

Captopril Shortage

Background:

Supply of captopril tablets is limited following the discontinuation of Teva's products and ongoing manufacturing disruptions affecting several Apotex strengths.¹ While oral solution formulations remain available, tablet supplies are expected to become increasingly constrained over time. The Tier Assignment Committee determined that this shortage does not currently meet the criteria for a Tier 3 shortage. For the current status of drug shortages and discontinuations, refer to Drug Shortages Canada at www.healthproductshortagescanada.ca.

Captopril Supply Situation

Table 1: Captopril Product Comparison^{2,3}

Product	Strength	Manufacturer	Notes
Captopril Tablet	12.5mg, 25mg, 50mg, 100mg	Teva	Teva has discontinued all captopril tablet strengths
Captopril Tablet	12.5mg, 25mg, 50mg, 100mg	Apotex	Current shortage of 25mg and 50mg strengths Manufacturing disruption anticipated for the 12.5mg and 100mg tablets.
Captopril Oral Suspension	5 mg/5 mL 25 mg/5 mL	Ethypharm	Available but is not expected to offset national tablet demand.

Practice Considerations

Healthcare professionals should consider the following actions while shortages persist:

- Reserve remaining captopril tablet inventory for patients with limited therapeutic alternatives, including:
 - Patients with advanced heart failure requiring short-acting ACE inhibition.
 - Infants and young children requiring individualized ACE inhibitor titration.
 - Other patients where a short-acting ACE inhibitor provides a distinct clinical advantage.
- Prioritize use of available oral solution formulations for patients unable to swallow tablets or requiring liquid dosage forms, recognizing that national supplies are insufficient to replace tablet demand.
- Transition appropriate patients to alternative ACE inhibitors. There is no direct milligram-to-milligram conversion between ACE inhibitors. Table 2 provides typical starting maintenance equivalents and should be individualized based on indication, renal function, blood pressure, and clinical response.
- Limit new starts of captopril
- Monitor renal function, serum potassium, blood pressure, and clinical response following conversion to an alternative ACE inhibitor.
- Engage cardiology, nephrology, neurology, and pediatric specialists when managing complex patients or those with limited therapeutic alternatives.

Table 2: Approximate ACE Inhibitor Conversion Guide⁴

Current Captopril Daily Dose	Approximate Equivalent Starting Daily Dose*
25 mg/day	Enalapril 2.5–5 mg/day • Lisinopril 2.5–5 mg/day • Ramipril 1.25–2.5 mg/day
50 mg/day	Enalapril 5 mg/day • Lisinopril 5 mg/day • Ramipril 2.5 mg/day
75 mg/day	Enalapril 5–10 mg/day • Lisinopril 10 mg/day • Ramipril 2.5–5 mg/day
150 mg/day	Enalapril 10–20 mg/day • Lisinopril 20 mg/day • Ramipril 5–10 mg/day

Therapeutic Alternatives

Depending on the indication, possible alternatives to captopril may include:

Cardiovascular Indications^{5,6}

Clinical Situation	Considerations
Hypertension	Most patients can be converted to another ACE inhibitor (e.g., enalapril, lisinopril, ramipril) or an ARB if clinically appropriate.
Heart failure	Most stable patients can transition to longer-acting guideline-directed ACE inhibitors, ARBs or ARNIs according to current heart failure guidelines.
Acute heart failure requiring short-acting ACE inhibition	Captopril remains uniquely useful because of its short half-life and ability to rapidly assess tolerance before initiating longer-acting RAAS inhibitors. Hydralazine may be considered when appropriate but does not reliably predict tolerance to ACE inhibitors, ARBs or ARNIs. Consultation with cardiology is recommended.
Post-myocardial infarction	Alternative ACE inhibitors may generally be substituted based on patient-specific factors.

ACE Inhibitors (Angiotensin-Converting Enzyme Inhibitors); ARBs (Angiotensin II Receptor Blockers); ARNIs (Angiotensin Receptor-Nepriylsin Inhibitors); RAAS (Renin-Angiotensin-Aldosterone System)

Pediatric Indications^{7,8}

Patient Population	Considerations
Infants and young children	Captopril may be preferred because of its short half-life, particularly during dose titration. Remaining inventory should be prioritized where clinically necessary.
Older pediatric patients	Liquid enalapril and liquid lisinopril are potential alternatives for many patients. Consultation with pediatric cardiology is recommended before switching therapy.

Neurological Indications (Autonomic Dysreflexia, Acute Stroke)^{9,10}

Alternative	Notes
IV enalaprilat	Appropriate where intravenous ACE inhibition is required.
IV labetalol	Common alternative depending on patient-specific contraindications.
IV hydralazine	May be appropriate in selected patients.
Sublingual nifedipine	May be considered when appropriate but carries risk of rapid blood pressure reduction.
Sublingual nitroglycerin	Alternative in selected patients; use cautiously because of potential precipitous hypotension.

References

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