Drug News
藥 物 情 報

Issue Number 147

This is a monthly digest of local and overseas drug safety news released by the Drug Office of the Department of Health in January 2022 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

Australia: Tenofovir alafenamide and renal adverse effects

On 6 January 2022, Therapeutic Goods Administration (TGA) announced that the Product Information (PI) for tenofovir alafenamide is being updated to include a warning about renal adverse effects. Health professionals should be aware of predisposing risk factors for these adverse effects and monitor patients appropriately.

Tenofovir alafenamide is an antiviral nucleoside analogue marketed under several brand names in Australia. It is a prodrug which is available as monotherapy and as part of fixed-dose combination products.

To 7 December 2021, 14 cases of renal adverse events in people taking tenofovir alafenamide have been reported to the TGA. These reports are included in the TGA's Database of Adverse Event Notifications (DAEN). Internationally, there have also been updates to product information sheets to include renal adverse effects.

Following an evaluation by the TGA, a warning is being added to section 4.4 of the PI:

- Post marketing cases of renal impairment, including acute renal failure, proximal renal tubulopathy (PRT), and Fanconi syndrome have been reported with tenofovir alafenamide containing products; while most of these cases were characterised by potential confounders that may have contributed to the reported renal events, it is also possible these factors may have predisposed patients to tenofovir-related adverse events.
- Patients taking tenofovir prodrugs who have impaired renal function and those taking nephrotoxic agents, including non-steroidal anti-inflammatory drugs, are at increased risk of developing renal-related adverse reactions.
- Prior to or when initiating tenofovir alafenamide, and during treatment with tenofovir alafenamide on a clinically appropriate schedule, assess serum creatinine, estimated creatinine clearance, urine glucose, and urine protein in all patients. In patients with chronic kidney disease, also assess serum phosphorus. Discontinue tenofovir alafenamide in patients who develop clinically significant decreases in renal function or evidence of Fanconi syndrome.

Section 4.8 of the PI listing adverse effects is being updated to include:

- Renal and Urinary disorders: acute renal failure, proximal renal tubulopathy and Fanconi syndrome.

Health professionals are advised that renal adverse events with tenofovir alafenamide can have serious consequences for patients and should be managed promptly. Risk factors include existing renal impairment and concomitant use of nephrotoxic drugs, such as non-steroidal anti-inflammatory drugs. Renal function should be assessed before patients start tenofovir alafenamide, and then monitored during treatment. Consider stopping the medicine if they suspect declining renal function or Fanconi syndrome.

In Hong Kong, there are 7 registered pharmaceutical products containing tenofovir alafenamide. All products are prescription-only medicines. As of the end of January 2022, the Department of Health (DH) has received 6 cases of adverse drug reaction related to tenofovir alafenamide, but these cases were not related to renal adverse effects. In light of the above TGA's announcement, the DH issued letters to inform local healthcare professionals to draw their attention on

6 January 2022, and the matter will be discussed by the Registration Committee of the Pharmacy and Poisons Board.

The United States: FDA warns about dental problems with buprenorphine medicines dissolved in the mouth to treat opioid use disorder and pain

On 12 January 2022, US Food and Drug Administration (FDA) announced it is warning that dental problems have been reported with medicines containing buprenorphine that are dissolved in the mouth. The dental problems, including tooth decay, cavities, oral infections, and loss of teeth, can be serious and have been reported even in patients with no history of dental issues. Despite these risks, buprenorphine is an important treatment option for opioid use disorder (OUD) and pain, and the benefits of these medicines clearly outweigh the risks.

FDA is requiring a new warning about the risk of dental problems be added to the prescribing information and the patient medication guide for all buprenorphine-containing medicines dissolved in the mouth. The prescribing and patient information will also include strategies to maintain or improve oral health while undergoing treatment with these medicines. These strategies will include recommending that prescribers refer patients to dental care services and encourage them to have regular checkups while taking these products. Patients should tell the dentist about all medicines they take, including buprenorphine.

The buprenorphine medicines that are associated with dental problems are tablets and films dissolved under the tongue or placed against the inside of the cheek. There are also buprenorphine products for pain and OUD delivered by other routes such as a skin patch and injection, but FDA has not identified a concern for dental health related to these other forms.

Since buprenorphine was approved, FDA identified 305 cases of dental problems (131 cases classified as serious) with buprenorphine medicines dissolved in the mouth. These only include cases reported to FDA or published in the medical literature, so there may be additional cases about which FDA is unaware. The average age of the patients was 42 years, but those as young as 18 years were also affected. Most cases were in patients using the medicines for OUD; however, 28 cases of dental problems occurred in patients using it to treat pain. In 26 cases, patients had no prior history of dental problems. Some cases reported dental problems occurring as soon as 2 weeks after treatment began, with the median time to diagnosis being approximately 2 years after starting treatment. Many cases were reported by healthcare professionals and provided documentation of extensive dental adverse events. Of the 305 cases, 113 mentioned two or more teeth were affected. The most common treatment for these dental problems was tooth extraction/removal, which was reported in 71 cases. Other cases reported requiring root canals, dental surgery, and other procedures such as crowns and implants.

Healthcare professionals should be aware the benefits of buprenorphine medicines clearly outweigh the risks and are an important tool to treat OUD. Ask patients about their oral health history prior to prescribing treatment with a transmucosal buprenorphine medicine. These serious dental problems have been reported even in patients with no history of dental issues, so refer them to a dentist as soon as possible after starting transmucosal buprenorphine. Counsel patients about the potential for dental problems and the importance of taking extra steps after the medicine has completely dissolved, including to gently rinse their teeth and gums with water and then swallow. Patients should be advised to wait at least 1 hour before brushing their teeth. Dentists treating someone taking a transmucosal buprenorphine product should perform a baseline dental evaluation and caries risk assessment, establish a dental caries preventive plan, and encourage regular dental checkups.

In Hong Kong, there are 8 registered pharmaceutical products containing buprenorphine, of which 3 products are sublingual tablets. All products are prescription-only medicines. As of the end of January 2022, the Department of Health (DH) has not received any case of adverse drug reaction related to buprenorphine. In light of the above FDA's announcement, the DH issued letters to inform local healthcare professionals to draw their attention on 13 January 2022, and the matter will be discussed by the Registration Committee of the Pharmacy and Poisons Board.

Canada: Safety review found a link between the use of Xeljanz/Xeljanz XR (tofacitinib) and the risks of serious heart-related problems and cancer: Update

On 12 January 2022, Health Canada announced that it completed a safety review which confirmed a link between the use of Xeljanz/Xeljanz XR (tofacitinib) and the increased risks of serious heart-related problems and cancer, especially in older patients, patients who are current or past smokers, and patients with cardiovascular or cancer risk factors. Health Canada's review also found that all patients treated with Xeljanz 10 mg twice daily had a higher risk of death, blood clots and serious infections, compared to patients treated with Xeljanz 5 mg twice daily or tumour necrosis factor inhibitors.

As a result, Health Canada has worked with the manufacturer to update the product labels to further strengthen the warnings on the risks of serious heart -related problems and cancer. Healthcare professionals have been informed of these updates in order to advise their patients.

To ensure the benefits outweigh the risks in patients receiving Xeljanz/Xeljanz XR, the approved use for rheumatoid arthritis is now limited to certain patients who are unable to use other drugs for this condition or when at least two different other drugs do not work. The higher dose of Xeljanz 10 mg twice daily is only authorized for patients with ulcerative colitis who have not responded well to other medications. For patients with ulcerative colitis, the prescribing information recommends that they use the lowest effective dose and for the shortest duration needed to help them improve their condition.

Healthcare professionals are advised:

- Consider the benefits and risks for the individual patient prior to initiating or continuing therapy with Xeljanz/Xeljanz XR, particularly in geriatric patients, in patients who are current or past smokers, those with other cardiovascular or malignancy risk factors, those who develop a malignancy, and those with a known malignancy other than a successfully treated non-melanoma skin cancer.
- Inform patients that Xeljanz/Xeljanz XR may increase their risk of major adverse cardiovascular events including non-fatal myocardial infarction. Instruct all patients, especially geriatric patients, current or past smokers, or patients with other cardiovascular risk factors, to be alert for signs and symptoms of cardiovascular events.
- Inform patients that Xeljanz/Xeljanz XR may increase their risk of certain cancers, and that lung cancer, lymphoma and other cancers have been observed in patients taking Xeljanz. Instruct patients to inform their healthcare provider if they have ever had any type of cancer.
- Advise patients to stop taking Xeljanz/Xeljanz XR and to call their healthcare professional right away if they experience any symptoms of thrombosis (sudden shortness of breath, chest pain worsened with breathing, swelling of leg or arm, leg pain or tenderness, red or discoloured skin in the affected leg or arm).
- Avoid Xeljanz/Xeljanz XR in patients who may be at increased risk of thrombosis.
- Closely monitor patients for signs and symptoms of infection during and after treatment with Xeljanz/Xeljanz XR.
- Xeljanz/Xeljanz XR should be interrupted if a patient develops a serious infection, an opportunistic infection, or sepsis. If a patient develops a new infection during treatment with Xeljanz/Xeljanz XR, they should undergo prompt and complete diagnostic testing appropriate for an immunocompromised patient, and appropriate antimicrobial therapy should be initiated.
- Use Xeljanz 5 mg twice daily or Xeljanz XR 11 mg once daily for the treatment of rheumatoid arthritis, and Xeljanz 5 mg twice daily for the treatment of psoriatic arthritis. Health Canada has not authorized the sale of the higher dose of 10 mg twice daily for rheumatoid arthritis or psoriatic arthritis.
- In patients with ulcerative colitis, use Xeljanz at the lowest effective dose and for the shortest duration needed to achieve/maintain therapeutic response.
- Be aware that the indication for Xeljanz/Xeljanz XR in rheumatoid arthritis patients is now limited to certain patients who have not responded well to other medications.

In Hong Kong, there are 3 registered pharmaceutical products containing tofacitinib, namely Xeljanz Tablets 5mg (HK-63303), Xeljanz XR Extended Release Tablets 11mg (HK-66141) and Xeljanz Tablets 10mg (HK-66833). All products are registered by Pfizer Corporation Hong Kong Limited. They are prescription-only medicines. As of the end of January 2022, the Department of Health (DH) has received 8 cases of adverse drug reaction related to tofacitinib, of which one case was related to lung cancer, 3 cases were related to deep vein

thrombosis, one case was related to pneumonia, one case was related to herpes zoster disseminated, one case was related to cellulitis and one case was related to disseminated tuberculosis.

Related news on the risk of blood clots and death of tofacitinib was previously issued by various overseas drug regulatory authorities, and was reported in Drug News Issues Nos. 112, 115, 117, 120, 121, 125, 128, 136, 138 and 143. The DH issued letters to inform local healthcare professionals to draw their attention on 29 July 2019 and 19 June 2020. In December 2019, the Registration Committee of the Pharmacy and Poisons Board discussed the matter, and decided that the sales pack or package insert of tofacitinib products should include safety information about increased risk of blood clots and death with higher dose (10 mg twice daily).

Related news on the risk of serious heart-related problems and cancer of tofacitinib was previously issued by various overseas drug regulatory authorities, and was reported in Drug News Issues Nos. 136, 137, 138, 140, 143 and 144. The DH issued letters to inform local healthcare professionals to draw their attention on 15 June 2021. As previously reported, the matter will be discussed by the Registration Committee of the Pharmacy and Poisons Board.

European Union: Review of terlipressin medicines started

On 14 January 2022, European Medicines Agency (EMA) announced that it has started a review of medicines that contain terlipressin. These medicines are authorised in several EU countries to treat increased pressure in central veins causing kidney problems in people with advanced liver disease (hepatorenal syndrome; HRS), as well as bleeding from enlarged veins in the passage between the mouth and the stomach (the oesophagus) and certain forms of bleeding associated with surgery.

EMA's safety committee (PRAC) started this review due to safety concerns about results from a large clinical trial involving patients with a form of HRS where kidney function declines rapidly. The results suggest that patients who were treated with terlipressin were more likely to experience and die from respiratory disorders within 90 days after the first dose than those who were given placebo (a dummy treatment). Respiratory disorders, such as respiratory failure (severe breathing difficulties), are a known risk of these medicines. However, the frequency of respiratory failure seen in this study (10%) was higher than reported in the product information, where it is listed as uncommon (i.e., affecting up to 1% of patients).

As a result of these concerns, the Danish medicines agency requested a review of the safety of terlipressin medicines in the context of their benefits when used to treat HRS. At present, this review does not cover the use of terlipressin for the treatment of bleeding, since no new information on safety concerns has emerged for these uses.

In Hong Kong, there are 4 registered pharmaceutical product containing terlipressin. All these products are prescription-only medicines. As of the end of January 2022, the Department of Health (DH) has not received any cases of adverse drug reaction related to terlipressin. In light of the above EMA's announcement, the DH will remain vigilant on the conclusion of the review and any safety updates issued by other overseas drug regulatory authorities for consideration of any action deemed necessary.

European Union: Mavenclad: risk of serious liver injury

On 14 January 2022, European Medicines Agency (EMA) announced that the Pharmacovigilance Risk Assessment Committee (PRAC) discussed direct healthcare professional communication (DHPC) containing important safety information for Mavenclad. This DHPC aims to inform healthcare professionals about adverse events of liver injury with Mavenclad (cladribine), and gives new recommendations about liver function monitoring.

Mavenclad is a medicine used to treat adults with the relapsing forms (repeated flare-ups of the symptoms) of multiple sclerosis, a disease in which inflammation damages the protective sheath around the nerve cells in the brain and spinal cord (demyelination). Mavenclad is used in patients whose disease is highly active.

Liver injury, including serious cases and cases leading to discontinuation of treatment, has been reported in patients treated with Mavenclad. A recent review of available safety data has concluded on an increased risk for liver injury following treatment with Mavenclad. Most patients who experienced liver injury had mild clinical

symptoms. However, in some cases, transitory high levels of enzyme transaminase exceeding 1000 units per litre and jaundice (liver affection causing, amongst others, yellowing of the skin and eyes) were described.

Liver injury will be included in the product information of Mavenclad as an adverse drug reaction of uncommon frequency.

Healthcare professionals are advised to perform a detailed review of patient history of underlying liver disorders or episodes of liver injury with other medicines before initiating patient treatment. During treatment, liver function tests should be conducted, and repeated as necessary. In case a patient develops liver injury, treatment with Mavenclad should be interrupted or discontinued, as appropriate.

Patients should be advised to report immediately to their healthcare professional any signs or symptoms of liver injury. Healthcare professionals are asked to report any suspected adverse reactions via their national reporting system. Reporting suspected adverse reactions after authorisation of the medicinal product is important to ensure patient safety.

The DHPC for Mavenclad will be forwarded to EMA's human medicines committee, the CHMP. Following the CHMP decision, the DHPC will be disseminated to healthcare professionals by the marketing authorisation holder, according to an agreed communication plan, and published on the Direct healthcare professional communications page and in national registers in EU Member States.

In Hong Kong, there is 1 registered pharmaceutical product containing cladribine. The product is a prescription-only medicine. As of the end of January 2022, the Department of Health (DH) has not received any cases of adverse drug reaction related to cladribine. In light of the above EMA's announcement, the DH issued letters to inform local healthcare professionals to draw their attention on 15 January 2022. The DH will remain vigilant on safety update of the drug issued by the EMA and other overseas drug regulatory authorities and consider if any further action deemed necessary.

The United Kingdom: Brolucizumab (Beovu): risk of intraocular inflammation and retinal vascular occlusion increased with short dosing intervals

On 18 January 2022, Medicines and Healthcare products Regulatory Agency (MHRA) announced that maintenance doses of brolucizumab (after the first 3 doses) should not be given at intervals of less than 8 weeks apart.

Intraocular inflammation, including retinal vasculitis, and retinal vascular occlusion are adverse drug reactions known to be associated with brolucizumab. New information on these adverse events, including risk factors and possible mechanism, was considered in a recent European safety review. The product information of brolucizumab will also be updated to reflect this information.

Preliminary results were recently received from the MERLIN study. This is a 2-year United States multicentre, randomised, double-masked phase 3A study to assess the safety and efficacy of the recommended dose of brolucizumab (6mg), administered every 4 weeks, compared to aflibercept 2mg every 4 weeks, in patients with neovascular (wet) age-related macular degeneration (AMD) with persistent retinal fluid. In MERLIN, intraocular inflammation, including retinal vasculitis, were reported with a higher frequency in the group receiving brolucizumab 6mg every 4 weeks compared with those receiving aflibercept 2mg every 4 weeks (9.3% versus 4.5%, respectively). Frequency of retinal vascular occlusion was also higher with brolucizumab (2.0% versus 0%, respectively). In addition, the incidence of intraocular inflammation with 4-weekly dosing of brolucizumab in MERLIN (9.3%) was of a higher frequency than that recorded in the pivotal phase 3 clinical studies using a brolucizumab dosing interval of 6mg every 8 weeks and 12 weeks (4.4%).

Two non-interventional retrospective studies (NCT05082415 and NCT05111743) of large United States real-world databases in patients with neovascular AMD aimed to better understand the incidence of these adverse events up to 6 months after initiating treatment with brolucizumab. The results of these studies suggest that patients with a medical history of intraocular inflammation or retinal vascular occlusion in the year before treatment with brolucizumab are more likely to present with similar events after brolucizumab injection, as compared with patients with

neovascular AMD with no history of these events. In addition, a higher risk of intraocular inflammation (including retinal vasculitis and retinal vascular occlusion) in female patients was observed both in the two retrospective studies and also in the clinical trials (5.3% of female patients and 3.2% of male patients in the pivotal clinical trials). A higher incidence of these events was also seen in patients of Japanese ancestry than in those of non-Japanese ancestry.

The review also considered new data to elucidate the mechanism of these adverse events. As brolucizumab is a therapeutic protein, there is a potential for immunogenicity and consequently intraocular inflammation. Evidence to support this mechanism comes from a study in 5 patients with neovascular AMD injected with brolucizumab who subsequently developed retinal vasculitis or retinal vascular occlusion. Blood samples from these 5 patients identified a humoral and cellular immune response against brolucizumab 3 to 5 months after the last brolucizumab dose. In samples from 6 control patients who had no signs or symptoms of intraocular inflammation while receiving brolucizumab, anti-drug antibodies, when present, had lower titres.

Advice for healthcare professionals:

- Intraocular inflammation, including retinal vasculitis, and retinal vascular occlusion are adverse drug reactions uncommonly associated with intravitreal injection of brolucizumab.
- In patients who develop intraocular inflammation or retinal vascular occlusion, discontinue treatment with brolucizumab and manage events promptly.
- To reduce the risk of these events, do not administer maintenance doses of brolucizumab (after the first 3 doses) at intervals of less than 8 weeks apart.
- Closely monitor patients treated with brolucizumab who have a medical history of intraocular inflammation or retinal vascular occlusion (within 12 months before the first brolucizumab injection) since they are at increased risk of developing these adverse reactions post-injection.
- Intraocular inflammation or retinal vascular occlusion may occur at any time during brolucizumab treatment but occur more frequently during early treatment.
- Based on observational studies, retinal vasculitis and retinal vascular occlusion after brolucizumab treatment appear to be more frequent in female patients and in patients of Japanese ancestry.

In Hong Kong, there are 2 registered pharmaceutical products containing brolucizumab, namely Beovu Solution For Injection 6mg/0.05ml (HK-67008) and Beovu Solution for Injection In Pre-filled Syringe 6mg/0.05ml (HK-67009). Both products are registered by Novartis Pharmaceuticals (HK) Limited. They are prescription-only medicines. As of the end of January 2022, the Department of Health (DH) has received 9 cases of adverse drug reaction related to brolucizumab, of which one case was related to retinal vasculitis and another case was related to retinal vasculitis and retinal vein occlusion. In light of the above MHRA's announcement, the DH issued letters to inform local healthcare professionals to draw their attention on 19 January 2022 and the matter will be discussed by the Registration Committee of the Pharmacy and Poisons Board.

The United Kingdom: Paclitaxel formulations (conventional and nab-paclitaxel) - caution required due to potential for medication error

On 18 January 2022, Medicines and Healthcare products Regulatory Agency (MHRA) announced that albumin-bound paclitaxel formulations for infusion (nab-paclitaxel; brand names Abraxane, Pazenir) differ from conventional paclitaxel medicines in their authorised indications, pharmacokinetics, recommended dosages, and preparation and administration instructions. Healthcare professionals should use caution when prescribing, dispensing, preparing, and administering any paclitaxel formulations to prevent medication errors, which have the potential to cause harm.

A healthcare organisation recently contacted the MHRA to enquire whether the packaging of a nab-paclitaxel medicine should more clearly state the formulation. Inadvertent administration of a different paclitaxel formulation could result in a higher dose than intended with increased toxicity, or sub-dosing with subtherapeutic effects. Nab-paclitaxel may be recommended in patients who have developed hypersensitivity to paclitaxel. As such, mix-ups between the two types of formulations may also present the risk of a hypersensitivity reaction, in addition to the risk of underdosing or overdosing.

As of September 2021, MHRA had not received any cases reported to the Yellow Card scheme for Abraxane and Pazenir suggesting a mix-up with conventional formulations associated with patient harm. Cases of medication error resulting in harm are not always reported to the Yellow Card scheme, and MHRA encourages healthcare professionals to report cases if they occur. MHRA is working with manufacturers to optimise the safety of these products. In the meantime, MHRA issues this communication on a precautionary basis. MHRA asks healthcare professionals to remain vigilant around these medicines.

Advice for healthcare professionals:

- Compared with conventional formulations, paclitaxel medicines formulated as albumin-bound nanoparticles (nab-paclitaxel) have different authorised indications, pharmacokinetics, dosages, and preparation and administration instructions.
- Conventional paclitaxel and nab-paclitaxel formulations are not interchangeable.
- Although MHRA has not received reports to suggest harm has occurred in the United Kingdom due to a mix-up of these paclitaxel formulations, errors in dosing or administration could have potential consequences for clinical response and increased toxicity or adverse reactions during cancer treatment.
- Make a clear distinction between paclitaxel formulations when prescribing, dispensing, administering, and communicating about these medicines – use of brand names is advised for nab-paclitaxel formulations.
- Verify the product name and dose before administration and ensure the specific Summary of Product Characteristics (SmPC) instructions are followed for preparation and administration.

In Hong Kong, there are 18 registered pharmaceutical products containing paclitaxel. All products are prescription-only medicines. One of these products contains paclitaxel formulated as albumin bound nanoparticles, namely Abraxane Powder For Injectable Suspension 100mg (HK-62459), which is registered by Bristol-Myers Squibb Pharma (HK) Ltd. As of the end of January 2022, the Department of Health (DH) has received 56 cases of adverse drug reaction related to paclitaxel, but none of these cases was related to medication error.

Currently, the locally registered sales pack of Abraxane states that it is albumin-bound. The locally registered package insert also contains safety information that the product should not be substituted for or with other paclitaxel formulations. The DH will remain vigilant on any safety update of the drug issued by MHRA and other overseas drug regulatory authorities for consideration of any action deemed necessary.

European Union: COVID-19: latest safety data provide reassurance about use of mRNA vaccines during pregnancy

On 18 January 2022, European Medicines Agency (EMA) announced that its COVID-19 task force highlighted the growing evidence indicating that mRNA COVID-19 vaccines do not cause pregnancy complications for expectant mothers and their babies.

The task force undertook a detailed review of several studies involving around 65,000 pregnancies at different stages. The review did not find any sign of an increased risk of pregnancy complications, miscarriages, preterm births or adverse effects in the unborn babies following mRNA COVID-19 vaccination. Despite some limitations in the data, the results appear consistent across studies looking at these outcomes. Studies also showed that COVID-19 vaccines are as effective at reducing the risk of hospitalisation and deaths in pregnant people as they are in non-pregnant people. The most common side effects of the vaccines in pregnant people also match those in the overall vaccinated population. They include pain at the injection site, tiredness, headache, redness and swelling at the site of injection, muscle pain and chills. These effects are usually mild or moderate and improve within a few days of vaccination.

Most of the information so far has come from mRNA vaccines (Comirnaty and Spikevax). EMA will also review data for other authorised COVID-19 vaccines as they become available.

In Hong Kong, the above products are not registered pharmaceutical products under the Pharmacy and Poisons Ordinance (Cap. 138). The COVID-19 vaccine by Fosun Pharma/BioNTech (i.e. Comirnaty) is authorised for emergency use in Hong Kong in accordance with the Prevention and Control of Disease (Use of Vaccines) Regulation (Cap. 599K). The DH will remain vigilant on safety

update of the product issued by other overseas drug regulatory authorities.

Drug Recall

Recall of Belkyra Solution for Injection 20mg/2ml

On 11 January 2022, the Department of Health (DH) endorsed a drug registration holder, Allergan Hong Kong Limited (Allergan), to recall all batches of Belkyra Solution for Injection 20mg/2ml (Hong Kong Registration number HK-65660) from the market because the product's label and package insert do not match with the registered ones.

The DH received notification from Allergan that during a product review conducted by the company, it was found that certain minor information on the label and package insert of the above product was different from the registered version, which renders the product unregistered. Since supply of unregistered pharmaceutical product contravenes the Pharmacy and Poisons Regulations (Cap. 138A), Allergan voluntarily recalls the product from the market. DH's investigation is continuing.

The above product, containing deoxycholic acid, is a prescription medicine used to improve the appearance of moderate to severe fullness associated with submental fat (also known as double chin) when injected into tissue. According to Allergan, the product was distributed by a licensed wholesaler, DKSH Hong Kong Limited, and had been supplied to private doctors only.

As of the end of January 2022, the DH has not received any adverse drug reaction report related to the affected product. A notice was posted in the Drug Office website on 11 January 2022 to alert the public of the product recall. The DH will closely monitor the recall.

Batch Recall of "Piperacillin and Tazobactam for Injection 4.5g"

On 17 January 2022, the Department of Health (DH) endorsed a licensed drug wholesaler, Luen Cheong Hong Ltd. (LCH), to recall a batch of Piperacillin and Tazobactam for Injection 4.5g (batch number: 305756) from the market due to the presence of visible particles in vials following reconstitution.

The DH received notification from LCH stating that the overseas manufacturer informed them that visible particles were observed in vials of several batches of the product following reconstitution on 17 January 2022. According to LCH, the batch 305756 is the only affected batch which has been imported into Hong Kong and supplied to Hospital Authority (HA). As a precautionary measure, LCH is voluntarily recalling the above batch from the market.

The above product contains Piperacillin and Tazobactam as active ingredients, and is a prescription medicine used for treatment of various infections. The product was unregistered but imported for the treatment of particular patients by the HA.

As of the end of January 2022, the DH has not received any adverse reaction reports in connection with the above batch of product. A notice was posted in the Drug Office website on 17 January 2022 to alert the public of the product recall. The DH noted that the recall was completed.

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 $50,000 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.

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: Adverse Drug Reaction and Adverse Event Following Immunization Unit,
Drug Office, Department of Health,
Room 1856, 18/F, Wu Chung House,
213 Queen's Road East,
Wanchai, 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.