely to cause systemic effects in the infant. Infants of mothers taking higher doses than this may have a degree of adrenal suppression, but the benefits of breastfeeding are likely to outweigh any theoretical risk.

**Effects on Ability to Drive and Use Machines**

The effect of corticosteroids on the ability to drive or use machinery has not been systematically evaluated. Undesirable effects, such as syncope, vertigo, and convulsions are possible after treatment with corticosteroids. If affected, patients should not drive or operate machinery.

**Undesirable Effects**

Since *EFCORLIN SOLUBLE* is normally employed on a short-term basis it is unlikely that side-effects will occur; however, the possibility of side-effects attributable to corticosteroid therapy should be recognised (see *Special Warnings and Special Precautions for Use*). Such side-effects include:

<table>
<thead>
<tr>
<th>Adverse Reactions table</th>
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<tbody>
<tr>
<td><strong>System Organ Class</strong></td>
</tr>
<tr>
<td><strong>Infections and infestations</strong></td>
</tr>
<tr>
<td><strong>Neoplasms benign, malignant and unspecified (including)</strong></td>
</tr>
<tr>
<td>Cystic and polyps)</td>
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<tr>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Immune system disorders</strong></td>
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<tr>
<td><strong>Blood and lymphatic system disorders</strong></td>
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<tr>
<td><strong>Endocrine disorders</strong></td>
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<tr>
<td><strong>Metabolism and nutrition disorders</strong></td>
</tr>
<tr>
<td><strong>Psychiatric disorders</strong></td>
</tr>
<tr>
<td><strong>Nervous system disorders</strong></td>
</tr>
<tr>
<td><strong>Eye disorders</strong></td>
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<tr>
<td>Category</td>
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<tr>
<td>--------------------------------------------------</td>
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<tr>
<td><strong>Cardiac disorders</strong></td>
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<tr>
<td><strong>Vascular disorders</strong></td>
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<tr>
<td><strong>Respiratory, thoracic and mediastinal disorders</strong></td>
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<tr>
<td><strong>Gastrointestinal disorders</strong></td>
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<tr>
<td><strong>Skin &amp; subcutaneous tissue disorders</strong></td>
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<tr>
<td><strong>Musculoskeletal, connective tissue and bone disorders</strong></td>
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<tr>
<td><strong>Reproductive system and breast disorders</strong></td>
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<tr>
<td><strong>General disorders and administration site conditions</strong></td>
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<tr>
<td><strong>Investigations</strong></td>
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</tbody>
</table>
Urine calcium increased; Alanine aminotransferase increased; Aspartate aminotransferase increased; Blood alkaline phosphatase increased

| Injury, poisoning and procedural complications | Spinal compression fracture; Tendon rupture (particularly of the Achilles tendon) |

Overdose

There is no clinical syndrome of acute overdosage with EFCORLIN SOLUBLE. Hydrocortisone is dialysable.

PHARMACOLOGICAL PROPERTIES

Pharmacotherapeutic group: Glucocorticoids, ATC code: H02AB09.

Pharmacodynamic Properties

Hydrocortisone sodium succinate has the same metabolic and anti-inflammatory actions as hydrocortisone. It is a glucocorticosteroid. Used in pharmacological doses, its actions suppress the clinical manifestations of disease in a wide range of disorders.

Pharmacokinetic Properties

Twelve normal subjects received 100, 200 or 400 mg hydrocortisone intravenously. Radio-immunoassay results were as follows:

<table>
<thead>
<tr>
<th>DOSE (mg)</th>
<th>CMAX (mcg/100 ml)</th>
<th>TMAX (hr)</th>
<th>12-HR AUC (mG/100 ml x hr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>132.3</td>
<td>0.35</td>
<td>418.0</td>
</tr>
<tr>
<td>200</td>
<td>231.8</td>
<td>0.25</td>
<td>680.0</td>
</tr>
<tr>
<td>400</td>
<td>629.8</td>
<td>0.37</td>
<td>1024.0</td>
</tr>
</tbody>
</table>

In another study, a 1 mg/kg i.m. dose of hydrocortisone peaked in 30-60 minutes, with a plasma cmax of 80 mg/100 ml.

In analysing hydrocortisone metabolism, a 25 mg IV dose resulted in higher plasma concentrations in females than in males.

PHARMACEUTICAL PARTICULARS

List of Excipients

Sodium Bicarbonate
Sodium Acid Phosphate
Sodium Phosphate
Water for Injection.

**Incompatibilities**

There are no relevant data available.

**Shelf Life**

18 months.

The expiry date is indicated on the label and packaging.

**Special Precautions for Storage**

Keep in a cool dry place.

Keep out of reach of children.

**Nature and Specification of Container**

Pack: 10 x 4 ml Tubular vials in a rondo.

**Instructions for Use/Handling**

There are no special requirements for use or handling of this product.

**For further information please contact:**
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