



This is a monthly digest of local and overseas drug safety news released by the Drug Office of the Department of Health in February 2026 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

The United Kingdom: Semaglutide (Wegovy, Ozempic and Rybelsus): risk of Non-arteritic Anterior Ischemic Optic Neuropathy (NAION)

On 5 February 2026, the Medicines and Healthcare products Regulatory Agency (MHRA) announced that non-arteritic anterior ischemic optic neuropathy (NAION), a condition that can cause sudden deterioration in vision, usually in one eye at a time, has been very rarely reported in association with semaglutide in the treatment of type 2 diabetes, weight management and cardiovascular risk reduction. Patients reporting a sudden loss of vision (including partial loss) while on semaglutide treatment should be urgently referred for ophthalmological examination.

Advice for Healthcare Professionals:

- semaglutide is a glucagon-like peptide-1 (GLP-1) receptor agonist used to treat type 2 diabetes mellitus and for weight management and cardiovascular risk reduction
- semaglutide treatment may be very rarely associated with NAION, a condition which can cause vision loss, typically in one eye
- NAION typically causes sudden, painless vision loss in one eye that is often described as a blurring or cloudiness of vision.
- privately prescribed semaglutide may not appear on the patient's medical history so if a patient presents with these symptoms, enquire about semaglutide use
- patients reporting a sudden loss of vision (including partial loss) should be urgently referred for specialist examination by an ophthalmologist
- discontinue semaglutide treatment if NAION is confirmed
- advise new patients, or existing patients during medication reviews, to urgently attend eye casualty or A&E if they experience a sudden

loss of vision or rapidly worsening eyesight

Advice for Healthcare Professionals to Provide to Patients:

- semaglutide treatment has, in extremely rare cases, been linked to a serious eye condition called NAION, which can affect your vision
- NAION usually affects one eye at a time
- if you notice a change in your eyesight, such as sudden blindness or your eyesight gets worse very quickly in one or both of your eyes during treatment with semaglutide, urgently attend eye casualty (if available in your area) or A&E
- you may be referred for an eye examination by an ophthalmologist

Background

Non-arteritic anterior ischemic optic neuropathy (NAION) is a condition affecting the optic nerve head (ONH). It typically causes sudden, painless vision loss, usually in one eye that is often described as a blurring or cloudiness of vision.

NAION occurs due to reduced blood flow to the front portion of the optic nerve. It is termed 'non-arteritic' because this reduction in circulation occurs without inflammation of the blood vessels, distinguishing it from arteritic causes. Patients with type 2 diabetes are at increased risk of NAION as a result of their condition. Other risk factors for developing NAION include smoking, hypertension and hypercholesterolemia.

Estimates of the background incidence of NAION vary widely, with the incidence in patients with Type 2 diabetes varying from 11.4 per 100,000 person-years to 82 per 100,000 person-years and the incidence in the general population ranging from 7.73 to 11.35 per 100,000 person-years among individuals aged 40 years and older; 10.2 per 100,000 person-years among individuals aged 50

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years and older; and 14.79 per 100,000 person-years among individuals aged 60 years and older.

Studies suggest semaglutide treatment may be very rarely associated with NAION; this means it may affect up to 1 in 10,000 people taking semaglutide.

A European review of evidence from clinical studies, post authorisation reports and the literature suggests that exposure to semaglutide in adults with type 2 diabetes may be associated with an approximately two-fold increase in the relative risk of developing NAION. This corresponds to approximately one additional person affected out of every 10,000 treated per year. The review was considered by the Pharmacovigilance Expert Advisory Group (PEAG) of the Commission on Human Medicines (CHM), which while noting that there was conflicting evidence in the literature, agreed with the recommendations to update the product information for semaglutide products in the UK to include this possible side effect. Other GLP-1 agonists were not included in this review.

UK reports

In the UK, since semaglutide's first authorisation in 2018 up to 1st August 2025 the Yellow Card scheme has received three spontaneous reports suggestive of NAION with semaglutide. For context, in the past 5 years, it is estimated that roughly 10.2 million packs of semaglutide have been dispensed. The reporting of a case to the MHRA does not mean that it was definitely linked to the medicine, but that the reporter suspected that it may have been.

The MHRA is reviewing any evidence for an association with other GLP-1 agonists.

Updated product information for patients and healthcare professionals

The Summary of Product Characteristics (SmPC) and Patient information Leaflet (PIL) for semaglutide products will be updated in the coming months to describe the risk of NAION. They will advise that patients reporting a sudden loss of vision are urgently referred for ophthalmological examination.

About semaglutide

Semaglutide is a glucagon-like peptide-1 receptor agonist (GLP-1RA) sold under brand names Ozempic and Rybelsus, which are indicated for type 2 diabetes (T2D); and Wegovy, which is

indicated for weight management and cardiovascular risk reduction as an adjunct to a reduced-calorie diet and increased physical activity in patients with overweight or obesity.

In Hong Kong, there are 11 registered pharmaceutical products containing semaglutide. All products are prescription-only medicines. As of the end of February 2026, the Department of Health (DH) had received 10 cases of adverse drug reaction reports with regard to semaglutide, but these cases were not related to NAION. Related news was previously issued by the European Medicines Agency, and was reported in the Drug News Issue No. 183 and 188. The DH issued letters to inform local healthcare professionals to draw their attention on 9 June 2025. As previously reported, the matter will be discussed by the Registration Committee of the Pharmacy and Poisons Board of Hong Kong.

The United States: Safety labeling update for capecitabine and fluorouracil (5-FU) on risks associated with dihydropyrimidine dehydrogenase (DPD) deficiency

On 5 February 2026, the United States Food and Drug Administration (FDA) provided this communication to increase awareness of recent updates to the product labeling of capecitabine (Xeloda) and fluorouracil (5-FU) related to risks associated with dihydropyrimidine dehydrogenase (DPD) deficiency. All healthcare providers should be aware of the risks of DPD deficiency, inform patients prior to treatment about the potential for serious and life-threatening toxicities due to DPD deficiency, and test patients for genetic variants of DPYD prior to initiating treatment with capecitabine or 5-FU unless immediate treatment is necessary.

The DPYD gene encodes the enzyme DPD, which breaks down >80% of fluorouracil. Patients with certain homozygous or compound heterozygous variants in the DPYD gene, known to result in complete or near complete absence of DPD activity (complete DPD deficiency), are at increased risk for acute early-onset toxicity and serious, including fatal, adverse reactions (e.g., mucositis, diarrhea, neutropenia, and neurotoxicity) when exposed to capecitabine or fluorouracil. Patients with partial DPD activity (partial DPD deficiency) may also have an increased risk of serious, including fatal, adverse reactions.

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The FDA recently approved revisions to the Xeloda (capecitabine) and 5-FU product labeling to provide further information on DPD deficiency. The following summarizes the key changes that were made to the labeling of both drugs:

- **Boxed Warning:** The Boxed Warning now highlights the risk of serious adverse reactions or death in patients with complete DPD deficiency. It also advises DPYD testing prior to initiating capecitabine or 5-FU, unless immediate treatment is necessary, and recommends avoiding use in patients with certain homozygous or compound heterozygous DYPD variants that result in complete DPD deficiency.
- **Dosage and Administration:** A new subsection, 2.1 Evaluation and Testing for DPD Deficiency Before Initiating capecitabine or 5-FU, has been added and instructs to avoid use of these drugs in patients known to have certain homozygous or compound heterozygous DYPD variants that result in complete DPD deficiency. For patients with partial DPD deficiency, dosing should be individualized.
- **Warnings and Precautions:** Reiterates that prior to initiating capecitabine or 5-FU, patients should be tested for genetic variants of the DPYD gene unless immediate treatment is necessary.

See the full prescribing information for Xeloda (capecitabine) and 5-FU for additional information on DPD deficiency, located in the Boxed Warning and Sections 2, 5, 12, and 17.

The FDA will continue to monitor this safety issue and evaluate the evolving landscape and impact of DPD deficiency on the safety of capecitabine and fluorouracil; additional regulatory actions may be considered.

Capecitabine is indicated for colorectal, colon, gastric and breast cancer. 5-FU is indicated for gastrointestinal cancer; breast cancer; other malignant neoplasms such as those of the head and neck, liver, and pancreas; actinic keratoses and other superficial tumours and premalignant conditions of the skin.

In Hong Kong, there are registered pharmaceutical products containing capecitabine (26 products) and fluorouracil (3 products). All products are prescription-only medicines. As of the end of February 2026, the Department of Health (DH) had

received adverse drug reaction reports with regard to capecitabine (84 cases including one case related to DPD deficiency) and fluorouracil (113 cases but they were not related to DPD deficiency). Related news was previously issued by various overseas drug regulatory authorities, and was reported in the Drug News Issue No. 113. The DH issued letters to inform local healthcare professionals to draw their attention on 18 March 2019.

In June 2021, the Registration Committee of the Pharmacy and Poisons Board of Hong Kong discussed the matter, and decided that the sales pack labels and/or package inserts of registered pharmaceutical products containing capecitabine and fluorouracil should contain the relevant safety information about DPD deficiency. The DH will continue to remain vigilant on any safety update of the drugs issued by other drug regulatory authorities.

Singapore: Rhinathiol Promethazine – Restriction of oral formulation use in children less than 6 years of age for safety reasons

On 11 February 2026, the Health Sciences Authority (HSA) announced that a Dear Healthcare Professional Letter has been issued by Opella Healthcare Singapore Pte. Ltd. to inform healthcare professionals about restrictions in the use of Rhinathiol Promethazine oral formulation in children less than 6 years of age due to safety reasons. The product information has been updated to reflect these restrictions, with amendments made in the sections regarding indication, posology, undesirable effects and warnings/precautions. Healthcare professionals are advised to refer to the updated product information.

The product is used for the alleviation of unproductive and irritative coughs in adults and children aged 6 years and above, particularly when coughing occurs at night.

In Hong Kong, there are 236 registered oral pharmaceutical products containing promethazine. As of the end of February 2026, the Department of Health (DH) had not received any adverse drug reaction report with regard to the use of promethazine in children less than 6 years of age. Related news on restriction of use of cough and cold medicines in children under 6 years of age was previously issued by various overseas drug regulatory authorities, and was reported in the Drug News Issue No. 153. The DH issued letters to

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inform local healthcare professionals to draw their attention on 21 July 2011 and 13 July 2022. In April 2009, the Registration Committee of the Pharmacy and Poisons Board of Hong Kong decided that the sales pack label and/or package insert of over-the-counter cough and cold medicines should not contain dosage instructions for children under 6 years of age.

Related news on restriction of use and the risk of psychiatric and central nervous system side effects associated with oral promethazine in children under 6 years of age was previously issued by Australian Therapeutic Goods Administration, and was reported in the Drug News Issue No. 181. The DH issued letters to inform local healthcare professionals to draw their attention on 20 November 2024. As previously reported, the matter will be discussed by the Registration Committee of the Pharmacy and Poisons Board of Hong Kong .

The United States: FDA approves labeling changes to menopausal hormone therapy products

On 12 February 2026, the United States Food and Drug Administration (FDA) announced that it has approved drug labeling changes to six menopausal hormone therapy products, also known as hormone replacement therapy (HRT), to clarify risk considerations for these drugs. Specifically, risk statements related to cardiovascular disease, breast cancer and probable dementia were removed from the “boxed warning”, the agency’s most prominent safety-related warning.

“This decision reflects our commitment to follow the science wherever it leads and to correct course when the evidence demands it,” Health and Human Services Secretary Robert F. Kennedy, Jr. said. “By removing these boxed warnings, we ensure that women receive accurate information about hormone therapy—free from exaggeration or fear. A healthcare system worthy of public trust tells the truth, updates its guidance as science evolves, and respects women’s ability to make informed choices about their own health.”

The FDA initiated the removal of these warnings in November 2025, following a comprehensive review of the scientific literature. At the FDA’s request, 29 drug companies have submitted proposed labeling changes. This first batch of six products with approved labeling changes includes products from each of the four categories of HRT

for menopausal women:

- Systemic combination therapy (estrogen and progestogen)
- Systemic estrogen-alone therapy
- Systemic progestogen-alone therapy for women with a uterus using systemic estrogen
- Topical vaginal estrogen therapy

“With today’s action, we are delivering on our promise to make sure women have accurate, scientifically grounded information about the potentially life-changing benefits of HRT,” said FDA Commissioner Marty Makary, M.D., M.P.H. “Women face symptoms of menopause that can last for years, and our efforts will help these women make well-informed medical decisions.”

Menopause is a normal life stage, but its symptoms can significantly reduce quality of life. Common symptoms include hot flashes and night sweats (called vasomotor symptoms or VMS); vaginal, vulvar, and urinary tract changes caused by lower estrogen levels; and osteoporosis (thinning bones), which increases fracture risk.

The FDA has approved multiple hormone therapies for moderate-to-severe hot flashes, vaginal dryness and discomfort, and preventing bone loss. In addition, randomized studies show that women who initiate HRT within 10 years of the onset of menopause (generally before age 60) have a reduction in all-cause mortality and fractures. Just a small fraction of women who could benefit from these treatments, however, are using them. In 2020, about 41 million U.S. women were ages 45–64 — yet only about 2 million women ages 46–65 received a hormone-therapy prescription.

Today’s action will allow women, working with their healthcare professionals, to make better-informed decisions about their treatment plan for menopause symptoms. Women are encouraged to consult the drug label for more detailed information about the benefits and risks of these products.

In Hong Kong, hormone replacement therapy (HRT) products are registered pharmaceutical products. As of the end of February 2026, the Department of Health (DH) had not received any adverse drug reaction reports with regard to HRT.

Related news regarding the associated risk of HRT was previously issued by FDA and various overseas drug regulatory authorities, and was

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reported in the Drug News since Issue No. 118, with the latest update reported in the Drug News Issue No. 193. The DH issued letters to inform local healthcare professionals to draw their attention on 2 September 2019. In December 2021, the Registration Committee of the Pharmacy and Poisons Board discussed the matter, and decided that the sales pack labels and/or package inserts should contain safety information about the risk of breast cancer, stroke and/or endometrial cancer for different types of locally registered HRT products. The risk of breast cancer, cardiovascular diseases, dementia and endometrial cancer associated with the use of HRT is also documented in overseas reputable drug references such as the “Martindale: The Complete Drug Reference”. As previously reported, the above FDA announcement will be discussed by the Registration Committee of the Pharmacy and Poisons Board of Hong Kong.

Australia: Medicine Safety Update: Medicines containing vitamin B6 (pyridoxine, pyridoxal or pyridoxamine)

On 19 February 2026, the Therapeutic Goods Administration (TGA) announced that some dosages of vitamin B6 will be rescheduled as Pharmacist Only Medicines.

Summary

Oral preparations containing more than 50 mg but not more than 200 mg per recommended daily dose of vitamin B6 will be rescheduled as Pharmacist Only Medicines from 1 June 2027.

Vitamin B6 is also known as pyridoxine, pyridoxal, or pyridoxamine.

The effect of TGA’s decision is that from 1 June 2027 products with low doses of vitamin B6 will continue to be available for general sale, while products containing higher doses will require advice from a pharmacist or a prescription from a doctor, depending on the dose:

- oral preparations containing 50 mg or less per recommended daily dose will continue to be available for general retail sale.
- oral preparations containing more than 50 mg but not more than 200 mg per recommended daily dose will be available over the counter with the advice of a pharmacist.
- oral preparations containing more than 200 mg per recommended daily dose will continue to require a prescription.

Vitamin B6 can cause peripheral neuropathy, and while the risk is greatest for higher intakes of vitamin B6, it cannot be excluded for doses less than 50 mg/day. It can be difficult for consumers to estimate their vitamin B6 intake because of the widespread presence of vitamin B6 in listed medicines and food supplements and the different ways vitamin B6 is labelled on products.

The scheduling for vitamin B6 intersects with other regulatory controls which also require changes following the scheduling decision. Additional recommendations for improved consumer safety are also under consideration. The rescheduling implementation date of 1 June 2027 allows for necessary regulatory and industry changes.

What health professionals should do

While the implementation date for these regulatory changes is not until 1 June 2027, health professionals can take action now to consider vitamin B6 toxicity in patients presenting with symptoms of peripheral neuropathy.

A review of the patient’s vitamin B6 intake is recommended, paying close attention to potential sources such as B vitamins, multivitamins and magnesium and zinc products, particularly when taken in combination. Various food and beverages supplemented with vitamin B6 should also be taken into consideration when estimating a person’s total vitamin B6 intake.

Health professionals should be alert to the paradox that the most common symptoms associated with vitamin B6 toxicity are similar to those of vitamin B6 deficiency. Therefore, it is important to be aware that consumers may inadvertently exacerbate the symptoms they are trying to treat by taking supplements containing vitamin B6.

Adverse event reports submitted to TGA suggest there is a lack of awareness that vitamin B6 can cause peripheral neuropathy. Most consumers who use complementary medicines perceive these medicines to be safe and effective.

Adverse event reports also suggest a lack of awareness about the presence of vitamin B6 in medicines, particularly if the label lists the chemical name without the common name ‘vitamin B6’. Health professionals should be alert to this as consumers may not recall use if asked, leading to delayed diagnosis and medicine cessation.

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Following the scheduling decision, TGA is considering recommendations on ways to make it clearer for consumers that vitamin B6 is present and how much is in the medicine.

There are currently three forms of vitamin B6 in low-risk products available in the Australian market through self-selection:

- pyridoxine hydrochloride
- pyridoxal 5-phosphate
- pyridoxal 5-phosphate monohydrate.

When included as active ingredients, pharmaceutical companies must list these names on the label.

Where a label is not available for the medicine, formulation details of medicines that can be supplied within Australia can be found by searching the Australian Register of Therapeutic Goods (ARTG). The available PDF summary will list the vitamin B6 ingredient, if present, using one of the above names and state how much is in the medicine as the equivalent amount of pyridoxine.

Background

Vitamin B6 is a water-soluble vitamin that acts as a co-enzyme in more than 150 enzymatic reactions in the metabolism of amino acids, carbohydrates and lipids. Vitamin B6 is also important for the synthesis of many neurotransmitters, haemoglobin formation and immune functions. Vitamin B6 deficiency can cause peripheral neuropathy, seborrheic dermatitis (scaly, flaky, and sometimes itchy patches of skin), glossitis (inflammation of the tongue), and cheilosis (inflammation, cracking, and sores at the corners of the mouth), and, in adults, confusion and seizures.

In Australia, the estimated average requirement for vitamin B6 for adults is 1.1 to 1.3 mg/day and the recommended dietary intake (RDI) is 1.3 to 1.7 mg/day. Vitamin B6 is found in a wide range of foods including meats, breakfast cereals, vegetables and fruits and the RDI is easily met through dietary intake alone for most Australians. Clinical deficiency of vitamin B6 is rare.

Peripheral neuropathy is a known side effect of vitamin B6 toxicity and is characterised by tingling, burning, or numbness, usually in the hands or feet. Delayed diagnosis and continued exposure can lead to progression of the disease.

Because of this risk, since 1 March 2022,

medicines containing daily doses of vitamin B6 over 10 mg or equivalent have been required to carry the following statement:

“WARNING - Stop taking this medication if you experience tingling, burning or numbness and see your healthcare practitioner as soon as possible. (Contains vitamin B6)”⁴

This label warning was previously only required for daily doses of vitamin B6 over 50 mg. During the transition period, TGA published a Medicine Safety Update (MSU) article warning that vitamin B6 can cause peripheral neuropathy. Following the implementation of the label warning statement at daily doses above 10 mg, TGA continued to monitor any emerging evidence and reports of adverse events related to this issue.

An application to amend the Poisons Standard in relation to vitamin B6 was referred to the Advisory Committee on Medicines Scheduling (ACMS) in November 2024. TGA released an interim decision on 26 June 2025.

Following public consultation, we released the final decision on 25 November 2025.

A wide range of materials was considered in making the scheduling change including:

- advice received from the ACMS
- 21 public submissions received in response to consultation before the ACMS meeting
- the interim decision and the materials considered as part of this, as published on 26 June 2025
- 248 submissions received in response to the public consultation on the interim decision

At the time of the final decision, there were at least 125 medicines on the Australian market providing more than 50 mg but not more than 200 mg vitamin B6 per maximum recommended daily dose. Of these, 116 were listed complementary medicines. These ARTG listed medicine entries will be cancelled. To continue to be available on the Australian market, applications must be made for their evaluation as registered medicines.

Adverse events reported to TGA

The scheduling decision-maker considered adverse events as part of the relevant information. From the final decision document, as of 31 October 2025, there were 250 reports of peripheral neuropathy, peripheral sensory neuropathy, peripheral sensorimotor neuropathy, small fibre neuropathy, polyneuropathy or chronic polyneuropathy for

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products containing vitamin B6 on the TGA's Database of Adverse Event Notifications (DAEN).

Of these, 152 also reported 'Hypervitaminosis B6' and/or 'Vitamin B6 increased'. There were another 162 reports of 'Hypervitaminosis B6' and/or 'Vitamin B6 increased' with less specific reaction terms such as paraesthesia, burning sensation etc. possibly suggestive of neuropathies.

In Hong Kong, there are registered pharmaceutical products containing vitamin B6 substance including pyridoxine, while there is no registered pharmaceutical product containing pyridoxal or pyridoxamine. As of the end of February 2026, the Department of Health (DH) had received 8 cases of adverse drug reaction reports with regard to pyridoxine, but these cases were not related to peripheral neuropathy.

Related news regarding vitamin B6 and the risk of peripheral neuropathy was previously issued by TGA and Singapore Health Sciences Authority, and was reported in the Drug News Issue No. 156 and 163. The DH issued letters to inform local healthcare professionals to draw their attention on 5 October 2022. In December 2024, the Registration Committee of the Pharmacy and Poisons Board of Hong Kong discussed the matter, and decided that the sales pack labels and/or package inserts of registered products containing daily doses over 10mg of vitamin B6 should contain the warning statement related to peripheral neuropathy referenced in the above TGA announcement "Stop taking this medication if you experience tingling, burning or numbness and see your healthcare practitioner as soon as possible (Contains vitamin B6)". The DH will remain vigilant on any safety update of the drugs issued by other drug regulatory authorities.

Drug Recall

Batch Recall of Gastrografin Liq Oral/Rectal

On 24 February 2026, the Department of Health (DH) endorsed a licensed drug wholesaler, Bayer Healthcare Limited (Bayer), to recall a total of 5 batches (batch number: MA04HF2-H1, MA04MPR-H1, MA04MPR-H2, MA04P3R-H1, MA04S8L-H1) of the product, namely Gastrografin Liq Oral/Rectal (Hong Kong Registration number: HK-46076) from the market as a precautionary measure due to the presence of impurity in the product.

The DH received notification from Bayer that the overseas manufacturer of the concerned product is recalling the above batches of Gastrografin Liq Oral/Rectal as they exceed the accepted level of an impurity, N-Nitroso-Meglumine (NO-Meglumine). NO-Meglumine is classified as a probable human

carcinogen based on results from laboratory tests. As a precautionary measure, Bayer is voluntarily recalling the affected batches of product from the market.

The above product, containing meglumine amidotrizoate and sodium amidotrizoate, is a contrast medium used for examination of the gastrointestinal tract. According to Bayer, the affected batches had been imported into Hong Kong and supplied to Hospital Authority, private hospitals, private doctors, and exported to Macao.

As of the end of February 2026, the DH had not received any adverse reaction report in connection with the product. A notice was posted in the Drug Office website on 24 February 2026 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.

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/

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>

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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.