



*This is a monthly digest of local and overseas drug safety news and information released in the previous month. For the latest news and information, please refer to public announcements or the website of the Pharmaceutical Service of the Department of Health (<http://www.psdh.gov.hk>).*

## Safety Update

### **US: Recall of two lots of Topamax (topiramate) due to musty odour**

16 April 2011 - Ortho-McNeil Neurologics Division of Ortho-McNeil-Janssen Pharmaceuticals, Inc., recalled two lots of Topamax (topiramate) 100mg Tablets, which were distributed in U.S. and Puerto Rico. The recall stemmed from four consumer reports of an uncharacteristic odour thought to be caused by trace amounts of TBA (2,4,6 tribromoanisole). Although TBA was not considered to be toxic, it could generate an offensive odour and a small number of patients had reported temporary gastrointestinal symptoms. According to FDA, there had been no reports of serious adverse events caused by the presence of TBA in Topamax.

In Hong Kong, Topamax 100 mg Tablets (topiramate) is a prescription medicine registered by Johnson & Johnson (Hong Kong) Ltd. It is indicated as monotherapy in patients with newly diagnosed epilepsy or for conversion to monotherapy in patients with epilepsy; as adjunctive therapy for adults and children with partial onset seizures, seizures associated with Lennox-Gastaut syndrome, and generalized tonic-clonic seizures; and for the prophylaxis of migraine headache. The company confirmed that no affected product was imported into Hong Kong.

### **Australia: TGA issues precautionary advice about revaccination of pneumococcal vaccine**

18 April 2011 - The Therapeutic Goods Administration (TGA) issued precautionary advice to doctors not to give patients a second dose of the vaccine Pneumovax, a pneumococcal 23 vaccine, until a review of an apparent increased rate of adverse events in people receiving the vaccine for

the second time was completed. According to the current recommendation in Australia, the vaccine is only required once every five years. The issue was brought out following the notification of a cluster of adverse events related to the use of a single batch of Pneumovax 23 and a subsequent recall of the implicated batch in March 2011. As a follow-up action, the TGA worked with all States and Territories to enhanced monitoring of rates of adverse reactions with Pneumovax vaccine. It was found that there was a higher rate of reports of pain, swelling and soreness at the site of injection this year. In fact, these adverse events are well described in the product information of the vaccine but as of 14 April 2011, the TGA received 173 reports of adverse reactions to Pneumovax, compared to 63 at a similar date in 2010 and 34 in 2009. Preliminary analysis suggested that majority of reactions occurred in people receiving their second five yearly dose of the vaccine. Further detailed analysis of case reports, adverse reaction databases and clinical trial data would be undertaken by the TGA and the Australian Technical Advisory Group on Immunisation.

In Hong Kong, there are two registered 23-valent pneumococcal vaccines used for immunisation against pneumococcal infection. Both are prescription pharmaceutical products. One of them is registered by Merck Sharp & Dohme (Asia) Ltd under the name of Pneumovax 23 vaccine. The other is registered by Sanofi-Aventis Hong Kong Ltd. under the name of Pneumo 23 Polyvalent Pneumococcal Vaccine and is currently used in the public sector under the Government Vaccination Programme. Regarding the batch recall of Pneumovax in Australia in March 2011, DH has issued letters to inform healthcare professionals and reported the issue in Issue No. 18 of Drug News. In response to the release of this new precautionary

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advice, DH issued letters to inform healthcare professionals again on 18 April 2011. DH has no record of untoward event report associated with pneumococcal vaccines.

### **US: Ongoing safety review of Benicar (olmesartan)**

18 April 2011- After reviewing the results of the two clinical trials in which patients with type II diabetes taking Benicar (olmesartan) were found to have a higher death rate from a cardiovascular cause compared to patients taking a placebo, US Food and Drug Administration (FDA) considered that the benefits of olmesartan continued to outweigh its potential risks when used for treating patients with high blood pressure according to the drug label. Olmesartan was not recommended as a treatment to delay or prevent protein in the urine (microalbuminuria) in diabetic patients. Daiichi Sankyo, the makers of Benicar, agreed to work with the FDA to perform additional studies, as well as conduct additional analyses of completed clinical studies, to obtain more information about the cardiovascular risks or benefits of olmesartan in various clinical settings. FDA would update the public when new information is available.

In Hong Kong, olmesartan tablet is registered in three different strengths, namely 10mg, 20mg and 40mg under the brand name “Olmetec”. All these products are registered by Pfizer Corporation Hong Kong Ltd. and are prescription medicines. Olmesartan is an angiotensin II receptor blocker indicated for treatment of essential hypertension. DH remains vigilant to any new findings about Benicar.

### **Macau: Counterfeit product of Panadol Extra Tablet (batch no.: XNK099)**

20 April 2011 – The Health Bureau of Macau was notified by the manufacturer, GlaxoSmithKline, that a batch of Panadol Extra Tablet (paracetamol 500mg, caffeine 65mg) (batch no. XNK099) was suspected to be counterfeited. The counterfeit product was found to fade with yellowish spots and strong odour. In response, the Health Bureau had drawn samples on the market for analysis and advised the public not to take Panadol Extra Tablet of this batch with the aforesaid characteristics.

In Hong Kong, Panadol Extra Tablet is registered by

GlaxoSmithKline Limited. The product is used for treatment of pain and fever. The company informed DH and the Customs and Excise Department about the matter. DH had reinforced its market surveillance in collaboration with the Customs and Excise Department.

### **UK: Reports of hypersensitivity including angioedema with the use of Efient (prasugrel)**

5 May 2011 - In agreement with the European Medicines Agency (EMA) and Medicines and Healthcare products Regulatory Agency (MHRA), Daiichi-Sankyo and Eli Lilly and Company informed the healthcare professionals that cases of serious hypersensitivity reactions including angioedema in patients receiving prasugrel had been reported. Prasugrel is a thienopyridine antiplatelet drug and is used with aspirin for the prevention of atherothrombotic events in patients with acute coronary syndrome undergoing percutaneous coronary intervention. Some of the cases involved patients with a history of hypersensitivity reactions to clopidogrel, another thienopyridine antiplatelet drug. In response, the product information of Efient (prasugrel) had been updated accordingly. Healthcare professionals were advised to be aware of this potential risk when prescribing to patients with previous history of hypersensitivity reactions to thienopyridines. Patients should be informed of the risk upon prescription and advised to tell their doctor immediately if they developed symptoms suggestive of hypersensitivity after consumption.

In Hong Kong, prasugrel tablet is registered in two different strengths, namely 5mg and 10mg under the brand name “Effient”. All these products are registered by Eli Lilly Asia, Inc. and are prescription medicines. Their package inserts are being updated to include the appropriate warnings. DH also issued letters to inform healthcare professionals about this issue on 5 May 2011.

### **UK: Recall of Zoladex 3.6mg Single-dose syringe applicator**

12 May 2011 - AstraZeneca UK Ltd initiated a recall of a specific batch of Zoladex 3.6mg Single-dose syringe applicator at hospital and pharmacy level because of concerns about the integrity of the pouch in a small number of cases. The issue was limited to

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one batch and had arisen during packing at the factory. According to the company, the pouch was not the primary sterility barrier but the performance of desiccant material in the pouch could be adversely affected during storage.

In Hong Kong, Zoladex Depot Inj 3.6mg (goserelin) is a prescription medicine registered by AstraZeneca Hong Kong Ltd. It is used for treatment of prostate cancer and advanced breast cancer in pre- and perimenopausal women suitable for hormonal manipulation. The company confirmed that the concerned batch has not been imported into Hong Kong. DH issued letters to inform healthcare professionals about the news on 12 May 2011.

### Canada: Detection of Crystallization in Cytarabine Injection 2 g/ 20 mL (100 mg/mL) vials

12 May 2011 - Hospira alerted the healthcare professionals about the potential Cytarabine crystallization in certain lots of Cytarabine Injection 2 g/ 20 mL (100 mg/mL) product on the Canadian market. The issue followed the detection of Cytarabine crystallization in certain vials of Cytarabine lots outside of Canada. Upon investigation, the crystals were identified as the active pharmaceutical ingredient. Corrective actions had been taken and the issue had been resolved for future lots. Healthcare professionals were advised to inspect the Cytarabine vial for any crystallization prior to administration and not to use those which contained crystals.

In Hong Kong, Cytarabine Inj. is a prescription medicine registered by Hospira Limited. It is used for acute leukaemias and lymphomas. The company confirmed that the concerned lots have not been imported into Hong Kong. DH issued letters to inform healthcare professionals about the news on 12 May 2011.

### Germany, Austria, UK, Ireland and Canada: recall of Prezista Tablets 400mg & 600mg Tablets

12 May 2011 - Janssen-Cilag Ltd initiated a recall of certain batches of Prezista Tablets in different countries following complaints of musty and mouldy odours. The problem was caused by trace amounts of 2, 4, 6-tribromoanisole (TBA) in some bottles which was derived from a preservative used on wooden pallets during distribution. The affected countries and related products were listed as follows:

Countries	Affected product (batch number)
Germany	Prezista 400mg (AKZ0B00) Prezista 600mg (ALZ0E00, AKZ0D00)
Austria	Prezista 400mg (AKZ0B00) Prezista 600mg (ALZ0E00)
UK and Ireland	Prezista 400mg (AFZ0C00)
Canada	Prezista 600mg (ALZ0J00)

According to the company, no serious adverse events had been associated with this contamination issue which included additional batches distributed elsewhere in Europe. Patients were advised not to discontinue their antiretroviral treatment without first consulting their healthcare professional.

In Hong Kong, Prezista Tab 400mg & Prezista Tab 600mg (darunavir) are prescription medicines registered by Johnson & Johnson (Hong Kong) Ltd. They are used for treatment of Human Immunodeficiency Virus (HIV) infection in antiretroviral treatment-experienced adult patients in combination with ritonavir and other antiretroviral agents. The company confirmed that the affected batches have not been distributed in Hong Kong. DH issued letters to inform healthcare professionals about the news on 12 May 2011.

## Drug Recall

### Recall of Supirocin Ointment 2% 10g

On 26 April 2011, DH instructed a pharmaceutical product registration certificate holder, Nidoway Investment Ltd (Nidoway), to recall Supirocin Ointment 2% 10g because the item had not been registered as a pharmaceutical product and discrepancy was found between the labelled and

actual active ingredient content. Analysis of the item samples purchased during routine market surveillance detected 0.25% of the active ingredient mupirocin, instead of 2% as listed on its label.

Supirocin Ointment 2% (mupirocin), manufactured in India, is a topical antibiotic for the treatment of bacterial skin infection. The lowered active

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ingredient content may lead to ineffective treatment and contribute to antibiotic resistance.

Healthcare professionals and retailers were advised to stop supplying the said product to their clients. DH closely monitored the recall.

### **Recall of Cyclovax Cream 5% (HK-43836)**

On 4 May 2011, DH instructed a pharmaceutical product registration certificate holder, Healthcare Pharmascience Ltd (Pharmascience), to recall from consumers of a batch (Lot 44254) of Cyclovax Cream 5% because the active ingredient in the product was insufficient. During routine market surveillance, samples of Cyclovax Cream 5% were purchased and chemical analysis by the Government

Laboratory revealed that only 3.2% of the active ingredient aciclovir was identified, instead of 5% as listed on label. Further investigation revealed that the quality defect involved more batches and DH instructed Pharmascience to recall all of its "Cyclovax Cream 5%" on 12 May 2011.

Cyclovax Cream 5% (aciclovir) is a topical antiviral drug for the treatment of herpes simplex virus skin infection. It is manufactured by Remedica Limited in Cyprus and is a prescription medicine. The lowered active ingredient content is a quality defect which can lead to ineffective treatment. DH closely monitored the recall and investigated the quality of other registered pharmaceutical products from the same manufacturer. The drug authority in Cyprus was also informed. Healthcare professionals and retailers were advised to stop supplying the said

## Drug Incident

### **Woman arrested for selling slimming product with banned drug ingredients**

On 29 April 2011, a joint operation was conducted by DH and the Police and a 43-year-old woman was arrested for suspected illegal sale of a slimming product containing banned Western drug ingredients. The investigation followed a report by the Hospital Authority concerning a 39-year-old woman who felt unwell after consuming a slimming product called "Botanical Slimming" which was found to contain two banned Western drugs, namely phenolphthalein and sibutramine.

### **Two women arrested for selling slimming product with banned drug ingredients**

On 6 May 2011, two joint operations were conducted by DH and the Police, resulting in the arrest of two women aged 24 and 29 respectively for suspected sale of four slimming products containing undeclared and banned drug ingredients. The four products were "Six Clock Natural Leptin Coffee 柳の美神奇26燃脂咖啡", "Aisam Wellness Sport Burner - Quan Shen Huan Rao Xing 運動溶脂彈——全身環繞型", "Aisam Wellness Sport Burner - Xiu Yao Xing 運動溶脂彈——修腰型" and "Aisam Wellness Sport Burner - Xiu Tui Xing 運動溶脂彈——修腿型". DH obtained the four products

concerned from Internet auction websites during the department's surveillance operation. Laboratory tests confirmed that all four products contained sibutramine and phenolphthalein, and three of them contained sibutramine analogues.

DH appealed to members of the public not to buy or consume unknown or doubtful slimming products from the Internet as they may contain undeclared and banned drug ingredients that are dangerous to health.

Phenolphthalein was once used for treating constipation but has been banned for its cancer-causing effect. Sibutramine was once a western medicine used as appetite suppressant. In November 2010, sibutramine-containing products have been banned because of the increased cardiovascular risk. Sibutramine analogues, being chemically similar to sibutramine, are expected to have the same side effects as sibutramine.

Weight control should be achieved through good diet and appropriate exercise. People should consult healthcare professionals before using any medication for weight control.



# Drug Incident

The products mentioned in the above drug incidents were not registered pharmaceutical products under the Pharmacy and Poisons Ordinance in Hong Kong. A product containing any western drug ingredient must be registered under the Ordinance before it can be sold in Hong Kong. Under the Pharmacy and Poisons Ordinance, possession or sale of unregistered pharmaceutical product is an offence liable to the maximum penalties of a \$100,000 fine and two year's imprisonment. Members of the public were exhorted not to sell products of unknown or doubtful composition. Members of the public should stop using the aforementioned products that contained undeclared western drug ingredients and they should see doctors if they feel unwell after using the products. They should destroy, dispose or submit them to the Department's Pharmaceutical Service during office hours.

## *Useful Contact*

### **Drug Complaint:**

**Tel: 2572 2068**

**Fax: 2147 0457 & 2123 1996**

**E-mail: [pharmgeneral@dh.gov.hk](mailto:pharmgeneral@dh.gov.hk)**

### **Adverse Drug Reaction (ADR)**

#### **Reporting:**

You are encouraged to report any suspected or confirmed ADR cases to our office by:

**Fax: 2147 0457**

**E-mail: [adr@dh.gov.hk](mailto:adr@dh.gov.hk)**

**Post: *ADR Monitoring Unit,  
Pharmaceutical Service, Department of Health,  
3/F, Public Health Laboratory Centre,  
382 Nam Cheong Street, Kowloon***