



This is a monthly digest of local and overseas drug safety news released by the Drug Office of the Department of Health in December 2018 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: Summary Safety Review - Vascular endothelial growth factor receptor tyrosine kinase inhibitors (VEGFR TKIs) - Assessing the potential risk of abnormal structural changes of the artery walls including rupture (artery dissections and artery aneurysms)

On 3 December 2018, Health Canada announced that it reviewed the potential risk of 2 types of abnormal structural changes of the artery walls (artery dissections and artery aneurysms) with the use of VEGFR TKIs. This review was triggered by the publication of a Canadian case of artery dissection with the use of the VEGFR TKI drug Sutent. There are currently 8 VEGFR TKIs marketed in Canada: Sutent (sunitinib), Nexavar (sorafenib), Inlyta (axitinib), Votrient (pazopanib), Iclusig (ponatinib), Stivarga (regorafenib), Caprelsa (vandetanib) and Lenvima (lenvatinib).

An artery dissection is a tear of the inside lining of an artery. An artery aneurysm is a balloon-like bulge in the wall of a blood vessel that carries oxygen to various tissues in the body (artery). A rupture of the aneurysm can cause bleeding and may lead to death. These disorders of the arterial wall occur more frequently in the largest artery of the body (the aorta), but can also develop in any other artery. High blood pressure (hypertension) and the build-up of plaques inside arteries (atherosclerosis) are major risk factors for artery dissections and/or aneurysms (D/A). Hypertension is a well-known side effect of VEGFR TKIs.

At the time of the review, Health Canada had received 1 Canadian report of artery dissection and 1 Canadian report of artery aneurysm suspected to

be linked to Sutent use. Health Canada also looked at 208 international reports of artery D/A suspected to be linked to the use of VEGFR TKIs. Of the 210 reports (2 Canadian and 208 international), 80 reports (43 artery dissections and 37 artery aneurysms) were further reviewed as they contained the necessary information for a thorough assessment.

Of the 43 reports of artery dissections, 20 showed a possible link between VEGFR TKIs use and artery dissections. In 2 of these reports, dissection occurred without hypertension. For the remaining 23 reports, the dissection was more likely due to another medical condition (3 reports), or the link could not be assessed due to insufficient information (20 reports).

Of the 37 reports of artery aneurysms, only 3 had a documented absence of aneurysm prior to VEGFR TKI use and were further assessed. Of these 3 reports, 1 report showed a possible link between VEGFR TKI use and the artery aneurysm; in the other 2 reports, the aneurysm was either due to another condition, or the link could not be assessed due to insufficient information. The review of the remaining 34 reports revealed a worsening of the condition, with a rupture of the aneurysm in the majority of cases (23/34) during VEGFR TKI use.

Of the 46 reports that were further assessed to find if VEGFR TKIs use was the cause of the artery D/A (43 artery dissections and 3 artery aneurysms), 10 deaths were reported (9 artery dissections and 1 artery aneurysm). Of these, 3 deaths were found to have a possible link with VEGFR TKI use; 1 was more likely due to another condition, and in 6 reports the link could not be assessed due to

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insufficient information.

Health Canada's review of the available information found that there may be a link between the use of VEGFR TKIs and the risk of artery dissections and aneurysms (including rupture), in individuals with or without hypertension. Health Canada is working with the manufacturers to update the product safety information for all VEGFR TKIs to inform the Canadian public and healthcare professionals about this risk.

In Hong Kong, there are registered pharmaceutical products containing sunitinib (4 products), sorafenib (1 product), axitinib (2 products), pazopanib (4 products), regorafenib (1 product), vandetanib (2 products) and lenvatinib (2 products). All products are prescription-only medicines. There is no registered pharmaceutical product containing ponatinib.

As of 7 January 2019, the Department of Health (DH) has received cases of adverse drug reaction (ADR) related to sunitinib (8 cases), sorafenib (11 cases), axitinib (16 cases), pazopanib (4 cases), regorafenib (31 cases), vandetanib (1 case), lenvatinib (4 cases) and ponatinib (1 case), but these cases are not related to artery dissections and artery aneurysms.

In light of the above Health Canada's announcement, the DH issued a letter to inform local healthcare professionals to draw their attention on 4 December 2018 and the matter will be discussed by the Registration Committee of the Pharmacy and Poisons Board (the Registration Committee).

UK: Oral lidocaine-containing products for infant teething: only to be available under the supervision of a pharmacist

On 13 December 2018, the Medicines and Healthcare products Regulatory Agency (MHRA) of the United Kingdom (UK) announced that oral lidocaine-containing products for infant teething are only to be available under the supervision of a pharmacist so that parents and caregivers can receive guidance about managing infant teething symptoms. Non-medicinal options such as a teething ring or massaging the gum should be the

first line for relieving infant teething symptoms, and lidocaine-containing products should only be used when simple measures have failed to provide sufficient relief. Sugar-free paracetamol or ibuprofen suspensions, administered according to the approved indication and dose for weight and age, can also be considered for the relief of teething symptoms.

The Commission on Human Medicines (CHM) has advised on measures to improve the safe use of lidocaine-containing products for teething in children. In an in-depth review of the benefits and risks of these products, CHM identified a number of reports of medication error received via the Yellow Card Scheme. Most reports did not include an associated adverse event and were not thought to result in harm, but the committee recommended that the administration instructions should be improved and harmonised to ensure parents and caregivers received consistent advice on the safe use of these medicines in babies. CHM recommended that pharmacists were best placed to provide guidance to parents and caregivers on options for teething symptoms, including when symptoms could suggest more serious conditions that need medical assessment.

The legal status of newly manufactured stock of oral lidocaine-containing products indicated for infant teething is changing from general sale (GSL) to pharmacy (P) in UK. This change means that oral lidocaine products for infant teething can only be sold in pharmacies where advice can be given by the pharmacist. Instructions for administration and safety warnings are being updated in the new patient information leaflet. Advice is being given to parents and caregivers to seek medical attention if their child's condition does not improve and not to use more than one product containing lidocaine at the same time.

Oral lidocaine products that are approved in adults or in other conditions (e.g. mouth ulcers) will remain GSL but should not be used in infants for teething because they have different approved dosing regimens. The patient information leaflets and cartons of these oral lidocaine-containing products without a teething indication in UK are being updated accordingly.

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In Hong Kong, there are 48 registered pharmaceutical products containing lignocaine for dental/oromucosal applications. As of 7 January 2019, the DH has not received any case of ADR related to these products.

News related to the safety of lignocaine viscous products in infants and children was previously issued by the United States (US) Food and Drug Administration (FDA), and was reported in the Drug News Issue No. 56. The DH issued a letter to inform local healthcare professionals to draw their attention on 27 June 2014. In February 2015, the Registration Committee decided that topical oral lignocaine products (for strength $\geq 2\%$) should not be used to treat infants and children with teething pain.

In light of the above MHRA's announcement on the update of patient information of oral lignocaine products, the DH issued a letter to inform local healthcare professionals to draw their attention on 14 December 2018 and the matter will be discussed by the Registration Committee.

EU: EMA recommends aligning doses of metamizole medicines and their use during pregnancy and breastfeeding

On 14 December 2018, the European Medicines Agency (EMA) of the European Union (EU) recommended that the maximum daily dose of metamizole and the contraindications to its use in pregnancy or women who are breastfeeding should be harmonised for all products on the EU market following a review of the medicines containing this painkiller. The recommendation addresses inconsistencies in the product information for metamizole medicines, which are marketed in many EU member states to treat severe pain and fever that cannot be controlled with other treatments.

The review was carried out by the EMA's Committee for Medicinal Products for Human Use (CHMP) at the request of Poland, which was concerned by the substantial differences in the recommendations on the use of metamizole in different EU countries, given that it is known the medicine may occasionally cause severe side

effects, such as effects on the blood. The Agency reviewed the available information on the way the medicine is distributed in the body, how it works and the limited data on its effects on the unborn child or breast-fed infant.

The EMA's recommendations include setting a maximum single dose by mouth of 1,000 mg, taken up to 4 times daily (a maximum daily dose of 4,000 mg), in patients from 15 years of age. Treatment should start at the lowest recommended dose and only be increased if needed. If given by injection the total daily dose should not exceed 5,000 mg. Doses in younger patients should be based on their body weight but some products may be unsuitable because of their strength.

Although metamizole has been on the market for nearly a century, evidence of its effects in pregnancy and breastfeeding is scarce. The review found little to suggest problems in early pregnancy, and single doses in the first 6 months might be acceptable if other analgesics cannot be used. However, there is some evidence of effects on the kidneys and circulation of the fetus if the medicine is used in the last 3 months of pregnancy, and the medicine should therefore not be used in this period. As a precaution, metamizole should not be used during breastfeeding because the infant may receive high amounts of the medicine in the milk relative to the infant's weight.

The EMA has recommended changes to the product information of metamizole, to ensure that advice on the maximum daily doses and warnings not to use the medicine during the last 3 months of pregnancy or during breastfeeding are consistent across the EU.

In Hong Kong, there are 2 registered pharmaceutical products containing metamizole (also known as noramidopyrine methanesulphonate in Hong Kong) which are Sulpyrin Inj 25% (HK-02899) and Olan-gin (with Lidocaine HCl) Inj 1g/2ml (HK-16283). Both products are prescription-only medicines. As of 7 January 2019, the DH has not received any case of ADR related to metamizole. In light of the above EMA's announcement, the DH issued a letter to inform local healthcare professionals to draw their attention on 17 December 2018 and the matter will

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be discussed by the Registration Committee.

UK: Direct-acting antivirals for chronic hepatitis C: risk of hypoglycaemia in patients with diabetes

On 18 December 2018, the MHRA announced that studies show that some patients with diabetes initiating direct-acting antiviral therapy for hepatitis C have experienced hypoglycaemia. The studies indicate that achieving sustained virological response (SVR) is associated with improvements in glycaemic control, compared to patients who relapse or are non-responders. Many studies recorded these changes in glycaemic control in the first 3 months of treatment. Some studies reported the need to adjust patient's diabetic medication following changes in glucose metabolism, with up to 30% of patients requiring adjustments to their treatment.

An EU review confirmed the risk of hypoglycaemia in patients with diabetes who had been initiated on direct-acting antivirals for chronic hepatitis C. Information on the risk is being added to the Summary of Product Characteristics and Patient Information Leaflet for these medicines.

Patients with diabetes should be closely monitored for changes in glucose levels, particularly in the first 3 months of treatment, and adjustments to their diabetic medication or doses made where necessary.

In UK, direct-acting antivirals for chronic hepatitis C infection include: daclatasvir (Daklinza ▼); sofosbuvir/velpatasvir (Epclusa ▼); ledipasvir/sofosbuvir (Harvoni ▼); sofosbuvir (Sovaldi ▼); sofosbuvir/velpatasvir/voxilaprevir (Vosevi ▼); dasabuvir (Exviera ▼); ombitasvir/paritaprevir/ritonavir (Viekirax ▼); glecaprevir/pibrentasvir (Maviret ▼); and elbasvir/grazoprevir (Zepatier ▼).

Healthcare professionals are advised:

- Rapid reduction in hepatitis C viral load during direct-acting antiviral therapy for

hepatitis C may lead to improvements in glucose metabolism in patients with diabetes, potentially resulting in symptomatic hypoglycaemia if diabetic treatment is continued at the same dose.

- Be vigilant for changes in glucose tolerance and advise patients of the risk of hypoglycaemia during direct-acting antiviral therapy, particularly within the first 3 months when the viral load is being reduced, and modify diabetic medication or doses when necessary.
- Physicians who initiate direct-acting antiviral therapy in patients with diabetes should inform the healthcare professional in charge of the diabetic care of the patient.
- Report any suspected ADRs associated with direct-acting antiviral therapies.

In Hong Kong, there are eight registered pharmaceutical products which are direct-acting antivirals, namely: Sovaldi Tablets 400mg containing sofosbuvir (HK-63501), Harvoni Tablets containing the combination of sofosbuvir and ledipasvir (HK-63886), Epclusa Tablets 400mg/100mg containing the combination of sofosbuvir and velpatasvir (HK-65046), and Vosevi Tablets containing the combination of sofosbuvir, velpatasvir and voxilaprevir (HK-65775), which are registered by Gilead Sciences Hong Kong Limited; Viekira Pak Tablets containing the combination of ombitasvir, paritaprevir, ritonavir and dasabuvir (HK-63695), and Maviret Tablets containing the combination of glecaprevir and pibrentasvir (HK- 65653), which are registered by Abbvie Limited; Daklinza Tablets 60mg containing daclatasvir (HK-64505) which is registered by Bristol-Myers Squibb Pharma (HK) Ltd; and Zepatier Tablets containing the combination of grazoprevir and elbasvir (HK-65571) which is registered by Merck Sharp & Dohme (Asia) Ltd. All are prescription-only medicines.

As of 7 January 2019, the DH has received 46 cases of ADR related to above mentioned registered direct-acting antivirals, including 3 cases related to sofosbuvir, 5 cases related to sofosbuvir and ledipasvir combination products, 34 cases related to ombitasvir, paritaprevir, ritonavir and dasabuvir combination products, 1 case related to daclatasvir, and 3 cases related to glecaprevir and

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pibrentasvir combination products; but none of these cases was related to hypoglycaemia. In view of the above MHRA announcement, the DH issued a letter to inform local healthcare professionals to draw their attention on 19 December 2018, and the matter will be discussed by the Registration Committee.

US: FDA warns about increased risk of ruptures or tears in the aorta blood vessel with fluoroquinolone antibiotics in certain patients

On 20 December 2018, the US FDA announced that a FDA review found that fluoroquinolone antibiotics can increase the occurrence of rare but serious events of ruptures or tears in the main artery of the body, called the aorta. These tears, called aortic dissections, or ruptures of an aortic aneurysm can lead to dangerous bleeding or even death. They can occur with fluoroquinolones for systemic use given by mouth or through an injection.

Fluoroquinolones should not be used in patients at increased risk unless there are no other treatment options available. People at increased risk include those with a history of blockages or aneurysms of the aorta or other blood vessels, high blood pressure, certain genetic disorders that involve blood vessel changes, and the elderly. The FDA is requiring that a new warning about this risk be added to the prescribing information and patient Medication Guide for all fluoroquinolones.

Healthcare professionals should

- Avoid prescribing fluoroquinolone antibiotics to patients who have an aortic aneurysm or are at risk for an aortic aneurysm, such as patients with peripheral atherosclerotic vascular diseases, hypertension, certain genetic conditions such as Marfan syndrome and Ehlers-Danlos syndrome, and elderly patients.
- Prescribe fluoroquinolones to these patients only when no other treatment options are available.
- Advise all patients to seek immediate medical treatment for any symptoms associated with aortic aneurysm.
- Stop fluoroquinolone treatment immediately if a patient reports side effects suggestive of aortic aneurysm or dissection.

Patients should

- Seek medical attention immediately by going to an emergency room or calling 911 if they experience sudden, severe, and constant pain in the stomach, chest or back.
- Be aware that symptoms of an aortic aneurysm often do not show up until the aneurysm becomes large or bursts, so report any unusual side effects from taking fluoroquinolones to their healthcare professional immediately.
- Before starting an antibiotic prescription, inform their healthcare professional if they have a history of aneurysms, blockages or hardening of the arteries, high blood pressure, or genetic conditions such as Marfan syndrome or Ehlers-Danlos syndrome.
- If they have been prescribed a fluoroquinolone to treat an infection, do not stop the antibiotic without first talking to their healthcare professional.

The FDA reviewed cases reported to the FDA Adverse Event Reporting System (FAERS) and four published observational studies that showed an increased risk of aortic aneurysm or dissection associated with fluoroquinolone use. How some of the studies were designed or carried out, and the ways the data were analyzed could affect the study findings; however, taken together, the results of all four studies provide consistent evidence of an association between fluoroquinolone use and aortic aneurysm or dissection. The underlying mechanism for this risk cannot be determined from these studies, and the background risk of aortic aneurysm can vary depending on the population. The background risk has been estimated from nine aortic aneurysm events per 100,000 people per year in the general population to 300 aortic aneurysm events per 100,000 people per year in individuals at highest risk. Because multiple studies showed higher rates of about twice the risk of aortic aneurysm rupture and dissection in those taking fluoroquinolones, the FDA determined the warnings were warranted to alert healthcare professionals and patients.

List of FDA-approved systemic fluoroquinolones include moxifloxacin, delafloxacin, ciprofloxacin, ciprofloxacin extended-release, gemifloxacin, levofloxacin and ofloxacin.

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In Hong Kong, there are 188 registered pharmaceutical products containing fluoroquinolones which are oral preparations or injectables for use in human, including ciprofloxacin (81 products), levofloxacin (62 products), moxifloxacin (6 products), norfloxacin (7 products), ofloxacin (30 products), prulifloxacin (1 product) and sparfloxacin (1 product). All products are prescription-only medicines. As of 7 January 2019, the DH has received 4 cases of ADR related to levofloxacin and 1 case related to moxifloxacin, but these cases are not related to aortic aneurysm and dissection.

Related news was previously issued by the MHRA and was reported in the Drug News Issue No. 109. The DH issued a letter to inform local healthcare professionals to draw their attention on 15 November 2018. In light of the MHRA's and above FDA's announcement, the matter will be discussed by the Registration Committee.

Taiwan: Recall of Cosar F.C. Tablets 50 mg 脈莎平膜衣錠 50 毫克 by Siu Guan Chem. Ind. Co., Ltd.

On 29 December 2018, the Taiwan Food and Drug Administration (TFDA) announced that it received notification from Siu Guan Chem. Ind. Co., Ltd. on 26 December 2018 regarding an impurity, *N*-nitrosodiethylamine (NDEA) detected in one batch of the losartan Active Pharmaceutical Ingredient (API) manufactured by IPCA in India. 11 batches of Cosar F.C. Tablets 50 mg 脈莎平膜衣錠 50 毫克 (batch numbers: 511193, 601083, 601233, 601243, 606193, 607023, 607033, 609173, 610013, 610023 and 702043) were manufactured using this batch of losartan API. Recall was initiated immediately on 27 December 2018.

In Hong Kong, as of 7 January 2019, there are 251 registered pharmaceutical products containing valsartan (83 products), candesartan (19 products), irbesartan (63 products), losartan (69 products) and olmesartan (17 products). All products are prescription-only medicines.

Regarding impurities in valsartan, a public announcement was issued on 6 July 2018, and the DH issued letters to inform local healthcare

professionals on 6 July 2018, 9 July 2018, 25 July 2018 and 3 August 2018. Related news for the detection of impurities in sartan-containing products was also previously issued by various overseas drug regulatory authorities, and was reported in the Drug News Issue No. 105, 106, 107, 108 and 109.

In brief, there are four manufacturers, namely Zhejiang Huahai, Zhejiang Tianyu and Zhuhai Rundu in China and Hetero Labs Limited in India, reported to have detection of trace amounts of *N*-nitrosodimethylamine (NDMA) in the valsartan API by various overseas drug regulatory authorities. The DH contacted the certificate holders of all registered valsartan products to follow up on the local impact regarding valsartan API produced by the above mentioned manufacturers.

For API produced by Zhejiang Huahai, there are 5 affected products (HK-60794, HK-61784, HK-61785, HK-61786 and HK-61787) marketed in Hong Kong. The DH instructed the certificate holders to recall all the products from the market as a precautionary measure on 6 July 2018, and the DH noted that all the recalls have been completed.

For API produced by Zhejiang Tianyu, amongst the registered pharmaceutical products containing valsartan, there is only one product namely Retoni Tablets 80mg (HK-65604) registered by Swiss Pharmaceutical Co Limited (Swiss Pharmaceutical) which has used API produced by Zhejiang Tianyu and is available in the local market. As confirmed with Swiss Pharmaceutical, the API was tested by the TFDA and the company has not received any notice from the TFDA for NDMA contamination. The DH collected samples of Retoni tablets for analysis and no NDMA was detected.

For API produced by Zhuhai Rundu and Hetero Labs Limited, the certificate holders confirmed that the valsartan products available in local market are not manufactured using API produced by Zhuhai Rundu or Hetero Labs Limited.

Regarding the announcements issued by various overseas drug regulatory authorities on the detection of the second impurity of NDEA in the valsartan API produced by Zhejiang Huahai, there

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should be no local impact as all valsartan products manufactured using API produced by Zhejiang Huahai have been recalled from the market.

Regarding the announcements issued by various overseas drug regulatory authorities on the detection of NDEA in the valsartan API produced by Mylan Laboratories Limited in India, the certificate holders confirmed that the valsartan products available in local market are not manufactured using API produced by this company.

Regarding the EMA's and the US FDA's announcement on the detection of NDEA in the losartan API produced by Hetero Labs Limited, the FDA's announcement on NDEA in the losartan API produced by Zhejiang Huahai, the above TFDA's announcement on NDEA in the losartan API produced by IPCA in India, and the announcements issued by the EMA, FDA and TFDA on NDEA in the irbesartan API produced by Aurobindo Pharma in India, the DH has contacted the certificate holders of all registered candesartan, irbesartan, losartan and olmesartan products and will continue to follow up on the impact of NDEA impurities on the products available in the local market. On 20 December 2018, the DH endorsed Actavis Hong Kong Limited to recall one batch (batch number: 058818) of Irbesartan HCT Actavis

Tablets 150/12.5mg (HK-63378) from the market as a precautionary measure because an impurity was detected in one of the raw materials of this batch of product, a public announcement was issued on 20 December 2018. The DH is closely monitoring the recall.

As of 7 January 2019, the DH has received 16 cases of ADR related to valsartan, candesartan, irbesartan, losartan and olmesartan. None of them is concluded to be related to the presence of NDMA and/or NDEA. The DH will keep vigilant on any further updates on the matter issued by overseas regulatory authorities.

Patients who are taking the above products should not stop taking the medicines, but should seek advice from their healthcare professionals as soon as possible for proper arrangement.

The DH has provided update information at Drug Office's website (www.drugoffice.gov.hk) and will remain vigilant on any safety update related to the impurities NDMA and NDEA in sartan-containing (candesartan, irbesartan, losartan, olmesartan and valsartan) products.

Drug Recall

DH endorsed recall of Moxipen Suspension 125mg/5ml (HK-36163)

On 19 December 2018, the DH endorsed a licenced pharmaceutical secondary packaging manufacturer, U. S. Summit Co. Ltd. (Summit), to recall all batches of Moxipen Suspension 125mg/5ml (HK-36163) from the market because the product's label does not match with the registered one.

During the DH's routine inspection, it was found that the label of the above product was different from the registered label, which render the product unregistered. Since the supply of unregistered pharmaceutical product contravenes the Pharmacy and Poisons Regulations (Cap. 138A), Summit voluntarily recalls the product from the market.

The above product, containing amoxicillin, is an antibiotic used for treatment of various bacterial infections. According to Summit, the product has been supplied to local private doctors.

As of 7 January 2019, the DH has not received any ADR report related to the affected product. A notice was posted on the Drug Office website on 19 December 2018 to alert the public of the product recall.

DH endorsed batch recall of Irbesartan HCT Actavis Tablets 150/12.5mg (HK-63378)

On 20 December 2018, the DH endorsed a product registration certificate holder, Actavis Hong Kong

Drug Recall

Limited (Actavis), to recall one batch (batch number: 058818) of Irbesartan HCT Actavis Tablets 150/12.5mg (HK-63378) from the market as a precautionary measure because an impurity was detected in one of the raw materials of this batch of product.

The DH received notification from Actavis on 20 December 2018 that, through its analytical testing, certain batches of the irbesartan raw materials were found to contain an impurity, NDEA. NDEA is classified as a probable human carcinogen (a substance that could cause cancer). A number of irbesartan-containing products using these raw materials were thus affected. Among the affected products, the above batch of tablets has been imported into and supplied in Hong Kong. As a precautionary measure, Actavis has voluntarily recalled the affected batch from the market.

The above product, containing irbesartan and hydrochlorothiazide, is a prescription medicine used to lower blood pressure. According to Actavis, the affected batch has been supplied to local private doctors, pharmacies and one private hospital.

As of 7 January 2019, the DH has not received any ADR report related to the affected product. Press release was posted on the Drug Office website on 20 December 2018 to alert the public of the product recall.

Patients who are taking the above product should not stop taking the medicines, but should seek advice from their healthcare professionals for appropriate management.

Drug Incident

Public urged not to buy or consume slimming product with undeclared controlled ingredients sibutramine, fluoxetine and orlistat

On 27 December 2018, the DH appealed to the public not to buy or consume a slimming product named "BBS Super Fast" as it was found to contain undeclared and controlled drug ingredients that might be dangerous to health.

Following a public enquiry, the DH collected a sample of the above product from the market for analysis. Test results from the Government Laboratory revealed that the sample contains sibutramine, fluoxetine and orlistat, which are all Part 1 poisons under the Pharmacy and Poisons Ordinance (Cap. 138).

Sibutramine was once used as an appetite suppressant. Since November 2010, products containing sibutramine have been banned in Hong Kong because of increased cardiovascular risk. Fluoxetine is used for treatment of mood disorder and may cause hallucination and insomnia. Meanwhile, orlistat is 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.

The public may visit the Drug Office's pages for health messages on [weight control and slimming products](#) and [information on slimming products with undeclared Western drug ingredients](#).

Press release was posted on the Drug Office website on 27 December 2018 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.

Under the Import and Export Ordinance (Cap. 60), pharmaceutical products must be imported or exported under and in accordance with an import or export licence issued under the Import and Export Ordinance. Illegal import or export of pharmaceutical products are offences under the Import and Export Ordinance (Cap. 60) and the maximum penalty is a fine of \$500,000 and 2 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.

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

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.