

# Summary of Product Characteristics

## 1 NAME OF THE MEDICINAL PRODUCT

Lidocaine B. Braun 1%

## 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

One ml of the solution for injection contains 10mg of Lidocaine Hydrochloride Monohydrate (1% w/v)

Accordingly, the contents per ampoule are as follows:

One ampoule of 5ml contains 50mg of Lidocaine Hydrochloride Monohydrate

One ampoule of 10ml contains 100mg of Lidocaine Hydrochloride Monohydrate

One ampoule of 20ml contains 200mg of Lidocaine Hydrochloride Monohydrate

*Excipients with known effect:*

Sodium (as sodium chloride and sodium hydroxide) 123 micromol/ml

For a full list of excipients, see section 6.1.

## 3 PHARMACEUTICAL FORM

Solution for injection

Clear, colourless aqueous solution

## 4 CLINICAL PARTICULARS

### 4.1 Therapeutic Indications

Local and regional anaesthesia

### 4.2 Posology and method of administration

#### Posology

#### *Local and regional anaesthesia*

As a matter of principle the smallest possible dose that produces adequate anesthesia should be administered. The dosage should be adjusted individually according to the particulars of each case.

#### Adults:

When injected into tissues with marked systemic absorption, without combination with a vasoconstrictor, a single dose of lidocaine Hydrochloride monohydrate should not exceed 4.5 mg/kg body weight (BW) (or 300 mg). If combined with a vasoconstrictor, 7 mg/kg BW (or 500 mg) of lidocaine Hydrochloride monohydrate per single dose should not be exceeded.

For the clinical uses listed below, recommendations for single doses and strengths of the injection solution to be administered to adults with average body weight (70 kg) are as follows:

Type of anaesthesia	Concentration [%]	Usual volume [ml]	Maximum dose [mg]
Infiltration	0.5-1		300 500 (with epinephrine)
Major nerve blocks	1-2	30-50	500 (with epinephrine)
Minor nerve blocks	1	5-20	200
Epidural	1-2	15-30*	500 (with epinephrine)
Spinal	1.5 or 5 in 7.5% glucose	1-2	100
Intravenous regional anaesthesia (IVRA)			
- upper limb	0.5	40	
- lower limb	0.25	50-100	

\*1.5 ml per segment in average

For prolongation of anaesthesia lidocaine may be combined with a vasoconstrictor, e.g. epinephrine. Addition of epinephrine at a concentration of 1:100 000 to 1:200 000 has proven useful.

### Paediatric population

For children, the doses are calculated individually according to the patients' age body weight and the nature of the procedure. Up to 5 mg/kg BW may be administered. With the addition of epinephrine, up to 7 mg/kg can be used. In children with a high body weight a gradual reduction of the dosage is often necessary and should be based on the ideal body weight. Standard textbooks should be consulted for factors affecting specific block techniques and for individual patient requirements. For anaesthesia in children, only a low strength (0.5 % w/v) of the local anaesthetic should be used. To achieve a complete motor block, a higher strength (1 % w/v) may be required.

Lidocaine should be used with caution in children younger than two years of age as there are limited data to support the safety and efficacy of this product in this patient population at this time.

### Elderly patients

For elderly patients, the doses must be calculated individually according to the patients' age and body weight. Dosages may need adaptation as cardiac output and hepatic blood flow may decrease with advanced age indicating a decreased clearance of lidocaine (see section 5.2).

### Other special patient groups

Doses should be reduced in patients in poor general condition or in those with reduced protein binding capacity (resulting e.g. from renal insufficiency, liver insufficiency, cancer, pregnancy).

In patients with severe renal insufficiency the dose may need to be adapted due to reduced clearance and increased half-life of lidocaine (see section 5.2).

Patients with liver diseases show reduced tolerance towards amide-type local anaesthetics. This may be due to reduced hepatic metabolism and decreased protein synthesis resulting in a lower protein binding rate of the local anaesthetic. Dose reduction is advisable in such cases. The dose should be reduced in patients showing clinical signs of cardiac insufficiency. Nevertheless, local or regional nerve blockage can be the anaesthetic method of choice in such patients.

During pregnancy, the dose may need to be reduced depending on the type of anaesthesia. Regional anaesthetic blocks in which usually large doses are required should be avoided during the first trimester. For use in anaesthetic blocks in which smaller doses are administered the dosage may need to be reduced because of the altered anatomical and physiological characteristics in late pregnancy.

### Method of administration

Local and regional anaesthesia

Intradermal, intramuscular subcutaneous, or submucosal use (infiltration) perineural (injection into the surroundings of peripheral nerves), epidural or spinal use. Intravenous use regarding intravenous regional anaesthesia (Bier's block).

Every local anaesthetic procedure should only be carried out by personnel adequately skilled in the respective anaesthetic technique.

## 4.3 Contraindications

### General

- hypersensitivity towards lidocaine, amide-type local anaesthetics or to any of the excipients listed in section 6.1,

### Local and regional anaesthesia

The special contraindications for spinal and epidural anaesthesia must also be observed:

- uncorrected hypovolaemia,
- coagulopathy (acquired, induced, genetic),
- increased intracranial pressure,
- intracranial or intraspinal haemorrhage.

## 4.4 Special warnings and precautions for use

### General

In the case of known allergy towards other amide-type local anaesthetics, group allergy towards lidocaine should be considered.

Lidocaine should only be used with particular caution in patients with liver or kidney diseases or with *myasthenia gravis*, impaired cardiac conduction (see also section 4.3), cardiac insufficiency, bradycardia, impaired respiratory function and severe shock (see also section 4.2).

In general, prior to injection of lidocaine, it must be made sure that all equipment for resuscitation and emergency medication for the treatment of toxic reactions are instantly available.

Patients with **epilepsy** should be carefully monitored for the occurrence of central nervous symptoms. An increased tendency to convulsions should be considered even with doses below maximum.

## Local and regional anaesthesia

Sudden arterial hypotension may occur as a complication of spinal and epidural anaesthesia, in particular in elderly patients.

Particular caution should also be exercised if the local anaesthetic is to be injected into inflamed (infected) tissue because of increased systemic absorption due to higher blood flow and decreased effect due to the lower pH of infected tissue.

A risk of post-spinal headache is associated with spinal anaesthesia mainly in adolescents and in adults up to the age of 30 years. This risk of post-spinal headache can be markedly reduced by choosing sufficiently thin injection cannulae.

After removing the tourniquet after intravenous regional anaesthesia there is an increased risk of adverse effects. Therefore the local anaesthetic should be drained off in several portions.

During anaesthetic procedures in the neck and head region patients are at increased risk of central nervous toxic effects of the drug. See also section 4.8.

### Special warnings/precautions regarding excipients

5ml ampoule

This medicinal product contains sodium, but less than 1 mmol (23 mg) per ampoule, i.e. it is 'essentially sodium free'.

10 ml ampoule:

This medicinal product contains 1.23 mmol (28.3 mg) sodium per ampoule equivalent to 1.4% of the WHO recommended maximum daily intake of 2 g sodium for an adult.

20 ml ampoule:

This medicinal product contains 2.46 mmol (56.6 mg) per ampoule, equivalent to 2.8 % of the WHO recommended maximum daily intake of 2 g sodium for an adult.

## 4.5 Interaction with other medicinal products and other forms of interactions

### Pharmacodynamic interactions

- *Vasoconstrictors*  
The local anaesthetic effect is prolonged by combination with a vasoconstrictor, e.g. epinephrine.
- *Sedatives, hypnotics*  
Lidocaine should be administered with due caution to patients receiving medication with sedatives that also affect the function of the CNS and therefore may alter the toxicity of lidocaine. There may be an additive effect between the local anaesthetic and sedatives or hypnotics.
- *Muscle relaxants*  
The effect of muscle relaxants is prolonged by lidocaine.
- *Combination with other local anaesthetics*  
Combination of different local anaesthetics may lead to additive effects on the cardiovascular and the central nervous system.
- *Volatile anaesthetics*  
If lidocaine and volatile anaesthetics are given simultaneously, the depressive effects of both may be intensified.

### Pharmacokinetic interactions

- *Medicinal products that alter the hepatic blood flow, cardiac output or peripheral distribution of lidocaine* may influence plasma levels of lidocaine.
- *Beta receptor blockers, vasoconstrictors, cimetidine*

Beta receptor blockers (e. g. propranolol, metoprolol, see also below), cimetidine (see also below) and vasoconstrictors like norepinephrine reduce cardiac output and/or hepatic blood flow and therefore reduce the plasma clearance of lidocaine prolonging its elimination half life. Therefore, due account should be taken of the possibility of accumulation of lidocaine.

- As lidocaine is metabolized mainly via the cytochrome P 450 isoenzymes CYP 3A4 and CYP 1A2 concurrently administered drug substances that are **substrates, inhibitors or inducers of hepatic enzyme, isoenzyme CYP 3A4 and CYP 1A2**, may have an influence on the pharmacokinetics of lidocaine and thus also on its effect.

#### *Inhibitors of CYP 3A4 and/or CYP 1A2*

Concurrent administration of Lidocaine with inhibitors of CYP3A4 and/or CYP 1A2 may lead to accelerated plasma concentrations of

lidocaine. Increased plasma levels have been reported for e.g. **erythromycine, fluvoxamine, amiodarone, cimetidine, protease inhibitors.**

#### *Inducers of CYP 3A4 and/or CYP 1A2*

Drugs inducing CYP3A4 and/or CYP 1A2, e.g. barbiturates (mainly **phenobarbital**), **carbamazepine, phenytoin** or **primidone**, accelerate the plasmatic clearance of lidocaine and thus reduce the efficacy of lidocaine.

#### *Substrates of CYP 3A4 and/or CYP 1A2:*

Co-administration with other substrates of CYP 3A4 and/or CYP 1A2 may lead to increased plasma levels of the drugs.

## **4.6 Fertility, pregnancy and lactation**

### **Pregnancy**

There are no or a limited amount of data from the use of lidocaine in pregnant women. Animal studies do not indicate direct or indirect harmful effects with respect to reproductive toxicity (see 5.3). However, lidocaine rapidly crosses the placenta. Therefore high plasma concentrations of lidocaine in the mother's plasma may cause central nervous depression, alteration of the peripheral vascular tone and cardiac function in the foetus/neonate.

Lidocaine should only be used in pregnancy if there is an imperative indication. Then doses should be as low as possible.

#### **Local and regional anaesthesia**

Use of lidocaine for epidural, pudendal, caudal or paracervical block may cause varying degrees of foetal and neonatal toxicity (e.g. bradycardia, hypotonia or respiratory depression). An accidental subcutaneous injection of lidocaine in the foetus during paracervical or perineal block may cause apnoea, hypotension and convulsive fits and may thus put the new-born at vital risk.

In general lidocaine in strengths of 10 mg/ml should be preferred during pregnancy.

### **Breastfeeding**

Lidocaine metabolites are excreted in small amounts into human milk but at therapeutic doses of Lidocaine B.Braun 1% no effects on the breast-fed newborns/infants are anticipated.

### **Fertility**

No data available

## **4.7 Effects on ability to drive and use machines**

In general Lidocaine B. Braun 1% has negligible influence on the ability to drive and use machines.

However, when outpatient anaesthesia affects areas of the body involved in driving or operating machinery, patients should be advised to avoid these activities until normal function is fully restored. So when using this medicinal product, the doctor has to assess in each individual case whether a patient is able to take part in traffic or to operate machinery.

## **4.8 Undesirable effects**

### **General**

The frequency and severity of the undesirable effects of lidocaine depend upon the dose, the method of administration and the patient's individual sensitivity.

Symptoms of local toxicity may occur after the administration of lidocaine. Systemic adverse effects may be expected at plasma concentrations of lidocaine exceeding 5-10 mg/l. They become manifest in the form of both CNS symptoms and cardiovascular symptoms (see also section 4.9).

The possible undesirable effects after administration of lidocaine as local anaesthetic are largely the same as those produced by other amide-type local anaesthetics.

#### **Listing of undesirable effects**

##### **Definition of frequency terms used in this section:**

Very common:	( $\geq$ 1/10)
Common:	( $\geq$ 1/100 to $<$ 1/10)
Uncommon:	( $\geq$ 1/1,000 to $<$ 1/100)
Rare:	( $\geq$ 1/10,000 to $<$ 1/1,000)
Very rare	( $<$ 1/10,000)

Not known: (frequency cannot be estimated from the available data)

### **Local and regional anaesthesia**

#### **Blood and the lymphatic system disorders**

Not known: Methaemoglobinaemia

#### **Immune system disorders**

Rare: Anaphylactic reactions manifesting as urticaria, oedema, bronchospasm, respiratory distress and circulatory symptoms up to anaphylactic shock.

#### **Nervous system disorders**

Common: Transient neurological symptoms especially after spinal and epidural anaesthesia, (up to 5 days).

Rare: Neurological complications following central nervous blocks – mainly spinal anaesthesia – such as persistent anaesthesia, paraesthesia, paresis up to paraplegia, *Cauda equina* syndrome (i.e. bilateral leg weakness up to paraplegia, saddle anaesthesia, urinary retention and fecal incontinence), headache accompanied by tinnitus and photophobia

Cranial nerve lesions, neurosensory deafness (if administered in head and neck regions).

Horner's syndrome, associated with epidural anaesthesia or regional applications in the head/neck region.

#### **Gastrointestinal disorder**

Very common: Nausea, vomiting

#### **Injury, poisoning and procedural complications**

Rare: Trauma, transient radicular irritation due to spinal anaesthesia, compression of the spinal cord after development of haematoma

#### **General disorders and administration site conditions**

Rare: Shivering (after epidural use)

#### **Information on particular undesirable effects**

none

#### **Paediatric population**

Frequency, type and severity of adverse reactions in children are expected to be the same as in adults.

#### **Elderly patients**

In elderly patients the incidence of undesirable effects may be increased (see section 4.4).

#### **Reporting of suspected adverse reactions**

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product.

Any suspected adverse events should be reported to the Ministry of Health according to the National Regulation by using an online form (<https://sideeffects.health.gov.il>)

## **4.9 Overdose**

The toxic effects of lidocaine depend on the level of the plasma concentration; the higher the plasma concentration and the more rapid its rise, the more frequent and more serious are the toxic reactions.

Depending on the individual sensitivity, toxic reactions occur from a concentration of approximately 5 – 9 mg lidocaine per litre upward in venous blood.

The lethal plasma concentration for humans is in the range 6 to 33 mg lidocaine per litre.

### **Symptoms**

#### **Effects on the CNS:**

Low toxic overdose of lidocaine results in stimulation of the CNS. Gross overdose, producing high toxic plasma concentrations, causes depression of the central functions.

Two phases of lidocaine intoxication can be distinguished:

#### *Stimulation*

At the beginning of intoxication with lidocaine patients mainly show symptoms of excitation: unrest, vertigo, disturbances of hearing and vision, unpleasant perioral sensations, agitation, hallucination, euphoria, paraesthesias (e.g. circumoral paraesthesia and numbness of the tongue), dizziness, tinnitus, blurred visions, nausea, vomiting, dysarthria. Shivering and muscular twitching may be signs of imminent attacks of generalized convulsion. Subconvulsive plasma levels of lidocaine often also lead to sleepiness and sedation. Tachycardia, hypertension and flushing may occur as a sign of initial stimulation of the sympathetic nervous system.

### *Depression*

During progress of the intoxication of the CNS increasing impairment of the brain stem functions appears in the form of respiratory depression and coma, even up to death.

### ***Effects on cardiovascular circulation:***

Unpalpable pulse, pallor, hypotension, bradycardia, arrhythmias, cardiovascular collapse, ventricular fibrillation, cardiac arrest. Sudden hypotension is often the first sign of cardiovascular toxicity of lidocaine. The hypotension is mainly caused by an impairment or block of cardiac impulse conduction. These toxic effects, however, are less relevant than those on the CNS.

### **Treatment**

The occurrence of central nervous or cardiovascular symptoms demands the following emergency treatment:

- Immediately discontinue administration.
- Ensure patency of the airways.
- Supply additional oxygen. If necessary provide artificial ventilation with pure oxygen – assisted or controlled – initially via mask and air bag, then intubate. The oxygen therapy must be continued until all vital functions have returned to normal.
- Monitor blood pressure, pulse and pupil width carefully.
- Maintain the circulation by sufficient supply of intravenous fluid.
- Immediately start cardio-pulmonary resuscitation, if necessary.

These measures are also applicable in the case of accidental total spinal anaesthesia, first manifesting as unrest, whispering voice, and sleepiness. The latter can proceed to unconsciousness and respiratory arrest.

Further therapeutic measures include the following:

Acute life-threatening hypotension should be treated with intravenous vasopressors. Bradycardia caused by increased vagal tone should be treated with intravenous atropine. Convulsions not reacting to sufficient oxygenation should be treated with intravenous benzodiazepins or ultra-short-acting barbiturates

Centrally acting analeptics are contraindicated.

There is no specific antidote.

Lidocaine cannot be eliminated by haemodialysis.

## **5 PHARMACOLOGICAL PROPERTIES**

### **5.1 Pharmacodynamic properties**

#### **Pharmacotherapeutic group**

Anaesthetics, local, amides

ATC code: N01B B02

#### **Mechanism of action**

##### ***Local and regional anaesthesia***

Lidocaine is a local anaesthetic agent of the amide type.

Lidocaine reduces the permeability of cell membranes for cations, in particular sodium ions, at higher concentrations also for potassium ions. This leads, depending on the concentration of lidocaine, to reduced excitability of the nerve fibres because the increase of sodium permeability producing the action potential is slowed down. From inside the cell the lidocaine molecule enters the open sodium channel and blocks it by binding to a specific receptor. A direct effect of incorporation of lidocaine in the cell membrane is much less relevant.

Because lidocaine, before reaching its site of action, must pass into the cell, its effect depends on its pKa and on the environmental pH, i.e. on the proportion of the free base which is the moiety predominantly migrating through the lipophilic membranes of nerve fibres.

In inflamed tissues, the local anaesthetic effect is reduced due to the lower pH in such regions.

#### **Clinical efficacy and safety**

##### ***Local and regional anaesthesia***

Lidocaine inhibits the function of excitable structures such as sensor, motor and autonomic nerve fibres and the cardiac impulse conducting system. Lidocaine reversibly inhibits the conduction in sensitive nerve fibres in the area of application. The order of loss of nerve function is as follows: pain, temperature, touch and pressure.

The local anaesthetic effect of lidocaine lasts for about 30 minutes -3 hours depending on the type of anaesthesia.

#### **Other pharmacological effects**

Lidocaine shows weak parasympatholytic activity. Intradermally administered lidocaine acts at low concentrations as a mild vasoconstrictor

and at higher concentrations as vasodilator.

### Paediatric population

There are no data indicating that the pharmacodynamic properties of lidocaine in children should be different from those established for adults.

## 5.2 Pharmacokinetic properties

### Absorption

Plasma levels depend on the site and mode of administration. However, there is a poor relationship between the amount of local anaesthetic injected and peak plasma levels. After intravenous administration the bio-availability is 100 %.

Maximum concentrations are achieved within latest 30 minutes, in the majority of patients maximum concentrations are met within 10-20 minutes.

After *intramuscular injection* of 400 mg of lidocaine Hydrochloride monohydrate for intercostal block the maximum plasma concentration ( $C_{max}$ ) has been determined to be 6.48 mg/l, attained after 5 – 15 min ( $t_{max}$ ).

After *intravenous administration* onset of the therapeutic effect of lidocaine is rapid. Therapeutic plasma concentrations are reached within 1 - 2 min. The effect of a bolus injection lasts for 10 - 20 min; in order to maintain the therapeutic effect of lidocaine, its administration must be continued in the form of an intravenous infusion.

After *continuous infusion* and when no loading dose is given the steady state of plasma concentration was achieved not earlier than 5 hours (range, 5 – 10 hours) of beginning of the infusion. However, therapeutic concentrations had already been achieved after 30 – 60 min.

After *subcutaneous administration*,  $C_{max}$  values reached 4.91 mg/l (vaginal injection) or 1.95 mg/l (abdominal injection), respectively. In a study involving 5 healthy volunteers, after maxillar-buccal infiltration anaesthesia with 36mg of lidocaine, using a 2 % solution, the  $C_{max}$  value reached 0.31 mg/l.

After *epidural injection* the measured maximum plasma concentrations do not seem to be directly proportional to the dose applied. Administration of 400 mg resulted in  $C_{max}$  values of 3 - 4 mg/l.

No data are available on pharmacokinetics after *intrathecal administration*.

### Distribution

Lidocaine follows a biphasic elimination kinetic. After intravenous administration the drug substance is first rapidly distributed from the central compartment into intensively perfused tissues and organs ( $\alpha$ -distribution phase). This phase is followed by redistribution into skeletal muscles and adipose tissue. The half life time during the  $\alpha$ -distribution phase is approx. 4 - 8 minutes. Distribution into peripheral tissues is predicted to occur within 15 min.

The plasma protein binding rate is approximately 60 – 80 per cent in adults. It is dependant on the drug concentration and additionally on the concentration of the  $\alpha$ -1-acid glycoprotein (AAG). The AAG is an acute phase protein that is binding free lidocaine and may be increased e.g. after trauma, surgery or burns depending on the pathophysiological condition of the patient. To the contrary it had been shown that AAG concentrations are low in neonates and patients suffering from liver impairment leading to a marked reduction of lidocaine plasma protein binding.

The distribution volume may be altered in patients suffering from further diseases, e.g. heart insufficiency, liver insufficiency or renal insufficiency.

### Biotransformation

Besides distribution of Lidocaine in other compartments (e.g. cerebrospinal fluid), the drug is rapidly metabolised in the liver by mono-oxygenases mainly via oxidative desalkylation, hydroxylation at the aromatic ring and hydrolysis of the amide bond.

Hydroxylated derivatives undergo conjugation. In total, approx. 90 % of lidocaine is metabolised to 4-hydroxy-2,6-xylidine, to 4-hydroxy-2,6-xylidine glucuronide and to a lower degree to the active metabolites monoethyl glycine xylidide (MEGX) and glycine xylidide (GX). The latter may accumulate during infusions of longer duration or in the presence of renal insufficiency due to their longer half life time as compared to lidocaine itself. In the presence of liver diseases the metabolic rate may be reduced to 10 – 50 per cent of normal.

Results with human liver microsomes and recombinant human CYP isoforms demonstrated that CYP1A2 and CYP3A4 enzymes are the major CYP isoforms involved in lidocaine N-deethylation.

The hepatic blood flow appears to limit the rate of lidocaine metabolism. As a consequence the plasma  $t_{1/2}$  of lidocaine and its metabolites may be prolonged and significant effects on pharmacokinetics and dosage requirements of lidocaine are to be expected in patients with impaired liver perfusion, e.g. after acute myocardial infarction, in the presence of cardiac insufficiency, liver disease or congestive heart failure.

### Elimination

Less than 10 per cent of lidocaine are excreted unchanged in urine, the remaining proportion in the form of the metabolites.

The elimination half-life time is 1.5 – 2 hours in adults and approx. 3 hours in new-borns.

The half-life times of the active metabolites monoethyl glycine xylidide (MEGX) and glycine xylidide (GX) are 2-6 hours and 10 hours,

respectively.

Since their plasma  $t_{1/2}$  are longer than that of lidocaine, accumulation of metabolites, particularly GX, may occur during prolonged infusion.

Additionally, the elimination rate depends on the pH; it can be increased by acidification of the urine. The plasma clearance is about 0.95 ml/min.

### **Paediatric population**

After epidural anaesthesia of the mother, the elimination half-life time in the new-born was approximately 3 hours; after infiltration of the perineum and after paracervical block lidocaine was found in the urine of the new-born during 48 hours following anaesthesia.

The plasma  $t_{1/2}$  is increased 2-3 fold in neonates, due to a slower rate of metabolism and in parts to the expanded distribution volume. Absorption and elimination may be faster in children than adults, although other studies suggested that differences in pharmacokinetics (between children and adults) decrease by correcting for BW.

### **Pharmacokinetics in other special patient groups**

#### *Renal impairment*

In the presence of **renal insufficiency** the plasma half-life time of lidocaine seemed to be unaltered except for some accumulation of GX during infusion of 12 hours or more. This accumulation seemed to be associated with long-term administration of the drug. However in patients with severe renal insufficiency clearance of lidocaine was approximately halved and half-life time of lidocaine was about twice the amount than in healthy patients.

#### *Elderly*

Elimination half-life and volume of distribution appear to be prolonged resp. increased in **the elderly** due to reduced cardiac output and/or hepatic blood flow.

### **Pregnancy and lactation**

Lidocaine passes across the placental barrier by simple diffusion and reaches the foetus within a few minutes of administration. After epidural administration, the foetal to maternal plasma concentration ratio is 0.5 – 0.7.

After infiltration of the perineum and after paracervical block, markedly higher concentrations of lidocaine have been found in umbilical blood.

The foetus is able to metabolise lidocaine. The levels in foetal blood are approximately 60% of the concentrations in the maternal blood. Due to a lower plasma protein binding in foetal blood, the concentration of the pharmacologically active free lidocaine is 1.4 fold the maternal concentration.

Lidocaine is secreted into breast milk only in small amounts.

## **5.3 Preclinical safety data**

Non-clinical data reveal no special hazard for humans based on conventional data of safety pharmacology, repeated dose toxicity, genotoxicity, carcinogenic potential and toxicity to development.

### **Single-dose toxicity**

Numerous studies on acute toxicity of lidocaine have been carried out in various animal species. Toxicity manifested in the form of CNS symptoms. These included also convulsions with lethal outcome.

In man, toxic plasma lidocaine concentrations leading to cardiovascular or central nervous symptoms have been reported to be in the range of 5-10 mg/l.

### **Mutagenic and tumorigenic potential**

Mutagenicity studies with lidocaine showed negative results. However, there are findings indicating that a metabolite of lidocaine, 2,6-xylidine, appearing in rats and possibly also in man, might be mutagenic. The mutagenic effect was shown in *in-vitro* tests applying very high, nearly toxic doses of the metabolite.

At present there are no indications of a mutagenic effect of lidocaine itself.

In a carcinogenicity study with transplacental exposure of rats to 2,6-xylidine and subsequent treatment with the same substance for 2 years a tumorigenic potential was shown. This highly sensitive test demonstrated the incidence of benign and malignant tumours in the nasal cavity (*ethmoturbinalia*).

A relevance of these findings for humans cannot be definitely ruled out if high-dose were administered over long periods. However as lidocaine is usually not used over longer periods no risks are to be expected if used according to the directions given.

### **Reproduction toxicity**

Investigations of reproduction toxicity did not reveal embryotoxic or teratogenic effects. Only a reduction of foetal weight has been observed.

When administered to pregnant rats at doses almost as high as the therapeutic maximum doses applied in man, neurological behavioural deviations in the offspring had been seen.



## **6 PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

Sodium chloride  
Sodium hydroxide  
Water for injections

### **6.2 Incompatibilities**

Lidocaine B. Braun 1% is incompatible with solutions containing sodium bicarbonate, and other alkaline solutions. It must therefore not be mixed with those.

### **6.3 Shelf life**

Unopened: The expiry date of the product is indicated on the packaging materials.

### **6.4 Special precautions for storage**

Do not store above 25°C

### **6.5 Nature and contents of container**

Lidocaine B. Braun 1% is supplied in:

- low density polyethylene ampoules (Mini-Plasco), contents: 5ml, 10ml, 20ml available in packs of:  
20 × 5 ml  
20 × 10 ml  
20 × 20 ml

Not all pack-sizes may be marketed.

### **6.6 Special precautions for disposal and other handling**

#### **Precautions for disposal**

No special requirements for disposal.

#### **Instructions for use and handling**

Only to be used if the solution is clear and colourless and the container and its closure are undamaged. Containers are for single use only. Discard container and any unused content after use.

## **7 MANUFACTURER:**

B. Braun Melsungen AG  
Carl-Braun-Straße 1  
D-34212 Melsungen, Germany

## **8 REGISTRATION HOLDER:**

Lapidot Medical Import and Marketing Ltd.  
8 Hashita Street, Industrial Park Caesarea 3088900, ISRAEL

## **9 MARKETING AUTHORISATION NUMBER**

156-33-34107-00

*Revised in June 2024*