

PRODUCT INFORMATION

Cardol 160mg TABLETS

Sotalol hydrochloride

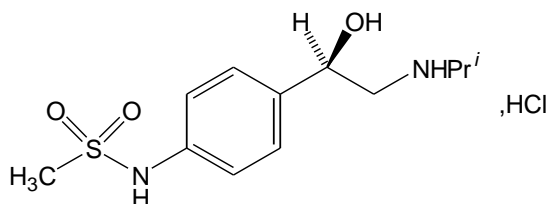


NAME OF THE MEDICINE

Active ingredient : Sotalol hydrochloride

Chemical name : 4'-(2-isopropylamino-1-hydroxy-ethyl)-methanesulfonanilide hydrochloride

Structural formula :



and enantiomer

Molecular formula : C₁₂H₂₀N₂O₃S·HCl

Molecular weight : 303.83

CAS Registry no. : 959-24-0

DESCRIPTION

Sotalol is a white crystalline solid. It is soluble in water (50% w/v) and has a melting point of 210°C.

Each CARDOL tablet contains sotalol hydrochloride 160 mg as the active ingredient. The tablets also contain the following inactive ingredients: calcium hydrogen phosphate anhydrous, starch – maize, povidone, sodium starch glycollate, talc – purified, magnesium stearate.

PHARMACOLOGY

Sotalol is a non-selective beta-adrenoreceptor antagonist without sympathomimetic activity or membrane stabilising activity. It causes a decrease in heart rate and a limited reduction in the force of contraction of the heart. There is a reduction in cardiac work and in myocardial oxygen demand. Sotalol does not decrease blood pressure in normotensive subjects.

Sotalol also possesses Class III antiarrhythmic activity. Sotalol has no known effect on the upstroke velocity of the action potential and therefore no known effect on the depolarisation phase. Its major effects are prolongation of the atrial, ventricular and accessory pathway effective refractory periods. The effect on the ventricular myocardium may be reflected by a lengthening of the QTc interval on electrocardiographic recordings.

Like most other beta-blockers, sotalol inhibits renin release. This suppressive effect is significant both at rest and during exercise.

Pharmacokinetics

Absorption

Sotalol is well absorbed from the gastrointestinal tract. Peak plasma concentrations of 1.4 to 1.7 mg/L are reached at 2 to 3 hours after a 160 mg oral dose.

Distribution

Total apparent volume of distribution of sotalol ranges from 1.6 to 2.4 L/kg. The volume of distribution at steady state is approximately halved in the elderly.

Protein Binding

Sotalol does not bind to plasma proteins and does not significantly cross the blood-brain barrier. However, it is excreted in breast milk and may cross the placental barrier.

Metabolism

Sotalol is not metabolised by the liver and does not undergo biotransformation (no first-pass effect). There is a positive correlation between sotalol dose and plasma concentration.

Excretion

Sotalol is excreted by glomerular filtration and to a small degree by tubular secretion. After oral administration, about 75% of the dose is excreted in the urine within 72 hours as unchanged sotalol. Less than 10% is excreted in the faeces. The mean elimination half-life of sotalol is 12.7 ± 1.6 (SE) hours.

Bioavailability

The absolute bioavailability on oral administration is close to 100%. The bioavailability is decreased when sotalol is administered with food, especially milk.

Clinical Implications of Pharmacokinetic Data

As sotalol is primarily excreted by the kidneys, dosage adjustment is necessary in patients with moderate renal impairment. Severe renal impairment (creatinine clearance <10 mL/min) is a contraindication.

INDICATIONS

Prevention and treatment of supraventricular and ventricular arrhythmias.

CONTRAINDICATIONS

Bronchospasm (e.g. bronchial asthma or chronic obstructive airway disease)

Allergic disorders (including allergic rhinitis) which may suggest a predisposition to bronchospasm

Right ventricular failure secondary to pulmonary hypertension

Significant right ventricular hypertrophy

Sinus bradycardia (less than 45 to 50 beats/minute)

Second and third degree A-V block or sick sinus syndrome unless a functioning pacemaker is present

Shock (including cardiogenic and hypovolaemic shock)

Uncontrolled congestive heart failure

Severe renal impairment (creatinine clearance <10 mL/min)

Congenital or acquired long QT syndromes

Hypersensitivity to sotalol hydrochloride or the excipients

Anaesthesia that produces myocardial depression.

PRECAUTIONS

No antiarrhythmic drug has been shown to decrease the incidence of sudden death in patients with supraventricular or asymptomatic ventricular arrhythmias. Since most antiarrhythmic drugs have the potential to cause proarrhythmias or increase the incidence of sudden death, physicians should carefully consider the risks and benefits of antiarrhythmic therapy in these patients.

Proarrhythmia

Post-Marketing Experience. The most dangerous adverse effect of antiarrhythmic agents is the aggravation of pre-existing arrhythmias or the provocation of new arrhythmias. Agents that prolong the QT interval may cause *Torsade de Pointes*, a polymorphic ventricular tachycardia associated with prolongation of the QT interval. Experience to date indicates that the risk of *Torsade de Pointes* is associated with the prolongation of the QT interval, reduction in heart rate, reduction in serum potassium and magnesium (e.g. as a consequence of diuretic use), high plasma drug concentrations (e.g. as a consequence of overdosage or renal insufficiency), and with the concomitant use of sotalol and other medication such as antidepressants and Class I antiarrhythmics which have been associated with *Torsade de Pointes*. Females appear to be at increased risk of developing *Torsade de Pointes*. ECG monitoring immediately prior to or following the episodes usually reveals a significantly prolonged QT interval and a significantly prolonged QTc interval. In clinical trials, sotalol generally has not been administered to patients whose pretreatment QTc interval exceeded 450 msec. Sotalol should be titrated very cautiously in patients with prolonged QT intervals.

Torsade de Pointes is dose dependent, usually occurs early after commencing therapy or increasing the dose, and terminates spontaneously in the majority of patients. Although most episodes of *torsade de pointes* are self-limited or associated with symptoms (e.g. syncope), they can progress to ventricular fibrillation.

Clinical Studies for Arrhythmia. During clinical trials, 4.3% of 3257 patients with arrhythmias experienced a new or worsened ventricular arrhythmia, including sustained ventricular tachycardia (approximately 1%) and *Torsade de Pointes* (2.4%). In addition, in approximately 1% of patients, deaths were considered possibly drug related. In patients with other, less serious, ventricular arrhythmias and supraventricular arrhythmias, the incidence of *Torsade de Pointes* was 1% and 1.4% respectively.

Serious proarrhythmias including *Torsade de Pointes* were dose related as indicated below:

Percent Incidence of Serious Proarrhythmias* by Dose for Patients With Sustained VT/VF

Daily Dose (mg)	Incidence of Serious Proarrhythmias	Patients (n)
1-80	0%	(0/72)
81-160	0.5%	(4/838)
161-320	1.8%	(17/960)
321-480	4.5%	(21/471)
481-640	4.6%	(15/327)
>640	6.8%	(7/103)

* *Torsade de Pointes* or New Sustained VT/VF

Other risk factors for *Torsade de Pointes* were excessive prolongation of the QTc and history of cardiomegaly or congestive heart failure. Patients with sustained ventricular tachycardia and a history of congestive heart failure have the highest risk of serious proarrhythmia (0.7%). Proarrhythmic events must be anticipated not only on initiating therapy, but with every upward dose adjustment; events tend to occur within 7 days of initiating therapy or with an increase in dose. Initiating therapy at 80 mg twice a day with gradual upward dose titration thereafter decreases the risk of proarrhythmia (see **DOSAGE AND ADMINISTRATION**). Sotalol should be used with caution if the QTc is greater than 500 msec on-therapy, and serious consideration should be given to reducing the dose or discontinuing therapy when the QT interval exceeds 550 msec. Due to the multiple risk-factors associated with *Torsade de Pointes*, however, caution should be exercised regardless of the QTc interval.

Cardiac Failure

Beta-blockade depresses myocardial contractility and may precipitate cardiac failure in some patients with a history of cardiac failure, chronic myocardial insufficiency or unsuspected cardiomyopathy. In patients without a history of cardiac failure, continuing depression of the myocardium may lead to cardiac failure. If cardiac failure persists, CARDOL should be withdrawn (see **PRECAUTIONS - Abrupt Withdrawal**). Caution is advised when initiating therapy in patients with left ventricular dysfunction controlled by therapy (i.e. ACE inhibitors, diuretics, digitalis, etc); a low initial dose and careful dose titration is appropriate.

(Note. Although congestive heart failure has been considered to be a contraindication to the use of beta-blockers, there is a growing literature on the experimental use of beta-adrenergic blocking drugs in heart failure. As further trials are needed to identify which patients are most likely to respond to which drugs, beta-blockers should not normally be prescribed for heart failure outside of specialist centres.)

Recent Myocardial Infarction

In post-infarction patients with impaired left ventricular function, the risk versus benefit of sotalol administration must be considered. Careful monitoring and dose titration are critical during initiation and follow-up of treatment. The adverse results of clinical trials involving antiarrhythmic drugs (ie. apparent increase in mortality) suggest that sotalol should be avoided in patients with left ventricular ejection fractions $\leq 40\%$ without serious ventricular arrhythmias.

In a large controlled trial in patients with a recent myocardial infarction without heart failure, who did not necessarily have ventricular arrhythmias, oral sotalol hydrochloride therapy was associated with a non-statistically significant risk reduction in mortality compared to the placebo group (18%). In this post-infarction study using a fixed dose of 320 mg once a day and in a second small randomised trial in high-risk post-infarction patients with left ventricular ejection fractions $\leq 40\%$ treated with high doses (640 mg/day), there were suggestions of an excess of early sudden deaths.

Abrupt Withdrawal

Care should be taken if beta-blockers have to be withdrawn abruptly in patients with coronary artery disease. Severe exacerbation of angina and precipitation of myocardial infarction and ventricular arrhythmias have occurred following abrupt discontinuation of beta-blockade in patients with ischaemic heart disease. Therefore, it is recommended that the dosage be reduced gradually over a period of 8 to 14 days during which time the patient's progress should be assessed. Sotalol should be reinstated temporarily if the angina worsens.

If the drug must be withdrawn abruptly in these patients, close observation is required since latent coronary insufficiency may be unmasked. In the peri-operative period, sotalol should not be withdrawn, unless indicated.

Concomitant therapy with Calcium Channel Blocking Drugs

Concomitant use of beta-blockers and calcium channel blockers has resulted in hypotension, bradycardia, conduction defects and cardiac failure. Beta-blocking agents should be avoided in combination with cardiodepressant calcium-channel blockers because of the additive effect on atrioventricular conduction and ventricular function.

Peripheral Circulation

Beta-blockade may impair the peripheral circulation and exacerbate the symptoms of peripheral vascular disease.

Antiarrhythmic Drugs

Interactions have been reported during concomitant beta-blocker therapy with the Class IA agents disopyramide, and less frequently quinidine; Class IB agents, tocainide, mexiletine and lignocaine; Class IC agents, flecainide and propafenone (not available in Australia); the Class III agent, amiodarone; and the Class IV antiarrhythmic agents. Concomitant use of sotalol with these agents, and with other beta- blocking drugs is not recommended.

Prinzmetal Angina

There is a risk of exacerbating coronary artery spasm if patients with Prinzmetal or variant angina are treated with a beta-blocker. If this treatment is essential, it should only be undertaken in a Coronary or Intensive Care Unit.

Euthyroid Hyperthyroxinaemia

The effects of beta-blockers on thyroid hormone metabolism may result in elevations of serum free thyroxine (T₄) levels. In the absence of any signs or symptoms of hyperthyroidism, additional investigation is necessary before a diagnosis of thyrotoxicosis can be made.

Anaphylaxis

Patients with a history of anaphylactic reaction to a variety of allergens may have a more severe reaction on repeated challenge while taking beta-blocking agents. Such patients may be unresponsive to the usual doses of adrenaline used to treat the allergic reaction.

Anaesthesia and the Peri-Operative Period

Beta-blockade may have beneficial effects in decreasing the incidence of arrhythmias and myocardial ischaemia during anaesthesia and the post-operative period. It is currently recommended that maintenance beta-blockade be continued peri-operatively. The anaesthetist must be made aware of beta-blockade because of the potential for interactions with other drugs, resulting in severe bradyarrhythmias and hypotension, the decreased reflex ability to compensate for blood loss, hypovolaemia and regional sympathetic blockade, and the increased propensity for vagal-induced bradycardia. Incidents of protracted severe hypotension or difficulty restoring normal cardiac rhythm during anaesthesia have been reported.

Modern inhalational anaesthetic agents are generally well tolerated, although older agents (ether, cyclopropane, methoxyflurane, trichloroethylene) were sometimes associated with severe circulatory depression in the presence of beta-blockade.

Diabetes

Beta-blockers affect glucose metabolism and may mask some important premonitory signs of acute hypoglycaemia, such as tachycardia.

In patients with insulin or non-insulin dependent diabetes, especially labile diabetes, or with a history of spontaneous hypoglycaemia, beta-blockade may result in the loss of diabetic control and delayed recovery from hypoglycaemia. The dose of insulin or oral hypoglycaemic agent may need adjustment.

Other Metabolic Effects

Beta-adrenoreceptors are involved in the regulation of lipid as well as carbohydrate metabolism. Some drugs affect the lipid profile adversely, although the long-term clinical significance of this change is unknown and the effect appears to be less for drugs with intrinsic sympathomimetic activity.

Renal Disease

In patients with severe renal disease, haemodynamic changes following beta-blockade may impair renal function further. Beta-blockers which are excreted mainly by the kidney may require dose adjustment in patients with renal impairment. Sotalol excretion is reduced in patients with renal impairment. Dosage should therefore be adjusted accordingly. Sotalol is contraindicated in patients with severe renal impairment (creatinine clearance <10 mL/min).

Use of Catecholamine-Depleting Agents

Concomitant use of drugs such as reserpine and guanethidine requires careful monitoring since the added effect of a beta-blocker may produce an excessive reduction of the resting sympathetic nervous tone.

Clonidine

Concurrent use of beta-blockers and clonidine should be avoided because of the risk of adverse interaction and severe withdrawal symptoms. If administered concomitantly, the clonidine should not be discontinued until several days after the withdrawal of the beta-blocker.

Phaeochromocytoma

In patients with this condition, an alpha-blocking drug (eg. phentolamine/ phenoxybenzamine) should be administered before the beta-blocker to avoid exacerbation of hypertension.

Eye and Skin Reactions

Various skin rashes and conjunctival xerosis have been reported with beta-blockers. Cross-reactions may occur between beta-blockers, therefore substitutions within the group may not necessarily preclude occurrence of symptoms.

Allergic Conditions

These may be exaggerated by beta-blockade (e.g. allergic rhinitis during the pollen season and allergic reactions to bee and wasp stings). Beta-blockers should be avoided if there is a risk of bronchospasm.

Hyperthyroidism

Because beta-blockers may mask the clinical signs of developing or continuing hyperthyroidism, resulting in symptomatic improvement without any change in thyroid hormone status, special care should be exercised in those patients who are hyperthyroid and are also receiving beta-blockers.

Abrupt withdrawal of beta-blockade in hyperthyroid patients may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm, and should be avoided in these patients.

Electrocardiographic Monitoring

Regular electrocardiographic monitoring should be carried out during sotalol therapy because of prolongation of the QT interval (see **PRECAUTIONS - Proarrhythmia, Post-Marketing Experience**). Excessive prolongation of the QT interval, >550 msec, can be a sign of toxicity and should be avoided. Sinus bradycardia (heart rate <50 bpm) occurred at a frequency of 13% in arrhythmia patients receiving sotalol in clinical trials. Bradycardia itself increases the rate of *Torsade de Pointes*. Sinus pause, sinus arrest and sinus node dysfunction occur in less than 1% of patients. The incidence of 2nd or 3rd degree AV block is approximately 1%.

Electrolyte Disturbances

Before initiating sotalol therapy, serum electrolytes should be obtained and any electrolyte imbalance corrected. Hypokalaemia and hypomagnesaemia can exaggerate the degree of QT prolongation, and increase the potential for torsade de pointes. It is important to monitor electrolyte balance at regular intervals and correct any imbalance throughout therapy. When significant diarrhoea or other intercurrent illness associated with electrolyte losses occurs during treatment with sotalol patients should be instructed to contact their doctors so that they can be closely monitored with frequent checks of plasma electrolytes and receive replacement therapy as appropriate (see **PRECAUTIONS - Proarrhythmia, Post-Marketing Experience**).

Excessive Bradycardia

If excessive bradycardia occurs alone or with hypotension, atropine 0.5 to 2 mg should be given intravenously and immediately followed, if necessary, by a beta-receptor stimulating agent such as isoprenaline (see **OVERDOSAGE**).

Patients experiencing this effect on initial administration of sotalol should be removed temporarily from therapy. Sotalol may be reintroduced later at a lower dosage level.

A reduction in dosage by 80 or 160 mg/day may be advisable to alleviate symptoms of weakness and dizziness in cases where the blood pressure continues to fall after a month or two of sotalol administration.

Psoriasis

Beta-blockers have been reported rarely to exacerbate the symptoms of psoriasis vulgaris.

Hepatic Impairment

Since sotalol is not subject to first-pass metabolism, patients with hepatic impairment show no alteration in clearance of sotalol.

Use in Pregnancy (Category C)

Beta-adrenergic blocking agents may cause bradycardia in the foetus and newborn infant. Sotalol has been shown to cross the placental barrier and cause bradycardia in the newborn.

During the late stages of pregnancy these drugs should only be given after weighing the needs of the mother against the risk to the foetus.

Use in Lactation

Sotalol is actively excreted in breast milk (milk:plasma ratio = 5.4:1) and therefore should not be administered to nursing mothers.

Paediatric Use

The safety and effectiveness of sotalol in children under 18 has not been established.

INTERACTIONS WITH OTHER MEDICINES

Alcohol

The plasma clearance of sotalol is reduced after alcohol ingestion.

Insulin and Oral Hypoglycaemics

Beta-blocking drugs may prolong the hypoglycaemic action of these drugs especially in conditions where glucose mobilisation may be compromised, e.g. labile diabetes, diabetic ketoacidosis and fasting diabetic patients. Symptoms of hypoglycaemia may be masked by sotalol. Hyperglycaemia may occur, and the dosage of antidiabetic drugs may require adjustment (see **PRECAUTIONS - Diabetes**).

Anaesthetics

Agents such as ether, chloroform and cyclopropane are contraindicated with sotalol (see **PRECAUTIONS - Anaesthesia and the Peri-Operative Period**).

Beta₂-Receptor Stimulants

Beta-agonists such as salbutamol, terbutaline and isoprenaline may have to be administered in increased dosages when used concomitantly with CARDOL.

Calcium Channel Blocking Drugs

Concomitant use of beta-blocking drugs and calcium channel blockers has resulted in hypotension, bradycardia, conduction defects and cardiac failure. Beta-blockers should be avoided in combination with cardiodepressant calcium-channel blocking agents because of the additive effects on atrioventricular conduction and ventricular function (see **PRECAUTIONS - Concomitant therapy with Calcium Channel Blocking Drugs**).

Catecholamine-Depleting Agents

Concurrent use of catecholamine-depleting drugs, such as reserpine and guanethidine, with a beta-blocking agent may produce an excessive reduction of resting sympathetic nervous tone. Patients should be closely monitored for evidence of hypotension and/or marked bradycardia which may produce syncope.

Clonidine

An antagonistic effect between clonidine and sotalol has been observed. Concurrent administration of clonidine and sotalol has caused increased blood pressure compared with clonidine or sotalol alone. The combination of beta-adrenoreceptor antagonists and clonidine should be avoided (see **Precautions - Clonidine**).

Drugs Prolonging the QT interval

Drugs known to prolong the QT interval and/or to be associated with atypical ventricular tachycardia (AVT, *Torsade de Pointes*) especially quinidine, disopyramide and tricyclic antidepressants, terfenadine, astemizole and certain quinolone antibiotics should be avoided (see **PRECAUTIONS - Proarrhythmia, Post-Marketing Experience**).

Antiarrhythmic Agents

Interactions have been reported during concomitant use of beta-blockers with the Class IA agents disopyramide, and less frequently quinidine; Class IB agents, tocainide, mexiletine and lignocaine; Class IC agents, flecainide and propafenone (not available in Australia); the Class III agent, amiodarone; and the Class IV antiarrhythmic agents. Concomitant sotalol therapy with these drugs, and with other beta-blocking agents is not recommended.

Potassium-Depleting Diuretics

Hypokalaemia or hypomagnesaemia may occur, increasing the potential for *Torsade de Pointes* (see **PRECAUTIONS - Electrolyte Disturbances**).

Digoxin

Single and multiple doses of sotalol do not significantly affect serum digoxin levels. Proarrhythmic events were more common in patients treated with sotalol who are also receiving digoxin; however, this may be related to the presence of congestive heart failure, a known risk factor for proarrhythmia, in the patient treated with digoxin.

Drug/Laboratory Interaction

The presence of sotalol in the urine may result in falsely elevated levels of urinary metanephrine when measured by photometric methods. Patients suspected of having pheochromocytoma and who are receiving sotalol should have their urine screened utilising the high performance liquid chromatographic assay with solid phase extraction.

ADVERSE EFFECTS

Sotalol is well tolerated in the majority of patients, with the most frequent adverse events arising from its beta-blockade properties. Adverse events are usually transient in nature and rarely necessitate interruption of, or withdrawal from, treatment. These include dyspnoea, fatigue, dizziness, headache, fever, excessive bradycardia and/or hypotension. If they do occur, these side effects usually disappear when the dosage is lowered. The most significant adverse events, however, are those due to proarrhythmia, including *Torsade de Pointes*.

In clinical trials, 3256 patients with cardiac arrhythmias (1363 with sustained ventricular tachycardia) received oral sotalol, of whom 2451 received the drug for at least two weeks. The most significant adverse events were *Torsade de Pointes* and other serious new ventricular arrhythmias (see **PRECAUTIONS - Proarrhythmia, Post-Marketing Experience**), which occurred at the following rates:

	Patient Population		
	VT/VF (n=1363)	NSVT/PVC (n=946)	SVA (n=947)
Torsade de Pointes	4.1%	1.0%	1.4%
Sustained VT/VF	1.2%	0.7%	0.3%
VT = ventricular tachycardia VF = ventricular fibrillation NSVT = nonsustained ventricular tachycardia PVC = premature ventricular contraction SVA = supraventricular arrhythmia			

Overall, discontinuation of sotalol due to unacceptable adverse events was necessary in 18% of all patients in cardiac arrhythmia trials. The most common adverse events leading to discontinuation of sotalol were: fatigue 4%, bradycardia (<50 bpm) 3%, dyspnoea 3%, proarrhythmia 2%, asthenia 2% and dizziness 2%.

More Common Reactions >1%

Biochemical Abnormalities. Changes in plasma lipid concentrations (see Precautions - Other Metabolic Effects).

Cardiovascular. Ventricular tachyarrhythmias, *Torsade de Pointes*, chest pain, bradycardia, hypotension, cold extremities, dyspnoea, palpitations, oedema, ECG abnormalities, proarrhythmia, syncope, heart failure, presyncope. Hypotension and bradycardia are more frequent after intravenous administration.

Dermatological. Rash.

Gastrointestinal. Diarrhoea, nausea/vomiting, flatulence, dyspepsia, abdominal pain.

General. Headache, tiredness, fever.

Musculoskeletal. Cramps.

Nervous System. Dizziness, drowsiness, lethargy, weakness, vertigo, light-headedness, headache, sleep disturbances, depression, paraesthesia, mood changes, anxiety.

Special Senses. Visual disturbances (including eye irritation, deterioration of eyesight, blurred vision, photophobia), taste abnormalities, hearing disturbances.

Urogenital. Sexual dysfunction.

Respiratory. Shortness of breath.

Less Common Reactions <1%

Biochemical Abnormalities. Changes in antinuclear factor (ANF) titres have been reported but the clinical significance of this is not clear.

Cardiovascular. Congestive heart failure, prolonged QT interval. Increased ventricular ectopic beat frequency, cardiogenic shock and AV block (I) have been observed after intravenous administration.

Dermatological. Cutaneous thickening, pruritus.

Psychiatric. Unusual dreams.

Others. Retroperitoneal fibrosis, facial atrophy.

Serious or Life-Threatening Reactions

Myocardial insufficiency may require treatment with digitalis and diuretics. Bradycardia may respond to atropine (see **PRECAUTIONS - Excessive Bradycardia**). Bronchospasm may be reversed with a beta₂-stimulant. Hypotension, if severe, may require use of a vasopressor. Cardiac infarction following too abrupt a withdrawal of the beta-blocker from patients with ischaemic heart disease can be avoided by gradual reduction of dose. Temporary overdrive pacing is suggested as treatment of ventricular arrhythmias in association with prolonged QT interval.

DOSAGE AND ADMINISTRATION

Sotalol is used orally for the prevention and treatment of arrhythmias.

As with other antiarrhythmic agents, sotalol should be initiated and doses increased in a facility capable of monitoring and assessing cardiac rhythm. The dosage must be individualised for each patient on the basis of therapeutic response and tolerance. Proarrhythmic events can occur not only at commencement of therapy, but also with each upward dosage adjustment.

Sotalol should be taken preferably 1 to 2 hours before meals.

Oral dosage of sotalol should be adjusted gradually allowing 2 to 3 days between dosing increments in order to attain steady-state, and to allow monitoring of QT intervals. Graded dose adjustment will help prevent the use of doses which are higher than necessary to control the arrhythmia. The recommended initial oral dosing schedule is 160 mg/day, given in two divided doses at approximately 12 hour intervals. This dose may be increased, if necessary, after appropriate evaluation to 240 or 320 mg/day. In most patients, a therapeutic response is obtained at a total daily dose of 160 to 320 mg/day, given in 2 divided doses. Some patients with life-threatening refractory ventricular arrhythmias may require doses as high as 480 to 640 mg/day; however, these doses should only be prescribed when the potential benefit outweighs the increased risk of adverse events particularly proarrhythmias.

Because of the long elimination half-life of sotalol, dosing on more than a twice daily regimen is not usually necessary.

With Impaired Renal Function

As sotalol is primarily excreted by the kidneys, a dosage adjustment should be made.

OVERDOSAGE

Symptoms

Several cases, one fatal, of sotalol intoxication have been reported. Clinical features include: asystole, severe bradycardia, congestive heart failure, hypotension, prolongation of QT interval, premature ventricular complexes, ventricular tachyarrhythmias, *Torsade de Pointes*, hypoglycaemia and bronchospasm.

Treatment

Close monitoring of the electrocardiogram in patients with suspected sotalol intoxication is recommended. Every effort should be made to correct, promptly, metabolic and electrolyte imbalances which might contribute to the initiation of ventricular arrhythmias.

Gastric lavage, and activated charcoal should be administered when an overdose of sotalol tablets is suspected. Bradycardia and hypotension should be corrected prior to gastric lavage or endotracheal intubation as these procedures may increase vagal tone.

Depending on the symptoms, the following therapeutic measures are suggested:

Severe Bradycardia. Atropine 1 to 2 mg intravenously may be used to induce vagal blockade. If bradycardia persists, intravenous isoprenaline may be given. An appropriate regime would be 5 micrograms bolus, followed by an infusion of 0.5 to 10 micrograms per minute, titrated to achieve the desired effect. In refractory cases, the use of a cardiac pacemaker should be considered.

Heart Block (second and third degree). Transvenous cardiac pacing.

Hypotension. Severe hypotension should respond to a sympathomimetic amine, such as isoprenaline or noradrenaline. In refractory cases, the use of glucagon hydrochloride should be considered.

Torsade de Pointes. Direct current (DC) cardioversion, transvenous cardiac pacing, adrenaline, and/or intravenous magnesium sulphate.

Dialysis. Dialysis lowers the plasma sotalol concentration by approximately 20%.

Bronchospasm. A beta₂-agonist and/or aminophylline.

For information on the management of overdosage, contact the Poison Information Centre on 13 11 26 (Australia).

PRESENTATION AND STORAGE CONDITIONS

CARDOL : 160 mg tablet: white, marked " $\frac{SL}{160}$ " on one side, "α" on the reverse

Available in [PVC/PVDC/Al] blister packs or [HDPE] bottles* of 60's.

Store below 30°C.

* Not marketed in Australia.

NAME AND ADDRESS OF THE SPONSOR

Alphapharm Pty Limited

Level 1, 30 The Bond

30-34 Hickson Road

Millers Point NSW 2000

www.mylan.com.au

POISON SCHEDULE OF THE MEDICINE

S4 (Prescription Only Medicine)

DATE OF FIRST INCLUSION IN THE AUSTRALIAN REGISTER OF THERAPEUTIC GOODS (THE ARTG)

04/02/1993

DATE OF MOST RECENT AMENDMENT

24 January 2017

cardol_pi\jan17/00