Only for the use of a Registered Medical Practitioner or a Hospital or a laboratory

Biocon

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Heparin Injection IP

THINLA™ 5 K / 25 K थिनला ५के / २५के

COMPOSITION:
THINLA™ 5K
Each mL contains
Heparin Sodium IP 1000 IU
(Derived from Porcine Intestinal Mucosa)
Benzyl Alcohol IP 0.95% w/v
(as preservative)
Water for Injections IP q.s.

THINLA™ 25K
Each mL contains
Heparin Sodium IP 5000 IU
(Derived from Porcine Intestinal Mucosa)
Benzyl Alcohol IP 0.95% w/v
(as preservative)
Water for Injections IP q.s.

DESCRIPTION
Heparin is a heterogenous group of straight-chain anionic mucopolysaccharides, called glycosaminoglycans, having anticoagulant properties. Although others may be present, the main sugars occurring in heparin are: (1) α-L-iduronic acid 2-sulfate, (2) 2-deoxy-2-sulfamino-α-D glucose 6-sulfate, (3) β-D-glucuronic acid, (4) 2-acetamido-2-deoxy-α-D-glucose, and (5) α-L-iduronic acid. These sugars are present in decreasing amounts, usually in the order (2)> (1)> (4)> (3)> (5), and are joined by glycosidic linkages, forming polymers of varying sizes. Heparin is strongly acidic because of its content of covalently linked sulfate and carboxylic acid groups. In heparin sodium, the acidic protons of the sulfate units are partially replaced by sodium ions.

Heparin Injection IP is a sterile solution of heparin sodium derived from porcine intestinal mucosa, standardized for anticoagulant activity. It is to be administered by intravenous or deep subcutaneous routes.

Heparin injection IP is available in the following concentrations:
1. 5 mL vials of 5000 units – 1000 IU/mL
2. 5 mL vials of 25000 units – 5000 IU/mL

CLINICAL PHARMACOLOGY
Heparin inhibits reactions that lead to the clotting of blood and the formation of fibrin clots both in vitro and in vivo. Heparin acts at multiple sites in the normal coagulation system. Small amounts of heparin in combination with antithrombin III (heparin cofactor) can inhibit thrombosis by inactivating activated Factor X and inhibiting the conversion of prothrombin to thrombin. Once active thrombosis has developed, larger amounts of heparin can inhibit further coagulation by inactivating thrombin and preventing the conversion of fibrinogen to fibrin. Heparin also prevents the formation of a stable fibrin clot by inhibiting the activation of the fibrin-stabilizing factor.

Bleeding time is usually unaffected by heparin. Clotting time is prolonged by full therapeutic doses of heparin; in most cases, it is not measurably affected by low doses of heparin.
Patients over 60 years of age, following similar doses of heparin, may have higher plasma levels of heparin and longer activated partial thromboplastin times (APTTs) compared with patients under 60 years of age.

Peak plasma levels of heparin are achieved 2 to 4 hours following subcutaneous administration, although there are considerable individual variations. Log linear plots of heparin plasma concentrations with time, for a wide range of dose levels, are linear which suggest the absence of zero order processes. The liver and reticulo-endothelial systems are the sites of biotransformation.

The biphasic elimination curve, a rapidly declining alpha phase ($t_{1/2}$ = 10 min.), and after the age of 40 a slower beta phase, indicates uptake in organs. The absence of a relationship between anticoagulant half-life and concentration half-life may reflect factors such as protein binding of heparin.

Heparin does not have fibrinolytic activity; therefore, it will not lyse existing clots.

INDICATIONS AND USAGE
Heparin injection is indicated for:

- Anticoagulant therapy in prophylaxis and treatment of venous thrombosis and its extension
- Low-dose regimen for prevention of postoperative deep venous thrombosis and pulmonary embolism in patients undergoing major abdomino-thoracic surgery or who for other reasons are at risk of developing thromboembolic disease
- Prophylaxis and treatment of pulmonary embolism
- Atrial fibrillation with embolization
- Diagnosis and treatment of acute and chronic consumptive coagulopathies (disseminated intravascular coagulation)
- Prevention of clotting in arterial and cardiac surgery
- Prophylaxis and treatment of peripheral arterial embolism
- As an anticoagulant in blood transfusions, extracorporeal circulation, dialysis procedures, and in blood samples for laboratory purposes

CONTRAINDICATIONS
Heparin sodium should NOT be used in patients with the following conditions:
1. Severe thrombocytopenia
2. When suitable blood-coagulation tests - e.g., the whole-blood clotting time, partial thromboplastin time, etc. cannot be performed at appropriate intervals (this contraindication refers to full-dose heparin; there is usually no need to monitor coagulation parameters in patients receiving low-dose heparin)
3. An uncontrollable active bleeding state, except when this is due to disseminated intravascular coagulation.

WARNINGS
Heparin is not intended for intramuscular use.

Fatal Medication Errors
Do not use Heparin Sodium Injection as a "catheter lock flush" product. Fatal hemorrhages have occurred in pediatric patients due to medication errors in which 10,000 units in1 mL Heparin Sodium Injection vials were confused with 1 mL "catheter lock flush" vials. Carefully examine all Heparin Sodium Injection vials to confirm the correct product choice prior to administration of the drug.

Hypersensitivity
Patients with documented hypersensitivity to heparin should be given the drug only in clearly life threatening situations.

Hemorrhage
Hemorrhage can occur at virtually any site in patients receiving heparin. An unexplained fall in hematocrit, fall in blood pressure, or any other unexplained symptom should lead to serious consideration of a hemorrhagic event.

Heparin sodium should be used with extreme caution in disease states in which there is increased danger of hemorrhage. Some of the conditions in which increased danger of hemorrhage exists are:
Cardiovascular - Subacute bacterial endocarditis and severe hypertension.
Surgical - During and immediately following (a) spinal tap or spinal anesthesia or (b) major surgery, especially involving the brain, spinal cord, or eye.
Hematologic - Conditions associated with increased bleeding tendencies, such as hemophilia, thrombocytopenia, and some vascular purpuras.
Gastrointestinal - Ulcerative lesions and continuous tube drainage of the stomach or small intestine.
Other - Menstruation and liver disease with impaired hemostasis.

Coagulation Testing
When heparin sodium is administered in therapeutic amounts, its dosage should be regulated by frequent blood-coagulation tests. If the coagulation test is unduly prolonged or if hemorrhage occurs, heparin sodium should be discontinued promptly.

Thrombocytopenia
Thrombocytopenia has been reported to occur in patients receiving heparin with a reported incidence of 0 to 30%. Platelet counts should be obtained at baseline and periodically during heparin administration. Mild thrombocytopenia (count greater than 100,000/mm^3) may remain stable or reverse even if heparin is continued. However, thrombocytopenia of any degree should be monitored closely. If the count falls below 100,000/mm^3 or if recurrent thrombosis develops, the heparin product should be discontinued, and if necessary, an alternative anticoagulant administered.

Heparin-induced Thrombocytopenia (HIT) and Heparin-induced Thrombocytopenia and Thrombosis (HITT)
Heparin-induced thrombocytopenia (HIT) is a serious antibody-mediated reaction resulting from irreversible aggregation of platelets. HIT may progress to the development of venous and arterial thrombosis, a condition referred to as Heparin-induced Thrombocytopenia and Thrombosis (HITT). Thrombotic events may also be the initial presentation for HITT. These serious thromboembolic events include deep vein thrombosis, pulmonary embolism, cerebral vein thrombosis, limb ischemia, stroke, myocardial infarction, mesenteric thrombosis, renal artery thrombosis, skin necrosis, gangrene of the extremities that may lead to amputation, and possibly death. Thrombocytopenia of any degree should be monitored closely. If the count falls below 100,000/mm^3 or if recurrent thrombosis develops, the heparin product should be promptly discontinued and alternative anticoagulants considered, if patients require continued anticoagulation.

Delayed Onset of HIT and HITT
Heparin-induced Thrombocytopenia and Heparin-induced Thrombocytopenia and Thrombosis can occur up to several weeks after the discontinuation of heparin therapy. Patients presenting with thrombocytopenia or thrombosis after discontinuation of heparin should be evaluated for HIT and HITT.

Use in Neonates
This product contains the preservative benzyl alcohol and is not recommended for use in neonates. There have been reports of fatal 'gasping syndrome' in neonates (children less than one month of age) following the administration of intravenous solutions containing the preservative benzyl alcohol. Symptoms include a striking onset of gasping respiration, hypotension, bradycardia, and cardiovascular collapse.

Carefully examine all Heparin Sodium Injection vials to confirm choice of the correct strength prior to administration of the drug. Pediatric patients, including neonates, have died as a result of medication errors in which Heparin Sodium Injection vials have been confused with "catheter lock flush" vials.

PRECAUTIONS
General
Heparin Resistance
Increased resistance to heparin is frequently encountered in fever, thrombosis, thrombophlebitis, infections with thrombosing tendencies, myocardial infarction, cancer, and in postsurgical patients.

Increased Risk to Older Patients, Especially Women
A higher incidence of bleeding has been reported in patients, particularly women over 60 years of age.

Laboratory Tests
Periodic platelet counts, hematocrits, and tests for occult blood in stool are recommended during the entire course of heparin therapy, regardless of the route of administration

Drug Interactions
Oral Anticoagulants:
Heparin sodium may prolong the one-stage prothrombin time. Therefore, when heparin sodium is given with dicumarol or warfarin sodium, a period of at least 5 hours after the last intravenous dose or 24 hours after the last subcutaneous dose should elapse before blood is drawn if a valid prothrombin time is to be obtained.

Platelet Inhibitors:
Drugs such as acetylsalicylic acid, dextran, phenylbutazone, ibuprofen, indomethacin, dipyridamole, hydroxychloroquine, and others that interfere with platelet-aggregation reactions (the main hemostatic defense of heparinized patients) may induce bleeding and should be used with caution in patients receiving heparin sodium.

Other Interactions
Digitalis, tetracyclines, nicotine, or antihistamines may partially counteract the anticoagulant action of heparin sodium. Intravenous nitroglycerin administered to heparinized patients may result in a decrease of the partial thromboplastin time with subsequent rebound effect upon discontinuation of nitroglycerin. Careful monitoring of partial thromboplastin time and adjustment of heparin dosage are recommended during coadministration of heparin and intravenous nitroglycerin.

Drug/Laboratory Test Interactions
Hyperaminotransferasemia:
Significant elevations of aminotransferase (SGOT [S-AST] and SGPT [S-ALT]) levels have occurred in a high percentage of patients (and healthy subjects) who have received heparin. Since aminotransferase determinations are important in the differential diagnosis of myocardial infarction, liver disease, and pulmonary emboli, rises that might be caused by drugs (like heparin) should be interpreted with caution.

Carcinogenesis, Mutagenesis, Impairment of Fertility
No long-term studies in animals have been performed to evaluate the carcinogenic potential of heparin. Also, no reproduction studies in animals have been performed concerning mutagenesis or impairment of fertility.

Pregnancy
Teratogenic Effects - Pregnancy Category C:
Animal reproduction studies have not been conducted with heparin sodium. It is also not known whether heparin sodium can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Heparin sodium should be given to a pregnant woman only if clearly needed.

Nonteratogenic Effects:
Heparin does not cross the placental barrier.

Nursing Mothers
Heparin is not excreted in human milk.

Geriatric Use
A higher incidence of bleeding has been reported in patients over 60 years of age, especially women. Clinical studies indicate that lower doses of heparin may be indicated in these patients

ADVERSE REACTIONS
Hemorrhage
Hemorrhage is the chief complication that may result from heparin therapy. An overly prolonged clotting time or minor bleeding during therapy can usually be controlled by withdrawing the drug. It should be appreciated that gastrointestinal or urinary-tract bleeding during anticoagulant therapy may indicate the presence of an underlying occult lesion. Bleeding can occur at any site but certain specific hemorrhagic complications may be difficult to detect:

A. Adrenal hemorrhage, with resultant acute adrenal insufficiency, has occurred during anticoagulant therapy. Therefore, such treatment should be discontinued in patients who develop signs and symptoms of acute adrenal hemorrhage and insufficiency. Initiation of corrective therapy should not depend on laboratory confirmation of the diagnosis, since any delay in an acute situation may result in the patient's death.

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B. Ovarian (corpus luteum) hemorrhage developed in a number of women of reproductive age receiving short- or long-term anticoagulant therapy. This complication, if unrecognized, may be fatal.
C. Retroperitoneal hemorrhage.

Local Irritation
Local irritation, erythema, mild pain, hematoma, or ulceration may follow deep, subcutaneous (intrafat) injection of heparin sodium. These complications are much more common after intramuscular use, and such use is not recommended.

Hypersensitivity
Generalized hypersensitivity reactions have been reported, with chills, fever, and urticaria as the most usual manifestations, and asthma, rhinitis, lacrimation, headache, nausea and vomiting, and anaphylactoid reactions, including shock, occurring more rarely. Itching and burning, especially on the plantar side of the feet, may occur. Thrombocytopenia has been reported to occur in patients receiving heparin with a reported incidence of 0 to 30%. While often mild and of no obvious clinical significance, such thrombocytopenia can be accompanied by severe thromboembolic complications, such as skin necrosis, gangrene of the extremities that may lead to amputation, myocardial infarction, pulmonary embolism, stroke, and possibly death.

Certain episodes of painful, ischemic and cyanosed limbs have in the past been attributed to allergic vasospastic reactions. Whether these are, in fact, identical to the thrombocytopenia associated complications remains to be determined.

Miscellaneous
Osteoporosis following long-term administration of high doses of heparin, cutaneous necrosis after systemic administration, suppression of aldosterone synthesis, delayed transient alopecia, priapism, and rebound hyperlipemia on discontinuation of heparin sodium have also been reported. Significant elevations of aminotransferase (SGOT [S-AST] and SGPT [S-ALT]) levels have occurred in a high percentage of patients (and healthy subjects) who have received heparin.

OVERDOSAGE
Symptoms
Bleeding is the chief sign of heparin overdosage. Nosebleeds, blood in urine, or tarry stools may be noted as the first sign of bleeding. Easy bruising or petechial formations may precede frank bleeding.

Treatment – Neutralization of heparin effect.
When clinical circumstances (bleeding) require reversal of heparinization, protamine sulfate (1% solution) by slow infusion will neutralize heparin sodium. No more than 50 mg should be administered, very slowly, in any 10-minute period. Each mg of protamine sulfate neutralizes approximately 100 heparin units. The amount of protamine required decreases over time as heparin is metabolized. Although the metabolism of heparin is complex, it may, for the purpose of choosing a protamine dose, be assumed to have a half-life of about ½ hour after intravenous injection.

Administration of protamine sulfate can cause severe hypotensive and anaphylactoid reactions. Because fatal reactions often resembling anaphylaxis have been reported, the drug should be given only when resuscitation techniques and treatment of anaphylactoid shock are readily available.

DOSAGE AND ADMINISTRATION
Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit. Slight discoloration does not alter potency.

Confirm the choice of the correct Heparin Sodium Injection vial prior to administration of the drug to a patient. Heparin Sodium Injection products must not be confused with "catheter lock flush" products. When heparin is added to an infusion solution for continuous intravenous administration, the container should be inverted at least six times to ensure adequate mixing and prevent pooling of the heparin in the solution.

Heparin sodium is not effective by oral administration and should be given by intermittent intravenous injection, intravenous infusion, or deep subcutaneous (intrafat, i.e., above the iliac crest or abdominal fat layer) injection. The intramuscular route of administration should be avoided because of the frequent occurrence of hematoma at the injection site.

The dosage of heparin sodium should be adjusted according to the patient's coagulation-test results. When heparin is given by continuous intravenous infusion, the coagulation time should be determined approximately every 4 hours in the early stages of treatment. When the drug is administered intermittently by intravenous injection, coagulation tests should be performed before each injection during the early stages of treatment and at appropriate intervals thereafter. Dosage is considered adequate when the activated partial thromboplastin time (APTT) is 1.5 to 2 times normal or when the whole blood clotting time is elevated approximately 2.5 to 3 times the control value. After deep subcutaneous (intrafat) injections, tests for adequacy of dosage are best performed on samples drawn 4 to 6 hours after the injections. Periodic platelet counts, hematocrits, and tests for occult blood in stool are recommended during the entire course of heparin therapy, regardless of the route of administration.

Converting to Oral Anticoagulant
When an oral anticoagulant of the coumarin or similar type is to be begun in patients already receiving heparin sodium, baseline and subsequent tests of prothrombin activity must be determined at a time when heparin activity is too low to affect the prothrombin time. This is about 5 hours after the last IV bolus and 24 hours after the last subcutaneous dose. If continuous IV heparin infusion is used, prothrombin time can usually be measured at any time. In converting from heparin to an oral anticoagulant, the dose of the oral anticoagulant should be the usual initial amount, and thereafter prothrombin time should be determined at the usual intervals. To ensure continuous anticoagulation, it is advisable to continue full heparin therapy for several days after the prothrombin time has reached the therapeutic range. Heparin therapy may then be discontinued without tapering.

Therapeutic Anticoagulant Effect With Full-Dose Heparin
Although dosage must be adjusted for the individual patient according to the results of suitable laboratory tests, the following dosage schedules may be used as guidelines:
Pediatric Use
Follow recommendations of appropriate pediatric reference texts. In general, the following dosage schedule may be used as a guideline:
Initial Dose: 50 units/kg (IV drip)
Maintenance Dose: 100 units/kg (IV drip) every four hours, or 20,000 units/m^2/24 hours continuously.

Therapeutic Anticoagulant Effect With Full-Dose Heparin
Although dosage must be adjusted for the individual patient according to the results of suitable laboratory tests, the following dosage schedules may be used as guidelines:

METHOD OF ADMINISTRATION	FREQUENCY	RECOMMENDED DOSE [Based on 68 kg patient]
Deep, Subcutaneous (Intrafat) Injection	Initial Dose	5,000 units by IV injection, followed by 10,000 to 20,000 units of a concentrated solution, subcutaneously
A different site should be used for each injection to prevent the development of massive hematoma.	Every 8 hours or Every 12 hours	8,000 to 10,000 units of a concentrated solution 15,000 to 20,000 units of a concentrated solution
Intermittent Intravenous Injection	Initial Dose	10,000 units, either undiluted or in 50 or 100 mL of 0.9% Sodium Chloride Injection.
	Every 4 to 6 hours	5,000 to 10,000 units, either undiluted or in 50 to 100 mL of 0.9% Sodium Chloride Injection.
Intravenous Infusion	Initial Dose	5,000 units by IV injection
	Continuous	20,000 to 40,000 units/24 hours in 1,000 mL of 0.9% Sodium Chloride Injection, (or in any compatible solution) for infusion

Geriatric Use
Patients over 60 years of age may require lower doses of heparin.

Surgery of the Heart and Blood Vessels
Patients undergoing total body perfusion for open-heart surgery should receive an initial dose of not less than 150 units of heparin sodium per kilogram of body weight. Frequently, a dose of 300 units of heparin sodium per kilogram of body weight is used for procedures estimated to last less than 60 minutes; or 400 units per kilogram for those estimated to last longer than 60 minutes.

Low-Dose Prophylaxis of Postoperative Thromboembolism
A number of well-controlled clinical trials have demonstrated that low-dose heparin prophylaxis, given just prior to and after surgery, will reduce the incidence of postoperative deep vein thrombosis in the legs (as measured by the I-125 fibrinogen technique and venography) and of clinical pulmonary embolism. The most widely used dosage has been 5,000 units 2 hours before surgery and 5,000 units every 8 to 12 hours thereafter for 7 days or until the patient is fully ambulatory, whichever is longer. The heparin is given by deep subcutaneous injection in the arm or abdomen with a fine needle (25 to 26 gauge) to minimize tissue trauma. A concentrated solution of heparin sodium is recommended. Such prophylaxis should be reserved for patients over the age of 40 who are undergoing major surgery. Patients with bleeding disorders, those having neurosurgery, spinal anesthesia, eye surgery, or potentially sanguineous operations should be excluded, as well as patients receiving oral anticoagulants or platelet-active drugs. The value of such prophylaxis in hip surgery has not been established. The possibility of increased bleeding during surgery or postoperatively should be borne in mind. If such bleeding occurs, discontinuance of heparin and neutralization with protamine sulfate is advisable. If clinical evidence of thromboembolism develops despite low-dose prophylaxis, full therapeutic doses of anticoagulants should be given unless contraindicated. All patients should be screened prior to heparinization to rule out bleeding disorders, and monitoring should be performed with appropriate coagulation tests just prior to surgery. Coagulation-test values should be normal or only slightly elevated at these times. There is usually no need for daily monitoring of the effect of low-dose heparin in patients with normal coagulation parameters.

Extracorporeal Dialysis
Chronic Renal Failure
The use of hemodialysis in this area has increased dramatically in recent years and may be in-hospital or home dialysis. It is most important to stress that the instructions for each equipment manufacturer's unit must be followed scrupulously.

The following is merely intended as an overall summary of possible general procedures:
- 3,000 units of Heparin Sodium Injection, is added to 1,000 mL of sterile saline as a dialyser flush prior to connection.
- Initial dosage: 5,000 units of Heparin Sodium Injection, into the venous shunt or 2,500 units into the arterial fistula needle.
- With the shunt type, the usual continuing dosage is 2,000 units per hour; with the fistula type, 1,500 units per hour by means of a suitable syringe and a pump to allow continuing infusion. Heparin Sodium Injection, reversal with protamine sulfate will be decided by the individual physician. Usually this is not done unless dialysis is being performed soon after surgery.

Blood Transfusion
Addition of 400 to 600 units per 100 mL of whole blood is usually employed to prevent coagulation. Usually, 7500 units of heparin sodium are added to 100 mL of 0.9% Sodium Chloride Injection, (or 75,000 units per 1,000 mL of 0.9% Sodium Chloride Injection) and mixed, and from this sterile solution, 6 mL to 8 mL are added per 100 mL of whole blood.

Laboratory Samples
Addition of 70 to 150 units of heparin sodium per 10 to 20 mL sample of whole blood is usually employed to prevent coagulation of the sample. Leukocyte counts should be performed on heparinized blood within two hours after addition of the heparin. Heparinized blood should not be used for isoagglutinin, complement, erythrocyte fragility tests or platelet counts.

HOW SUPPLIED
Heparin Injection, IP
(Derived from porcine intestinal mucosa)
Preserved with0.95% w/v benzyl alcohol,
is available as follows
For IV/SC use

Presentation
1. 5 mL vials of 5000 units – 1000 IU/mL
2. 5 mL vials of 25000 units – 5000 IU/mL

Each box contains 10 vials

Shelf Life : Please refer to expiry date on Vial Label / Carton.

Storage
Store at temperature not exceeding 30°C.
Keep out of reach of children

Use only if solution is clear. Discard unused portion.

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To report adverse events and/or product complaints visit our website **www.biocon.com** or call toll free No: **1800 102 9465** or e mail us at **drugsafety@biocon.com**

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