Drug News
藥 物 情 報

Issue Number 79

This is a monthly digest of local and overseas drug safety news released by the Drug Office of the Department of Health in May 2016 with relevant information update before publish. For the latest news and information, please refer to public announcements or the website of the Drug Office of the Department of Health (http://www.drugoffice.gov.hk).

Safety Update

Canada: BCR-ABL Tyrosine Kinase Inhibitors [GLEEVEC (imatinib mesylate), TASIGNA (nilotinib), BOSULIF (bosutinib), SPRYCEL (dasatinib), ICLUSIG (ponatinib hydrochloride)] - Risk of Hepatitis B Reactivation

On 4 May 2016, Health Canada reported that a recent review of data from clinical trials and postmarketing experience has shown that hepatitis B virus (HBV) reactivation can occur in chronic HBV carriers, after they received BCR-ABL tyrosine kinase inhibitors (TKIs). Some of these cases included acute hepatic failure or fulminant hepatitis leading to liver transplantation or death. These case reports indicate that HBV reactivation may occur at any time during BCR-ABL TKI treatment. Some of these patients had a documented history of hepatitis B. An increase in viral load or positive serology after initiating treatment with a BCR-ABL TKI occurred with HBV reactivation. For other cases, the serologic status at baseline was not known. HBV reactivation is considered to be a class-effect of BCR-ABL TKIs, although the mechanism and the frequency of HBV reactivation during exposure is not known.

BCR-ABL TKIs are used for the treatment of specific types of blood cancers, including Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) and Ph+ acute lymphoblastic leukemia (ALL), and less commonly, other types of cancers. A recent review of clinical trials and reports received in the post-marketing period as well as published medical literature indicate that cases of HBV reactivation have occurred in patients who are carriers for the virus after receiving BCR-ABL TKIs. In some of the cases, HBV reactivation caused acute liver failure or fulminant hepatitis requiring liver transplantation or death. HBV reactivation occurred at different points during therapy, with cases reported worldwide between three weeks and more than 8 years after starting treatment. Although no mechanism for HBV reactivation has been identified to date, based on a review of the available evidence, HBV reactivation is considered to be a class effect of BCR-ABL TKIs.

Patients should be tested for HBV infection status before initiating treatment with BCR-ABL TKIs. Healthcare professionals should consult experts in liver disease and in the treatment of HBV promptly before starting treatment with BCR-ABL TKIs in patients with positive HBV serology (including those with active disease) and in patients who test positive for HBV infection during treatment.

Healthcare professionals should closely monitor patients who are carriers of HBV, who are currently on or require a BCR-ABL TKI treatment for signs and symptoms of active HBV infection throughout therapy and for several months

following termination of therapy. The Canadian Product Monographs will be updated to reflect this new safety information.

In Hong Kong, there are 13 registered pharmaceutical products belong to the class of BCR-ABL TKIs (including 8 containing imatinib, 2 containing nilotinib and 3 containing dasatinib), while there is no registered product containing bosutinib and ponatinib. All of the products are prescription only medicines. Related news has been released by the Health Science Authority (HSA) of Singapore, and was reported in the Drug News Issue No. 77. The Department of Health (DH) issued a letter to inform local healthcare professionals on 31 March 2016. As on 16 August 2016, DH has received seven adverse drug reaction (ADR) cases, three involved imatinib, one involved dasatinib, two involved bosutinib and one involved ponatinib. Amongst which, one case of suspected drug-induced liver injury was related to imatinib. In view of Health Canada's announcement on the risk of hepatitis B reactivation after received BCR-ABL TKIs, DH issued a letter to inform local healthcare professionals on 5 May 2016 to draw their attention. As previously reported, the matter will be discussed by the Registration Committee of the Pharmacy and Poisons Board; and DH will remain vigilant on the safety updates on the products from other overseas drug regulatory authorities.

US: FDA warns about rare but serious skin reactions with mental health drug olanzapine, including Zyprexa, Zyprexa Zydis, Zyprexa Relprevv, and Symbyax

On 10 May 2016, the United States (US) Food and Drug Administration (FDA) was warning that the antipsychotic medicine olanzapine can cause a rare but serious skin reaction that can progress to affect other parts of the body. The FDA is adding a new warning to the drug labels for all olanzapine-containing products that describes this severe condition known as Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS).

Olanzapine is an antipsychotic medicine used to treat mental health disorders schizophrenia and bipolar disorder. It can decrease hallucinations, in which people hear or see things that do not exist, and other psychotic symptoms such as disorganized thinking. Olanzapine is available under the brand names Zyprexa, Zyprexa Zydis, Zyprexa Relprevv, and Symbyax in the US, and also as generics.

DRESS may start as a rash that can spread to all parts of the body. It can include fever and swollen lymph nodes and a swollen face. It causes a higher-than-normal number of infection-fighting white blood cells called eosinophils that can cause inflammation, or swelling. DRESS can result in injury to organs including the liver, kidneys, lungs, heart, or pancreas, and can lead to death.

A search of the FDA Adverse Event Reporting System (FAERS) database identified 23 cases of DRESS reported with olanzapine worldwide since 1996, when the first olanzapine-containing product was approved in the US. FAERS includes only reports submitted to the FDA, so there are likely to be additional cases about which the FDA is unaware. One patient taking olanzapine experienced DRESS and died; however, this patient was taking multiple medicines that could also have contributed to death.

Patients taking olanzapine-containing products who develop a fever with a rash and swollen lymph glands, or swelling in the face, should seek medical care right away.

Health care professionals should immediately stop treatment with olanzapine if DRESS is suspected. When prescribing the medicine, explain the signs

and symptoms of severe skin reactions to patients and tell them when to seek immediate medical care.

In Hong Kong, there are 53 registered pharmaceutical products containing olanzapine, and are prescription only medicines. As on 16 August 2016, DH has received three ADR cases in connection with olanzapine, but they were not related to DRESS. In view of the above FDA announcement, DH issued a letter to inform local healthcare professionals on 11 May 2016 and the matter will be discussed by the Registration Committee of the Pharmacy and Poisons Board.

UK: Pomalidomide (Imnovid ▼): risk of hepatitis B reactivation

On 10 May 2016, the Medicines and Healthcare products Regulatory Agency (MHRA) advised that before starting treatment with pomalidomide, hepatitis B virus status should be established in all patients.

In the UK, pomalidomide (Imnovid ▼) combined with dexamethasone is indicated for adults with relapsed and refractory multiple myeloma who have received at least two previous treatment regimens, including lenalidomide and bortezomib, and who have shown disease progression on the last therapy.

A review by European Union (EU) medicines regulators of clinical studies and cases of suspected adverse drug reactions reported by healthcare professionals and in the literature has concluded that pomalidomide can cause hepatitis B reactivation. The review assessed cases worldwide up to 7 August 2015 and identified 5 patients who developed hepatitis B reactivation while receiving treatment with pomalidomide. 2 cases resulted in acute liver failure, 1 of which had a fatal outcome. 4 cases occurred within a month of starting pomalidomide.

The MHRA advised healthcare professionals of the following:

- Hepatitis B virus status should be established before starting treatment with pomalidomide.
- For patients who test positive, consultation with a physician with expertise in the treatment of hepatitis B is recommended.
- Previously infected patients should be closely monitored for signs and symptoms of active infection throughout pomalidomide treatment.

In Hong Kong, there are four registered pharmaceutical products containing pomalidomide, namely Pomalyst Capsules 1mg (HK-64091), 2mg (HK-64089), 3mg (HK-64090) and 4mg (HK-64092). All these products are registered by Celgene Limited, and are prescription only medicines. As on 16 August 2016, DH has received two ADR cases in connection with pomalidomide, but they were not related to hepatitis B reactivation. In view of the above MHRA announcement, DH issued a letter to inform local healthcare professionals on 11 May 2016, and the matter will be discussed by the Registration Committee of the Pharmacy and Poisons Board.

US: FDA advises restricting fluoroquinolone antibiotic use for certain uncomplicated infections; warns about disabling side effects that can occur together

On 12 May 2016, the US FDA is advising that the serious side effects associated with fluoroquinolone antibacterial drugs generally outweigh the benefits for patients with acute sinusitis, acute bronchitis, and uncomplicated urinary tract infections who have other treatment options. For patients with these conditions, fluoroquinolone should be reserved for those who do not have alternative treatment options.

An FDA safety review has shown that fluoroquinolones when used systemically (i.e. tablets, capsules, and injectable) are associated with disabling and potentially permanent serious side effects that can occur together. These side effects can involve the tendons, muscles, joints, nerves, and central nervous system.

As a result, the FDA is requiring the drug labels and Medication Guides for all fluoroquinolone antibacterial drugs in the US to be updated to reflect this new safety information. Currently available FDA-approved fluoroquinolone antibacterial drugs for systemic use include moxifloxacin, ciprofloxacin, gemifloxacin, levofloxacin and ofloxacin. The FDA is continuing to investigate safety issues with fluoroquinolones and will update the public with additional information if it becomes available.

Patients should contact their health care professional immediately if they experience any serious side effects while taking fluoroquinolone medicine. Some signs and symptoms of serious side effects include tendon, joint and muscle pain, a "pins and needles" tingling or pricking sensation, confusion, and hallucinations.

Health care professionals should stop systemic fluoroquinolone treatment immediately if a patient reports serious side effects, and switch to a non-fluoroquinolone antibacterial drug to complete the patient's treatment course.

In Hong Kong, there are 248 registered pharmaceutical products which are fluoroquinolone antibacterial drugs, including 106 ciprofloxacin products, 66 levofloxacin products, 52 ofloxacin products, 9 moxifloxacin products, 11 norfloxacin products, 2 lomefloxacin products, 1 prulifloxacin product and 1 sparfloxacin product. All these products are prescription only medicines. As on 16 August 2016, DH has received one ADR in connection with levofloxacin, but it was not related to the serious side effects mentioned in the above announcement. No ADR case has been received for the other fluoroquinolone drugs. In view of the FDA announcement, DH issued a letter to inform local healthcare professionals on 13 May 2016 to draw their attention, and the matter will be discussed by the Registration Committee of the Pharmacy and Poisons Board.

EU: PRAC concludes on meta-analysis on the risk of inhibitor development in severe haemophilia patients receiving recombinant factor VIII products

On 13 May 2016, the Pharmacovigilance Risk Assessment Committee (PRAC), at its May meeting, adopted a summary report following the review of a meta-analysis of data from three observational studies, aiming to assess the risk of developing inhibitors (antibodies) against individual recombinant factor VIII products in previously untreated patients with severe haemophilia A. Factor VIII is lacking in patients with haemophilia A and is given to these patients either to treat bleeding episodes on demand or regularly as prophylaxis to allow their blood to clot normally; the development of inhibitors can lead to a reduction of the therapeutic action of the medicine.

The PRAC agreed that overall, the currently available evidence does not confirm that Kogenate Bayer/Helixate NexGen, both products containing the recombinant factor VIII known as octocog alfa, is associated with an increased risk of factor VIII inhibitors, compared with other recombinant factor VIII products in previously untreated patients. These conclusions are consistent with the previous conclusions drawn by the PRAC within the review carried out on Kogenate Bayer/Helixate NexGen in 2013.

The PRAC recommended that the marketing-authorisation holders of recombinant factor VIII products should monitor published studies on drug inhibitor development with the aim of keeping the product information up-to-date. This meta-analysis was made possible through close collaboration with academia. The investigators of the studies provided anonymised raw data for a rigorous analysis led by the PRAC rapporteur, enabling an additional independent evaluation to further assess the safety profile of these medicines.

In Hong Kong, there are 10 registered pharmaceutical products containing octocog alfa, including Kogenate FS for Inj 1000IU (HK-54067), 500IU (HK-54069) and 250IU (HK-54068) which are registered by Bayer Healthcare Ltd; Advate for Inj 1000IU (HK-56260) and 250IU (HK-56259), Advate Inj 1500IU (HK-56372) and 500IU (HK-56371), and Recombinate Antihemophilic Factor 1000IU (HK-40476), 500IU (HK-40477) and 250IU (HK-40724) which are registered by Baxalta Hong Kong Ltd. All these products are prescription only medicines. Helixate NexGen is not a registered pharmaceutical product in Hong Kong. Related news was previously issued by the European Medicines Agency (EMA), and was reported in the Drug News Issue No.50 and 61. As on 16 August 2016, DH has not received any ADR case related to octocog alfa. In line with the PRAC recommendation to the marketing authorization holders, DH will inform Bayer Healthcare Ltd and Baxalta Hong Kong Ltd on the above EMA announcement to monitor published studies on drug inhibitor development and to keep the product information up-to-date. DH will continue to remain vigilant on the safety of octocog alfa.

US: Neonatal opioid withdrawal syndrome and medication-assisted treatment with methadone and buprenorphine

On 26 May 2016, the US FDA announced that they are requiring safety labeling changes for methadone and buprenorphine products when used by pregnant women for medication-assisted treatment (MAT) of opioid use disorder to ensure providers have complete information about the benefits and risks of these products.

National guidelines from the American College of Obstetricians and Gynecologists (ACOG) and the Substance Abuse and Mental Health Services Administration (SAMHSA), and international guidelines from the World Health Organization, recommend that pregnant women with opioid addiction be treated with methadone or buprenorphine. According to these guidelines, the rationale for MAT during pregnancy is to prevent complications of opioid abuse, addiction and withdrawal, and encourage prenatal care and drug treatment.

However, MAT can also present challenges due to the risk of the developing fetus being exposed to opioids, which can lead to neonatal opioid withdrawal syndrome (NOWS). NOWS can be effectively managed, but may be life-threatening if not recognized and treated.

Since NOWS can result from in utero exposure to opioids – whether medically authorized or illicit – the risk of NOWS from MAT must be balanced against the risk of untreated opioid addiction during pregnancy; an independent advisory committee and numerous reproductive health experts agree this balance is important. If left untreated, illicit opioid use is associated with poor

pregnancy outcomes such as low birth weight, preterm birth, or fetal death.

The FDA's action requiring safety labeling changes for MAT-only methadone and buprenorphine products is intended to appropriately inform prescribers about the risks of NOWS without inadvertently discouraging treatment for pregnant women with opioid addiction.

This action is among a number of steps the agency has taken recently to inform prescribers about the appropriate use of opioid medications. Labels for buprenorphine products that are used to treat pain in the US are already required to provide information to prescribers about the risks associated with NOWS in a boxed warning, which is the FDA's strongest warning. These new safety labeling change requirements for methadone and buprenorphine products that are used for MAT include a statement in the Warnings and Precautions section about the risk of NOWS, as well as related modifications to the Pregnancy, Dependence, and Patient Counseling Information sections. (A boxed warning for NOWS is not being required in the US for the MAT-only methadone and buprenorphine products.)

Furthermore, as recently outlined in an action plan, the FDA is reassessing its approach to opioid medications to combat this public health crisis and its profound impact on individuals, families and communities across the country.

In Hong Kong, there are five registered pharmaceutical products containing methadone, and eight products containing buprenorphine. All products are prescription only medicines. As on 16 August 2016, DH has not received any ADR case related to methadone or buprenorphine. In view of the above FDA announcement, DH issued a letter to inform local healthcare professionals on 27 May 2016 to draw their attention, and the matter will be discussed by the Registration Committee of the Pharmacy and Poisons Board.

Singapore: Temporary and voluntary hold on manufacturing and release of anaesthetic medicines Ultiva®, Tracrium® & Mivacron® at its manufacturing site

On 31 May 2016, Singapore HSA announced that GlaxoSmithKline (GSK) would like to inform healthcare professionals of a temporarily and voluntary hold on manufacturing and release of the anaesthetic medicines ULTIVA® For Injection 1mg/vial (Remifentanil Hydrochloride), TRACRIUM® Injection 10mg/ml (5ml ampoule) (Atracurium Besylate), MIVACRON® Injection 2mg/ml (10ml ampoule) (Mivacurium chloride), from its Parma manufacturing site. This was a precautionary measure while GSK investigated and resolved an issue with data inconsistencies at this facility. There are no concerns over the quality of products already distributed or those held in Singapore at warehouses.

GSK is advising healthcare providers in Singapore of a potential and temporary lack of disruption to the availability of the above listed anaesthetic products. In view of the anticipated tight supply of these medicines, healthcare providers are recommended to consider alternatives in place of the above medicines during this period of time.

In Hong Kong, GlaxoSmithKline Limited (GSK HK) notified DH of the above incident on 19 May 2016. GSK HK confirmed that eight products registered by the company which are manufactured in Parma manufacturing site are

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affected by the incident, including Ultiva for Inj 1mg (HK-43301), and 2mg (HK-43302), Tracrium Inj 1% (HK-23717), Mivacron Inj 0.2% (HK-37866), Ventolin Soln for I.V. Infusion 1mg/ml (HK -02796), Zovirax IV for Intravenous Infusion 250mg (HK-18668), Nimbex Inj 2mg/ml (HK-42333), and Zantac Inj 25mg/ml (HK-42045). In view of the incident, there may be a temporary supply interruption of the products in the local market. As on 16 August 2016, DH has not received any ADR case related to the products. DH will remain vigilant on the above incident.

Singapore: Temporary and voluntary hold on manufacturing and release of Ventolin® Solution for Intravenous Infusion 5mg/5ml (salbutamol sulphate) at its manufacturing site

On 31 May 2016, Singapore HSA announced that GSK would like to inform healthcare professionals of a temporarily and voluntary hold on manufacturing and release of Ventolin® Solution for Intravenous Infusion 5mg/5ml (salbutamol sulphate) at its Parma manufacturing site. This was a precautionary measure while GSK investigated and resolved an issue with data inconsistencies at this facility. There are no concerns over the quality of products already distributed or those held in Singapore at warehouses.

Healthcare providers in Singapore are advised to consider alternative treatments if necessary, for patients who currently use this product. To ensure sufficient supply is available for patients currently being treated with Ventolin® Solution for Intravenous Infusion, GSK recommends healthcare professionals consider not initiating treatment in new patients until supplies return to normal.

In Hong Kong, GSK HK notified DH of the above incident on 19 May 2016. GSK HK confirmed that eight products registered by the company which are manufactured in Parma manufacturing site are affected by the incident, including Ultiva for Inj 1mg (HK-43301), and 2mg (HK-43302), Tracrium Inj 1% (HK-23717), Mivacron Inj 0.2% (HK-37866), Ventolin Soln for I.V. Infusion 1mg/ml (HK-02796), Zovirax IV for Intravenous Infusion 250mg (HK-18668), Nimbex Inj 2mg/ml (HK-42333), and Zantac Inj 25mg/ml (HK-42045). In view of the incident, GSK HK foresees that there will be a temporary supply interruption of the products in the local market. As on 16 August 2016, DH has not received any ADR case related to the products. DH will remain vigilant on the above incident.

Drug Recall

DH endorsed batch recall of Rifadin 600mg Infusion

On 9 May 2016, DH endorsed three licensed drug wholesalers, Hua Tai Pharmaceuticals Co. Ltd. (Hua Tai), Sino-Asia Pharmaceutical Supplies Ltd. (Sino-Asia) and Vantone Medical Supplies Co. Ltd. (Vantone), to recall one batch of Rifadin 600mg Infusion (batch number: A5545) from the market because of a quality issue.

DH received notifications from Hua Tai, Sino-Asia and Vantone that the product's British manufacturer was recalling the above batch of product because it had been contaminated with chilled water circulating the equipment during

manufacture. DH's investigation was continuing.

The above product containing rifampicin is a prescription medicine used for the treatment of certain infections. According to the three wholesalers, a total of 422 vials of the product have been imported for the use of particular patients in four Hospital Authority hospitals and two private hospitals. Hua Tai, Sino-Asia and Vantone have already notified the hospitals involved.

As on 16 August 2016, DH has not received any ADR case related to this batch of product. A notice was released on the website of the Drug Office on 9 May 2016 to alert the public of the recall.

DH endorsed recall of eight products manufactured by Ta Fong Pharmaceutical Co., Ltd.

On 27 May 2016, DH endorsed two licensed drug wholesalers, Vast Resources Pharmaceutical Limited (Vast Resources) and Yat Seng Trading Co. (Yat Seng), to recall eight pharmaceutical products from the market for a potential quality issue.

The eight products are:

1. Urodine F.C. tablets 100mg (registration number: HK-56569);
2. Dicokan tablets 30mg (HK-56102);
3. Toeefon tablets 250mg (HK-56387);
4. Shoren suppositories 12.5mg (HK-60943);
5. Molin tablets 10mg (HK-62483); and
6. Famoster Film Coated tablets 20mg (HK-62850) imported by Vast Resources; and
7. Lincomycin Solution for Injection 300mg/ml (Ta Fong) (HK-61712); and
8. Clindamycin capsules 150mg (HK-64191) imported by Yat Seng.

Upon notification from Vast Resources and Yat Seng that the Taiwanese manufacturer, Ta Fong Pharmaceutical Co., Ltd. notified them to recall affected batches of these eight products as they had not been properly packed and stored in Taiwan.

The above eight products include six prescription-only medicines, a Part I poison and an over-the-counter medicine used for the treatment of various conditions. According to Vast Resources and Yat Seng, the products have been supplied to private doctors and local pharmacies.

As on 16 August 2016, DH has not received any ADR case related to the products concerned. A notice was released on the website of the Drug Office on 27 May 2016 to alert the public of the recall.

People who have used the above products should consult their healthcare professionals when in doubt.

Drug Incident

DH raided a shop for suspected illegal sale of slimming product with undeclared banned drug ingredients

On 11 May 2016, DH raided a retail shop in Mong Kok in a joint operation with the Police for suspected illegal sale of a slimming product, namely Fizzle Pop Soda, suspected to contain undeclared banned drug ingredients.

Following a public complaint, a sample of the above product was previously purchased from the shop for analysis. Test results from the Government Laboratory revealed that the sample contained banned ingredients, sibutramine and phenolphthalein.

A man aged 45 and two women aged 21 and 51 were arrested by the Police for suspected illegal sale and possession of Part 1 poison and an unregistered pharmaceutical product in the operation.

Sibutramine is a Part 1 poison once used as an appetite suppressant. Since November 2010, products containing sibutramine have been banned because of increased cardiovascular risk. Phenolphthalein was once used to treat constipation, but has been banned in Hong Kong for its cancer-causing effect.

A notice was released on the website of the Drug Office on the same day to alert the public of the drug incident.

News in Brief

Amendment of the Dangerous Drugs Ordinance (Cap 134)

The following substances are added to Part I of the First Schedule to the Dangerous Drugs Ordinance with effect from 8 July 2016.

1. Tapentadol
2. 3,4-Dichloro-N-[[1-(dimethylamino) cyclohexyl]methyl]benzamide.

Healthcare professionals are advised to take note of the above and to comply with the legal requirements accordingly, in particular on the storage inside locked receptacle, keeping of register, and preservation of documents under different provisions to the Dangerous Drugs Ordinance and Regulations. DH issued a letter to inform local healthcare professionals on the amendment on 9 May 2016.

A product containing any western drug ingredient must be registered under the Pharmacy and Poisons Ordinance before it can be sold in Hong Kong. Part 1 poisons should be sold at registered pharmacies under the supervision of registered pharmacists. Illegal sale or possession of Part 1 poisons and unregistered pharmaceutical products are offences under the Pharmacy and Poisons Ordinance (Cap 138). The maximum penalty is a fine of $100,000 and 2 years' imprisonment for each offence. Antibiotics defined under the Antibiotics Ordinance (Cap. 137) and dangerous drugs defined under the Dangerous Drugs Ordinance (Cap. 134) are prescription only medicines. They can only be supplied at registered pharmacies by registered pharmacists or under their supervision and upon a doctor's prescription. They should only be used under the advice of a doctor. Illegal sale or possession of antibiotics are offences under the Antibiotics Ordinance (Cap 137) and the maximum penalty is a $30,000 fine and 1 year's imprisonment for each offence. Trafficking in dangerous drugs is a criminal offence under the Dangerous Drugs Ordinance (Cap 134) and the maximum penalty is a $5,000,000 fine and life imprisonment. Failing to keep dangerous drugs in a locked receptacle is an offence under the Dangerous Drugs Ordinance and the maximum penalty is a fine of $5,000. Failing to keep a proper register of dangerous drugs is an offence under the Dangerous Drug Regulations (Cap. 134A) and the maximum penalty is a fine of $450,000 and 3 years imprisonment.

All registered pharmaceutical products should carry a Hong Kong registration number on the package in the format of "HK-XXXXX". The products mentioned in the above incidents were not registered pharmaceutical products under the Ordinance in Hong Kong. Their safety, quality and efficacy cannot be guaranteed. Members of the public were exhorted not to use products of unknown or doubtful composition. They should stop using the aforementioned products immediately if they had them in their possession and to consult healthcare professionals if they felt unwell after taking the products. The products should be destroyed or disposed properly, or submitted to the Department's Drug Office during office hours.

Useful Contact

Drug Complaint:

Tel: 2572 2068

Fax: 3904 1224

E-mail: pharmgeneral@dh.gov.hk

Adverse Drug Reaction (ADR) Reporting:

Tel: 2319 2920

Fax: 2319 6319

E-mail: adr@dh.gov.hk

Link: http://www.drugoffice.gov.hk/adr.html

Post: ***Pharmacovigilance Unit,***
Drug Office, Department of Health,
Rm 1856, 18/F, Wu Chung House,
213 Queen's Road East,
Wan Chai, Hong Kong

The purpose of Drug News is to provide healthcare professionals with a summary of local and overseas drug safety news released. Healthcare professionals are advised to keep update with the information and provide corresponding advice or therapeutic measure to patients and public.