

NEW ZEALAND DATA SHEET

1. PRODUCT NAME

Pamisol™ concentrate for injection

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Pamisol™ are available in 3 mg/mL, 6 mg/mL and 9 mg/mL strengths.

For the full list of excipients, see section 6.1

3. PHARMACEUTICAL FORM

Concentrate for injection

Pamisol™ is a clear, colourless, sterile solution.

The pH of the solution is approximately 6.5

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Treatment of conditions associated with increased osteoclast activity:

- Predominantly lytic bone metastases from breast cancer and advanced multiple myeloma
- Acute management of tumour induced hypercalcaemia (hypercalcaemia of malignancy)
- Treatment of symptomatic Paget's disease of bone

4.2 Dose and method of administration

Dose

Pamisol™ must never be given as a bolus injection since severe local reactions and thrombophlebitis may occur as a result of high local concentrations (see sections 4.3, 4.4 and 4.8). Pamisol™ should be administered by infusion in 0.9% sodium chloride or 5% glucose.

Pamisol™ contains no antimicrobial agent. The product is for single use only and any residue should be discarded after use. When the product was diluted to the following concentrations in PVC infusion bags, it was found to be chemically stable with 0.9% NaCl and 5% glucose for the periods shown in the following table:

Infusion Solution	Concentration (mg/mL)	Storage Condition	Stability Period (hours)
0.9% NaCl	0.06 to 0.36	25°C in the presence of light	24
0.9% NaCl	0.06 to 0.36	2 to 8°C in dark	24
5% Glucose	0.06 to 0.36	25°C in the presence of light	24
5% Glucose	0.06 to 0.36	2 to 8°C in dark	24

To reduce microbiological hazard, the diluted solution should preferably be used immediately and any residue remaining discarded. If the diluted product cannot be used immediately or as soon as practicable after preparation, store between 2° to 8°C for not more than 24 hours.

In order to minimise local reactions at the infusion site, the cannula should be inserted carefully into a relatively large vein.

Dosage regimens

Predominantly lytic bone metastases from breast cancer and advanced multiple myeloma

The recommended dose of pamidronate for the treatment of predominantly lytic bone metastases from breast cancer and advanced multiple myeloma is 90 mg administered as a single infusion every 4 weeks.

In patients with bone metastases who receive chemotherapy at 3-weekly intervals Pamisol™ 90 mg may also be given on a 3-weekly schedule.

The infusion rate should not exceed 60 mg/h (1 mg/min), and the concentration of pamidronate in the infusion solution should not exceed 90 mg/250 mL. In breast cancer patients, a dose of 90 mg should normally be administered as a 2-hour infusion in 250 mL infusion solution. However, in patients with multiple myeloma, it is recommended not to exceed 90 mg in 500 mL administered over 4 hours.

Tumour induced hypercalcaemia

Rehydration with sodium chloride 0.9% before or during treatment is necessary.

Initial treatment:

The total dose for a treatment course can be given as a single infusion. It can also be divided into 2 or 3 consecutive daily doses. The infusion rate should not exceed 60 mg/hour (1 mg/min), and the concentration of disodium pamidronate in the infusion solution should not exceed 90 mg/250 mL. However, it is recommended not to exceed a concentration of 90 mg in 500 mL over 4 hours.

The recommended total doses for each treatment course with disodium pamidronate are related to initial plasma calcium levels. A dosing guideline is shown in the table.

Initial serum calcium*		Recommended total dose (mg)
(mmol/L)	(mg %)	
up to 3.0	up to 12.0	30
3.0 - 3.5	12.0 - 14.0	30 - 60
3.5 - 4.0	14.0 - 16.0	60 - 90
> 4.0		90

*measured values not corrected for albumin

Repeated treatment:

If hypercalcaemia recurs, or if plasma calcium does not decrease within 2 days, further infusions of disodium pamidronate may be given, according to the guidelines for initial treatment.

Clinical experience to date has revealed a possibility of a weaker therapeutic response in patients with advanced malignant disease and/or with increased number of treatments.

The **maximum dose per treatment course** of disodium pamidronate is 90 mg whether for initial or repeat treatment. Higher doses bring no greater clinical benefit.

Paget's disease of bone

The recommended dose of disodium pamidronate in patients with symptomatic Paget's disease is a single infusion of 60 mg. The infusion rate should not exceed 15 to 30 mg/2 hours and the concentration of disodium pamidronate should not exceed 90 mg/L.

Re-treatment:

When clinically indicated, patients should be re-treated at the dose of initial therapy.

Renal impairment

Disodium pamidronate is not recommended for patients with severe renal impairment (see section 4.4).

In mild to moderate renal impairment, the maximum recommended disodium pamidronate infusion rate is 90 mg over 4 hours (approximately 20 – 22 mg/h).

Hepatic impairment

Dose reduction does not appear necessary in patients with mild to moderate hepatic impairment, however the data are limited (see section 5.2). There are no data in patients with severe hepatic impairment. Until further experience is gained, a maximum infusion rate of 20 mg/hour disodium pamidronate is recommended in patients with mild to moderate hepatic impairment. Disodium pamidronate has not been studied in patients with severe hepatic impairment. No specific recommendation can be given for patients with severe hepatic impairment.

Patient monitoring

Serum creatinine should be measured prior to each dose of disodium pamidronate.

In patients receiving disodium pamidronate for bone metastases, multiple myeloma or for tumour induced hypercalcaemia who have a deterioration in renal function defined as:

- for patients with normal baseline serum creatinine, an increase of >45 micromol/L and
- for patients with abnormal baseline serum creatinine, an increase of >90 micromol/L,

Disodium pamidronate should be withheld until serum creatinine returns to within 10% of the baseline value, unless treatment is required immediately for life-threatening hypercalcaemia.

Standard hypercalcemia-related metabolic parameters, including serum electrolytes, calcium and phosphate should be monitored after commencing disodium pamidronate. Patients who have undergone thyroid surgery may be particularly susceptible to develop hypocalcaemia due to relative hypoparathyroidism.

Serum electrolytes, calcium and phosphate should be monitored following initiation of therapy with disodium pamidronate. Patients with anaemia, leucopenia or thrombocytopenia should have regular haematology assessments. Individual data revealed significant decreases in white cell and platelet counts in several patients.

Patients should have standard laboratory (serum creatinine and BUN) and clinical renal function parameters periodically evaluated, especially those receiving frequent disodium pamidronate infusions over a prolonged period of time, and those with pre-existing renal disease or a predisposition to renal impairment (e.g. patients with multiple myeloma and/or tumour induced hypercalcaemia). Fluid balance (urine output, daily weights) should also be followed carefully. The infusion must be stopped if there is deterioration of renal function during disodium pamidronate therapy (see section 4.5).

In the initial treatment of tumour induced hypercalcaemia, it is essential that intravenous rehydration be instituted to restore urine output. Patients should be hydrated adequately throughout treatment, but overhydration must be avoided.

In patients with cardiac disease, especially in the elderly, additional saline overload may precipitate cardiac failure (left ventricular failure or congestive heart failure). Therefore, overhydration should be avoided especially in patients at risk of cardiac failure. Fever (influenza-like symptoms) may also contribute to this deterioration.

Patients with Paget's disease of the bone, who are at risk of calcium or vitamin D deficiency, should be given oral calcium supplements and vitamin D in order to minimise the risk of hypocalcaemia.

Individual data revealed significant decreases in white cell and platelet counts in several patients. Haematological testing should be carried out if clinically indicated.

In tumour induced hypercalcaemia, either ionised calcium, or total serum calcium corrected (adjusted) for albumin, should be monitored during treatment with disodium pamidronate. Serum calcium levels in patients who have hypercalcaemia of malignancy may not reflect the severity of hypercalcaemia, since hypoalbuminaemia is commonly present. Corrected serum calcium values should be calculated using established algorithms, such as: $cCa = tCa + (0.02 \times [40 - ALB])$
where: cCa = adjusted calcium concentration (millimole/L)
tCa = measured total calcium concentration (millimole/L)
ALB = measured albumin concentration (g/L).

4.3 Contraindications

Pamisol™ is contraindicated:

- In patients with known hypersensitivity to pamidronate or to other bisphosphonates or to any of the other ingredients in the formulation of Pamisol™.
- In pregnancy.
- In breastfeeding.

4.4 Special warnings and precautions for use

Pamisol™ should not be given as a bolus injection, since severe local reactions and thrombophlebitis may occur as a result of high local concentrations. It should always be diluted and given as a slow intravenous infusion (see section 4.2). Regardless of the volume of solution in which Pamisol™ is diluted, slow intravenous infusion is absolutely necessary for safety.

Pamisol™ should not be given with other bisphosphonates because their combined effects have not been investigated.

The safety and efficacy of disodium pamidronate in the treatment of hyperparathyroidism has not been established.

Disodium pamidronate should be administered under the supervision of a physician with the right equipment for the monitoring of clinical and biochemical parameters.

Patients must be assessed prior to administration of disodium pamidronate to assure that they are appropriately hydrated. This is especially important for patients receiving diuretic therapy.

The onset of action of disodium pamidronate is not immediate. Therefore, disodium pamidronate should be considered as only one component of the acute clinical management of tumour induced hypercalcaemia.

Pamisol™ should not be added to intravenous infusion fluids containing calcium, such as Ringer's Solution and Hartmann's Solution.

Patients receiving frequent infusions of pamidronate over a prolonged period of time, especially those with pre-existing renal disease or a predisposition to renal impairment (e.g. patients with multiple myeloma and/or tumour induced hypercalcaemia), should have periodic evaluations of standard laboratory and clinical parameters of renal function as deterioration of renal function (including renal failure) has been reported following long-term treatment with pamidronate in patients with multiple myeloma. However, underlying disease progression and/or concomitant complications were also present and therefore a causal relationship with pamidronate is unproven.

Convulsions have been precipitated in some patients with tumour induced hypercalcaemia due to the electrolyte changes associated with this condition and its effective treatment.

Use in patients with renal impairment

Bisphosphonates, including disodium pamidronate have been associated with renal toxicity manifested as deterioration of renal function and potential renal failure. Disodium pamidronate is excreted intact primarily via the kidney and, therefore, the risk of renal adverse reactions may be greater in patients with impaired renal function. Renal deterioration, progression to renal failure and dialysis has been reported in patients after the initial dose or a single dose of disodium pamidronate.

Deterioration of renal function (including renal failure) has also been reported following long-term treatment with disodium pamidronate in patients with multiple myeloma.

Disodium pamidronate should not be administered to patients with severe renal impairment (creatinine clearance <30 mL/min) except in cases of life-threatening tumour induced hypercalcaemia where the benefit outweighs the potential risk. Although disodium pamidronate is excreted unchanged by the

kidneys (see section 5.2), the drug has been used without apparent increase in adverse effects in patients with significantly elevated plasma creatinine levels (including patients undergoing renal replacement therapy with both haemodialysis and peritoneal dialysis). However, experience with disodium pamidronate in patients with severe renal impairment (serum creatinine: >440 micromoles/L, or 5 mg/dL in T1H patients; >180 micromoles/L, or 2 mg/dL in multiple myeloma patients) is limited. If clinical judgment determines that the potential benefits outweigh the risk in such cases, disodium pamidronate should be used cautiously and renal function carefully monitored.

Although a pharmacokinetic study conducted in patients with cancer and normal or impaired renal function indicates that a dose reduction may not be necessary in patients with mild (creatinine clearance 61 – 90 mL/min) to moderate (creatinine clearance 30-60 mL/min) renal impairment, there are insufficient clinical data on the use of disodium pamidronate in such patients to support this recommendation (see section 4.2).

Hepatic impairment

As there are no clinical data available in patients with severe hepatic impairment, no specific recommendations can be given for this patient population but caution should be exercised when disodium pamidronate is given to these patients (see section 4.2 and 5.2).

Osteonecrosis of the jaw

Osteonecrosis of the jaw (ONJ) has been reported predominantly in patients with cancer receiving treatment with bisphosphonates including disodium pamidronate. Many of these patients were also receiving chemotherapy and corticosteroids. Many had signs of local infection including osteomyelitis. Presentation may include jaw pain, toothache, exposed bone, altered sensation and local infection, including osteomyelitis. The condition may result in chronic pain, may be resistant to treatment, and in serious cases may result in disfigurement.

Post-marketing experience and the literature suggest a greater frequency of reports of ONJ based on tumour type (advanced breast cancer, multiple myeloma), and dental status (dental extraction, periodontal disease, local trauma including poorly fitting dentures).

Cancer patients should maintain good oral hygiene and should have a dental examination with preventive dentistry prior to treatment with bisphosphonates. Patients and their dentists should be advised of the reports of osteonecrosis of the jaw so that dental symptoms developing during treatment can be fully assessed before commencing dental procedures.

While on treatment, these patients should avoid invasive dental procedures if possible. For patients who develop osteonecrosis of the jaw while on bisphosphonate therapy, dental surgery may exacerbate the condition. For patients requiring dental procedures, there are no data available to suggest whether discontinuation of bisphosphonate treatment reduces the risk of osteonecrosis of the jaw. Clinical judgment of the treating physician should guide the management plan of each patient based on individual benefit/risk assessment.

Osteonecrosis of other anatomical sites

Cases of osteonecrosis of other anatomical sites including the hip, femur and external auditory canal have been reported predominantly in adult cancer patients treated with bisphosphonates, including disodium pamidronate.

Atypical femur fracture

Atypical subtrochanteric and diaphyseal femoral fractures have been reported with bisphosphonate therapy, primarily in patients receiving long-term treatment for osteoporosis. These transverse or short oblique fractures can occur anywhere along the femur from just below the lesser trochanter to just above the supracondylar flare. These fractures occur after minimal or no trauma and some patients experience thigh or groin pain, often associated with imaging features of stress fractures, weeks to months before presenting with a completed femoral fracture. Fractures are often bilateral; therefore the contralateral femur should be examined in bisphosphonate-treated patients who have sustained a femoral shaft fracture. Poor healing of these fractures has also been reported. Discontinuation of bisphosphonate

therapy in patients suspected to have an atypical femur fracture should be considered pending evaluation of the patient, based on an individual benefit risk assessment.

During bisphosphonate treatment patients should be advised to report any thigh, hip or groin pain and any patient presenting with such symptoms should be evaluated for an incomplete femur fracture.

Musculoskeletal Pain

In post-marketing experience, severe and occasionally incapacitating bone, joint, and/or muscle pain has been reported in patients taking bisphosphonates. However, such reports have been infrequent. This category of drugs includes disodium pamidronate (for infusion). The time to onset of symptoms varied from one day to several months after starting the drug. Most patients had relief of symptoms after stopping treatment. A subset had recurrence of symptoms when rechallenged with the same drug or another bisphosphonate.

Preclinical Safety Data

The toxicity of disodium pamidronate is characterised by direct (cytotoxic) effects on organs with a copious blood supply, particularly the kidneys following i.v. exposure. In animal studies with intravenous administration, renal tubular lesions were the prominent and consistent untoward effects of treatment.

Use in children

There is limited clinical experience to date in children. Disodium pamidronate should not be given to children unless other measures have either failed to control life-threatening hypercalcaemia or are deemed inappropriate. Until further experience is gained, disodium pamidronate is only recommended for use in adult patients.

4.5 Interaction with other medicines and other forms of interaction

Disodium pamidronate has been used concomitantly with commonly used antitumour drugs (including aminoglutethimide, cisplatin, corticosteroids, cyclophosphamide, cytarabine, doxorubicin, etoposide, fluorouracil, megestrol, melphalan, methotrexate, mitoxantrone, paclitaxel, tamoxifen, vinblastine and vincristine) without significant interactions.

Disodium pamidronate should not be used concomitantly with other bisphosphonates. Significant hypocalcaemia may result if other calcium lowering agents are used in conjunction with disodium pamidronate.

It has also been used with mithramycin in patients with severe hypercalcaemia without significant interactions.

Disodium pamidronate has been used in combination with calcitonin in patients with severe hypercalcaemia, resulting in a synergistic effect with a more rapid fall in serum calcium.

Concomitant administration of a loop diuretic had no effect on the calcium lowering action of disodium pamidronate.

Caution is warranted when disodium pamidronate is used with other potentially nephrotoxic drugs.

In multiple myeloma patients, the risk of renal dysfunction may be increased when disodium pamidronate is used in combination with thalidomide.

Interference with laboratory tests

Since disodium pamidronate binds to bone it can interfere with bone scintigraphy examinations.

4.6 Fertility, pregnancy and lactation

Fertility

Fertility and general reproductive performance was not affected by oral disodium pamidronate doses (to 150 mg/kg/day), although prolonged and abnormal parturition was seen; there were no such studies with intravenous administration.

Pregnancy (Category B3)

Pamidronate has been shown to cross the placenta and has produced marked maternal and non-teratogenic embryo/foetal effects in rats and rabbits. It accumulates in foetal bone in a manner similar to that observed in adult animals. Disodium pamidronate has been shown to increase the length of gestation and parturition in rats resulting in an increasing pup mortality when given orally at daily doses of 60 mg/kg and above (0.7 times the highest recommended human dose for a single intravenous infusion). In pregnant rats high doses of intravenous pamidronate (12 and 15 mg/kg/day) were associated with maternal toxicity and foetal developmental abnormalities (foetal oedema and shortened bones) and doses of 6 mg/kg and above with reduced ossification. Lower intravenous disodium pamidronate doses (1 to 6 mg/kg/day) interfered (prepartum distress and foetotoxicity) with normal parturition in the rat, and this may be associated with maternal hypocalcaemia.

Only low intravenous doses have been investigated in pregnant rabbits, because of maternal toxicity, and the highest dose used (1.5 mg/kg/day) was associated with an increased resorption rate and reduced ossification.

It is not known if disodium pamidronate crosses the human placenta. There are no adequate and well controlled studies in pregnant women and no clinical experience to support the use of disodium pamidronate in pregnant women. Therefore, disodium pamidronate should not be used during pregnancy (see section 4.3).

Women of child-bearing potential must use highly effective contraception during treatment.

Bisphosphonates are incorporated into the bone matrix, from where they are gradually released over periods of weeks to years. The extent of bisphosphonate incorporation into adult bone, and hence, the amount available for release back into the systemic circulation, is directly related to the total dose and duration of bisphosphonate use. Although there are very limited data on foetal risk in humans, bisphosphonates do cause foetal harm in animals. Therefore, there is a theoretical risk of foetal harm (e.g. skeletal and other abnormalities) if a woman becomes pregnant after completing a course of bisphosphonate therapy. The impact of variables such as time between cessation of bisphosphonate therapy to conception, the particular bisphosphonate used, and the route of administration (intravenous versus oral) on this risk has not been established.

Australian categorisation definition of Category B3:

Drugs which have been taken by only a limited number of pregnant women and women of childbearing age, without an increase in the frequency of malformation or other direct or indirect harmful effects on the human foetus having been observed. Studies in animals have shown evidence of an increased occurrence of foetal damage, the significance of which is considered uncertain in humans.

Lactation

There is no clinical experience with Pamisol™ in lactating women. It is not known if disodium pamidronate and/or its metabolites pass into human milk. A study in lactating rats has shown that disodium pamidronate will pass into the milk. Therefore, mothers taking disodium pamidronate should not breastfeed (see section 4.3)

4.7 Effects on ability to drive and use machines

Patients should be warned that in rare cases somnolence and/or dizziness may occur following Pamisol™ infusion, in which case they should not drive, operate potentially dangerous machinery, or engage in other activities that may be hazardous because of decreased alertness. This effect rarely lasts

more than 24 hours. Outpatients who have received a disodium pamidronate infusion should not drive themselves home.

4.8 Undesirable effects

Adverse reactions to pamidronate are usually mild and transient. The most common adverse reactions are asymptomatic hypocalcaemia, influenza like symptoms, joint swelling and mild fever (an increase in body temperature of $>1^{\circ}\text{C}$, which may last up to 48 hours). Fever usually resolves spontaneously and does not require treatment. Acute "influenza like" reactions usually occur only with the first disodium pamidronate infusion. Symptomatic hypocalcaemia is uncommon. Local soft tissue inflammation at the infusion site also occurs, especially at the highest dose (90 mg).

The frequency estimate for the adverse reactions below is as follows:

Very common: ($>1/10$), common: ($>1/100$ and $<1/10$) uncommon: ($>1/1000$, $<1/100$), rare: ($>1/10,000$, $<1/1000$) and very rare: ($<1/10,000$), including isolated reports.

Body as a whole

Very common: fever and influenza-like symptoms sometimes accompanied by malaise, rigor, fatigue, and flushes

Very rare: allergic reaction (swollen and itchy eyes, runny nose and scratchy throat).

Biochemical changes

Very common: hypocalcaemia, hypophosphataemia
Common: hypomagnesaemia, hyperkalaemia, increase in serum creatinine

Uncommon: abnormal liver function tests, increase in serum urea

Very rare: hypokalaemia, hypernatraemia
Many of these undesirable effects may have been related to the underlying disease.

Blood

Common: anaemia, lymphocytopenia, thrombocytopenia

Very rare: leukopenia

One case of acute lymphoblastic leukaemia has been reported in a patient with Paget's disease. The causal relationship to the treatment or the underlying disease is unknown.

Cardiovascular system

Common: hypertension, atrial fibrillation

Uncommon: hypotension

Very rare: left ventricular failure (dyspnoea, pulmonary oedema), congestive heart failure (oedema) due to fluid overload

Central nervous system

Common: headache, insomnia, symptomatic hypocalcaemia (paraesthesia, tetany), somnolence

Uncommon: lethargy, seizures, agitation, dizziness

Very rare: confusion, visual hallucinations

Gastrointestinal tract

Common: nausea, vomiting, anorexia, abdominal pain, constipation, gastritis, diarrhoea

Uncommon: dyspepsia

Local reactions

Common: reactions at the infusion site: pain, redness, swelling, induration, phlebitis, thrombophlebitis

Musculoskeletal system

Common: transient bone pain, arthralgia, myalgia, generalised pain, skeletal pain

Uncommon: muscle cramps

Renal system

Uncommon: acute renal failure

Rare: focal segmental glomerulosclerosis, including the collapsing variant nephrotic syndrome

Very rare: haematuria, deterioration of pre-existing renal disease (see comments below).

Respiratory

Very rare: adult respiratory distress syndrome, interstitial pneumonitis

Skin and subcutaneous disorders

Common: rash

Uncommon: pruritus

Eye disorders

Common: conjunctivitis

Uncommon: uveitis (iritis, iridocyclitis)

Very rare: scleritis, episcleritis, xanthopsia

Others

Rare: allergic reaction anaphylactic reactions, bronchospasm (dyspnoea), Quincke's oedema

Very rare: anaphylactic shock, Tumour induced hypercalcaemia and Paget's disease

Deterioration of renal function has been noted in patients treated with bisphosphonates. Since many patients with tumour induced hypercalcaemia have compromised renal function prior to receiving antihypercalcaemia therapy (see section 4.4), it is difficult to estimate the role of individual bisphosphonates in subsequent changes in renal function. Deterioration of renal function (elevation of serum creatinine of >20% above baseline) which could not be readily explained in terms of pre-existing renal disease, prior nephrotoxic chemotherapies or compromised intravascular volume status has been noted in 7 cases of 404 patients treated with disodium pamidronate where these data have been reported. The role of disodium pamidronate in these changes in renal function is unclear, but merits cautious observation.

Bone metastases and multiple myeloma

Deterioration of renal function (including renal failure) has been reported following long term treatment with disodium pamidronate in patients with multiple myeloma. However, underlying disease progression and/or concomitant complications were also present and therefore a causal relationship with disodium pamidronate is unproven.

Post-marketing

The following adverse reactions have been reported during post-approval use of disodium pamidronate. Because these reports are from a population of uncertain size and are subject to confounding factors, it is not possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Frequency not known

Respiratory, thoracic and mediastinal disorders: acute respiratory distress syndrome (ARDS), interstitial lung disease (ILD)

Musculoskeletal and connective tissue disorders: severe and occasionally incapacitating bone, joint and/or muscle pain (infrequent cases reported). Cases of atypical subtrochanteric and diaphyseal femoral fractures have been reported with bisphosphonates (class adverse reaction).

Renal and urinary disorders: renal tubular disorders (RTD), tubulointerstitial nephritis, and glomerulonephropathies

Eye disorders: optic neuritis

Description of selected adverse effects

Atrial fibrillation: Isolated instances of higher incidence of atrial fibrillation have been reported in a few studies with some bisphosphonates. The mechanism of this increased incidence of atrial fibrillation in isolated studies within these bisphosphonates is unknown.

Osteonecrosis of the jaw: Cases of osteonecrosis (primarily of the jaws) but also of other anatomical sites including the hip, femur and external auditory canal have been reported predominantly in cancer patients treated with bisphosphonates, including disodium pamidronate (uncommon). Many of these patients had signs of local infection including osteomyelitis and the majority of the reports refer to cancer patients following tooth extractions or other dental surgeries. Osteonecrosis of the jaws has multiple well documented risk factors including a diagnosis of cancer, concomitant therapies (e.g. chemotherapy, radiotherapy, anti-angiogenic drugs, corticosteroids) and co-morbid conditions (e.g. anaemia, coagulopathies, infection, pre-existing oral disease). Although causality has not been determined, it is prudent to avoid dental surgery as recovery may be prolonged (see section 4.4). Data suggest a greater frequency of reports of ONJ based on tumour type (advanced breast cancer, multiple myeloma).

Reporting of Suspected Adverse Reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions <https://nzphvc.otago.ac.nz/reporting/>.

4.9 Overdose

Symptoms

Overdosage with disodium pamidronate would be likely to result in symptoms of hypocalcaemia, such as paraesthesia, tetany and hypotension.

Treatment

Patients who have received doses of Pamisol™ higher than those recommended should be carefully monitored. In the event of clinically significant hypocalcaemia with paraesthesia, tetany and hypotension, reversal may be achieved with an infusion of calcium gluconate. Acute hypocalcaemia is not expected to occur with disodium pamidronate since plasma calcium levels fall progressively for several days after treatment.

In case of overdose, immediately contact the Poisons Information Centre for advice. (In Australia, call 13 11 26; in New Zealand call 0800 764 766.)

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Disodium pamidronate, the active substance of Pamisol™, is a potent inhibitor of osteoclastic bone resorption. This antiresorptive activity is responsible for its therapeutic effect.

Pamisol™ inhibits the formation and dissolution of calcium apatite crystals *in vitro*. The physicochemical interaction of disodium pamidronate with apatite crystals accounts for its avid binding to bone, but the mechanism for the anti-osteoclastic activity at the cellular level is unknown at present.

Disodium pamidronate suppresses the accession of osteoclast precursors onto the bone and their subsequent transformation into the mature, resorbing osteoclasts. However, the local and direct antiresorptive effect of bone-bound bisphosphonate appears to be the predominant mode of action *in vitro* and *in vivo*.

Changes in biochemical parameters which reflect a decrease in bone resorption and improvements secondary to normalisation of plasma calcium include decreased urinary hydroxyproline, urinary calcium and serum phosphate.

Hypercalcaemia can lead to haemoconcentration by inhibition of tubular reabsorption of water, and to decreased glomerular filtration rate (GFR), both of which lead to increased plasma creatinine

concentration. A direct consequence of treatment with disodium pamidronate is improvement in GFR and decreased creatinine levels in most patients.

Paget's disease of bone, which is characterised by local areas of increased bone resorption and formation with qualitative changes in bone remodelling, responds well to treatment with pamidronate. Clinical and biochemical remission of the disease has been demonstrated by bone scintigraphy, decreases in urinary hydroxyproline and serum alkaline phosphatase, and by symptomatic improvement.

5.2 Pharmacokinetic properties

General characteristics

Pamidronate has a strong affinity for calcified tissues, and total elimination of pamidronate from the body is not observed within the time frame of experimental studies. Calcified tissues are therefore regarded as site of "apparent elimination".

Absorption

Pamisol™ is given by intravenous infusion. By definition, absorption is complete at the end of the infusion.

Distribution

Plasma concentrations of pamidronate rise rapidly after the start of an infusion and fall rapidly when the infusion is stopped. The apparent half-life in plasma is about 0.8 hours. Apparent steady-state concentrations are therefore achieved with infusions of more than about 2-3 hours' duration. Peak plasma pamidronate concentrations of about 10 nmol/mL are achieved after an intravenous infusion of 60 mg given over 1 hour.

In animals and in man, a similar percentage of the dose is retained in the body after each dose of disodium pamidronate. Thus, the accumulation of pamidronate in bone is not capacity-limited, and is dependent solely on the total cumulative dose administered. Clinicians should be aware that some 50% of the infused material will remain in the patient's skeleton for years.

The percentage of circulating pamidronate bound to plasma proteins is relatively low (about 54%), and increases when calcium concentrations are pathologically elevated.

Elimination

Pamidronate does not appear to be eliminated by biotransformation. After an intravenous infusion, about 20-55% of the dose is recovered in the urine within 72 hours as unchanged pamidronate. Within the time frame of experimental studies the remaining fraction of the dose is retained in the body. The percentage of the dose retained in the body is independent of both the dose (range 15-180 mg) and the infusion rate (range 1.25-60 mg/h). The elimination of pamidronate in the urine is biexponential, with apparent half-lives of about 1.6 and 27 hours. The apparent total plasma clearance is about 180 mL/min and the apparent renal clearance is about 54 mL/min. There is a tendency for the renal clearance of pamidronate to correlate with creatinine clearance.

Characteristics in patients

Hepatic and metabolic clearance of pamidronate are insignificant. Impairment of liver function is therefore not expected to influence the pharmacokinetics of pamidronate. Pamidronate thus displays little potential for drug-drug interactions both at the metabolic level and at the level of protein binding (see above).

The mean plasma area under the curve (AUC) is approximately doubled in patients with severe renal impairment (creatinine clearance < 30 mL/min). Urinary excretion rate decreases with decreasing creatinine clearance, although the total amount excreted in the urine is not greatly influenced by renal function. Body retention of pamidronate is therefore similar in patients with and without impaired renal function. Although this suggests that a dose reduction may not be necessary in patients with impaired renal function, there is insufficient clinical data on the use of Pamisol™ in such patients to support this recommendation (see section 4.4).

5.3 Preclinical safety data

Studies conducted in young rats have reported the disruption of dental dentine formation following single and multiple dose administration of bisphosphonates. The clinical significance of these findings is unknown.

Carcinogenicity and mutagenicity

There is a lack of long term toxicology data from animal studies with intravenous administration. In a 104 week carcinogenicity study of daily oral administration to rats, there was a positive dose response relationship for benign phaeochromocytoma in male animals.

Although this condition was also observed in female animals, the incidence was not statistically significant. When the dosage calculations were adjusted to account for the limited oral bioavailability of disodium pamidronate in rats, the lowest daily dose associated with adrenal phaeochromocytoma was similar to the intended clinical dose in humans. In a second rat carcinogenicity study, adrenal phaeochromocytomas were not reported at doses similar to the intended clinical dose in humans. Disodium pamidronate by daily oral administration was not carcinogenic in a 80 week or a 104 week study in mice.

Disodium pamidronate showed no genotoxic activity in a standard battery of assays for gene mutations and chromosomal damage.

Clinical trials

Three randomised, double blind, placebo controlled trials investigated the effects of disodium pamidronate on the occurrence of skeletal related events (SREs: pathological fractures, radiation therapy or surgery to bone, spinal cord compression) and pain score in patients with multiple myeloma and in breast cancer patients with predominantly lytic bone metastases.

In the first trial, patients with advanced multiple myeloma received 90 mg of disodium pamidronate or placebo as a monthly 4 hour intravenous infusion for 9 months, in addition to antimyeloma therapy. Patients had received appropriate chemotherapy for a minimum 2 months prior to entry into the trial. A total of 196 disodium pamidronate patients and 181 placebo patients were evaluable for efficacy. Compared with placebo, significantly fewer patients in the disodium pamidronate group had any SRE (24% vs 41%, $p < 0.001$) and the mean skeletal morbidity rate was lower (1.1 vs 2.1 SREs/year, $p < 0.02$). The times to first SRE, pathological fracture and radiation therapy to bone were significantly longer in the disodium pamidronate group ($p = 0.001$, 0.006, and 0.046, respectively). Fewer disodium pamidronate patients suffered any pathological fracture (17% vs 30%, $p = 0.004$) or needed radiation therapy to bone (14% vs 22%, $p = 0.049$). In patients with pain at baseline, pain scores at the last assessment were significantly reduced with disodium pamidronate treatment ($p < 0.05$) but not with placebo.

Patients completing the first part of the trial continued to receive 4-weekly infusions of disodium pamidronate or placebo for a further 11 infusions during the maintenance phase of the trial (observation period). After 21 months, the proportion of patients with any SRE was significantly less in the disodium pamidronate group than in the placebo group ($p = 0.015$), the mean skeletal morbidity rate was lower ($p = 0.008$) and the time to first SRE was longer ($p = 0.016$). There was an increased incidence of renal toxicity observed in patients receiving disodium pamidronate during the observation period of the trial, although this was not statistically significantly different from the placebo group (see section 4.4).

In the second and third trials, breast cancer patients with at least one predominantly osteolytic bone metastasis received 90 mg of disodium pamidronate or placebo as a 2 hour intravenous infusion every 3 or 4 weeks for 12 months.

Breast cancer patients in the second trial were treated with cytotoxic chemotherapy. A total of 185 disodium pamidronate patients and 195 placebo patients were evaluable for efficacy. Compared with placebo, significantly fewer patients in the disodium pamidronate group had any SRE (43% vs 56%, $p < 0.01$), the mean skeletal morbidity rate was lower (2.5 vs 3.3 SREs/year, $p < 0.01$) and the time to first SRE was longer (median 13.1 vs 7.0 months, $p < 0.01$). Fewer patients in the disodium pamidronate group than the placebo group needed radiation therapy to bone, the mean skeletal morbidity rate for radiation therapy to bone was lower and the time to first radiation therapy was longer ($p < 0.01$ for each).

The complete plus partial response rate for bone lesions was 33% in disodium pamidronate patients and 18% in placebo patients (p=0.001).

Breast cancer patients in the third trial were treated with hormonal therapy at trial entry. A total of 182 disodium pamidronate patients and 189 placebo patients were evaluable for efficacy. The mean skeletal morbidity rate for radiation therapy to bone was lower with disodium pamidronate treatment than with placebo (0.6 vs 1.1 SREs/year, p<0.01) and the time to first radiation therapy was longer (p<0.01; median time not reached during the trial). The proportion of patients having any radiation to bone was lower with disodium pamidronate treatment than with placebo (21% vs 33% at 12 months, p<0.01). There was no statistically significant difference in the proportion of patients with any SRE, in the skeletal morbidity rate for any SRE, in the time to first SRE and in the bone lesion response rate.

In both trials, pain scores (mean change from baseline at last measurement) showed that breast cancer patients treated with disodium pamidronate had significantly less pain than patients treated with placebo (p<0.05 for chemotherapy patients, p<0.01 for hormonal therapy patients).

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Mannitol
Phosphoric acid (for pH-adjustment)
Sodium hydroxide (for pH-adjustment)
Water for injection

6.2 Incompatibilities

Pamidronate will form complexes with divalent cations and should not be added to calcium-containing intravenous solutions.

6.3 Shelf life

24 months

6.4 Special precautions for storage

Store below 25°C.

6.5 Nature and contents of container

Pamisol™	Strength	Pack size
15 mg disodium pamidronate/5 mL	3 mg/mL	1 x 5 mL or 5 x 5 mL vial
30 mg disodium pamidronate/10 mL	3 mg/mL	1 x 10 mL vial
60 mg disodium pamidronate/10 mL	6 mg/mL	1 x 10 mL vial
90 mg disodium pamidronae/10 mL	9 mg/mL	1 x 10 mL vial

6.6 Special precautions for disposal and other handling

None stated.

7. MEDICINE SCHEDULE

Prescription Medicine.

8. SPONSOR

Pfizer New Zealand Ltd
P O Box 3998
Auckland, New Zealand, 1140.

Toll Free Number: 0800 736 363

9. DATE OF FIRST APPROVAL

22/02/2001

10. Date of REVISION OF THE TEXT

10 October 2017

Summary tables of changes

Section changed	Summary of new Information
All sections	Reformat of datasheet to the SPC format, effective 01 March 2017
4.2	Addition of text in patient monitoring section regarding hypercalcemia and overhydration in patients at risk of cardiac failure.
4.4	Addition of hepatic impairment, osteonecrosis of other anatomical sites and musculoskeletal pain information
4.6	Addition of text regarding women of child-bearing potential must use a highly effective contraception during treatment
4.8	Addition of diarrhoea and atrial fibrillation as an undesirable effect
4.8	Addition of post-marketing information