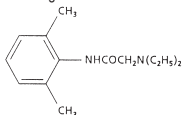


R_x Only
LIDAMANTLE HC[®] RELIEF PAD[™]
(Lidocaine HCl 2% - Hydrocortisone Acetate 2%)

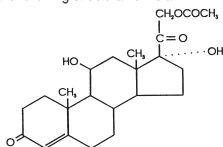
DESCRIPTION: LIDAMANTLE HC[®] RELIEF PAD[™] contains lidocaine HCl 2% and hydrocortisone acetate 2%. Lidocaine is chemically designated as acetamide, 2-(diethylamino)-N-(2,6-dimethylphenyl), and has the following structure:



C₁₄H₂₂N₂O

Mol. wt. 234.34

Hydrocortisone acetate has a chemical name pregn-4-ene-3, 20-dione, 21-(acetyloxy)-11,17-dihydroxy-(11 β)-. It has the following structural formula:



C₂₃H₃₂O₆

Mol. wt. 404.50

Each **LIDAMANTLE HC[®] RELIEF PAD[™]** contains a solution of lidocaine HCl 2% and hydrocortisone acetate 2% on a textured pad. Each gram of medicated solution contains lidocaine hydrochloride 20 mg and hydrocortisone acetate 20 mg along with the following inactive ingredients: acrylates/acrylamide copolymer, aluminum sulfate, calcium acetate, citric acid, glycerin, methylparaben, mineral oil, polysorbate 85, propylene glycol, propylparaben, purified water, sodium citrate and urea.

CLINICAL PHARMACOLOGY:

MECHANISM OF ACTION: Each **LIDAMANTLE HC[®] RELIEF PAD[™]** releases lidocaine to stabilize the neuronal membrane by inhibiting the ionic fluxes required for initiation and conduction of impulses, thereby effecting local anesthetic action. Hydrocortisone acetate provides relief of inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses.

PHARMACOKINETICS: Lidocaine may be absorbed following topical administration to mucous membranes, its rate and extent of absorption depending upon the specific site of application, duration of exposure, concentration, and total dosage. In general, the rate of absorption of local anesthetic agents following topical application occurs most rapidly after intratracheal administration. Lidocaine is also well-absorbed from the gastrointestinal tract, but little intact drug appears in the circulation because of biotransformation in the liver.

Lidocaine is metabolized rapidly by the liver, and metabolites and unchanged drug are excreted by the kidneys. Biotransformation includes oxidative N-dealkylation, ring hydroxylation, cleavage of the amide linkage, and conjugation. N-dealkylation, a major pathway of biotransformation, yields the metabolites monoethylglycinyloxide and glycinyloxide. The pharmacological/toxicological actions of these metabolites are similar to, but less potent than, those of lidocaine. Approximately 90% of lidocaine administered is excreted in the form of various metabolites, and less than 10% is excreted unchanged. The primary metabolite in urine is a conjugate of 4-hydroxy-2, 6-dimethylaniline.

The plasma binding of lidocaine is dependent on drug concentration, and the fraction bound decreases with increasing concentration. At concentrations of 1 to 4 g of free base per mL, 60 to 80 percent of lidocaine is protein bound. Binding is also dependent on the plasma concentration of the alpha-1-acid glycoprotein.

Lidocaine crosses the blood-brain and placental barriers, presumably by passive diffusion.

Studies of lidocaine metabolism following intravenous bolus injections have shown that the elimination half-life of this agent is typically 1.5 to 2 hours. Because of the rapid rate at which lidocaine is metabolized, any condition that affects liver function may alter lidocaine kinetics. The half-life may be prolonged two-fold or more in patients with liver dysfunction. Renal dysfunction does not affect lidocaine kinetics but may increase the accumulation of metabolites.

Factors such as acidosis and the use of CNS stimulants and depressants affect the CNS levels of lidocaine required to produce overt systemic effects. Objective adverse manifestations become increasingly apparent with increasing venous plasma levels above 6 g free base per mL. In the rhesus monkey, arterial blood levels of 18-21 g/mL have been shown to be threshold for convulsive activity.

The extent of percutaneous absorption of topical corticosteroids is determined by many factors including the vehicle, the integrity of the epidermal barrier, and the use of occlusive dressings.

Topical corticosteroids can be absorbed from normal intact skin. Inflammation and/or other disease processes in the skin increase percutaneous absorption. Occlusive dressings substantially increase the percutaneous absorption of topical corticosteroids. Thus, occlusive dressings may be a valuable therapeutic adjunct for treatment of resistant dermatoses.

Once absorbed through the skin, topical corticosteroids are handled through pharmacokinetic pathways similar to systemically administered corticosteroids. Corticosteroids are bound to plasma protein in varying degrees.

Corticosteroids are metabolized primarily in the liver and are then excreted by the kidneys. Some of the topical corticosteroids and their metabolites are also excreted into the bile.

INDICATIONS: Anti-inflammatory anesthetic for relief of pruritus, pruritic eczemas, abrasions, minor burns, insect bites, pain, soreness and discomfort due to pruritus ani, pruritus vulvae, hemorrhoids, anal fissures, and similar conditions of the skin and mucous membranes.

CONTRAINDICATIONS: Tuberculous or fungal lesions of skin, varicella, varicella and acute herpes simplex and in persons who have shown hypersensitivity to any of its components. Lidocaine is contraindicated in patients with a known history of hypersensitivity to local anesthetics of the amide type. Topical corticosteroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

WARNINGS: For external use only. Not for ophthalmic use.

PRECAUTIONS: If irritation or sensitivity occurs or infection appears, discontinue use and institute appropriate therapy. If extensive areas are treated, the possibility of systemic absorption exists. Systemic absorption of topical steroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glycosuria in some patients. Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings. Therefore, patients receiving a large dose of potent topical steroids applied to a large surface area, or under an occlusive dressing, should be evaluated periodically for evidence of HPA axis suppression. If noted, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid. Recovery of the HPA axis function is generally prompt and complete upon discontinuation of the drug. Infrequently, signs and symptoms of steroid withdrawal may occur, requiring supplemental systemic corticosteroids. Children may absorb proportionately larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity. If irritation develops, topical steroids should be discontinued and appropriate therapy instituted. In the presence of dermatological infections, the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

CARCINOGENESIS, MUTAGENESIS, AND IMPAIRMENT OF FERTILITY: Long-term animal studies have not been performed to evaluate the carcinogenic potential or the effect on fertility of topical corticosteroids.

Studies to determine mutagenicity with prednisolone and hydrocortisone have revealed negative results.

Studies of lidocaine in animals to evaluate the carcinogenic and mutagenic potential of the effect on fertility have not been conducted.

USE IN PREGNANCY: Teratogenic Effects: Pregnancy Category C. Reproduction studies have been performed for lidocaine in rats at doses up to 6.6 times the human dose and have revealed no evidence of harm to the fetus caused by lidocaine. There are, however, no adequate and well-controlled studies in pregnant women. Animal reproduction studies are not always predictive of human response. General consideration should be given to this fact before administering lidocaine to women of childbearing potential, especially during early pregnancy when maximum organogenesis takes place.

Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. There are no adequate and well-controlled studies in pregnant women on teratogenic effects from topically applied corticosteroids. Therefore, topical corticosteroids should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Drugs of this class should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when this drug is administered to a nursing mother.

PEDIATRIC USE: Dosage in pediatric patients would be reduced commensurate with age, body weight and physical condition.

ADVERSE REACTIONS: During or immediately after treatment, the skin at the site of treatment may develop erythema or edema or may be the locus of abnormal sensation.

DOSAGE AND ADMINISTRATION: Apply to the affected area two or three times daily or as directed by a physician.

HOW SUPPLIED:

LIDAMANTLE HC® RELIEF PAD™:

Contains 60 Foil Pouches, each with a single-use medicated pad (6 mL each).

NDC 10337-716-60.

KEEP THIS AND ALL MEDICATIONS OUT OF THE REACH OF CHILDREN.

Store at controlled room temperature 15°-30° C (59°-86° F). Protect from freezing.

U.S. Pat. No. 6,495,602

Mfd. for:



DOAK DERMATOLOGICS

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IL297
ISS. 09/07