

1. NAME OF THE MEDICINAL PRODUCT

Ramipril-HCT 2.5 mg/12.5 mg tabletten

Ramipril-HCT 5 mg/25 mg tabletten

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Ramipril-HCT 2,5 mg/12,5 mg tablets:

Each tablet contains 2,5 mg Ramipril and 12,5 mg hydrochlorothiazide.

Ramipril-HCT 5 mg/25 mg tablets:

Each tablet contains 5 mg Ramipril and 25 mg Hydrochlorothiazid.

For a full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Tablet

Ramipril/Hydrochlorothiazide 2.5/12.5 tablets:

White, modified capsule-shaped tablet. Embossed with a score on both sides, with "2.5" and "12.5" on each side of the score on one side.

The tablet can be divided into equal halves.

Ramipril/Hydrochlorothiazide 5/25 tablets:

White, modified capsule-shaped tablet. Embossed with a score on both sides, with "5" and "25" on each side of the score on one side.

The tablet can be divided into equal halves.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Treatment of hypertension.

This fixed dose combination is indicated in patients whose blood pressure is not adequately controlled with ramipril alone or hydrochlorothiazide alone.

4.2 Posology and method of administration

Oral use

It is recommended that Ramipril-HCT is taken once daily, at the same time of the day, usually in the morning.

Ramipril-HCT can be taken before, with or after meals, because food intake does not modify its bioavailability (see section 5.2). Ramipril-HCT has to be swallowed with liquid. It must not be chewed or crushed.

Adults

The dose should be individualised according to the patient profile (see section 4.4) and blood pressure control. The administration of the fixed combination of ramipril and hydrochlorothiazide is usually recommended after dosage titration with one of the individual components.

Ramipril-HCT should be started at the lowest available dosage. If necessary, the dose can be progressively increased to achieve target blood pressure; the maximum permitted doses are 10 mg of ramipril and 25 mg of hydrochlorothiazide daily.

Special populations

Diuretic-treated patients

In patients concurrently treated with diuretics, as hypotension may occur following initiation of the treatment, caution is recommended. Consideration must be given to reducing the diuretic dose or

discontinuing the diuretic before starting treatment with Ramipril-HCT.

Patients with renal impairment

Ramipril-HCT is contraindicated in severe renal impairment due to the hydrochlorothiazide component (creatinine clearance < 30 ml/min) (see section 4.3). Patients with impairment of renal function may require reduced doses of Ramipril-HCT. Patients with creatinine clearance levels between 30 and 60 ml/min should only be treated with the lowest fixed dose combination of ramipril and hydrochlorothiazide after administration of ramipril alone. The maximum permitted doses are 5 mg of ramipril and 25 mg of hydrochlorothiazide daily.

Patients with hepatic impairment

In patients with mild to moderate hepatic impairment, treatment with Ramipril-HCT must be initiated only under close medical supervision and the maximum daily doses are 2.5 mg of ramipril and 12.5 mg of hydrochlorothiazide.

Ramipril-HCT is contraindicated in severe hepatic impairment (see section 4.3).

Elderly

Initial doses should be lower and subsequent dose titration should be more gradual because of greater chance of undesirable effects especially in very old and frail patients.

Paediatric population

Ramipril-HCT is not recommended for use in children and adolescents below 18 years of age due to insufficient data on safety and efficacy.

4.3 Contraindications

- Hypersensitivity to the active substance or to any other ACE (Angiotensin Converting Enzyme) inhibitor, hydrochlorothiazide, other thiazide diuretics, sulfonamides or any of the excipients of Ramipril-HCT (see section 6.1).
- History of angioedema (hereditary, idiopathic or due to previous angioedema with ACE inhibitors or AIIRAs)
- Extracorporeal treatments leading to contact of blood with negatively charged surfaces (see section 4.5)
- Significant bilateral renal artery stenosis or renal artery stenosis in a single functioning kidney
- 2nd and 3rd trimester of pregnancy (see sections 4.4 and 4.6)
- Lactation (see section 4.6)
- Severe impairment of renal function with a creatinine clearance below 30 ml/min in undialysed patients
- Clinically relevant electrolyte disturbances which may worsen following treatment with Ramipril-HCT (see section 4.4)
- Severe impairment of liver function, hepatic encephalopathy

4.4 Special warnings and precautions for use

Special populations

Pregnancy: ACE inhibitors such as ramipril, or Angiotensin II Receptor Antagonists (AIIRAs) should not be initiated during pregnancy. Unless continued ACE inhibitor/ AIIRAs therapy is considered essential, patients planning pregnancy should be changed to alternative anti-hypertensive treatments which have an established safety profile for use in pregnancy. When pregnancy is diagnosed, treatment with ACE inhibitors/ AIIRAs should be stopped immediately, and, if appropriate, alternative therapy should be started (see sections 4.3 and 4.6).

• *Patients at particular risk of hypotension*

Patients with strongly activated renin-angiotensin-aldosterone system

Patients with strongly activated renin-angiotensin-aldosterone system are at risk of an acute pronounced fall in blood pressure and deterioration of renal function due to ACE inhibition, especially when an ACE inhibitor or a concomitant diuretic is given for the first time or at first dose increase. Significant activation of renin-angiotensin-aldosterone system is to be anticipated and medical supervision including blood pressure monitoring is necessary, for example in:

- patients with severe hypertension
- patients with decompensated congestive heart failure

- patients with haemodynamically relevant left ventricular inflow or outflow impediment (e.g. stenosis of the aortic or mitral valve)
- patients with unilateral renal artery stenosis with a second functional kidney
- patients in whom fluid or salt depletion exists or may develop (including patients with diuretics)
- patients with liver cirrhosis and/or ascites
- patients undergoing major surgery or during anaesthesia with agents that produce hypotension.

Generally, it is recommended to correct dehydration, hypovolaemia or salt depletion before initiating treatment (in patients with heart failure, however, such corrective action must be carefully weighed out against the risk of volume overload).

Surgery

It is recommended that treatment with angiotensin converting enzyme inhibitors such as ramipril should be discontinued where possible one day before surgery.

-Patients at risk of cardiac or cerebral ischemia in case of acute hypotension The initial phase of treatment requires special medical supervision.

- *Primary Hyperaldosteronism* The combination ramipril + hydrochlorothiazide does not represent a treatment of choice for primary hyperaldosteronism. If ramipril + hydrochlorothiazide is used in a patient with primary hyperaldosteronism, then careful monitoring of plasma potassium level is required.

- *Elderly patients*

See section 4.2

- *Patients with liver disease* Electrolyte disturbances due to diuretic therapy including hydrochlorothiazide may cause hepatic encephalopathy in patients with liver disease.

Monitoring of renal function

Renal function should be assessed before and during treatment and dosage adjusted especially in the initial weeks of treatment. Particularly careful monitoring is required in patients with renal impairment (see section 4.2). There is a risk of impairment of renal function, particularly in patients with congestive heart failure or after renal transplant.

Renal impairment

In patients with renal disease, thiazides may precipitate uraemia. Cumulative effects of the active substance may develop in patients with impaired renal function. If progressive renal impairment becomes evident, as indicated by a rising non-protein nitrogen, careful reappraisal of therapy is necessary, with consideration given to discontinuing diuretic therapy (see section 4.3).

Electrolyte imbalance

As for any patient receiving diuretic therapy, periodic determination of serum electrolytes should be performed at appropriate intervals. Thiazides, including hydrochlorothiazide, can cause fluid or electrolyte imbalance (hypokalaemia, hyponatraemia and hypochloroemic alkalosis). Although hypokalaemia may develop with the use of thiazide diuretics, concurrent therapy with ramipril may reduce diuretic-induced hypokalaemia. The risk of hypokalaemia is greatest in patients with cirrhosis of the liver, in patients experiencing rapid diuresis, in patients who are receiving inadequate electrolytes and in patients receiving concomitant therapy with corticosteroids or ACTH (see section 4.5). The first measurement of plasma potassium levels should be carried out during the first week following the start of treatment. If low potassium levels are detected, correction is required. Dilutional hyponatraemia may occur. Reduction in sodium levels can be initially asymptomatic and regular testing is therefore essential. Testing should be more frequent in elderly and cirrhotic patients. Thiazides have been shown to increase the urinary excretion of magnesium, which may result in hypomagnesaemia.

Hyperkalaemia

Hyperkalaemia has been observed in some patients treated with ACE inhibitors including Ramipril-HCT. Patients at risk for development of hyperkalaemia include those with renal insufficiency, age (> 70 years), uncontrolled diabetes mellitus, or those using potassium salts, potassium retaining diuretics and other plasma

potassium increasing active substances or conditions such as dehydration, acute cardiac decompensation, metabolic acidosis. If concomitant use of the above mentioned agents is deemed appropriate, regular monitoring of serum potassium is recommended (see section 4.5).

Hepatic Encephalopathy

Electrolyte disturbances due to diuretic therapy including hydrochlorothiazide may cause hepatic encephalopathy in patients with liver disease. Treatment should be immediately discontinued in case of hepatic encephalopathy.

Hypercalcaemia

Hydrochlorothiazide stimulates renal calcium reabsorption and may cause hypercalcaemia. It may interfere with test for parathyroid function.

Angioedema

Angioedema has been reported in patients treated with ACE inhibitors including ramipril (see section 4.8). In case of angioedema Ramipril-HCT must be discontinued. Emergency therapy should be instituted promptly. Patient should be kept under observation for at least 12 to 24 hours and discharged after complete resolution of the symptoms. Intestinal angioedema has been reported in patients treated with ACE inhibitors including Ramipril-HCT (see section 4.8). These patients presented with abdominal pain (with or without nausea or vomiting).

Anaphylactic reactions during desensitization

The likelihood and severity of anaphylactic and anaphylactoid reactions to insect venom and other allergens are increased under ACE inhibition. A temporary discontinuation of Ramipril-HCT should be considered prior to desensitization.

Neutropenia/agranulocytosis

Neutropenia/agranulocytosis have been rarely seen and bone marrow depression has also been reported. It is recommended to monitor the white blood cell count to permit detection of a possible leucopenia. More frequent monitoring is advised in the initial phase of treatment and in patients with impaired renal function, those with concomitant collagen disease (e.g. lupus erythematosus or scleroderma), and all those treated with other medicinal products that can cause changes in the blood picture (see sections 4.5 and 4.8).

Ethnic differences

ACE inhibitors cause higher rate of angioedema in black patients than in non black patients. As with other ACE inhibitors, ramipril may be less effective in lowering blood pressure in black people than in non black patients, possibly because of a higher prevalence of hypertension with low renin level in the black hypertensive population.

Athletes

Hydrochlorothiazide may produce a positive analytic result in the anti-doping test.

Metabolic and endocrine effects

Thiazide therapy may impair glucose tolerance. In diabetic patients dosage adjustments of insulin or oral hypoglycaemic agents may be required. Latent diabetes mellitus may become manifest during thiazide therapy. Increases in cholesterol and triglyceride levels have been associated with thiazide diuretic therapy. Hyperuricaemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Cough

Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Other

Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

4.5 Interaction with other medicinal products and other forms of interaction

Contra-indicated combinations

Extracorporeal treatments leading to contact of blood with negatively charged surfaces such as dialysis or haemofiltration with certain high-flux membranes (e.g. polyacrylonitril membranes) and low density lipoprotein apheresis with dextran sulphate due to increased risk of severe anaphylactoid reactions (see section 4.3). If such treatment is required, consideration should be given to using a different type of dialysis membrane or a different class of antihypertensive agent.

Precautions for use

Potassium salts, heparin, potassium-retaining diuretics and other plasma potassium increasing active substances (including Angiotensin II antagonists, trimethoprim, tacrolimus, ciclosporin): Hyperkalaemia may occur; therefore close monitoring of serum potassium is required.

Antihypertensive agents (e.g. diuretics) and other substances that may decrease blood pressure (e.g. nitrates, tricyclic antidepressants, anaesthetics, acute alcohol intake, baclofen, alfuzosin, doxazosin, prazosin, tamsulosin, terazosin): Potentiation of the risk of hypotension is to be anticipated (see section 4.2 for diuretics).

Vasopressor sympathomimetics and other substances (epinephrine) that may reduce the antihypertensive effect of ramipril: Blood pressure monitoring is recommended.

Allopurinol, immunosuppressants, corticosteroids, procainamide, cytostatics and other substances that may change the blood cell count: Increased likelihood of haematological reactions (see section 4.4).

Lithium salts: Excretion of lithium may be reduced by ACE inhibitors and therefore lithium toxicity may be increased. Lithium levels must be monitored. Concomitant use of thiazide diuretics may increase the risk of lithium toxicity and enhance the already increased risk of lithium toxicity with ACE inhibitors. The combination of ramipril and hydrochlorothiazide with lithium is therefore not recommended.

Antidiabetic agents including insulin: Hypoglycaemic reactions may occur. Hydrochlorothiazide may attenuate the effect of antidiabetic medicines. Particularly close blood glucose monitoring is therefore recommended in the initial phase of co-administration.

Nonsteroidal anti-inflammatory drugs and acetylsalicylic acid: Reduction of the antihypertensive effect of Ramipril-HCT is to be anticipated. Furthermore, concomitant treatment of ACE inhibitors and NSAIDs may lead to an increased risk of worsening of renal function and to an increase in kalaemia.

Oral anticoagulants: anticoagulant effect may be decreased due to concomitant use of hydrochlorothiazide.

Corticosteroids, ACTH, amphotericin B, carbenoxolone, large amounts of liquorice, laxatives (in case of a prolonged use), and other kaliuretic or plasma potassium decreasing agents: increased risk of hypokalaemia.

Digitalis preparations, active substances known to prolong the QT interval and antiarrhythmics: their proarrhythmic toxicity may be increased or their antiarrhythmic effect decreased in the presence of electrolyte disturbances (e.g. hypokalaemia, hypomagnesaemia).

Methyldopa: Haemolysis possible.

Colestyramine or other enterally administered ion exchangers: reduced absorption of hydrochlorothiazide. Sulphonamide diuretics should be taken at least one hour before or four to six hours after these medications.

Curare-type muscle relaxants: Possible intensification and prolongation of the muscular relaxing effect.

Calcium salts and plasma calcium increasing medicinal products: Rise in serum calcium concentration is to be anticipated in case of concomitant administration of hydrochlorothiazide; therefore close monitoring of serum calcium is required.

Carbamazepine: risk of hyponatraemia due to additive effect with hydrochlorothiazide.

Iodine containing contrast media: in case of dehydration induced by diuretics including hydrochlorothiazide, there is increased risk of acute renal impairment, in particular when use of important doses of iodine containing contrast media.

Penicillin: hydrochlorothiazide is excreted in the distal tubulus, and reduces excretion of penicillin.

Quinine : hydrochlorothiazide reduces quinine excretion.

4.6 Pregnancy and lactation

Ramipril-HCT is not recommended during the first trimester of pregnancy (see section 4.4) and contraindicated during the second and third trimesters of pregnancy (see section 4.3).

Epidemiological evidence regarding the risk of teratogenicity following exposure to ACE inhibitors during the first trimester of pregnancy has not been conclusive; however a small increase in risk cannot be excluded. Unless continued ACE inhibitor therapy is considered essential, patients planning pregnancy should be changed to alternative anti-hypertensive 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. ACE inhibitor/ Angiotensin II Receptor Antagonist (AIIRA) therapy exposure during the second and third trimesters is known to induce human fetotoxicity (decreased renal function, oligohydramnios, skull ossification retardation) and neonatal toxicity (renal failure, hypotension, hyperkalaemia). (See also 5.3 'Preclinical safety data'). Should exposure to ACE inhibitor have occurred from the second trimester of pregnancy, ultrasound check of renal function and skull is recommended. Newborns whose mothers have taken ACE inhibitors should be closely observed for hypotension, oliguria and hyperkalaemia (see also sections 4.3 and 4.4).

Hydrochlorothiazide, in cases of prolonged exposure during the third trimester of pregnancy, may cause a foeto-placental ischaemia and risk of growth retardation. Moreover, rare cases of hypoglycaemia and thrombocytopenia in neonates have been reported in case of exposure near term. Hydrochlorothiazide can reduce plasma volume as well as the uteroplacental blood flow.

Ramipril-HCT is contraindicated during breast-feeding. Ramipril and hydrochlorothiazide are excreted in breast milk to such an extent that effects on the suckling child are likely if therapeutic doses of ramipril and hydrochlorothiazide are administered to breast-feeding women. Insufficient information is available regarding the use of ramipril during breast-feeding and alternative treatments with better established safety profiles during breast-feeding are preferable, especially while nursing a newborn or preterm infant. Hydrochlorothiazide is excreted in human milk. Thiazides during breast-feeding by lactating mothers have been associated with a decrease or even suppression of lactation. Hypersensitivity to sulphonamide-derived active substances, hypokalaemia and nuclear icterus might occur. Because of the potential for serious reactions in nursing infants from both active substances, a decision should be made whether to discontinue nursing or to discontinue therapy taking account of the importance of this therapy to the mother.

4.7 Effects on ability to drive and use machines

Some adverse effects (e.g. symptoms of a reduction in blood pressure such as dizziness) may impair the patient's ability to concentrate and react and, therefore, constitute a risk in situations where these abilities are of particular importance (e.g. operating a vehicle or machinery). This can happen especially at the start of treatment, or when changing over from other preparations. After the first dose or subsequent increases in dose it is not advisable to drive or operate machinery for several hours.

4.8 Undesirable effects

The safety profile of ramipril + hydrochlorothiazide includes adverse reactions occurring in the context of hypotension and/or fluid depletion due to increased diuresis. The ramipril active substance may induce persistent dry cough, while the hydrochlorothiazide active substance may lead to worsening of glucose, lipid and uric acid metabolism. The two active substances have inverse effects on plasma potassium. Serious adverse reactions include angioedema or anaphylactic reaction, renal or hepatic impairment, pancreatitis, severe skin reactions and neutropenia/agranulocytosis.

Adverse reactions frequency is defined using the following convention: Very common ($\geq 1/10$); common ($\geq 1/100$ to $< 1/10$); uncommon ($\geq 1/1,000$ to $< 1/100$); rare ($\geq 1/10,000$ to $< 1/1,000$); very rare ($< 1/10,000$), not known (cannot be estimated from the available data). Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness.

	Common	Uncommon	Very rare	Not known
<u>Cardiac disorders</u>		Myocardial ischaemia including angina pectoris, tachycardia, arrhythmia, palpitations, oedema peripheral		Myocardial infarction
<u>Blood and lymphatic system disorders</u>		White blood cell count decreased, red blood cell count decreased, haemoglobin decreased, haemolytic anaemia, platelet count decreased		Bone marrow failure, neutropenia including agranulocytosis, pancytopenia, eosinophilia Haemoconcentration in the context of fluid depletion
<u>Nervous system disorders</u>	Headache, dizziness	Vertigo, paraesthesia, tremor, balance disorder, burning sensation, dysgeusia, ageusia		Cerebral ischaemia including ischaemic stroke and transient ischaemic attack, psychomotor skills impaired, parosmia
<u>Eye disorders</u>		Visual disturbance including blurred vision, conjunctivitis		Xanthopsia, lacrimation decreased due to hydrochlorothiazide
<u>Ear and labyrinth disorders</u>		Tinnitus		Hearing impaired
<u>Respiratory, thoracic and mediastinal disorders</u>	Non-productive tickling cough. bronchitis	Sinusitis, dyspnoea, nasal congestion		Bronchospasm including asthma aggravated Alveolitis allergic, non cardiogenic pulmonary oedema due to hydrochlorothiazide
<u>Gastrointestinal disorders</u>		Gastrointestinal inflammation, digestive disturbances, abdominal discomfort, dyspepsia, gastritis, nausea, constipation Gingivitis due to hydrochlorothiazide	Vomiting aphtous stomatitis, glossitis, diarrhoea, abdominal pain upper, dry mouth	Pancreatitis (cases of fatal outcome have been very exceptionally reported with ACE inhibitors), pancreatic enzymes increased, small bowel angioedema Sialoadenitis due to hydrochlorothiazide
<u>Renal and urinary disorders</u>		Renal impairment including renal failure acute, urine output increased, blood urea		Worsening of a preexisting Proteinuria Interstitial nephritis

		increased, blood creatinine increased		due to hydrochlorothiazide
<u>Skin and subcutaneous tissue disorders</u>		Angioedema: very exceptionally, the airway obstruction resulting from angioedema may have a fatal outcome; dermatitis psoriasiform, hyperhidrosis, rash, in particular maculo-papular, pruritus, alopecia		Toxic epidermal necrolysis, Stevens-Johnson syndrome, erythema multiforme, pemphigus, psoriasis aggravated, exfoliative dermatitis, photosensitivity reaction, onycholysis, pemphigoid or lichenoid exanthema or enanthema, urticaria Systemic lupus erythematosus due to hydrochlorothiazide
<u>Musculoskeletal and connective tissue disorders</u>	Diabetes mellitus inadequate control, glucose tolerance decreased, blood glucose increased, blood uric acid increased, gout aggravated, blood cholesterol and/or triglycerides increased due to hydrochlorothiazide	Anorexia, decreased appetite Blood potassium decreased, thirst due to hydrochlorothiazide	Blood potassium increased due to ramipril	Blood sodium decreased Glycosuria, metabolic alkalosis, hypochloraemia, hypomagnesaemia, hypercalcaemia, dehydration due to hydrochlorothiazide
<u>Vascular disorders</u>		Hypotension, orthostatic blood pressure decreased, syncope, flushing		Thrombosis in the context of severe fluid depletion, vascular stenosis, hypoperfusion, Raynaud's phenomenon, vasculitis
<u>General disorders and administration site conditions</u>	Fatigue, asthenia	Chest pain, pyrexia		
<u>Immun system disorders</u>				Anaphylactic or anaphylactoid reactions to either ramipril or anaphylactic reaction to hydrochlorothiazide, antinuclear antibody increased
<u>Hepatobiliary disorders</u>		Cholestatic or cytolytic hepatitis (fatal outcome has		Acute hepatic failure, jaundice cholestatic, hepatocellular

		been very exceptional), hepatic enzyme and /or bilirubin conjugated increased Calculous cholecystitis due to hydrochlorothiazide		damage
<u>Reproductive system and breast disorders</u>		Transient erectile impotence		Libido decreased, gynaecomastia
<u>Psychiatric disorders</u>		Depressed mood, apathy, anxiety, nervousness, sleep disorders including somnolence,		Confusional state, restlessness, disturbance in attention

4.9 Overdose

Symptoms associated with overdosage of ACE inhibitors may include excessive peripheral vasodilatation (with marked hypotension, shock), bradycardia, electrolyte disturbances, renal failure, cardiac arrhythmia, impairment of consciousness including coma, cerebral convulsions, pareses, and paralytic ileus.

In predisposed patients (e.g. prostatic hyperplasia) hydrochlorothiazide overdose may induce acute urinary retention.

The patient should be closely monitored and the treatment should be symptomatic and supportive. Suggested measures include primary detoxification (gastric lavage, administration of adsorbents) and measures to restore haemodynamic stability, including administration of alpha 1 adrenergic agonists or angiotensin II (angiotensinamide) administration. Ramiprilat, the active metabolite of ramipril is poorly removed from the general circulation by haemodialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: ramipril and diuretics, ATC code C09BA05

Mechanism of action

Ramipril

Ramiprilat, the active metabolite of the prodrug ramipril, inhibits the enzyme dipeptidylcarboxypeptidase I (synonyms: angiotensin-converting enzyme; kininase II). In plasma and tissue, this enzyme catalyses the conversion of angiotensin I to the active vasoconstrictor substance angiotensin II, as well as the breakdown of the active vasodilator bradykinin. Reduced angiotensin II formation and inhibition of bradykinin breakdown lead to vasodilatation.

Since angiotensin II also stimulates the release of aldosterone, ramiprilat causes a reduction in aldosterone secretion. The average response to ACE inhibitor monotherapy was lower in black (Afro-Caribbean) hypertensive patients (usually a low-renin hypertensive population) than in non-black patients.

Hydrochlorothiazide

Hydrochlorothiazide is a thiazide diuretic. The mechanism of antihypertensive effect of thiazide diuretics is not fully known. It inhibits the reabsorption of sodium and chloride in the distal tubule. The increased renal excretion of these ions is accompanied by increased urine output (due to osmotic binding of water). Potassium and magnesium excretion are increased, uric acid excretion is decreased. Possible mechanisms of the antihypertensive action of hydrochlorothiazide could be: the modified sodium balance, the reduction in extracellular water and plasma volume, a change in renal vascular resistance as well as a reduced response to norepinephrine and angiotensin II.

Pharmacodynamic effects

Ramipril

Administration of ramipril causes a marked reduction in peripheral arterial resistance. Generally, there are no major changes in renal plasma flow and glomerular filtration rate. Administration of ramipril to patients with hypertension leads to a reduction in supine and standing blood pressure without a compensatory rise in heart rate. In most patients the onset of the antihypertensive effect of a single dose becomes apparent 1 to 2 hours after oral administration. The peak effect of a single dose is usually reached 3 to 6 hours after oral administration. The antihypertensive effect of a single dose usually lasts for 24 hours. The maximum antihypertensive effect of continued treatment with ramipril is generally apparent after 3 to 4 weeks. It has been shown that the antihypertensive effect is sustained under long term therapy lasting 2 years. Abrupt discontinuation of ramipril does not produce a rapid and excessive rebound increase in blood pressure.

Hydrochlorothiazide

With hydrochlorothiazide, onset of diuresis occurs in 2 hours, and peak effect occurs at about 4 hours, while the action persists for approximately 6 to 12 hours. The onset of the antihypertensive effect occurs after 3 to 4 days and can last up to one week after discontinuation of therapy. The blood-pressure-lowering effect is accompanied by slight increases in the filtration fraction, renal vascular resistance and plasma renin activity.

Concomitant administration of ramipril-hydrochlorothiazide

In clinical trials, the combination led to greater reductions in blood pressure than when either of the products was administered alone. Presumably through blockade of the renin-angiotensin-aldosterone system, co-administration of ramipril to hydrochlorothiazide tends to reverse the potassium loss associated with these diuretics. Combination of an ACE-inhibitor with a thiazide diuretic produces a synergistic effect and also lessens the risk of hypokalaemia provoked by the diuretic alone.

5.2 Pharmacokinetic properties

Pharmacokinetics and Metabolism

Ramipril

Absorption

Following oral administration ramipril is rapidly absorbed from the gastrointestinal tract; peak plasma concentrations of ramipril are reached within one hour. Based on urinary recovery, the extent of absorption is at least 56 % and is not significantly influenced by the presence of food in the gastrointestinal tract. The bioavailability of the active metabolite ramiprilat after oral administration of 2.5 mg and 5 mg ramipril is 45 %. Peak plasma concentrations of ramiprilat, the sole active metabolite of ramipril are reached 2-4 hours after ramipril intake. Steady-state plasma concentrations of ramiprilat after once daily dosing with the usual doses of ramipril are reached by about the fourth day of treatment.

Distribution

The serum protein binding of ramipril is about 73 % and that of ramiprilat about 56 %.

Metabolism

Ramipril is almost completely metabolised to ramiprilat, and to the diketopiperazine ester, the diketopiperazine acid, and the glucuronides of ramipril and ramiprilat.

Elimination

Excretion of the metabolites is primarily renal. Plasma concentrations of ramiprilat decline in a polyphasic manner. Because of its potent, saturable binding to ACE and slow dissociation from the enzyme, ramiprilat shows a prolonged terminal elimination phase at very low plasma concentrations. After multiple once-daily doses of ramipril, the effective half-life of ramiprilat concentrations was 1317 hours for the 5-10 mg doses and longer for the lower 1.25-2.5 mg doses. This difference is related to the saturable capacity of the enzyme to bind ramiprilat. A single oral dose of ramipril produced an undetectable level of ramipril and its metabolites in breast milk. However, the effect of multiple doses is not known.

Patients with renal impairment (see section 4.2).

Renal excretion of ramiprilat is reduced in patients with impaired renal function, and renal ramiprilat clearance is proportionally related to creatinine clearance. This results in elevated plasma concentrations of ramiprilat, which decrease more slowly than in subjects with normal renal function.

Patients with liver impairment (see section 4.2).

In patients with impaired liver function, the metabolism of ramipril to ramiprilat was delayed due to diminished activity of hepatic esterases, and plasma ramipril levels in these patients were increased. Peak concentrations of ramiprilat in these patients, however, are not different from those seen in subjects with normal hepatic function.

Hydrochlorothiazide

Absorption

Following oral administration about 70 % of hydrochlorothiazide is absorbed from the gastrointestinal tract. Peak plasma concentrations of hydrochlorothiazide are reached within 1.5 to 5 hours.

Distribution

The plasma protein binding of hydrochlorothiazide is 40 %.

Metabolism

Hydrochlorothiazide undergoes negligible hepatic metabolism.

Elimination

Hydrochlorothiazide is eliminated almost completely (> 95 %) in an unchanged form through the kidneys; 50 to 70 % of a single oral dose is eliminated within 24 hours. The elimination half-life is 5 to 6 hours.

Patients with renal impairment (see section 4.2)

Renal excretion of hydrochlorothiazide is reduced in patients with impaired renal function, and renal hydrochlorothiazide clearance is proportionally related to creatinine clearance. This results in elevated plasma concentrations of hydrochlorothiazide, which decrease more slowly than in subjects with normal renal function.

Patients with liver impairment (see section 4.2)

In patients with hepatic cirrhosis the pharmacokinetics of hydrochlorothiazide has not changed significantly. The pharmacokinetics of hydrochlorothiazide has not been studied in patients with cardiac failure.

Ramipril and Hydrochlorothiazide

The concurrent administration of ramipril and hydrochlorothiazide does not affect their bioavailability. The combination product can be considered as bioequivalent to products containing the individual components.

5.3 Preclinical safety data

In rats and mice the combination of ramipril and hydrochlorothiazide has no acute toxic activity up to 10,000 mg/kg. Repeated doses administration studies performed in rats and monkeys revealed only disturbances in electrolytes balance.

No studies on mutagenicity and carcinogenicity have been performed with the combination as studies with individual components showed no risk.

Reproduction studies in rats and rabbits revealed that the combination is somewhat more toxic than either of the single components but none of the studies revealed a teratogenic effect of the combination.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Lactose monohydrate
Hypromellose
Crospovidone
Microcrystalline cellulose
Sodium stearyl fumarate

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

3 years.

6.4 Special precautions for storage

Do not store above 25 °C. Store in the original package in order to protect from moisture.

6.5 Nature and contents of container

PVC / PCTFE / Aluminium blister package
containing 7, 10, 14, 20, 28, 50, 98, 100, 2x14, 300 (10 x 30) tablets.
Not all pack sizes may be marketed.

6.6 Special precautions for disposal

Not special requirements.

7. MARKETING AUTHORISATION HOLDER

ALFRED E. TIEFENBACHER (GmbH & Co. KG)
Van-der-Smissen-Str. 1
22767 Hamburg
Germany

8. MARKETING AUTHORISATION NUMBER(S)

Ramipril-HCT 2,5 mg/12,5 mg tabletten: RVG 30670
Ramipril-HCT 5 mg/25 mg tabletten: RVG 30671

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

26.07.2005

10. DATE OF REVISION OF THE TEXT