הודעה על החמרה (מידע בטיחות) בעלון לרופא

תאריך _____ December 26, 2012 _____

שם תכשיר באנגלית_

DEXACORT FORTE INJECTION 40mg/2ml _

מספר רישום _127 46 21680 21

שם בעל הרישום Teva Pharmaceutical Industries Ltd. ,P.O. Box 3190 Petach Tikva.

פרטים על השינוי/ים המבוקש/ים		
טקסט חדש	**טקסט נוכחי**	**פרק בעלון**
Undesirable effects may be minimised by using the lowest effective dose for the minimum period, and by administering the daily requirement as a single morning dose or whenever possible as a single morning dose on alternative days. Frequent patient review is required to appropriately titrate the dose against disease activity.(1) 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 (1). After parenteral administration of glucocorticoids serious anaphylactoid reactions, such as glottis oedema, urticaria and bronchospasm, have occasionally occurred, particularly in patients with a history of allergy. If such an anaphylactoid reaction occurs, the following measures are recommended: immediate slow intravenous injection of 0.1 - 0.5 ml of adrenaline (solution of 1:1000: 0.1 - 0.5 mg adrenaline dependent on body weight), intravenous administration of aminophylline and artificial respiration if necessary (1). Corticosteroids should not be used for the management of head injury or stroke because it is unlikely to be of any benefit and may even be harmful (1) Use in the Elderly (1) 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.		**Warnings**
Special Precautions (1) *(see also Contraindications)* Particular care is required when considering the use of systemic corticosteroids in patients with the following conditions and frequent patient monitoring is necessary. a. Osteoporosis (post-menopausal females are particularly at risk). b. Hypertension or congestive heart failure. c. Existing or previous history of severe affective disorders (especially previous steroid psychosis). d. Diabetes mellitus (or a family history of diabetes). e. History of tuberculosis, since glucocorticoids may induce reactivation. f. Glaucoma (or a family history of glaucoma). g. Previous corticosteroid-induced myopathy. h. Liver failure. i. Renal insufficiency. j. Epilepsy.		**Precautions**

k. Gastro-intestinal ulceration. l. Migraine m. Certain parasitic infestations in particular amoebiasis. n. Incomplete statural growth since glucocorticoids on prolonged administration may accelerate epiphyseal closure o. Patients with Cushing's syndrome In the treatment of conditions such as tendinitis or tenosynovitis care should be taken to inject into the space between the tendon sheath and the tendon as cases of ruptured tendon have been reported.		
Known hypersensitivity to any ingredient of the product (including sulfites). Systemic infection unless specific anti-infective therapy is employed (1) Systemic fungal infections (see also Warnings), bacteremia, unstable joints, infection at the injection site, e.g. septic arthritis resulting from gonorrhea or tuberculosis. (1) Systemic viral infections and patients with peptic ulcer, osteoporosis and psychoses (2) Immunization procedures with live, or live-attenuated vaccines, including smallpox, in patients receiving immunosuppressive doses of corticosteroids, because of possible neurological complications and a lack of antibody response.	Known hypersensitivity to any ingredient of the product (including sulfites). Systemic fungal infections (see also Warnings) Immunization procedures with live, or live-attenuated vaccines, including smallpox, in patients receiving immunosuppressive doses of corticosteroids, because of possible neurological complications and a lack of antibody response.	**Contraindications**
Local adverse reactions include post-injection flare, and a painless destruction of the joint reminiscent of Charcots arthropathy especially with repeated intra-articular injection. The incidence of predictable undesirable effects, including hypothalamic-pituitary-adrenal suppression correlates with the relative potency of the drug, dosage, timing of administration and the duration of treatment. Cases of ruptured tendon have been reported. Local injection of glucocorticoid may produce systemic effects (1). *Musculoskeletal* Muscle weakness, steroid myopathy, loss of muscle mass muscular atrophy) (2) , tendon rupture, osteoporosis, vertebral compression fractures, aseptic necrosis of femoral and humeral heads, pathological fractures of long bones, proximal myopathy (1) . *Gastrointestinal* Peptic ulcer with possible subsequent perforation and hemorrhage, perforation of the intestine particularly in patients with inflammatory bowel disease, pancreatitis, candidiasis (1), abdominal distension, ulcerative esophagitis. *Neurological* A wide range of psychiatric reactions including affective disorders (such as irritable, euphoric, depressed and labile mood, and suicidal thoughts), psychotic reactions (including mania, delusions, hallucinations, and aggravation of schizophrenia), behavioural disturbances, irritability, anxiety, sleep disturbances, and cognitive dysfunction including confusion and amnesia have been reported. Reactions are common and may occur in both adults and children. In adults, the frequency of severe reactions has been estimated to be 5-6%. Psychological effects have been reported on withdrawal of corticosteroids; the frequency is unknown (1) Convulsions, increased intracranial pressure with papilledema (pseudotumor cerebri) usually after treatment, vertigo, headache, psychic disturbances, euphoric side effects (2) cerebral palsy in preterm infants.	*Musculoskeletal* Muscle weakness, steroid myopathy, , tendon rupture, osteoporosis, vertebral compression fractures, aseptic necrosis of femoral and humeral heads, pathological fractures of long bones. *Gastrointestinal* Peptic ulcer with possible subsequent perforation and hemorrhage, perforation of the intestine particularly in patients with inflammatory bowel disease, pancreatitis, abdominal distension, ulcerative esophagitis. *Neurological* Convulsions, increased intracranial pressure with papilledema (pseudotumor cerebri) usually after treatment, vertigo, headache, psychic disturbances, cerebral palsy in preterm infants	**Adverse events**

Endocrine Menstrual irregularities, amenorrhea (1), development of Cushingoid state, suppression of growth in children, secondary adrenocortical and pituitary unresponsiveness (particularly in times of stress, as in trauma, surgery, or illness), decreased carbohydrate tolerance, manifestations of latent diabetes mellitus, increased requirements of insulin or oral hypoglycemic agents in diabetics, hirsutism. *Blood/Vascular Disorders (2) :* Thromboembolism, polymorphonuclear leucocytosis, neuropathy, vasculitis, development of Diabetes Mellitus *Effect on Bones and Joints (2)* Osteoporosis, arthropathy, osteonecrosis of femoral and/or humeral heads (aseptic or avascular necrosis). *Cardiovascular* Myocardial rupture following recent myocardial infarction. Hypertrophic cardiomyopathy in low birth weight infants Impaired cardiac contractility (2) *Anti-inflammatory and Immunosuppressive effects (1)* Increased susceptibility and severity of infections with suppression of clinical symptoms and signs. Diminished lymphoid tissue and immune response. Opportunistic infections, recurrence of dormant tuberculosis and decreased responsiveness to vaccination and skin tests. *Withdrawal Symptoms (1)* Too rapid a reduction of corticosteroid dosage following prolonged treatment can lead to acute adrenal insufficiency, hypotension and death. A 'withdrawal syndrome' may also occur including, fever, myalgia, arthralgia, rhinitis, conjunctivitis, painful itchy skin nodules and loss of weight.	*Endocrine* Menstrual irregularities, development of Cushingoid state, suppression of growth in children, secondary adrenocortical and pituitary unresponsiveness (particularly in times of stress, as in trauma, surgery, or illness), decreased carbohydrate tolerance, manifestations of latent diabetes mellitus, increased requirements of insulin or oral hypoglycemic agents in diabetics, hirsutism. *Cardiovascular* Myocardial rupture following recent myocardial infarction. Hypertrophic cardiomyopathy in low birth weight infants	
CorticosteroidsCytochrome P450 3A4 {CYP 3 A4} Enzyme Inducers (such as Phenytoin, Primidone (1) Phenylbutazone (1) Carbamazepine, Phenobarbital, Rifampicin, Rifabutin(1, Aminoglutethemide (1))) : Cytochrome P450 3A4 (CYP 3A4) enzyme inducers, such as phenytoin, barbiturates (e.g., phenobarbital), carbamazepine, and rifampin may enhance the metabolic clearance of corticosteroids. resulting in reduced therapeutic effects, that require dosage adjustment of the corticosteroid to achieve the desired response.	***CorticosteroidsCytochrome P450 3A4 {CYP 3 A4} Enzyme Inducers (such as Phenytoin, Carbamazepine, Phenobarbital, Rifampicin,) :*** Cytochrome P450 3A4 (CYP 3A4) enzyme inducers, such as phenytoin, barbiturates (e.g., phenobarbital), carbamazepine, and rifampin may enhance the metabolic clearance of corticosteroids. resulting in reduced therapeutic effects, that require dosage adjustment of the corticosteroid to achieve the desired response.	**Drug Interactions**

General Patients and/or carers should be warned that potentially severe psychiatric adverse reactions may occur with systemic steroids. Symptoms typically emerge within a few days or weeks of starting the treatment. Risks may be higher with high doses/systemic exposure, 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 also 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. (1)		**Information for Patients**