

PRODUCT INFORMATION

ARIDOL

Mannitol powder for inhalation

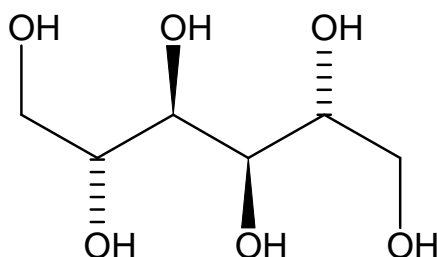
Name

Mannitol. Also known as D-mannitol.

The empirical formula is C₆H₁₄O₆. Molecular weight is 182.2

CAS number: 69-65-8.

Structural Formula:



Description

Mannitol is a hexahydric alcohol. The powder is a white or almost white, crystalline powder of free-flowing granules. Mannitol is freely soluble in water, and very slightly soluble in alcohol. Mannitol shows polymorphism.

Mannitol is the only ingredient in the contents of Aridol hard gelatin capsules. Colouring agents are used on the caps of the 5, 10, 20 and 40 mg capsules (the 0 mg capsule and the bodies of the other capsules are clear). The colouring agents are titanium dioxide (5, 10, 20 and 40 mg), yellow iron oxide (10 mg) and red iron oxide (20 and 40 mg). The delivered dose from each of the 5, 10, 20 and 40mg capsules is approximately 3, 8, 16 and 31mg, respectively.

Pharmacology

Pharmacodynamics

When inhaled, mannitol induces an increase in osmolarity in the airways similar to other bronchial provocation tests such as hypertonic saline, exercise and the hyperpnea of dry air. The increase in osmolarity is associated with the release of a wide variety of mediators of bronchoconstriction from inflammatory cells within the airways. These mediators then act via specific receptors on bronchial smooth muscle to cause contraction and the airways to narrow. The airway response is most pronounced (hyperresponsiveness) in patients with asthma and exercise-induced asthma. The airway response to Aridol is measured using the forced expiratory volume in one second (FEV₁). The sensitivity to mannitol is reported as the delivered dose of mannitol to cause a 15% reduction in FEV₁.

The involvement of airway inflammation has been demonstrated by a reduction in the sensitivity to inhaled mannitol following treatment with inhaled corticosteroids. The involvement of mediators has been demonstrated by the reduction in response to mannitol after specific antagonists. The histamine antagonist, fexofenadine, has been shown to reduce the airway sensitivity to mannitol. The time to recover to baseline FEV₁ is reduced after treatment with the cysteinyl leukotriene receptor antagonist, montelukast although there was no effect observed on the sensitivity to mannitol. Nedocromil sodium, a drug that inhibits mast cell mediator release as well as reducing sensory nerve activation, has been shown to reduce sensitivity to mannitol and in some cases the airway response to mannitol was inhibited.

Pharmacokinetics

There are no pharmacokinetic data available for mannitol following inhalation using a dry powder inhaler although limited animal data on mannitol solution indicates an absorption half-life of approximately 0.2-1 hours. Following absorption, the pharmacokinetic profile of inhaled mannitol can be expected to follow that of intravenous administered mannitol.

When administered intravenously, mannitol is eliminated largely unchanged by glomerular filtration and 80% of the dose is excreted in the urine within 3 hours. The elimination half-life in adults is approximately 1-2 hours. In the presence of renal failure, the half-life is extended.

Clinical trials

The pivotal trial in the clinical development program was a controlled, randomised, crossover study which compared Aridol with hypertonic (4.5%) saline in identifying bronchial hyperresponsiveness. The study enrolled 646 subjects of whom 592 completed both arms of the trial. The study enrolled both asthmatic (n=551) and non-asthmatic (n=95) subjects aged 6 to 83 years.

The mannitol challenge test was positive (15% fall in FEV₁) in 296 subjects at a mean dose of 186 mg. In non-asthmatic subjects the mean maximum fall in FEV₁ was 4.95% +/- 4.7%. Compared to the hypertonic saline challenge, the mannitol challenge had a sensitivity of 81% and a specificity of 87%. The mean maximum FEV₁ fall (\pm SD) for the two challenges was comparable: 21.02% (\pm 5.7) for mannitol and 21.34% (\pm 5.9) for hypertonic saline.

Following completion of the two challenge tests, a respiratory physician assessed the data and categorised the subjects as being asthmatic or non-asthmatic on the basis of their medical history, history of respiratory symptoms, and the results of the hypertonic saline challenge. Compared to this clinical diagnosis, the mannitol challenge had a sensitivity of 60%, and a specificity of 95%. The hypertonic saline challenge had a sensitivity of 65% and a specificity of 95%. The positive and negative predictive values for the mannitol challenge were 98.3% and 33.9% respectively, resulting in positive and negative likelihood ratios of 12.55 and 0.42 respectively.

Of the 196 subjects classified as asthmatic by the respiratory physician, but having a negative mannitol challenge, 159 (81%) were taking glucocorticosteroids, 72.7% had no wheezing in the week prior to the challenge and 65.6% had not used a reliever puffer more than once in the previous week. It is important to consider current glucocorticosteroid therapy when interpreting indirect challenge test results.

Indications

Aridol is indicated for identifying bronchial hyperresponsiveness to assist in the diagnosis of asthma.

Contraindications

Known hypersensitivity to mannitol or any of the excipients.

Aridol should not be given to patients with conditions that may be compromised by induced bronchospasm or repeated blowing manouevres. These include: aortic or cerebral aneurysm, uncontrolled hypertension, myocardial infarction or a cerebral vascular accident in the previous six months.

Precautions

Aridol is to be administered by inhalation only. The Aridol inhalation test should be conducted only under the supervision of a physician or other appropriate trained personnel thoroughly familiar with all aspects of bronchial provocation tests and the management of acute bronchospasm. Patients should not be left unattended during the procedure once the administration of Aridol has begun.

Medications to treat severe bronchospasm must be present in the testing area including bronchodilators and oxygen.

General precautions when conducting spirometry and bronchial provocation testing should be observed, including using caution in patients with the following: ventilatory impairment (resting FEV₁ of less than 70% of normal predicted values or an absolute value of 1.5L in adults); spirometry induced bronchoconstriction, haemoptysis of unknown origin, pneumothorax, recent abdominal or thoracic surgery, recent eye surgery, unstable angina, inability to perform spirometry of acceptable quality or upper or lower respiratory tract infection in the previous 2 weeks.

If a patient has spirometry induced asthma or the FEV₁ fall following the 0 mg capsule is greater than 10%, a standard dose of bronchodilator should be given and the Aridol challenge discontinued.

Use in pregnancy

Category B2

Animal reproduction studies have not been carried out with inhaled mannitol. However, studies with orally administered mannitol indicate no teratogenic effects in mice or rats, at doses of up to 1.6g/kg, or in hamsters at 1.2g/kg. The effects of a possible hyperresponsiveness reaction on the mother and/or the foetus are unknown and therefore Aridol should not be given to pregnant women.

Use in lactation

It is not known whether this drug is excreted in human milk. Many compounds are excreted in human milk, and therefore caution should be exercised when mannitol is administered to breastfeeding women.

Paediatric use

The Aridol test should not be used in patients below 6 years of age due to their inability to produce acceptable quality spirometric measurements.

The pivotal trial enrolled 138 children (125 asthmatic and 13 non-asthmatic subjects). Also there have been a small number of other studies investigating the safety and efficacy of Aridol in children. It appears the sensitivity and specificity as well as adverse event profile is comparable with adults. The mean maximum fall in FEV₁ was approx 21% in children which was the same as in adults.

Use in the elderly

Aridol has been given to a limited number of elderly patients

Carcinogenicity

Dietary mannitol ($\leq 5\%$) given for 2 years had no significant effect on tumour incidence in B6C3F₁ mice and F344 rats. Animal carcinogenicity studies have not been carried out with inhaled mannitol.

Genotoxicity

Mannitol was not genotoxic in *Salmonella typhimurium* and *E. coli* strain WP2. Negative results were also recorded in *Saccharomyces cerevisiae*, rat bone marrow cells and human WI-38 cells. Doses of up to 5 g/kg by gavage were also negative in a dominant lethal assay in rats.

Effects on fertility

The effect of inhaled mannitol on fertility has not been investigated.

Interactions

Regular use of inhaled corticosteroids reduces the airway sensitivity to Aridol and in many individuals, complete inhibition of the airway response occurs.

The following should be withheld before conducting an Aridol test as they may affect the results:

Medicines: Recommended periods for withholding medicines before the Aridol test are listed below.

Time to Withhold	Medication
6-8 hours	INHALED NON-STEROIDAL ANTI-INFLAMMATORY AGENTS e.g. sodium cromoglycate, nedocromil sodium
8 hours	SHORT-ACTING BETA₂ AGONISTS eg salbutamol, terbutaline
12 hours	INHALED CORTICOSTEROIDS e.g. beclomethasone dipropionate; budesonide; fluticasone propionate
12 hours	IPRATROPIUM BROMIDE
24 hours	INHALED CORTICOSTEROIDS PLUS LONG-ACTING BETA₂ AGONISTS eg fluticasone and salmeterol; budesonide and eformoterol
24 hours	LONG-ACTING BETA₂ AGONISTS e.g. salmeterol; eformoterol
24 hours	THEOPHYLLINE
72 hours	TIOTROPIUM BROMIDE
72 hours	ANTIHISTAMINES eg cetirizine, fexofenadine and loratadine
4 days	LEUKOTRIENE-RECEPTOR ANTAGONISTS e.g. montelukast sodium

Foods: Ingestion of significant quantities of coffee, tea, cola drinks, chocolate or other food containing caffeine may decrease bronchial responsiveness. These substances should be withheld on the day of the test.

Exercise: Vigorous exercise should not be performed prior to testing on the day of the test.

Smoking: Patients should refrain from smoking for at least 6 hours prior to testing.

Adverse Effects

A positive result with Aridol may produce symptoms of bronchospasm such as chest tightness, cough or wheezing.

Most patients experience cough during the challenge; however, it is only occasional in the vast majority of patients (83%) experiencing cough. In the remainder, it is frequent enough to cause some delay in continuation of the challenge (16%) or discontinuation (1%). Pharyngolaryngeal pain, a commonly reported adverse event, may be reduced if the mouth is rinsed after the test.

Adverse events were monitored in the pivotal clinical trial from the beginning of the challenge to a week following the challenge day. Due to the short half-life of mannitol, the causal link would be expected to diminish over that time. Most adverse events were reported to be mild and transient. The following is a table of adverse events reported in the trial (compared to hypertonic saline) at an incidence of 1% or more.

Adverse event	Mannitol (%)	Hypertonic saline (%)
<i>Ophthalmic</i>		
Eye pruritus	1.0	0.6
<i>Gastrointestinal</i>		
Nausea	4.3	3.0
Upper abdominal pain	1.9	1.4
Diarrhoea	1.3	0.6
Vomiting	1.3	0.9
<i>Infections</i>		
Nasopharyngitis	1.4	3.1
Upper respiratory tract infection	1.3	1.7
<i>Musculoskeletal</i>		
Back pain	1.0	0.6
<i>Neuronal</i>		
Headache	17.2	19.0
Dizziness	1.1	1.3
<i>Respiratory</i>		
Pharyngolaryngeal pain	5.1	3.0
Cough*	2.2	2.4
Rhinorrhoea	2.1	1.4
Throat irritation	1.3	0.2
Asthma aggravated	1.1	1.3
Chest tightness	1.0	0.6
Dyspnoea	1.0	0.8
Sneezing	0.8	1.1
Nasal congestion	0.6	1.1
Wheezing	0.5	1.1
<i>General</i>		
Fatigue	1.1	0.5

* Cough was defined as an adverse event during the challenge only if it led to discontinuation of the challenge

Dosage and administration

Aridol is supplied in kit form containing sufficient capsules to complete one complete challenge, and the inhalation device (Osmohaler™).

Prior to the challenge, spirometry should be performed and the reproducibility of the resting FEV₁ established.

The patient should be seated comfortably and encouraged to maintain good posture to assist the effective delivery of Aridol to the lungs. The test should proceed as follows:

1. Apply nose clip and subject should be directed to breathe through the mouth
2. Insert 0 mg capsule into inhalation device. Puncture capsule by depressing buttons on side of device slowly, and once only (a second puncture may fragment the capsules)
3. The patient should exhale completely, before inhaling from device in a controlled rapid deep inspiration
4. At the end of deep inspiration, start 60 second timer, subject should hold breath for 5 seconds and exhale through mouth before removal of nose clip
5. At the end of 60 seconds, measure the FEV₁ in duplicate (this becomes **baseline FEV₁**)
6. Insert 5 mg capsule into inhalation device, and proceed as above
7. Repeat steps 1 – 4 following the dose steps in the table below until the patient has a positive response or 635mg has been administered.

DOSE STEPS FOR ARIDOL CHALLENGE			
Dose #	Dose mg	Cumulative Dose mg	Capsules per dose
1	0	0	1
2	5	5	1
3	10	15	1
4	20	35	1
5	40	75	1
6	80	155	2 x 40 mg
7	160	315	4 x 40 mg
8	160	475	4 x 40 mg
9	160	635	4 x 40 mg

A positive response is achieved when the patient experiences either of the following:

- 15% fall in FEV₁ from baseline (0 mg dose)
- or
- 10% incremental fall in FEV₁ between doses

Examples of positive tests:

1. FEV₁ fall following dose step 2: 3%
FEV₁ fall following dose step 3: 8%
FEV₁ fall following dose step 4: 16%
- as the total fall is 16% ($\geq 15\%$), the test is positive
2. FEV₁ fall following dose step 2: 3%
FEV₁ fall following dose step 3: 14%
- although the total fall is $< 15\%$, the incremental fall is 11% ($\geq 10\%$) and the test is positive

Points to remember:

1. There should be minimal delay between FEV₁ measurement and the next dose so that the osmotic effect in the airway is cumulative.
2. At least 2 repeatable FEV₁ measures should be obtained after each dose.
3. The 80 and 160 mg doses are administered in multiples of 40 mg capsules (i.e., 2 x 40 mg and 4 x 40 mg, respectively). There is no interval between administering multiple capsules for these doses. One capsule should be followed immediately by the next until that total dose has been inhaled.
4. After inhalation of each dose, the capsule should be checked to ensure it is empty. A second inhalation from the same capsule may be required if the dose has not been entirely dispersed from the capsule.
5. The gelatin capsules may fragment when punctured. To minimise the possibility of this occurring, each capsule should not be punctured more than once.
6. A new inhalation device is to be used for each test which should not be cleaned during the test.

As with all challenge tests, most patients recover spontaneously. Those with a positive challenge result should receive a standard dose of a beta₂ agonist to expedite recovery. Following administration of a beta₂ agonist FEV₁ usually recovers within 10-20 minutes. Patients should be monitored until their FEV₁ is to within 5% of baseline levels.

Overdosage

Susceptible persons may suffer a hyperresponsiveness reaction from an overdose. The reaction can be treated with a bronchodilator. There is some experience with Aridol in clinical studies where patients experienced a 15% fall and inhaled a further dose. These studies used 20-25% as the target FEV₁ fall. The maximum fall measured was 50.2%. If excessive bronchoconstriction occurs, a beta₂ agonist should be given, and oxygen if necessary.

Presentation and storage conditions

Aridol is provided as a complete diagnostic kit. Each kit contains:

- 1 x empty clear capsule
- 1 x 5mg white/clear capsule
- 1 x 10 mg yellow/clear capsule
- 1 x 20mg pink/clear capsule
- 15 x 40mg red/clear capsule
- 1 x Inhalation device (Osmohaler™)

Aridol should be stored below 25°C.

Name and address of sponsor

Pharmaxis Ltd.
2/10 Rodborough Rd
Frenchs Forest NSW 2086
Australia

Poison schedule

Unscheduled

Date of approval

22 March 2006