

SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Duohal 25 micrograms/125 micrograms /dose pressurised inhalation, suspension

Duohal 25 micrograms/250 micrograms /dose pressurised inhalation, suspension

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each metered dose of Duohal provides:

25 micrograms of salmeterol (as salmeterol xinafoate) and 125 or 250 micrograms of fluticasone propionate (delivered from the valve). This is equivalent to 21 micrograms of salmeterol and 110 or 220 micrograms of fluticasone propionate delivered from the actuator (delivered dose).

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Pressurised inhalation, suspension.

The canister contains a white homogeneous suspension.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Duohal is indicated in the regular treatment of asthma where use of a combination product (long-acting β_2 agonist and inhaled corticosteroid) is appropriate:

- patients not adequately controlled with inhaled corticosteroids and 'as needed' inhaled short acting β_2 agonist

or

- patients already adequately controlled on both inhaled corticosteroids and long-acting β_2 agonist.

4.2 Posology and method of administration

Posology

Duohal is for inhalation use only.

Patients should be made aware that Duohal must be used daily for optimum benefit, even when asymptomatic.

Patients should be regularly reassessed by a doctor, so that the strength of Duohal they are receiving remains optimal and is only changed on medical advice. **The dose should be titrated to the lowest dose at which effective control of symptoms is maintained.**

Where the control of symptoms is maintained with the lowest strength of Duohal (25/125

microgram), the next step could include a swap to a different inhaled salmeterol fluticasone product available in a lower strength (25/50 micrograms).

As an alternative, patients requiring a long-acting β_2 agonist could be titrated to salmeterol/fluticasone propionate given once daily if, in the opinion of the prescriber, it would be adequate to maintain disease control. In the event of once daily dosing when the patient has a history of nocturnal symptoms the dose should be given at night and when the patient has a history of mainly daytime symptoms the dose should be given in the morning.

Patients should be given the strength of a salmeterol/fluticasone propionate product containing the appropriate fluticasone propionate dosage for the severity of their disease. Prescribers should be aware that, in patients with asthma, fluticasone propionate is as effective as other inhaled steroids at approximately half the microgram daily dose. If an individual patient should require dosages outside the recommended regimen, appropriate doses of β_2 agonist and/or corticosteroid should be prescribed.

Note: If a higher than 250 micrograms dose of fluticasone propionate is required, an alternative product must be used.

Recommended doses

Adults and adolescents 12 years and older

- Two inhalations of 25 micrograms salmeterol and 125 micrograms fluticasone propionate twice daily.
- or
- Two inhalations of 25 micrograms salmeterol and 250 micrograms fluticasone propionate twice daily.

A clear benefit has not been shown as compared to inhaled fluticasone propionate alone used as initial maintenance therapy when one or two of the criteria of severity are missing. In general inhaled corticosteroids remain the first line treatment for most patients. Duohal is not intended for the initial management of mild asthma.

Use of a spacer device with Duohal is recommended in patients who have, or are likely to have difficulties to coordinate actuation with inspiration.

A spacer device such as the Volumatic or AeroChamber Plus or other spacer devices can be used (depending on National Guidance). Single dose pharmacokinetic data have demonstrated that the systemic exposure to salmeterol and fluticasone propionate may change when different spacer devices are used (see section 4.4).

Patients should be instructed in the proper use and care of their inhaler and spacer and their technique checked to ensure optimum delivery of the inhaled medicinal product to the lungs.

Patients should continue to use the same make of spacer device as switching between spacer devices can result in changes in the dose delivered to the lungs (see section 4.4).

Re-titration to the lowest effective dose should always follow the introduction or change of a spacer device.

Special patient groups

There is no need to adjust the dose in elderly patients or in those with renal impairment. There are no data available for use of salmeterol/fluticasone propionate in patients with hepatic impairment.

Instructions for use

Patients should be instructed in the proper use of their inhaler (see patient information leaflet).

During inhalation, the patient should preferably sit or stand. The inhaler has been designed for use in a vertical position.

Testing the inhaler

Before using for the first time patients should remove the mouthpiece cover by gently squeezing the sides of the cover, shake the inhaler well, hold the inhaler between the fingers and thumb with their thumb on the base, below the mouthpiece and release four puffs into the air to make sure that it works. The inhaler should be shaken immediately before releasing each puff. If the inhaler has not been used for a week or more remove the mouthpiece cover, the patients should shake the inhaler well and release two puffs into the air.

Use of the inhaler

1. Patients should remove the mouthpiece cover by gently squeezing the sides of the cover
2. Patients should check inside and outside of the inhaler including the mouthpiece for the presence of loose objects.
3. Patients should shake the inhaler well to ensure that any loose objects are removed and that the contents of the inhaler are evenly mixed
4. Patients should hold the inhaler upright between fingers and thumb with their thumb on the base, below the mouthpiece.
5. Patients should breathe out as far as is comfortable and then place the mouthpiece in their mouth between their teeth and close their lips around it. Patients should be instructed not to bite the mouth piece.
6. Just after starting to breathe in through their mouth, patients should press firmly down on the top of the inhaler to release Duohal, while still breathing in steadily and deeply.
7. While holding their breath, patients should take the inhaler from their mouth and take their finger from the top of the inhaler. Patients should continue holding their breath for as long as is comfortable.
8. To take a second inhalation, patients should keep the inhaler upright and wait about half a minute before repeating steps 3 to 7.
9. Patients should immediately replace the mouthpiece cover in the correct orientation by firmly pushing and snapping the cap into position. The cover does not require excessive force and it will click into position.

IMPORTANT

Patients should not rush stages 5, 6 and 7. It is important that patients start to breathe in as slowly as possible just before operating their inhaler. Patients should practice in front of a mirror for the first few times. If they see "mist" coming from the top of their inhaler or the sides of their mouth they should start again from stage 3.

Patients should rinse their mouth out with water and spit out, and/or brush their teeth after each dose of medicine, in order to minimise the risk of oropharyngeal candidiasis and hoarseness.

Patients should consider getting a replacement when the indicator shows the number '40' and the colour on the dose indicator will change from green to red. Stop using the inhaler when the indicator shows '0' as any puffs left in the device may not be enough to give you a full dose.

Never try to alter the numbers on the indicator or detach the indicator from the actuator. The indicator cannot be reset and is permanently attached to the actuator.

Cleaning

Your inhaler should be cleaned at least once a week.

1. Remove the mouth piece cover.
2. Do not remove the canister from the plastic casing.
3. Wipe the inside and outside of the mouthpiece and the plastic casing with a dry cloth or tissue.
4. Replace the mouthpiece cover in the correct orientation. This does not require excessive force, the cover should click into position.

DO NOT PUT THE METAL CONTAINER IN WATER

4.3 Contraindications

Hypersensitivity to the active substances or to any of the excipients listed in section 6.1.

4.4 Special warnings and precautions for use

The management of asthma should normally follow a stepwise programme and patient response should be monitored clinically and by lung function tests.

Salmeterol/fluticasone propionate should not be used to treat acute asthma symptoms for which a fast- and short-acting bronchodilator is required. Patients should be advised to have their medicinal product to be used for relief in an acute asthma attack available at all times.

Patients should not be initiated on salmeterol/fluticasone propionate during an exacerbation, or if they have significantly worsening or acutely deteriorating asthma.

Serious asthma-related adverse events and exacerbations may occur during treatment with salmeterol/fluticasone propionate. Patients should be asked to continue treatment but to seek medical advice if asthma symptoms remain uncontrolled or worsen after initiation on salmeterol/fluticasone propionate.

Increased requirements for use of reliever medication (short-acting bronchodilators), or decreased response to reliever medication indicate deterioration of asthma control and patients should be reviewed by a physician.

Sudden and progressive deterioration in control of asthma is potentially life-threatening and the patient should undergo urgent medical assessment. Consideration should be given to increasing corticosteroid therapy.

The patient should also be medically reviewed where the current dosage of salmeterol/fluticasone propionate has failed to give adequate control of asthma. Consideration should be given to additional corticosteroid therapies.

Once asthma symptoms are controlled, consideration may be given to gradually reducing the dose of salmeterol/fluticasone propionate. Regular review of patients as treatment is stepped down is important. The lowest effective dose of salmeterol/fluticasone propionate should be used (see section 4.2).

Treatment with salmeterol/fluticasone propionate should not be stopped abruptly due to risk of exacerbation. Therapy should be down-titrated under physician supervision.

As with all inhaled medication containing corticosteroids, salmeterol/fluticasone propionate should be administered with caution in patients with active or quiescent pulmonary tuberculosis and fungal, viral or other infections of the airway. Appropriate treatment should be promptly instituted, if indicated.

Rarely, salmeterol/fluticasone propionate may cause cardiac arrhythmias e.g. supraventricular tachycardia, extrasystoles and atrial fibrillation, and a mild transient reduction in serum potassium at high therapeutic doses. Salmeterol/fluticasone propionate should be used with caution in patients with severe cardiovascular disorders or heart rhythm abnormalities and in patients with diabetes mellitus, thyrotoxicosis, uncorrected hypokalaemia or patients predisposed to low levels of serum potassium.

There have been very rare reports of increases in blood glucose levels (see section 4.8) and this should be considered when prescribing to patients with a history of diabetes mellitus.

As with other inhalation therapy paradoxical bronchospasm may occur with an immediate increase in wheezing and shortness of breath after dosing. Paradoxical bronchospasm responds to a rapid-acting bronchodilator and should be treated straightaway. Salmeterol/fluticasone propionate should be discontinued immediately, the patient assessed and alternative therapy instituted if necessary.

Care should be taken when transferring patients to salmeterol/fluticasone propionate therapy, particularly if there is any reason to suppose that adrenal function is impaired from previous systemic steroid therapy.

The pharmacological side effects of β_2 agonist treatment, such as tremor, palpitations and headache, have been reported, but tend to be transient and reduce with regular therapy.

Systemic effects may occur with any inhaled corticosteroid, particularly at high doses prescribed for long periods. These effects are much less likely to occur than with oral corticosteroids. Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression, decrease in bone mineral density, cataract and glaucoma and more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression or aggression (particularly in children) (see Paediatric population sub-heading below for information on the systemic effects of inhaled corticosteroids in children and adolescents). It is important, therefore, that the patient is reviewed regularly and the dose of inhaled corticosteroid is reduced to the lowest dose at which effective control of asthma is maintained.

Visual disturbance may be reported with systemic and topical corticosteroid use. If a patient presents with symptoms such as blurred vision or other visual disturbances, the patient should be considered for referral to an ophthalmologist for evaluation of possible causes which may include cataract, glaucoma or rare diseases such as central serous chorioretinopathy (CSCR) which have been reported after use of systemic and topical corticosteroids.

Prolonged treatment of patients with high doses of inhaled corticosteroids may result in adrenal suppression and acute adrenal crisis. Very rare cases of adrenal suppression and acute adrenal crisis have also been described with doses of fluticasone propionate between 500 and less than 1000 micrograms. Situations, which could potentially trigger acute adrenal crisis, include trauma, surgery, infection or any rapid reduction in dosage. Presenting symptoms are typically vague and may include anorexia, abdominal pain, weight loss, tiredness, headache, nausea, vomiting, hypotension, decreased level of consciousness, hypoglycaemia, and seizures. Additional systemic corticosteroid cover should be considered during periods of stress or elective surgery.

Systemic absorption of salmeterol and fluticasone propionate is largely through the lungs. As the use of a spacer device with a metered dose inhaler may increase drug delivery to the lungs it should be noted that this could potentially lead to an increase in the risk of systemic adverse effects. Single dose pharmacokinetic data have demonstrated that the systemic exposure to salmeterol and fluticasone propionate may change when the different spacer devices are used.

The benefits of inhaled fluticasone propionate therapy should minimise the need for oral steroids, but patients transferring from oral steroids may remain at risk of impaired adrenal reserve for a

considerable time. Therefore these patients should be treated with special care and adrenocortical function regularly monitored. Patients who have required high dose emergency corticosteroid therapy in the past may also be at risk. This possibility of residual impairment should always be borne in mind in emergency and elective situations likely to produce stress, and appropriate corticosteroid treatment must be considered. The extent of the adrenal impairment may require specialist advice before elective procedures.

Ritonavir can greatly increase the concentration of fluticasone propionate in plasma. Therefore, concomitant use should be avoided, unless the potential benefit to the patient outweighs the risk of systemic corticosteroid side effects. There is also an increased risk of systemic side effects when combining fluticasone propionate with other potent CYP3A inhibitors, including cobicistat-containing products (see section 4.5).

There was an increased reporting of lower respiratory tract infections (particularly pneumonia and bronchitis) in a 3-year study in patients with Chronic Obstructive Pulmonary Disease (COPD) receiving salmeterol and fluticasone propionate as a fixed-dose combination administered via the Diskus/Accuhaler compared with placebo (see section 4.8). In a 3-year COPD study, older patients, patients with a lower body mass index ($<25\text{kg/m}^2$) and patients with very severe disease ($\text{FEV1} < 30\%$ predicted) were at greatest risk of developing pneumonia regardless of treatment. Physicians should remain vigilant for the possible development of pneumonia and other lower respiratory tract infections in patients with COPD as the clinical features of such infections and exacerbation frequently overlap. If a patient with severe COPD has experienced pneumonia the treatment with salmeterol/fluticasone propionate should be re-evaluated. The safety and efficacy of salmeterol/fluticasone propionate has not been established in patients with COPD and therefore salmeterol/fluticasone propionate is not indicated for use in the treatment of patients with COPD. Concomitant use of systemic ketoconazole significantly increases systemic exposure to salmeterol. This may lead to an increase in the incidence of systemic effects (e.g. prolongation in the QTc interval and palpitations). Concomitant treatment with ketoconazole or other potent CYP3A4 inhibitors should therefore be avoided unless the benefits outweigh the potentially increased risk of systemic side effects of salmeterol treatment (see section 4.5).

Paediatric population

Adolescents < 16 years taking high doses of fluticasone propionate (typically ≥ 1000 micrograms/day) may be at particular risk of systemic effects. Systemic effects may occur, particularly at high doses prescribed for long periods. Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression, acute adrenal crisis and growth retardation in adolescents and more rarely, a range of psychological or behavioural effects including psychomotor hyperactivity, sleep disorders, anxiety, depression or aggression. Consideration should be given to referring the adolescent to a paediatric respiratory specialist.

It is recommended that the height of adolescents receiving prolonged treatment with inhaled corticosteroid is regularly monitored.

The dose of inhaled corticosteroid should be reduced to the lowest dose at which effective control of asthma is maintained.

4.5 Interaction with other medicinal products and other forms of interaction

β adrenergic blockers may weaken or antagonise the effect of salmeterol. Both non-selective and selective β blockers should be avoided in patients with asthma, unless there are compelling reasons for their use. Potentially serious hypokalaemia may result from β_2 agonist therapy. Particular caution is advised in acute severe asthma as this effect may be potentiated by concomitant treatment with xanthine derivatives, steroids and diuretics.

Concomitant use of other β adrenergic containing medicinal products can have a potentially additive effect.

Fluticasone propionate

Under normal circumstances, low plasma concentrations of fluticasone propionate are achieved after inhaled dosing, due to extensive first pass metabolism and high systemic clearance mediated by cytochrome CYP3A4 in the gut and liver. Hence, clinically significant drug interactions mediated by fluticasone propionate are unlikely.

In an interaction study in healthy subjects with intranasal fluticasone propionate, ritonavir (a highly potent cytochrome CYP3A4 inhibitor) 100 mg b.i.d. increased the fluticasone propionate plasma concentrations several hundred fold, resulting in markedly reduced serum cortisol concentrations. Information about this interaction is lacking for inhaled fluticasone propionate, but a marked increase in fluticasone propionate plasma levels is expected. Cases of Cushing's syndrome and adrenal suppression have been reported. The combination should be avoided unless the benefit outweighs the increased risk of systemic glucocorticoid side effects.

In a small study in healthy volunteers, the slightly less potent CYP3A inhibitor ketoconazole increased the exposure of fluticasone propionate after a single inhalation by 150%. This resulted in a greater reduction of plasma cortisol as compared with fluticasone propionate alone. Co-treatment with other potent CYP3A inhibitors, such as itraconazole and cobicistat-containing products, and moderate CYP 3A inhibitors, such as erythromycin, is also expected to increase the systemic fluticasone propionate exposure and the risk of systemic side-effects. The combination should be avoided unless the benefit outweighs the increased risk of systemic corticosteroid side-effects, in which case patients should be monitored for systemic corticosteroid side-effects.

Salmeterol

Potent CYP3A4 inhibitors

Co-administration of ketoconazole (400 mg orally once daily) and salmeterol (50 micrograms inhaled twice daily) in 15 healthy subjects for 7 days resulted in a significant increase in plasma salmeterol exposure (1.4-fold C_{max} and 15-fold AUC). This may lead to an increase in the incidence of other systemic effects of salmeterol treatment (e.g. prolongation of QTc interval and palpitations) compared with salmeterol or ketoconazole treatment alone (see section 4.4).

Clinically significant effects were not seen on blood pressure, heart rate, blood glucose and blood potassium levels. Co-administration with ketoconazole did not increase the elimination half-life of salmeterol or increase salmeterol accumulation with repeat dosing.

The concomitant administration of ketoconazole should be avoided, unless the benefits outweigh the potentially increased risk of systemic side effects of salmeterol treatment. There is likely to be a similar risk of interaction with other potent CYP3A4 inhibitors (e.g. itraconazole, telithromycin, ritonavir).

Moderate CYP 3A4 inhibitors

Co-administration of erythromycin (500 mg orally three times a day) and salmeterol (50 micrograms inhaled twice daily) in 15 healthy subjects for 6 days resulted in a small but non-statistically significant increase in salmeterol exposure (1.4-fold C_{max} and 1.2-fold AUC). Co-administration with erythromycin was not associated with any serious adverse effects.

4.6 Fertility, pregnancy and lactation

Fertility

There are no data in humans. However, animal studies showed no effects of salmeterol or fluticasone propionate on fertility.

Pregnancy

A large amount of data on pregnant women (more than 1000 pregnancy outcomes) indicate no malformative or feto/neonatal toxicity related to salmeterol and fluticasone propionate. Animal studies have shown reproductive toxicity after administration of β_2 adrenoreceptor agonists and glucocorticosteroids (see section 5.3).

Administration of salmeterol/fluticasone propionate to pregnant women should only be considered if the expected benefit to the mother is greater than any possible risk to the fetus.

The lowest effective dose of fluticasone propionate needed to maintain adequate asthma control should be used in the treatment of pregnant women.

Breastfeeding

It is unknown whether salmeterol and fluticasone propionate/metabolites are excreted in human milk.

Studies have shown that salmeterol and fluticasone propionate, and their metabolites, are excreted into the milk of lactating rats.

A risk to breastfed newborns/infants cannot be excluded. A decision must be made whether to discontinue breastfeeding or to discontinue salmeterol/fluticasone propionate therapy taking into account the benefit of breastfeeding for the child and the benefit of therapy for the woman.

4.7 Effects on ability to drive and use machines

Salmeterol/fluticasone propionate has no or negligible influence on the ability to drive and use machines.

4.8 Undesirable effects

As Duohal contains salmeterol and fluticasone propionate, the type and severity of adverse reactions associated with each of the compounds may be expected. There is no incidence of additional adverse events following concurrent administration of the two compounds.

Adverse events which have been associated with salmeterol/fluticasone propionate are given below, listed by system organ class and frequency. Frequencies are defined as: very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1000$ to $< 1/100$), rare ($< 1/10,000$ to $< 1/1000$) and not known (cannot be estimated from the available data).

Frequencies were derived from clinical trial data. The incidence in placebo was not taken into account.

System Organ Class	Adverse Event	Frequency
Infections and infestations	Candidiasis of the mouth and throat	Common
	Pneumonia	Common ^{1,3}
	Bronchitis	Common ^{1,3}
	Oesophageal candidiasis	Rare
Immune system disorders	Hypersensitivity reactions with the following manifestations:	
	Cutaneous hypersensitivity reactions	Uncommon

	Dyspnoea	Uncommon
	Angioedema (mainly facial and oropharyngeal oedema)	Rare
	Bronchospasm	Rare
	Anaphylactic reactions including anaphylactic shock	Rare
Endocrine disorders	Cushing's syndrome, Cushingoid features, Adrenal suppression, Growth retardation in children and adolescents, Decreased bone mineral density	Rare ⁴
Metabolism and nutrition disorders	Hypokalaemia	Common ³
	Hyperglycaemia	Uncommon ⁴
Psychiatric disorders	Anxiety	Uncommon
	Sleep disorders	Uncommon
	Behavioural changes, including psychomotor hyperactivity and irritability (predominantly in children)	Rare
	Depression, aggression (predominantly in children)	Not Known
Nervous system disorders	Headache	Very common ¹
	Tremor	Uncommon
Eye disorder	Cataract	Uncommon
	Glaucoma	Rare ⁴
	Vision, blurred (see section 4.4)	Not Known
Cardiac disorders	Palpitations	Uncommon
	Tachycardia	Uncommon
	Atrial fibrillation	Uncommon
	Angina pectoris	Uncommon
	Cardiac arrhythmias (including supraventricular tachycardia and extrasystoles).	Rare
Respiratory, thoracic and mediastinal disorders	Nasopharyngitis	Very common ^{2,3}
	Throat irritation	Common
	Hoarseness/dysphonia	Common
	Sinusitis	Common ^{1,3}

	Paradoxical bronchospasm	Rare ⁴
Skin and subcutaneous tissue disorders	Contusions	Common ^{1,3}
Musculoskeletal and connective tissue disorders	Muscle cramps	Common
	Traumatic fractures	Common ^{1,3}
	Arthralgia	Common
	Myalgia	Common

1. Reported commonly in placebo
2. Reported very commonly in placebo
3. Reported over 3 years in a COPD study
4. See section 4.4

Description of selected adverse reactions

The pharmacological side effects of β_2 agonist treatment, such as tremor, palpitations and headache, have been reported, but tend to be transient and reduce with regular therapy.

As with other inhalation therapy paradoxical bronchospasm may occur with an immediate increase in wheezing and shortness of breath after dosing. Paradoxical bronchospasm responds to a rapid-acting bronchodilator and should be treated straightaway. Salmeterol/fluticasone should be discontinued immediately, the patient assessed and alternative therapy instituted if necessary.

Due to the fluticasone propionate component, hoarseness and candidiasis (thrush) of the mouth and throat and, rarely, of the oesophagus can occur in some patients. Both hoarseness and incidence of mouth and throat candidiasis may be relieved by rinsing the mouth with water and/or brushing the teeth after using the medicinal product. Symptomatic mouth and throat candidiasis can be treated with topical anti-fungal therapy whilst still continuing with the salmeterol/fluticasone propionate.

Paediatric population

Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression and growth retardation in adolescents (see section 4.4). Adolescent may also experience anxiety, sleep disorders and behavioural changes, including hyperactivity and irritability.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/ risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the national reporting systems listed in Appendix V*.

4.9 Overdose

There are no data available from clinical trials on overdose with salmeterol/fluticasone propionate, however data on overdose with both medicinal products are given below:

The signs and symptoms of salmeterol overdose are dizziness, increase in systolic blood pressure, tremor, headache and tachycardia. The preferred antidotes are cardioselective β blocking agents, which should be used with caution in patients with a history of bronchospasm. If salmeterol/fluticasone propionate therapy has to be withdrawn due to overdose of the β agonist component of the medicinal product, provision of appropriate replacement steroid therapy should

be considered. Additionally, hypokalaemia can occur and therefore serum potassium levels should be monitored. Potassium replacement should be considered.

Acute

Acute inhalation of fluticasone propionate doses in excess of those recommended may lead to temporary suppression of adrenal function. This does not need emergency action as adrenal function is recovered in a few days, as verified by plasma cortisol measurements.

Chronic overdose of inhaled fluticasone propionate

Adrenal reserve should be monitored and treatment with a systemic corticosteroid may be necessary. When stabilised, treatment should be continued with an inhaled corticosteroid at the recommended dose. Refer to section 4.4: risk of adrenal suppression.

Monitoring of adrenal reserve may be necessary. In cases of both acute and chronic fluticasone propionate overdose, salmeterol/fluticasone propionate therapy should be continued at a suitable dosage for symptom control.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Adrenergics in combination with corticosteroids or other drugs, excl. Anticholinergics.

ATC Code: R03AK06

Mechanism of action and pharmacodynamics effects

Duohal contains salmeterol and fluticasone propionate which have differing modes of action.

The respective mechanisms of action of both medicinal products are discussed below.

Salmeterol

Salmeterol is a selective long-acting (12 hour) β_2 adrenoceptor agonist with a long side chain which binds to the exo-site of the receptor.

Salmeterol produces a longer duration of bronchodilation, lasting for at least 12 hours, than recommended doses of conventional short-acting β_2 agonists.

Fluticasone propionate

Fluticasone propionate given by inhalation at recommended doses has a glucocorticoid anti-inflammatory action within the lungs, resulting in reduced symptoms and exacerbations of asthma, with less adverse effects than when corticosteroids are administered systemically.

Clinical efficacy and safety

Salmeterol/fluticasone propionate asthma clinical trials

A twelve month study (Gaining Optimal Asthma Control, GOAL), in 3416 adult and adolescent patients with persistent asthma, compared the safety and efficacy of salmeterol/fluticasone propionate versus inhaled corticosteroid (fluticasone propionate) alone to determine whether the goals of asthma management were achievable. Treatment was stepped up every 12 weeks until

****Total control** was achieved or the highest dose of study drug was reached. GOAL showed more patients treated with salmeterol/fluticasone propionate achieved asthma control than patients treated with ICS alone and this control was attained at a lower corticosteroid dose.

***Well controlled** asthma was achieved more rapidly with salmeterol/fluticasone propionate than with ICS alone. The time on treatment for 50% of subjects to achieve a first individual *well controlled* week was 16 days for salmeterol/fluticasone propionate compared to 37 days for the ICS group. In the subset of steroid naive asthmatics the time to an individual *well controlled* week was 16 days in the salmeterol/fluticasone propionate treatment compared to 23 days following treatment with ICS.

The overall study results showed:

Percentage of Patients Attaining *Well Controlled (WC) and **Totally Controlled (TC) Asthma over 12 months				
Pre-Study Treatment	Salmeterol/FP		FP	
	WC	TC	WC	TC
No ICS (SABA alone)	78%	50%	70%	40%
Low dose ICS (≤ 500 microgram BDP or equivalent/day)	75%	44%	60%	28%
Medium dose ICS (> 500 -1000 microgram BDP or equivalent/day)	62%	29%	47%	16%
Pooled results across the 3 treatment levels	71%	41%	59%	28%

***Well controlled** asthma; less than or equal to 2 days with symptoms score greater than 1 (symptom score 1 defined as 'symptoms for one short period during the day') SABA use on less than or equal to 2 days and less than or equal to 4 occasions/week, greater than or equal to 80% predicted morning peak expiratory flow, no night-time awakenings, no exacerbations and no side effects enforcing a change in therapy.

****Total control** of asthma; no symptoms, no SABA use, greater than or equal to 80% predicted morning peak expiratory flow, no night-time awakenings, no exacerbations and no side effects enforcing a change in therapy.

A double blind, randomised, parallel group study in 318 patients with persistent asthma aged ≥ 18 years evaluated the safety and tolerability of administering two inhalations twice daily (double dose) of salmeterol/fluticasone propionate for two weeks. The study showed that doubling the inhalations of each strength of salmeterol/fluticasone propionate for up to 14 days resulted in a small increase in β agonist-related adverse events (tremor; 1 patient [1%] vs 0, palpitations; 6 [3%] vs 1 [$<1\%$], muscle cramps; 6 [3%] vs 1 [$<1\%$]) and a similar incidence of inhaled corticosteroid related adverse events (e.g. oral candidiasis; 6 [6%] vs 16 [8%], hoarseness; 2 [2%] vs 4 [2%]) compared to one inhalation twice daily. The small increase in β agonist-related adverse events should be taken into account if doubling the dose of salmeterol/fluticasone propionate is considered by the physician in adult patients requiring additional short-term (up to 14 days) inhaled corticosteroid therapy.

Asthma

The Salmeterol Multi-center Asthma Research Trial (SMART)

The Salmeterol Multi-center Asthma Research Trial (SMART) was a 28-week US study that evaluated the safety of salmeterol compared to placebo added to usual therapy in adult and adolescent subjects. Although there were no significant differences in the primary endpoint of the combined number of respiratory-related deaths and respiratory-related life-threatening

experiences, the study showed a significant increase in asthma-related deaths in patients receiving salmeterol (13 deaths out of 13,176 patients treated with salmeterol versus 3 deaths out of 13,179 patients on placebo). The study was not designed to assess the impact of concurrent inhaled corticosteroid use, and only 47% of subjects reported ICS use at baseline.

Safety and efficacy of salmeterol-FP versus FP alone in asthma

Two multi-centre 26-week studies were conducted to compare the safety and efficacy of salmeterol-FP versus FP alone, one in adult and adolescent subjects (AUSTRI trial), and the other in paediatric subjects 4-11 years of age (VESTRI trial). For both studies, enrolled subjects had moderate to severe persistent asthma with history of asthma-related hospitalisation or asthma exacerbation in the previous year. The primary objective of each study was to determine whether the addition of LABA to ICS therapy (salmeterol-FP) was non-inferior to ICS (FP) alone in terms of the risk of serious asthma related events (asthma-related hospitalisation, endotracheal intubation, and death). A secondary efficacy objective of these studies was to evaluate whether ICS/LABA (salmeterol-FP) was superior to ICS therapy alone (FP) in terms of severe asthma exacerbation (defined as deterioration of asthma requiring the use of systemic corticosteroids for at least 3 days or an in-patient hospitalisation or emergency department visit due to asthma that required systemic corticosteroids).

A total of 11,679 and 6,208 subjects were randomized and received treatment in the AUSTRI and VESTRI trials, respectively. For the primary safety endpoint, non-inferiority was achieved for both trials (see Table below).

Serious Asthma-Related Events in the 26-Week AUSTRI and VESTRI Trials

	AUSTRI		VESTRI	
	Salmeterol-FP (n = 5,834)	FP Alone (n =5,845)	Salmeterol-FP (n = 3,107)	FP Alone (n =3,101)
Composite endpoint (Asthma-related hospitalisation, endotracheal intubation, or death)	34 (0.6%)	33 (0.6%)	27 (0.9%)	27 (0.7%)
Salmeterol-FP/FP Hazard ratio (95% CI)	1.029 (0.638-1.662) ^a		1.285 (0.726-2.272) ^b	
Death	0	0	0	0
Asthma-related hospitalisation	34	33	27	21
Endotracheal intubation	0	2	0	0

^a If the resulting upper 95% CI estimate for the relative risk was less than 2.0, then non-inferiority was concluded.

^b If the resulting upper 95% CI estimate for the relative risk was less than 2.675, then non-inferiority was concluded.

For the secondary efficacy endpoint, reduction in time to first asthma exacerbation for salmeterol-FP relative to FP was seen in both studies, however only AUSTRI met statistical significance

	AUSTRI		VESTRI	
	Salmeterol-FP	FP Alone	Salmeterol-FP	FP Alone

	(n = 5,834)	(n = 5,845)	(n = 3,107)	(n = 3,101)
Number of subjects with an asthma exacerbation	480 (8%)	597 (10%)	265 (9%)	309 (10%)
Salmeterol-FP/FP Hazard ratio (95% CI)	0.787 (0.698, 0.888)		0.859 (0.729, 1.012)	

Fluticasone propionate containing medications in asthma during pregnancy

An observational retrospective epidemiological cohort study utilising electronic health records from the United Kingdom was conducted to evaluate the risk of MCMs following first trimester exposure to inhaled FP alone and salmeterol-FP relative to non-FP containing ICS. No placebo comparator was included in this study.

Within the asthma cohort of 5362 first trimester ICS-exposed pregnancies, 131 diagnosed MCMs were identified; 1612 (30%) were exposed to FP or salmeterol-FP of which 42 diagnosed MCMs were identified. The adjusted odds ratio for MCMs diagnosed by 1 year was 1.1 (95%CI: 0.5 – 2.3) for FP exposed vs non-FP ICS exposed women with moderate asthma and 1.2 (95%CI: 0.7 – 2.0) for women with considerable to severe asthma. No difference in the risk of MCMs was identified following first trimester exposure to FP alone versus salmeterol-FP. Absolute risks of MCM across the asthma severity strata ranged from 2.0 to 2.9 per 100 FP-exposed pregnancies which is comparable to results from a study of 15,840 pregnancies unexposed to asthma therapies in the General Practice Research Database (2.8 MCM events per 100 pregnancies).

5.2 Pharmacokinetic properties

When salmeterol and fluticasone propionate were administered in combination by the inhaled route, the pharmacokinetics of each component were similar to those observed when the medicinal products were administered separately. For pharmacokinetic purposes therefore each component can be considered separately.

Salmeterol

Salmeterol acts locally in the lung therefore plasma levels are not an indication of therapeutic effects. In addition there are only limited data available on the pharmacokinetics of salmeterol because of the technical difficulty of assaying the drug in plasma due to the low plasma concentrations at therapeutic doses (approximately 200 picogram/mL or less) achieved after inhaled dosing.

Fluticasone propionate

The absolute bioavailability of a single dose of inhaled fluticasone propionate in healthy subjects varies between approximately 5 to 11% of the nominal dose depending on the inhalation device used. In patients with asthma a lesser degree of systemic exposure to inhaled fluticasone propionate has been observed.

Systemic absorption occurs mainly through the lungs and is initially rapid then prolonged. The remainder of the inhaled dose may be swallowed but contributes minimally to systemic exposure due to the low aqueous solubility and pre-systemic metabolism, resulting in oral availability of less than 1%. There is a linear increase in systemic exposure with increasing inhaled dose.

The disposition of fluticasone propionate is characterised by high plasma clearance (1150 mL/min), a large volume of distribution at steady-state (approximately 300 L) and a terminal half-life of approximately 8 hours.

Plasma protein binding is 91%.

Fluticasone propionate is cleared very rapidly from the systemic circulation. The main pathway is metabolism to an inactive carboxylic acid metabolite, by the cytochrome P450 enzyme CYP3A4. Other unidentified metabolites are also found in the faeces.

The renal clearance of fluticasone propionate is negligible. Less than 5% of the dose is excreted in urine, mainly as metabolites. The main part of the dose is excreted as faeces as metabolites and unchanged drug.

5.3 Preclinical safety data

The only safety concerns for human use derived from animal studies of salmeterol and fluticasone propionate given separately were effects associated with exaggerated pharmacological actions.

In animal reproduction studies, glucocorticosteroids have been shown to induce malformations (cleft palate, skeletal malformations). However, these animal experimental results do not seem to be relevant for man given recommended doses. Animal studies with salmeterol have shown embryofetal toxicity only at high exposure levels. Following co-administration, increased incidences of transposed umbilical artery and incomplete ossification of occipital bone were found in rats at doses associated with known glucocorticoid-induced abnormalities. Neither salmeterol xinafoate or fluticasone propionate have shown any potential for genetic toxicity.

The non-CFC propellant, norflurane, has been shown to have no toxic effect at very high vapour concentrations, far in excess of those likely to be experienced by patients, in a wide range of animal species exposed daily for periods of two years.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Norflurane (HFA 134a).

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

2 years

6.4 Special precautions for storage

Replace the mouthpiece cover firmly and snap it into position.

The canister contains a pressurised liquid. Do not expose to temperatures higher than 50°C. Do not pierce the canister.

As with most inhaled medicinal products in pressurised containers, the therapeutic effect of this medicinal product may decrease when the container is cold.

6.5 Nature and contents of container

Aluminium canister with a suitable metering valve and a polypropylene actuator with dust cap having dose indicator.

Each container is filled to deliver 120 doses.

Pack sizes:

1, 2 (bundled package 2x1) or 3 (bundled package 3x1) canisters containing 120 doses.
10 (bundled package 10x1) canisters containing 120 doses -hospital/pharmacy use only

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

No special requirements for disposal.

7. MARKETING AUTHORISATION HOLDER

Cipla Europe NV
De Keyserlei, 60C, Bus-1301,
2018 Antwerp,
Belgium

8. MARKETING AUTHORISATION NUMBER(S)

<[To be completed nationally]>

9. DATE OF FIRST AUTHORISATION / RENEWAL OF THE AUTHORISATION

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10. DATE OF REVISION OF THE TEXT

2025-01-24