

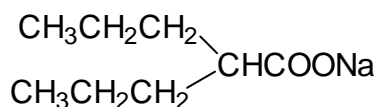
PRODUCT INFORMATION

EPILIM[®]

NAME OF THE MEDICINE

Approved name: Sodium valproate

Chemical name: Sodium di-n-propylacetic acid. Empirical formula: C₈H₁₅O₂Na.



CAS Registry Number: 1069-66-5

DESCRIPTION

Active:

Sodium valproate. Sodium valproate is a white, odourless, crystalline powder with a saline taste. It is highly soluble in water and alcohol. Its molecular weight is 166. It is quite dissimilar to other established anticonvulsants such as barbiturates, hydantoin, succinamides, oxazolinediones and acetylureas in that it has no nitrogen or aromatic moiety.

Inactive:

Crushable: includes maize starch, kaolin, silicon dioxide and magnesium stearate.

Enteric-Coated: includes povidone, purified talc, magnesium stearate, calcium silicate, anhydrous citric acid, macrogol 6000, hypromellose, polyvinyl acetate phthalate, diethyl phthalate, stearic acid, amaranth aluminium lake, indigo carmine aluminium lake, titanium dioxide.

Sugar-Free Liquid: includes hydroxyethylcellulose, saccharin sodium, sorbitol solution (70%) (non-crystallising), anhydrous citric acid, brilliant scarlet 4R, purified water, flavour imitation cherry 17.40.0740, sodium methyl hydroxybenzoate and sodium propyl hydroxybenzoate.

Syrup: includes sucrose, sorbitol, saccharin sodium, brilliant scarlet 4R, purified water, flavour imitation cherry 17.40.0740, sodium methyl hydroxybenzoate and sodium propyl hydroxybenzoate.

PHARMACOLOGY

Class: Anticonvulsant, antipsychotic.

Site and Mode of Action: The mode of action of Epilim has not been fully established. Its anticonvulsant effect is attributed to the blockade of voltage dependent Na⁺ channels and increased brain levels of γ -aminobutyric acid (GABA). The GABA-ergic effect is also believed to possibly contribute towards the antimanic properties of sodium valproate.

In animals, Epilim raises cerebral and cerebellar levels of the inhibitory synaptic transmitter, GABA, possibly by inhibiting GABA degradative enzymes, such as GABA transaminase and/or succinic semialdehyde dehydrogenase and/or by inhibiting the reuptake of GABA by neuronal cells.

Epilim exhibits marked anticonvulsant activity in animals, demonstrated by the various tests used to detect antiepileptic activity.

Metabolism: Its metabolism is complex; the major elimination pathway is via glucuronidation (40-60%). The remainder is largely metabolised via oxidation pathways, β -oxidation accounting for 30-40% and ω -oxidation (cytochrome P450 dependent), the remaining fraction. Only 1 to 3% of the ingested dose is found to be excreted unchanged in the urine.

Excretion: Sodium valproate is almost completely metabolised prior to excretion. Plasma half-life is variable but generally appears to be 8 to 12 hours (range 3.84 to 15.77 hours). It may be shorter in patients receiving other anticonvulsants or in children and patients receiving the medicine for long periods. In cases of overdose, long half-lives up to 30 hours have been reported. Antipsychotic agents or antidepressants including MAOIs, tricyclics and SSRIs co-administered with sodium valproate may result in competitive metabolism or enzyme inhibition, thereby increasing valproate levels (see **Interactions with other medicines**).

Clinical Trials

In epilepsy: Epilim's efficacy in this therapeutic indication is widely known and recognised.

In mania: There have been at least five double-blind trials comparing sodium valproate or the bioequivalent active, divalproex sodium with either placebo and/or lithium in the treatment of mania. Only one of these trials was of adequate size. Bowden et al (1994) demonstrated most convincingly the superior effectiveness of valproate as compared to placebo in the treatment of acute mania. Marked improvement, defined as at least 50% improvement on the Manic Syndrome Subscale of the Mania Rating Scale occurred in 48% of valproate-treated patients and 25% of placebo-treated patients respectively ($p=0.0040$). Comparable efficacy to lithium in this study was reported. Marked improvement, defined as at least 50% improvement on the Manic Syndrome Subscale of the Mania Rating Scale, occurred in a similar number of patients receiving sodium valproate and lithium, 48% and 49% respectively.

INDICATIONS

Epilepsy: Primary generalised epilepsy (petit mal absences, various forms of myoclonic epilepsy and tonic-clonic grand mal seizures). Partial (focal) epilepsy either alone or as adjuvant therapy.

Mania: For the treatment of mania where other therapy has proved inadequate or is inappropriate.

CONTRAINDICATIONS

Pregnancy (see **PRECAUTIONS**). Pre-existing hepatic dysfunction or family history of severe hepatitis, particularly medicine related. Known hypersensitivity to the medicine. Known urea cycle disorders (see **PRECAUTIONS**). Known hepatic porphyria.

PRECAUTIONS

1. Use with caution in the following circumstances:

Pancreatitis: Cases of life-threatening pancreatitis have been reported in both children and adults receiving sodium valproate. Some cases have occurred shortly after initial use while others have occurred after several years of use. There have also been cases in which pancreatitis recurred after rechallenge with sodium valproate. Some of the cases have been described as haemorrhagic with a rapid progression from initial symptoms to death. In clinical trials, there were two cases of pancreatitis without alternative aetiology in 2416 patients, representing 1044 patient-years experience. Patients and guardians should be warned that abdominal pain, nausea, vomiting, and/or anorexia can be symptoms of pancreatitis that require prompt medical attention. If pancreatitis is diagnosed, sodium valproate should be discontinued and alternative treatment for the underlying medical condition initiated as clinically indicated.

Abrupt withdrawal: The possible risk of fits after sudden cessation of Epilim should be borne in mind. If it is the only anticonvulsant used and has to be withdrawn for more than 12 hours because of surgery, control of epilepsy may be lost.

Diabetes: Care should be taken when treating diabetic patients with Epilim syrup which contains sucrose 3.6 g/5 mL. In such patients, Epilim Sugar-Free Liquid would be a preferable medication. See also **Interference with Clinical and Other Tests.**

Dilutions: If it is necessary to dilute the syrup, the recommended diluent is Syrup BP. Syrup containing sulfur dioxide as a preservative should not be used. The diluted product will have a 14-day shelf-life. The Sugar-Free Liquid should not be diluted.

Hepatic dysfunction: Hepatic failure resulting in fatalities has occurred in patients whose treatment included valproic acid or sodium valproate. Patients most at risk are children, particularly those under the age of 3 years and those with congenital metabolic or degenerative disorders, organic brain disease or severe seizure disorders associated with mental retardation.

The incidents usually occurred during the first six months of therapy, the period of maximum risk being 2 to 12 weeks, and usually involved multiple anticonvulsant therapy. Monotherapy is to be preferred in this group of patients.

Clinical symptoms are usually more helpful than laboratory investigations in the early stages of hepatic failure. Serious or fatal hepatotoxicity may be preceded by nonspecific symptoms, usually of sudden onset, such as loss of seizure control, malaise, weakness, lethargy, facial oedema, anorexia, vomiting, abdominal pain, drowsiness, jaundice. These are an indication for immediate withdrawal of the medicine. Patients should be monitored closely for the appearance of these symptoms and should be instructed to report any such signs to the clinician for investigation should they occur.

Although published evidence does not establish which, if any investigation could predict this possible adverse effect, liver function tests should be performed prior to therapy and frequently thereafter until 6 months after the controlling dose is reached, when less frequent monitoring may be appropriate. It is also advisable to monitor tests which reflect protein synthesis, e.g. prothrombin time, serum fibrinogen and albumin levels, especially in those who seem most at risk and those with a prior history of hepatic disease.

Raised liver enzymes are not uncommon during treatment with Epilim, **particularly if used in conjunction with other anticonvulsants**, and are usually transient or respond to dosage reduction. Patients with such biochemical abnormalities should be reassessed clinically and tests of liver function should be monitored more frequently. An abnormally low prothrombin level, particularly in association with other relevant abnormalities requires cessation of treatment and the substitution of alternative medicines to avoid precipitating convulsions. Uneventful recovery has been recorded in several cases where therapy with Epilim has ceased, but death has occurred in some patients in spite of the medicine being withdrawn. Any concomitant use of salicylates should be stopped, since they employ the same metabolic pathway.

Hyperammonaemia: When urea cycle enzymatic deficiency is suspected, metabolic investigations should be performed prior to treatment because of the risk of hyperammonaemia with valproate.

Hyperammonaemia, which may be present in the absence of abnormal liver function tests, can occur in patients during treatment with sodium valproate. This may occasionally present clinically, with or without lethargy or coma, as vomiting, ataxia and increasing clouding of consciousness. Should these symptoms occur, hyperammonaemic encephalopathy should be considered (see **Urea Cycle Disorders**) and Epilim should be discontinued.

Urea Cycle Disorders (UCD): Hyperammonaemic encephalopathy, sometimes fatal, has been reported following initiation of valproate therapy in patients with urea cycle disorders, a group of uncommon genetic abnormalities, particularly ornithine transcarbamylase deficiency. Prior to the initiation of valproate therapy, evaluation for UCD should be considered in the following patients: 1) those with a history of unexplained encephalopathy or coma, encephalopathy associated with a protein load, pregnancy-related or postpartum encephalopathy, unexplained mental retardation, or history of elevated plasma ammonia or glutamine; 2) those with cyclical vomiting and lethargy, episodic extreme irritability, ataxia, low BUN, or protein avoidance; 3) those with a family history of UCD or a family history of unexplained infant deaths (particularly males); 4) those with other signs or symptoms of UCD. Patients who develop symptoms of unexplained hyperammonaemic encephalopathy while receiving valproate therapy should receive prompt treatment (including discontinuation of valproate therapy) and be evaluated for underlying urea cycle disorders.

Ornithine Transcarbamylase (OTC) Deficiency: The females who are heterozygous for OTC deficiency have a spectrum of clinical and biochemical findings, depending on the extent of inactivation of the X-chromosome. Females may show a range of symptoms due to hyperammonaemia which, may be episodic, and therefore difficult to diagnose. The acute symptoms include headaches, vomiting, irritability, bizarre behaviour, lethargy, ataxia, tremors, seizures (generalised tonic-clonic or focal) and coma. Valproate may precipitate hyperammonaemia symptoms in those who have pre-existing OTC deficiency. As the symptoms may include seizures, any female with valproate-associated symptomatic hyperammonaemia should be evaluated for OTC deficiency. Investigations should include measurement of plasma amino acids and the immediate cessation of valproate should result in clinical improvement.

Impaired renal function: Lower doses may be required since free drug levels may be high owing to lowered serum albumin and poor urinary excretion of free drug metabolites.

Pharmaceutical precautions: Epilim tablets are hygroscopic and must be kept in protective foil until taken. See also **PRESENTATION AND STORAGE CONDITIONS**.

Surgery: Prolongation of bleeding time, sometimes with thrombocytopenia, has occurred with Epilim therapy. Platelet function should be monitored before surgery is undertaken in patients receiving Epilim.

2. Check the following before use:

Thrombocytopenia: Because of reports of thrombocytopenia, inhibition of the secondary phase of platelet aggregation, and abnormal coagulation parameters, platelet counts and coagulation tests are recommended before initiating therapy and at periodic intervals. Evidence of haemorrhage, bruising or a disorder of haemostasis/coagulation is an indication for reduction of Epilim dosage or withdrawal of therapy.

Ornithine Transcarbamylase (OTC) Deficiency: A familial history of infant mortality or patient history of OTC deficiency, or of seizures or coma in the presence of mental retardation suggests the need to exclude OTC deficiency.

Weight Gain: Patients should be warned of the risk of weight gain at the initiation of therapy, and appropriate strategies should be adopted to minimise it.

Women of child bearing potential: Adequate counselling should be made available to all women of child bearing potential with epilepsy regarding the risks associated with pregnancy.

Use in Pregnancy (Category D)

The risk of a mother with epilepsy giving birth to a baby with an abnormality is about three times that of the normal population. An increased incidence of minor or major malformations including neural tube defects, craniofacial defects, malformation of the limbs, cardiovascular malformations and multiple anomalies involving various body systems has been reported in children born to mothers with epilepsy treated with valproate. Mothers taking more than one anticonvulsant medicine might have a higher risk of having a baby with a malformation than mothers taking one medicine. Sodium valproate (valproic acid), if taken in the first trimester of pregnancy, is suspected of causing an increased risk of neural tube defects (especially spina bifida) in the exposed foetus. This has been estimated to be in the region of 1-2%.

There have been rare reports of haemorrhagic syndrome in neonates whose mothers have taken sodium valproate during pregnancy. This syndrome is related to hypofibrinaemia. Afibrinaemia has also been reported and may be fatal. Hypofibrinaemia is possibly associated with a decrease of coagulation factors. Haemorrhagic syndrome may also be induced by phenobarbital and other enzyme inducers. Platelet count, fibrinogen plasma level and coagulation status should be investigated in neonates.

Women taking sodium valproate (valproic acid) who become or wish to become pregnant should be encouraged to consider routine ultrasound and amniocenteses for prenatal diagnosis of such abnormalities. As folic acid may have a role in the prevention of neural tube defects in infants of women taking antiepileptic therapy, such women are recommended to take folic acid supplementation (5mg daily) four weeks prior to and 12 weeks after conception.

Developmental delay has been very rarely reported in children born to mothers with epilepsy. It is not possible to differentiate what may be due to genetic, social, environmental factors, maternal epilepsy or antiepileptic treatment.

Some data have suggested an association between in-utero valproate exposure and the risk of developmental delay (frequently associated with craniofacial abnormalities), particularly of verbal IQ.

Notwithstanding the potential risks, no sudden discontinuation of antiepileptic therapy should be undertaken, as this may lead to breakthrough seizures which could have serious consequences for both the mother and the foetus.

Overall, the risk of having a child with abnormalities as a result of antiepileptic medication is far outweighed by the dangers to the mother and foetus of uncontrolled epilepsy.

It is recommended that:

- women on antiepileptic drugs (AEDs) receive pre-pregnancy counselling with regard to the risk of foetal abnormalities;
- AEDs should be continued during pregnancy and monotherapy should be used if possible at the lowest effective dose as risk of abnormality is greater in women taking combined medication;
- folic acid supplementation (5mg) should be commenced four weeks prior to and continue for twelve weeks after conception;
- specialist prenatal diagnosis including detailed mid-trimester ultrasound should be offered.

Before Epilim is prescribed for use in women with epilepsy of any form, who could become pregnant, they should receive specialist advice. Due to the potential risks to the foetus, the benefits of its use should be weighed against the risks. When treatment with Epilim is deemed necessary, precautions to minimise the potential teratogenic risk should be followed (see above recommendations).

Use in Lactation

Epilim is excreted in breast milk. Concentrations in breast milk have been reported to be 1 to 10% of serum concentration. It is not known what effect this would have on a breast-fed infant. As a general rule, breastfeeding should not be undertaken whilst a patient is receiving Epilim.

Paediatric Use

The potential benefit of Epilim should be weighed against the risk of pancreatitis or liver damage in such patients prior to initiation of therapy (see the **PRECAUTIONS** section). The concomitant use of salicylates should be avoided in children under 3 due to the risk of liver toxicity and the concomitant use of barbiturates may require dosage adjustment (see 'Interactions with other medicines'). Monotherapy is recommended in children under 3 years of age, when prescribing Epilim. Young children are at particular risk for pancreatitis, however this risk decreases with increasing age.

Carcinogenicity/Mutagenicity

Carcinogenesis: Sodium valproate was administered in the diet to Sprague-Dawley rats and ICR (HA/ICR) mice at approximate dosage levels of 0, 80 and 160 mg/kg/day for up to 2 years. There was equivocal evidence of an increased incidence of subcutaneous fibrosarcomas in male rats and of bronchoalveolar adenomas in male mice. The presence of these tumours was not considered to be biologically significant because of the published variable incidence of spontaneously occurring fibrosarcomas and pulmonary adenomas in rats and mice respectively and the fact that statistical significance of tumour incidence was only attained in males. The significance of these findings for humans is unknown at present.

Toxicology: No significant toxic effects were seen in rats receiving 270 mg/kg/day for 3 months or in dogs receiving 90 mg/kg/day for 12 months. At higher doses sedation, ataxia and various histopathological effects (testicular atrophy and reduction in lymphoid tissue) were observed at levels of 256 to 568 microgram/mL (1.78 to 3.94 mmol/L).

Testicular function: Epilim has been shown to cause atrophy of the seminiferous epithelium with impairment of spermatogenesis, and to cause a decrease of the testicular weight of adult rats and of offspring of female rats, when administered in high doses. On the other hand, reproductive studies carried out in rats with similarly high doses in both sexes has not shown any evidence of impaired fertility. The relevance of these findings to humans is not clear.

Interactions with other medicines

a. Effects of valproate on other medicines: sodium valproate is an inhibitor of a variety of hepatic enzymes, including cytochrome P450, glucuronyl transferase and epoxide hydrolase, and may displace various drugs from plasma protein binding sites. The following list provides information about potential effects of valproate co-administration on a range of commonly prescribed medications. The list is not exhaustive, as new interactions may be reported.

Alcohol: Valproic acid may potentiate the CNS depressant activity of alcohol.

Antiepileptic drugs: Several antiepileptic drugs often used in conjunction with valproate (eg phenytoin, carbamazepine, phenobarbitone) have the ability to increase the intrinsic clearance of valproate, presumably by enzymatic induction of metabolism.

Carbamazepine: Valproate may displace carbamazepine from protein binding sites and may inhibit the metabolism of both carbamazepine and its metabolite carbamazepine 10, 11 epoxide and consequently potentiate toxic effects of carbamazepine. Clinical monitoring is recommended especially at the beginning of combined therapy, with dosage adjustment when appropriate.

Lamotrigine: Sodium valproate may reduce lamotrigine metabolism. Clinical monitoring is recommended and lamotrigine dosage should be decreased as appropriate. There are suggestions, yet to be proven, that the risk of rash may be increased by co-administration of lamotrigine with valproate.

Phenobarbitone: Sodium valproate may block the metabolism of barbiturates causing an increase in phenobarbitone plasma levels, which, particularly in children, may be associated with sedation. Combination of sodium valproate and phenobarbitone can cause CNS depression without significant elevation of serum level of either drug. A reduction in the dose of phenobarbitone and/or valproate may be necessary and this should also be borne in mind if medicines which are metabolised to phenobarbitone (e.g. primidone, methylphenobarbitone) are given with sodium valproate.

Phenytoin: There have been reports of breakthrough seizures occurring with the combination of sodium valproate and phenytoin. Most reports have noted a decrease in total plasma phenytoin concentration, however increases in total phenytoin levels have been reported. An initial fall in total phenytoin levels with subsequent increase in phenytoin levels has also been reported. In addition, a decrease in total serum phenytoin with an increase in the free versus protein bound phenytoin levels has been reported. The dosage of phenytoin may require adjustment when given in conjunction with valproate as required by the clinical situation.

Medicines with extensive protein binding: The concomitant administration of sodium valproate with medicines that exhibit extensive protein binding (e.g. aspirin, carbamazepine, phenytoin, warfarin) may result in alteration of serum drug levels.

Anticoagulants: The effect of Epilim on anticoagulants which modify platelet function is unknown (see **ADVERSE EFFECTS**). Caution is recommended when administering anticoagulants and other products which have anticoagulant properties (e.g. warfarin and aspirin).

Ethosuximide: The interaction between ethosuximide and valproate is not normally of clinical significance. There is evidence that sodium valproate may inhibit ethosuximide metabolism, especially in the presence of other anticonvulsants. Patients receiving this combination should be monitored clinically.

Oral contraceptives: The enzyme inducing effect of valproate is appreciably less than that of certain other anticonvulsants and loss of efficacy of oral contraceptive agents does not appear to be a problem.

Psychotropic agents: Epilim may potentiate the effects of MAOIs, neuroleptics and other antidepressants, and the dose of these medicines should be reduced accordingly.

Clonazepam: The concomitant use of sodium valproate and clonazepam may produce absence status.

Clozapine: Caution is advised during concomitant administration as competitive protein binding may potentiate an increase in clozapine or valproate levels.

Diazepam: Sodium valproate displaces diazepam from its plasma binding sites and inhibits its metabolism. Monitoring of free diazepam levels may be necessary if the patient becomes sedated.

Lorazepam: A decrease in lorazepam plasma clearance may occur with concomitant administration of sodium valproate.

Midazolam: Free plasma midazolam may increase in patients receiving valproate. It appears likely that sodium valproate displaces midazolam from its plasma binding sites, potentially leading to an increase of the midazolam response.

Primidone: Valproate increases primidone plasma levels with exacerbation of its adverse effects (such as sedation); these signs cease with long-term treatment. Clinical monitoring is recommended especially at the beginning of combined therapy with dosage adjustment when appropriate.

Zidovudine: Valproate may raise zidovudine plasma concentrations leading to increased zidovudine toxicity.

Other medicines: There was no notable interaction between valproate and lithium.

Tricyclic antidepressants: Sodium valproate may inhibit the metabolism of tricyclic antidepressants. Clinical monitoring of free antidepressant levels may be necessary.

b. Effects of other medicines on valproate: the dosage of Epilim may need to be increased by 5 to 10 mg/kg/day when used in combination with medicines which induce hepatic enzymes and thereby increase the clearance of valproate. In contrast, medicines that are inhibitors of cytochrome P450, may be expected to have only a minor effect on valproate clearance as cytochrome P450 mediated microsomal oxidation is a relatively minor secondary metabolic pathway to glucuronidation and β -oxidation. The list is not exhaustive, as new interactions may be reported.

Aspirin: Concomitant administration of sodium valproate and aspirin may result in displacement of valproate from protein binding sites, resulting in a rise in free levels. In addition, aspirin appears to inhibit the metabolism of valproate. Thus caution is advisable when patients on sodium valproate are prescribed aspirin. Furthermore, patients requiring long-term aspirin therapy may require a reduction in dosage of sodium valproate.

Felbamate: Felbamate may increase valproate serum concentrations. Valproate dosage should be monitored when given in combination with felbamate.

Phenobarbitone, Phenytoin and Carbamazepine: These medicines can decrease steady-state valproate levels in patients by increasing the intrinsic clearance of valproate, presumably through enzymic induction of metabolism. The half-life is significantly reduced in patients on polytherapy with these medicines.

Antidepressants: Antidepressants (including MAOIs, tricyclic antidepressants and SSRIs) may have the potential to inhibit the metabolism of valproate via the cytochrome P450 system. However, there is not expected to be any significant interaction within normal therapeutic doses. Antidepressants can lower the seizure threshold of non-stabilised epileptic patients, and so careful and regular monitoring of their condition is indicated.

Clozapine: Caution is advised during concomitant administration as competitive protein binding may potentiate an increase in clozapine or valproate levels.

Chlorpromazine: Chlorpromazine may inhibit the metabolism of valproate.

Fluoxetine: Fluoxetine may inhibit the metabolism of valproate as it does with tricyclic antidepressants, carbamazepine and diazepam.

Mefloquine: Mefloquine increases valproic acid metabolism and has a convulsing effect; therefore epileptic seizures may occur in cases of combined therapy.

Cimetidine or Erythromycin: Valproate serum levels may be increased (as a result of reduced hepatic metabolism) in case of concomitant use with cimetidine or erythromycin.

Carbapenem antibiotics: Decreases in valproate blood level sometimes associated with convulsions has been observed when valproate and carbapenem antibiotics (panipenem, meropenem, imipenem, ertapenem, biapenem) were combined. If these antibiotics have to be administered, close monitoring of valproate blood levels is recommended.

Interference with Clinical Laboratory and Other Tests

Epilim is eliminated mainly through the kidneys, partly in the form of ketone bodies. This may give false positives in the urine testing of possible diabetics.

There have been reports of altered thyroid function test results associated with sodium valproate. The clinical significance of this is unknown.

Effect on Ability to Drive or Operate Machinery

Use of Epilim may provide seizure control such that the patient may be eligible to hold a driving licence. However, patients should be warned of the risk of transient drowsiness, especially in cases of anticonvulsant polytherapy, too high a starting dose, too rapid a dose escalation or association with benzodiazepines.

ADVERSE EFFECTS

In Epilepsy

The incidence of adverse reactions to marketed medicines such as Epilim is difficult to reliably assess due to the nature of spontaneous reporting systems and the problems associated with estimating the total exposure to the medicine. With these limitations in mind, adverse events received by the Australian Drug Reactions Committee (ADRAC) on sodium valproate products for the twenty-year period 1977-1997 are presented, summarised in Table 1. The data are presented in accordance with system organ class and include all adverse events reported, independent of drug causality i.e. adverse events classified as certain, probable or possible.

Table 1. Distribution of adverse events for sodium valproate products reported to ADRAC in the period 1977-1997 according to organ system or symptomatology.

Organ System/Symptom	Sodium Valproate	
	1977-1997	
	Frequency (%)	Frequency (CIOMS Format)
Gastro-Intestinal System	20.0	Very common
Nervous & Cerebral System	16.0	Very common
Skin & Appendages/Glands	12.0	Very common
Abnormal Lab/ Electrolytes	8.0	Common
Blood Cells & Clotting Disorders	7.0	Common
Malformations	6.0	Common
Liver & Biliary System	5.0	Common
Endocrine Disorders	4.0	Common
Fatigue & sleeping disorders	4.0	Common
Circulatory System	3.0	Common
Metabolic Disorders	3.0	Common
Urinary & Renal System Disorders	3.0	Common
Special senses	2.25	Common
Pyrexia or Flu-Like Symptoms	2.0	Common
Psychiatric/Affective Reactions/Disorders	2.0	Common
Therapeutic Inefficiency	2.0	Common
Body as a Whole	1.4	Common
Abdomen Disorders	1.0	Common
Cardiovascular	1.0	Common
Neonatal & Infancy Disorders	1.0	Common
Pain	1.0	Common
Reproductive/Gynaecological Disorders	1.0	Common
Respiratory Disorders	1.0	Common
Drug levels in/decreased	0.9	Uncommon
Musculo-skeletal System	0.9	Uncommon
Pulmonary System	0.9	Uncommon
Drug Interaction	0.25	Uncommon
Total Adverse Events Reported	791 (27*) (based on 384 drug reports)	

* Events leading to death

In relation to the 791 events (384 reports) received by ADRAC on sodium valproate products (brandname not stated in 95 drug reports)

very common $\geq 10\%$

common $\geq 1\%$ and $< 10\%$

uncommon $\geq 0.1\%$ and $< 1\%$

rare $\geq 0.01\%$ and $< 0.1\%$

Dermatological: Transient increase in hair loss has been observed. This effect does not appear to be dose-related and regrowth may occur, although the hair may become more curly than previously. Dermatological reactions consistent with immune adverse reactions such as pruritis, rash, urticaria, Stevens Johnson Syndrome have been noted. Caution should be observed when using the medicine in patients with systemic lupus erythematosus.

Endocrine: There have been reports of irregular menses and secondary amenorrhoea and rare cases of breast enlargement and galactorrhoea.

Gastrointestinal: Nausea, vomiting, abdominal cramp, anorexia, increased appetite and diarrhoea are usually transient and rarely require discontinuation of therapy or limitation of dose. The overall incidence of adverse GI effects are reported to be 9 to 16% in adults and over 22% in children when plain tablets are prescribed. GI side effects may be minimised by taking the tablets with or after food or by substituting the enteric-coated tablets. As some of these symptoms may also indicate early stage hepatic dysfunction, patients should be monitored closely for the appearance of these symptoms. Patients should be instructed to report such signs to the clinician for investigation should they occur (refer **PRECAUTIONS** section).

Haematological: Valproic acid inhibits the second stage of platelet aggregation. Reversible prolongation of bleeding time, as well as thrombocytopenia, have been reported but have usually been associated with doses above those recommended (see **Check the Following Before Use**). Frequent occurrence of thrombocytopaenia, rare cases of pancytopaenia with or without bone marrow depression. Isolated reduction of fibrinogen has been reported.

Spontaneous bruising or bleeding is an indication for withdrawal of medication pending investigation (see **PRECAUTIONS**).

Anaemia, red cell hypoplasia, neutropenia and leucopenia have also been reported. In most cases the blood picture returned to normal when the medicine was discontinued.

Hepatic: Hepatic dysfunction, including hepatic failure resulting in fatalities, has occurred in patients whose treatment included valproic acid or sodium valproate (see **PRECAUTIONS**).

Metabolic: Hyperammonaemia has been reported in association with valproate therapy and may be present despite normal liver function tests.

In patients who develop unexplained lethargy and vomiting or changes in mental status, hyperammonaemic encephalopathy should be considered. In these patients, EEG and ammonia level should be checked and, if ammonia is increased, valproate therapy should be discontinued. Appropriate interventions for treatment of hyperammonaemia should be initiated, and such patients should undergo investigation for underlying urea cycle disorders (see **PRECAUTIONS**).

Asymptomatic elevations of ammonia are more common and, when present, require close monitoring of plasma ammonia levels. If the elevation is significant (above 3N) and persists, discontinuation of valproate therapy should be considered.

Very rare cases of hyponatremia have been reported.

Nervous system: The true incidence of drowsiness and sedation with Epilim is difficult to assess, as mostly it was administered in combination with other medicines. Epilim, however, may have an intrinsic sedative action in addition to potentiating sedative effects of other anticonvulsants (e.g. barbiturates, clonazepam) and CNS depressants, including alcohol.

Uncommon cases of ataxia have been reported. Headache, nystagmus, diplopia, tremor, dizziness, depression, hallucinations and coma have occurred rarely and usually in association with other anticonvulsants. Excitement, hyperactivity, aggression and behavioural disorders have been rarely reported, usually in children at the start of treatment. Stupor, either isolated or in conjunction with recurrence of seizures, may occur and is most often associated with polytherapy, too high a starting dose or too rapid a dose escalation.

Rare cases of lethargy and confusion.

Very rare cases of reversible dementia associated with reversible cerebral atrophy have been reported. Isolated reversible parkinsonism have been reported.

Pancreatitis: There have been very rare reports of pancreatitis, sometimes lethal, occurring in patients receiving valproic acid or sodium valproate, usually within the first 6 months of therapy. Patients experiencing acute abdominal pain should have the serum amylase estimated promptly; if these levels are elevated the medicine should be withdrawn (see **PRECAUTIONS**).

Other: Oedema has been reported. Increase in appetite and weight may occur. Very rare cases of enuresis have been reported.

The occurrence of vasculitis has been reported. Allergic reactions have been reported.

Hearing loss, either reversible or irreversible, has been reported rarely; however a cause and effect relationship has not been established.

In exceptional cases, toxic epidermal necrolysis has been reported.

There have been isolated reports of a reversible Fanconi's syndrome associated with valproate therapy but the mode of action is as yet unclear.

In Mania

No new or unexpected adverse events have been reported in clinical trials of Epilim in mania. The frequencies of adverse events (%) reported on valproate (as divalproex) in the largest controlled clinical trial described under **PHARMACOLOGY (Clinical Trials)** are summarised in Table 2.

Table 2. Adverse events reported on divalproex in the Bowden *et al.* study (1994)

Adverse event	Bowden <i>et al.</i> 1994		
	VPA* n = 69	Lithium n = 36	Placebo n = 74
Body as a whole			
Pain	19	3	20
Asthenia	13	19	9
Fever	1	14	4
Gastrointestinal			
Nausea	23	31	15
Diarrhoea	12	14	18
Vomiting	14	25	4
Constipation	10	17	7
Nervous system			
Headache	22	39	32
Somnolence/Sedation/ Fatigue	19	19	15

Twitching	3	8	0
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Adverse events reported at a frequency: >15% or significantly different between treatment groups, or > 5% or common events to other study (no events significantly more frequent in this study).

*VPA as divalproex

In this study, there were differences with placebo for vomiting only for divalproex (45% vs 14%), fever was more common for lithium (14%) than for divalproex (1%) and placebo (4%), pain was less common with lithium (3%) than with either divalproex (19%) or placebo (20%).

DOSAGE AND ADMINISTRATION

Epilim tablets may be given twice daily. Uncoated tablets may be crushed if necessary. Epilim Syrup and Sugar-Free Liquid should be given in divided doses.

Epilim should preferably be taken with or after food: the enteric-coated tablet (lilac) must be swallowed whole, if necessary with a little water: the plain tablet (white, 100 mg) may be taken whole or crushed and swallowed with water (not aerated).

Epilim 500 mg enteric-coated is recommended for patients requiring high doses. Where the possibility of dental caries represents a risk through long-term therapy with Epilim Syrup, it may be beneficial to consider Epilim Sugar-Free Liquid. Epilim may take several days to show an initial effect and in some cases may take from 2 to 6 weeks to exhibit its maximum effect.

Epilepsy

Monotherapy: Usual requirements are as follows:

Adults: Dosage should start with 600 mg daily increasing by 200 mg/day at three-day intervals until control is achieved. This is generally within the range 1,000 to 2,000 mg/day, (i.e. 20 to 30 mg/kg/day). Where adequate control is not achieved within this range the dose may be further increased to 2,500 mg/day.

Children > 20 kg: Initial dosage should be 400 mg/day (irrespective of weight) with spaced increases until control is achieved; this is usually within the range 20 to 30 mg/kg/day.

Children < 20 kg: 20 mg/kg/day: in severe cases this may be increased but only in patients in whom plasma valproic acid levels can be monitored. Above 40 mg/kg/day, clinical chemistry and haematological parameters should be monitored.

General considerations: Optimum dosage is mainly determined by seizure control and routine measurement of plasma levels is unnecessary. However, a method for measurement of plasma levels is available and may be helpful where there is poor control or side effects are suspected.

Combined therapy: In certain cases it may be necessary to raise the dose by 5 to 10 mg/kg/day when used in combination with anticonvulsants which induce liver enzyme activity, e.g. phenytoin, phenobarbitone and carbamazepine. Once known enzyme inducers have been withdrawn it may be possible to maintain seizure control on a reduced dose of Epilim. When barbiturates are being administered concomitantly, the dosage of barbiturate should be reduced if sedation is observed.

Mania

Initially dosage should start with 600 mg daily increasing by 200 mg/day at three-day intervals until control is achieved. This is generally within the range 1,000 to 2,000 mg/day, (i.e. 20 to 30 mg/kg/day). Where adequate control is not achieved within this range the dose may be further increased to 2,500 mg/day.

The Bowden *et al* study (see **PHARMACOLOGY, Clinical Trials**) provided strong support for the greater efficacy of serum levels above 45 µg/mL (these levels achieved 20% or greater improvement on both subscales of the Mania Rating Scale). Bowden noted that > 125 µg/mL had greater drug-related adverse events. Between these extremes there does not appear to be a clear dose-response relationship.

Hepatic Impairment: Liver dysfunction, including hepatic failure resulting in fatalities, has occurred in patients whose treatment included valproic acid or sodium valproate (see **PRECAUTIONS**).

Impaired renal function: Lower doses may be required since free drug levels may be high owing to lowered serum albumin and poor urinary excretion of free drug metabolites (see **PRECAUTIONS**).

Use in the elderly: Although the pharmacokinetics of Epilim are modified in the elderly, they have limited clinical significance and dosage should be determined by seizure control. The volume of distribution is increased in the elderly and because of decreased binding to serum albumin, the proportion of free drug is increased. This will affect the clinical interpretation of plasma valproic acid levels.

OVERDOSAGE

Cases of accidental and suicidal overdose have been reported. Fatalities are rare.

Symptoms

Symptoms of overdose may include serious CNS depression and impairment of respiration. In cases of overdose, long half-lives up to 30 hours have been reported. Signs of an acute massive overdose usually include coma, with muscular hypotonia, hyporeflexia and miosis, impaired respiratory functions and metabolic acidosis. Symptoms may however be variable and seizures have been reported in the presence of very high plasma levels. Cases of intracranial hypertension related to cerebral oedema have been reported. Deaths have occurred following massive overdose; nevertheless, a favourable outcome is usual.

Treatment

Establish airway and breathing and evaluate circulatory status. Assisted mechanical ventilation may be required in cases of respiratory depression. Activated charcoal may reduce the absorption of the medicine if given within one or two hours after ingestion. In patients who are not fully conscious or have impaired gag reflex, consideration should be given to administering activated charcoal via nasogastric tube, once the airway is protected. Haemodialysis and haemoperfusion have been used successfully. Intravenous naloxone has also been used sometimes in association with activated charcoal given orally.

Provided that adequate supportive treatment is given, full recovery usually occurs. Particular attention should be given to the maintenance of an adequate urinary output. Hepatic and pancreatic function should be monitored.

Contact the Poisons Information Centre for advice on management of overdose.

PRESENTATION AND STORAGE CONDITIONS

1. Crushable Tablets, 100 mg (white, scored):
Blister packs of 100 tablets. Store below 30°C. Store in a dry place. Keep in protective foil until taken.
2. Tablets, 200 mg (lilac, enteric-coated):

Blister packs of 10, 20 and 100 tablets. Store below 30°C. Store in a dry place. Keep in protective foil until taken.

3. Tablets, 500 mg (lilac enteric-coated):

Blister packs of 10, 20 and 100 tablets. Store below 30°C. Store in a dry place. Keep in protective foil until taken.

4. Syrup, 200 mg/5 mL (red, cherry flavoured):

300 mL amber glass bottle. Store below 25°C. Store away from direct sunlight.

5. Sugar free liquid, 200 mg/5 mL (red, cherry flavoured):

300 mL amber glass bottle. Store below 25°C. Store away from direct sunlight.

POISON SCHEDULE OF THE MEDICINE

Prescription Only Medicine (S4)

NAME AND ADDRESS OF THE SPONSOR:

sanofi-aventis australia pty ltd
12-24 Talavera Road
Macquarie Park NSW 2113

Date of TGA Approval: 22 March 2004

Safety Related Notification: 20th March 2007