

# Summary of Product Characteristics

## 1 NAME OF THE MEDICINAL PRODUCT

Naropin® 2 mg/ml solution for injection

## 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

1 ml solution for injection contains ropivacaine hydrochloride monohydrate equivalent to 2 mg ropivacaine hydrochloride.  
1 ampoule of 10 ml or 20 ml solution for injection contains ropivacaine hydrochloride monohydrate equivalent to 20 mg and 40 mg ropivacaine hydrochloride respectively.

Excipients with known effect:

Each 10 ml ampoule contains 1.48 mmol (33.87 mg) sodium.

Each 20 ml ampoule contains 2.96 mmol (67.74 mg) sodium.

For the full list of excipients, see section 6.1.

## 3 PHARMACEUTICAL FORM

Solution for injection.

Clear, colourless solution.

## 4 CLINICAL PARTICULARS

### 4.1 Therapeutic indications

**Naropin 7.5 mg/ml is indicated in adults and adolescents aged above 12 years of age for:**

**Surgical anaesthesia:**

- Epidural blocks for surgery, including Caesarean section.
- Major nerve blocks.
- Field blocks.

**Naropin 10 mg/ml is indicated in adults and adolescents aged above 12 years of age for:**

**Surgical anaesthesia:**

- Epidural blocks for surgery.

**Naropin 2 mg/ml is indicated for acute pain management**

In adults and adolescents above 12 years of age for:

- Intermittent bolus administration during postoperative or labour pain.
- Field blocks.
- Continuous peripheral nerve block via intermittent bolus injections, e.g. postoperative pain management

In infants from 1 year and children up to and including 12 years of age (per- and postoperative):

- Single and continuous peripheral nerve block.

In neonates, infants and children up to and including 12 years of age for(per- and postoperative):

- Caudal epidural block

### 4.2 Posology and method of administration

Naropin should only be used by, or under the supervision of, clinicians experienced in regional anaesthesia.

#### Posology

**Adults and adolescents above 12 years of age:**

The following table is a guide to dosage for the more commonly used blocks. The smallest dose required to produce an effective block should be used. The clinician's experience and knowledge of the patient's physical status are of importance when deciding the dose.

**Table 1 Adults and adolescents above 12 years of age**

Conc.	Volume	Dose	Onset	Duration
mg/ml	ml	mg	minutes	hours

#### SURGICAL ANAESTHESIA

##### Lumbar Epidural Administration

	<b>Conc.</b> mg/ml	<b>Volume</b> ml	<b>Dose</b> mg	<b>Onset</b> minutes	<b>Duration</b> hours
Surgery	7.5	15–25	113–188	10–20	3–5
	10.0	15–20	150–200	10–20	4–6
Caesarean section	7.5	15–20	113–150 <sup>(1)</sup>	10–20	3–5
<b>Thoracic Epidural Administration</b>					
To establish block for postoperative pain relief	7.5	5–15 (dependent on the level of injection)	38–113	10–20	n/a <sup>(2)</sup>
<b>Major Nerve Block*</b>					
Brachial plexus block	7.5	30–40	225–300 <sup>(3)</sup>	10–25	6–10
<b>Field Block</b>	7.5	1–30	7.5–225	1–15	2–6
(e.g. minor nerve blocks and infiltration)					
<b>ACUTE PAIN MANAGEMENT</b>					
<b>Lumbar Epidural Administration</b>					
Bolus	2.0	10–20	20–40	10–15	0.5–1.5
Intermittent injections (top up) (e.g. labour pain management)	2.0	10–15 (minimum interval 30 minutes)	20–30		
Postoperative pain management	2.0	6–14 ml/h	12–28 mg/h	n/a <sup>(2)</sup>	n/a <sup>(2)</sup>
<b>Field Block</b>					
(e.g. minor nerve blocks and infiltration)	2.0	1–100	2–200	1–5	2–6
Peripheral nerve block (Femoral or interscalene block)					
Intermittent injections (e.g. postoperative pain management)	2.0	5–10 ml/h	10–20 mg/h	n/a	n/a

The doses in the table are those considered to be necessary to produce a successful block and should be regarded as guidelines for use in adults. Individual variations in onset and duration occur. The figures in the column 'Dose' reflect the expected average dose range needed. Standard textbooks should be consulted for both factors affecting specific block techniques and individual patient requirements.

\* With regard to major nerve block, only for brachial plexus block a dose recommendation can be given. For other major nerve blocks lower doses may be required. However, there is presently no experience of specific dose recommendations for other blocks.

(1) Incremental dosing should be applied, the starting dose of about 100 mg (97.5 mg = 13 ml; 105 mg = 14 ml) to be given over 3–5 minutes. Two extra doses, in total an additional 50mg, may be administered as needed.

(2) n/a = not applicable

(3) The dose for a major nerve block must be adjusted according to site of administration and patient status. Interscalene and supraclavicular brachial plexus blocks may be associated with a higher frequency of serious adverse reactions, regardless of the local anaesthetic used, (see section 4.4).

In general, surgical anaesthesia (e.g. epidural administration) requires the use of the higher concentrations and doses. The Naropin 10 mg/ml formulation is recommended for epidural anaesthesia in which a complete motor block is essential for the surgery. For analgesia (e.g. epidural administration for acute pain management) the lower concentrations and doses are recommended.

#### **Method of administration**

Careful aspiration before and during injection is recommended to prevent intravascular injection. When a large dose is to be injected, a test dose of 3–5 ml lidocaine (lignocaine) with adrenaline (epinephrine) is recommended. An inadvertent intravascular injection may be recognised by a temporary increase in heart rate and an accidental intrathecal injection by signs of a spinal block.

Aspiration should be performed prior to and during administration of the main dose, which should be injected slowly or in incremental doses, at a rate of 25–50 mg/min, while closely observing the patient's vital functions and maintaining verbal contact. If toxic symptoms occur, the injection should be stopped immediately.

In epidural block for surgery, single doses of up to 250 mg ropivacaine have been used and well tolerated.

In brachial plexus block a single dose of 300 mg has been used in a limited number of patients and was well tolerated.

When prolonged blocks are used, through repeated bolus administration, the risks of reaching a toxic plasma concentration or inducing local neural injury must be considered. Cumulative doses up to 675 mg ropivacaine for surgery and postoperative analgesia administered over 24 hours were well tolerated in adults. In a limited number of patients, higher doses of up to 800 mg/day have been administered with relatively few adverse reactions.

When prolonged peripheral nerve blocks are applied, through repeated injections, the risks of reaching a toxic plasma concentration or inducing local neural injury must be considered. In clinical studies, femoral nerve block was established with 300 mg Naropin 7.5 mg/ml and interscalene block with 225 mg Naropin 7.5 mg/ml, respectively, before surgery. Analgesia was then maintained with Naropin 2 mg/ml. Intermittent injections of 10–20 mg per hour for 48 hours provided adequate analgesia and were well tolerated.

Concentrations above 7.5 mg/ml Naropin have not been documented for Caesarean section.

### Paediatric population

**Table 2 Epidural Block: Paediatric patients 0 (term neonates) up to and including 12 years of age**

	<b>Conc. mg/ml</b>	<b>Volume ml/kg</b>	<b>Dose mg/kg</b>
<b>ACUTE PAIN MANAGEMENT (per and postoperative)</b>			
<b>Single Caudal Epidural Block</b>	2.0	1	2
Blocks below T12, in children with a body weight up to 25 kg			

The dose in the table should be regarded as guidelines for use in paediatrics. Individual variations occur. In children with a high body weight, a gradual reduction of the dosage is often necessary and should be based on the ideal body weight. The volume for single caudal epidural block should not exceed 25 mL in any patient. Standard textbooks should be consulted for factors affecting specific block techniques and for individual patient requirements.

The use of ropivacaine 7.5 and 10 mg/ml may be associated with systemic and central toxic events in children. Lower strength (2 mg/ml) is more appropriate for administration in this population.

The use of ropivacaine in premature children has not been documented.

**Table 3 Peripheral nerve blocks: Infants and children aged 1-12 years**

	<b>Conc. mg/ml</b>	<b>Volume ml/kg</b>	<b>Dose mg/kg</b>
<b>ACUTE PAIN MANAGEMENT (per- and postoperative)</b>			
<b>Single injections for peripheral nerve block</b>	2.0	0.5-0.75	1.0-1.5
e.g. ilioinguinal nerve block, brachial plexus block, fascia iliaca compartment block			
Multiple blocks	2.0	0.5-1.5	1.0-3.0

The dose in the table should be regarded as guidelines for use in paediatrics. Individual variations occur. In children with a high body weight a gradual reduction of the dosage is often necessary and should be based on the ideal body weight. Standard textbooks should be consulted for factors affecting specific block techniques and for individual patient requirements.

Single injections for peripheral nerve block (e.g. ilioinguinal nerve block, brachial plexus block, fascia iliaca compartment block) should not exceed 2.5-3.0 mg/kg.

The doses for peripheral block in infants and children provide guidance for use in children without severe disease. More conservative doses and close monitoring are recommended for children with severe diseases.

### Method of Administration

Careful aspiration before and during injection is recommended to prevent intravascular injection. The patient's vital functions should be observed closely during the injection. If toxic symptoms occur, the injection should be stopped immediately.

A single caudal epidural injection of ropivacaine 2 mg/ml produces adequate postoperative analgesia below T12 in the majority of patients when a dose of 2 mg/kg is used in a volume of 1 ml/kg. The volume of the caudal epidural injection may be adjusted to achieve a different distribution of sensory block, as recommended in standard textbooks. In children above 4

years of age, doses up to 3 mg/kg of a concentration of ropivacaine 3 mg/ml have been studied. However, this concentration is associated with a higher incidence of motor block.

Fractionation of the calculated local anaesthetic dose is recommended, whatever the route of administration.

### 4.3 Contraindications

Hypersensitivity to ropivacaine or to other local anaesthetics of the amide type.

General contra-indications related to epidural anesthesia, regardless of the local anaesthetic used, should be taken into account.

Intravenous regional anaesthesia.

Obstetric paracervical anaesthesia

Hypovolaemia

### 4.4 Special warnings and precautions for use

Regional anaesthetic procedures should always be performed in a properly equipped and staffed area. Equipment and drugs necessary for monitoring and emergency resuscitation should be immediately available.

Patients receiving major blocks should be in an optimal condition and have an intravenous line inserted before the blocking procedure.

The clinician responsible should take the necessary precautions to avoid intravascular injection (see section 4.2) and be appropriately trained and familiar with diagnosis and treatment of side effects, systemic toxicity and other complications (see sections 4.8 and 4.9) such as inadvertent subarachnoid injection, which may produce a high spinal block with apnoea and hypotension. Convulsions have occurred most often after brachial plexus block and epidural block. This is likely to be the result of either accidental intravascular injection or rapid absorption from the injection site.

Caution is required to prevent injections in inflamed areas.

#### Cardiovascular

Epidural and intrathecal anaesthesia may lead to hypotension and bradycardia. Hypotension should be treated promptly with a vasopressor intravenously, and with an adequate vascular filling.

Patients treated with anti-arrhythmic drugs class III (e.g. amiodarone) should be under close surveillance and ECG monitoring considered, since cardiac effects may be additive.

There have been rare reports of cardiac arrest during the use of Naropin for epidural anaesthesia or peripheral nerve blockade, especially after unintentional accidental intravascular administration in elderly patients and in patients with concomitant heart disease. In some instances, resuscitation has been difficult. Should cardiac arrest occur, prolonged resuscitative efforts may be required to improve the possibility of a successful outcome.

#### Head and neck blocks

Certain local anaesthetic procedures, such as injections in the head and neck regions, may be associated with a higher frequency of serious adverse reactions, regardless of the local anaesthetic used.

#### Major peripheral nerve blocks

Major peripheral nerve blocks may imply the administration of a large volume of local anaesthetic in highly vascularised areas, often close to large vessels where there is an increased risk of intravascular injection and/or rapid systemic absorption, which can lead to high plasma concentrations.

#### Hypersensitivity

A possible cross-hypersensitivity with other amide-type local anaesthetics should be taken into account.

#### Hypovolaemia

Patients with hypovolaemia due to any cause can develop sudden and severe hypotension during epidural anaesthesia, regardless of the local anaesthetic used.

#### Patients in poor general health

Patients in poor general condition due to ageing or other compromising factors such as partial or complete heart conduction block, advanced liver disease or severe renal dysfunction require special attention, although regional anaesthesia is frequently indicated in these patients.

#### Patients with hepatic and renal impairment

Ropivacaine is metabolised in the liver and should therefore be used with caution in patients with severe liver disease; repeated doses may need to be reduced due to delayed elimination. Normally there is no need to modify the dose in patients with impaired renal function when used for single dose or short-term treatment. Acidosis and reduced plasma protein concentration, frequently seen in patients with chronic renal failure, may increase the risk of systemic toxicity.

#### Acute porphyria

Naropin solution for injection is possibly porphyrinogenic and should only be prescribed to patients with acute porphyria when no safer alternative is available. Appropriate precautions should be taken in the case of vulnerable patients, according to standard textbooks and/or in consultation with disease area experts.

### **Chondrolysis**

There have been post-marketing reports of chondrolysis in patients receiving post-operative intra-articular continuous infusion of local anaesthetics, including ropivacaine. The majority of reported cases of chondrolysis have involved the shoulder joint. Intra-articular continuous infusion is not an approved indication for Naropin. Intra-articular continuous infusion with Naropin should be avoided, as the efficacy and safety has not been established.

### **Excipients with recognised action/effect**

This medicinal product contains 33.87mg sodium per 10ml ampoule of solution, equivalent to 1.69% of the WHO recommended maximum daily intake of 2g sodium for an adult.

This medicinal product contains 67.74mg sodium per 20ml ampoule of solution, equivalent to 3.39% of the WHO recommended maximum daily intake of 2g sodium for an adult.

### **Prolonged administration**

Prolonged administration of ropivacaine should be avoided in patients concomitantly treated with strong CYP1A2 inhibitors, such as fluvoxamine and enoxacin (see section 4.5).

### **Paediatric population**

Neonates may need special attention due to immaturity of metabolic pathways. The larger variations in plasma concentrations of ropivacaine observed in clinical trials in neonates suggest that there may be an increased risk of systemic toxicity in this age group. The recommended doses in neonates are based on limited clinical data. When ropivacaine is used in this patient group, regular monitoring of systemic toxicity (e.g. by signs of CNS toxicity, ECG, SpO<sub>2</sub>) and local neurotoxicity (e.g. prolonged recovery) is required, due to a slow elimination in neonates.

- The safety and efficacy of ropivacaine 7.5 mg/ml and 10 mg/ml in children up to and including 12 years has not been established.
- The safety and efficacy of ropivacaine 2 mg/ml for field block in children up to and including 12 years has not been established.
- The safety and efficacy of ropivacaine 2 mg/ml for peripheral nerve blocks in infants below 1 year has not been established.

## **4.5 Interaction with other medicinal products and other forms of interaction**

Naropin should be used with caution in patients receiving other local anaesthetics or agents structurally related to amide-type local anaesthetics, e.g. certain antiarrhythmics, such as lidocaine and mexiletine, since the systemic toxic effects are additive. Simultaneous use of Naropin with general anaesthetics or opioids may potentiate each others' (adverse) effects. Specific interaction studies with ropivacaine and anti-arrhythmic drugs class III (e.g. amiodarone) have not been performed, but caution is advised (see also section 4.4).

Cytochrome P450 (CYP) 1A2 is involved in the formation of 3-hydroxy-ropivacaine, the major metabolite. *In vivo*, the plasma clearance of ropivacaine was reduced by up to 77% during co-administration of fluvoxamine, a selective and potent CYP1A2 inhibitor. Thus, strong inhibitors of CYP1A2, such as fluvoxamine and enoxacin given concomitantly during prolonged administration of Naropin, can interact with Naropin. Prolonged administration of ropivacaine should be avoided in patients concomitantly treated with strong CYP1A2 inhibitors, see also section 4.4.

*In vivo*, the plasma clearance of ropivacaine was reduced by 15% during co-administration of ketoconazole, a selective and potent inhibitor of CYP3A4. However, the inhibition of this isozyme is not likely to have clinical relevance.

*In vitro*, ropivacaine is a competitive inhibitor of CYP2D6 but does not seem to inhibit this isozyme at clinically attained plasma concentrations.

## **4.6 Fertility, pregnancy and lactation**

### **Pregnancy**

Apart from epidural administration for obstetrical use, there are no adequate data on the use of ropivacaine in human pregnancy. Experimental animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryonal/fœtal development, parturition or postnatal development (see section 5.3).

### **Breastfeeding**

There is no data available concerning the excretion of ropivacaine into human milk.

## **4.7 Effects on ability to drive and use machines**

No data is available. Depending on the dose, local anaesthetics may have a minor influence on mental function and co-ordination even in the absence of overt CNS toxicity and may temporarily impair locomotion and alertness.

#### 4.8 Undesirable effects

##### General

The adverse reaction profile for Naropin is similar to those for other long acting local anaesthetics of the amide type. Adverse drug reactions should be distinguished from the physiological effects of the nerve block itself e.g. a decrease in blood pressure and bradycardia during spinal/epidural block.

##### Table 4 Table of adverse drug reactions

The frequencies used in the table in Section 4.8 are: 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 ( $< 1/10,000$ ), and not known (cannot be estimated from the available data).

System Organ Class	Frequency	Undesirable Effect
Immune system disorders	Rare	Allergic reactions (anaphylactic reactions, anaphylactic shock, angioneurotic oedema and urticaria)
Psychiatric disorders	Uncommon	Anxiety
Nervous System disorders	Common	Paraesthesia, Dizziness, Headache
	Uncommon	Symptoms of CNS toxicity (Convulsions, Grand mal convulsions, Seizures, Light headedness, Circumoral paraesthesia, Numbness of the tongue, Hyperacusis, Tinnitus, Visual disturbances, Dysarthria, Muscular twitching, Tremor)*, Hypoaesthesia
	Not known	Dyskinesia, Horner's syndrome
Cardiac disorders	Common	Bradycardia, Tachycardia
	Rare	Cardiac arrest, Cardiac arrhythmias
Vascular disorders	Very common	Hypotension <sup>a</sup>
	Common	Hypertension
	Uncommon	Syncope
Respiratory, Thoracic and Mediastinal disorders	Uncommon	Dyspnoea
Gastrointestinal disorders	Very common	Nausea
	Common	Vomiting <sup>b</sup>
Musculoskeletal and connective tissue disorders	Common	Back pain
Renal and Urinary disorders	Common	Urinary retention
General disorders and Administrative site conditions	Common	Temperature elevation, Chills
	Uncommon	Hypothermia

<sup>a</sup> Hypotension is less frequent in children ( $> 1/100$ ).

<sup>b</sup> Vomiting is more frequent in children ( $> 1/10$ ).

\* These symptoms usually occur because of inadvertent intravascular injection, overdose or rapid absorption, see section 4.9.

##### Class-related adverse drug reactions

###### Neurological complications

Neuropathy and spinal cord dysfunction (e.g. anterior spinal artery syndrome, arachnoiditis, cauda equina), which may result in rare cases of permanent sequelae, have been associated with regional anaesthesia, regardless of the local anaesthetic used. Following epidural administration, cranial spread of local anaesthetic especially in pregnant women may occasionally result in Horner's syndrome characterised by miosis, ptosis, and anhidrosis. Spontaneous resolution occurs upon discontinuation of treatment.

###### Total spinal block

Total spinal block may occur if an epidural dose is inadvertently administered intrathecally.

###### Acute systemic toxicity

Systemic toxic reactions primarily involve the central nervous system (CNS) and the cardiovascular system (CVS). Such reactions are caused by high blood concentration of a local anaesthetic, which may appear due to (accidental) intravascular injection, overdose or exceptionally rapid absorption from highly vascularised areas, see also section 4.4. CNS reactions are similar for all amide local anaesthetics, while cardiac reactions are more dependent on the drug, both quantitatively and qualitatively.

###### Central nervous system toxicity

Central nervous system toxicity is a graded response with symptoms and signs of escalating severity. Initially symptoms such as visual or hearing disturbances, perioral numbness, dizziness, light-headedness, tingling and paraesthesia are seen. Dysarthria, muscular rigidity and muscular twitching are more serious and may precede the onset of generalised convulsions.

These signs must not be mistaken for neurotic behaviour. Unconsciousness and grand mal convulsions may follow, which may last from a few seconds to several minutes. Hypoxia and hypercarbia occur rapidly during convulsions due to the increased muscular activity, together with the interference with respiration. In severe cases even apnoea may occur. The respiratory and metabolic acidosis increases and extends the toxic effects of local anaesthetics.

Recovery follows the redistribution of the local anaesthetic drug from the central nervous system and subsequent metabolism and excretion. Recovery may be rapid unless large amounts of the drug have been injected.

#### *Cardiovascular system toxicity*

Cardiovascular toxicity indicates a more severe situation. Hypotension, bradycardia, arrhythmia and even cardiac arrest may occur as a result of high systemic concentrations of local anaesthetics.

Cardiovascular toxic effects are generally preceded by signs of toxicity in the central nervous system, unless the patient is receiving a general anaesthetic or is heavily sedated with drugs such as benzodiazepines or barbiturates.

In children, early signs of local anaesthetic toxicity may be difficult to detect since they may not be able to verbally express them. See also section 4.4.

#### **Paediatric population**

Frequency, type and severity of adverse reactions in children are expected to be the same as in adults except for hypotension which happens less often in children (<1 in 10) and vomiting which happens more often in children (>1 in 10).

In children, early signs of local anaesthetic toxicity may be difficult to detect since they may not be able to verbally express them. (see also section 4.4.)

#### **Treatment of acute systemic toxicity**

See section 4.9.

#### **Reporting of suspected adverse reactions**

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via:

HPRA Pharmacovigilance

Website: [www.hpra.ie](http://www.hpra.ie)

## **4.9 Overdose**

### **Symptoms**

Accidental intravascular injections of local anaesthetics may cause immediate (within seconds to a few minutes) systemic toxic reactions. In the event of overdose, peak plasma concentrations may not be reached for one to two hours, depending on the site of the injection, and signs of toxicity may thus be delayed. (see section 4.8.)

### **Treatment**

If signs of acute systemic toxicity appear, injection of the local anaesthetic should be stopped immediately and CNS symptoms (convulsions, CNS depression) must promptly be treated with appropriate airway/respiratory support and the administration of anticonvulsant drugs.

If circulatory arrest should occur, immediate cardiopulmonary resuscitation should be instituted. Optimal oxygenation and ventilation and circulatory support as well as treatment of acidosis are of vital importance.

If cardiovascular depression occurs (hypotension, bradycardia), appropriate treatment with intravenous fluids, vasopressor, and/or inotropic agents should be considered. Children should be given doses commensurate with age and weight.

Should cardiac arrest occur, a successful outcome may require prolonged resuscitative efforts.

## **5 PHARMACOLOGICAL PROPERTIES**

### **5.1 Pharmacodynamic properties**

Pharmacotherapeutic group: Anaesthetics, local, Amides

ATC code: N01B B09

#### Mechanism of action

Ropivacaine is a long-acting, amide-type local anaesthetic with both anaesthetic and analgesic effects. At high doses Naropin produces surgical anaesthesia, while at lower doses it produces sensory block with limited and non-progressive motor block. The mechanism is a reversible reduction of the membrane permeability of the nerve fibre to sodium ions. Consequently, the depolarisation velocity is decreased, and the excitable threshold increased, resulting in a local blockade of nerve impulses. The most characteristic property of ropivacaine is the long duration of action. Onset and duration of the local anaesthetic efficacy are dependent upon the administration site and dose, but are not influenced by the presence of a vasoconstrictor (e.g.

adrenaline (epinephrine)). For details concerning the onset and duration of action, see Table 1 under posology and method of administration.

## 5.2 Pharmacokinetic properties

### Absorption

Ropivacaine has a chiral center and is available as the pure S-(-)-enantiomer. It is highly lipid-soluble. All metabolites have a local anaesthetic effect but of considerably lower potency and shorter duration than that of ropivacaine.

There is no evidence of *in vivo* racemisation of ropivacaine.

The plasma concentration of ropivacaine depends upon the dose, the route of administration and the vascularity of the injection site. Ropivacaine follows linear pharmacokinetics and the  $C_{max}$  is proportional to the dose.

Ropivacaine shows complete and biphasic absorption from the epidural space with half-lives of the two phases of the order of 14 min and 4 h in adults. The slow absorption is the rate-limiting factor in the elimination of ropivacaine, which explains why the apparent elimination half-life is longer after epidural than after intravenous administration. Ropivacaine shows a biphasic absorption from the caudal epidural space also in children.

### Distribution

Ropivacaine has a mean total plasma clearance in the order of 440 ml/min, a renal clearance of 1 ml/min, a volume of distribution at steady state of 47 litres and a terminal half-life of 1.8 h after iv administration. Ropivacaine has an intermediate hepatic extraction ratio of about 0.4. It is mainly bound to  $\alpha_1$ -acid glycoprotein in plasma with an unbound fraction of about 6%.

### Elimination

Since ropivacaine has an intermediate to low hepatic extraction ratio, its rate of elimination should depend on the unbound plasma concentration. A postoperative increase in AAG will decrease the unbound fraction due to increased protein binding, which will decrease the total clearance and result in an increase in total plasma concentrations, as seen in the paediatric and adult studies. It is the unbound plasma concentration that is related to systemic pharmacodynamic effects and toxicity.

Ropivacaine readily crosses the placenta and equilibrium in regard to unbound concentration will be rapidly reached. The degree of plasma protein binding in the foetus is less than in the mother, which results in lower total plasma concentrations in the foetus than in the mother.

Ropivacaine is extensively metabolised, predominantly by aromatic hydroxylation. In total, 86% of the dose is excreted in the urine after intravenous administration, of which only about 1% relates to unchanged drug. The major metabolite is 3-hydroxy-ropivacaine, about 37% of which is excreted in the urine, mainly conjugated. Urinary excretion of 4-hydroxy-ropivacaine, the N-dealkylated metabolite (PPX) and the 4-hydroxy-dealkylated accounts for 1–3%. Conjugated and unconjugated 3-hydroxy-ropivacaine shows only detectable concentrations in plasma.

A similar pattern of metabolites has been found in children above one year.

Impaired renal function has little or no influence on ropivacaine pharmacokinetics. The renal clearance of PPX is significantly correlated with creatinine clearance. A lack of correlation between total exposure, expressed as AUC, with creatinine clearance indicates that the total clearance of PPX includes a non-renal elimination in addition to renal excretion. Some patients with impaired renal function may show an increased exposure to PPX resulting from a low non-renal clearance. Due to the reduced CNS toxicity of PPX as compared to ropivacaine the clinical consequences are considered negligible in short-term treatment. Patients with end-stage renal disease undergoing dialysis have not been studied.

### Paediatrics

The pharmacokinetics of ropivacaine was characterized in a pooled population PK analysis on data in 192 children between 0 and 12 years. Unbound ropivacaine and PPX clearance and ropivacaine unbound volume of distribution depend on both body weight and age up to the maturity of liver function, after which they depend largely on body weight. The maturation of unbound ropivacaine clearance appears to be complete by the age of 3 years, that of PPX by the age of 1 year and unbound ropivacaine volume of distribution by the age of 2 years. The PPX unbound volume of distribution only depends on body weight.

Unbound ropivacaine clearance ( $Cl_u$ ) for ages above 6 months has reached values within the range of those in adults. Total ropivacaine clearance (CL) values displayed in Table 5 are those not affected by the postoperative increase in AAG.

**Table 5 Estimates of pharmacokinetic parameters derived from the pooled paediatric population PK analysis**

Age Group	BW <sup>a</sup> kg	Cl <sub>u</sub> <sup>b</sup> (L/h/kg)	Vu <sup>c</sup> (L/kg)	CL <sup>d</sup> (L/h/kg)	t <sub>1/2</sub> <sup>e</sup> (h)	t <sub>1/2ppx</sub> <sup>f</sup> (h)
<b>Newborn</b>	3.27	2.40	21.86	0.096	6.3	43.3
<b>1m</b>	4.29	3.60	25.94	0.143	5.0	25.7
<b>6m</b>	7.85	8.03	41.71	0.320	3.6	14.5
<b>1y</b>	10.15	11.32	52.60	0.451	3.2	13.6
<b>4y</b>	16.69	15.91	65.24	0.633	2.8	15.1
<b>10y</b>	32.19	13.94	65.57	0.555	3.3	17.8



- <sup>a</sup> Median bodyweight for respective age from WHO database.  
<sup>b</sup> Unbound ropivacaine clearance  
<sup>c</sup> Ropivacaine unbound volume of distribution  
<sup>d</sup> Total ropivacaine clearance  
<sup>e</sup> Ropivacaine terminal half life  
<sup>f</sup> PPX terminal half life

The simulated mean unbound maximal plasma concentration ( $Cu_{max}$ ) after a single caudal block tended to be higher in neonates and the time to  $Cu_{max}$  ( $t_{max}$ ) decreased with an increase in age (Table 6). See also section 4.4.

**Table 6 Simulated mean and observed range of unbound  $Cu_{max}$  after a single caudal block**

Age group	Dose (mg/kg)	$Cu_{max}$ <sup>a</sup> (mg/L)	$t_{max}$ <sup>b</sup> (h)	$Cu_{max}$ <sup>c</sup> (mg/L)
0-1m	2.00	0.0582	2.00	0.05-0.08 (n=5)
1-6m	2.00	0.0375	1.50	0.02-0.09 (n=18)
6-12m	2.00	0.0283	1.00	0.01-0.05 (n=9)
1-10y	2.00	0.0221	0.50	0.01-0.05 (n=60)

- <sup>a</sup> Unbound maximal plasma concentration  
<sup>b</sup> Time to unbound maximal plasma concentration  
<sup>c</sup> Observed and dose-normalised unbound maximal plasma concentration

Simulations on the sum of unbound plasma concentrations of ropivacaine and PPX, based on the PK parameters and their variance in the population analysis, indicate that for a single caudal block the recommended dose must be increased by a factor of 2.7 in the youngest group and a factor of 7.4 in the 1 to 10 year group in order for the upper prediction 90% confidence interval limit to touch the threshold for systemic toxicity.

Simulations on the sum of unbound plasma concentrations of ropivacaine and PPX, based on the PK parameters and their variance in the population analysis, indicate that for 1- to 12- year-old infants and children receiving 3 mg/kg single peripheral (ilioinguinal) nerve block the median unbound peak concentration reached after 0.8 h is 0.0347 mg/L, one-tenth of the toxicity threshold (0.34 mg/L). The upper 90% confidence interval for the maximum unbound plasma concentration is 0.074 mg/L, one-fifth of the toxicity threshold. Similarly, for continuous peripheral block (0.6 mg ropivacaine/kg for 72 h) preceded by a 3 mg/kg single peripheral nerve block, the median unbound peak concentration is 0.053 mg/L. The upper 90% confidence interval for the maximum unbound plasma concentration is 0.088 mg/L, one-quarter of the toxicity threshold.

### 5.3 Preclinical safety data

Based on conventional studies of safety pharmacology, single and repeated dose toxicity, reproduction toxicity, mutagenic potential and local toxicity, no hazards for humans were identified other than those which can be expected on the basis of the pharmacodynamic action of high doses of ropivacaine (e.g. CNS signs, including convulsions, and cardiotoxicity).

## 6 PHARMACEUTICAL PARTICULARS

### 6.1 List of excipients

Sodium chloride  
 Hydrochloric acid  
 Sodium hydroxide  
 Water for injections

### 6.2 Incompatibilities

None.

### 6.3 Shelf life

3 years.

Shelf life after first opening:

From a microbiological point of view, the product should be used immediately. If not used immediately, in-use storage times and conditions prior to use are the responsibility of the user and would normally not be longer than 24 hours at 2-8°C.

#### **6.4 Special precautions for storage**

Do not store above 30°C. Do not freeze.  
For storage after opening, see section 6.3

#### **6.5 Nature and contents of container**

10 ml polypropylene ampoules (Polyamp) in packs of 5 and 10.  
10 ml polypropylene ampoules (Polyamp) in sterile blister packs of 5 and 10.  
20 ml polypropylene ampoules (Polyamp) in packs of 5 and 10.  
20 ml polypropylene ampoules (Polyamp) in sterile blister packs of 5 and 10.  
Not all pack sizes may be marketed.  
The polypropylene ampoules (Polyamp) are specially designed to fit Luer lock and Luer fit syringes.

#### **6.6 Special precautions for disposal and other handling**

Naropin products are preservative-free and are intended for single use only. Discard any unused solution.  
The intact container must not be re-autoclaved. A blistered container should be chosen when a sterile outside is required.  
The medicinal product should be visually inspected prior to use. The solution should only be used if it is clear, practically free from particles and if the container is undamaged.

### **7 MARKETING AUTHORISATION HOLDER**

Aspen Pharma Trading Limited  
3016 Lake Drive  
Citywest Business Campus  
Dublin 24  
Ireland

### **8 MARKETING AUTHORISATION NUMBER**

PA1691/026/001

### **9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION**

Date of first authorisation: 26 June 1996  
Date of last renewal: 13 November 2009

### **10 DATE OF REVISION OF THE TEXT**

October 2023