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Captopril—Cont.

Hypertension: Initiation of therapy requires consideration of recent antihypertensive drug treatment, the extent of blood pressure elevation, salt restriction, and other clinical circumstances. If possible, discontinue the patient's previous antihypertensive drug regimen for one week before starting captopril.

The initial dose of captopril is 25 mg bid or tid. If satisfactory reduction of blood pressure has not been achieved after one or two weeks, the dose may be increased to 50 mg bid or tid. Concomitant sodium restriction may be beneficial when captopril is used alone.

The dose of captopril in hypertension usually does not exceed 50 mg tid. Therefore, if the blood pressure has not been satisfactorily controlled after one to two weeks at this dose, (and the patient is not already receiving a diuretic), a modest dose of a thiazide-type diuretic (e.g., hydrochlorothiazide, 25 mg daily), should be added. The diuretic dose may be increased at one- to two-week intervals until its highest usual antihypertensive dose is reached.

If captopril is being started in a patient already receiving a diuretic, captopril therapy should be initiated under close medical supervision (see WARNINGS and PRECAUTIONS [Drug Interactions] regarding hypotension), with dosage and titration of captopril as noted above.

If further blood pressure reduction is required, the dose of captopril may be increased to 100 mg bid or tid and then, if necessary, to 150 mg bid or tid (while continuing the diuretic). The usual dose range is 25 to 150 mg bid or tid. A maximum daily dose of 450 mg captopril should not be exceeded.

For patients with severe hypertension (e.g., accelerated or malignant hypertension), when temporary discontinuation of current antihypertensive therapy is not practical or desirable, or when prompt titration to more normotensive blood pressure levels is indicated, diuretic should be continued but other current antihypertensive medication stopped and captopril dosage promptly initiated at 25 mg bid or tid, under close medical supervision.

When necessitated by the patient's clinical condition, the daily dose of captopril may be increased every 24 hours or less under continuous medical supervision until a satisfactory blood pressure response is obtained or the maximum dose of captopril is reached. In this regimen, addition of a more potent diuretic, e.g., furosemide, may also be indicated.

Beta-blockers may also be used in conjunction with captopril therapy (see PRECAUTIONS: Drug Interactions), but the effects of the two drugs are less than additive.

Heart Failure: Initiation of therapy requires consideration of recent diuretic therapy and the possibility of severe salt/volume depletion. In patients with either normal or low blood pressure, who have been vigorously treated with diuretics and who may be hyponatremic and/or hypovolemic, a starting dose of 6.25 or 12.5 mg tid may minimize the magnitude or duration of the hypotensive effect (see WARNINGS: Hypotension); for these patients, titration to the usual daily dosage can then occur within the next several days.

For most patients the usual initial daily dosage is 25 mg tid. After a dose of 50 mg tid is reached, further increases in dosage should be delayed, where possible, for at least two weeks to determine if a satisfactory response occurs. Most patients studied have had a satisfactory clinical improvement at 50 or 100 mg tid. A maximum daily dose of 450 mg of captopril should not be exceeded.

Captopril should generally be used in conjunction with a diuretic and digitalis. Captopril therapy must be initiated under very close medical supervision.

Left Ventricular Dysfunction After Myocardial Infarction: The recommended dose for long-term use in patients following a myocardial infarction is a target maintenance dose of 50 mg tid.

Therapy may be initiated as early as three days following a myocardial infarction. After a single dose of 6.25 mg, captopril therapy should be initiated at 12.5 mg tid. Captopril should then be increased to 25 mg tid during the next several days and to a target dose of 50 mg tid over the next several weeks as tolerated (see CLINICAL PHARMACOLOGY).

Captopril may be used in patients treated with other post-myocardial infarction therapies, e.g., thrombolytics, aspirin, beta-blockers.

Dosage Adjustment in Renal Impairment: Because captopril is excreted primarily by the kidneys, excretion rates are reduced in patients with impaired renal function. These patients will take longer to reach steady-state captopril levels and will reach higher steady-state levels for a given daily dose than patients with normal renal function. Therefore, these patients may respond to smaller or less frequent doses.

Accordingly, for patients with significant renal impairment, initial daily dosage of captopril should be reduced, and smaller increments utilized for titration, which should be quite slow (one- to two-week intervals). After the desired therapeutic effect has been achieved, the dose should be slowly back-titrated to determine the minimal effective dose. When concomitant diuretic therapy is required, a loop diuretic (e.g., furosemide), rather than a thiazide diuretic, is preferred in patients with severe renal impairment. (See WARNINGS: Anaphylactoid Reactions During Membrane Exposure and PRECAUTIONS: Hemodialysis.)

HOW SUPPLIED

Captopril tablets are available containing 12.5 mg, 25 mg, 50 mg or 100 mg of captopril.

The 12.5 mg tablets are white, partially scored (both sides), oval tablets marked with M to the left of the score and C1 to the right of the score on one side. They are available as follows:

NDC 0378-3007-01
bottles of 100 tablets
NDC 0378-3007-10
bottles of 1000 tablets

The 25 mg tablets are white, quadrisect scored, round tablets marked with M over C2 on the non-scored side. They are available as follows:

NDC 0378-3012-01
bottles of 100 tablets
NDC 0378-3012-10
bottles of 1000 tablets

The 50 mg tablets are white, scored, round tablets marked with M over C3 on the scored side. They are available as follows:

NDC 0378-3017-01
bottles of 100 tablets
NDC 0378-3017-10
bottles of 1000 tablets

The 100 mg tablets are white, scored, round tablets marked with M over C4 on the scored side. They are available as follows:

NDC 0378-3022-01
bottles of 100 tablets

Captopril tablets may exhibit a slight sulfurous odor.

Bottles contain a desiccant-charcoal canister.

STORE AT CONTROLLED ROOM TEMPERATURE 15°–30°C (59°–86°F).

PROTECT FROM MOISTURE.

Dispense in a tight container using a child-resistant closure.

Rx only

Mylan Pharmaceuticals Inc.
Morgantown, WV 26505

REVISED MARCH 1998
CAPT:R7

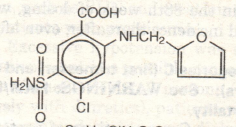
FUROSEMIDE TABLETS, USP
20 mg, 40 mg and 80 mg ℞

WARNING: Furosemide is a potent diuretic which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required, and dose and dose schedule must be adjusted to the individual patient's needs. (See "DOSAGE AND ADMINISTRATION".)

DESCRIPTION

Furosemide is a diuretic which is an anthranilic acid derivative. Chemically, it is 4-chloro-*N*-furfuryl-5-sulfamoylanthranilic acid. Furosemide is a white to slightly yellow odorless, crystalline powder. It is practically insoluble in water, sparingly soluble in alcohol, freely soluble in dilute alkali solutions and insoluble in dilute acids.

The structural formula is as follows:



$C_{12}H_{11}ClN_2O_5S$
M.W. 330.75

Each tablet for oral administration contains 20 mg, 40 mg or 80 mg of furosemide and the following inactive ingredients: colloidal silicon dioxide, lactose monohydrate, microcrystalline cellulose, pregelatinized starch and stearic acid. Furosemide Tablets, USP 20 mg, 40 mg and 80 mg meet *USP DISSOLUTION TEST 1.*

CLINICAL PHARMACOLOGY

Investigations into the mode of action of furosemide have utilized micropuncture studies in rats, stop flow experiments in dogs, and various clearance studies in both humans and experimental animals. It has been demonstrated that furosemide inhibits primarily the reabsorption of sodium and chloride not only in the proximal and distal tubules but also in the loop of Henle. The high degree of efficacy is largely due to this unique site of action. The action on the distal tubule is independent of any inhibitory effect on carbonic anhydrase and aldosterone.

Recent evidence suggests that furosemide glucuronide is the only or at least the major biotransformation product of furosemide in man. Furosemide is extensively bound to plasma proteins, mainly to albumin. Plasma concentrations ranging from 1 to 400 µg/mL are 91 to 99% bound in healthy individuals. The unbound fraction averages 2.3 to 4.1% at therapeutic concentrations.

The onset of diuresis following oral administration is within one hour. The peak effect occurs within the first or second hour. The duration of diuretic effect is 6 to 8 hours.

In fasted normal men, the mean bioavailability of furosemide from furosemide tablets and furosemide oral solution has been shown to be about 60% of that from an intravenous injection of the drug. Although furosemide is more rapidly absorbed from the oral solution than from the tablet, peak plasma levels and area under the plasma concentration-time curves do not differ significantly. Peak plasma concentrations of furosemide increase with increasing dose but times-to-peak do not differ among doses. The terminal half-life of furosemide is approximately 2 hours.

Significantly more furosemide is excreted in urine following the IV injection than after the tablet or oral solution. There are no significant differences between the two oral formulations in the amount of unchanged drug excreted in urine.

INDICATIONS AND USAGE

Edema: Furosemide is indicated in adults, infants, and children for the treatment of edema associated with congestive heart failure, cirrhosis of the liver, and renal disease, including the nephrotic syndrome. Furosemide is particularly useful when an agent with greater diuretic potential is desired.

Hypertension: Oral furosemide may be used in adults for the treatment of hypertension alone or in combination with other antihypertensive agents. Hypertensive patients who cannot be adequately controlled with thiazides will probably also not be adequately controlled with furosemide alone.

CONTRAINDICATIONS

Furosemide is contraindicated in patients with anuria and in patients with a history of hypersensitivity to furosemide.

WARNINGS

In patients with hepatic cirrhosis and ascites, furosemide therapy is best initiated in the hospital. In hepatic coma and in states of electrolyte depletion, therapy should not be instituted until the basic condition is improved. Sudden alteration of fluid and electrolyte balance in patients with cirrhosis may precipitate hepatic coma; therefore, strict observation is necessary during the period of diuresis. Supplemental potassium chloride and, if required, an aldosterone antagonist are helpful in preventing hypokalemia and metabolic alkalosis.

If increasing azotemia and oliguria occur during treatment of severe progressive renal disease, furosemide should be discontinued.

Cases of tinnitus and reversible or irreversible hearing impairment have been reported. Usually, reports indicate that furosemide ototoxicity is associated with rapid injection, severe renal impairment, doses exceeding several times the usual recommended dose, or concomitant therapy with aminoglycoside antibiotics, ethacrynic acid, or other ototoxic drugs. If the physician elects to use high dose parenteral therapy, controlled intravenous infusion is advisable (for adults, an infusion rate not exceeding 4 mg furosemide per minute has been used).

PRECAUTIONS

General: Excessive diuresis may cause dehydration and blood volume reduction with circulatory collapse and possible vascular thrombosis and embolism, particularly in elderly patients. As with any effective diuretic, electrolyte depletion may occur during furosemide therapy, especially in patients receiving higher doses and a restricted salt intake. Hypokalemia may develop with furosemide, especially with brisk diuresis, inadequate oral electrolyte intake, when cirrhosis is present or during concomitant use of corticosteroids or ACTH. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially myocardial effects.

All patients receiving furosemide therapy should be observed for these signs or symptoms of fluid or electrolyte imbalance (hyponatremia, hypochloremic alkalosis, hypokalemia, hypomagnesemia or hypocalcemia): dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, arrhythmia, or gastrointestinal disturbances such as nausea and vomiting.

Increases in blood glucose and alterations in glucose tolerance tests (with abnormalities of the fasting and 2-hour postprandial sugar) have been observed, and rarely, precipitation of diabetes mellitus has been reported.

Asymptomatic hyperuricemia can occur and gout may rarely be precipitated.

Patients allergic to sulfonamides may also be allergic to furosemide.

The possibility exists of exacerbation or activation of systemic lupus erythematosus.

As with many other drugs, patients should be observed regularly for the possible occurrence of blood dyscrasias, liver or kidney damage or other idiosyncratic reactions.

Information for Patients: Patients receiving furosemide should be advised that they may experience symptoms from excessive fluid and/or electrolyte losses. The postural hypotension that sometimes occurs can usually be managed by getting up slowly. Potassium supplements and/or dietary measures may be needed to control or avoid hypokalemia.

Patients with diabetes mellitus should be told that furosemide may increase blood glucose levels and thereby affect urine glucose tests. The skin of some patients may be more sensitive to the effects of sunlight while taking furosemide.

Hypertensive patients should avoid medications that may increase blood pressure, including over-the-counter products for appetite suppression and cold symptoms.

Laboratory Tests: Serum electrolytes, (particularly potassium), CO_2, creatinine and BUN should be determined frequently during the first few months of furosemide therapy and periodically thereafter. Serum and urine electrolyte determinations are particularly important when the patient is vomiting profusely or receiving parenteral fluids. Abnormalities should be corrected or the drug temporarily withdrawn. Other medications may also influence serum electrolytes.

Reversible elevations of BUN may occur and are associated with dehydration which should be avoided, particularly in patients with renal insufficiency.

Urine and blood glucose should be checked periodically in diabetics receiving furosemide, even in those suspected of latent diabetes.
Furosemide may lower serum levels of calcium (rarely cases of tetany have been reported) and magnesium. Accordingly, serum levels of these electrolytes should be determined periodically.
Drug Interactions: Furosemide may increase the ototoxic potential of aminoglycoside antibiotics, especially in the presence of impaired renal function. Except in life threatening situations, avoid this combination.
Furosemide should not be used concomitantly with ethacrynic acid because of the possibility of ototoxicity.
Patients receiving high doses of salicylates concomitantly with furosemide, as in rheumatic disease, may experience salicylate toxicity at lower doses because of competitive renal excretory sites.
Furosemide has a tendency to antagonize the skeletal muscle relaxing effects of tubocurarine and may potentiate the action of succinylcholine.
Lithium generally should not be given with diuretics because they reduce lithium's renal clearance and add a high risk of lithium toxicity.
Furosemide may add to or potentiate the therapeutic effect of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.
Furosemide may decrease arterial responsiveness to norepinephrine. However, norepinephrine may still be used effectively.
Simultaneous administration of sucralfate and furosemide tablets may reduce the natriuretic and antihypertensive effects of furosemide. Patients receiving both drugs should be observed closely to determine if the desired diuretic and/or antihypertensive effect of furosemide is achieved. The intake of furosemide and sucralfate should be separated by at least two hours.
One study in six subjects demonstrated that the combination of furosemide and acetylsalicylic acid temporarily reduced creatinine clearance in patients with chronic renal insufficiency. There are case reports of patients who developed increased BUN, serum creatinine and serum potassium levels, and weight gain when furosemide was used in conjunction with NSAIDs.
Literature reports indicate that coadministration of indomethacin may reduce the natriuretic and antihypertensive effects of furosemide in some patients by inhibiting prostaglandin synthesis. Indomethacin may also affect plasma renin levels, aldosterone excretion and renin profile evaluation. Patients receiving both indomethacin and furosemide should be observed closely to determine if the desired diuretic and/or antihypertensive effect of furosemide is achieved.
Carcinogenesis, Mutagenesis, Impairment of Fertility: Furosemide was tested for carcinogenicity by oral administration in one strain of mice and one strain of rats. A small but significantly increased incidence of mammary gland carcinomas occurred in female mice at a dose 17.5 times the maximum human dose of 600 mg. There were marginal increases in uncommon tumors in male rats at a dose of 15 mg/kg (slightly greater than the maximum human dose) but not at 30 mg/kg.
Furosemide was devoid of mutagenic activity in various strains of *Salmonella typhimurium* when tested in the presence or absence of an *in vitro* metabolic activation system, and questionably positive for gene mutation in mouse lymphoma cells in the presence of rat liver S9 at the highest dose tested. Furosemide did not induce sister chromatid exchange in human cells *in vitro,* but other studies on chromosomal aberrations in human cells *in vitro* gave conflicting results. In Chinese hamster cells it induced chromosomal damage but was questionably positive for sister chromatid exchange. Studies on the induction by furosemide of chromosomal aberrations in mice were inconclusive. The urine of rats treated with this drug did not induce gene conversion in *Saccharomyces cerevisiae*.
Furosemide produced no impairment of fertility in male or female rats at 100 mg/kg/day (the maximum effective diuretic dose in the rat and 8 times the maximal human dose of 600 mg/day).
Pregnancy: *Teratogenic Effects:* *Pregnancy Category C:* Furosemide has been shown to cause unexplained maternal deaths and abortions in rabbits at 2, 4 and 8 times the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Furosemide should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
The effects of furosemide on embryonic and fetal development and on pregnant dams were studied in mice, rats, and rabbits.
Furosemide caused unexplained maternal deaths and abortions in the rabbit at the lowest dose of 25 mg/kg (two times the maximal recommended human dose of 600 mg/day). In another study, a dose of 50 mg/kg (four times the maximal recommended human dose of 600 mg/day) also caused maternal deaths and abortions when administered to rabbits between Days 12 and 17 of gestation. In a third study, none of the pregnant rabbits survived a dose of 100 mg/kg. Data from the above studies indicate fetal lethality that can precede maternal deaths.
The results of the mouse study and one of the three rabbit studies also showed an increased incidence and severity of hydronephrosis (distention of the renal pelvis and in some cases of the ureters) in fetuses derived from the treated dams as compared with the incidence in fetuses from the control group.
Nursing Mothers: Because it appears in breast milk, caution should be exercised when furosemide is administered to a nursing mother.

ADVERSE REACTIONS

Adverse reactions are categorized below by organ system and listed by decreasing severity.

Gastrointestinal System Reactions
1. pancreatitis
2. jaundice (intrahepatic cholestatic jaundice)
3. anorexia
4. oral and gastric irritation
5. cramping
6. diarrhea
7. constipation
8. nausea
9. vomiting

Systemic Hypersensitivity Reactions
1. systemic vasculitis
2. interstitial nephritis
3. necrotizing angiitis

Central Nervous System Reactions
1. tinnitus and hearing loss
2. paresthesias
3. vertigo
4. dizziness
5. headache
6. blurred vision
7. xanthopsia

Hematologic Reactions
1. aplastic anemia (rare)
2. thrombocytopenia
3. agranulocytosis (rare)
4. hemolytic anemia
5. leukopenia
6. anemia

Dermatologic-Hypersensitivity Reactions
1. exfoliative dermatitis
2. erythema multiforme
3. purpura
4. photosensitivity
5. urticaria
6. rash
7. pruritus

Cardiovascular Reaction
Orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates, or narcotics.

Other Reactions
1. hyperglycemia
2. glycosuria
3. hyperuricemia
4. muscle spasm
5. weakness
6. restlessness
7. urinary bladder spasm
8. thrombophlebitis
9. fever

Whenever adverse reactions are moderate or severe, furosemide dosage should be reduced or therapy withdrawn.

OVERDOSAGE

The principal signs and symptoms of overdosage with furosemide are dehydration, blood volume reduction, hypotension, electrolyte imbalance, hypokalemia and hypochloremic alkalosis, and are extensions of its diuretic action.
The acute toxicity of furosemide has been determined in mice, rats, and dogs. In all three, the oral LD_{50} exceeded 1000 mg/kg body weight while the intravenous LD_{50} ranged from 300 to 680 mg/kg. The acute intragastric toxicity in neonatal rats is 7 to 10 times that of adult rats.
The concentration of furosemide in biological fluid associated with toxicity or death is not known.
Treatment of overdosage is supportive and consists of replacement of excessive fluid and electrolyte losses. Serum electrolytes, carbon dioxide level and blood pressure should be determined frequently. Adequate drainage must be assured in patients with urinary bladder outlet obstruction (such as prostatic hypertrophy).
Hemodialysis does not accelerate furosemide elimination.

DOSAGE AND ADMINISTRATION

Edema: Therapy should be individualized according to patient response to gain maximal therapeutic response and to determine the minimal dose needed to maintain that response.
Adults: The usual initial dose of furosemide is 20 to 80 mg given as a single dose. Ordinarily a prompt diuresis ensues. If needed, the same dose can be administered 6 to 8 hours later or the dose may be increased. The dose may be raised by 20 to 40 mg and given not sooner than 6 to 8 hours after the previous dose until the desired diuretic effect has been obtained. This individually determined single dose should then be given once or twice daily (e.g., at 8 am and 2 pm). The dose of furosemide may be carefully titrated up to 600 mg/day in patients with clinically severe edematous states. Edema may be most efficiently and safely mobilized by giving furosemide on 2 to 4 consecutive days each week.
When doses exceeding 80 mg/day are given for prolonged periods, careful clinical observation and laboratory monitoring are particularly advisable. (See PRECAUTIONS: Laboratory Tests.)
Infants and Children: The usual initial dose of oral furosemide in infants and children is 2 mg/kg body weight, given as a single dose. If the diuretic response is not satisfactory after the initial dose, dosage may be increased by 1 or 2 mg/kg no sooner than 6 to 8 hours after the previous dose. Doses greater than 6 mg/kg body weight are not recommended. For maintenance therapy in infants and children, the dose should be adjusted to the minimum effective level. For ease of administration, and to allow maximum flexibility in dosing, the use of Furosemide Oral Solution is suggested.
Hypertension: Therapy should be individualized according to the patient's response to gain maximal therapeutic response and to determine the minimal dose needed to maintain that therapeutic response.
Adults: The usual initial dose of furosemide for hypertension is 80 mg, usually divided into 40 mg twice a day. Dosage should then be adjusted according to response. If response is not satisfactory, add other antihypertensive agents.
Changes in blood pressure must be carefully monitored when furosemide is used with other antihypertensive drugs, especially during initial therapy. To prevent excessive drop in blood pressure, the dosage of other agents should be reduced by at least 50 percent when furosemide is added to the regimen. As the blood pressure falls under the potentiating effect of furosemide, a further reduction in dosage or even discontinuation of other antihypertensive drugs may be necessary.

HOW SUPPLIED

The 20 mg tablets are white, round, unscored, flat-beveled-edged tablets marked with M2. They are available as follows:
NDC 0378-0208-01 bottles of 100 tablets
NDC 0378-0208-10 bottles of 1000 tablets
The 40 mg tablets are white, round, scored, flat-bevel-edged tablets marked with MYLAN over 216 on one side and 40 on the other side. They are available as follows:
NDC 0378-0216-01 bottles of 100 tablets
NDC 0378-0216-10 bottles of 1000 tablets
The 80 mg tablets are white, round, scored, flat-bevel-edged tablets marked with MYLAN over 232 on one side and 80 on the other side. They are available as follows:
NDC 0378-0232-01 bottles of 100 tablets
NDC 0378-0232-05 bottles of 500 tablets
STORE AT CONTROLLED ROOM TEMPERATURE 15°–30°C (59°–86°F).
PROTECT FROM LIGHT.
Dispense in a tight, light-resistant container using a child-resistant closure. Exposure to light may cause slight discoloration. Discolored tablets should not be dispensed.
MYLAN®
Mylan Pharmaceuticals Inc.
Morgantown, WV 26505

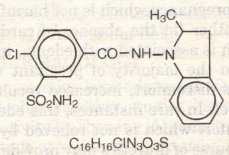
REVISED MARCH 1998
FUR:R24

INDAPAMIDE TABLETS, USP ℞

1.25 mg and 2.5 mg

DESCRIPTION

Indapamide is an oral antihypertensive/diuretic. Its molecule contains both a polar sulfamoyl chlorobenzamide moiety and a lipid-soluble methylindoline moiety. It differs chemically from the thiazides in that it does not possess the thiazide ring system and contains only one sulfonamide group. The chemical name of indapamide is 1-(4-chloro-3-sulfamoylbenzamido)-2-methylindoline, and its molecular weight is 365.83. The compound is a weak acid, pK_a=8.8, and is soluble in aqueous solutions of strong bases. It is a white to yellow-white crystalline (tetragonal) powder.



$C_{16}H_{16}ClN_3O_3S$

Each tablet, for oral administration, contains 1.25 mg or 2.5 mg of indapamide and the following inactive ingredients: anhydrous lactose, colloidal silicon dioxide, hydroxypropyl methylcellulose, magnesium stearate, microcrystalline cellulose, polydextrose, polyethylene glycol, pregelatinized starch, sodium lauryl sulfate, and titanium dioxide. Additionally, the 1.25 mg product contains glyceryl triacetate and D&C Red No. 30 Aluminum Lake and the 2.5 mg product contains triacetin.

CLINICAL PHARMACOLOGY

Indapamide is the first of a new class of antihypertensive/diuretics, the indolines. It has been reported that the oral administration of 5 mg (two 2.5 mg tablets) of indapamide to healthy male subjects produced peak concentrations of approximately 260 ng/mL of the drug in the blood within two hours. A minimum of 70% of a single oral dose is eliminated by the kidneys and an additional 23% by the gastrointestinal tract, probably including the biliary route. The half-life of indapamide in whole blood is approximately 14 hours.
Indapamide is preferentially and reversibly taken up by the erythrocytes in the peripheral blood. The whole blood/

Continued on next page