

Seretide Accuhaler

Salmeterol / fluticasone propionate

QUALITATIVE AND QUANTITATIVE COMPOSITION

Moulded plastic device containing a foil strip with 60 regularly placed blisters each containing 50 mcg of salmeterol (as salmeterol xinafoate) and 100 mcg of fluticasone propionate.

Moulded plastic device containing a foil strip with 60 regularly placed blisters each containing 50 mcg of salmeterol (as salmeterol xinafoate) and 250 mcg of fluticasone propionate.

Moulded plastic device containing a foil strip with 60 regularly placed blisters each containing 50 mcg of salmeterol (as salmeterol xinafoate) and 500 mcg of fluticasone propionate.

CLINICAL INFORMATION

Indications

Pharmaceutical form: Inhalation powder.

Seretide is indicated in the regular treatment of asthma where use of a combination (bronchodilator and inhaled corticosteroid) has been found to be appropriate.

Seretide is indicated for the symptomatic treatment of patients with severe COPD (FEV₁ <50% predicted normal) and a history of repeated exacerbations, who have significant symptoms despite regular bronchodilator therapy.

Dosage and Administration

Seretide Accuhaler is for oral inhalation only.

Patients should be made aware that Seretide Accuhaler must be used regularly for optimum benefit, even when asymptomatic.

Patients should be regularly reassessed by a doctor, so that the strength of Seretide they are receiving remains optimal and is only changed on medical advice.

Asthma

The dose should be titrated to the lowest dose at which effective control of symptoms is maintained.

Patients should be given the strength of Seretide containing the appropriate fluticasone propionate dosage for the severity of their disease.

If a patient is inadequately controlled on inhaled corticosteroid therapy alone, substitution with Seretide at a therapeutically equivalent corticosteroid dose may result in an improvement in asthma control.

Recommended Doses:

Adults and adolescents 12 years and older:

One inhalation (50 mcg salmeterol and 100 mcg fluticasone propionate) twice daily.

or

One inhalation (50 mcg salmeterol and 250 mcg fluticasone propionate) twice daily.

or

One inhalation (50 mcg salmeterol and 500 mcg fluticasone propionate) twice daily.

Children 4 years and older:

One inhalation (50 mcg salmeterol and 100 mcg fluticasone propionate) twice daily.

There are no data available for use of Seretide in children aged under 4 years.

Chronic Obstructive Pulmonary Disease (COPD)

For adult patients the recommended dose is one inhalation (50 mcg salmeterol and 500 mcg fluticasone propionate) twice daily.

Special patient groups

There is no need to adjust the dose in elderly patients or in those with renal or hepatic impairment.

Contraindications

Seretide is contraindicated in patients with a history of hypersensitivity to any of the ingredients.

Seretide Accuhaler is contraindicated in patients with severe milk protein allergy.

Warnings and Precautions

Seretide Accuhaler is not for relief of acute symptoms for which a fast and short-acting bronchodilator (e.g. salbutamol) is required. Patients should be advised to have their relief medication available at all times.

Increasing use of short-acting bronchodilators to relieve symptoms indicates deterioration of 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 be reviewed by a physician. Consideration should be given to increasing corticosteroid therapy. Also, where the current dosage of Seretide has failed to give adequate control of asthma, the patient should be reviewed by a physician.

Treatment with Seretide should not be stopped abruptly in patients with asthma due to risk of exacerbation, therapy should be titrated-down under physician supervision. For patients with COPD cessation of therapy may be associated with symptomatic decompensation and should be supervised by a physician.

There was an increased reporting of pneumonia in studies of patients with COPD receiving Seretide (see *Adverse Reactions*). Physicians should remain vigilant for the possible development of pneumonia in patients with COPD as the clinical features of pneumonia and exacerbation frequently overlap.

As with all inhaled medication containing corticosteroids, Seretide should be administered with caution in patients with active or quiescent pulmonary tuberculosis.

Seretide should be administered with caution in patients with thyrotoxicosis.

Cardiovascular effects, such as increases in systolic blood pressure and heart rate, may occasionally be seen with all sympathomimetic drugs, especially at higher than therapeutic doses. For this reason, Seretide should be used with caution in patients with pre-existing cardiovascular disease.

A transient decrease in serum potassium may occur with all sympathomimetic drugs at higher therapeutic doses. Therefore, Seretide should be used with caution in patients predisposed to low levels of serum potassium.

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 (see *Overdose*). Possible systemic effects include Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation in children and adolescents, decrease in bone mineral density, cataract, glaucoma and central serous chorioretinopathy. It is important, therefore for asthma patients, that the dose of inhaled corticosteroid is titrated to the lowest dose at which effective control is maintained.

The possibility of impaired adrenal response should always be borne in mind in emergency and elective situations likely to produce stress and appropriate corticosteroid treatment considered (see *Overdose*).

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

Because of the possibility of impaired adrenal response, patients transferring from oral steroid therapy to inhaled fluticasone propionate therapy should be treated with special care, and adrenocortical function regularly monitored.

Following introduction of inhaled fluticasone propionate, withdrawal of systemic therapy should be gradual and patients encouraged to carry a steroid warning card indicating the possible need for additional therapy in times of stress.

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

A drug interaction study in healthy subjects has shown that ritonavir (a highly potent cytochrome P450 3A4 inhibitor) can greatly increase fluticasone propionate plasma concentrations, resulting in markedly reduced serum cortisol concentrations. During post-marketing use, there have been reports of clinically significant drug interactions in patients receiving fluticasone propionate and ritonavir, resulting in systemic corticosteroid effects including Cushing's syndrome and adrenal suppression. Therefore, concomitant use of fluticasone propionate and ritonavir should be avoided, unless the potential benefit to the patient outweighs the risk of systemic corticosteroid side-effects.

It was observed in a drug interaction study that concomitant use of systemic ketoconazole increases exposure to Serevent. This may lead to prolongation in the QTc interval. Caution should be exercised when strong CYP3A4 inhibitors (e.g. ketoconazole) are co-administered with Serevent (see *Interactions* and *Pharmacokinetics*).

As with other inhalation therapy paradoxical bronchospasm may occur with an immediate increase in wheezing after dosing. This should be treated immediately with a fast and short-acting inhaled bronchodilator. Seretide Accuhaler should be discontinued immediately, the patient assessed and alternative therapy instituted if necessary (see *Adverse Reactions*).

The pharmacological side-effects of beta₂-agonist treatment, such as tremor, subjective palpitations and headache have been reported, but tend to be transient and to reduce with regular therapy (see *Adverse Reactions*).

Interactions

Both non-selective and selective beta-blockers should be avoided unless there are compelling reasons for their use.

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 P450 3A4 in the gut and liver. Hence, clinically

significant drug interactions mediated by fluticasone propionate are unlikely.

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Studies have shown that other inhibitors of cytochrome P450 3A4 produce negligible (erythromycin) and minor (ketoconazole) increases in systemic exposure to fluticasone propionate without notable reductions in serum cortisol concentrations. Nevertheless, care is advised when co-administering potent cytochrome P450 3A4 inhibitors (e.g. ketoconazole) as there is potential for increased systemic exposure to fluticasone propionate.

Co-administration of ketoconazole and Serevent resulted in a significant increase in plasma salmeterol exposure (1.4-fold C_{max} and 15-fold AUC) and this may cause a prolongation of the QTc interval (see *Warnings and Precautions* and *Pharmacokinetics*).

Pregnancy and Lactation

Fertility

There are no data on human fertility. Animal studies indicate no effects of fluticasone propionate or salmeterol xinafoate on male or female fertility (see *Pharmacodynamic Properties*).

Pregnancy

There are limited data in pregnant women. Administration of drugs during pregnancy should only be considered if the expected benefit to the mother is greater than any possible risk to the foetus or child.

Results from a retrospective epidemiological study did not find an increased risk of major congenital malformations (MCMs) following exposure to fluticasone propionate when compared to other inhaled corticosteroids, during the first trimester of pregnancy (see *Pharmacodynamics*).

Reproductive toxicity studies in animals, either with single drug or in combination, revealed the foetal effects expected at excessive systemic exposure levels of a potent β_2 -adrenoreceptor agonist and glucocorticosteroid.

Extensive clinical experience with drugs in these classes has revealed no evidence that the effects are relevant at therapeutic doses.

Lactation

Salmeterol and fluticasone propionate concentrations in plasma after inhaled therapeutic doses are very low and therefore concentrations in human breast milk are likely to be correspondingly low. This is supported by studies in lactating animals, in which low drug concentrations were measured in milk. There are no data available for human breast milk.

Administration during lactation should only be considered if the expected benefit to the mother is greater than any possible risk to the child.

Effects on Ability to Drive and Use Machines

There have been no specific studies of the effect of Seretide on the above activities, but the pharmacology of both drugs does not indicate any effect.

Adverse Reactions

All of the adverse reactions associated with the individual components, salmeterol xinafoate and fluticasone propionate, are listed below. There are no additional adverse reactions attributed to the combination product when compared to the adverse event profiles of the individual components.

Adverse events are listed below 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 ($\geq 1/10,000$ to $< 1/1000$) and very rare ($< 1/10,000$). The majority of frequencies were determined from pooled clinical trial data from 23 asthma and 7 COPD studies. Not all events were reported in clinical trials. For these events, the frequency was calculated based on spontaneous data.

Clinical Trial Data

Infections and infestations

Common: Candidiasis of mouth and throat, pneumonia (in COPD patients).

Rare: Oesophageal candidiasis.

Immune system disorders

Hypersensitivity Reactions:

Uncommon: Cutaneous hypersensitivity reactions, dyspnoea.

Rare: Anaphylactic reactions.

Eye disorders

Possible systemic effects include (see *Warnings and Precautions*):

Uncommon: Cataract.

Rare: Glaucoma.

Metabolism and nutrition disorders

Uncommon: Hyperglycaemia.

Psychiatric disorders

Uncommon: Anxiety, sleep disorders.

Rare: Behavioural changes, including hyperactivity and irritability (predominantly in children).

Nervous system disorders

Very common: Headache (see *Warnings and Precautions*).

Uncommon: Tremor (see *Warnings and Precautions*).

Cardiac disorders

Uncommon: Palpitations (see *Warnings and Precautions*), tachycardia, atrial fibrillation.

Rare: Cardiac arrhythmias including supraventricular tachycardia and extrasystoles.

Respiratory, thoracic and mediastinal disorders

Common: Hoarseness/dysphonia.

Uncommon: Throat irritation.

Skin and subcutaneous tissue disorders

Uncommon: Contusions.

Musculoskeletal and connective tissue disorders

Common: Muscle cramps, arthralgia.

Postmarketing Data**Immune system disorders**

Hypersensitivity reactions manifesting as:

Rare: Angioedema (mainly facial and oropharyngeal oedema) and bronchospasm.

Endocrine disorders

Possible systemic effects include (see *Warnings and Precautions*):

Rare: Cushing's syndrome, Cushingoid features, adrenal suppression, growth retardation in children and adolescents, decreased bone mineral density.

Respiratory, thoracic and mediastinal disorders

Rare: Paradoxical bronchospasm (see *Warnings and Precautions*).

Overdose

The available information on overdose with Seretide, salmeterol and/or fluticasone propionate is given below:

The expected symptoms and signs of salmeterol overdosage are those typical of excessive beta₂-adrenergic stimulation, including tremor, headache, tachycardia, increases in systolic blood pressure and hypokalaemia. There is no specific treatment for an overdose of salmeterol and fluticasone propionate. If overdose occurs, the patient should be treated supportively with appropriate monitoring as necessary.

Acute inhalation of fluticasone propionate doses in excess of those approved may lead to temporary suppression of the hypothalamic-pituitary-adrenal axis. This does not usually require emergency action as normal adrenal function typically recovers within a few days.

If higher than approved doses of Seretide are continued over prolonged periods, significant adrenocortical suppression is possible. There have been very rare reports of acute adrenal crisis, mainly occurring in children exposed to higher than approved doses over prolonged periods (several months or years); observed features have included hypoglycaemia associated with decreased consciousness and/or convulsions. Situations which could potentially trigger acute adrenal crisis include exposure to trauma, surgery, infection or any rapid reduction in the dosage of the inhaled fluticasone propionate component.

It is not recommended that patients receive higher than approved doses of Seretide. It is important to review therapy regularly and titrate down to the lowest approved dose at which effective control of disease is maintained (see *Dosage and Administration*).

PHARMACODYNAMIC PROPERTIES

Pharmacodynamics

Asthma

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.

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%)	21 (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 (n = 5,834)	FP Alone (n = 5,845)	Salmeterol-FP (n = 3,107)	FP Alone (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)	

Twelve month study

A large twelve-month study (Gaining Optimal Asthma Control, GOAL) in 3416 asthma patients compared the efficacy and safety of Seretide versus inhaled corticosteroid alone in achieving pre-defined levels of asthma control. Treatment was stepped-up every 12 weeks until ^{##}‘Total control’ was achieved or the highest dose of study drug was reached. Control needed to be sustained for at least 7 out of the last 8 weeks of treatment. The study showed that:

- 71% of patients treated with Seretide achieved [#]‘Well-controlled’ asthma compared with 59% of patients treated with inhaled corticosteroid alone.
- 41% of patients treated with Seretide achieved ^{##}‘Total control’ of asthma compared with 28% of patients treated with inhaled corticosteroid alone.

These effects were observed earlier with Seretide compared with inhaled corticosteroid alone and at a lower inhaled corticosteroid dose.

The GOAL study also showed that:

- The rate of exacerbations was 29% lower with Seretide compared to inhaled corticosteroid treatment alone.
- Attaining ‘Well-controlled’ and ‘Totally controlled’ asthma improved Quality of Life (QoL). 61% of patients reported minimal or no impairment on QoL, as measured by an asthma specific quality of life questionnaire, after treatment with Seretide compared to 8% at baseline.

[#]Well-controlled asthma; less than or equal to 2 days with symptom 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.

COPD

Placebo-controlled clinical trials, over 6 and 12 months, have shown that regular use of Seretide 50/500 micrograms improves lung function, and reduces breathlessness and the use of relief medication. Over a 12-month period the risk of COPD exacerbations was reduced from 1.42 per year to 0.99 per year compared with placebo and the risk of exacerbations requiring oral corticosteroids was significantly reduced from 0.81 to 0.47 per year compared with placebo.

TORCH study (TOwards a Revolution in COPD Health):

TORCH was a 3-year study to assess the effect of treatment with Seretide Accuhaler 50/500 micrograms twice daily, salmeterol Accuhaler 50 micrograms twice daily, fluticasone propionate (FP) Accuhaler 500 micrograms twice daily or placebo on all-cause mortality in patients with COPD. Patients with moderate to severe COPD with a baseline (pre-bronchodilator) FEV₁ <60% of predicted normal were randomised to double-blind medication. During the study, patients were permitted usual COPD therapy with the exception of other inhaled corticosteroids, long-acting bronchodilators, and long-term systemic corticosteroids. Survival status at 3 years was determined for all patients regardless of withdrawal from study medication. The primary endpoint was reduction in all-cause mortality at 3 years for Seretide vs placebo.

	Placebo N = 1524	Salmeterol 50 N = 1521	FP 500 N = 1534	Seretide 50/500 N = 1533
All cause mortality at 3 years				
Number of deaths (%)	231 (15.2%)	205 (13.5%)	246 (16.0%)	193 (12.6%)
Hazard Ratio vs Placebo (CIs) p value	N/A	0.879 (0.73, 1.06) 0.180	1.060 (0.89, 1.27) 0.525	0.825 (0.68, 1.00) 0.052 ¹
Hazard Ratio Seretide 50/500 vs components (CIs) p value	N/A	0.932 (0.77, 1.13) 0.481	0.774 (0.64, 0.93) 0.007	N/A

1. P value adjusted for 2 interim analyses on the primary efficacy comparison from a log-rank analysis stratified by smoking status

Seretide reduced the risk of dying at any time during the 3 years by 17.5% compared to placebo (Hazard Ratio 0.825 (95% CI: 0.68, 1.00, p=0.052); all adjusted for interim analyses). There was a 12% reduction in the risk of dying at any time within 3 years from any cause for salmeterol compared with placebo (p=0.180) and a 6% increase for FP compared with placebo (p=0.525). There was a trend towards improved survival in subjects treated with Seretide compared with placebo over 3 years however this did not achieve the statistical significance level p≤0.05.

A supporting analysis using Cox's Proportional Hazards model gave a hazard ratio of 0.811 (95% CI: 0.670, 0.982, p=0.031) for Seretide vs placebo which represented a 19% reduction in the risk of dying at any time within 3 years. The model adjusted for important factors (smoking status, age, sex, region, baseline FEV₁ and Body Mass Index). There was no evidence that treatment effects varied for these factors.

The percentage of patients who died within 3 years due to COPD-related causes was 6.0% for placebo, 6.1% for salmeterol, 6.9% for FP and 4.7% for Seretide.

Seretide reduced the rate of moderate to severe exacerbations by 25% (95% CI: 19% to 31%, p<0.001) compared with placebo. Seretide reduced the exacerbation rate by 12%

compared with salmeterol (95% CI: 5% to 19%, $p=0.002$) and 9% compared with FP (95% CI: 1% to 16%, $p=0.024$). Salmeterol and FP significantly reduced exacerbation rates compared with placebo by 15% (95% CI: 7% to 22%, $p<0.001$) and 18% (95% CI: 11% to 24%, $p<0.001$) respectively.

Health Related Quality of Life, as measured by the St George's Respiratory Questionnaire (SGRQ) was improved by all active treatments in comparison with placebo. The average improvement over three years for Seretide compared with placebo was -3.1 units (95% CI: -4.1 to -2.1, $p<0.001$), compared with salmeterol was -2.2 units ($p<0.001$) and compared with FP was -1.2 units ($p=0.017$). A 4-unit decrease is considered clinically relevant.

Over the 3 year treatment period, FEV₁ values were higher in subjects treated with Seretide than for those treated with placebo (average difference over 3 years 92 mL, 95% CI: 75 to 108 mL, $p<0.001$). Seretide was also more effective than salmeterol or FP in improving FEV₁ (average difference 50 mL, $p<0.001$ for salmeterol and 44 mL, $p<0.001$ for FP).

The estimated 3 year probability of having pneumonia reported as an adverse event was 12.3% for placebo, 13.3% for salmeterol, 18.3% for FP and 19.6% for Seretide (Hazard ratio for Seretide vs placebo: 1.64, 95% CI: 1.33 to 2.01, $p<0.001$). There was no increase in pneumonia related deaths; deaths while on treatment that were adjudicated as primarily due to pneumonia were 7 for placebo, 9 for salmeterol, 13 for FP and 8 for Seretide. There was no significant difference in probability of bone fracture (5.1% placebo, 5.1% salmeterol, 5.4% FP and 6.3% Seretide; Hazard ratio for Seretide vs placebo: 1.22, 95% CI: 0.87 to 1.72, $p=0.248$). The incidence of adverse events of eye disorders, bone disorders, and HPA axis disorders was low and there was no difference observed between treatments. There was no evidence of an increase in cardiac adverse events in the treatment groups receiving salmeterol.

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 Seretide 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 Seretide 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. The adjusted odds ratio for MCMs diagnosed by 1 year was 0.9 (95% CI: 0.3-2.9) for FP alone and 1.3 for Seretide (95% CI: 0.5-3.2) as compared to any non-fluticasone propionate inhaled corticosteroid for women with moderate asthma. The adjusted odds ratio for MCMs diagnosed by 1 year was 1.3 (95% CI: 0.6-3.0) for FP alone and 1.1 for Seretide (95% CI: 0.6-2.0) as compared to any non-fluticasone propionate inhaled corticosteroid for women with severe asthma. 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).

Mechanism of action

Seretide contains salmeterol and fluticasone propionate which have differing modes of action. Salmeterol protects against symptoms, fluticasone propionate improves lung function and prevents exacerbations of the condition. Seretide can offer a more convenient regime for patients on concurrent beta-agonist and inhaled corticosteroid therapy. The respective mechanisms of action of both drugs are discussed below:

Salmeterol

Salmeterol is a selective long-acting (12 hour) beta₂-adrenoceptor agonist with a long side chain which binds to the exo-site of the receptor.

These pharmacological properties of salmeterol offer more effective protection against histamine-induced bronchoconstriction and produce a longer duration of bronchodilation, lasting for at least 12 hours, than recommended doses of conventional short-acting beta₂-agonists.

In vitro tests have shown salmeterol is a potent and long-lasting inhibitor of the release, from human lung, of mast cell mediators such as histamine, leukotrienes and prostaglandin D₂.

In man, salmeterol inhibits the early and late phase response to inhaled allergen; the latter persisting for over 30 hours after a single dose when the bronchodilator effect is no longer evident. Single dosing with salmeterol attenuates bronchial hyper-responsiveness. These properties indicate that salmeterol has additional non-bronchodilator activity but the full clinical significance is not yet clear. This mechanism is different from the anti-inflammatory effect of corticosteroids.

Fluticasone propionate

Fluticasone propionate given by inhalation at recommended doses has a potent glucocorticoid anti-inflammatory action within the lungs, resulting in reduced symptoms and exacerbations of asthma, without the adverse effects observed when corticosteroids are administered systemically.

Daily output of adrenocortical hormones usually remain within the normal range during chronic treatment with inhaled fluticasone propionate, even at the highest recommended doses in children and adults. After transfer from other inhaled steroids, the daily output gradually improves despite past and present intermittent use of oral steroids, thus demonstrating return of normal adrenal function on inhaled fluticasone propionate. The adrenal reserve also remains normal during chronic treatment, as measured by a normal increment on a stimulation test. However, any residual impairment of adrenal reserve

from previous treatment may persist for a considerable time and should be borne in mind (see *Warnings and Precautions*).

Pharmacokinetics

There is no evidence in animal or human subjects that the administration of salmeterol and fluticasone propionate together by the inhaled route affects the pharmacokinetics of either component.

For pharmacokinetic purposes therefore each component can be considered separately.

In a placebo-controlled, crossover drug interaction study in 15 healthy subjects, co-administration of Serevent (50 mcg twice daily inhaled) and the CYP3A4 inhibitor ketoconazole (400 mg once daily orally) for 7 days resulted in a significant increase in plasma salmeterol exposure (1.4-fold C_{max} and 15-fold AUC). There was no increase in salmeterol accumulation with repeat dosing. Three subjects were withdrawn from Serevent and ketoconazole co-administration due to QTc prolongation or palpitations with sinus tachycardia. In the remaining 12 subjects, co-administration of Serevent and ketoconazole did not result in a clinically significant effect on heart rate, blood potassium or QTc duration (see *Warnings and Precautions* and *Interactions*).

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 pg/mL or less) achieved after inhaled dosing. After regular dosing with salmeterol xinafoate, hydroxynaphthoic acid can be detected in the systemic circulation, reaching steady state concentrations of approximately 100 ng/mL. These concentrations are up to 1000 fold lower than steady state levels observed in toxicity studies. No detrimental effects have been seen following long-term regular dosing (more than 12 months) in patients with airway obstruction.

An *in vitro* study showed that salmeterol is extensively metabolised to α -hydroxysalmeterol (aliphatic oxidation) by cytochrome P450 3A4 (CYP3A4). A repeat dose study with salmeterol and erythromycin in healthy volunteers showed no clinically significant changes in pharmacodynamic effects at 500 mg three times daily doses of erythromycin. However, a salmeterol-ketoconazole interaction study resulted in a significant increase in plasma salmeterol exposure (see *Warnings and Precautions* and *Interactions*).

Fluticasone propionate

The absolute bioavailability of fluticasone propionate for each of the available inhaler devices has been estimated from within and between study comparisons of inhaled and intravenous pharmacokinetic data. In healthy adult subjects, the absolute bioavailability has been estimated for fluticasone propionate Accuhaler (7.8%), fluticasone propionate

Diskhaler (9.0%), fluticasone propionate Evohaler (10.9%), salmeterol-fluticasone propionate Evohaler (5.3%) and salmeterol-fluticasone propionate Accuhaler (5.5%) respectively. In patients with asthma or COPD, 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 moderately high (91%). Fluticasone propionate is cleared very rapidly from the systemic circulation, principally by metabolism to an inactive carboxylic acid metabolite, by the cytochrome P450 enzyme CYP3A4. The renal clearance of fluticasone propionate is negligible (<0.2%) and less than 5% as the metabolite. Care should be taken when co-administering known CYP3A4 inhibitors, as there is potential for increased systemic exposure to fluticasone propionate.

Non-Clinical Information

Reproductive toxicology

Fluticasone propionate, administered subcutaneously at doses of up to 50 mcg/kg/day (up to 100 mcg/kg/day in males, prior to Day 36), did not affect the fertility or mating performance of the F0 and F1 generation rats, when given throughout the periods of gametogenesis, mating, gestation, parturition and lactation. No effects were identified on the fertility of male and female rats treated orally with salmeterol xinafoate during gametogenesis using a maximum dosage level of 2 mg/kg/day. An equivalent oral fertility study with salmeterol base that used a high dose level of 10 mg/kg/day was also without effect.

Pharmaceutical Information

List of excipients

Lactose (which contains milk protein).

Storage

The storage conditions are detailed on the packaging

Store in a dry place.

The Accuhaler is sealed in a foil overwrap, which should be opened when it is to be used for the first time. Once opened, the foil overwrap should be discarded after the Accuhaler is used for the first time.

Incompatibilities

None reported.

Version number: GDS37/IPI22 (SI)

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SERETIDE ACCUHALER

USE AND HANDLING

The Accuhaler is sealed in a foil overwrap. The overwrap provides moisture protection and should only be opened when you are ready to use it for the first time. Once removed/opened the foil overwrap should be discarded.

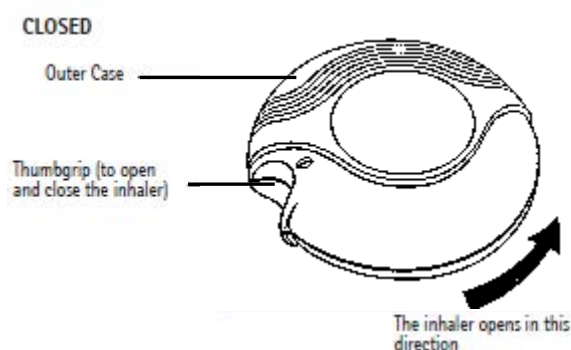
The Accuhaler releases a powder which is inhaled into the lungs.

The device is opened and primed by sliding the lever. The mouthpiece is then placed in the mouth and the lips closed around it. The dose can then be inhaled and the device closed.

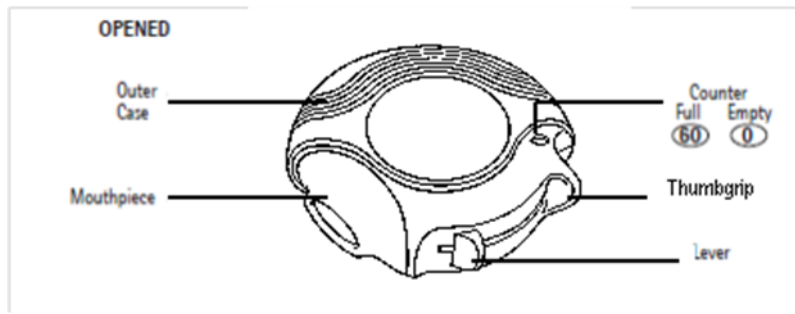
A dose indicator on the Accuhaler indicates the number of doses left.

INSTRUCTIONS FOR USE OF YOUR SERETIDE ACCUHALER

When you take your Accuhaler out of its box and remove the foil overwrap, the Accuhaler will be in the closed position.



A new Accuhaler contains 60 doses individually protected doses of your medicine, in powder form. The dose indicator tells you how many doses are left.



Each dose is accurately measured and hygienically protected. It requires no maintenance and no refilling.

The dose indicator on top of your Accuhaler tells you how many doses are left. Numbers 5 to 0 will appear in RED, to warn you when there are only a few doses left.

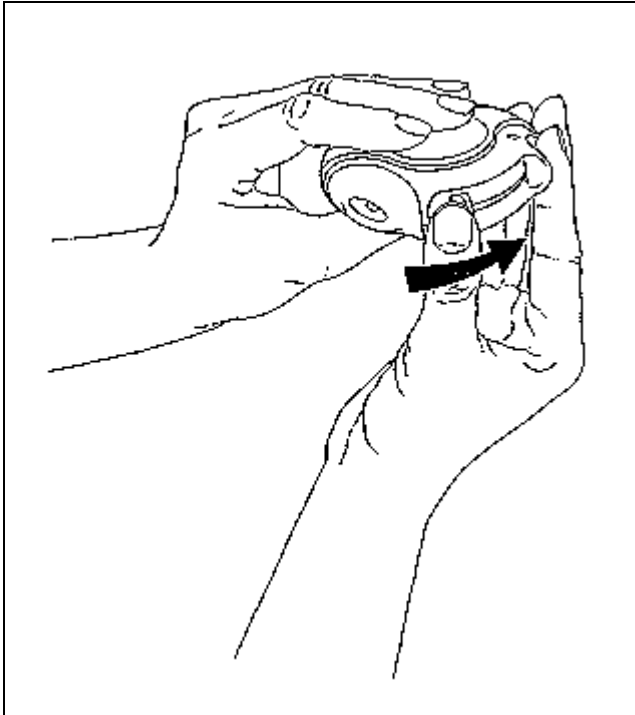
The Accuhaler is easy to use. When you need a dose, just follow the five simple steps illustrated:

1. OPEN.
2. SLIDE.
3. INHALE.
4. CLOSE.
5. RINSE.

HOW YOUR ACCUHALER WORKS

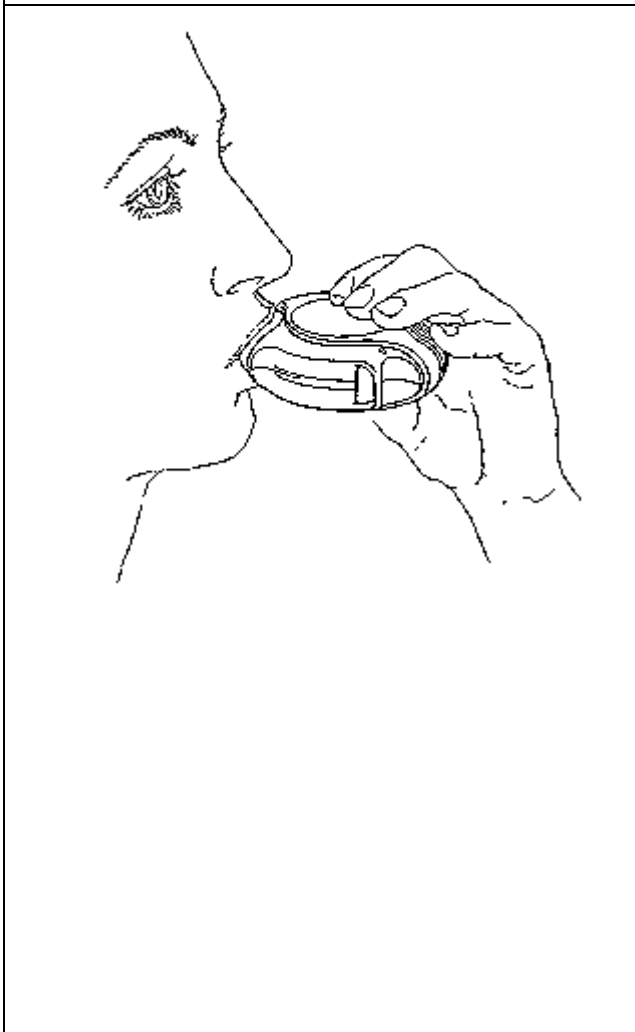
Sliding the lever of your Accuhaler opens a small hole in the mouthpiece and unwraps a dose, ready for you to inhale it. When you close the Accuhaler, the lever automatically moves back to its original position, ready for your next dose when you need it. The outer case protects your Accuhaler when it is not in use.

	<p>1. OPEN - HOW TO USE THE ACCUHALER</p> <p>To open your Accuhaler, hold the outer case in one hand and put the thumb of your other hand on the thumbgrip. Push your thumb away from you as far as it will go.</p>
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2. SLIDE

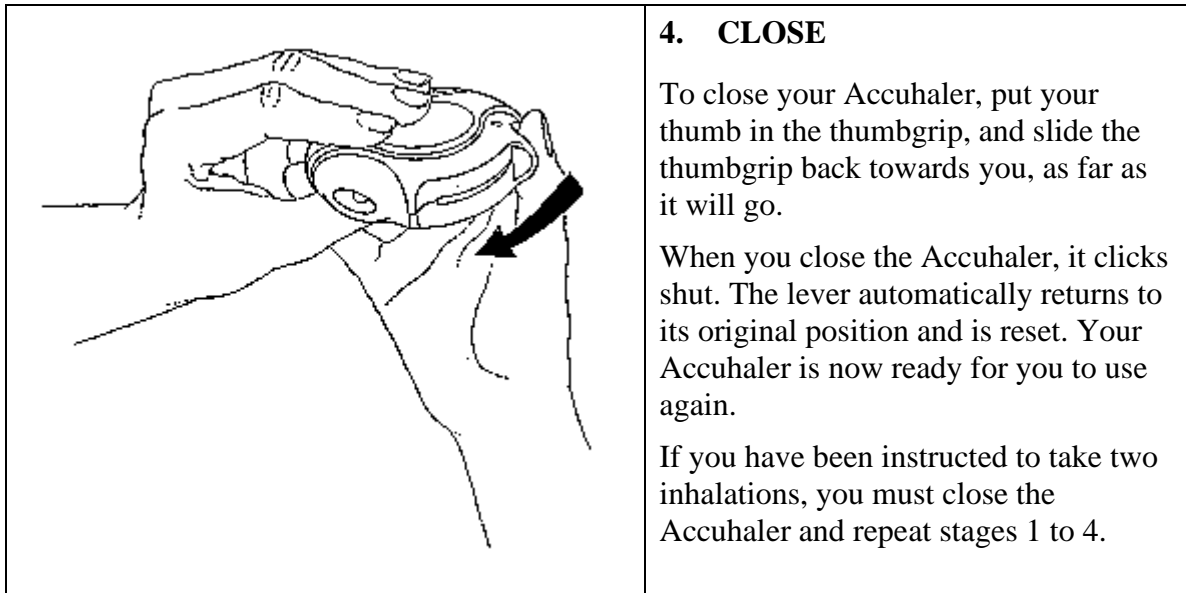
Hold your Accuhaler with the mouthpiece towards you. Slide the lever away from you, as far as it will go - until it clicks. Your Accuhaler is now ready to use. Every time the lever is pushed back, a dose is made available for inhaling. This is shown by the dose counter. Do not play with the lever as this releases doses which will be wasted.



3. INHALE

BEFORE YOU START TO INHALE THE DOSE, READ THROUGH THIS SECTION CAREFULLY.

- Hold the Accuhaler away from your mouth. Breathe out as far as is comfortable. Remember - never breathe into your Accuhaler.
- Put the mouthpiece to your lips. Breathe in steadily and deeply - through the Accuhaler, not through your nose.
- Remove the Accuhaler from your mouth.
- Hold your breath for about 10 seconds, or for as long as is comfortable.
- Breathe out slowly.
- You may not be able to taste or feel the powder on your tongue, even if you have used the Accuhaler/Diskus correctly.



5. RINSE

Afterwards, rinse your mouth with water and spit it out.

Both hoarseness and incidence of candidiasis may be relieved by gargling with water after use of Seretide Accuhaler.

REMEMBER

Keep your Accuhaler dry.

Keep it closed when not in use.

Never breathe into your Accuhaler.

Only slide the lever when you are ready to take a dose.

Do not exceed the stated dose.

Keep out of reach of children.

Made by
GlaxoSmithKline LLC
Zebulon, USA

[GSK logo]