

Forane
Inhalation Anaesthetic

NAME OF THE MEDICINAL PRODUCT

Forane

QUALITATIVE AND QUANTITATIVE COMPOSITION

Isoflurane 99.9% w/w

PHARMACEUTICAL FORM

Isoflurane is an inhalation anaesthetic with a mildly pungent ethereal odour. No additive or stabiliser present.

CLINICAL PARTICULARS

Therapeutic indications

Isoflurane is indicated as a general anaesthetic by inhalation.

Posology and method of administration

Vaporisers specially calibrated for Isoflurane should be used so that the concentration of anaesthetic delivered can be accurately controlled.

MAC values for Isoflurane vary with age. The table below indicates average MAC values for different age groups.

Age	Average MAC Value In 100% Oxygen	70% N ₂ O
0-1 month	1.60%	
1-6 months	1.87%	
6-12 months	1.80%	
1-5 years	1.60%	
26 ± 4 years	1.28%	0.56%
44 ± 7 years	1.15%	0.50%
64 ± 5 years	1.05%	0.37%

Premedication: Drugs used for premedication should be selected for the individual patient bearing in mind the respiratory depressant effect of Isoflurane. The use of anticholinergic drugs is a matter of choice, but may be advisable for inhalation induction in paediatrics.

Induction: A short-acting barbiturate or other intravenous induction agent is usually administered followed by inhalation of the Isoflurane mixture. Alternatively, Isoflurane with oxygen or with an oxygen/nitrous oxide mixture may be used. It is recommended that induction with Isoflurane be initiated at a concentration of 0.5%. Concentrations of 1.5 to 3.0% usually produce surgical anaesthesia in 7 to 10 minutes.

Maintenance: Surgical levels of anaesthesia may be maintained with 1.0-2.5% Isoflurane in oxygen/nitrous oxide mixtures. An additional 0.5-1.0% Isoflurane may be required when given with oxygen alone.

For caesarean section, 0.5-0.75% Isoflurane in a mixture of oxygen/nitrous oxide is suitable to maintain anaesthesia for this procedure.

Arterial pressure levels during maintenance tend to be inversely related to alveolar Isoflurane concentrations in the absence of other complicating factors. Excessive falls in blood pressure may be due to depth of anaesthesia and in these circumstances, should be corrected by reducing the inspired Isoflurane concentration.

Elderly: As with other agents, lesser concentrations of Isoflurane are normally required to maintain surgical anaesthesia in elderly patients. See above for MAC values related to age.

Contraindications

Isoflurane is contra-indicated in patients with known sensitivity to Isoflurane or other halogenated anaesthetics. It is also contraindicated in patients with known or suspected genetic susceptibility to malignant hyperpyrexia.

Special warnings and precautions for use

Vaporisers specially calibrated for isoflurane should be used so that the concentration of anaesthetic delivered can be accurately controlled. Hypotension and respiratory depression increase as anaesthesia is deepened.

Increased blood losses comparable with those found following anaesthesia with other inhalation agents have been recorded with isoflurane in patients undergoing induced abortion.

Isoflurane relaxes the uterus muscle, and the lowest possible concentration of isoflurane should be used in obstetrical operations.

Isolated cases of increased carboxyhaemoglobin have been reported with the use of halogenated inhalation agents with a –CF₂H moiety (i.e., desflurane, enflurane and isoflurane). No clinically significant concentrations of carbon monoxide are produced in the presence of normally hydrated absorbents. Care should be taken to follow manufacturer's instructions for CO₂ absorbents.

Isoflurane has been reported to interact with dry carbon dioxide absorbents to form carbon monoxide. In order to minimise the risk of formation of carbon monoxide in rebreathing circuits and the possibility of elevated carboxyhaemoglobin levels, carbon dioxide absorbent should not be allowed to dry out.

Rare cases of extreme heat, smoke and/or spontaneous fire in the anaesthesia machine have been reported during the administration of general anaesthesia with drugs in this class when used in conjunction with desiccated CO₂ absorbents, specifically those containing potassium hydroxide (e.g. Baralyme). When a clinician suspects that the CO₂ absorbent may be desiccated, it should be replaced before administration of isoflurane. The colour indicator of most CO₂ absorbents does not necessarily change as a result of desiccation. Therefore, the lack of significant colour change should not be taken as an assurance of adequate hydration. CO₂ absorbents should be replaced routinely regardless of the state of the colour indicator.

General

As with any potent general anaesthetic, isoflurane should only be administered in an adequately equipped anaesthetising environment by those who are familiar with the pharmacology of the drug and qualified by training and experience to manage the anaesthetised patient.

Since levels of anaesthesia may be altered quickly and easily with isoflurane, only vaporisers which deliver a predictable output with reasonable accuracy, or techniques during which inspired or expired concentrations can be monitored, should be used. The degree of hypotension and respiratory depression may provide some indication of anaesthetic depth.

Reports demonstrate that isoflurane can produce hepatic injury ranging from mild transient increases of liver enzymes to fatal hepatic necrosis in very rare instances.

It has been reported that previous exposure to halogenated hydrocarbon anaesthetics, especially if the interval is less than 3 months, may increase the potential for hepatic injury. Cirrhosis, viral hepatitis or other pre-existing liver disease can be a reason to select an anaesthetic other than a halogenated anaesthetic.

Regardless of the anaesthetics employed, maintenance of normal haemodynamics is important to the avoidance of myocardial ischaemia in patients with coronary artery disease.

Isoflurane markedly increases cerebral blood flow at deeper levels of anaesthesia. There may be a transient rise in cerebral spinal fluid pressure which is fully reversible with hyperventilation.

Isoflurane must be used with caution in patients with increased intracranial pressure. In such cases hyperventilation may be necessary.

Use of isoflurane in hypovolaemic, hypotensive and debilitated patients has not been extensively investigated. A lower concentration of isoflurane is recommended for use in these patients.

The action of non-depolarising relaxants is markedly potentiated with isoflurane.

Isoflurane may cause a slight decrease in intellectual function for 2-4 days following anaesthesia. Small changes in moods and symptoms may persist for up to 6 days after administration. This must be taken into account when patients resume normal daily activities, including driving or operating heavy machinery.

A potentiation of neuromuscular fatigue can be seen in patients with neuromuscular diseases, such as myasthenia gravis. Isoflurane should be used with caution in these patients.

Isoflurane should be administered with caution to patients who can develop bronchoconstriction since bronchospasm can occur.

Isoflurane may cause respiratory depression which may be augmented by narcotic premedication or other agents causing respiratory depression. Respiration should be supervised and if necessary, assisted.

During the induction of anaesthesia, saliva flow and tracheobronchial secretion can increase and can be the cause of laryngospasm, particularly in children.

Children Under Two Years of Age

Caution should be exercised when isoflurane is used in small children due to limited experience with this patient-group.

Malignant Hyperthermia

In susceptible individuals, isoflurane anaesthesia may trigger a skeletal muscle hypermetabolic state leading to high oxygen demand and the clinical syndrome known as malignant hyperthermia. The syndrome includes nonspecific features such as muscle rigidity, tachycardia, tachypnoea, cyanosis, arrhythmias, and unstable blood pressures. (It should also be noted that many of these nonspecific signs may appear with light anaesthesia, acute hypoxia, etc.) An increase in overall metabolism may be reflected in an elevated temperature (which may rise rapidly early or late in the case, but usually is not the first sign of augmented metabolism) and an increased usage of the CO₂ absorption system (hot canister). PaO₂ and pH may decrease, and hyperkalaemia and a base deficit may appear. Treatment includes discontinuance of triggering agents (e.g. isoflurane), intravenous administration of dantrolene sodium, and application of supportive therapy. Such therapy includes vigorous efforts to restore body temperature to normal, respiratory and circulatory support as indicated, and management of electrolyte-fluid-acid-base derangements. (Consult prescribing information for dantrolene sodium intravenous for additional information on patient management.) Renal failure may appear later.

Use of inhaled anaesthetic agents has been associated with rare increases in serum potassium levels that have resulted in cardiac arrhythmias and death in paediatric patients during the post-operative period. Patients with latent as well as overt neuromuscular disease, particularly Duchenne muscular dystrophy, appear to be most vulnerable. Concomitant use of succinylcholine has been associated with most, but not all, of these cases. These patients also experienced significant elevations in serum creatine kinase levels and, in some cases, changes in urine consistent with myoglobinuria. Despite the similarity in presentation to malignant hyperthermia, none of these patients exhibited signs or symptoms of muscle rigidity or hypermetabolic state. Early and aggressive intervention to treat the hyperkalaemia and resistant arrhythmias is recommended, as is subsequent evaluation for latent neuromuscular disease.

Interaction with other medicinal products and other forms of interaction

Combinations advised against:

Beta- sympathomimetic agents like isoprenaline and alpha- and beta- sympathomimetic agents like adrenaline and noradrenaline should be used with caution during isoflurane narcosis, due to a potential risk of ventricular arrhythmia.

Non-selective MAO-inhibitors: Risk of crisis during the operation. Treatment should be stopped 15 days prior to surgery.

Combinations requiring precautions in using:

Indirect-acting sympathomimetics (amphetamines and their derivatives, psychostimulants, appetite suppressants, ephedrine and its derivatives): Risk of peri-operative hypertension. In patients undergoing elective surgery, treatment should ideally be discontinued several days before surgery.

Adrenaline, by subcutaneous or gingival injections: risk of serious ventricular arrhythmia as a consequence of increased heart rate, although the myocardial sensitivity with respect to adrenaline is lower with the use of isoflurane than in the case of halothane.

Cardiovascular compensation reactions may be impaired by beta-blockers.

Use of isoflurane and, in particular dihydropyridine derivatives: isoflurane may lead to marked hypotension in patients treated with calcium antagonists.

Caution should be exercised when calcium antagonists are used concomitantly with inhalation anaesthetics due to the risk of additive negative inotropic effect.

Opioids, benzodiazepines and other sedative agents are associated with respiratory depression, and caution should be exercised when concomitantly administered with isoflurane.

Muscle relaxants are markedly potentiated by isoflurane. Neostigmine has an effect on the non-depolarising relaxants, but has no effect on the relaxing action of isoflurane itself.

MAC (minimum alveolar concentration) is reduced by concomitant administration of N₂O in adults.

Fertility, pregnancy and lactation

Use in Pregnancy

There are no or limited amount of data from the use of isoflurane in pregnant women. Studies in animals have shown reproductive toxicity. Isoflurane should only be used during pregnancy if the benefit outweighs the potential risk.

Isoflurane relaxes the uterus muscle, and the lowest possible concentration of isoflurane should be used in obstetrical operations.

Use in Caesarean Section

Isoflurane, in concentrations up to 0.75%, has been shown to be safe for the maintenance of anaesthesia for caesarean section.

Nursing Mothers

It is not known whether isoflurane/metabolites are excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when isoflurane is administered to a nursing woman.

Effects on ability to drive and use machines

The medicinal product can have influence on driving and using machines. The patient should not drive or use machines for at least 24 hours after anaesthesia with isoflurane. Changes in behaviour and intellectual function may persist for up to 6 days after administration. This must be taken into account when patients resume normal daily activities, including driving or operating heavy machinery.

Undesirable effects

a. Summary of the safety profile

Adverse reactions encountered in the administration of isoflurane are in general dose dependent extensions of pharmaco-physiologic effects and include respiratory depression, hypotension and arrhythmias. Potential serious undesirable effects include malignant hyperthermia, anaphylactic reactions and liver adverse reactions. Shivering, nausea, vomiting and ileus have been observed in the post-operative period.

b. Tabulated summary of adverse reactions

The following table displays adverse reactions reported in clinical trials and from post-marketing experience. Frequency cannot be estimated from the available data, therefore it is “not known”.

SUMMARY OF MOST FREQUENT ADVERSE DRUG REACTIONS		
SOC	FREQUENCY	ADVERSE REACTIONS
Blood and lymphatic system disorders	Not known	Carboxyhaemoglobinaemia ²
Immune system disorders	Not known	Anaphylactic reaction ¹
	Not known	Hypersensitivity ¹
Metabolism and nutrition disorders	Not known	Hyperkalaemia ²
	Not known	Blood glucose increased
Psychiatric disorders	Not known	Agitation
	Not known	Delirium
	Not known	Mood altered ⁵
Nervous system disorders	Not known	Convulsion
	Not known	Mental impairment ⁴
Cardiac disorders	Not known	Arrhythmia
Vascular disorders	Not known	Hypotension ²
	Not known	Haemorrhage ³
Respiratory, thoracic and mediastinal disorders	Not known	Bronchospasm ²
	Not known	Dyspnoea ¹
	Not known	Wheezing ¹
	Not known	Respiratory depression ²
	Not known	Laryngospasm ²
Gastrointestinal disorders	Not known	Ileus
	Not known	Vomiting
	Not known	Nausea
Hepatobiliary disorders	Not known	Hepatic necrosis ²
	Not known	Hepatocellular injury ²
	Not known	Blood bilirubin increased.
Skin and subcutaneous tissue disorders	Not known	Swelling face ¹
	Not known	Dermatitis contact ¹
	Not known	Rash ¹
Renal and urinary disorders	Not known	Blood creatinine increased
	Not known	Blood urea decreased
General disorders and administration site conditions	Not known	Hyperthermia malignant ²
	Not known	Chest discomfort ¹
	Not known	Chills
Investigations	Not known	White blood cell count increased ¹
	Not known	Hepatic enzyme increased ²
	Not known	Fluoride increased ¹
	Not known	Electroencephalogram abnormal
	Not known	Blood cholesterol decreased
	Not known	Blood alkaline phosphatase decreased

¹ See undesirable effects(c)

² See special warnings and precautions for use

³ In patients undergoing induced abortion. See special warnings and precautions for use.

⁴ May cause a slight decrease in intellectual function for 2-4 days after anaesthesia. See special warnings and precautions for use.

⁵ Small changes in moods and symptoms may persist for up to 6 days. See special warnings and precautions for use.

c. Description of selected adverse reactions

Transient elevations in white blood count have been observed even in the absence of surgical stress. Rare reports of hypersensitivity (including dermatitis contact, rash, dyspnoea, wheezing, chest discomfort, swelling face, or anaphylactic reaction) have been received, especially in association with long-term occupational exposure to inhaled anaesthetic agents, including isoflurane. These reactions have been confirmed by clinical testing (e.g., methacholine challenge). The etiology of anaphylactic reactions experienced during inhalational anaesthetic exposure is, however, unclear because of the exposure to multiple concomitant drugs, many of which are known to cause such reactions. Minimally raised levels of serum inorganic fluoride occur during and after isoflurane anaesthesia, due to biodegradation of the agent. It is unlikely that the low levels of serum inorganic fluoride observed (mean 4.4 µmol/l in one study) could cause renal toxicity, as these are well below the proposed threshold levels for kidney toxicity.

d. Paediatric population

Use of inhaled anaesthetic agents has been associated with rare increases in serum potassium levels that have resulted in cardiac arrhythmias and death in paediatric patients during the post-operative period.

During the induction of anaesthesia, saliva flow and tracheobronchial secretion can increase and can be the cause of laryngospasm.

e. Other special populations

Neuromuscular disease:

Use of inhaled anaesthetic agents has been associated with rare increases in serum potassium levels that have resulted in cardiac arrhythmias and death in paediatric patients during the post-operative period. Patients with latent as well as overt neuromuscular disease, particularly Duchenne muscular dystrophy, appear to be most vulnerable.

Elderly:

Lesser concentrations of isoflurane are normally required to maintain surgical anaesthesia in elderly patients.

Overdose

As with other halogenated anaesthetics, hypotension and respiratory depression have been observed. Close monitoring of blood pressure and respiration is recommended. Supportive measures may be necessary to correct hypotension and respiratory depression resulting from excessively deep levels of anaesthesia.

PHARMACOLOGICAL PROPERTIES

Pharmacodynamic properties

Induction and particularly recovery are rapid. Although slight pungency may limit the rate of induction, excessive salivation and tracheo-bronchial secretions are not stimulated. Pharyngeal and laryngeal reflexes are diminished quickly. Levels of anaesthesia change rapidly with Isoflurane. Heart rhythm remains stable. Spontaneous respiration becomes depressed as depth of anaesthesia increases and should be closely monitored.

During induction there is a decrease in blood pressure which returns towards normal with surgical stimulation.

Blood pressure tends to fall during maintenance in direct relation to depth of anaesthesia, due to peripheral vasodilation, but cardiac rhythm remains stable. With controlled respiration and normal PaCO₂, cardiac output tends to be maintained despite increasing depth of anaesthesia, primarily through a rise in heart rate. With spontaneous respiration, the resulting hypercapnia may increase heart rate and cardiac output above awake levels.

Cerebral blood flow remains unchanged during light isoflurane anaesthesia but tends to rise at deeper levels. Increases in cerebrospinal fluid pressure may be prevented or reversed by hyperventilating the patient before or during anaesthesia. Electro-encephalographic changes and convulsion are extremely rare with isoflurane.

Isoflurane appears to sensitise the myocardium to adrenaline to an even lesser extent than Enflurane. Limited data suggest that subcutaneous infiltration of up to 50ml of 1:200,000 solution adrenaline does not induce ventricular arrhythmias, in patients anaesthetised with isoflurane.

Muscular relaxation may be adequate for some intra-abdominal operations at normal levels of anaesthesia, but should greater relaxation be required small doses of intravenous muscle relaxants may be used. All commonly used muscle relaxants are markedly potentiated by isoflurane, the effect being most profound with non-depolarising agents. Neostigmine reverses the effects of non-depolarising muscle relaxants but has no effect on the relaxant properties of isoflurane itself. All commonly used muscle relaxants are compatible with isoflurane.

Isoflurane may be used for the induction and maintenance of general anaesthesia. Adequate data are not available to establish its place in pregnancy or obstetric anaesthesia other than for caesarean section.

Relatively little metabolism of isoflurane occurs in the human body. In the post operative period only 0.17% of the isoflurane taken up can be recovered as urinary metabolites. Peak serum inorganic fluoride values usually average less than 5µmol/litre and occur about four hours after anaesthesia, returning to normal levels within 24 hours. No signs of renal injury have been reported after isoflurane administration.

Pharmacokinetic properties

MAC (Minimum Alveolar Concentration in man):

Age	100% Oxygen	70% N ₂ O
26 ± 4	1.28	0.56
44 ± 7	1.15	0.50
64 ± 5	1.05	0.37

PHARMACEUTICAL PARTICULARS

List of excipients

None

Incompatibilities

Isoflurane has been reported to interact with dry carbon dioxide absorbents to form carbon monoxide. In order to minimise the risk of formation of carbon monoxide in rebreathing circuits and the possibility of elevated carboxyhaemoglobin levels, carbon dioxide absorbents should not be allowed to dry out.

Special precautions for storage

Do not store above 25°C. Keep container well closed.

Nature and contents of container

100 ml and 250 ml glass bottles.

Special precautions for disposal and other handling

Vaporisers specially calibrated for Isoflurane should be used so that the concentration of anaesthetic delivered can be accurately controlled.

It is recommended that vapour from this and other inhalation agents be efficiently extracted from the area of use.

Manufacturer

See outer pack

Name of Marketing Authorization Holder

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