Drug News
藥 物 情 報

Issue Number 130

This is a monthly digest of local and overseas drug safety news released by the Drug Office of the Department of Health in August 2020 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

UK: Stimulant laxatives (bisacodyl, senna and sennosides, sodium picosulfate) available over-the-counter: new measures to support safe use

On 18 August 2020, the Medicines and Healthcare products Regulatory Agency (MHRA) of the United Kingdom (UK) announced that it has introduced pack size restrictions, revised recommended ages for use, and new safety warnings for over-the-counter stimulant laxatives (orally and rectally administered) following a national safety review.

Stimulant laxatives are used to treat constipation. Medicines available in the UK over-the-counter are bisacodyl, senna and sennosides, and sodium picosulfate.

The safety of stimulant laxatives has been under close review by the MHRA for many years following concerns relating to misuse and abuse. Previous measures have included the addition of warnings to some products to advise that laxatives do not aid weight loss and that long-term use may be harmful.

Following a national safety review, including advice from expert advisory groups and an Expert Working Group, the Commission on Human Medicines (CHM) has recommended the MHRA introduce a package of measures to support the safe use of over-the-counter stimulant laxatives in the UK. In their in-depth review of the benefits and risks of these medicines, the CHM noted that stimulant laxatives have an acceptable safety profile, have been widely used for many years, and are generally used responsibly. However, the CHM also considered evidence that stimulant laxatives are subject to misuse and overuse. Such cases mostly concern people with eating disorders, although misuse and overuse are likely to be under-reported. Occasional, serious reports of misuse and overdose have been received, including rare reports of fatalities. Furthermore, the CHM noted that current clinical guidance in the UK recommends that stimulant laxatives should not be used first-line for short-term constipation. The CHM concluded that stimulant laxatives could continue to be available to patients to purchase, subject to a range of proportionate measures to reduce the risk of misuse and support correct use.

Changes to stimulant laxatives to support safety:

Pack size restrictions

- Smaller packs will continue to be available for general sale for the treatment of short-term, occasional constipation for use in adults only. Products available for general sale will be limited to a pack size of two short treatment courses (up to 20 standard-strength tablets, 10 maximum-strength tablets or 100ml solution/syrup). This limit is to reflect that these medicines should be used for only short-term, occasional constipation.

Revised recommended ages for use

- Stimulant laxatives on general sale (in shops and supermarkets) will be recommended for use only in people 18 years or older. Stimulant laxatives should no longer be used in children under 12 years without advice from a prescriber, while products for children aged 12 to 17 years can be supplied under the supervision of a pharmacist.

Harmonisation of indications and new safety warnings

- The indications for all stimulant laxative products available over-the-counter have been made consistent and any uses not appropriate for the self-care setting have been removed.

Where stimulant laxatives are required regularly for longer-term use in chronic constipation or for indications not appropriate for the self-care setting, such as bowel clearance before surgery, they will be available as prescription-only products.
- Warnings in the patient information leaflets that accompany these medicines in the UK will be made consistent and advise patients that overuse of stimulant laxatives may be harmful due to the risk of fluid and electrolyte disturbances and potential disruption of intestinal function. Warnings are also being added to packaging in the UK to support awareness. The product information will also include the new age recommendations.

Advice for healthcare professionals:

Constipation treatment options

- For constipation, manage underlying causes and advise adult patients on appropriate first-line dietary and lifestyle measures, such as increasing dietary fibre, fluid intake, and activity levels.
- Stimulant laxatives should only be used if other laxatives (bulk-forming and osmotic) are ineffective (as clinical guidance).
- Children younger than 12 years should not use stimulant laxatives without advice from a prescriber and clinical guidance should be followed.

Changes to availability

- Large packs of stimulant laxatives will no longer be available from general sale outlets in the UK, such as newsagents and supermarkets; smaller packs will continue to be available in these outlets for short-term, occasional constipation in adults.
- Pharmacies will continue to hold larger packs of up to 100 tablets for use in adults and children aged 12 years or older, under the supervision of a pharmacist.

Advice to provide to patients

- Seek support from a doctor, nurse, or pharmacist for ongoing constipation, rather than self-medicating with laxatives in the long-term.
- If symptoms of constipation persist after dietary and lifestyle changes and short-term laxative treatment (under the advice of pharmacist), or in case of persistent abdominal pain or passing blood, consult a doctor.
- Parents and caregivers should seek medical advice about constipation in children – children younger than 12 years should not use stimulant laxatives unless told to do so by their prescriber.

In Hong Kong, there are registered pharmaceutical products containing bisacodyl (39 products), senna and sennosides (18 products), and sodium picosulfate (4 products). All products are over-the-counter medicines. As on 7 September 2020, the Department of Health (DH) has not received any case of adverse drug reaction (ADR) related to bisacodyl, senna and sennosides, and sodium picosulfate.

In light of the above MHRA's announcement, the DH issued a letter to inform local healthcare professionals to draw their attention on 19 August 2020, and the matter will be discussed by the Registration Committee of the Pharmacy and Poisons Board (Registration Committee).

Australia: Hydrochlorothiazide: increased risk of non-melanoma skin cancer

On 24 August 2020, the Therapeutic Goods Administration (TGA) of Australia announced that the Product Information (PI) and Consumer Medicine Information (CMI) for medicines containing hydrochlorothiazide in Australia are being updated to include details about an increased risk of non-melanoma skin cancer. Hydrochlorothiazide is a diuretic that is used to treat high blood pressure, usually in combination with other blood pressure medicines.

Epidemiological studies have found that there is an increased risk of non-melanoma skin cancers associated with medicines containing hydrochlorothiazide. The two most common types of non-melanoma skin cancer are basal cell carcinoma (BCC) and squamous cell carcinoma (SCC). Hydrochlorothiazide is known to cause photosensitivity, and it is thought that this is the reason for an increased risk of developing non-melanoma skin cancer. The findings of studies using population-level data from Denmark have been supported in a recently published study of data from Australian patients undertaken by the University of New South Wales.

The TGA is working with sponsors of products that contain hydrochlorothiazide to include a warning about the increased risk of non-melanoma skin cancers, together with advice about avoiding ultraviolet (UV) exposure and getting regular skin

checks, in their PI and CMI documents. This will help consumers and their doctors to make informed choices about the benefits and risks of hydrochlorothiazide-containing medicines.

Information for consumers:
- If they or someone they provide care for takes a medicine that contains hydrochlorothiazide, please be aware of the above information. They should use effective UV protection and get regular skin checks.
- Non-melanoma skin cancers are the most common cancers in Australia, but most are not life threatening.
- BCC is the more common form of non-melanoma skin cancer and often has no symptoms. However, symptoms can include: a pearly lump; a scaly, dry area that is shiny and pale or bright pink in colour.
- Symptoms of SCC may include: a thickened red, scaly spot; a rapidly growing lump; an area that looks like a sore but has not healed; an area that may be tender to touch.

Information for health professionals:
- If they are treating patients with a medicine that contains hydrochlorothiazide, please be aware of the above information and discuss it with those patients.
- Educate them on the signs and symptoms of non-melanoma skin cancer and advise them to use effective UV protection and to get regular skin checks.

In Hong Kong, there are 104 registered pharmaceutical products containing hydrochlorothiazide, and all products are prescription-only medicines. As on 7 September 2020, the DH has received 4 cases of ADR related to hydrochlorothiazide, but these cases are not related to skin cancer. Related news was previously issued by various overseas drug regulatory authorities, and was reported in the Drug News Issue No. 109, 111, 113 and 117. The DH issued a letter to inform local healthcare professionals to draw their attention on 15 November 2018. In April 2019 and September 2019, the Registration Committee discussed the matter, and decided that the DH would continue to remain vigilant on any related safety updates by other overseas drug regulatory authorities. As previously reported, the matter will be further discussed by the Registration Committee.

UK: Clozapine and other antipsychotics: monitoring blood concentrations for toxicity

On 26 August 2020, the MHRA announced that blood level monitoring of clozapine and other antipsychotic medicines can be beneficial in the care and management of patients, particularly those with treatment-resistant conditions. For example, monitoring of blood clozapine levels may be useful when a patient starts (or restarts) smoking as this may lead to a decrease in blood clozapine levels and dose adjustment may be necessary. However, the advice below focuses on drug blood level monitoring for toxicity of clozapine and other antipsychotics.

The MHRA has received 2 separate reports from Coroners raising concerns regarding the need for monitoring of clozapine blood levels in one report and monitoring antipsychotic blood levels during long-term high-dose antipsychotic use in the other. In the first report, the individual's death was determined to have been caused by clozapine toxicity, pneumonia, and treatment-resistant schizophrenia. In the second report, the death of a patient on long-term high-dose antipsychotic treatment was determined to have been caused by coronary artery atherosclerosis and amisulpride toxicity. In both Coroner's reports, the MHRA was asked to take action to prevent further deaths.

Expert Advisory Groups of the CHM considered safety data for clozapine and other antipsychotic drugs and advised that blood concentrations of clozapine should be monitored for toxicity in certain clinical situations. The Groups also advised that, where assays and suggested reference values are available, blood level monitoring of other antipsychotic drugs may be helpful in certain circumstances.

At the time of publication, assays and suggested reference values for therapeutic blood concentrations are known to be available for amisulpride, aripiprazole, olanzapine, quetiapine, risperidone and sulpiride, although availability of testing may vary locally.

Advice for healthcare professionals:
- Monitoring blood clozapine levels for toxicity is now advised in certain clinical situations such as when: a patient stops smoking or switches to an electronic cigarette; concomitant medicines may interact to increase blood clozapine levels; a patient has

pneumonia or other serious infection; poor (reduced) clozapine metabolism is suspected; toxicity is suspected.
- If blood clozapine level monitoring is carried out, this should be in addition to the required blood tests to manage the risk of agranulocytosis.
- For other antipsychotics, where assays and suggested reference values are available, blood level monitoring for toxicity may be helpful in certain circumstances, for example in the event of symptoms suggestive of toxicity or when concomitant medicines may interact to increase antipsychotic drug levels.
- Refer to the full Summaries of Product Characteristics for other important warnings, interactions, and recommendations for clozapine and other individual antipsychotics.

In Hong Kong, there are registered pharmaceutical products containing clozapine (9 products) and other antipsychotic medicines such as amisulpride (15 products), aripiprazole (29 products), olanzapine (57 products), quetiapine (61 products), risperidone (58 products) and sulpiride (10 products). All products are prescription-only medicines.

As on 7 September 2020, the DH has received ADR related to clozapine (3 cases), amisulpride (2 cases), olanzapine (23 cases), quetiapine (6 cases) and risperidone (5 cases). The DH has not received any case of ADR related to aripiprazole or sulpiride.

In light of the above MHRA's announcement, the DH issued a letter to inform local healthcare professionals to draw their attention on 27 August 2020. The DH will remain vigilant on safety update of the drugs issued by other overseas drug regulatory authorities.

UK: Baricitinib (Olumiant▼): increased risk of diverticulitis, particularly in patients with risk factors

On 26 August 2020, the MHRA announced that a European review has assessed cases of diverticulitis associated with baricitinib reported in clinical trials and in clinical (post-marketing) use worldwide. The risk of diverticulitis has been added to the product information for baricitinib in the UK with an uncommon frequency and healthcare professionals are asked to use caution in patients at risk of this condition.

Baricitinib (Olumiant▼) is a Janus kinase (JAK) inhibitor drug. Diverticulitis is also a potential side effect of tofacitinib (Xeljanz▼), another JAK inhibitor. Prescribers of tofacitinib should exercise the same caution in patients with risk factors for diverticulitis.

In clinical trials of baricitinib to treat rheumatoid arthritis, there were 21 cases of diverticulitis (including 3 [14%] with a complication of gastrointestinal perforation) in 3770 patients across 13,380 patient-years of observation (incidence rate 0.16 per 100 patient-years [95% CI 0.10–0.24]).

Of the 21 patients, 7 (33%) had diverticulosis or diverticulitis noted in their medical history. For concomitant medicines, 13 (62%) of the 21 patients were on chronic corticosteroid treatment, 9 patients were chronically treated with non-steroidal anti-inflammatory drugs (NSAIDs), and 4 patients with acetylsalicylic acid (aspirin) medications. Cases of diverticulitis and diverticulosis were also reported in clinical trials of baricitinib for other conditions not authorised in the UK. Overall, the observed frequency of diverticulitis in baricitinib use in clinical trials was 0.43% (uncommon).

For post-marketing use of baricitinib outside of clinical trials, 35 spontaneous cases of diverticulitis have been reported worldwide up to 31 December 2019. Of these, 25 (71%) cases specifically included a medical history of diverticulitis and/or chronic use of NSAIDs, corticosteroids or opioids, which are known important risk factors for diverticulitis. However, 10 cases had no pre-existing conditions or use of concomitant medications as confounding factors. Gastrointestinal perforation as a complication of diverticulitis was reported in 5 (14%) cases. None of the cases were fatal.

The time to onset of clinical trial and post-marketing cases ranged from 6 days to 6 years. The majority of cases occurred after more than 90 days of treatment.

Advice for healthcare professionals:
- Cases of diverticulitis and gastrointestinal perforation have been reported in patients taking baricitinib.
- Most, but not all, cases of diverticulitis occurred in patients who were concomitantly taking medicines associated with an increased risk of diverticulitis.

- Use caution in patients with pre-existing diverticular disease and in patients on long-term concomitant medications associated with an increased risk of diverticulitis such as NSAIDs, corticosteroids, and opioids.
- Advise patients on baricitinib to seek immediate medical care if they experience severe abdominal pain especially accompanied with fever, nausea and vomiting or other symptoms of diverticulitis.
- Ensure prompt evaluation of any patients on baricitinib who present with new-onset abdominal signs and symptoms to identify early diverticulitis or gastrointestinal perforation.

In Hong Kong, Olumiant Tablets 2mg (HK-65663) and Olumiant Tablets 4mg (HK-65664) are pharmaceutical products registered by Eli Lilly Asia, Inc. Xeljanz Tablets 5mg (HK-63303) and Xeljanz XR Extended Release Tablets 11mg (HK-66141) are pharmaceutical products registered by Pfizer Corporation Hong Kong Limited. All products are prescription-only medicines.

As on 7 September 2020, the DH has not received any case of ADR related to baricitinib. The DH has received 7 cases of ADR related to tofacitinib, but these cases are not related to diverticulitis and gastrointestinal perforation.

The current package insert of the local Xeljanz products contain safety information on the risk of diverticulitis and gastrointestinal perforation.

In light of the above MHRA's announcement, the DH issued a letter to inform local healthcare professionals to draw their attention on 27 August 2020, and the matter will be discussed by the Registration Committee.

US: FDA works to mitigate shortages of rifampin and rifapentine after manufacturers find nitrosamine impurities

On 26 August 2020, the United States (US) Food and Drug Administration (FDA) announced that it recently became aware of nitrosamine impurities in certain samples of rifampin and rifapentine. These are antibacterial drugs used to treat tuberculosis; rifampin is also used to treat other serious infections. Patients taking rifampin or rifapentine should continue taking their current medicine and consult with their healthcare professional about any concerns.

To mitigate or avoid shortages and to help ensure patients have access to these necessary medicines, the FDA will not object to certain manufacturers temporarily distributing rifampin containing 1-methyl-4-nitrosopiperazine (MNP) or rifapentine containing 1-cyclopentyl-4-nitrosopiperazine (CPNP) above the acceptable intake limits until they can reduce or eliminate the impurities.

The acceptable intake limits are 0.16 parts per million (ppm) for MNP in rifampin and 0.1 ppm for CPNP in rifapentine. The FDA will not object to certain manufacturers temporarily distributing rifampin containing MNP below 5 ppm. The FDA also will not object to certain manufacturers temporarily distributing rifapentine containing CPNP below 14 ppm. The FDA will not object to these higher exposures to maintain patient access to these life-saving medications.

Manufacturers should contact the Center for Drug Evaluation and Research's Drug Shortages Staff when their testing of rifampin or rifapentine shows levels of nitrosamines that exceed the acceptable intake limits of 0.16 ppm for MNP and 0.1 ppm for CPNP. The FDA will determine on a case-by-case basis whether those drugs should be released for distribution.

The FDA and manufacturers are investigating the origin of these impurities in rifampin and rifapentine, and the FDA is developing testing methods for regulators and industry to detect MNP and CPNP in these medicines. The FDA continues its ongoing review, surveillance, compliance and pharmaceutical quality efforts across every product area and will continue to work with drug manufacturers to ensure safe, effective and high-quality drugs for the American public.

MNP and CPNP belong to the nitrosamine class of compounds, some of which are classified as probable or possible human carcinogens (substances that could cause cancer), based on laboratory tests such as rodent carcinogenicity studies. Although there are no data available to directly evaluate the carcinogenic potential of MNP and CPNP, information available on closely related nitrosamine compounds was used to calculate lifetime exposure limits for MNP and CPNP.

Tuberculosis is a potentially deadly disease that affects the lungs and sometimes other parts of the body, and the risk of not taking the medicine outweighs any potential risk from MNP or CPNP.

Safety Update

Patients taking rifampin for other conditions should discuss with their healthcare professional whether they can use an alternative medicine.

In Hong Kong, there are 28 registered pharmaceutical products containing rifampicin (also known as rifampin). There is only one registered pharmaceutical product containing rifapentine, namely Priftin Tablets 150mg (HK-65512), which is registered by Sanofi Hong Kong Limited. All products are prescription-only medicines.

As on 7 September 2020, the DH has received 22 cases of ADR related to rifampicin. None of them is concluded to be related to the presence of 1-methyl-4-nitrosopiperazine (MNP). The DH has not received any case of ADR related to rifapentine.

The DH has been contacting the certificate holders of all registered rifampicin and rifapentine products for follow up on the impact of the local marketed products; and will remain vigilant on the development of the issue and any safety update of the drugs issued by overseas drug regulatory authorities for consideration of any action deemed necessary.

Patients who are taking rifampicin- and rifapentine-containing products should not stop taking the medicines unless advised by their prescribers.

Drug Recall

DH endorsed recall of Glucofit Film Coated Tablets 500mg (HK-64639)

On 24 August 2020, the DH endorsed a licensed drug wholesaler, Suntol Medical Ltd. (Suntol), to recall a metformin-containing product, Glucofit Film Coated Tablets 500mg (HK-64639), from the market as a precautionary measure due to the possible presence of an impurity in the product.

The DH received notification from Suntol on the afternoon of 24 August 2020 that following the recall of Glucofit Extended-Release Tablets 500mg (HK-64640) on 22 July 2020, the Taiwan manufacturer of the product decided to extend the recall to Glucofit Film Coated Tablets 500mg as a precautionary measure, as the product might contain an impurity of *N*-nitrosodimethylamine (NDMA).

NDMA is classified as a probable human carcinogen based on results from laboratory tests and overseas drug regulatory authorities, which have been reviewing the safety impact of NDMA found in some medicinal products including metformin.

The above product, containing metformin, is a prescription medicine used for the treatment of diabetes mellitus. According to Suntol, the product has been supplied to local private doctors and pharmacies.

Patients who are taking the above product should not stop taking the medicine, and should seek advice from their healthcare professionals as soon as possible for appropriate arrangements.

As on 7 September 2020, the DH has not received any adverse reaction reports in connection with the product. Press release was posted on the Drug Office website on 24 August 2020 to alert the public of the product recall.

Overall situation related to detection of NDMA in metformin

As on 7 September 2020 in Hong Kong, there are 122 registered pharmaceutical products containing metformin. All products are prescription-only medicines.

Related news on the detection of NDMA in metformin products was previously issued by various overseas drug regulatory authorities, and was reported in the Drug News Issue No. 122 and 124. The DH issued a letter to inform local healthcare professionals to draw their attention on 6 December 2019. The DH has contacted the certificate holders of all registered metformin products for follow up on the local impact of the issue, and collected samples of metformin-containing products in the local market for analysis. When there are any health risks identified and posed to the public, a press statement will be issued as soon as possible. Please find update information at Drug Office's website (www.drugoffice.gov.hk). The following is the main content of the press statement issued previously:

- On 11 March 2020, the DH endorsed a licensed wholesale dealer, the International

Medical Company Ltd, to recall 3 batches of Metformin-Teva 500mg Tablets (HK-60334) (batch number: 16532717, 16532817 and 16532917) from the market due to the potential presence of NDMA in the product.
- On 22 July 2020, the DH endorsed licensed wholesaler dealers Suntol and Hovid Limited to recall Glucofit Extended-Release Tablets 500mg (HK-64640) and Diabetmin XR Extended-Release Tablets 500mg (HK-63333) respectively.

The above recalls were reported in the Drug News Issue No. 125 and 129. As on 7 September 2020, the DH has received 17 cases of ADR related to metformin. None of them is concluded to be related to the presence of NDMA. The DH will remain vigilant on the development of the issue and any safety update of the drug issued by overseas drug regulatory authorities for consideration of any action deemed necessary.

Patients who are taking metformin-containing products should not stop taking the medicines, but should seek advice from their healthcare professionals for proper arrangement.

DH endorsed recall of Vesyca FC Tablets 150mg (HK-36650)

On 27 August 2020, the DH endorsed a licensed drug wholesaler, Yung Shin Co. Ltd., to recall a ranitidine-containing product, namely Vesyca FC Tablets 150mg (HK-36650) from the market as a precautionary measure due to the possible presence of an impurity in the product.

The DH received notification from the wholesaler that the manufacturer of the product in Taiwan is recalling the above product because it might contain an impurity, namely NDMA. As a precautionary measure, the wholesaler is voluntarily recalling the above product from the local market.

NDMA is classified as a probable human carcinogen based on results from laboratory tests. The DH noted that certain ranitidine-containing products were found to contain NDMA in other countries.

The above product, containing ranitidine, is an over-the-counter medicine used for the treatment of gastric diseases. According to the wholesaler, the product has been supplied to private doctors and pharmacies.

Patients who are taking the above product should seek advice from their healthcare professionals for appropriate management. There are alternative medicines available on the market with similar indications.

As on 7 September 2020, the DH has not received any adverse reaction reports in connection with the product. Press release was posted on the Drug Office website on 27 August 2020 to alert the public of the product recall.

Overall situation related to detection of NDMA in ranitidine

As on 7 September 2020, there are 52 registered pharmaceutical products containing ranitidine in Hong Kong. These products in the forms of oral preparations and injections are controlled as over-the-counter medicines and prescription-only medicines respectively. As on 7 September 2020, the DH has not received any case of ADR related to ranitidine.

Related news on the detection of NDMA in ranitidine products was previously issued by various overseas drug regulatory authorities, and was reported in the Drug News Issue No. 122, 123, 124, 126 and 129. The DH issued letters to inform local healthcare professionals to draw their attention on 18 September 2019 and 2 April 2020. The DH has contacted the relevant overseas drug regulatory authorities for further information regarding the detection of NDMA in ranitidine products, and continues to remain vigilant on the update findings and investigation result announced by the authorities.

The DH has contacted the certificate holders of all registered ranitidine products for follow up on the local impact of the issue; and to provide evidence that NDMA in the products are below the acceptable limit, and samples of ranitidine-containing products have been collected from the market for analysis. When any health risks are posed to the public, a press statement will be issued as soon as possible. Please find update information at Drug Office's website (www.drugoffice.gov.hk). The following are the main content of the press statements issued previously:
- On 24 September 2019, the DH endorsed a licensed drug wholesaler, GlaxoSmithKline Ltd, to recall all Zantac products (HK-42792, HK-42793, HK-30459, HK-42045) from the

Drug Recall

Hong Kong market as a precautionary measure due to the presence of NDMA in the products.

- On 25 September 2019, the DH endorsed licensed drug wholesalers Hind Wing Co Ltd and Top Harvest Pharmaceuticals Co Ltd to recall Apo-Ranitidine Tablets (HK-42273, HK-41873) and Zantidon Tablets 150mg (HK-64329) respectively.
- On 27 September 2019, the DH endorsed licensed drug manufacturer APT Pharma Limited and licensed drug wholesaler Eugenpharm International Limited to recall Amratidine Tablets 150mg (HK-53143) and Peptil H 150 Tablets 150mg (HK-65103) respectively.
- On 30 September 2019, the DH endorsed licensed drug wholesaler Vast Resources Pharmaceutical Limited to recall Weidos Tablets 150mg (HK-62210).
- On 11 October 2019, the DH endorsed licensed drug wholesaler Hind Wing Co Ltd to recall Epadoren Solution for Injection 50mg/2ml (HK-61752).
- On 1 November 2019, the DH endorsed licensed drug wholesaler Welldone Pharmaceuticals Limited to recall six ranitidine-containing products: Epirant Tab 150mg (HK-56826), Welldone Ranitidine Tab 150mg (HK-57473), Kin Pak Tab 150mg (HK-56824), Wah Tat Tab 150mg (HK-56823), Super Pro Tab 150mg (HK-56825) and Glo-Tac Tab 150mg (HK-57472).
- On 7 November 2019, the DH endorsed licensed drug wholesalers Healthcare Pharmascience Limited, Julius Chen & Co (HK) Limited and Atlantic Pharmaceutical Limited to recall five ranitidine-containing products: Raniplex 150 Tablet 150mg (HK-43456), Tupast Tablet 150mg (HK-50378), Wontac Tablet 150mg (HK-60085), Jecefarma Ranitidine Tablet 150mg (HK-64041) and Ratic Tablet 150mg (HK-61083).
- On 12 November 2019, the DH endorsed registration certificate holder Medreich Far East Limited to recall Ulticer Tab 150mg (HK-53488).
- On 27 November 2019, the DH endorsed drug suppliers Cera Medical Limited and Sincerity (Asia) Company Limited to recall Emtac 150 Tab 150mg (HK-59353) and Ranitid 150 Tab 150mg (HK-59429) respectively.

The above recalls were reported in the Drug News Issue No. 119, 120 and 121. On 16 June 2020, the Registration Committee discussed the matter and decided to keep vigilant on any safety update issued by overseas drug regulatory authorities for consideration of any action deemed necessary. Patients who are taking ranitidine-containing products should seek advice from their healthcare professionals for proper arrangement, e.g. use of alternative medicines with similar uses.

Drug Incident

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

On 13 August 2020, the DH appealed to the public not to buy or consume a slimming product named Fit Fit Day as it was found to contain undeclared and banned drug ingredients that might be dangerous to one's health.

Acting upon a public complaint, a sample of the above product was purchased via a social media network platform for analysis. Test results from the Government Laboratory revealed that the sample contained 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, pharmaceutical products containing sibutramine have been banned in Hong Kong because of an increased cardiovascular risk. Fluoxetine is used for treatment of mood disorders and may cause hallucinations 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, headaches 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. They may visit the website of the Drug Office of the DH for "Health messages on overweight problem and slimming products" and "Information on slimming

products with undeclared Western drug ingredients" for more information.

Press release was posted on the Drug Office website on 13 August 2020 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: ***Undesirable Medical Advertisements and Adverse Drug Reaction Unit,***
Drug Office, Department of Health,
Suites 2002-05, 20/F, AIA Kowloon Tower,
Landmark East, 100 How Ming Street,
Kwun Tong, Kowloon

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.