

Seroxat™ 20 mg

Film-coated tablets
Paroxetine

NAME OF MEDICINAL PRODUCT

Seroxat 20 mg film-coated tablets.

QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 20 mg paroxetine (as paroxetine hydrochloride hemihydrate).

For the full list of excipients, see "List of excipients".

PHARMACEUTICAL FORM

White, film-coated, oval shaped biconvex tablets debossed with "20" on one side and a break bar on the other.

The 20 mg tablet can be divided into equal doses if required.

CLINICAL PARTICULARS

Therapeutic indications

Treatment of

- Major Depressive Episode
- Obsessive Compulsive Disorder
- Panic Disorder with and without agoraphobia
- Social Anxiety Disorders/Social phobia
- Generalised Anxiety Disorder
- Post-Traumatic Stress Disorder

Posology and method of administration

Posology

MAJOR DEPRESSIVE EPISODE

The recommended dose is 20 mg daily. In general, improvement in patients starts after one week but may only become evident from the second week of therapy.

As with all antidepressant medicinal products, dosage should be reviewed and adjusted if necessary within 3 to 4 weeks of initiation of therapy and thereafter as judged clinically appropriate. In some patients, with insufficient response to 20 mg, the dose may be increased gradually up to a maximum of 50 mg a day in 10 mg steps according to the patient's response.

Patients with depression should be treated for a sufficient period of at least 6 months to ensure that they are free from symptoms.

OBSESSIVE COMPULSIVE DISORDER

The recommended dose is 40 mg daily. Patients should start on 20 mg/day and the dose may be increased gradually in 10 mg increments to the recommended dose. If after some weeks on the recommended dose insufficient response is seen some patients may benefit from having their dose increased gradually up to a maximum of 60 mg/day.

Patients with OCD should be treated for a sufficient period to ensure that they are free from symptoms. This period may be several months or even longer (see "Pharmacodynamic properties").

PANIC DISORDER

The recommended dose is 40 mg daily. Patients should be started on 10 mg/day and the dose gradually increased in 10 mg steps according to the patient's response up to the recommended dose. A low initial starting dose is recommended to minimise the potential worsening of panic symptomatology, which is generally recognised to occur early in the treatment of this disorder. If after some weeks on the recommended dose insufficient response is seen some patients may benefit from having their dose increased gradually up to a maximum of 60 mg/day.

Patients with panic disorder should be treated for a sufficient period to ensure that they are free from symptoms. This period may be several months or even longer (see "Pharmacodynamic properties").

SOCIAL ANXIETY DISORDER/SOCIAL PHOBIA

The recommended dose is 20 mg daily. If after some weeks on the recommended dose insufficient response is seen some patients may benefit from having their dose increased gradually in 10 mg steps up to a maximum of 50 mg/day. Long-term use should be regularly evaluated (see "Pharmacodynamic properties").

GENERALISED ANXIETY DISORDER

The recommended dose is 20 mg daily. If after some weeks on the recommended dose insufficient response is seen some patients may benefit from having their dose increased gradually in 10 mg steps up to a maximum of 50 mg/day. Long-term use should be regularly evaluated (see "Pharmacodynamic properties").

POST-TRAUMATIC STRESS DISORDER

The recommended dose is 20 mg daily. If after some weeks on the recommended dose insufficient response is seen some patients may benefit from having their dose increased gradually in 10 mg steps up to a maximum of 50 mg/day. Long-term use should be regularly evaluated (see "Pharmacodynamic properties").

GENERAL INFORMATION

WITHDRAWAL SYMPTOMS SEEN ON DISCONTINUATION OF PAROXETINE

Abrupt discontinuation should be avoided (see "Special warnings and precautions for use" and "Undesirable effects"). The taper phase regimen used in clinical trials involved decreasing the daily dose by 10 mg at weekly intervals. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose, but at a more gradual rate.

Special Populations:

• Older people
Increased plasma concentrations of paroxetine occur in elderly subjects, but the range of concentrations overlaps with that observed in younger subjects. Dosing should commence at the adult starting dose. Increasing the dose might be useful in some patients, but the maximum dose should not exceed 40 mg daily.

• Children and adolescents (7-17 years)

Paroxetine should not be used for the treatment of children and adolescents as controlled clinical trials have found paroxetine to be associated with increased risk for suicidal behaviour and hostility. In addition, in these trials efficacy has not been adequately demonstrated (see "Special warnings and precautions for use" and "Undesirable effects").

• Children aged below 7 years

The use of paroxetine has not been studied in children less than 7 years. Paroxetine should not be used, as long as safety and efficacy in this age group have not been established.

• Renal/hepatic impairment

Increased plasma concentrations of paroxetine occur in patients with severe renal impairment (creatinine clearance less than 30 ml/min) or in those with hepatic impairment. Therefore, dosage should be restricted to the lower end of the dosage range.

Method of administration

It is recommended that paroxetine is administered once daily in the morning with food.

The tablet should be swallowed rather than chewed.

Contraindications

Hypersensitivity to the active substance(s) or to any of the excipients listed in "List of excipients".

Paroxetine is contraindicated in combination with monoamine oxidase inhibitors (MAOIs). In exceptional circumstances, linezolid (an antibiotic which is a reversible non-selective MAOI) can be given in combination with paroxetine provided that there are facilities for close observation of symptoms of serotonin syndrome and monitoring of blood pressure (see "Interaction with other medicinal products and other forms of interaction"). Treatment with paroxetine can be initiated:

- two weeks after discontinuation of an irreversible MAOI, or
- at least 24hrs after discontinuation of a reversible MAOI (e.g. moclobemide, linezolid, methylthionium chloride (methylene blue)).

At least one week should elapse between discontinuation of paroxetine and initiation of therapy with any MAOI.

Paroxetine should not be used in combination with thiordiazine, because, as with other drugs which inhibit the hepatic enzyme CYP450 2D6, paroxetine can elevate plasma levels of thiordiazine (see "Interactions with other medicinal products and other forms of interaction").

Administration of thiordiazine alone can lead to QTc interval prolongation with associated serious ventricular arrhythmia such as torsades de pointes, and sudden death.

Paroxetine should not be used in combination with pimozide (see "Interactions with other medicinal products and other forms of interaction").

Special warnings and precautions for use

Treatment with paroxetine should be initiated cautiously two weeks after terminating treatment with an irreversible MAOI or 24 hours after terminating treatment with a reversible MAOI inhibitor. Dose of paroxetine should be increased gradually until an optimal response is reached (see "Contraindications" and "Interactions with other medicinal products and other forms of interaction").

Paediatric population

Paroxetine should not be used in the treatment of children and adolescents under the age of 18 years. Suicide-related behaviours (suicide attempt and suicidal thoughts), and hostility (predominantly aggression, oppositional behaviour and anger) were more frequently observed in clinical trials among children and adolescents treated with antidepressants compared to those treated with placebo. If, based on clinical need, a decision to treat is nevertheless taken, the patient should be carefully monitored for the appearance of suicidal symptoms. In addition, long-term safety data in children and adolescents concerning growth, maturation and cognitive and behavioural development are lacking.

Suicide/suicidal thoughts or clinical worsening

Depression is associated with an increased risk of suicidal thoughts, self harm and suicide (suicide-related events). This risk persists until significant remission occurs. As improvement may not occur during the first few weeks or more of treatment, patients should be closely monitored until such improvement occurs. It is general clinical experience that the risk of suicide may increase in the early stages of recovery. Other psychiatric conditions for which paroxetine is prescribed can also be associated with an increased risk of suicide-related events. In addition, these conditions may be co-morbid with major depressive disorder. The same precautions observed when treating patients with major depressive disorder should therefore be observed when treating patients with other psychiatric disorders.

Patients with a history of suicide-related events, or those exhibiting a significant degree of suicidal ideation prior to commencement of treatment are known to be at greater risk of suicidal thoughts or suicide attempts, and should receive careful monitoring during treatment. A meta-analysis of placebo-controlled clinical trials of antidepressant drugs in adult patients with psychiatric disorders showed an increased risk of suicidal behaviour with antidepressants compared to placebo in paties less than 25 years old (see also "Pharmacodynamic properties"). Close supervision of patients and in particular those at high risk should accompany drug therapy especially in early treatment and following dose changes. Patients (and caregivers of patients) should be alerted about the need to monitor for any clinical worsening, suicidal behaviour or thoughts and unusual changes in behaviour and to seek medical advice immediately if these symptoms present.

Akathisia/psychomotor restlessness

The use of paroxetine has been associated with the development of akathisia, which is characterized by an inner sense of restlessness and psychomotor agitation such as an inability to sit or stand still usually associated with subjective distress. This is most likely to occur within the first few weeks of treatment. In patients who develop these symptoms, increasing the dose may be detrimental.

Serotonin Syndrome/Neuroleptic Malignant Syndrome

On rare occasions development of a serotonin syndrome or neuroleptic malignant syndrome-like events may occur in association with treatment of paroxetine, particularly when given in combination with other serotonergic and/or neuroleptic drugs. As these syndromes may result in potentially life-threatening conditions, treatment with paroxetine should be discontinued if such events (characterised by clusters of symptoms such as hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, mental status changes including confusion, irritability, extreme agitation progressing to delirium and coma) occur and supportive symptomatic treatment should be initiated. Paroxetine should not be used in combination with serotonin-precursors (such as L-tryptophan, oxitriptan) due to the risk of serotonergic syndrome. (See "Contraindications" and "Interactions with other medicinal products and other forms of interaction").

Mania

As with all antidepressants, paroxetine should be used with caution in patients with a history of mania. Paroxetine should be discontinued in any patient entering a manic phase.

Renal/hepatic impairment

Caution is recommended in patients with severe renal impairment or in those with hepatic impairment (see "Posology and method of administration").

Diabetes

In patients with diabetes, treatment with an SSRI may alter glycaemic control. Insulin and/or oral hypoglycaemic dosage may need to be adjusted. Additionally, there have been studies suggesting that an increase in blood glucose levels may occur when paroxetine and pravadatin are co-administered (see "Interaction with other medicinal products and other forms of interaction").

Epilepsy

As with other antidepressants, paroxetine should be used with caution in patients with epilepsy.

Seizures

Overall the incidence of seizures is less than 0.1% in patients treated with paroxetine. The drug should be discontinued in any patient who develops seizures.

Electroconvulsive therapy (ECT)

There is little clinical experience of the concurrent administration of paroxetine with ECT.

Glaucoma

As with other SSRIs, paroxetine can cause mydriasis and should be used with caution in patients with narrow angle glaucoma or history of glaucoma.

Cardiac Conditions

The usual precautions should be observed in patients with cardiac conditions.

Hyponatraemia

Hyponatraemia has been reported rarely, predominantly in the elderly. Caution should also be exercised in those patients at risk of hyponatraemia e.g. from concomitant medications and cirrhosis. The hyponatraemia generally reverses on discontinuation of paroxetine.

Haemorrhage

There have been reports of cutaneous bleeding abnormalities such as ecchymoses and purpura with SSRIs. Other haemorrhagic manifestations e.g. gastrointestinal and gynaecological haemorrhage have been reported. Elderly patients may be at an increased risk for non-menses related events of bleeding.

Caution is advised in patients taking SSRIs concomitantly with oral anticoagulants, drugs known to affect platelet function or other drugs that may increase risk of bleeding (e.g. atypical antipsychotics such as clozapine, phenothiazines, most TCAs, acetylsalicylic acid, NSAIDs, COX-2 inhibitors) as well as in patients with a history of bleeding disorders or conditions which may predispose to bleeding (see "Undesirable effects").

Interaction with tamoxifen

Paroxetine, a potent inhibitor of CYP2D6, may lead to reduced concentrations of endoxifen, one of the most important active metabolites of tamoxifen. Therefore, paroxetine should whenever possible be avoided during tamoxifen treatment (see "Interaction with other medicinal products and other forms of interaction").

Withdrawal symptoms seen on discontinuation of paroxetine treatment

Withdrawal symptoms when treatment is discontinued are common, particularly if discontinuation is abrupt (see "Undesirable effects"). In clinical trials adverse events seen on treatment discontinuation occurred in 30% of patients treated with paroxetine compared to 20% of patients treated with placebo. The occurrence of withdrawal symptoms is not the same as the drug being additive or dependence producing.

The risk of withdrawal symptoms may be dependent on several factors including the duration and dose of therapy and the rate of dose reduction. Dizziness, sensory disturbances (including paraesthesia, electric shock sensations and tinnitus), sleep disturbances (including intense dreams), agitation or anxiety, tremor, confusion, sweating, headache, diarrhoea, palpitations, emotional instability, irritability, and visual disturbances have been reported. Generally these symptoms are mild to moderate; however, in some patients they may be severe in intensity. They usually occur within the first few days of discontinuing treatment, but there have been very rare reports of such symptoms in patients who

have inadvertently missed a dose. Generally these symptoms are self-limiting and usually resolve within two weeks, though in some individuals they may be prolonged (two-three months or more). It is therefore advised that paroxetine should be gradually tapered when discontinuing treatment over a period of several weeks or months, according to the patient's needs (see "Withdrawal Symptoms Seen on Discontinuation of Paroxetine", under "Posology and method of administration").

Interaction with other medicinal products and other forms of interaction

Serotonergic drugs

As with other SSRIs, co-administration with serotonergic drugs may lead to an incidence of 5-HT associated effects (serotonin syndrome: see "Special warnings and precautions for use"). Caution should be advised and a closer clinical monitoring is required when serotonergic drugs (such as L-tryptophan, triptans, tramadol, linezolid, methylthionium chloride (methylene blue), SSRIs, lithium, pethidine and St. John's Wort – *Hypericum perforatum* – preparations) are combined with paroxetine. Caution is also advised with fentanyl used in general anaesthesia or in the treatment of chronic pain. Concomitant use of paroxetine and MAOIs is contraindicated because of the risk of serotonin syndrome (see "Contraindications").

Pimozide

Increased pimozide levels of on average 2.5 times have been demonstrated in a study of a single low dose pimozide (2 mg) when co-administered with 60 mg paroxetine. This may be explained by the known CYP2D6 inhibitory properties of paroxetine. Due to the narrow therapeutic index of pimozide and its known ability to prolong QT interval, concomitant use of pimozide and paroxetine is contraindicated (see "Contraindications").

Drug metabolising enzymes

The metabolism and pharmacokinetics of paroxetine may be affected by the induction or inhibition of drug metabolising enzymes.

When paroxetine is to be co-administered with a known drug metabolising enzyme inhibitor, consideration should be given to using paroxetine doses at the lower end of the range.

No initial dosage adjustment is considered necessary when the drug is to be co-administered with known drug metabolising enzyme inducers (e.g. carbamazepine, rifampicin, phenobarbital, phenytoin) or with fosamprenavir/ritonavir. Any paroxetine dosage adjustment (either after initiation or following discontinuation of an enzyme inducer) should be guided by clinical effect (tolerability and efficacy).

Neuromuscular Blockers

SSRIs may reduce plasma cholinesterase activity resulting in a prolongation of the neuromuscular blocking action of mivacurium and suxamethonium. **Fosamprenavir/ritonavir:** Co-administration of fosamprenavir/ritonavir 700/100 mg twice daily with paroxetine 20 mg daily in healthy volunteers for 10 days significantly decreased plasma levels of paroxetine by approximately 55%. The plasma levels of fosamprenavir/ritonavir during co-administration of paroxetine were similar to reference values of other studies, indicating that paroxetine had no significant effect on metabolism of fosamprenavir/ritonavir. There are no data available about the effects of long-term co-administration of paroxetine and fosamprenavir/ritonavir exceeding 10 days.

Procyclidine: Daily administration of paroxetine increases significantly the plasma levels of procyclidine. If anti-cholinergic effects are seen, the dose of procyclidine should be reduced.

Anticonvulsants: carbamazepine, phenytoin, sodium valproate. Concomitant administration does not seem to show any effect on pharmacokinetic/dynamic profile in epileptic patients.

CYP2D6 inhibitory potency of paroxetine

As with other antidepressants, including other SSRIs, paroxetine inhibits the hepatic cytochrome P450 enzyme CYP2D6. Inhibition of CYP2D6 may lead to increased plasma concentrations of co-administered drugs metabolised by this enzyme. These include certain tricyclic antidepressants (e.g. clomipramine, nortriptyline, and desipramine), phenothiazine neuroleptics (e.g. perphenazine and thioridazine, see "Contraindications"), risperidone, atomoxetine, certain Type 1c antiarrhythmics (e.g. propafenone and flecainide) and metoprolol. It is not recommended to use paroxetine in combination with metoprolol when given in cardiac insufficiency, because of the narrow therapeutic index of metoprolol in this indication.

Pharmacokinetic interaction between CYP2D6 inhibitors and tamoxifen, showing a 65-75% reduction in plasma levels of one of the more active forms of tamoxifen, i.e. endoxifen, has been reported in the literature. Reduced efficacy of tamoxifen has been reported with concomitant usage of some SSRI antidepressants in some studies. As a reduced effect of tamoxifen cannot be excluded, co-administration with potent CYP2D6 inhibitors (including paroxetine) should whenever possible be avoided (see "Special warnings and precautions for use").

Alcohol

As with other psychotropic drugs patients should be advised to avoid alcohol use while taking paroxetine.

Oral anticoagulants

A pharmacodynamic interaction between paroxetine and oral anticoagulants may occur. Concomitant use of paroxetine and oral anticoagulants can lead to an increased anticoagulant activity and haemorrhagic risk. Therefore, paroxetine should be used with caution in patients who will be treated with oral anticoagulants (see "Special warnings and precautions for use").

NSAIDs and acetylsalicylic acid, and other antiplatelet agents

A pharmacodynamic interaction between paroxetine and NSAIDs/acetylsalicylic acid may occur. Concomitant use of paroxetine and NSAIDs/acetylsalicylic acid can lead to an increased haemorrhagic risk (see "Special warnings and precautions for use").

Caution is advised in patients taking SSRIs, concomitantly with oral anticoagulants, drugs known to affect platelet function or increase risk of bleeding (e.g. atypical antipsychotics such as clozapine, phenothiazines, most TCAs, acetylsalicylic acid, NSAIDs, COX-2 inhibitors) as well as in patients with a history of bleeding disorders or conditions that may predispose to bleeding.

Pravastatin

An interaction between paroxetine and pravastatin has been observed in studies suggesting that co-administration of paroxetine and pravastatin may lead to an increase in blood glucose levels. Patients with diabetes mellitus receiving both paroxetine and pravastatin may require dosage adjustment of oral hypoglycaemic agents and/or insulin (see "Special warnings and precautions for use")

Fertility, pregnancy and lactation

Pregnancy

Some epidemiological studies suggest an increased risk of congenital malformations, particularly cardiovascular (e.g. ventricular and atrial septum defects) associated with the use of paroxetine during the first trimester. The mechanism is unknown. The data suggest that the risk of having an infant with a cardiovascular defect following maternal paroxetine exposure is less than 2/100 compared with an expected rate for such defects of approximately 1/100 in the general population.

Paroxetine should only be used during pregnancy when strictly indicated. The prescribing physician will need to weigh the option of alternative treatments in women who are pregnant or are planning to become pregnant. Abrupt discontinuation should be avoided during pregnancy (see "Withdrawal Symptoms Seen on Discontinuation of Paroxetine", under "Posology and method of administration").

Neonates should be observed if maternal use of paroxetine continues into the later stages of pregnancy, particularly the third trimester.

The following symptoms may occur in the neonate after maternal paroxetine use in later stages of pregnancy: respiratory distress, cyanosis, apnoea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycaemia, hypertonia, hypotonia, hyperreflexia, tremor, jitteriness, irritability, lethargy, constant crying, somnolence and difficulty in sleeping. These symptoms could be due to either serotonergic effects or withdrawal symptoms. In a majority of instances the complications begin immediately or soon (<24 hours) after delivery.

Epidemiological data have suggested that the use of SSRIs in pregnancy, particularly in late pregnancy, may have an increased risk of persistent pulmonary hypertension of the newborn (PPHN). The observed risk was approximately five cases per 1 000 pregnancies. In the general population are to one cases of PPHN per 1 000 pregnancies occur.

Animal studies showed reproductive toxicity, but did not indicate direct harmful effects with respect to pregnancy, embryonal/foetal development, pre- or postnatal development (see "Preclinical Safety Data").

Breast-feeding

Small amounts of paroxetine are excreted into breast milk. In published studies, serum concentrations in breast-fed infants were undetectable (<2 nanograms/ml) or very low (<4 nanograms/ml), and no signs of drug effects were observed in these infants. Since no effects are anticipated, breast-feeding can be considered.

Fertility

Animal data have shown that paroxetine may affect sperm quality (see "Preclinical Safety Data"). *In vitro* data with human material may suggest some effect on sperm quality, however, human case reports with some SSRIs (including paroxetine) have shown that an effect on sperm quality appears to be reversible. Impact on human fertility has not been observed so far.

Effects on ability to drive and use machines

Clinical experience has shown that therapy with paroxetine is not associated with impairment of cognitive or psychomotor function. However, as with all psychoactive drugs, patients should be cautioned about their ability to drive a car and operate machinery. Although paroxetine does not increase the mental and motor skill impairments caused by alcohol, the concomitant use of paroxetine and alcohol is not advised.

Undesirable effects

Some of the adverse drug reactions listed below may decrease in intensity and frequency with continued treatment and do not generally lead to cessation of therapy. Adverse drug reactions are listed below by system organ class and frequency. Frequencies are defined as: very common (≥ 1/10), common (≥ 1/100, <1/10), uncommon (≥ 1/1,000, <1/100), rare (≥ 1/10,000, <1/1,000), very rare (<1/10,000), including isolated reports.

Blood and lymphatic system disorders

Uncommon: abnormal bleeding, predominantly of the skin and mucous membranes (including ecchymosis and gynaecological bleeding).

Very rare: thrombocytopenia.

Immune system disorders

Very rare: severe and potentially fatal allergic reactions (including anaphylactoid reactions and angioedema).

Endocrine disorders

Very rare: syndrome of inappropriate anti-diuretic hormone secretion (SIADH).

Metabolism and nutrition disorders

Common: increases in cholesterol levels, decreased appetite.

Uncommon: altered glycaemic control has been reported in diabetic patients (see "Special warnings and precautions for use").

Rare: hyponatraemia.

Hyponatraemia has been reported predominantly in elderly patients and is sometimes due to syndrome of inappropriate anti-diuretic hormone secretion (SIADH).

Psychiatric disorders

Common: somnolence, insomnia, agitation, abnormal dreams (including nightmares).

Uncommon: confusion, hallucinations.

Rare: manic reactions, anxiety, depersonalisation, panic attacks, akathisia (see "Special warnings and precautions for use").

Frequency not known: suicidal ideation, suicidal behaviour, aggression.

Cases of suicidal ideation and suicidal behaviour have been reported during paroxetine therapy or early after treatment discontinuation (see "Special warnings and precautions for use").

Cases of aggression were observed in post marketing experience.

These symptoms may also be due to the underlying disease

Nervous system disorders

Common: dizziness, tremor, headache, concentration impaired.

Uncommon: extrapyramidal disorders.

Rare: convulsions, restless legs syndrome (RLS).

Very rare: serotonin syndrome (symptoms may include agitation, confusion, diaphoresis, hallucinations, hyperreflexia, myoclonus, shivering, tachycardia and tremor).

Reports of extrapyramidal disorder including oro-facial dystonia have been received in patients sometimes with underlying movement disorders or who were using neuroleptic medication.

Eye disorders

Common: blurred vision.

Uncommon: mydriasis (see "Special warnings and precautions for use").

Very rare: acute glaucoma.

Ear and labyrinth disorders

Frequency not known: tinnitus.

Cardiac disorders

Uncommon: sinus tachycardia.

Rare: bradycardia.

Vascular disorders

Uncommon: transient increases or decreases in blood pressure, postural hypotension.

Transient increases or decreases of blood pressure have been reported following treatment with paroxetine, usually in patients with pre-existing hypertension or anxiety.

Respiratory, thoracic and mediastinal disorders

Common: yawning.

Gastrointestinal disorders

Very common: nausea.

Common: constipation, diarrhoea, vomiting, dry mouth.

Very rare: gastrointestinal bleeding.

Hepato-biliary disorders

Rare: elevation of hepatic enzymes.

Very rare: hepatic events (such as hepatitis, sometimes associated with jaundice and/or liver failure).

Elevation of hepatic enzymes have been reported. Post-marketing reports of hepatic events (such as hepatitis, sometimes associated with jaundice and/or liver failure) have also been received very rarely. Discontinuation of paroxetine should be considered if there is prolonged elevation of liver function test results.

Skin and subcutaneous tissue disorders

Common: sweating.

Uncommon: skin rashes, pruritus

Very rare: severe cutaneous adverse reactions (including erythema multiforme, Stevens-Johnson syndrome and toxic epidermal necrolysis), urticaria, photosensitivity reactions.

Renal and urinary disorders