Abbreviated Prescribing Information for Use in the International Area. Based on full NCDS (V 07) and prepared to meet the requirements of the GSK International Pharmaceutical Promotional and Marketing Policy.

Capoten Tablets

Use in pregnancy: Not used in pregnancy, as it may cause injury and even death to the developing fetus.

COMPOSITION: Each tablet contains 25 mg or 50 mg of captopril. **INDICATIONS**: For the treatment of: essential hypertension, chronic heart failure, myocardial infarction: *short-term (4 weeks) treatment:* captopril is indicated in any clinically stable patients within the first 24 hours of an infraction, l*ong term prevention of symptomatic heart failure:* captopril is indicated in clinically stable patients with asymptomatic left ventricular dysfunction, macroproteinuric diabetic nephropathy in patients with type I diabetes. **Dosage and Administration**: Captopril may be taken before, during and after meals. Dose should be individualised according to patient's profile and blood pressure response. The recommended maximum daily dose is 150 mg. **Adults**: ***Hypertension:*** The recommended starting dose is 25-50 mg daily in two divided doses. The dose may be increased incrementally, with intervals of at least 2 weeks, to 100-150 mg/day in two divided doses as needed to reach target blood pressure. Captopril may be used alone or with other antihypertensive agents, especially thiazide diuretics. A once-daily dosing regimen may be appropriate when concomitant antihypertensive medication such as thiazide diuretics is added. In patients with a strongly active renin-angiotensin-aldosterone system (hypovolaemia, renovascular hypertension, cardiac decompensation) it is preferable to commence with a single dose of 6.25 mg or 12.5 mg. The inauguration of this treatment should preferably take place under close medical supervision. These doses will then be administered at a rate of two per day. The dosage can be gradually increased to 50 mg per day in one or two doses and if necessary to 100 mg per day in one or two doses. ***Heart failure:*** Treatment with captopril for heart failure should be initiated under close medical supervision. The usual starting dose is 6.25 mg-12.5 mg twice or three times a day. Titration to the maintenance dose (75-150 mg per day) should be carried out based on patient's response, clinical status and tolerability, up to a maximum of 150 mg per day in divided doses. The dose should be increased incrementally, with intervals of at least 2 weeks to evaluate patient's response. ***Myocardial infarction:*** S*hort-term treatment:* Captopril treatment should begin in hospital as soon as possible following the appearance of the signs and/or symptoms in patients with stable haemodynamics. A 6.25 mg test dose should be administered, with a 12.5 mg dose being administered 2 hours afterwards and a 25 mg dose 12 hours later. From the following day, captopril should be administered in a 100 mg/day dose, in two daily administrations, for 4 weeks, if warranted by the absence of adverse haemodynamic reactions. At the end of 4 weeks of treatment, the patient's state should be reassessed before a decision is taken concerning treatment for the post-myocardial infarction stage. *Chronic treatment:* If captopril treatment has not begun during the first 24 hours of the acute myocardial infarction stage, it is suggested that treatment should be instigated between the 3rd and 16th day post-infarction once the necessary treatment conditions have been attained (stable haemodynamics and management of any residual ischaemia). Treatment should be started in hospital under strict surveillance (particularly of blood pressure) until the 75 mg dose is reached. The initial dose must be low, particularly if the patient exhibits normal or low blood pressure at the initiation of therapy. Treatment should be initiated with a dose of 6.25 mg followed by 12.5 mg 3 times daily for 2 days and then 25 mg 3 times daily if warranted by the absence of adverse haemodynamic reactions. The recommended dose for effective

cardioprotection during long-term treatment is 75 to 150 mg daily in two or three doses. In cases of symptomatic hypotension, as in heart failure, the dosage of diuretics and/or other concomitant vasodilators may be reduced in order to attain the steady state dose of captopril. Where necessary, the dose of captopril should be adjusted in accordance with the patient's clinical reactions. Captopril may be used in combination with other treatments for myocardial infarction such as thrombolytic agents, beta-blockers and acetylsalicylic acid. ***Type I diabetic nephropathy:*** In patients with type I diabetic nephropathy, the recommended daily dose of captopril is 75 to 100 mg in divided doses. If additional lowering of blood pressure is desired, additional antihypertensive medications may be added. Children and adolescents: The efficacy and safety of captopril have not been fully established. The use of captopril in children and adolescents should be initiated under close medical supervision. The initial dose of captopril is about 0.3 mg/kg body weight. For patients requiring special precautions (children with renal dysfunction, premature infants, new-borns and infants, because their renal function is not the same with older children and adults) the starting dose should only be 0.15 mg captopril/kg weight. Generally, captopril is administered to children 3 times a day, but dose and interval of dose should be adapted individually according to patient's response. Elderly: As with other antihypertensive agents, consideration should be given to initiating therapy with a lower starting dose (6.25 mg twice a day) in elderly patients who may have reduced renal function and other organ dysfunctions. Dosage should be titrated against the blood pressure response and kept as low as possible to achieve adequate control. Renal impairment: Since captopril is excreted primarily via the kidneys, dosage should be reduced or the dosage interval should be increased in patients with impaired renal function. When concomitant diuretic therapy is required, a loop diuretic (e.g. furosemide), rather than a thiazide diuretic, is preferred in patients with severe renal impairment. In patients with impaired renal function, the following daily dose may be recommended to avoid accumulation of captopril.

Creatinine clearance **(ml/min/1.73m^2)**	**Daily starting dose (mg)**	**Daily maximum dose (mg)**
> 40	25 - 50	150
21 - 40	25	100
10 - 20	12.5	75
< 10	6.25	37.5

Hepatic impairment: Patients receiving ACE inhibitors who develop jaundice or marked elevations of hepatic enzymes should discontinue the ACE inhibitor and receive appropriate medical follow-up. **Contraindications:** Captopril is contraindicated in: history of hypersensitivity to captopril, its excipients or any other ACE inhibitor, history of angioedema associated with previous ACE inhibitor therapy, hereditary/idiopathic angioneurotic oedema, second and third trimesters of pregnancy, Lactation. The concomitant use of Captopril with aliskiren-containing products is contraindicated in patients with diabetes mellitus or renal impairment (GFR < 60ml/min/1.73m2). **Warnings and Precautions:** *Hypotension*: Rarely hypotension is observed in uncomplicated hypertensive patients. Symptomatic hypotension is more likely to occur in hypertensive patients who are volume and/or sodium depleted by vigorous

diuretic therapy, dietary salt restriction, diarrhoea, vomiting or haemodialysis. Volume and/or sodium depletion should be corrected before the administration of an ACE inhibitor and a lower starting dose should be considered. In patients with congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy for hypertension may cause an excessive drop in the blood pressure, which may be associated with oliguria, azotemia and in rare instances, with acute renal failure and death in such patients. Captopril should be started under close medical supervision and a lower starting dose is recommended when initiating therapy with an ACE inhibitor. The magnitude of the decrease is greatest early in the course of treatment; this effect stabilizes within a week or two, and generally returns to pre-treatment levels, without a decrease in therapeutic efficacy, within two months. Patients should be followed closely for the first two weeks of treatment and whenever the dosage is increased. As with any antihypertensive agent, excessive blood pressure lowering in patients with ischaemic cardiovascular or cerebrovascular disease may increase the risk of myocardial infarction or stroke. If hypotension develops, the patient should be placed in a supine position. Volume repletion with intravenous normal saline may be required. Infants, especially new-borns, may be more susceptible to the adverse haemodynamic effects of captopril. Excessive, prolonged and unpredictable decreases in blood pressure and associated complications, including oliguria and seizures have been reported. *Renovascular hypertension*: There is an increased risk of hypotension and renal insufficiency when patients with bilateral renal artery stenosis or stenosis of the artery to a single functioning kidney are treated with ACE inhibitors. Loss of renal function may occur with only mild changes in serum creatinine. In these patients, therapy should be initiated under close medical supervision with low doses, careful titration and monitoring of renal function. *Renal impairment*: In cases of renal impairment (creatinine clearance ≤ 40ml/min), the initial dosage of captopril must be adjusted according to the patient's creatinine clearance and then as a function of the patient's response to treatment. Routine monitoring of potassium and creatinine are part of normal medical practice for these patients. *Angioedema*: Angioedema of the extremities, face, lips, mucous membranes, tongue, glottis or larynx may occur in patients treated with ACE inhibitors including captopril. This may occur anytime during treatment. However, in rare cases, severe angioedema may develop after long-term treatment with an ACE inhibitor. In such cases, captopril should be discontinued promptly and appropriate monitoring should be instituted to ensure complete resolution of symptoms prior to dismissing the patient. In those instances where swelling has been confined to the face and lips the condition generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema involving the tongue, glottis or larynx may be fatal. Where there is involvement of the tongue, glottis or larynx, likely to cause airway obstruction, appropriate therapy, which may include subcutaneous epinephrine solution 1:1000 (0.3 ml to 0.5 ml) and/or measures to ensure a patent airway, should be administered promptly. The patient should be hospitalised and observed for at least 12 to 24 hours and should not be discharged until complete resolution of symptoms has occurred. Black patients receiving ACE inhibitors have been reported to have a higher incidence of angioedema compared to non-blacks. Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor. Intestinal angioedema has also been reported rarely in patients treated with ACE inhibitors. These patients presented with abdominal pain (with or without nausea or vomiting); in some cases there was no prior facial angioedema and C-1 esterase levels were normal. The angioedema was diagnosed by procedures including abdominal Computed Tomography (CT) scan, or ultrasound or at surgery and symptoms resolved after stopping the

ACE inhibitor. Intestinal angioedema should be included in the differential diagnosis of patients on ACE inhibitors presenting with abdominal pain.

Hypersensitivity/angioedema: Concomitant use of mTOR inhibitors (e.g. sirolimus, everolimus, temsirolimus).

Patients taking concomitant mTOR inhibitors (e.g. sirolimus, everolimus, temsirolimus) therapy may be at increased risk for angioedema (e.g. swelling of the airways or tongue, with or without respiratory impairment). *Cough*: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is non-productive, persistent and resolves after discontinuation of therapy. *Hepatic failure:* Rarely, ACE inhibitors have been associated with a syndrome that starts with cholestatic jaundice and progresses to fulminant hepatic necrosis and (sometimes) death. The mechanism of this syndrome is not understood. Patients receiving ACE inhibitors who develop jaundice or marked elevations of hepatic enzymes should discontinue the ACE inhibitor and receive appropriate medical follow-up. *Hyperkalemia*: Elevations in serum potassium have been observed in some patients treated with ACE inhibitors, including captopril. Patients at risk for the development of hyperkalaemia include those with renal insufficiency, diabetes mellitus, or those using concomitant potassium-sparing diuretics, potassium supplements or potassium-containing salt substitutes; or those patients taking other drugs associated with increases in serum potassium (e.g. heparin, co-trimoxazole also known as trimethoprim/sulfamethoxazole). If concomitant use of the above mentioned agents is deemed appropriate, regular monitoring of serum potassium is recommended. *Combination with lithium:* Captopril is not recommended in association with lithium due to the potentiation of lithium toxicity. *Aortic and mitral valve stenosis/ obstructive hypertropic cardiomyopathy:* ACE inhibitors should be used with caution in patients with left ventricular valvular and outflow tract obstruction and avoided in cases of cardiogenic shock and haemodynamically significant obstruction. *Neutropenia/ agranulocytosis*: Neutropenia/ agranulocytosis, thrombocytopenia and anaemia have been reported in patients receiving ACE inhibitors, including captopril. In patients with normal renal function and no other complicating factors, neutropenia occurs rarely. Captopril should be used with extreme caution in patients with collagen vascular disease, immunosuppressant therapy, treatment with allopurinol or procainamide, or a combination of these complicating factors, especially if there is a pre-existing impaired renal function. Some of these patients developed serious infections which in a few instances did not respond to intensive antibiotic therapy. If captopril is used in such patients, it is advised that white blood cell count and differential counts should be performed prior to therapy, every 2 weeks during the first 3 months of captopril therapy, and periodically thereafter. During treatment all patients should be instructed to report any sign of infection (e.g. sore throat, fever) when a differential white blood cell count should be performed. Captopril and other concomitant medication should be withdrawn if neutropenia (neutrophils less than 1000/mm3) is detected or suspected. In most patients neutrophil counts rapidly return to normal upon discontinuing captopril. *Proteinuria:* Proteinuria may occur particularly in patients with existing renal function impairment or on relatively high doses of ACE inhibitors. Total urinary proteins greater than 1 g per day were seen in about 0.7% of patients receiving captopril. The majority of patients had evidence of prior renal disease or had received relatively high doses of captopril (in excess of 150 mg/day), or both. Nephrotic syndrome occurred in about one-fifth of proteinuric patients. In most cases, proteinuria subsided or cleared within six months whether or not captopril was continued. Parameters of renal function, such as blood urea nitrogen and creatinine, were seldom altered in the patients with proteinuria. Patients with prior renal disease should have urinary protein estimations (dip-stick on first morning urine) prior to treatment, and periodically thereafter. *Anaphylactoid reactions during desensitization:* Sustained life-threatening anaphylactoid reactions have been rarely reported for patients undergoing desensitising treatment with

hymenoptera venom while receiving another ACE inhibitor. In the same patients, these reactions were avoided when the ACE inhibitor was temporarily withheld, but they reappeared upon inadvertent rechallenge. Therefore, caution should be used in patients treated with ACE inhibitors undergoing such desensitisation procedures. *Anaphylactoid reactions during high-flux dialysis/lipoprotein apheresis membrane exposure:* Anaphylactoid reactions have been reported in patients haemodialysed with high-flux dialysis membranes or undergoing low-density lipoprotein apheresis with dextran sulphate absorption. In these patients, consideration should be given to using a different type of dialysis; membrane or a different class of medication. *Surgery/anaesthesia:* Hypotension may occur in patients undergoing major surgery or during treatment with anaesthetic agents that are known to lower blood pressure. If hypotension occurs, it may be corrected by volume expansion. *Diabetic patients*: The blood glucose levels should be closely monitored in diabetic patients previously treated with oral antidiabetic drugs or insulin, namely during the first month of treatment with an ACE inhibitor. *Renal function in patients with Heart failure:* Some patients may develop stable elevations of BUN and serum creatinine >20% above normal or baseline upon long-term treatment with captopril. A few patients, generally those with severe preexisting renal disease, required discontinuation of treatment due to progressively increasing creatinine. *Risk of hypokalaemia:* The combination of an ACE inhibitor with a thiazide diuretic does not rule out the occurrence of hypokalaemia. Regular monitoring of serum potassium should be performed. Ethnic differences: As with other angiotensin converting enzyme inhibitors, captopril is apparently less effective in lowering blood pressure in black people than in non-blacks, possibly because of a higher prevalence of low-renin states in the black hypertensive population. *Dual blockade of the renin-angiotensin-aldosterone system (RAAS):* There is evidence that the concomitant use of ACE-inhibitors, angiotensin II receptor blockers or aliskiren increases the risk of hypotension, hyperkalaemia and decreased renal function (including acute renal failure). Dual blockade of RAAS through the combined use of ACE-inhibitors, angiotensin II receptor blockers or aliskiren is therefore not recommended. If dual blockade therapy is considered absolutely necessary, this should only occur under specialist supervision and subject to frequent close monitoring of renal function, electrolytes and blood pressure. ACE-inhibitors and angiotensin II receptor blockers should not be used concomitantly in patients with diabetic nephropathy. *Pregnancy*: ACE inhibitors should not be initiated during pregnancy. Unless continued ACE inhibitor therapy is considered essential, patients planning pregnancy should be changed to alternative antihypertensive treatments which have an established safety profile for use in pregnancy. When pregnancy is diagnosed, treatment with ACE inhibitors should be stopped immediately, and, if appropriate, alternative therapy should be started. *Lactose*: Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose and galactose malabsorption should not take this medicine. **Interactions:** *Agents increasing serum potassium:* ACE inhibitors attenuate diuretic induced potassium loss. Potassium sparing diuretics (e.g. spironolactone, triamterene or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. If concomitant use is indicated because of demonstrated hypokalaemia they should be used with caution and with frequent monitoring of serum potassium. *Diuretic therapy:* Prior treatment with high dose diuretics may result in volume depletion and a risk of hypotension when initiating therapy with captopril. The hypotensive effects can be reduced by discontinuation of the diuretic, by increasing volume or salt intake or by initiating therapy with a low dose of captopril. However, no clinically significant drug interactions have been found in specific studies with hydrochlorothiazide or furosemide. Other antihypertensive agents: Captopril has been safely co-administered with other commonly used anti-hypertensive agents (e.g. beta-blockers and long-acting calcium channel blockers). Concomitant use of these agents may increase the hypotensive

effect of captopril. Treatment with nitroglycerine and other nitrates, or other vasodilators, should be used with caution. Lower dosage should be considered. Alpha blocking agents: Concomitant use of alpha blocking agents may increase the antihypertensive effects of captopril and increase the risk of orthostatic hypotension. Co-trimoxazole (trimethoprim/sulfamethoxazole): Patients taking concomitant co-trimoxazole (trimethoprim/sulfamethoxazole) may be at increased risk for hyperkalaemia. Treatment of acute myocardial infarction: Captopril may be used concomitantly with acetylsalicylic acid (at cardiologic doses), thrombolytics, beta-blockers and/or nitrates in patients with myocardial infarction. Lithium: Reversible increases in serum lithium concentrations and toxicity have been reported during concomitant administration of lithium with ACE inhibitors. Concomitant use of thiazide diuretics may increase the risk of lithium toxicity and enhance the already increased risk of lithium toxicity with ACE inhibitors. Use of captopril with lithium is not recommended, but if the combination proves necessary, careful monitoring of serum lithium levels should be performed. Tricyclic antidepressants / antipsychotics: ACE inhibitors may enhance the hypotensive effects of certain tricyclic antidepressants and antipsychotics. Postural hypotension may occur. Allopurinol, procainamide, cytostatic or immunosuppressive agents: Concomitant administration with ACE inhibitors may lead to an increased risk for leucopenia especially when the latter are used at a higher than currently recommended dose. Non-steroidal anti-inflammatory medicinal products: It has been described that non-steroidal anti-inflammatory medicinal products (NSAIDs) and ACE inhibitors exert an additive effect on the increase in serum potassium whereas renal function may decrease. These effects are in principle, reversible. Rarely, acute renal failure may occur, particularly in patients with compromised renal function such as the elderly or dehydrated. Chronic administration of NSAIDs may reduce the antihypertensive effect of an ACE inhibitor. Sympathomimetics: Sympathomimetics may reduce the antihypertensive effects of ACE inhibitors therefore patients should be carefully monitored. Antidiabetics: Pharmacological studies have shown that ACE inhibitors, including captopril, can potentiate the blood glucose-reducing effects of insulin and oral antidiabetics such as sulphonylurea in diabetics. Should this very rare interaction occur, it may be necessary to reduce the dose of antidiabetic during simultaneous treatment with ACE inhibitors. Laboratory test interaction: Captopril may cause a false-positive urine test for acetone. *Dual blockade of the renin-angiotensin-aldosterone system (RAAS):* Clinical trial data has shown that dual blockade of the renin-angiotensin-aldosterone-system (RAAS) through the combined use of ACE-inhibitors, angiotensin II receptor blockers or aliskiren is associated with a higher frequency of adverse events such as hypotension, hyperkalaemia and decreased renal function (including acute renal failure) compared to the use of a single RAAS-acting agent. mTOR inhibitors (e.g. sirolimus, everolimus, temsirolimus): Patients taking concomitant mTOR inhibitors therapy may be at increased risk for angioedema. **Pregnancy and Lactation: Pregnancy:** Capoten is contraindicated during pregnancy. Controlled studies with ACE inhibitors have not been done in humans, but limited number of cases of first trimester exposures have not shown malformations.When pregnancy is diagnosed, treatment with ACE inhibitors should be stopped immediately, and, if appropriate, alternative therapy should be started. Exposure to ACE inhibitor therapy during the second and third trimesters is known to induce human foetotoxicity (decreased renal function, oligohydramnios, skull ossification retardation) and neonatal toxicity (renal failure, hypotension, hyperkalaemia). Should exposure to ACE inhibitors have occurred from the second trimester of pregnancy, ultrasound check of renal function and skull is recommended. Infants whose mothers have taken ACE inhibitors should be closely observed for hypotension. **Lactation**: The use of captopril in breastfeeding is Contraindicated. Limited pharmacokinetic data demonstrate very low concentrations in breast milk. Although these concentrations seem to be clinically irrelevant, the use of captopril in breastfeeding is not recommended for preterm infants and for the first few weeks

after delivery, because of the hypothetical risk of cardiovascular and renal effects and because there is not enough clinical experience. In the case of an older infant, the use of captopril in a breast-feeding mother may be considered if this treatment is necessary for the mother and the child is observed for any adverse effect. **Ability to perform tasks that require judgement, motor or cognitive skills:** As with other antihypertensive drugs, the ability to drive and use machines may be reduced, namely at the start of the treatment, or when posology is modified, and also when used in combination with alcohol, but these effects depend on the individual's susceptibility. **Adverse Reactions:** *Blood and lymphatic system disorders: Very rare:* neutropenia / agranulocytosis, pancytopenia, particularly in patients with renal dysfunction, anaemia (including aplastic and haemolytic), thrombocytopenia, lymphadenopathy, eosinophilia, leukocytopenia. *Immune system disorders: very rare:* auto-immune disorder. *Metabolism and nutrition disorders: Uncommon: decreased appetite. very rare:* hyperkalaemia, hyponatremia, hypoglycaemia, decrease of serum sodium. *Psychiatric disorders: common: insomnia. Very rare:* confusion state, depression. *Nervous system disorders: common:* dysgeusia, dizziness. uncommon: drowsiness, headache, paraesthesia. Rare: Somnolence. Very rare: cerebrovascular incidents, cerebrovascular insufficiency and syncope. *Eye disorders:* very rare: vision blurred. *Cardiac disorders:uncommon:* tachycardia, arrhythmia, angina pectoris, palpitations. Very rare: cardiac arrest, cardiogenic shock. *Vascular disorders: uncommon:* hypotension, Raynaud's phenomenon, flushing, pallor, orthostatic hypotension. *Respiratory, thoracic and mediastinal disorders: common:* dry, irritating (non productive) cough, dyspnea. Very rare: bronchospasm, rhinitis, alveolitis allergic / eosinophilic pneumonia. *Gastrointestinal disorders: common:* nausea, vomiting, gepigastric discomfort, abdominal pain, diarrhoea, constipation, dry mouth, peptic ulcer, dyspepsia. Rare: stomatitis/ aphthous stomatitis, small bowel angioedema. Very rare: glossitis, peptic ulcer, pancreatitis. *Hepatobiliary disorders: very rare:* hepatic function abnormal, cholestasis (jaundice), hepatitis necrosis, hepatic enzyme increased, blood bilirubin increased, transaminase increased, blood alkaline phosphatase increased. *Skin and subcutaneous tissue disorders: common:* pruritus with or without a rash, rash and alopecia. Uncommon: angioedema. Very rare: urticaria, Stevens Johnson syndrome, erythema multiforme, photosensitivity reaction, pemphigoid dermatitis exfoliative. *Musculoskeletal and connective tissue disorders: very rare:* myalgia, arthralgia. *Renal and urinary disorders:* rare: renal impairment, renal failure, polyuria, oliguria, pollakiuria. Very rare: nephrotic syndrome, proteinuria, elevation of blood urea nitrogen, elevated serum creatinine. *Reproductive system and breast disorders: very rare:* erectile dysfunction, gynaecomastia. *General disorders and administration site conditions: uncommon:* chest pain, fatigue, malaise, asthenia. Very rare: pyrexi. *Investigations: very rare:* proteinuria, eosinophilia, blood potassium increased, blood sodium decreased, blood urea increased, blood creatinine increased, blood bilirubin increased, haemoglobin decreased, haematocrit decreased, white blood cell count decreased, platelet count decreased, antinuclear antibody positive, red blood cell sedimentation rate increased. **Overdosage**: ***Symptoms and signs***: Symptoms of overdosage include: severe hypotension, shock, stupor, bradycardia, electrolyte disturbances and renal failure. ***Treatment***: Measures to prevent absorption (e.g. gastric lavage, administration of absorbents and sodium sulphate within 30 minutes after intake) and hasten elimination may be applied if ingestion is recent. If hypotension occurs, the patient should be placed in the shock position and salt and volume supplements should be given rapidly. Treatment with angiotension-II should be considered. Bradycardia or extensive vagal reactions should be treated by administering atropine. The use of a pacemaker may be considered. Captopril may be removed from circulation by haemodialysis. Capropril is not adequately cleared by peritoneal dialysis. Further management should be as clinically indicated or as recommended by

the national poisons centre, where available. **STORAGE**: Store below 25 C. **Full Prescribing Information is available on request. Please read the full prescribing information prior to administration. Version date: 26 June 2018.**