Drug News
藥 物 情 報

Issue Number 134

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

Canada: Direct-acting antiviral products containing a protease inhibitor: Assessing the potential risks of hepatic decompensation and hepatic failure

On 2 December 2020, Health Canada announced that it reviewed the potential risk of worsening liver function and liver failure with the use of direct-acting antiviral products containing a protease inhibitor. The safety review was triggered by a United States (US) Food and Drug Administration (FDA) Drug Safety Communication warning about these risks in chronic hepatitis C virus-infected patients with advanced liver disease.

Direct-acting antiviral products containing a protease inhibitor are prescription drugs authorized for sale in Canada to treat chronic hepatitis C virus infection. At the time of this review, Maviret (glecaprevir/pibrentasvir), Vosevi (sofosbuvir/velpatasvir/voxilaprevir) and Zepatier (grazoprevir/elbasvir) are authorized for sale in Canada as fixed dose combination products.

Health Canada reviewed information from searches of the Canada Vigilance database, international databases, from manufacturers and published scientific and medical literature. At the time of the review, Health Canada had received 53 case reports for Maviret (1 Canadian), 23 case reports for Vosevi (6 Canadian) and 18 case reports for Zepatier (1 Canadian) related to worsening liver function and liver failure. Health Canada's review found that there may be a link between the use of direct-acting antiviral products containing a protease inhibitor and worsening liver function and liver failure. For Maviret, 51 cases (1 Canadian) showed a possible link and 2 cases could not be assessed due to insufficient information in the reports. For Vosevi, 15 cases (3 Canadian) were found to be possibly linked, 1 case was not likely to be linked, and 7 cases (3 Canadian) did not have enough information to be assessed. For Zepatier, 16 cases (1 Canadian) were considered possibly linked, and 2 cases could not be assessed due to insufficient information in the reports. For most of these cases, contributing factors including existing medical conditions and other medications taken by the patient could not be ruled out. Pre-existing significant liver disease was present in all of the cases. Health Canada also reviewed 2 studies from the published scientific literature. These studies did not provide additional information beyond what was obtained from the above case reports.

Health Canada's review concluded that there may be a link between the use of direct-acting antiviral products containing a protease inhibitor and the risks of worsening liver function and liver failure in some patients with pre-existing significant liver disease. Health Canada has requested that the manufacturers of direct-acting antiviral products containing a protease inhibitor update the Canadian product safety information to include information about these risks.

In Hong Kong, there are registered pharmaceutical products which are direct-acting antivirals containing a protease inhibitor for the treatment of hepatitis C virus infection, namely Maviret Tablets (containing glecaprevir/pibrentasvir; HK-65653), which is registered by Abbvie Limited; Zepatier Tablets (containing grazoprevir/elbasvir; HK-65571) and Zepatier Tablets (HK-66768), which are registered by Merck Sharp & Dohme (Asia) Ltd; Vosevi Tablets (containing sofosbuvir/velpatasvir/voxilaprevir; HK-65775), which is registered by Gilead Sciences Hong Kong Limited; and Sunvepra Capsules 100mg (containing asunaprevir; HK-64506), which is registered by Bristol-Myers Squibb Pharma (HK) Ltd. All products are prescription-only medicines.

As on 5 January 2021, the Department of Health (DH) has received adverse drug reaction (ADR) related to glecaprevir/pibrentasvir (4 cases, of which one case is related to alanine aminotransferase increased and hyperbilirubinaemia), grazoprevir/elbasvir (one case, related to alanine aminotransferase increased) and asunaprevir (one case, related to alanine aminotransferase increased and bilirubin increased). The DH has not received any case of ADR related to sofosbuvir/velpatasvir/voxilaprevir.

Related news on the risk of serious liver injury with the use of medicines containing a hepatitis C virus protease inhibitor in patients with advanced liver disease was previously issued by the US FDA and the Taiwan Food and Drug Administration (TFDA), and was reported in the Drug News Issue No. 118. The DH issued a letter to inform local healthcare professionals to draw their attention on 29 August 2019. In light of the above Health Canada's announcement, the matter will be discussed by the Registration Committee of the Pharmacy and Poisons Board (Registration Committee).

US: FDA alerts healthcare professionals about the risk of medication errors with tranexamic acid injection resulting in inadvertent intrathecal (spinal) injection

On 3 December 2020, the US FDA announced that it is alerting healthcare professionals about the risk of inadvertent intrathecal administration of tranexamic acid injection. Intrathecal administration of tranexamic acid injection may result in serious life-threatening injuries, including seizures, cardiac arrhythmias, paraplegia, permanent neurological injury, and death. In most of the cases reported to the FDA, tranexamic acid injection was erroneously administered instead of the intended intrathecal anesthetic (e.g., bupvicaine injection) for neuraxial anesthesia.

Tranexamic acid injection is an antifibrinolytic indicated in patients with hemophilia for short-term use (2 to 8 days) to reduce or prevent hemorrhage and reduce the need for replacement therapy during and following tooth extraction. Healthcare professionals should administer tranexamic acid injection by the intravenous route.

Tranexamic acid injection, bupivacaine injection and other products used in the perioperative setting may have a similar appearance, such as similar vial cap color or packaging that may contribute to the mix-ups. Other practice-level and facility-level contributing factors such as storing products with similar appearance in close-proximity may also contribute to these errors.

The FDA is taking action to address tranexamic acid injection medication errors. This includes revising the tranexamic acid injection container labels and carton labeling to highlight the recommended intravenous route of administration; and strengthening the warnings in the tranexamic acid prescribing information to include the risk of medication errors due to incorrect route of administration.

In Hong Kong, there are 7 registered pharmaceutical products which are tranexamic acid injectables. All products are prescription-only medicines. As on 5 January 2021, the DH has received 6 cases of ADR related to tranexamic acid, but these cases are not related to medication errors. Healthcare professionals should check the product label carefully and follow the product instructions accordingly.

Canada: Clobazam-containing products: Assessing the potential risk of Drug Reaction with Eosinophilia and Systemic Symptoms

On 9 December 2020, Health Canada announced that it reviewed the potential risk of Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) with clobazam use after becoming aware of international case reports published in the medical literature.

DRESS is a rare, but serious, and potentially life-threatening drug reaction that includes fever, severe skin rash or peeling of the skin over large areas of the body, swollen face and high white blood cell count, affecting 1 or more organs. The symptoms of DRESS typically appear within 2 weeks to 2 months after starting a medication. DRESS is also known as Drug Rash with Eosinophilia and Systemic Symptoms, Drug Induced Hypersensitivity Syndrome or DRESS syndrome.

Health Canada reviewed information provided by the manufacturers, data from clinical studies, information resulting from searches of the Canada Vigilance database, and the published literature. Health Canada's review focused on 2 Canadian cases and 18 international cases of DRESS in

patients taking clobazam. From those cases, only 4 (international) met the criteria for further assessment to determine if there was a link between the use of clobazam and DRESS. Three of them were published in the medical literature and involved children. In all 4 cases, a link between clobazam use and DRESS could not be ruled out. Two cases were found to be probably linked to the use of clobazam. The 2 other cases were found to be possibly linked to clobazam use, however, these patients were also taking other medications that have been known to cause DRESS. There are no confirmed cases of DRESS in Canada associated with the use of clobazam.

Health Canada's review of the available information concluded that there may be a link between the use of clobazam and the potential risk of DRESS. Health Canada will work with the manufacturers to update the Canadian product safety information for clobazam-containing products to include the risk of DRESS.

In Hong Kong, there is one registered pharmaceutical product containing clobazam, namely Frisium 10 Tab 10mg (HK-05574). The product is registered by Sanofi Hong Kong Limited, and is a prescription-only medicine. As on 5 January 2021, the DH has not received any case of ADR related to clobazam. In light of the above Health Canada's announcement, the DH issued a letter to inform local healthcare professionals to draw their attention on 10 December 2020, and the matter will be discussed by the Registration Committee.

Singapore: Reminder to verify HLA-B*1502 status in new patients of Asian ancestry before starting carbamazepine treatment

On 10 December 2020, the Health Sciences Authority (HSA) of Singapore reminded healthcare professionals to verify the HLA-B*1502 status before starting carbamazepine (CBZ) treatment in new patients of Asian ancestry. Patients who are HLA-B*1502-positive are at increased risk of developing severe cutaneous adverse reactions (SCARs), particularly Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis (SJS/TEN) during treatment with CBZ.

Genotyping for HLA-B*1502 prior to treatment initiation with CBZ in new patients of Asian ancestry has been the standard of care in Singapore since 2013. This one-time test helps distinguish high-risk patients who should avoid CBZ from low-risk patients who are able to continue to use this low-cost yet effective medicine. The implementation of this recommendation has contributed to a 92% reduction in the number of CBZ-associated SJS/TEN cases in Singapore, from 50 cases in the 5-year pre-implementation period (2008 to 2013) to 4 cases in the post-implementation period (2013 to 2018).

Healthcare professionals are advised to take note of the following:

- HLA-B*1502 genotype testing specifically identifies patients at risk of developing CBZ-induced SJS/TEN, but not CBZ-induced DRESS.
- HLA-B*1502 test results should be obtained prior to prescribing CBZ as SJS/TEN can develop and progress in susceptible patients, even after prompt discontinuation of the drug.
- The use of CBZ should be avoided and treatment alternatives are strongly recommended in patients who are found to be positive for HLA-B*1502. As a precaution, these patients should also not be prescribed phenytoin, as there is preliminary data suggesting a suspected association between HLA-B*1502 and phenytoin-induced SJS/TEN.
- Although reported to be rare, patients who test negative for HLA-B*1502 may still be at risk of developing CBZ-induced SJS/TEN. The role of other factors which may contribute to the development of SJS/TEN in these patients, such as drug dose, concomitant medications and co-morbidities, have not been studied.
- Clinical vigilance for CBZ-induced SCARs including DRESS should continue, especially during the first 12 weeks following treatment initiation with CBZ.

In Hong Kong, there are 7 registered pharmaceutical products containing carbamazepine. All products are prescription-only medicines. As on 5 January 2021, the DH has received 3 cases of ADR related to carbamazepine, of which one case is related to Stevens-Johnson Syndrome. Related news was previously issued by the HSA, and was reported in the Drug News Issue No. 43. The DH issued a letter to inform local healthcare professionals to draw their attention on 2 May 2013. In September 2013, the Registration Committee discussed the matter, and decided that the sales pack label and/or package insert of carbamazepine products should include the relevant

safety information. The DH will remain vigilant on safety update of the drug issued by other overseas drug regulatory authorities.

Taiwan: Safety information for medicines containing fingolimod

On 15 December 2020, the TFDA announced that the European Medicines Agency (EMA) informed healthcare professionals on cases of acute liver failure requiring liver transplant and clinically significant liver injury have been reported in patients treated with fingolimod. The Product Information for fingolimod will be updated to reflect new recommendations to minimise the risk of drug-induced liver injury. (Related EMA website: https://www.ema.europa.eu/en/documents/dhpc/gilenya-fingolimod-updated-recommendations-minimise-risk-drug-induced-liver-injury-dili_en.pdf)

After investigation, there are two drugs containing fingolimod licensed in Taiwan. The TFDA is evaluating if it will take further risk control measures for this drug.

Please refer to the following website in TFDA for details: http://www.fda.gov.tw/TC/siteList.aspx?sid=1571

In Hong Kong, there are 3 registered pharmaceutical products containing fingolimod, namely Gilenya Hard Capsules 0.5mg (HK-61192) and Gilenya Hard Capsules 0.25mg (HK-66472) registered by Novartis Pharmaceuticals (HK) Limited; and Fingolimod Teva Capsules 0.5mg (HK-66882) registered by Teva Pharmaceutical Hong Kong. All products are prescription-only medicines. As on 5 January 2021, the DH has received 14 cases of ADR related to fingolimod, but these cases are not related to liver injury.

In light of the above TFDA's announcement and relevant information issued by the EMA, the DH issued a letter to inform local healthcare professionals to draw their attention on 16 December 2020. The DH will remain vigilant on any safety update of the drug issued by other overseas drug regulatory authorities for consideration of any action deemed necessary.

UK: Systemic and inhaled fluoroquinolones: small risk of heart valve regurgitation; consider other therapeutic options first in patients at risk

On 17 December 2020, the Medicines and Healthcare products Regulatory Agency (MHRA) of the United Kingdom (UK) announced the risk of heart valve regurgitation associated with the use of systemic and inhaled fluoroquinolones.

A European review has considered data from epidemiological and non-clinical studies indicating an increased risk of heart valve regurgitation after use of fluoroquinolones. An epidemiological study suggested an increased risk of aortic and mitral regurgitation associated with fluoroquinolone usage. The case-control study of US patient records retrospectively examined a cohort of 12,502 patients with valvular regurgitation (after excluding patients with other conditions that may be associated with valvulopathy). Prescriptions of oral fluoroquinolones were compared with those of amoxycillin within this group and within a control cohort of 125,020 people. Patients with mitral or aortic regurgitation were nearly twice as likely to have been exposed to fluoroquinolones (2.4% of cases) than to amoxycillin (1.6% of cases). The study reported an adjusted rate ratio for current fluoroquinolones use versus amoxicillin use of 2.40 (95% CI 1.82 to 3.16) and versus current azithromycin use of 1.75 (95% CI 1.34 to 2.29). A non-clinical study also reported that ciprofloxacin increases collagen degradation in heart muscle cells. These findings indicate that systemic or inhaled fluoroquinolones might contribute to heart valve regurgitation, particularly in patients with pre-existing risk factors.

The increased risk of heart valve regurgitation has been added to the product information for these medicines and a letter sent to relevant healthcare professionals in the UK.

Heart valve regurgitation, also called heart valve incompetence or insufficiency or leaking valve, occurs when blood flows back through the valves as they are closing or when they should be completely closed.

The risk of heart valve regurgitation is increased in the presence of risk factors such as pre-existing congenital heart valve disease or other risk factors or conditions predisposing for heart valve regurgitation, including connective tissue disorders (for example, Marfan syndrome, Ehlers-Danlos syndrome), hypertension, Turner's syndrome, Behcet's disease, rheumatoid arthritis, and infective endocarditis. Some people with heart valve regurgitation may experience symptoms of heart failure, including: shortness of breath, especially

when lying down flat in bed; swelling of the ankles, feet, or abdomen; new-onset heart palpitations.

Advice for healthcare professionals:

- Fluoroquinolones are authorised for use in serious, life-threatening bacterial infections.
- Systemic (by mouth or injection) and inhaled fluoroquinolones have been associated with a small increased risk of heart valve regurgitation, with one retrospective case-control study suggesting a 2-fold increased relative risk with current oral fluoroquinolone use compared with the risk with use of amoxicillin or azithromycin.
- Fluoroquinolones should only be used after careful benefit-risk assessment and after consideration of other therapeutic options in the following patients at risk:
  - patients with congenital heart valve disease or pre-existing heart valve disease;
  - patients diagnosed with connective tissue disorders (for example, Marfan syndrome or Ehlers-Danlos syndrome);
  - patients with other risk factors or conditions predisposing for heart valve regurgitation (for example, hypertension, Turner's syndrome, Behçet's disease, rheumatoid arthritis, and infective endocarditis).
- Advise patients, especially those at risk, of the importance of seeking immediate medical attention if they experience:
  - a rapid onset of shortness of breath, especially when lying down flat in bed;
  - swelling of the ankles, feet, or abdomen;
  - new-onset heart palpitations.

In Hong Kong, there are registered pharmaceutical products containing systemic fluoroquinolones for use in human, including ciprofloxacin (67 products), levofloxacin (54 products), moxifloxacin (7 products), norfloxacin (5 products), ofloxacin (22 products) and prulifloxacin (1 product). All products are prescription-only medicines. As on 5 January 2021, the DH has received 8 cases of ADR related to levofloxacin and 1 case related to moxifloxacin, but these cases are not related to heart valve regurgitation.

Related news was previously issued by the TFDA. The DH issued a letter to inform local healthcare professionals to draw their attention on 4 December 2020. In light of the above MHRA's announcement, the matter will be discussed by the Registration Committee.

Canada: Tramadol-containing products: Assessing the potential risk of hallucinations

On 29 December 2020, Health Canada announced that it reviewed the risk of hallucinations with tramadol-containing products. The safety review was triggered by information submitted from a manufacturer showing an increase in the number of reported cases (Canadian and international reports) of hallucinations with tramadol use at normal doses.

Health Canada reviewed the available information from searches of the Canada Vigilance database, international databases, scientific and medical literature as well as information received from one of the manufacturers. At the time of the review, Health Canada had received 54 Canadian reports of hallucinations related to the use of tramadol-containing products. Of the 54 Canadian reports, only 2 met the criteria for further assessment to determine if there was a link between the use of tramadol and hallucinations. The remaining 52 reports could not be assessed due to several contributing factors such as incomplete information in the reports, or the patients were taking other medications at the same time that may have contributed to this risk.

Health Canada reviewed 24 serious case reports (2 Canadian and 22 international) of hallucinations with the use of tramadol-containing products. Of the 24 case reports, 1 case (an elderly patient) was found to be probably linked, 18 cases (including 2 Canadian cases) were possibly linked, with 11 of these 18 cases involving elderly patients, 1 case was not likely to be linked, and 4 cases did not have enough information to be assessed. Health Canada also assessed a review from the published scientific literature that included 101 cases of hallucinations with the use of tramadol. Most reported hallucinations were visual and/or auditory and occurred in patients older than 65 years of age. Health Canada's review of the published study supported a possible link between hallucinations and tramadol use.

Health Canada's review of the available information has established a link between the use of tramadol-containing products, at normal doses, and the risk of visual and auditory hallucinations, especially in patients over 65 years of age. Health Canada will work with manufacturers to update the

Safety Update

Canadian product safety information for tramadol products to include the risk of visual and auditory hallucinations at normal doses, including a higher risk in patients over 65 years of age.

In Hong Kong, there are 49 registered pharmaceutical products containing tramadol. All products are prescription-only medicines. As on 5 January 2021, the DH has received 5 cases of ADR related to tramadol, but these cases are not related to hallucinations. In light of the above Health Canada's announcement, the DH issued a letter to inform local healthcare professionals to draw their attention on 30 December 2020, and the matter will be discussed by the Registration Committee.

Taiwan: Safety information for medicine containing dimethyl fumarate

On 31 December 2020, the TFDA announced that the EMA issued a direct healthcare professional communication to remind healthcare professionals and the patients that cases of progressive multifocal leukoencephalopathy (PML) have been reported in patients with mild lymphopenia and treated with dimethyl fumarate. The Product Information for dimethyl fumarate is being revised to include updated recommendations to help minimise the risk of PML in patients treated with dimethyl fumarate. (Related EMA website: https://www.ema.europa.eu/documents/dhpc/tecfidera-dimethyl-fumarate-updated-recommendations-light-cases-progressive-multifocal_en.pdf)

After investigation, there are two drugs containing dimethyl fumarate licensed in Taiwan. The Chinese package inserts in Taiwan do not include information such as "Dimethyl fumarate is contraindicated in patients with suspected or confirmed PML." The TFDA is evaluating if it will take further risk control measures for this drug.

Please refer to the following website in TFDA for details: http://www.fda.gov.tw/TC/siteList.aspx?sid=1571

In Hong Kong, there are 2 registered pharmaceutical products containing dimethyl fumarate, namely Tecfidera Gastro-Resistant Capsules 240mg (HK-64410) and Tecfidera Gastro-Resistant Capsules 120mg (HK-64411). Both products are registered by Eisai (Hong Kong) Co Ltd, and are prescription-only medicines. As on 5 January 2021, the DH has not received any case of ADR related to dimethyl fumarate.

Related news on the risk of progressive multifocal leukoencephalopathy associated with the use of dimethyl fumarate was previously issued by various overseas drug regulatory authorities, and was reported in the Drug News Issue No. 78. The DH issued a letter to inform local healthcare professionals to draw their attention on 19 April 2016.

The current package insert of the above registered products in Hong Kong include safety information on progressive multifocal leukoencephalopathy.

In light of the above TFDA's announcement and safety information issued by the EMA on cases of progressive multifocal leukoencephalopathy in patients with mild lymphopenia and updated recommendations, the DH issued a letter to inform local healthcare professionals to draw their attention on 31 December 2020. The DH will remain vigilant on any safety update of the drug issued by other overseas drug regulatory authorities for consideration of any action deemed necessary.

Drug Recall

DH endorsed recall of Zerbaxa Powder for concentrate for solution for infusion 1g/0.5g (HK- 65156)

On 17 December 2020, the DH endorsed a licensed drug wholesaler, Merck Sharp & Dohme (Asia) Ltd. (MSD), to recall all batches of Zerbaxa Powder for concentrate for solution for infusion 1g/0.5g (HK- 65156) from the market due to a potential quality issue.

The DH received notification from MSD that several batches of the above product produced recently have failed the sterility test before release. While these batches have not been released to the market and the batches supplied to the local market have passed the sterility test, MSD is recalling all batches of the product as a precautionary measure.

The above product, containing ceftolozane and tazobactam, is an antibiotic for the treatment of bacterial infections. According to MSD, the product has been supplied to the Hospital Authority and private hospitals. Some products were also

Drug Recall

re-exported to Macao.

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

As on 5 January 2021, the DH has not received any adverse reaction reports in connection with the affected product. Press release was posted on the Drug Office website on 17 December 2020 to alert the public of the product recall.

Drug Incident

Public urged not to buy or consume slimming product with undeclared Western drug ingredient sibutramine

On 16 December 2020, the DH appealed to the public not to buy or consume a slimming product named The Slim Queen as it was found to contain an undeclared and banned drug ingredient that might be dangerous to health.

Acting upon intelligence, a sample of the above product was purchased via a social media network platform for analysis. The test result from the Government Laboratory revealed that the sample contained the banned drug ingredient sibutramine.

Sibutramine is a Part 1 poison under the Pharmacy and Poisons Ordinance (Cap. 138). It 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.

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 16 December 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.

ADVERSE DRUG REACTION

Drug Office
Department of Health
Hong Kong SAR

Special Supplement to Drug News Issue No. 134

Background

The Adverse Drug Reaction Reporting System was formerly under Adverse Drug Reaction Monitoring Unit of the Pharmaceutical Service, Department of Health, from year 2005 (Trial run in year 2004). With the establishment of Drug Office in year 2011 and reorganized in year 2019, Adverse Drug Reaction Unit under the Drug Information and Pharmacovigilance Division of Drug Office, Department of Health, receives the local adverse drug reaction reports concerning the use of pharmaceutical products from healthcare professionals and pharmaceutical industry.

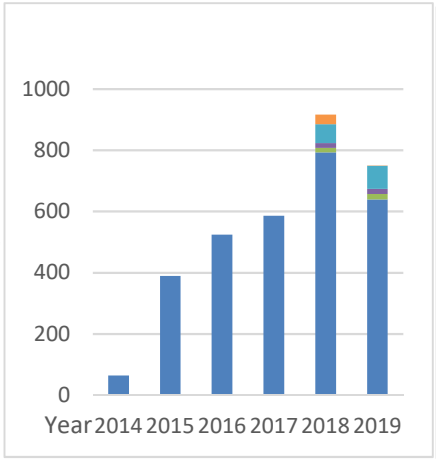
Guidance for Pharmaceutical Industry – Adverse Drug Reaction Reporting Requirements issued by Drug Office (since year 2015) sets out the requirements for reporting adverse drug reactions of all pharmaceutical products in Hong Kong by pharmaceutical industry to Drug Office, Department of Health. Pharmaceutical industry should comply with the guidance and report all serious adverse drug reactions occurring in Hong Kong to Drug Office, Department of Health as soon as possible and no later than 15 calendar days of receipt of information. A serious adverse drug reaction is any untoward medical occurrence that at any dose:

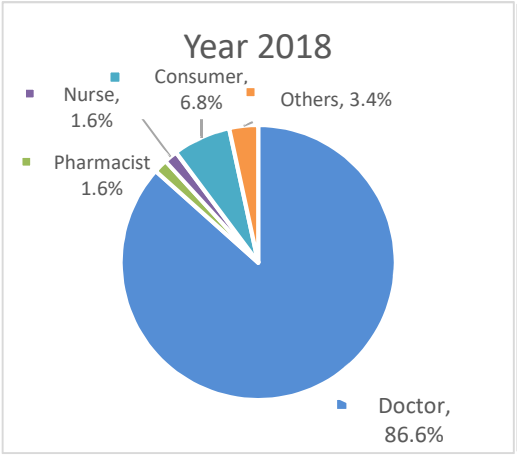
- results in death;
- is life threatening;
- requires inpatient hospitalization or results in prolongation of existing hospitalization;
- results in persistent or significant disability/incapacity;
- is a congenital anomaly/birth defect; or
- is a medically important event or reaction.

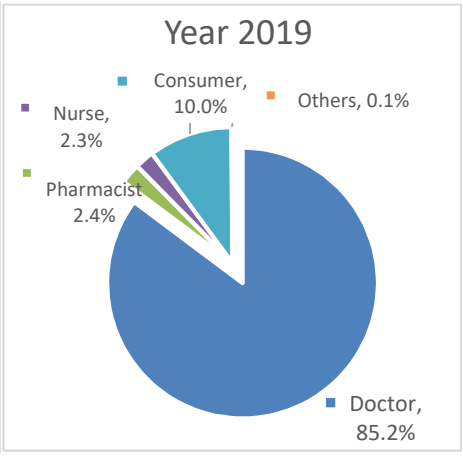
Report Analysis for 2018 and 2019

A. Number of adverse drug reaction (ADR) reports and sources of reports (initial reporters)

Drug Office received a total of 916 and 750 ADR reports in year 2018 and year 2019 respectively (an increase of over 56% and 27% when compared with that of year 2017). From year 2004 to year 2019, Drug Office had received over 3600 ADR reports. Among the received ADR reports, Doctor as initial reporter contributed most to the number of reports.

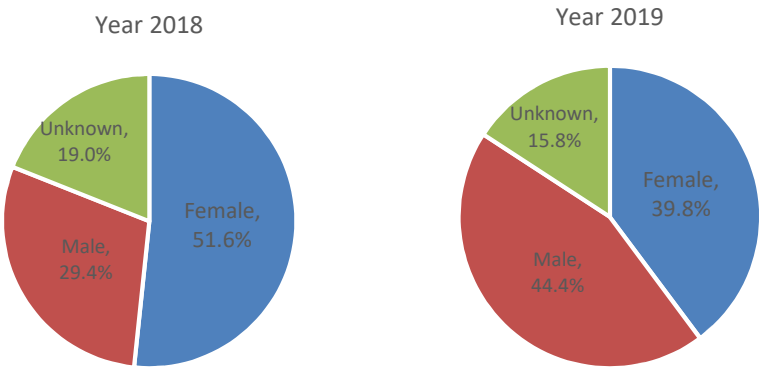




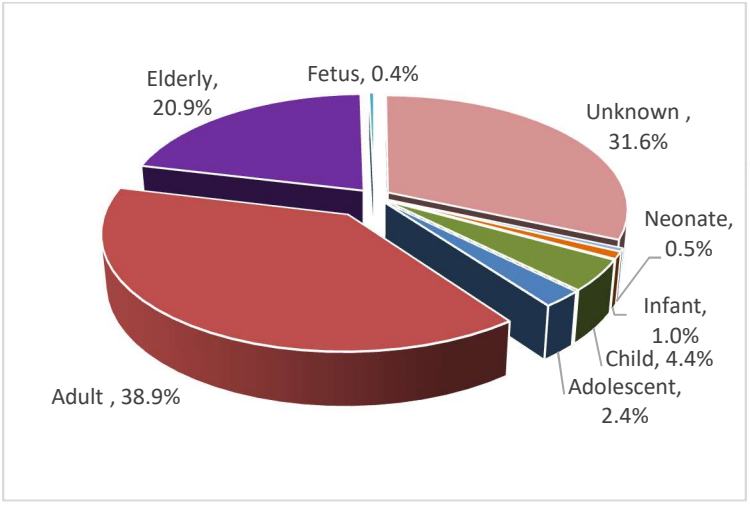


B. Demographics (Age group, Gender) of patients

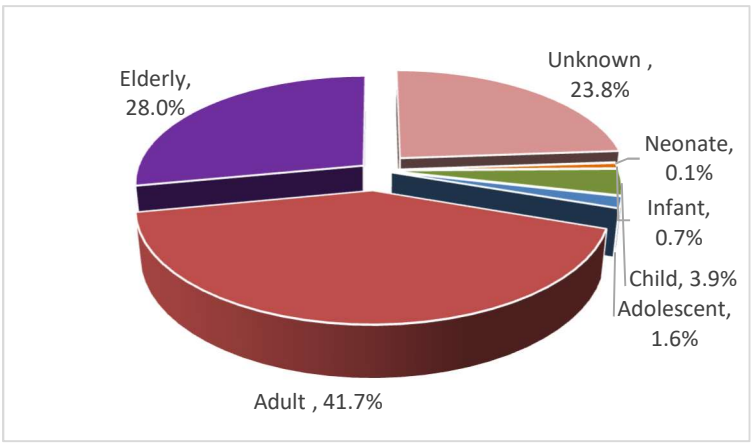
For the ADR cases received in year 2018, the gender female was reported in over 50% of the cases. However, among the ADR cases received in year 2019, there was no significant difference between the genders. Regarding the age group, around 38% and 41% of the cases were adults in year 2018 and year 2019 respectively. There was no age information provided in around 31% and 23% of cases respectively in year 2018 and year 2019.



Year 2018

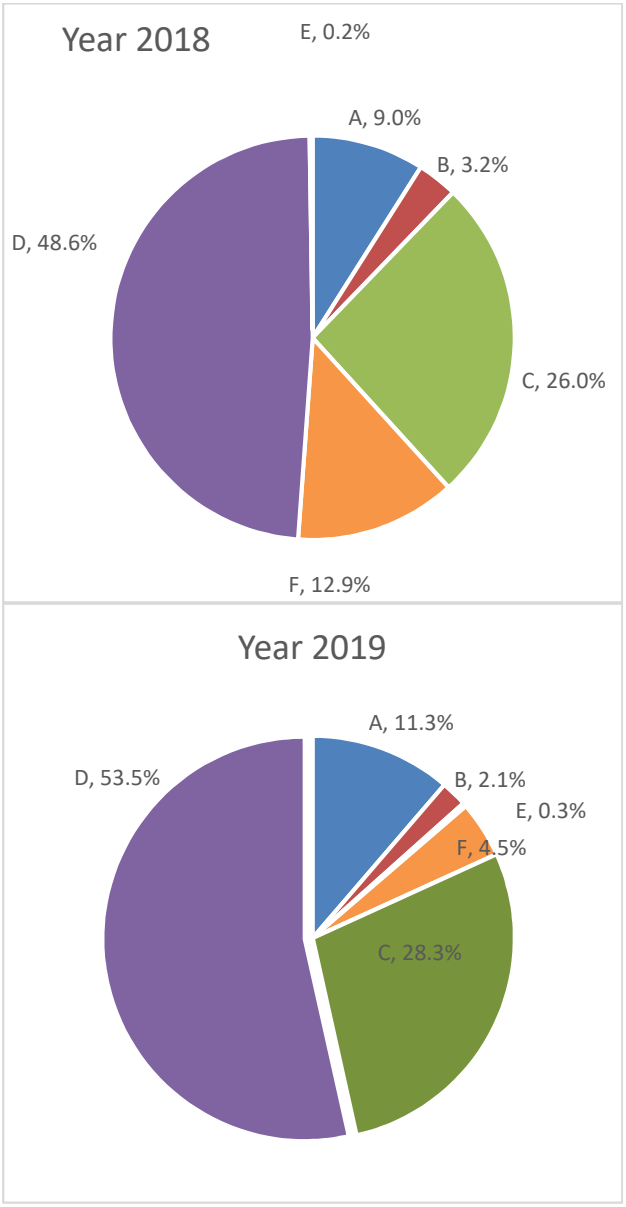


Year 2019



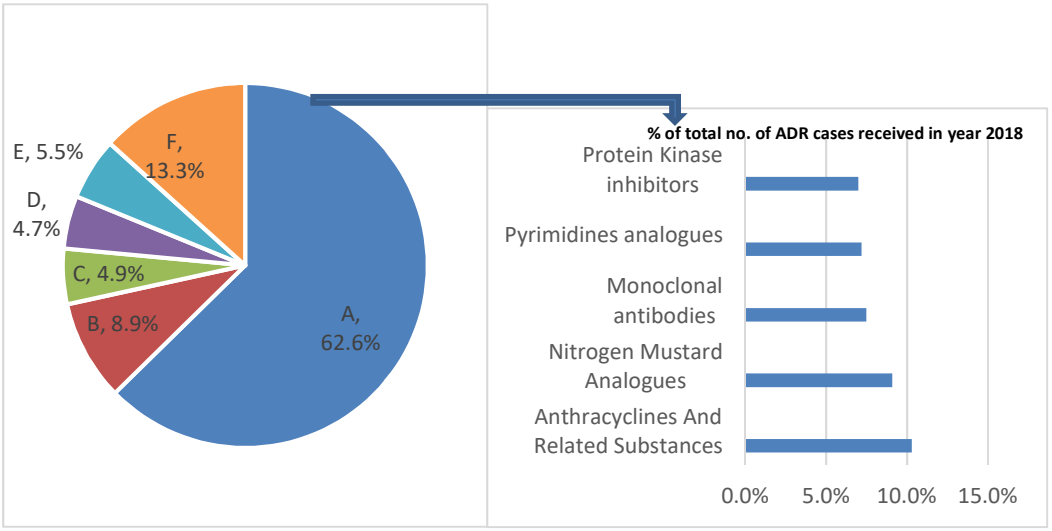
C. Seriousness

Most of the cases reported were serious as the pharmaceutical industry is obliged to report serious ADR cases.

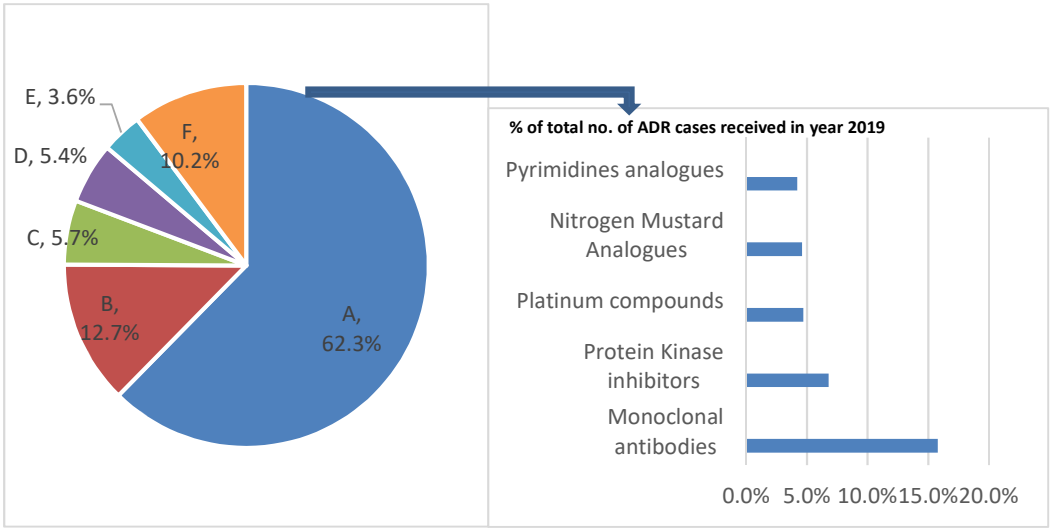


D. Suspect Drugs*

The top class of suspect drugs involved in the ADR cases received in year 2018 and 2019 was Antineoplastic and Immunomodulating Agents. Among this class, anthracyclines and related substances, nitrogen mustard analogues, monoclonal antibodies, pyrimidines analogues and protein kinase inhibitors were the top 5 types of drugs reported in year 2018, while monoclonal antibodies, protein kinase inhibitors, platinum compounds, nitrogen mustard analogues and pyrimidines analogues were the top 5 types of drugs reported in year 2019.



- A. Antineoplastic and Immunomodulating Agents
- B. Antiinfectives for Systemic Use
- C. Nervous system
- D. Alimentary tract and metabolism
- E. Blood and Blood Forming Organs
- F. Others



- A. Antineoplastic and Immunomodulating Agents
- B. Antiinfectives for Systemic Use
- C. Systemic Hormonal Preparations
- D. Alimentary tract and metabolism
- E. Blood and Blood Forming Organs
- F. Others

** Suspect drugs were classified according to The Anatomical Therapeutic Chemical (ATC) classification system developed by World Health Organization (WHO)*

E. Adverse events

In year 2018 and 2019, the top System Organ Class (SOC^) reported were General disorders and administration site conditions, as shown in the tables below.

Ranking	System Organ Class	% of cases in 2018
1	General disorders and administration site conditions (e.g. injection site reactions, fever)	18.3
2	Blood and lymphatic system disorders (e.g. neutropenia, anaemia)	12.7
3	Gastrointestinal disorders (e.g. nausea, vomiting)	7.3

Ranking	System Organ Class	% of cases in 2019
1	General disorders and administration site conditions (e.g. injection site reactions, fever)	11.5
2	Investigations (e.g. blood creatinine increased, ALT increased)	7.3
3	Blood and lymphatic system disorders (e.g. neutropenia, anaemia)	7.1

^The System Organ Class (SOC) refers to the medical terminology MedDRA (Medical Dictionary for Regulatory Authorities)

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

Disclaimers:

Information on suspected ADR should not be interpreted as meaning that the pharmaceutical product in question, or the active substance(s), generally causes the observed effect or is unsafe to use. Any robust conclusion with regard to benefits and risks of a specific pharmaceutical product always requires detailed evaluation and scientific assessment of all available data. The balance between benefit and risk of a specific pharmaceutical product also varies between individual patients. The information in these reports cannot be used to estimate the incidence (occurrence rates) of the reactions reported. If you think that you may be experiencing a side-effect from a pharmaceutical product, please seek advice from a health professional as soon as possible. Never stop or change the dose for prescription medicines without consulting your physician.