Drug News
藥 物 情 報

Issue Number 158

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

European Union: EMA recommends withdrawal of pholcodine medicines from EU market

On 2 December 2022, the European Medicines Agency (EMA) announced that the Pharmacovigilance Risk Assessment Committee (PRAC) has concluded its review of medicines containing pholcodine, which are used in adults and children to treat non-productive (dry) cough and, in combination with other active substances, for the treatment of symptoms of cold and flu, and has recommended the revocation of the EU marketing authorisations for these medicines.

During the review, the PRAC evaluated all available evidence including the final results of the ALPHO study, post-marketing safety data and information submitted by third parties such as healthcare professionals. The available data showed that use of pholcodine in the 12 months before general anaesthesia with neuromuscular blocking agents (NMBA) is a risk factor for developing an anaphylactic reaction (a sudden, severe and life-threatening allergic reaction) to NMBAs.

As it was not possible to identify effective measures to minimise this risk, nor to identify a patient population for whom the benefits of pholcodine outweigh its risks, pholcodine-containing medicines are being withdrawn from the EU market and will therefore no longer be available by prescription or over-the-counter.

Healthcare professionals should consider appropriate treatment alternatives and advise patients to stop taking pholcodine-containing medicines. Healthcare professionals should also check whether patients scheduled to undergo general anaesthesia with NMBAs have used pholcodine in the previous 12 months, and remain aware of the risk of anaphylactic reactions in these patients.

The PRAC recommendations will now be sent to the Coordination Group for Mutual Recognition and Decentralised Procedures – Human (CMDh) for consideration at its next meeting in December 2022.

In Hong Kong, there are 28 registered pharmaceutical products containing pholcodine. As of the end of December 2022, the Department of Health (DH) had received 1 case of adverse drug reaction related to pholcodine, but this case was not related to anaphylactic reaction. Related news was previously issued by EMA, and was reported in Drug News Issues No. 17, 26 and 155. As the above PRAC's recommendations will now be sent to CMDh for consideration, the DH will remain vigilant on the development of the issue and safety update of the drug issued by EMA and other overseas drug regulatory authorities for consideration of any action deemed necessary.

Singapore: Update to Fact Sheets of Paxlovid (nirmatrelvir 300mg co-packaged with ritonavir 100mg) tablets with new safety information and microbiological data

On 6 December 2022, the Health Sciences Authority (HSA) announced that a Dear Healthcare Professional Letter has been issued by Pfizer Private Limited to inform healthcare professionals of updates to the Paxlovid Fact Sheets for Healthcare Providers and Patients/Caregivers. The updates to the Fact Sheets include the addition of anaphylaxis as adverse reaction, addition of new drug interactions and antiviral data. Healthcare professionals are advised to assess patient's medication and supplement list before starting Paxlovid treatment, and to inform patients to discontinue Paxlovid immediately if they experience any symptoms of allergic reactions.

In Hong Kong, Paxlovid Tablets (HK-67360) is a pharmaceutical product registered by Pfizer Corporation Hong Kong Limited. The product is a prescription-only medicine. As of the end of December 2022, the Department of Health (DH) had received 63 cases of adverse drug reaction related to Paxlovid, but these cases were not related to anaphylaxis. In light of the above HSA's announcement, the DH issued letters to inform local healthcare professionals to draw their attention on 16 December 2022. The DH will remain vigilant on any safety update of the product issued by other overseas drug regulatory authorities for consideration of any action deemed necessary.

The United Kingdom: Valproate: reminder of current Pregnancy Prevention Programme requirements; information on new safety measures to be introduced in the coming months

On 12 December 2022, the Medicines and Healthcare products Regulatory Agency (MHRA) announced that, in view of data showing ongoing exposure to valproate in pregnancy, MHRA reminds healthcare professionals of the risks in pregnancy and the current Pregnancy Prevention Programme requirements, and provides information about the potential risks of valproate in other patients following a review of the latest safety data. Following advice from the Commission on Human Medicines (CHM), new safety measures for valproate-containing medicines are to be put in place in the coming months.

Valproate (as sodium valproate or valproic acid) has a high teratogenic potential. Exposure of an unborn child to valproate in utero is associated with a high risk of congenital malformations (11%) and neurodevelopmental disorders (30 - 40%), which may lead to permanent disability. The available evidence does not support a specific at-risk gestational period and the possibility of a risk of valproate throughout pregnancy cannot be excluded. Due to the serious harms to an unborn baby associated with use of valproate in pregnancy, the existing advice is that valproate should not be used in female children and women of childbearing potential unless other treatments are ineffective or not tolerated. As a further strengthening of this position in April 2018, MHRA introduced the Valproate Pregnancy Prevention Programme as a requirement of any valproate use in patients of childbearing potential.

In 2022, the CHM considered a review of safety data relating to valproate. This review included prescribing data showing continued use of valproate in female patients and also some use during pregnancy, as well as evolving information about potential risks in male patients. The CHM also considered the views of patients and other stakeholders on the current use of valproate and on how the risks of valproate are currently managed.

On the basis of the evidence, the CHM has recommended a number of regulatory actions to further strengthen safety measures for valproate. These measures will be introduced over the coming months according to patient priorities so they can be introduced safely. Advice on the timing of introduction will be provided once the CHM's implementation group has finalised plans and after full engagement with stakeholders. No action is needed at present except for women of childbearing potential not on the Pregnancy Prevention Programme.

The CHM recommends that no patients (male or female) under the age of 55 years should be initiated on valproate unless 2 specialists independently consider and document that there is no other effective or tolerated treatment. For patients under 55 years currently receiving valproate, 2 specialists should independently consider and document that there is no other effective or tolerated treatment or the risks do not apply. The CHM has advised that these measures should apply to people under the age of 55 because this is the age group most likely to be affected by the risks of valproate when taken during pregnancy and the possible risk of impaired fertility in males.

Other measures recommended by CHM included further warnings in the product information, improved educational materials, and better monitoring of healthcare professionals' compliance with the new measures.

Advice for healthcare professionals:

- Continue to follow the existing strict precautions, including that valproate should not be prescribed to female children or women of childbearing potential unless other treatments are ineffective or not tolerated and that any use of valproate in women of childbearing potential who cannot be treated with other medicines is in accordance with the Pregnancy Prevention Programme.
- Following a new safety review conducted in light of concerns that the current regulatory

requirements for safe use are not being consistently followed, the CHM has advised that there should be greater scrutiny of the way valproate is prescribed and that further risk minimisation measures are required - in particular that 2 specialists should independently consider and document that there is no other effective or tolerated treatment for patients aged under 55 years.
- Consider all other suitable therapeutic options before newly prescribing valproate in patients younger than 55 years.
- These new measures will be implemented over the coming months.
- Patients currently taking valproate must be advised not to stop taking it unless they are advised by a specialist to do so.

In Hong Kong, there are 10 registered pharmaceutical products containing valproate. All products are prescription-only medicines. As of the end of December 2022, the Department of Health (DH) had received 14 cases of adverse drug reaction related to valproate, but these cases were not related to the risks in pregnancy or impaired fertility in males.

Related news on the risks in pregnancy associated with the use of valproate was previously issued by various overseas drug regulatory authorities, and was reported in the Drug News since Issue No. 21, with the latest update reported in Drug News Issue No. 116. The DH issued letters to inform local healthcare professionals to draw their attention on 4 July 2011, 7 May 2013, 13 October 2014 and 12 February 2018.

The Registration Committee of the Pharmacy and Poisons Board discussed the matter related to the risks in pregnancy associated with the use of valproate in September 2011, December 2014, December 2018 and June 2019. Currently, the package insert or sales pack label of locally registered valproate-containing products should include safety information on the risk of malformations and impaired cognitive development in children exposed to valproate during pregnancy, and contraindications, e.g. in women of childbearing potential unless pregnancy preventive measures have been implemented, etc. The certificate holders of locally registered valproate-containing products are also required to implement risk minimisation measures, e.g. patient information leaflet should be provided, etc.

In light of the above MHRA's announcement, the DH issued letters to inform local healthcare professionals to draw their attention on 13 December 2022, and the matter will be further discussed by the Registration Committee of the Pharmacy and Poisons Board.

Singapore: Janus Kinase (JAK) inhibitors and risk of major adverse cardiovascular events, malignancy, thrombosis and death

On 13 December 2022, the Health Sciences Authority (HSA) announced that it has completed its assessment on the risk of major adverse cardiovascular events (MACE), malignancy, thrombosis and death associated with Janus Kinase (JAK) inhibitors for the treatment of inflammatory conditions. The assessment was conducted in response to findings from a post-authorisation safety study (ORAL Surveillance), which found an increased risk of these adverse events with tofacitinib compared to tumour necrosis factor (TNF) inhibitors in rheumatoid arthritis (RA) patients who were 50 years of age or older, and with at least one additional cardiovascular risk factor.

Based on currently available information, HSA, in consultation with its Product Vigilance Advisory Committee (PVAC), has concluded that the benefit -risk profile of JAK inhibitors for the treatment of inflammatory conditions remains positive for their approved indications, where the use of JAK inhibitors is already limited to second line or later therapy in Singapore. As other JAK inhibitors used in the treatment of inflammatory conditions may have similar risks as observed with tofacitinib in the ORAL Surveillance study, healthcare professionals are advised to consider the benefits and risks of JAK inhibitors before prescribing these drugs, and to monitor their patients for these potential risks during treatment, particularly the elderly, current or past smokers, or with other cardiovascular, malignancy or thromboembolic risk factors.

The JAK inhibitors approved in Singapore for the treatment of inflammatory conditions are Xeljanz® (tofacitinib), Olumiant® (baricitinib), Rinvoq® (upadacitinib) and Cibinqo® (abrocitinib). Other JAK inhibitors that are not indicated for the treatment of inflammatory conditions (e.g., ruxolitinib) were not included in the scope of HSA's benefit-risk assessment.

The ORAL Surveillance study was a randomised, open-label, noninferiority trial evaluating the safety of tofacitinib at two doses (5mg and 10mg twice daily) compared with a TNF inhibitor in patients with active RA despite treatment with methotrexate. A total of 4,362 subjects were randomised to receive treatment with at least one dose of tofacitinib 5mg twice daily (n=1,455), tofacitinib 10mg twice daily (n=1,456), or a TNF inhibitor (n=1,451). In February 2019, patients who were treated with tofacitinib 10mg twice daily were transitioned to the lower dose of 5mg twice daily, after an interim analysis of the ongoing study noted a higher incidence of pulmonary embolism and mortality among patients receiving tofacitinib 10mg twice daily than among those receiving tofacitinib 5mg twice daily or a TNF inhibitor. The median on-study follow-up time was four years and patients were analysed in their originally assigned group, including those who were switched from tofacitinib 10mg to 5mg twice daily.

In the final analysis, noninferiority was not shown for the combined doses of tofacitinib as compared with a TNF inhibitor for the co-primary endpoints of MACE and malignancy. The incidences of MACE and malignancy were higher with the combined tofacitinib doses than with a TNF inhibitor (Hazard ratio 1.33 [95% CI 0.91 – 1.94] and 1.47 [95% CI 1.04 – 2.09], respectively). The signal of malignancy was mainly driven by higher incidences of lung cancer and lymphoma. Adjudicated venous thromboembolism (VTE) and death from any cause were more frequent with both tofacitinib doses than with a TNF inhibitor. A dose-dependent increased risk for MACE, VTE and death was observed for both tofacitinib doses compared with the TNF inhibitor. In subgroup analyses stratified by age, the incidence rates of MACE and malignancy across trial groups were higher in patients 65 years of age or older than those younger than 65 years of age. Among patients aged 65 years and older, both tofacitinib doses were associated with a higher risk of MACE and malignancy than with a TNF inhibitor.

To date, HSA has received two adverse event reports of breast cancer and death associated with the use of tofacitinib. The event of breast cancer was assessed by the reporting company to be an intercurrent medical condition unrelated to tofacitinib treatment, while confounding factors (e.g., concomitant use of other chemotherapeutic agents) were present for the case with a fatal outcome following infections. HSA has also received one adverse event report of stroke associated with upadacitinib use. However, the event of stroke was assessed to be unlikely related to upadacitinib treatment and the patient was subsequently restarted on the same JAK inhibitor for treatment of RA with no reported issues. There have been no local adverse event reports of MACE, malignancy, thrombosis, or death with baricitinib and abrocitinib.

HSA has issued a Dear Healthcare Professional Letter on 17 November 2022 to inform healthcare professionals of HSA's advisory and actions following its benefit-risk assessment of JAK inhibitors. HSA is working with the product registrants to strengthen the package inserts of JAK inhibitors approved for the treatment of inflammatory conditions to include warnings on the increased risks of MACE, malignancy, thrombosis and death observed with tofacitinib in the ORAL Surveillance study. HSA will continue to closely monitor the international and local developments of this issue and update healthcare professionals of any new significant findings.

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) which are registered by Pfizer Corporation Hong Kong Limited; 2 products containing baricitinib, namely Olumiant Tablets 2mg (HK-65663) and Olumiant Tablets 4mg (HK-65664) which are registered by Eli Lilly Asia, Inc.; and 2 products containing upadacitinib, namely Rinvoq Prolonged-Release Tablets 15mg (HK-66872) and Rinvoq Prolonged-Release Tablets 30mg (HK-67512) which are registered by Abbvie Limited. All products are prescription-only medicines. There is no registered pharmaceutical product containing abrocitinib.

As of the end of December 2022, the Department of Health (DH) had received adverse drug reaction related to tofacitinib (9 cases; of which 2 cases were related to cancer and 3 cases were related to deep vein thrombosis), baricitinib (3 cases; of which one case was related to deep vein thrombosis) and upadacitinib (6 cases).

Related news on the risk of blood clots, serious heart-related problems and cancer of JAK inhibitors was previously issued by various overseas drug regulatory authorities, and was

reported in the Drug News since Issue No. 112, with the latest update reported in Drug News Issue No. 157. The DH issued letters to inform local healthcare professionals to draw their attention on 29 July 2019, 19 June 2020, 15 June 2021, 2 September 2021 and 31 October 2022.

In December 2019, the Registration Committee of the Pharmacy and Poisons Board (the Committee) discussed the matter on the risk of blood clots and death associated with the use of tofacitinib, 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).

In December 2021, the Committee discussed the matter on the risk of venous thromboembolic events (including deep vein thrombosis and pulmonary embolism) associated with the use of JAK inhibitors (tofacitinib, baricitinib and ruxolitinib), and decided that the sales pack or package insert of these products should include the relevant safety information.

As previously reported, the matter will be further discussed by the Committee.

Singapore: Topical corticosteroids and risk of topical steroid withdrawal

On 13 December 2022, the Health Sciences Authority (HSA) announced a safety alert on topical corticosteroids (TCS) and risk of topical steroid withdrawal (TSW).

TCS are used for the relief of the inflammatory and pruritic manifestations of various dermatoses, including eczema and psoriasis. In Singapore, the locally registered TCS include betamethasone, clobetasol, desonide, diflucortolone, fluocinolone, fluticasone, hydrocortisone, mometasone and triamcinolone. Based on HSA's experience, certain illicit skin-lightening creams have been found to contain these steroids as adulterants.

TSW refers to a mixed group of symptoms that has also been referred to as topical steroid addiction, red skin syndrome or steroid dermatitis. It has been suggested that this syndrome arises from a physical dependence on TCS, particularly in the context of increasing potency and frequency, and prolonged use of TCS. A rebound worsening of skin manifestations after discontinuation of TCS may occur, which may be more extensive or with a different morphological appearance from the initial skin condition.

Systematic reviews have attempted to collate and characterise the clinical features of TSW from published case reports, case series and cross-sectional studies. TSW was reported as predominantly affecting the face and genital area, with common symptoms including itch, burning and stinging. The duration of TCS use in the majority of the cases was 6 months or longer, and the time-to-onset of TSW ranged from days to months after TCS discontinuation. Two distinct clinical presentations of TSW were observed: 1) an erythematoedematous subtype that occurred in patients with an underlying eczematous dermatosis, presenting more frequently with burning, erythema and oedema, and 2) a papulopustular subtype that occurred primarily in patients who used TCS for cosmetic purposes (e.g., illicit skin-lightening creams). The reviews concluded that TSW is likely a distinct clinical adverse effect resulting from prolonged, inappropriate, and frequent use of moderate-to high-potency TCS. However, the reviewed evidence (i.e., observational studies) was of low quality and at risk of bias, necessitating further well-designed studies to better understand and define this entity.

The recognition and diagnosis of TSW remains a challenge. There is no consensus on the diagnostic criteria for TSW, and its features overlap with other clinical entities, such as allergic contact dermatitis and a flare-up of the pre-existing inflammatory condition or skin infection. In addition, investigations (such as a skin biopsy) are generally of limited use to distinguish TSW from a flare of the pre-existing skin condition. Proposed mechanisms for TSW include rebound vasodilation mediated by elevated nitric oxide, dysregulation of glucocorticoid receptors and tachyphylaxis. However, current evidence is limited and in certain areas, contradictory.

To date, HSA has received three reports of TSW, all of which were associated with long-term (several years) use of topical products that were tested to be adulterated with potent TCS. In response, HSA had issued a press release to warn members of the public against the purchase of such products from dubious sources and to raise awareness on the prolonged use of TCS and their associated withdrawal reactions. An Adverse Drug Reaction (ADR) News bulletin article was also published to inform healthcare professionals of

Safety Update

such illegal products purchased by consumers and to be vigilant of potential TSW adverse events arising from the use of such products in consumers.

As HSA continues to monitor reports of TSW with the use of TCS, healthcare professionals are advised to take into consideration the above information when prescribing TCS, and to consider the possibility of TSW in patients with a history of continuous prolonged TCS use who present with suggestive clinical signs.

In Hong Kong, there are registered pharmaceutical products containing topical corticosteroids such as betamethasone (194 products), clobetasol (286 products), desonide (4 products), diflucortolone (7 products), fluocinolone (50 products), fluticasone (4 products), hydrocortisone (69 products), mometasone (26 products) and triamcinolone (117 products). As of the end of December 2022, the Department of Health (DH) had received 5 cases of adverse drug reaction related to corticosteroids dermatological preparations, but these cases were not related to topical steroid withdrawal. Related news was previously issued by the United Kingdom Medicines and Healthcare products Regulatory Agency, and was reported in Drug News Issue No. 143. The DH issued letters to inform local healthcare professionals to draw their attention on 16 September 2021. As previously reported, the matter will be discussed by the Registration Committee of the Pharmacy and Poisons Board.

Drug Recall

Batch recall of "Fluphenazin-Neuraxpharm D Solution for Injection 25mg/ml"

On 1 December 2022, the Department of Health (DH) endorsed licensed wholesaler, Hind Wing Company Limited (Hind Wing), to recall a batch (batch number 202052) of Fluphenazin-Neuraxpharm D Solution for Injection 25mg/ml (HK- 64620) due to potential quality issue.

The DH received notification from Hind Wing that the overseas manufacturer has recalled several batches of the product because, based on tests done on the filter cartridges used in the production of the product, it was found that there was potential leach of additives from the filter cartridges. As a precautionary measure, Hind Wing is voluntarily recalling the affected batch. DH's investigation is continuing.

The above product is a prescription medicine and is indicated for schizophrenia. According to Hind Wing, only one affected batch of the product has been imported into Hong Kong and supplied to the Hospital Authority, private doctor and pharmacy.

As of the end of December 2022, the DH had not received any adverse reaction reports in connection with the above batch of product. A notice was posted on the Drug Office website on 1 December 2022 to alert the public of the product recall. The DH will closely monitor the recall.

Further batch recall of Allergenic Extract for diagnostic test – Peanut

On 14 December 2022 following the batch recall of the above product, the Department of Health (DH) endorsed licensed wholesaler, Ksena Healthcare Limited (Ksena), to further recall a batch (batch number 0004218744) of skin test reagent for allergy to peanut, namely Allergenic extract for diagnostic test-Peanut due to potential quality issue.

The DH received notification from Ksena that the overseas manufacturer has recalled the skin test reagent due to reports of individuals who were test-negative using the above product lot subsequently experienced allergic reactions to peanut. As a precautionary measure, Ksena voluntarily recall the affected batch. DH's investigation is continuing.

The above product is a skin test reagent for allergy to peanut, the product was unregistered but imported for named patient use by registered medical practitioners through Ksena.

As of the end of December 2022, the DH had not received any adverse reaction reports in connection with the above batch of product. A notice was posted on the Drug Office website on 14 December 2022 to alert the public of the product recall. The DH noted that the recall was completed.

Drug Incident

Public urged not to buy or use topical products containing undeclared controlled ingredients

On 6 December 2022, the Department of Health (DH) appealed to the public not to buy or use four types of topical products as they were found to contain undeclared controlled drug ingredients. These products include:

Product name	Part 1 poisons found
1.「草本专家止痒王抑菌乳膏」(no English name, please refer to the product at top left of the photo in press release)	Clobetasol propionate, ketoconazole and miconazole
2. MIAO XUAN WANG CAO BEN RU GAO	Clobetasol propionate, ketoconazole and miconazole
3. Zang yao xuan du wang	Clobetasol propionate, ketoconazole and miconazole
4.「百芙通九毒王藏药乳膏」(no English name, please refer to the product at bottom right of the photo in press release)	Miconazole

Acting upon a public complaint, samples of the products were collected from a retail stall in Sham Shui Po for analysis. Test results from the Government Laboratory revealed that the above products contained undeclared controlled drug ingredients, which are Part 1 poisons under the Pharmacy and Poisons Ordinance (Cap 138). These products are also suspected to be unregistered pharmaceutical products. The DH's investigation is continuing.

Clobetasol propionate is a steroid substance for treating inflammation. Inappropriate application of steroids could cause skin problems and systemic side effects such as moon face, high blood pressure, high blood sugar, adrenal insufficiency and osteoporosis. Products containing clobetasol propionate are prescription medicines that should be used under a doctor's directions and be supplied in a pharmacy under the supervision of a registered pharmacist upon a doctor's prescription. Ketoconazole and miconazole are used for the treatment of fungal infections with side effects including local irritation and sensitivity reactions.

A press release was posted on the Drug Office website on 6 December 2022 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 $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.

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: 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.