Drug News
藥 物 情 報

Issue Number 88

This is a monthly digest of local and overseas drug safety news released by the Drug Office of the Department of Health in February 2017 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

US: FDA warns about rare but serious allergic reactions with the skin antiseptic chlorhexidine gluconate

On 2 February 2017, the United States (US) Food and Drug Administration (FDA) warned that rare but serious allergic reactions have been reported with the widely used skin antiseptic products containing chlorhexidine gluconate. Although rare, the number of reports of serious allergic reactions to these products has increased over the last several years. As a result, FDA is requesting the manufacturers of over-the-counter (OTC) antiseptic products containing chlorhexidine gluconate to add a warning about this risk to the Drug Facts labels in US. Prescription chlorhexidine gluconate mouthwashes and oral chips used for gum disease already contain a warning about the possibility of serious allergic reactions in labels in US.

In US, chlorhexidine gluconate is mainly available in OTC products to clean and prepare the skin before surgery and before injections in order to help reduce bacteria that potentially can cause skin infections. These products are available as solutions, washes, sponges, and swabs and under many different brand names and as generics. Chlorhexidine gluconate is also available in US as a prescription mouthwash to treat gingivitis and as a prescription oral chip to treat periodontal disease. In 1998, FDA issued a Public Health Notice to warn health care professionals about the risk of serious allergic reactions with medical devices such as dressings and intravenous lines that contain chlorhexidine gluconate.

FDA identified 52 cases of anaphylaxis, a severe form of allergic reaction, with the use of chlorhexidine gluconate products applied to the skin. In the 46 years between January 1969 and early June 2015, FDA received reports of 43 cases worldwide. More than half of the 43 cases were reported after 2010, and after the FDA 1998 Public Health Notice. This number includes only reports submitted to FDA, so there are likely additional cases about which FDA is unaware. The serious allergic reaction cases reported outcomes that required emergency department visits or hospitalizations to receive drug and other medical treatments. These allergic reactions resulted in two deaths. Eight additional cases of anaphylaxis were published in the medical literature between 1971 and 2015, and one case was identified in the National Electronic Injury Surveillance System-Cooperative Adverse Drug Event Surveillance (NEISS-CADES) database between 2004 and 2013.

Patients and consumers should stop using the product that contains chlorhexidine gluconate and seek medical attention immediately if they experience symptoms of a serious allergic reaction. These reactions can occur within minutes of exposure. Symptoms include wheezing or difficulty breathing; swelling of the face; hives that can quickly progress to more serious symptoms; severe rash; or shock, which is a life-threatening condition that occurs when the body is not getting enough blood flow.

Health care professionals should always ask patients if they have ever had an allergic reaction to any antiseptic before recommending or prescribing a chlorhexidine gluconate product. Advise patients to seek immediate medical attention if they experience any symptoms of an allergic reaction

when using the products. Consider using alternative antiseptics such as povidone-iodine, alcohols, benzalkonium chloride, benzethonium chloride, or parachlorometaxylenol (PCMX) when any previous allergy to chlorhexidine gluconate is documented or suspected.

In Hong Kong, there are 81 registered pharmaceutical products containing chlorhexidine, of which 58 products are over-the-counter medicines. News related to anaphylactic reaction for medicinal products containing chlorhexidine was previously issued by the United Kingdom (UK) Medicines & Healthcare products Regulatory Agency (MHRA), and was reported in the Drug News Issue No. 36. The Department of Health (DH) issued a letter to inform local healthcare professionals on the warnings on 26 October 2012. As on 10 March 2017, DH has received two cases of adverse drug reaction (ADR) in connection with chlorhexidine mouthwash and spray, and the cases were not related to allergic reactions. In view of the above US FDA announcement, the matter will be discussed by the Registration Committee of the Pharmacy and Poisons Board (the Registration Committee).

EU: EMA reviews persistence of side effects known to occur with quinolone and fluoroquinolone antibiotics, focusing on long -lasting effects mainly affecting musculoskeletal and nervous systems

On 10 February 2017, the European Medicines Agency (EMA) announced that a review of systemic and inhaled quinolone and fluoroquinolone antibiotics to evaluate the persistence of serious side effects mainly affecting muscles, joints and the nervous system is being conducted. These side effects are of particular importance when the medicines are used for less severe infections.

The review is at the request of the German medicines authority (BfArM) following reports of long-lasting side effects in the national safety database and the published literature. There has been no previous European Union (EU)-wide review specifically focusing on the persistence of the side effects, but the side effects themselves are known and covered in the EU prescribing information for these medicines.

EMA's Pharmavigilance Risk Assessment Committee (PRAC) will now evaluate all available data and determine whether there is a need to introduce new measures to minimise these risks or modify how the medicines are used.

Quinolones and fluoroquinolones are widely prescribed in the EU and are important options for treating serious, life-threatening bacterial infections. Healthcare professionals using these medicines should continue to follow the official prescribing information

In Hong Kong, there are 199 registered pharmaceutical products for systemic administration containing quinolones and fluoroquinolones, including 84 ciprofloxacin, 60 levofloxacin, 37 ofloxacin, 5 moxifloxacin, 8 norfloxacin, 1 lomefloxacin, 1 prulifloxacin, 1 sparfloxacin, 1 nalidixic acid and 1 pipemidic acid products. All these products are prescription only medicines. There is no registered pharmaceutical product in Hong Kong for inhaled quinolone and fluoroquinolone.

Related news was previously issued by the US FDA and Health Canada, and the news associated with peripheral neuropathy was reported in the Drug News Issue No. 46, the news associated with disabling and potentially permanent side effects of the tendons, muscles, joints, nerves, and central nervous system was reported in the Drug News Issue No. 79, 81 and 87. DH issued letters to inform local healthcare professionals on the warnings on 16 August 2013 and 13 May 2016. In December 2013, the Registration Committee discussed the matters on peripheral neuropathy with fluoroquinolones, and decided that the relevant warnings should be included in the sales packs and/or package inserts of the products. In September 2016, the Registration Committee further discussed the matters on disabling and potentially permanent side effects of the tendons, muscles, joints, nerves, and central nervous system with fluoroquinolones, and decided to remain vigilant on any updates by other overseas drug regulatory authorities.

As on 10 March 2017, DH has received two cases of ADR with levofloxacin, which were not related to the adverse effects mentioned in the above EMA's announcement, and no ADR report has

been received for the remaining fluoroquinolones. In view of EMA's PRAC will now evaluate all available data and determine whether there is a need to introduce new measures to minimise these risks or modify how the medicines are used, DH will keep vigilant on the result and recommendation from EMA after review, and consider any action deemed necessary.

Canada: Health Canada safety review finds risk of serious skin burns with over-the-counter topical pain relievers containing menthol

On 13 February 2017, Health Canada advised Canadians that a safety review has found a risk of serious skin burns with the use of certain over-the-counter (OTC) topical pain relievers containing menthol.

These pain relievers are applied to the skin to produce mild irritation or inflammation intended to help relieve muscle and joint pain. They contain one or more active ingredients and come in various formulations, including creams, gels, liquids and patches.

While a minor rash or a burning sensation are a known side effect, more serious effects like skin burns, pain, blistering or other severe skin damage are not generally expected from the use of these products. Health Canada has received 21 reports of serious side effects involving OTC topical pain relievers containing menthol in various concentrations (containing 0.75% to 11% menthol), as a single ingredient or in combination with other ingredients (most commonly methyl salicylate). In many cases, the products were used as directed, with burns, severe swelling and blistering appearing within 24-48 hours of the first application.

From the available data, it was not possible to determine whether the risk of serious skin burns is linked to any specific brand, formulation or menthol concentration, or any ingredient other than menthol.

Some menthol-containing OTC topical pain relievers already warn about the risk of serious skin burns on their labels or packaging. Health Canada will publish an updated labelling standard for all menthol-containing topical pain relievers in the coming weeks to better inform consumers about the risk. The warnings will advise consumers to stop using the products and get medical help right away if they experience severe skin reactions.

Health Canada's safety review also looked at the ingredients methyl salicylate and capsaicin, in addition to menthol. While serious skin burns have been reported with the use of OTC topical pain relievers containing methyl salicylate or capsaicin, the review did not find sufficient evidence to confirm the same risk with methyl salicylate or capsaicin alone.

Health Canada continues to monitor these products, as part of Health Canada's role of monitoring all health products in Canada. Additional health and safety action to protect Canadians will be taken as needed.

Consumers are advised of the following:

- Stop use of the product and get medical help right away if they experience serious skin reactions such as pain, swelling or blistering.
- Know that all topical pain relievers containing menthol, methyl salicylate or capsaicin produce a warming or cooling sensation where they are applied. They should not cause severe pain or skin damage.
- Always follow the directions provided with the products. Do not apply the product to broken, damaged or irritated skin, and do not bandage the area tightly or apply heat (for example, by using heating pads, lamps, or hot water bottles). This can increase the risk of side effects including serious skin burns.

In Hong Kong, there are 141 registered pharmaceutical products which are topical preparations containing menthol or levomenthol, of which 136 products are over-the-counter medicines. As on 10 March 2017, DH has received two cases of ADR in connection with topical preparation containing menthol, which one was related to allergic dermatitis and another one was related to skin injury, skin red, blister, peeling and discomfort. As Health Canada will continue to monitor these products to determine if additional action is needed, DH will remain vigilant on any safety update on topical preparations containing menthol by Health Canada and other overseas drug

regulatory authorities.

Singapore: Zelboraf® (Vemurafenib) and the risks of Dupuytren's contracture and plantar fascial fibromatosis

On 2 February 2017, Singapore Health Sciences Authority (HSA) announced that Roche would like to inform healthcare professionals that cases of Dupuytren's contracture and plantar fascial fibromatosis have been reported with Zelboraf® (vemurafenib) use.

The reported cases of Dupuytren's contracture seen with Zelboraf® were characterized by thickening or appearance of visible cords in the palm of one or both hands. In the majority of patients, the event persisted when Zelboraf® treatment was maintained, while symptoms improved or resolved when Zelboraf® was interrupted or discontinued. In addition to Dupuytren's contracture, rare cases of mild and moderate plantar fascial fibromatosis were also reported.

Healthcare professionals are advised to inform patients of these risks and exercise caution in patients with pre-existing Dupuytren's contracture and plantar fascial fibromatosis and to follow the dose modification guidance for adverse events. Roche is working with HSA to strengthen the product label for Zelboraf® in Singapore.

In Hong Kong, Zelboraf Film-coated Tab 240mg (HK-61970) is a pharmaceutical product registered by Roche Hong Kong Limited (Roche HK), and is a prescription only medicine. As confirmed with Roche HK, the company has issued a "Dear Healthcare Professional Letter" on the above risks to oncologists, dermatologists and pharmacies under HA on 14 March 2017. As on 10 March 2017, DH has not received any ADR report related to the product. In view of the above HSA announcement on strengthening of product label of Zelboraf, the matter will be discussed by the Registration Committee.

UK: Hyoscine butylbromide (Buscopan) injection: risk of serious adverse effects in patients with underlying cardiac disease

On 20 February 2017, the Medicines and Healthcare products Regulatory Agency (MHRA) advised that prescribing information has been updated in the United Kingdom (UK) to help to minimise the risk of serious adverse reactions in patients with cardiac disease.

Hyoscine butylbromide (Buscopan), given intravenously or intramuscularly, is indicated in UK in acute muscular spasm, as in renal or biliary colic; in radiology for differential diagnosis of obstruction and to reduce spasm and pain in pyelography; and in other diagnostic procedures where spasm may be a problem (eg, gastroduodenal endoscopy).

MHRA has received 9 reports of patients who died after receiving hyoscine butylbromide injection (including a report from a coroner). In most of these cases, the fatal adverse reaction was reported as acute myocardial infarction or cardiac arrest.

Hyoscine butylbromide injection can cause adverse effects including tachycardia, hypotension, and anaphylaxis. These effects can be more serious in patients with underlying cardiac disease (eg, heart failure, coronary heart disease, cardiac arrhythmia, or hypertension). MHRA noted, based on several reports, anaphylaxis is more likely to be fatal in patients with underlying coronary heart disease compared with those without.

MHRA advised healthcare professionals of the following:

- hyoscine butylbromide injection can cause serious adverse effects including tachycardia, hypotension, and anaphylaxis
- these adverse effects can result in a fatal outcome in patients with underlying cardiac disease, such as those with heart failure, coronary heart disease, cardiac arrhythmia, or hypertension
- hyoscine butylbromide injection should be used with caution in patients with cardiac disease
- monitor these patients, and ensure that resuscitation equipment, and personnel who are trained how to use this equipment, are readily available
- hyoscine butylbromide injection remains contraindicated in patients with tachycardia

In Hong Kong, there are 7 registered

pharmaceutical products of hyoscine injection. As on 10 March 2017, DH has not received any ADR report on cardiac side effects after receiving hyoscine injection. In view of the above MHRA announcement, DH issued a letter to inform local healthcare professionals on the warnings on 21 February 2017, and the matter will be discussed by the Registration Committee.

EU: SGLT2 inhibitors: information on potential risk of toe amputation to be included in prescribing information

On 24 February 2017, EMA informed members of public about a potential increased risk of lower limb amputation (mostly affecting the toes) in patients taking the sodium-glucose co-transporter-2 (SGLT2) inhibitors canagliflozin, dapagliflozin and empagliflozin used for type 2 diabetes. Patients taking these medicines are reminded to check their feet regularly and follow their doctor's advice on routine preventative foot care. They should also tell their doctor if they notice any wounds or discoloration, or if their feet are tender or painful.

Canagliflozin, dapagliflozin and empagliflozin are type 2 diabetes mellitus medicines of the class SGLT2 inhibitors. They block a protein in the kidneys called SGLT2, which absorbs glucose back from the urine into the bloodstream as the blood is filtered in the kidneys. By blocking the action of SGLT2, these medicines cause more glucose to be lost in the urine, thereby reducing the levels of glucose in the blood.

The review of SGLT2 inhibitors was prompted by an increase in lower limb amputations (mostly affecting the toes) in patients taking canagliflozin in two clinical trials, CANagliflozin cardioVascular Assessment Study (CANVAS) and CANagliflozin cardioVascular Assessment Study-Renal (CANVAS-R). The studies, which are still ongoing, involved patients at high risk of heart problems and compared canagliflozin with placebo (a dummy treatment).

All patients with diabetes (especially those with poorly controlled diabetes and problems with the heart and blood vessels) are at higher risk of infection and ulcers (sores) which can lead to amputations. The mechanism by which canagliflozin may increase the risk of amputation is still unclear. An increase in lower limb amputations has not been seen in studies with other medicines in the same class, dapagliflozin and empagliflozin. However, data available to 24 February 2017 are limited and the risk may also apply to these other medicines. Further data are expected from ongoing studies with canagliflozin, dapagliflozin and empagliflozin.

A warning of the potential increased risk of toe amputation will be included in the prescribing information for these medicines. For canagliflozin, the prescribing information will also list lower limb amputation as an uncommon side effect (occurring in between 1 and 10 patients in 1,000). Doctors may consider stopping treatment with canagliflozin if patients develop significant foot complications such as infection or skin ulcers.

The review of SGLT2 inhibitors was carried out by EMA's PRAC. The PRAC recommendations have now been endorsed by Committee for Medicinal Products for Human Use (CHMP), and will be sent to the European Commission for a final legally-binding decision valid throughout the EU.

Healthcare professionals are advised of the followings:

- An increase in lower limb amputation (mostly affecting the toes) has been observed in two long-term clinical trials, CANVAS and CANVAS-R, in patients taking canagliflozin compared with those taking placebo. The studies, which are still ongoing, involved patients at high cardiovascular risk.
- Although an increase in amputations has not been seen in studies with other SGLT2 inhibitors, dapagliflozin and empagliflozin, data available to 24 February 2017 are limited and the risk may also apply to these other medicines.
- The underlying mechanism by which canagliflozin may increase the risk of amputation has not been established and no risk factors apart from general risk factors for amputation have been identified.
- As a precaution, patients taking an SGLT2-inhibitor should be counselled about the importance of routine preventative foot care.
- For canagliflozin, consideration should also be given to carefully monitoring patients at higher risk of amputation and counselling

them about the importance of maintaining adequate hydration.
- Consideration may be given to stopping treatment with canagliflozin in patients who develop events preceding amputation such as lower-extremity skin ulcer, infection, osteomyelitis or gangrene.

In Hong Kong, there are 10 registered pharmaceutical products containing SGLT2 inhibitors, including 2 canagliflozin products, namely Invokana Tablets 100mg (HK-63499) and 300mg (HK-63500) registered by Johnson & Johnson (HK) Ltd; 2 dapagliflozin products, namely Forxiga Tablet 10mg (HK-63302) and Forxiga Tablet 5mg (HK-63301) registered by Astrazeneca HK Ltd; and 6 empagliflozin products, namely Jardiance Tablets 10mg (HK-64095) and 25mg (HK-64096), Jardiance Duo Tablets 12.5mg/850mg (HK-64240), 5mg/850mg (HK-64241), 12.5mg/1000mg (HK-64242) and 5mg/1000mg (HK-64243) registered by Boehringer Ingelheim (HK) Ltd. All these 10 products are prescription only medicines.

Related news was previously issued by various overseas drug regulatory authorities, and was reported in the Drug News Issue No. 78. DH issued a letter to inform local healthcare professionals on the warnings on 18 April 2016. According to Johnson & Johnson (HK) Ltd, the 2 clinical trials CANVAS and CANVAS-R mentioned in the EMA announcement were not conducted in Hong Kong.

As on 10 March 2017, DH has received four cases of ADR related to SGLT2 inhibitors, but none of them were related to amputation. In light of the EMA announcement, the matter will be discussed by the Registration Committee. DH will continue to remain vigilant on further safety updates on SGLT2 inhibitors issued by other drug regulatory authorities.

Drug Recall

DH endorsed batch recall of Plasma-Lyte 148 Approx. pH 7.4 IV Infusion (HK-64576)

On 6 February 2017, DH endorsed a licenced drug wholesaler, Baxter Healthcare Ltd (Baxter), to recall one batch (batch number: W13X1) of Plasma -Lyte 148 Approx. pH 7.4 IV Infusion (HK-64576) from the market because the labeling of the product does not match with the registered record.

DH received notification from Baxter that they were informed by their customer that the product was missing ancillary labels that should contain information such as the name of the product, manufacturer's information, storage condition and Hong Kong registration number. According to Baxter, only one batch of the product was found to be affected. Since the issue renders the product unregistered, Baxter decided to recall the affected batch from the market.

The above product, containing electrolytes, is a non -prescription drug used as electrolyte supplement. According to Baxter, the affected products have been supplied to two hospitals under the Hospital Authority.

As on 10 March 2017, DH has not received any ADR report in connection with the affected product. A notice was posted on the Drug Office website on 6 February 2017 to alert the public of the product recall.

DH endorsed recall of Lipiduce-10 Tablet 10mg (HK-59662), Lipiduce-20 Tablet 20mg (HK-59661) and Pengesic SR Tablet 100mg (HK-59354)

On 27 February 2017, DH endorsed a licenced drug wholesaler, Hovid Ltd. (Hovid), to recall all batches of Lipiduce-10 Tab 10mg (HK-59662), Lipiduce-20 Tab 20mg (HK-59661) and Pengesic SR Tab 100mg (HK-59354) from the market because the label and package insert of the products do not match with the registered ones.

During DH market surveillance, sample of the above products were collected for analysis and examination. They were found that the label and package insert of the products were different from that of the registered products, which render the product unregistered. Since the supply of unregistered pharmaceutical product contravenes

the Pharmacy and Poisons Regulations (Cap. 138A), Hovid voluntary recalls the products from the market.

The above products Lipiduce-10 Tablet 10mg and Lipiduce-20 Tablet 20mg, containing atorvastatin, used for the reduction of lipids, while Pengesic SR Tablet 100mg containing tramadol used for relief of pain, all products are prescription only medicines products. According to Hovid, the products have been supplied to private doctors and local pharmacies.

As on 10 March 2017, DH has not received any ADR report in connection with the affected products. A notice was posted on the Drug Office website on 27 February 2017 to alert the public of the product recall.

DH endorsed recall of Mocam tab 7.5mg (HK-55792) and Lucidol Cap 50mg (HK-55355)

On 27 February 2017, DH endorsed a licenced drug wholesaler, Eugenpharm International Limited (Eugenpharm), to recall all batches of Mocam tab 7.5mg (30's tablet) (HK-55792) and Lucidol cap 50mg (HK-55355) from the market because of the unregistered 30's tablet pack size of Mocam tab 7.5mg while the label of the Lucidol cap 50mg does not match with the registered ones.

During DH market surveillance, sample of the above products were collected for analysis and examination. They were found that the pack size or label of the products were different from that of the registered product, which render the product unregistered. Since the supply of unregistered pharmaceutical product contravenes the Pharmacy and Poisons Regulations (Cap. 138A), Eugenpharm voluntary recalls the products from the market.

The above product Mocam tab 7.5mg, containing meloxicam used for control of pain and inflammation while Lucidol Cap 50mg containing tramadol used for control of pain, both are prescription only medicines. According to Eugenpharm, the products have been supplied to private doctors and local pharmacies.

As on 10 March 2017, DH has not received any ADR report in connection with the affected products. A notice was posted on the Drug Office website on 27 February 2017 to alert the public of the product recall.

DH endorsed recall of Flamic Cap 10mg (HK-33260)

On 27 February 2017, DH endorsed a licenced drug wholesaler, Kai Yuen Pharmaceutical Co. (Kai Yuen), to recall all batches of Flamic Cap 10mg (HK-33260) from the market because the label and package insert of the product do not match with the registered ones.

During DH market surveillance, sample of the above product was collected for analysis and examination. It was found that the label and package insert of the product were different from that of the registered product, which render the product unregistered. Since the supply of unregistered pharmaceutical product contravenes the Pharmacy and Poisons Regulations (Cap. 138A), Kai Yuen voluntary recalls the product from the market.

The above product, containing Piroxicam, is a prescription only medicines product used for the control of pain and inflammation. According to Kai Yuen, the product has been supplied to private doctors and local pharmacies.

As on 10 March 2017, DH has not received any ADR report in connection with the affected product. A notice was posted on the Drug Office website on 27 February 2017 to alert the public of the product recall.

Drug Incident

DH urges public not to buy or consume slimming product with undeclared Western drug ingredient orlistat

On 7 February 2017, DH appealed to the public not to buy or consume a slimming product called CA NI Slim BELLANCE as it was found to contain an undeclared Part 1 poison, orlistat.

During DH's market surveillance, a sample of the above product was purchased from a mobile application for analysis. Testing results of the Government Laboratory revealed that the sample contained orlistat.

Orlistat is a Part 1 poison used for the treatment of obesity. Its side-effects include faecal urgency, fatty stool, increased frequency of defecation, faecal incontinence, headache and abdominal pain. Severe liver injuries may also be induced.

Weight control should be achieved through a balanced diet and appropriate exercise. The public should consult healthcare professionals before using any medication for weight control.

A notice was posted on the Drug Office website on 7 February 2017 to alert the public of the drug incident.

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 two years' imprisonment for each offence. Antibiotics 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 one year's imprisonment for each offence.

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.

Update on Drug Office's website: You can now search the newly registered medicines in the past year at http://www.drugoffice.gov.hk/eps/drug/newsNRM60/en/healthcare_providers?pageNoRequested=1.
Details of ALL registered pharmaceutical products can still be found in the Drug Office website at http://www.drugoffice.gov.hk/eps/do/en/healthcare_providers/news_informations/reListRPP_index.html.

Useful Contact

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Adverse Drug Reaction (ADR) Reporting:

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E-mail: adr@dh.gov.hk

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

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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.