MINUTES OF THE TENTH MEETING OF THE MEDICINES CLASSIFICATION COMMITTEE HELD IN THE PORTLAND TOWERS HOTEL, HAWKESTONE STREET, WELLINGTON ON WEDNESDAY 11TH NOVEMBER COMMENCING AT 10AM.

PRESENT

Dr S Martindale (Chairperson)
Dr M Herbert
Dr J Wilcox
Ms L McLauchlan
Mr G Caves
Mr R Griffith
Mrs C Smith (Secretary)

IN ATTENDANCE

Dr R Boyd (Part of the afternoon session only)

WELCOME

Dr Martindale declared the meeting open at 10:20am and welcomed members. She explained that the new structure of the Department of Health had come into operation at the beginning of that week and she outlined the position of the Therapeutics Section as part of the Health Regulation and Protection group. Dr Martindale pointed out that although the structure of the Department had changed, the role of the Therapeutics Section remained essentially the same as before.

Dr Martindale also spoke of her recent discussions with Australian counterparts who deal with the scheduling and also the labelling and packaging of medicines in Australia and she outlined the system used in Australia. She said that the Department could soon expect a formal invitation for New Zealand to have a representative on the Australian scheduling committee to facilitate harmonisation between the two countries.

Dr Martindale then moved on to explain that this meeting was mainly to tidy up outstanding matters and to establish procedures both for making submissions to the committee and for assessing those submissions. With this in mind she stated that it would be more appropriate to move these items forward on the agenda so that the procedures adopted could be applied to the submissions on this agenda.

APOLOGIES

There were no apologies.

CONFIRMATION OF THE MINUTES OF THE NINTH MEETING

The minutes were confirmed and signed subject to the following amendments:

p2 Berberine. Delete from the last sentence the words "to be consistent with other quaternary ammonium compounds".

p5 Naproxen. Delete the last sentence referring to other companies who make similar applications.

p8 Beclomethasone dipropionate. Add "Nasal Preparations" to the heading.

p9 Prochlorperazine. In the first sentence replace the word "requested" with "presented a submission for ".

p11 Cetirizine. "remain" should be replaced with "become".

p11 Sennosides. replace "encouraged" with "preferred".

CORRESPONDENCE

Codeine

The secretary wrote to Sterling Pharmaceuticals requesting that they attempt to reformulate Panadeine in order to make the codeine less readily extractable. The company replied that they had been looking into the matter for some time. Committee members acknowledged that any possible change here would not be in the immediate future.

Ms McLauchlan asked if there had been any progress in resolving the matter of whether or not codeine-containing compounds would remain available over-the-counter. Dr Martindale replied that the matter had not yet been resolved.

PROCEDURES FOR CLASSIFICATION CHANGE

Dr Martindale explained that high expectations are placed on the committee to justify clearly the classification recommendations made. For that reason it would be easier for the committee if the quality of information submitted could be of a higher and more uniform standard. She thought it was reasonable to request this from the company making the submission.

Dr Martindale informed the committee that the Department was committed to providing a greater input as a cross-check to the information supplied by companies and that committee members were also being asked to approach the task in a more analytical manner in order to provide high quality recommendations of a uniform standard.

The committee considered the draft prepared by the secretary and agreed upon the following procedures:

SUBMISSIONS FOR CLASSIFICATION CHANGE

A submission for the reclassification of a medicine should include the following information:

Part A

i International Nonproprietary Name, British Approved Name or US Adopted Name of the medicine
ii Trade Name(s)
iii Name of company/organisation requesting reclassification
iv Dose form(s) and strength(s)
v Pack size and other qualifications
vi Indications for which change sought
vii Present classification of medicine
viii Classification sought
ix Classification status in other countries (esp Aus, UK, USA, Canada)
x Extent of usage elsewhere(eg sales volumes) and dates of registration

Part B

Reasons for requesting classification change.

This section should be supported where relevant by the following:

i A statement of the benefits, to both the individual and to the public, expected from the proposed change

ii Ease of self-diagnosis or diagnosis by a pharmacist for the condition indicated

iii Relevant comparative data for like compounds

iv Local data or special considerations relating to NZ

v Interactions with other medicines

vi Contraindications

vii Possible resistance

viii Adverse events - nature, frequency etc

ix Potential for abuse or misuse

CRITERIA FOR CLASSIFICATION OF A NEW CHEMICAL SUBSTANCE

A new chemical substance should be classified as a prescription medicine until it has been used widely. This will usually require a period of use over three years in at least one developed country on the grounds that most adverse events will have manifested themselves within this period.

CRITERIA FOR RECLASSIFICATION AS AN OVER-THE-COUNTER MEDICINE

A NEW CHEMICAL ENTITIES

To qualify for OTC status a relatively new chemical entity should:

1 Have been marketed by prescription for three years
2 Have had wide use during those three years
3 Have a record of adverse medicine reactions which is not alarming and which has not shown undue increase over the three years.
4 Qualify under the definition for suitability as an OTC medicine

B OTHER PRESCRIPTION MEDICINES

The committee agreed to adopt the proposed EC definition for qualification as an OTC medicine:

Medical products which may be available without prescription shall show a substantial safety in use in the treatment of minor ailments or symptoms, usually capable of rapid and spontaneous relief, which are easily identifiable by users and do not justify a medical consultation.

CRITERIA FOR CLASSIFYING OTC MEDICINES

The committee decided on the following criteria as being suitable topics for consideration when determining whether a medicine should be classified as Restricted, Pharmacy-Only or General Sales. The use of a points system to grade the medicine in question was discarded on the basis of its being too mechanical and that some areas would be more heavily weighted than others. It was agreed that some degree of judgment was necessary when classifying a medicine and that a suitable level of classification would probably become self-evident if the agreed criteria were used. Members also felt that use of the checksheet, amended to incorporate the improvements decided at the meeting, would help to make the appropriate classification clear.

1 **consumer convenience:** accessibility and suitability for self-treatment. Accessibility to include time and location factors. Conditions for self-treatment usually to be minor and self-limiting.

2 **potency:** the ability of a medicine to produce a wanted pharmacological effect

3 **current availability:** availability of products with a similar therapeutic purpose

4 **therapeutic index:** the margin between therapeutic and toxic effects

5 **toxicity:** the potential of a substance to produce adverse preclinical and clinical effects. Adverse clinical effects assessed by frequency and severity

6 **abuse potential:** use of a medicine for gratification-producing effects not required for therapy

7 **inappropriate use:** factors relevant to the minor ailment or symptom for which the medicine is indicated, including the suitability of the condition to be monitored by the patient; likelihood of misdiagnosis

8 **precautions:** factors relevant to the medicine under consideration such as contraindications, side-effects, interactions with other medicines

9 **communal harm:** the possibility of community harm resulting from wider use of the medicine in question, for example, the development of antibiotic resistance in bacteria

MATTERS ARISING

(1) Ibuprofen

Dr Martindale reminded members that a delay had been requested by the Boots Company to allow that company adequate time to produce its submission. It was noted that two companies had now made submissions for ibuprofen to remain as a Pharmacy-Only Medicine.

Members agreed that insufficient evidence had been found to justify a change of classification and that ibuprofen up to 200mg per tablet or capsule should remain a Pharmacy-Only Medicine.

However, it was noted that a constant watch should be kept on this medicine and that it would be returned to the agenda if any material emerged which was of a nature to cause concern.

(2) Ketoprofen

Rhone-Poulenc Rorer requested that if ibuprofen was not reclassified to a more restricted classification they wished ketoprofen to be treated in the same way as ibuprofen so that the 25mg ketoprofen tablet become a Pharmacy-Only Medicine.

Members agreed that for this to happen, ketoprofen would have to be shown to be as safe as ibuprofen.

The committee noted that the adverse reaction profiles for the two medicines are not the same. According to the CSM Update in the British Medical Journal of 3 May 1986, ketoprofen has three times the adverse reaction rates of ibuprofen.

Members also felt that as 25mg ketoprofen in limited pack sizes had been so recently reclassified as a Restricted Medicine (August 1992), there was a need to observe its use as an over-the-counter medicine before further relaxing its availability.

The recommendation was for no change to the classification of ketoprofen. That is, 25mg tablets in packages of up to 30 tablets should remain Restricted Medicine and that packages of more than 30 tablets should remain Prescription Medicine.

(3) Chloramphenicol for eye use

The Ophthalmological Society was consulted about chloramphenicol for eye use becoming available as a Restricted Medicine. The Society was strongly against such a move (see letter of 19 Aug 1992). A similar view was expressed by The NZ General Practitioners' Association (8 Sept 1992) and Dr G Gardiner of Blenheim (20 May 1992)

Ms McLauchlan expressed a strong view that this was an area in which she felt pharmacists were capable of making a diagnosis and that it was in their best interests not to misdiagnose. She did not believe that arguments put forward were satisfactory and still saw a place for OTC availability for chloramphenicol for use in the eye.

However, the committee recommended that, on the basis of advice sought from the Ophthalmological Society, chloramphenicol for eye use should remain a Prescription Medicine.

(4) Trimethoprim

Responses were received from Wellcome (15 Sept 1992) and from Dr Ross Bailey of Christchurch Hospital (29 Sept 1992). Both were against having trimethoprim made available over the counter as a single dose treatment for urinary tract infection.

Dr Wilcox agreed with Dr Bailey as did Dr Herbert who queried whether or not a singe dose would be sufficient as a single dose usually resulted in a relapse of the condition.

Ms Mclaughlan was strongly in favour of a single dose being available, suitably labelled and packaged for sexually active women. Mr Caves concurred with that view.

Dr Boyd said that the matter could be flagged as one suitable for consideration if wider prescribing rights were accorded under the new legislation. He suggested that companies could obtain a more favourable result if a presentation were made of the product ready packaged and labelled for a specific purpose.

Dr Martindale added that this type of presentation would tie in with the concept of a product licence system.

The recommendation was that, on the basis of outside information received, there be no change to the classification of trimethoprim.

(5) Metoclopramide

This was returned to the agenda in spite of the recommendation for Restricted Medicine classification at the last meeting. Metoclopramide had been considered as a preferable treatment to prochlorperazine but there was thought to have been insufficient discussion of metoclopramide in its own right as a suitable OTC treatment for nausea associated with migraine.

Dr Martindale commented that SmithKline Beecham who market metoclopramide did not consider it a suitable medicine for OTC sale.

Mr Griffith agreed with the company on the grounds of toxicity.

Ms McLauchlan was in favour of derestriction on the grounds that the medicine would be labelled and packaged for a specific purpose, that is, for adults only and for the treatment of nausea associated with migraine.

Dr Wilcox was of the opinion that it was better to treat the migraine itself and that if the headache were treated the nausea would go away. He was unhappy about the extrapyramidal effects of metoclopramide.

The recommendation was that metoclopramide remain a Prescription Medicine because of its adverse reaction profile and extrapyramidal effects.

Dr Martindale added that the move towards a system of product licensing will help solve the problems associated with medicines intended for sale at the restricted end of the OTC market.

(6) Cimetidine Effervescent 200mg

The Secretary explained that all effervescent H_2-receptor antagonists had been removed from the Drug Tariff and that this was behind SmithKline Beecham's appeal against the recommendation of the MCC at the May meeting for this product to remain on prescription.

Mr Griffith then described the situation in Denmark which he had visited recently and which appeared to be the only country where cimetidine, and also ranitidine, was available without prescription. Mr Griffith said that although cimetidine and ranitidine were available OTC in Denmark, most of that used was on prescription. He said that the Danish National Board of Health believed that OTC use was mainly short-term. A Danish hospital study over two years comparing

pre- and post- reclassification figures found no increase in admissions from gastro-intestinal bleeding.

Mr Griffith had also discussed the matter with Dr Gavin Kelloway who could see no reason why cimetidine or any of the other H_2-receptor antagonists should not be made available OTC.

After discussion the committee decided it was generally in favour of derestriction in this area but that more specific detail was needed on pack sizes, dosage and the wording of indications. Members also recognised that cimetidine might not necessarily be the most suitable H_2-receptor antagonist for derestriction in view of its potential to enhance the effects of alcohol.

The following action was decided upon:

i The Department of Health will consult with one or more specialists on
   a) cimetidine 200mg effervescent
   b) all H_2-receptor antagonists

-in respect of indications, dosages, strengths, pack sizes, warnings, whether or not in combination with an antacid and any other considerations relevant to a view as to what would be most appropriate for OTC availability.

ii The Department will consult with companies marketing H_2-receptor antagonists

iii The Department of Health will write to the Ministry of Transport seeking its comments on possible derestriction in view of the interaction between cimetidine and alcohol and a caution proposed in the package insert.

iv The specialist report on cimetidine and/or other H_2-receptor antagonists will be considered in a postal review by committee members.

If the members are unanimously in favour of derestriction the consultant's recommendation will be implemented before the next meeting. If not, the matter will be returned to the agenda at the next meeting.

(7) Erythromycin for topical use

On the basis of the advice of Dr Richard Meech (see letter of 8 August 1992), the committee recommended that erythromycin remain a Prescription Medicine.

(8) Benzoyl peroxide

As resolved at the last meeting, the secretary wrote to Reckitt and Colman requesting evidence that the 10% strength is as safe as the 5% strength of benzoyl peroxide. The company has not replied and no further action is required.

SUBMISSIONS FOR CLASSIFICATION CHANGE

(1) Piroxicam

The committee agreed that piroxicam has quite a different adverse reaction profile from those other NSAIDs already derestricted. They noted that it had a long half-life and a narrow therapeutic index. Members saw it more suited to the long-term treatment of conditions requiring medical intervention. Members also considered the toxicity too high for the treatment of dysmenorrhoea.

The recommendation was for piroxicam to remain a Prescription Medicine.

(2) Antibiotic preparations

The committee felt that there was nothing to be considered in the form in which this topic was presented by the Pharmacy Guild in their letter of 31 August 1992. The Guild is to be asked to make a submission in the new format established earlier in the meeting.

(3) B_2-adrenergic preparations

As for the item above, members felt there was nothing to be considered at this time. The committee felt there was little purpose in asking the Guild to make a submission as asthma is not a self-limiting condition and is an inappropriate indication for diagnosis by a pharmacist. In view of world-wide concern over the inappropriate use of these medicines and deaths associated with fenoterol and maybe some other inhaled preparations, members thought there would be little prospect of B_2-adrenergic preparations becoming more widely available over the counter.

(4) **Benzyl benzoate**

Parke Davis requested a change in the classification of benzyl benzoate when used as an excipient in order to make their Anusol products General Sale Medicines in line with Australia.

The committee agreed to leave it to the Department to fix a suitable level below which benzyl benzoate could become a General Sale Medicine. This level should be 10% or less and should just cover the Parke Davis requirement.

NEW MEDICINE FOR CLASSIFICATION

Lithium succinate for external use

The recommendation was for this to be classified as a Prescription Medicine on the basis of the newness of the medicine and the reasons given in the letter from the company (4 Sept 1992).

SUGGESTED ITEMS FOR THE NEXT MEETING

No new items were suggested though it was noted that H_2-receptor antagonists could be on the agenda.

GENERAL BUSINESS

Warrant system and prescribing rights

Mr Griffith commented that the matter of the warrant system and of prescribing rights had not been dealt with from the last meeting.

Dr Martindale explained that the possibilities for dealing with these matters lay in the new legislation. Members asked that any material be made available and Dr Martindale agreed to provide a progress report at the next meeting.

Dr Wilcox added that, in connection with the issue of prescribing rights, he had made a study on nursing training. He agreed to make this available to all members.

Terfenadine and other antihistamines

Mr Griffith noted that at the last meeting the recommendation to reclassify terfenadine as a General Sales Medicine had been reversed due to information coming to hand about possible cardiac effects. For this reason the reclassification of loratadine and astemizole was also postponed.

Mr Griffith suggested that the secretary of the Medicines Adverse Reactions Committee should be approached in order to see if there was any more information on the adverse cardiac effects of terfenadine.

He also suggested that the secretary write to Schering Plough informing them that loratadine would be on the agenda for the next meeting as a possible candidate for General Sales classification.

Members agreed to both courses of action.

Nicotine in Gum and Patches

Mr Griffith asked what progress had been made to find a way of making these products available through anti-smoking clinics.

Dr Martindale replied that as co-ordinator of the legislation review project she had received a letter from the sectretary about this and that the matter had been noted.

Mr Griffith suggested that as there was a case for these products being available other than as Pharmacy-Only, the secretary should contact the professional body for clinical psychologists. The secretary should enquire whether or not provision by a registered member of their society would be a desirable move from the point of view of the society and whether it would provide wide enough coverage of anti-smoking clinics.

The secretary pointed out that some concern had been expressed about the safety of patches when users continued to smoke and about the addictive potential of the gum. She said it was possible that a submission could be made at the next meeting to have the availability further restricted.

Lignocaine

The Pharmacy Guild had expressed concern that the 2% cut-off point for lignocaine for external use allowed a preparation presented in a urethral syringe to be sold as a General Sale Medicine.

Members thought that there should be no cause for concern as the company would be highly unlikely to market the product through a supermarket or similar outlet.

Dr Wilcox pointed out that further restriction would limit the sale of the product by district nurses and could cause disadvantage.

The committee concluded that there was no potential for harm with the current classification and that if a problem did arise it could be dealt with accordingly.

Reference list of Specialist Consultants

Dr Martindale suggested that as time was running short this matter could be dealt with by post. It was agreed that the Department list of specialists be circulated to members and a final list complied after their comments had been received.

Atropine

Ms McLauchlan queried the discrepancies in the classification of atropine.

The secretary replied that the Department was aware of the problem and that it was on the list of matters to be attended to.

Next Meeting

Dr Martindale suggested that the committee meet again the following March at the earliest. The secretary would arrange a suitable date in the new year.

The Meeting closed at 4.45pm.