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Prescriber Update

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MINISTRY OF HEALTH
MANATŪ HAUORA

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Dextropropoxyphene withdrawal on 1 August 2010 – a reminder

Healthcare professionals are reminded that the consent to distribute dextropropoxyphene containing medicines (Capadex and Paradex) will be revoked on **1 August 2010**. From this date it will no longer be legal to sell, distribute or advertise these medicines unless exempted under the Medicines Act 1981.[1]

This decision follows a review by the Medicines Adverse Reactions Committee (MARC), which concluded that the risks of these medicines outweigh their benefits.[2]

Medsafe advises prescribers not to start any new patients on Capadex or Paradex. Patients currently taking these medicines should be reviewed at the earliest opportunity.

The Best Practice Advocacy Centre (bpac^{NZ}) has recently issued the following advice for transferring patients from dextropropoxyphene[3]:

- Most patients can be transferred to full doses of paracetamol alone. If pain relief is not sufficient, the next step is to add a weak opioid such as codeine (or use a combined paracetamol/codeine preparation). Alternatively, codeine alone could be trialed.
- Oxycodone should not be prescribed in place of dextropropoxyphene unless there has been an inadequate response to a weak opioid. Oxycodone is a strong opioid and is only indicated as an alternative to morphine on step three on the WHO analgesic ladder.

As dextrpropoxyphene is a weak opioid it is possible that some patients may experience a withdrawal reaction upon abruptly stopping treatment. Should a patient experience a severe withdrawal reaction advice may be sought from a local alcohol and drug dependency service.

Further advice about transferring patients from dextropropoxyphene is planned in the next edition of *Best Practice Journal*.

From 1 August 2010 Capadex and Paradex can only be legally supplied in New Zealand under the provisions in the Medicines Act 1981 that relate to the supply of unapproved medicines (sections 25 and 29). Further information on the use of unapproved medicines in New Zealand is available from the Medsafe website at: **www.medsafe.govt.nz/profs/RIss/unapp.asp**

A copy of Medsafe's risk:benefit review of dextropropoxyphene and a Question and Answer document is available at: **www.medsafe.govt.nz/hot/MediaContents.asp**

References

1. Medsafe. DHCPL dated 26 March 2010. Available at: **www.medsafe.govt.nz/hot/media/2010/LtrtoHPCapadexandParadex.pdf**
2. MARC minute item for dextropropoxyphene, December 2009. Available at: **www.medsafe.govt.nz/profs/adverse/Minutes140.htm#3.1**
3. bpac^{NZ}. 2010. Dextropropoxyphene containing medicines to be withdrawn. Best Practice Journal. 26: 44.

Methylphenidate – updated guidance when treating children

The MARC has reviewed recent changes to the European product information for methylphenidate and has recommended that the New Zealand data sheets be updated to include these changes. The updated data sheets will shortly be published on the Medsafe website at: **www.medsafe.govt.nz/profs/Datasheet/dsform.asp**

The changes outline that patients being considered for methylphenidate treatment should be carefully screened for cardiovascular risk, heart disease and psychiatric disorders, including any family risk factors.

New contraindications (do not use in patients with) include:

- Diagnosis or history of severe depression, anorexic disorders, suicidal tendencies, psychotic symptoms, severe mood disorders, mania, schizophrenia, psychopathic/borderline personality disorder.
- Pre-existing cardiovascular disorders.
- Pre-existing cerebrovascular disorders.

Patients for whom methylphenidate treatment is deemed appropriate should be carefully monitored as follows:

- Blood pressure should be recorded at every dose adjustment and then at least every six months; pulse should also be recorded.

- Height, weight and appetite should be recorded at least every six months. Patients who are not gaining height or weight as expected may need a treatment break.
- Patients who develop symptoms suggestive of heart disease should undergo prompt specialist cardiac evaluation.
- Prescribers and pharmacists should look out for signs of diversion, misuse and abuse of methylphenidate.

Methylphenidate can cause or worsen some psychiatric disorders such as depression, suicidal thoughts, hostility, anxiety, agitation, psychosis and mania. Psychiatric well being should therefore be monitored in patients being treated with methylphenidate.

Further information on monitoring the psychiatric well being of young people is available in a special edition of the Best Practice Journal published in January 2010 (**www.bpac.org.nz/magazine/2010/youngdep/youngdep.asp?section=2**). This information is also included in the Ministry of Health's funded module of bpac's decision support software.

It is also important to remember that the long-term effects of methylphenidate treatment in children are not fully understood. For patients who require long-term treatment (more than 12 months) the data sheets will recommend that a treatment holiday occur at least once a year. A treatment holiday will help determine whether methylphenidate treatment needs to be continued.

Cough and cold medicines update and reminder

With winter approaching, healthcare professionals are reminded that medicines intended for the treatment of the symptoms of the common cold should not be used in children under six years of age if they contain one or more of the following substances:

guaifenesin	phenylephrine	doxylamine
ipecacuanha	brompheniramine	promethazine
dextromethorphan	chlorphenamine	triprolidine
pholcodine	diphenhydramine	pseudoephedrine

In addition medicines containing bromhexine, oxymetazoline and xylometazoline should not be used in children under two years of age.

Due to the long lead times between products being manufactured and their retail availability, medicines with updated package labelling may not start to appear until later this year. The deadline for updated package labelling is **May 2011**. Although the gradual change in product labelling may cause some confusion, Medsafe considers this is the best way to ensure these products remain available for adults over the coming winter season.

In its review, the Cough and Cold Review Group also recommended that children with colds should be allowed to rest, be made comfortable and be given plenty of fluids. In some cases it may be appropriate to use saline nose drops, or to give honey drinks to children over one year of age to help soothe a cough.

The Medicines Classification Committee (MCC) recently reviewed a submission to reclassify medicines containing dextromethorphan, guaiphenesin, ipecacuanha and phenylephrine, indicated for the treatment of the symptoms of the common cold. The outcome of the Committee's review will be published separately.

Tramadol – key points for prescribing

Tramadol will be fully funded in New Zealand for the first time from **1 June 2010**. Medsafe wishes to take this opportunity to provide a summary of key points for prescribers who are considering treatment with tramadol.

Prescribers are encouraged to familiarise themselves with the complete prescribing information for tramadol available on the Medsafe website at: **www.medsafe.govt.nz/profs/Datasheet/dsform.asp**

Tramadol is a synthetic opioid analgesic indicated for the treatment of moderate to severe pain at step 2 of the WHO analgesic ladder. Importantly tramadol inhibits the reuptake of serotonin and noradrenaline in addition to its opioid action.

The maximum daily dose of tramadol should not exceed 400 mg per day; however the elderly (over 75 years of age) and those with renal or hepatic impairment usually require lower doses.

Tramadol should not be used in patients:

- With acute intoxication with alcohol, hypnotics, analgesics, opioids or psychotropic medicinal products.
- Who are receiving monoamine oxidase inhibitors (MAOIs) or have taken them in the past 14 days.
- With epilepsy not adequately controlled by treatment.
- With severe renal impairment (creatinine clearance <10 mL/min).

Although tramadol causes less respiratory depression and addiction than codeine or morphine, it may increase the risk of nausea and vomiting, sedation and dizziness.[1] Tramadol can induce convulsions and increase the potential for selective serotonin re-uptake inhibitors, tricyclic antidepressants, antipsychotics and other seizure threshold lowering agents to cause convulsions.[2]

Tramadol is also known to cause Serotonin Syndrome when used concomitantly with other medicines that increase serotonin levels. A list of such medicines was provided in a previous *Prescriber Update* article.[3]

As at 14 April 2010, the Centre for Adverse Reactions Monitoring (CARM) had received a total of 162 reports associated with tramadol use. These reports include cases of Serotonin Syndrome, seizures, hyponatraemia, respiratory depression and hypotension in association with tramadol use. There have also been reports of increased INR and/or bleeding when used concomitantly with warfarin.

As with all medicines and vaccines, healthcare professionals are encouraged to report all suspected serious and unexpected adverse reactions associated with tramadol treatment to CARM.

References

1. Best Practice Advocacy Centre. (2008). WHO analgesic ladder: Which weak opioid to use at step two? *Best Practice Journal*. 18: 20-23.
2. Arrow Pharmaceuticals (NZ) Limited. 14 January 2010. Arrow-Tramadol (tramadol hydrochloride) data sheet. **http://www.medsafe.govt.nz/profs/Datasheet/a/arrowtramadolcap.pdf**
3. Savage R. (2007). Serious reactions with tramadol: Seizures and Serotonin Syndrome. *Prescriber Update*. 28(1): 11-13. **http://www.medsafe.govt.nz/profs/PUArticles/TramSerious.htm**

Omeprazole and risk of hypomagnesaemia

Healthcare professionals are advised that an association between omeprazole treatment and hypomagnesaemia has been identified. The data sheets for medicines containing omeprazole are in the process of being updated to include information about this association.

A safety signal was initially detected from adverse reaction reports describing cases of hypomagnesaemia in patients taking omeprazole. In 2008, two case reports of hypomagnesaemia and hypocalcaemia were identified by CARM; however at the time there was insufficient evidence to confirm an association. Since then a growing body of evidence has confirmed this association, including a further report of hypomagnesaemia to CARM, and the publication of case reports in the literature[1-3], and by the Netherlands Pharmacovigilance Centre.[4]

Most case reports of hypomagnesaemia have been associated with long-term use of omeprazole at normal doses (20-40 mg per day); magnesium levels normalised after stopping treatment. Reports of hypomagnesaemia were usually also associated with hypocalcaemia, with some patients displaying symptoms of severe hypocalcaemia and hypomagnesaemia (seizures, cardiac arrhythmia, tetany, severe vomiting leading to other electrolyte disturbances and psychiatric symptoms).

Magnesium has an important influence on calcium homeostasis through decreased parathyroid hormone secretion and diminished responsiveness of skeletal and renal tissue to parathyroid hormone.[4] Although the mechanism by which omeprazole induces hypomagnesaemia is unclear it has been postulated that it may be due to reduced absorption of magnesium through an active transport mechanism.[1]

Medsafe advises healthcare professionals to be alert to the possibility of hypomagnesaemia in patients taking omeprazole and displaying symptoms such as muscle cramps, weakness, irritability or confusion.

References

1. Cundy T, Dissanayake A 2009. Severe hypomagnesaemia in long-term users of proton-pump inhibitors *Clin Endocrinol. (Oxf.)* 69(2): 338-41.

2. Epstein M, McGrath S, Law F 2006. Proton-pump inhibitors and hypomagnesemic hypoparathyroidism *N Engl J Med* 355(17): 1834-6.

3. Shabajee N, Lamb EJ, Sturgess I, Sumathipala RW 2008. Omeprazole and refractory hypomagnesaemia *BMJ* 337: a425.

4. The Netherlands Pharmacovigilance Centre. 2009. **http://www.lareb.nl/documents/kwb_2009_2_omepr.pdf**

Update on rotavirus vaccines

In May this year the manufacturer of RotaTeq informed Medsafe that DNA fragments of both PCV-1 and PCV-2 had been identified in the vaccine. This follows an alert in March this year that PCV-1 virus had been found in Rotarix vaccine, manufactured by GlaxoSmithKline.

There is no evidence to suggest that the presence of DNA fragments of PCV-1 and PCV-2 in rotavirus vaccines poses a safety concern for patients. PCV-1 and PCV-2 are types of porcine circovirus and are composed of a single strand of DNA. These viruses are commonly found in pigs; although PCV-2 may cause illness in pigs neither virus is known to cause illness in humans.

Having considered relevant scientific information Medsafe has concluded that the continued use of both rotavirus vaccines is supported by the weight of current evidence of safe use of these vaccines. This advice is consistent with the views of the US Food and Drug Administration (FDA) and the Australian Therapeutic Goods Administration (TGA).

Medsafe advises prescribers to have a balanced discussion with people who are seeking rotavirus vaccination for their children. Discussing the potential benefits of the vaccine and any theoretical risks associated with PCV will help them to make an informed decision.[1,2]

Medsafe will continue to monitor this issue and provide further information as it becomes available. This issue is specific to rotavirus vaccines Rotarix and RotaTeq and there is no evidence that other vaccines produced using similar techniques are affected.

References

1. Allan G, Ellis JA. Porcine circoviruses: a review. Journal of Veterinary Diagnostic Investigation. 12:3-14.

2. Tham KM, Hansen M. 2003. Detection of porcine circovirus types 1 and 2 in abattoir-slaughtered pigs in New Zealand. Surveillance. 30(1): 3-5.

Interaction: Sodium valproate and carbapenems – new information

Prescribers are reminded of the clinically significant interaction between carbapenem antibiotics (such as imipenem, meropenem and ertapenem) and sodium valproate. Although this interaction is well established, international reports suggest it is more severe than initially thought.

The interaction has been reported to result in a 60-100% decrease in valproate plasma concentration within two days and reduced therapeutic effect. The underlying mechanism of action is yet to be explained.[1]

Monitoring valproate plasma levels or adjusting the dose is unlikely to manage this interaction given its extent and rapid onset. Prescribers are therefore advised to avoid the use of carbapenem antibiotics in patients taking sodium valproate.

New Zealand data sheets are currently being updated to strengthen the warnings about this interaction.

References

1. European Medicines Agency. 28 January 2010. Monthly Report – Pharmacovigilance Working Party – January 2010 Plenary Meeting. **http://www.ema.europa.eu/pdfs/human/phvwp/3313810en.pdf**

Case report: Stevens-Johnson syndrome associated with the use of allopurinol

Prescribers are reminded that allopurinol should be discontinued immediately if a rash appears during therapy.

A recent report received by CARM describes a case of Stevens-Johnson syndrome in a patient taking allopurinol. The patient developed a rash shortly after beginning treatment and was admitted to hospital with general malaise, fever, and confusion. The rash progressed and a diagnosis of Stevens-Johnson syndrome was made; the patient subsequently died.

A skin reaction such as a pruritic, maculopapular rash occurs in approximately 10% of patients treated with allopurinol. More serious allergic reactions may rarely occur and include exfoliative dermatitis, Stevens-Johnson syndrome, and toxic

epidermal necrolysis. Skin reactions may be delayed and have rarely been followed by severe hypersensitivity reactions, which may be fatal.

Allopurinol data sheets recommend that treatment be withdrawn immediately if a rash or other signs of allergy occur.[1] Future treatment with allopurinol is not recommended.

Patients should be advised to consult a healthcare professional promptly if they develop any type of skin reaction while being treated with allopurinol.

References

1. Apotex NZ Ltd. 18 September 2008. Apo-Allopurinol (allopurinol) data sheet. **http://www.medsafe.govt.nz/profs/Datasheet/dsform.asp**

Codeine – classification and labelling changes

Changes are being made to the classification and labelling of codeine containing medicines following the recommendations of the Medicines Classification Committee (MCC).

These changes will mean that:

- Codeine, when used as an analgesic, will be restricted to sale by a pharmacist.
- Codeine, when used as an analgesic, can be sold by a pharmacist only if the product contains no more than 15 mg codeine per dose and no more than 5 days supply.
- A warning statement is added on product labels that codeine is an addictive substance and should not be used for more than three days.

The codeine classification changes will come into effect on **4 October 2010**. The deadline for labelling changes to be in place is **1 May 2011**. This date has been agreed with industry and aligns with the timeframe for changes to labels on cough and cold medicines. This timeline means label changes can be made without disrupting the supply of these medicines.

The Pharmaceutical Society of New Zealand has recently issued advice to pharmacists that all codeine containing medicines, regardless of indication, should now be moved behind the counter so as not to be available for self selection.

The change in classification does not apply to codeine containing medicines indicated for cough and colds, which will remain Pharmacy Only medicines.

Adverse reactions associated with intra-articular use of local anaesthetics

The US Food and Drug Administration (FDA) has recently reported that it has received post-marketing reports of chondrolysis in patients given continuous intra-articular infusions of local anaesthetics.[1] The local anaesthetics were infused for extended periods of time and were given with or without adrenaline to control pain following surgery.

Almost all of the cases reported to the FDA involved the shoulder joint, with a variable time to onset of symptoms of joint pain, stiffness, and loss of motion. There is currently no effective treatment for chondrolysis; these patients have required additional procedures including surgery.

In New Zealand, lignocaine solutions are indicated for the production of local or regional anaesthesia by the following techniques:

- Local infiltration.
- Minor or major nerve blocks.
- Epidural block.
- Arthroscopy.
- Intravenous regional anaesthesia.[2]

Although there have been no reports in New Zealand to date, prescribers are advised that lignocaine should not be used as a continuous infusion in the joint space to control pain following surgery.

Prescribers are reminded to report any suspected adverse drug reactions associated with intra-articular use of local anaesthetics to CARM.

References

1. FDA.13 November 2009 Updated 16 February 2010. Information for Health Professionals – Intravenous Promethazine and Severe Tissue Injury, Including Gangrene. **http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/DrugSafetyInformationforHeathcareProfessionals/ucm190302.htm.** Accessed 12 April 2010

2. Astra Zeneca Limited. 3 July 2007. Xylocaine injection data sheet. **http://www.medsafe.govt.nz/profs/Datasheet/x/XylocaineAndAdrenalineinj.htm**

Acitretin (Neotigason) – points to remember

Acitretin is a synthetic aromatic analogue of retinoic acid indicated for the treatment of severe psoriasis, disorders of keratinisation and other dermatoses responsive to etretinate.[1] Acitretin is an active metabolite of etretinate.

Acitretin should only be prescribed by physicians who are experienced in the use of systemic retinoids and understand the risks associated with treatment. A number of important precautions must be considered when prescribing this medicine.

Acitretin is highly teratogenic and is contraindicated in pregnant women and nursing mothers. It should not be used in women of childbearing potential unless a number of prescribing conditions are met (see Neotigason data sheet).

If acitretin is used in a woman of childbearing potential, pregnancy must be avoided for two years following discontinuation of therapy. Strict contraception must be used for one month prior to, during, and for 24 months after treatment. In addition alcohol must be avoided during and for two months after treatment due to an interaction that increases the concentration of etretinate. Etretinate is also highly teratogenic and has a longer half life than acitretin. The mechanism for this interaction is not yet understood.

Acitretin is also contraindicated in patients with severely impaired hepatic or renal function and in patients with chronic abnormally elevated blood lipids. Hepatic function, serum cholesterol and serum triglycerides should be assessed prior to starting acitretin treatment and regularly during therapy.

In patients receiving acitretin, concomitant administration of vitamin A and other retinoids must be avoided due to the risk of hypervitaminosis A. Combined use of tetracyclcines or methotrexate with acitretin must also be avoided.

As for all medicines, prescribers are encouraged to familiarise themselves with the information contained in the data sheet before prescribing acitretin.

References

1. Pharmacy Retailing NZ Ltd, trading as Healthcare Logistics. 4 February 2010. Neotigason (acitretin) data sheet. **http://www medsafe.govt.nz/profs/Datasheet/n/Neotigasoncap.pdf**

Warfarin – reports of serious adverse reactions continue

The risk of major bleeding events in patients prescribed a combination of warfarin and aspirin was highlighted in *Prescriber Update* in August 2009.[1] Despite this ACC continues to receive reports of serious injury in patients receiving warfarin, including cerebrovascular accidents that have resulted in severe disability.

The ACC reports include cases of warfarin being prescribed concomitantly with aspirin, and of warfarin being prescribed with other medicines known to increase the risk of bleeding.

Healthcare professionals are reminded to regularly monitor INRs in patients prescribed warfarin. Patients on warfarin should also be advised to consult with a healthcare professional before taking over-the-counter medicines in addition to warfarin.

This reminder reflects action taken by medicines regulators around the world. Most recently, the Medicines and Healthcare products Regulatory Agency (MHRA) has updated UK prescribing information to give clearer and up-to-date advice, particularly with respect to haemorrhage.[2] Although no new safety issues were identified by the MHRA, advice was issued to healthcare professionals in an attempt to reduce the risk of harm associated with warfarin use.

References

1. Medsafe. August 2009. Combination anticoagulants – increased bleeding risk. **http://www.medsafe.govt.nz/profs/PUArticles/Combination%20anticoagulants%20-%20increased%20bleeding%20risk.htm**

2. MHRA. December 2009. Warfarin: changes to product safety information. **http://www.mhra.gov.uk/Safetyinformation/Safetywarningsalertsandrecalls/Safetywarningsandmessagesformedicines/index.htm**

Zoledronic acid associated with adverse effects on renal function

Prescribers are advised that zoledronic acid is associated with reports of renal impairment and renal failure, especially in patients with pre-existing renal dysfunction.

Two products containing zoledronic acid are available in New Zealand. Aclasta (zoledronic acid 5 mg injection) is indicated for the prevention or treatment of osteoporosis and the treatment of Paget's Disease of the bone.[1] Zometa (zoledronic acid 4 mg injection) is indicated for the treatment of osteolytic, osteoblastic and mixed bone metastases of solid tumour in cancer of the breast or prostate, and in the treatment of hypercalcaemia of malignancy.[2]

The data sheets for both products contain warnings about renal impairment and renal failure.

The manufacturer of Aclasta has recently issued advice to healthcare professionals about reports of renal impairment and renal failure.[3]

Worldwide, as of August 2009, there have been 139 suspected reports of renal impairment or renal failure associated with Aclasta. The majority of cases were reported in patients with pre-exisitng medical conditions (advanced age, renal impairment, concurrent or preceding dehydration), or who had concurrent treatment with nephrotoxic agents such as NSAIDs and/or diuretics). The following is advised to reduce the risk of renal adverse reactions:

- Creatinine clearance should be measured before each dose.
- Aclasta should not be used in patients with a creatinine clearance < 35 mL/min.
- Transient increases in serum creatinine may be greater in patients with underlying impaired renal function.
- Monitoring renal function should be considered, particularly in at-risk patients.
- Zoledronic acid should be used with caution with other medicines that could impair renal function.
- Healthcare professionals should ensure that all patients, especially the elderly and those receiving diuretics, are adequately hydrated prior to receiving zoledronic acid.
- Zoledronic acid infusions should be administered over at least 15 minutes.

Further information is available from the data sheets available on the Medsafe website at: **www.medsafe.govt.nz/profs/Datasheet/dsform.asp**

References

1. Novartis New Zealand Ltd. 16 December 2009. Aclasta (zoledronic acid) data sheet.
2. Novartis New Zealand Ltd. 8 June 2009. Zometa (zoledronic acid) data sheet.
3. Novartis New Zealand Ltd. 11 March 2010. Aclasta (zoledronic acid 5mg) Renal Education Letter. [Further information is available from Novartis Medical Information and Communication Department, phone 0800 354 335.

Medicine recalls

This article outlines the medicine recall process in New Zealand and how to obtain information about specific recalls.

The Recall Process

Most recalls are initiated by a medicine supplier in response to information suggesting there is an issue relating to the quality of one or more batches of their product.

Where a recall may be required a risk assessment is performed by Medsafe and appropriate action is agreed upon with the supplier. When it is known where the affected product has been distributed, a recall will be conducted targeting only those organisations who have received affected supplies of the product. A recall may be to wholesaler, retail/hospital, healthcare professional or consumer level.

Every New Zealand manufacturer, supplier and wholesaler must have a pre-determined system for recalling a medicine. All recalls must be carried out with the knowledge and consent of Medsafe and in accordance with the Code of Good Manufacturing Practice (GMP) part V which deals with the conduct of recalls. The Code is available for download at no cost from the Medsafe website at: **www.medsafe.govt.nz/downloads/GMPPart5.pdf**

Once a recall has been agreed, the supplier submits a draft recall letter to Medsafe for approval. A template for recall letters is included in the Code of GMP. The recall letter must include the following information:

- The reason for the recall.
- The health risk associated with the issue (if known).
- A clear indication of the action required.
- The need to immediately quarantine and prevent further use of the medicine.
- The procedure to be followed in returning the medicine.
- An acknowledgement form to be returned confirming the letter has been received and acted on.

The supplier will then arrange to send the letter by fax or, depending on the circumstances, Medsafe may agree to another form of distribution. Any recalls conducted by telephone must be promptly followed up by written confirmation.

When a medicine needs to be recalled down to consumer level a supplier is expected to notify wholesalers, retailers and health professionals prior to a notice appearing in newspapers.

Healthcare Professional Responsibilities

The prompt return of recall acknowledgement forms by healthcare professionals is very important, even if no affected stock is held. These forms demonstrate that those who may have affected stock have been informed of the recall. This also allows the company to monitor how effective the recall was and take further action if required.

Once the supplier has completed the recall process (usually between six weeks and three months) a final report is provided to Medsafe. This report includes a summary of the actions taken, the response from healthcare professionals, and details of any action taken to prevent the issue happening again. Actions may include changes to how the product is manufactured.

Further information on the recall process can be obtained from the Compliance Management Branch at Medsafe (Ph 04-819-6800). Information about specific recalls is available on the Medsafe website at: **www.medsafe.govt.nz/hot/recalls.asp**

Alendronate case report – the importance of patient counselling

A recent case report to CARM serves as a reminder to all healthcare professionals that it is important for patients to understand how to take alendronate tablets correctly.

This case report involves a patient who was intellectually impaired who developed a large fungating painful soft tissue lesion in the right buccal sulcus while being treated with alendronate. The lesion, which had the appearance of a chemical burn, was believed to be due to the patient retaining the alendronate tablet in the buccal pouch.

Alendronate causes local irritation of the oesophageal mucosa and for this reason patients must understand how to take these tablets correctly: the tablet should only be swallowed upon arising for the day with a full glass of water, and the patient should not lie down for at least 30 minutes and until after their first food of the day.[1]

Healthcare professionals are advised to exercise caution in patients who may have difficulty with understanding how to take alendronate tablets correctly.

References

1. Merck Sharp & Dohme NZ Ltd. 29 June 2009. Alendronate (Fosamax®) data sheet. **http://www.medsafe.govt.nz/profs/Datasheet/f/Fosamaxtab.htm**

Medicine quality complaints

Complaints relating to the quality of medicines are reported to Medsafe by Consumers, Pharmacists, Wholesalers, Prescribers and the Pharmaceutical Industry.

Complaints are received for a wide range of issues. Examples of complaints reported to Medsafe include:

- Inactive tablets found in the active blister pockets of an oral contraceptive. This complaint led to a product recall.

- Inconsistent viscosity in an antibiotic suspension. This complaint led to the supplier changing the bottle to provide more headroom for shaking.
- Foreign particles found in antibiotic powder for suspension. This complaint led to a product recall.

Complaints may also relate to a labeling error, a crumbling tablet, a break in the cold chain, or identified failures of the product to meet specification.

When an issue relating to the quality of a medicine is identified, it should be reported promptly. This ensures the issue can be investigated and any corrective action, if it is necessary, can be taken quickly. Issues relating to the quality of specific products can sometimes be an indicator of a larger problem that requires addressing.

Medsafe assesses all complaints, with most complaints followed up with the supplier to ensure that the product continues to meet required standards. Medsafe may then request additional information from the supplier including copies of the batch manufacturing records or a health risk assessment of the issue.

All issues relating to the quality of a medicine do not necessarily result in a recall. Determining whether a product should be recalled depends on factors such as the potential of the issue to cause harm, the timing and extent of distribution, and the availability of alternative treatments.

Reporting a Problem

Issues that could indicate a problem with the quality of a medicine should be reported to either the Compliance Management Branch at Medsafe, to the company that distributes the product in New Zealand, or to both.

Questions about the quality complaints processes should be directed to the Compliance Management Branch (Ph 04-819-6800).

Complaints relating to the safety of medicines should be reported to CARM.

IMMP
INTENSIVE MEDICINES MONITORING PROGRAMME

INTENSIVE MEDICINES MONITORING PROGRAMME

Which medicines are currently being monitored?

Varenicline (Champix)

What to report

Please report **all clinical events** in patients taking **Varenicline**, including:

- any suspected adverse reaction
- deaths (including cause if known)
- any new clinical events, even if minor or common
- accidents
- change in a pre-existing condition
- abnormal changes in laboratory test results
- possible interactions.

Where to report

Please report all adverse events occurring with IMMP medicines to: IMMP, NZ Pharmacovigilance Centre, PO Box 913, Dunedin 9054. Use the reporting form provided with each edition of *MIMS New Ethicals* or download it from either the NZ Pharmacovigilance Centre or Medsafe websites: **http://carm.otago.ac.nz/reporting.asp** or **www.medsafe.govt.nz/Profs/adverse.asp**

Further information on IMMP is available at: **http://carm.otago.ac.nz/index.asp?link=immp**

CARM
CENTRE FOR ADVERSE REACTIONS MONITORING

Fax: (03) 479 7150
Phone: (03) 479 7247

Reporting form for Adverse Reactions to Medicines, Vaccines and Devices and all Clinical Events for IMMP

PATIENT DETAILS

HP3442

Surname:	First Name/s:	NHI No:	
Address:		Date of Birth:	Sex:
		Ethnicity:	

ALL MEDICINES IN USE *ASTERISK SUSPECT MEDICINE/S* Include over-the-counter (OTC) and alternative medicines

Medicine or Vaccine+batch no. (and brand name if known)	Daily Dose	Route	Date Started	Date Stopped	Reason for Use

DESCRIPTION OF ADVERSE REACTION OR EVENT

Date of onset: _____

Recovered ☐ Not yet recovered but improved ☐ Not yet recovered ☐ Unknown ☐ Fatal ☐ - Date of Death: _____

Severe? - Yes ☐ No ☐ Rechallenged? - No ☐ Yes ☐ Result: _____

OTHER FACTORS - Please tick or specify as appropriate

Renal disease ☐ Allergy ☐: _____ Other Medical Conditions: _____

Hepatic disease ☐ Nutritional Suppl or OTC use ☐: _____ Industrial Chemicals ☐: _____

REPORTER - Please tick as appropriate: Doctor ☐ Pharmacist ☐ Dentist ☐ Nurse ☐ Other ☐: _____

Name:

Address:

Signature: _____

Phone: _____ Date: _____

Send completed form to CARM

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