

Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

AirFluSal MDI 25 microgram/125 microgram/dose pressurised inhalation, suspension

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each metered dose (ex valve) contains 25 micrograms of salmeterol (as salmeterol xinafoate) and 125 micrograms of fluticasone propionate. This is equivalent to a delivered dose (ex actuator) of 21 micrograms of salmeterol and 110 micrograms of fluticasone propionate.

For the full list of excipients, see section 6.1.

3 PHARMACEUTICAL FORM

Pressurised inhalation, suspension.

The container contains a white homogeneous suspension.

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

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

- patients not adequately controlled with inhaled corticosteroids and 'as needed' inhaled short-acting β_2 agonist or
- patients already adequately controlled on both inhaled corticosteroid and long-acting β_2 agonist

AirFluSal MDI is not recommended for use in children.

4.2 Posology and method of administration

Method of administration: Inhalation use.

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

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

The dose should be titrated to the lowest dose at which effective control of symptoms is maintained. Where the control of symptoms is maintained with the lowest strength of AirFluSal MDI (25 micrograms/125 micrograms) given twice daily then the next step would be to switch to a different salmeterol/fluticasone inhaled product in a lower strength (25 micrograms/50 micrograms).

Where the control of symptoms is maintained with the lowest strength of the combination given twice daily then the next step could include a test of inhaled corticosteroid alone.

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

Patients should be given the strength of AirFluSal MDI containing the appropriate fluticasone propionate dosage for the severity of their disease. If an individual patient should require dosages outside the recommended regimen, appropriate doses of β_2 agonist and/or corticosteroid should be prescribed.

Posology:

Adults:

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

or

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

A short-term trial of salmeterol/fluticasone may be considered as initial maintenance therapy in adults with moderate persistent asthma (defined as patients with daily symptoms, daily rescue use and moderate to severe airflow limitation) for whom rapid control of asthma is essential. In these cases, the recommended initial dose is two inhalations of 25 micrograms salmeterol and 50 micrograms fluticasone propionate twice daily. Once control of asthma is attained treatment should be reviewed and consideration given as to whether patients should be stepped down to an inhaled corticosteroid alone. Regular review of patients as treatment is stepped down is important.

A clear benefit has not been shown as compared to inhaled fluticasone propionate alone used as initial maintenance therapy when one or two of the criteria of severity are missing. In general inhaled corticosteroids remain the first line treatment for most patients. AirFluSal MDI is not intended for the initial management of mild asthma. It is recommended to establish the appropriate dosage of inhaled corticosteroid before any fixed-combination can be used in patients with severe asthma.

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

Patients should be instructed in the proper use and care of their inhaler and spacer and their technique checked to ensure optimum delivery of the inhaled drug to the lungs. **Patients should continue to use the same make of spacer device as switching between spacer devices can result in changes in the dose delivered to the lungs (see section 4.4).**

Re-titration to the lowest effective dose should always follow the introduction or change of a spacer device (see section 5.2).

Pediatric population:

AirFluSal MDI should not be used in children.

Special patient groups

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

Instructions for use:

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

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

Testing the inhaler:

Before using for the first time patients should remove the mouthpiece cover by gently squeezing the sides of the cover, shake the inhaler well, hold the inhaler between the fingers and thumb with their thumb on the base, below the mouthpiece and release 4 puffs into the air to make sure that it works. The inhaler should be shaken immediately before releasing each puff. If the inhaler has not been used for a week or more the mouthpiece cover should be removed, the patient should shake the inhaler well and should release two puffs into the air.

Use of the inhaler:

1. Patients should remove the mouthpiece cover by gently squeezing the sides of the cover
2. Patients should check inside and outside of the inhaler including the mouthpiece for the presence of loose objects.
3. Patients should shake the inhaler well to ensure that any loose objects are removed and that the contents of the inhaler are evenly mixed

4. Patients should hold the inhaler upright between fingers and thumb with their thumb on the base, below the mouthpiece.
5. Patients should breathe out as far as is comfortable and then place the mouthpiece in their mouth between their teeth and close their lips around it, Patients should be instructed not to bite the mouth piece.
6. Just after starting to breathe in through their mouth, patients should press firmly down on the top of the inhaler to release AirFluSal MDI, while still breathing in steadily and deeply.
7. While holding their breath, patients should take the inhaler from their mouth and take their finger from the top of the inhaler. Patients should continue holding their breath for as long as is comfortable.
8. To take a second inhalation, patients should keep the inhaler upright and wait about half a minute before repeating steps 3 to 7.
9. Patients should immediately replace the mouthpiece cover in the correct orientation by firmly pushing and snapping the cap into position. This does not require excessive force, the cover should click into position.

IMPORTANT

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

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

Patients should consider getting a replacement when the indicator shows the number 40 and changes the color of the indicator from green to red. The patient is to discontinue the use of the inhaler when the indicator indicates 0, as puffs which are still present in the device might not be sufficient for a full dose.

Patients should never try to alter the numbers on the indicator or detach the indicator from the metal canister. The indicator cannot be reset and is permanently attached to the canister.

Cleaning (also detailed in patient information leaflet):
Your inhaler should be cleaned at least once a week.

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

DO NOT PUT THE METAL CANISTER IN WATER

4.3 Contraindications

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

4.4 Special warnings and precautions for use

AirFluSal MDI should not be used to treat acute asthma symptoms for which a fast- and short-acting bronchodilator is required. Patients should be advised to have their inhaler to be used for relief in an acute asthma attack available at all times. Patients should not be initiated on AirFluSal MDI during an exacerbation, or if they have significantly worsening or acutely deteriorating asthma.

Serious asthma-related adverse events and exacerbations may occur during treatment with AirFluSal MDI. Patients should be

asked to continue treatment but to seek medical advice if asthma symptoms remain uncontrolled or worsen after initiation on AirFluSal MDI.

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

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

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

Treatment with AirFluSal MDI should not be stopped abruptly due to risk of exacerbation. Therapy should be down-titrated under physician supervision.

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

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

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

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

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

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

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

Visual disturbance

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

Systemic absorption of salmeterol and fluticasone propionate is largely through the lungs. As the use of a spacer device with a metered dose inhaler may increase drug delivery to the lungs it should be noted that this could potentially lead to an increase in the risk of systemic adverse effects. Single dose pharmacokinetic data (spacers washed in detergent solution and drip dried prior to use) have demonstrated that the systemic exposure to salmeterol and fluticasone propionate may be increased as

much as two-fold when the Volumatic spacer device is used with AirFluSal MDI inhaler as compared with the AeroChamber Plus spacer device (see section 5.2).

The benefits of inhaled fluticasone propionate therapy should minimise the need for oral steroids, but patients transferring from oral steroids may remain at risk of impaired adrenal reserve for a considerable time. Therefore these patients should be treated with special care and adrenocortical function regularly monitored. Patients who have required high dose emergency corticosteroid therapy in the past may also be at risk. This possibility of residual impairment should always be borne in mind in emergency and elective situations likely to produce stress, and appropriate corticosteroid treatment must be considered. The extent of the adrenal impairment may require specialist advice before elective procedures.

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

There was an increased reporting of lower respiratory tract infections (particularly pneumonia and bronchitis) in a 3-year study in patients with Chronic Obstructive Pulmonary Disease (COPD) receiving salmeterol and fluticasone propionate as a fixed-dose combination compared with placebo (see section 4.8). In a 3-year COPD study, older patients, patients with a lower body mass index ($<25 \text{ kg/m}^2$) and patients with very severe disease ($\text{FEV}_1 < 30\%$ predicted) were at greatest risk of developing pneumonia regardless of treatment. Physicians should remain vigilant for the possible development of pneumonia and other lower respiratory tract infections in patients with COPD as the clinical features of such infections and exacerbation frequently overlap. If a patient with severe COPD has experienced pneumonia the treatment with salmeterol/fluticasone should be re-evaluated. The safety and efficacy of AirFluSal MDI has not been established in patients with COPD and therefore AirFluSal MDI is not indicated for use in the treatment of patients with COPD.

Data from a large clinical trial (the Salmeterol Multi-Center Asthma Research Trial, SMART) suggested African-American patients were at increased risk of serious respiratory-related events or deaths when using salmeterol compared with placebo (see section 5.1). It is not known if this was due to pharmacogenetic or other factors. Patients of black African or Afro-Caribbean ancestry should therefore be asked to continue treatment but to seek medical advice if asthma symptoms remain uncontrolled or worsen whilst using AirFluSal MDI.

Concomitant use of systemic ketoconazole significantly increases systemic exposure to salmeterol. This may lead to an increase in the incidence of systemic effects (e.g. prolongation in the QTc interval and palpitations). Concomitant treatment with ketoconazole or other potent CYP3A4 inhibitors should therefore be avoided unless the benefits outweigh the potentially increased risk of systemic side effects of salmeterol treatment (see section 4.5).

4.5 Interaction with other medicinal products and other forms of interaction

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

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

Fluticasone Propionate

Under normal circumstances, low plasma concentrations of fluticasone propionate are achieved after inhaled dosing, due to extensive first pass metabolism and high systemic clearance mediated by cytochrome P450 3A4 in the gut and liver. Hence, clinically significant drug interactions mediated by fluticasone propionate are unlikely.

In an interaction study in healthy subjects with intranasal fluticasone propionate, ritonavir (a highly potent cytochrome P450 3A4 inhibitor) 100 mg b.i.d. increased the fluticasone propionate plasma concentrations several hundred fold, resulting in markedly reduced serum cortisol concentrations. Information about this interaction is lacking for inhaled fluticasone propionate, but a marked increase in fluticasone propionate plasma levels is expected. The combination should be avoided unless the benefit outweighs the increased risk of systemic glucocorticoid side effects.

In a small study in healthy volunteers, the slightly less potent CYP3A inhibitor ketoconazole increased the exposure of fluticasone propionate after a single inhalation by 150%. This resulted in a greater reduction of plasma cortisol as compared

with fluticasone propionate alone. Co-treatment with other potent CYP3A inhibitors, such as itraconazole and cobicistat-containing products, and moderate CYP3A inhibitors, such as erythromycin, is also expected to increase the systemic fluticasone propionate exposure and the risk of systemic side effects. The combination should be avoided unless the benefit outweighs the increased risk of systemic corticosteroid side-effects, in which case patients should be monitored for systemic corticosteroid side-effects.

Salmeterol

Potent CYP3A4 inhibitors

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

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

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

Moderate CYP 3A4 inhibitors

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

4.6 Fertility, pregnancy and lactation

Pregnancy

A moderate amount of data on pregnant women (between 300 to 1000 pregnancy outcomes) indicate no malformative or fetoneonatal toxicity of salmeterol and fluticasone propionate. Animal studies have shown reproductive toxicity after administration of β_2 adrenoreceptor agonists and glucocorticosteroids (see section 5.3).

Administration of AirFluSal MDI to pregnant women should only be considered if the expected benefit to the mother is greater than any possible risk to the fetus.

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

Breastfeeding

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

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

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

Fertility

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

4.7 Effects on ability to drive and use machines

AirFluSal MDI has no or negligible influence on the ability to drive and use machines.

4.8 Undesirable effects

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

Tabulated list of adverse reactions

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

System Organ Class	Adverse Event	Frequency
Infections & Infestations	Candidiasis of the mouth and throat	Common
	Pneumonia	Common ^{1,3}
	Bronchitis	Common ^{1,3}
	Oesophageal candidiasis	Rare
Immune System Disorders	Hypersensitivity reactions with the following manifestations:	
	Cutaneous hypersensitivity reactions	Uncommon
	Angioedema (mainly facial and oropharyngeal oedema)	Rare
	Respiratory symptoms (dyspnoea)	Uncommon
Endocrine Disorders	Respiratory symptoms (bronchospasm)	Rare
	Anaphylactic reactions including anaphylactic shock	Rare
	Cushing's syndrome, Cushingoid features, Adrenal suppression, Growth retardation in children and adolescents, Decreased bone mineral density	Rare ⁴
Metabolism & Nutrition Disorders	Hypokalaemia	Common ³
	Hyperglycaemia	Uncommon ⁴
Psychiatric Disorders	Anxiety	Uncommon
	Sleep disorders	Uncommon
	Behavioural changes, including psychomotor hyperactivity and irritability (predominantly in children)	Rare
	Depression, aggression (predominantly in children)	Not Known
Nervous System Disorders	Headache	Very Common ¹
	Tremor	Uncommon
Eye disorders	Cataract	Uncommon
	Glaucoma	Rare ⁴
	Vision, blurred (see also section 4.4)	Not Known
Cardiac Disorders	Palpitations	Uncommon
	Tachycardia	Uncommon
	Cardiac arrhythmias (including supraventricular tachycardia and extrasystoles).	Rare
	Atrial fibrillation	Uncommon
Respiratory, Thoracic & Mediastinal Disorders	Angina pectoris	Uncommon
	Nasopharyngitis	Very Common ^{2,3}
	Throat irritation	Common
	Hoarseness/dysphonia	Common
	Sinusitis	Common ^{1,3}
Skin and subcutaneous tissue disorders	Paradoxical bronchospasm	Rare ⁴
	Contusions	Common ^{1,3}
Musculoskeletal & Connective Tissue Disorders	Muscle cramps	Common
	Traumatic fractures	Common ^{1,3}
	Arthralgia	Common

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

Description of selected adverse reactions

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

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

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

Paediatric population

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

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the national reporting system: HPRC Pharmacovigilance; website: www.hpra.ie.

4.9 Overdose

There are no data available from clinical trials on overdose with AirFluSal MDI, however, data on overdose with both drugs are given below:

The signs and symptoms of salmeterol overdose are dizziness, increases in systolic blood pressure, tremor, headache and tachycardia. If AirFluSal MDI therapy has to be withdrawn due to overdose of the β agonist component of the drug, provision of appropriate replacement steroid therapy should be considered. Additionally, hypokalaemia can occur and therefore serum potassium levels should be monitored. Potassium replacement should be considered.

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

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

In cases of both acute and chronic fluticasone propionate overdose, AirFluSal MDI therapy should be continued at a suitable dosage for symptom control.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Drugs for obstructive airway diseases; adrenergics in combination with corticosteroids or other drugs, excl. anticholinergics

ATC code: R03AK06

Mechanism of action and pharmacodynamic effects

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

The respective mechanisms of action of both drugs are discussed below.

Salmeterol:

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

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

Fluticasone propionate:

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

Clinical efficacy and safety

Asthma clinical trials

A twelve month study (Gaining Optimal Asthma Control, GOAL), in 3416 adult and adolescent patients with persistent asthma, compared the safety and efficacy of salmeterol/fluticasone propionate (FP) versus inhaled corticosteroid (ICS) alone to determine whether the goals of asthma management were achievable. Treatment was stepped up every 12 weeks until ****total control** was achieved or the highest dose of study drug was reached. GOAL showed more patients treated with salmeterol/FP achieved asthma control than patients treated with ICS alone and this control was attained at a lower corticosteroid dose

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

The overall study results showed:

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

**Well controlled* asthma; less than or equal to 2 days with 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.

The results of this study suggest that salmeterol/FP 50/100 microgram bd may be considered as initial maintenance therapy in patients with moderate persistent asthma for whom rapid control of asthma is deemed essential (see section 4.2).

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

The Salmeterol Multi-center Asthma Research Trial (SMART)

SMART was a multi-centre, randomised, double blind, placebo-controlled, parallel group 28-week study in the US which randomised 13,176 patients to salmeterol (50 micrograms twice daily) and 13,179 patients to placebo in addition to the patients' usual asthma therapy. Patients were enrolled if ≥ 12 years of age, with asthma and if currently using asthma medication (but not a LABA). Baseline ICS use at study entry was recorded, but not required in the study. The primary endpoint in SMART was the combined number of respiratory-related deaths and respiratory-related life-threatening experiences.

Key findings from SMART: primary endpoint

Patient group	Number of primary endpoint events /number of patients		Relative Risk (95% confidence intervals)
	salmeterol	placebo	
All patients	50/13,176	36/13,179	1.40 (0.91, 2.14)
Patients using inhaled steroids	23/6,127	19/6,138	1.21 (0.66, 2.23)
Patients not using inhaled steroids	27/7,049	17/7,041	1.60 (0.87, 2.93)
African-American patients	20/2,366	5/2,319	4.10 (1.54, 10.90)

(Risk in bold is statistically significant at the 95% level.)

Key findings from SMART by inhaled steroid use at baseline: secondary endpoints

	Number of secondary endpoint events /number of patients		Relative Risk (95% confidence intervals)
	salmeterol	placebo	
Respiratory-related death			
Patients using inhaled steroids	10/6127	5/6138	2.01 (0.69, 5.86)
Patients not using inhaled steroids	14/7049	6/7041	2.28 (0.88, 5.94)
Combined asthma-related death or life-threatening experience			
Patients using inhaled steroids	16/6127	13/6138	1.24 (0.60, 2.58)
Patients not using inhaled steroids	21/7049	9/7041	2.39 (1.10, 5.22)
Asthma-related death			
Patients using inhaled steroids	4/6127	3/6138	1.35 (0.30, 6.04)
Patients not using inhaled steroids	9/7049	0/7041	*

(* = could not be calculated because of no events in placebo group. Risk in bold figures is statistically significant at the 95% level. The secondary endpoints in the table above reached statistical significance in the whole population.) The secondary endpoints of combined all cause death or life-threatening experience, all cause death, or all cause hospitalisation did not reach statistical significance in the whole population.

Pediatric population

In trial SAM101667, in 158 children aged 6 to 16 years with symptomatic asthma, the combination of salmeterol/fluticasone propionate is equally efficacious to doubling the dose of fluticasone propionate regarding symptom control and lung function. This study was not designed to investigate the effect on exacerbations.

A multi-centre 8-week, double-blind, study was conducted to evaluate the safety and efficacy of salmeterol-FP metred dose inhaler (50/25 micrograms, 1 or 2 inhalations twice daily) versus FP (50 micrograms, 1 or 2 inhalations twice daily) alone in Japanese paediatric (6-month to 4 years of age) patients with infantile bronchial asthma. The safety of long-term treatment with salmeterol-FP metred dose inhaler (50/25 micrograms, 1 or 2 inhalations twice daily) was evaluated in a 16-week, open-label, extension treatment period. Ninety-one percent (136/150) and eighty-eight percent (132/150) of randomised patients treated with salmeterol-FP and FP alone, respectively, completed the study. The study failed to meet its primary efficacy endpoint of mean change from baseline in total asthma symptom score (double blind period). No statistically significant superiority in favour of salmeterol-FP to FP was demonstrated (95% CI [-2.47; 0.54], $p=0.206$). No clinically significant differences were noted in the safety profile between salmeterol-FP and FP alone (8-week double-blind period); moreover, no new safety signals were identified with administration of salmeterol-FP in the 16-week open-label extension period. There were no patient deaths. It is difficult to make a confident diagnosis of asthma in children 4 years and younger, therefore conclusive data is difficult to obtain. Salmeterol-FP is not approved in children under 4 years old.

5.2 Pharmacokinetic properties

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

Salmeterol

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

Fluticasone propionate

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

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

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

Plasma protein binding is 91%.

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

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

Only limited data are available investigating the increase seen in drug delivery to the lungs with AirFluSal MDI when used with either the Volumatic spacer device or the AeroChamber Plus spacer device. However a single dose pharmacokinetic study, Study PRC/CRD/13/11 (with spacers washed in detergent solution and drip dried prior to use) has demonstrated that the systemic exposure to salmeterol and fluticasone propionate may be increased up to two-fold when the Volumatic spacer device is used with AirFluSal MDI inhaler as compared with the AeroChamber Plus spacer device (see section 4.4).

Based on data across studies it can be deduced that systemic exposure may increase about 3-fold with the AeroChamber Plus spacer device or 4-7-fold with the Volumatic spacer device, when compared to the use without spacer.

5.3 Preclinical safety data

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

In animal reproduction studies, glucocorticosteroids have been shown to induce malformations (cleft palate, skeletal malformations). However, these animal experimental results do not seem to be relevant for man given recommended doses. Animal studies with salmeterol have shown embryofetal toxicity only at high exposure levels. Following co-administration, increased incidences of transposed umbilical artery and incomplete ossification of occipital bone were found in rats at doses associated with known glucocorticoid-induced abnormalities.

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

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Propellant: Norflurane (HFA 134a)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

2 years.

6.4 Special precautions for storage

Store below 25°C.

Keep the container in the outer carton in order to protect from light.

The container contains a pressurised liquid.

Do not expose to temperatures higher than 50°C.

Do not pierce the canister.

The container should not be punctured, broken or burnt even when apparently empty.

Do not refrigerate or freeze.

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

6.5 Nature and contents of container

The inhaler consists of an aluminium canister (plasma FCP coated aerosol container) with a suitable metering valve and a polypropylene actuator with polypropylene cap having dose indicator packed in outer carton box.

Each container is filled to deliver 120 metered doses.

Pack size:

1; 2; 2 (bundled package 2x1); 3; 3 (bundled package 3x1); 4; 5; 6; 10; 10 (bundled package 10x1) x 120 actuations inhaler(s)

Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

No special requirements for disposal.

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7 MARKETING AUTHORISATION HOLDER

Rowex Ltd
Newtown
Bantry
Co. Cork
Ireland

8 MARKETING AUTHORISATION NUMBER

PA0711/270/001

9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 12th May 2017

Date of last renewal: 16th March 2022

10 DATE OF REVISION OF THE TEXT

September 2024