ISSN 1172-5648

Prescriber Update

Vol. 31 No. 1
February 2010

A publication of

MEDSAFE
NEW ZEALAND MEDICINES AND MEDICAL DEVICES SAFETY AUTHORITY
A BUSINESS UNIT OF THE MINISTRY OF HEALTH
www.medsafe.govt.nz

New Zealand Government

MINISTRY OF HEALTH
MANATŪ HAUORA

Prescriber Update is a member of the
INTERNATIONAL SOCIETY OF DRUG BULLETINS

Dextropropoxyphene – review concludes risk-benefit balance unfavourable

In December 2009 the Medicines Adverse Reactions Committee (MARC) reviewed the benefits and risks of dextropropoxyphene-containing medicines referred under section 36 of the Medicines Act 1981. This review was triggered by the results of a study evaluating the prescribing of these medicines in New Zealand. The study found that less than half of the prescriptions dispensed were in line with the approved indication, which had previously been restricted in 2006.[1]

A summary of the Committee's discussion is contained in the meeting minutes.[2] The MARC concluded that:

- Efficacy studies had demonstrated that these medicines were no better than paracetamol used at the maximum recommended dose.
- The available data on adverse reactions showed that these medicines have the potential to cause more adverse reactions than paracetamol used at recommended doses.
- These medicines are more dangerous than other analgesics in overdose.
- Overall the benefits of these medicines do not outweigh the risks associated with their use.

To protect the health of New Zealanders the MARC recommended consent to distribute these medicines in New Zealand be revoked. The MARC has also recommended that physicians be given sufficient time to review patients and arrange alternative treatments.

Medsafe is currently implementing the MARC's recommendations. In the interim Medsafe advises prescribers not to start any new patients on dextropropoxyphene containing medicines such as Paradex or Capadex and to start reviewing the analgesic requirements of patients currently taking these medicines.

Medsafe will issue further details regarding the withdrawal of dextropropoxyphene containing medicines in due course.

References

1. Medsafe Editorial Team. 2005. Dextropropoxyphene-paracetamol combination products and risk of overdose. *Prescriber Update* 27(2): 21-22.
2. Ministry of Health. 3 December 2009. Minutes of the 140th meeting of the Medicines Adverse Reaction Committee. Wellington. **www.medsafe.govt.nz/profs/adverse.asp**

Flutamide case report: Serious hepatic reaction

Flutamide has potent anti-androgenic effects and is indicated in New Zealand for the treatment of advanced prostate cancer.[1] Over recent years it has also been used to treat disorders associated with hyperandrogenism in females, an "off-label" use.

CARM has received a report of a serious hepatic adverse reaction that occurred in a female following the use of flutamide. The report describes subacute hepatic failure progressing to encephalopathy. The duration of flutamide use to the onset of the reaction was approximately three months. Hepatic function deteriorated irreversibly. The patient was also taking concomitant medicines at the time of the adverse reaction, however these were previously well tolerated.

Although it is not possible to conclusively state that flutamide was the causal agent, this report serves as a timely reminder of the potential for serious hepatic reactions associated with the use of this medicine.

The CARM database contains 11 reports of hepatic reactions associated with the use of flutamide in New Zealand; all reports concern males who were prescribed flutamide for prostate cancer or metastases. The literature also contains references to cases involving serious hepatic reactions following the use of flutamide.[2]

The flutamide data sheets published on Medsafe's website contain specific warnings and advice about its use in patients with existing hepatic injury. The data sheets also recommend that periodic liver function tests are performed in all patients. Treatment should be discontinued if the patient develops jaundice or if serum transaminases rise to two to three times the upper limit of normal.[1]

Prescribers are also reminded to advise patients of the possibility of hepatic dysfunction when prescribing flutamide and to consult a healthcare professional if symptoms of hepatic dysfunction occur.

References

1. Mylan New Zealand Limited. May 2009. Flutamin (flutamide data sheet) **www.medsafe.govt.nz/profs/Datasheet/dsform.asp**
2. Drugdex (database on the Internet). Thomson Reuters Healthcare. c 1974-2009, Drugdex Evaluations – Flutamide (cited 3 December 2009).

Clopidogrel and omeprazole – interaction now confirmed

In August 2009 Medsafe advised prescribers it was reviewing a possible interaction between clopidogrel and proton pump inhibitors (PPIs).[1] This review followed the publication of studies suggesting concomitant use of proton pump inhibitors can reduce the efficacy of clopidogrel.[2,3]

Clopidogrel inhibits platelet aggregation and is indicated for the prevention of vascular ischaemia associated with atherothrombotic events. Clopidogrel is a prodrug that is converted to its active form by drug metabolising enzymes CYP3A4 and 3A5, with contributions from CYP2C19, CYP2C9, and CYP1A2.

Proton pump inhibitors are frequently co-prescribed with clopidogrel to reduce the gastrointestinal irritation associated with clopidogrel use. Omeprazole is an inhibitor of CYP2C19.

A pharmacokinetic interaction between clopidogrel and omeprazole has now been confirmed following two pharmacokinetic/pharmacodynamic interaction studies. The results from these studies show that co-administration of clopidogrel with omeprazole results in significantly reduced exposure to the active metabolite of clopidogrel.

The first randomised crossover study involved 72 healthy subjects. In one treatment period subjects were given omeprazole (80mg/day) alone for a five day run-in period followed by clopidogrel (a single 300mg loading dose followed by a daily dose of 75 mg) and omeprazole (80mg/day) administered at the same time for a further five days. In the other treatment period subjects were given clopidogrel (300mg loading dose followed by 75mg/day) alone for five days. Subjects were crossed over to the alternate treatment period after a washout of at least 14 days.

When omeprazole was given with clopidogrel reductions of 42% and 40% were observed in maximum plasma concentration (C_{max}) and exposure (Area Under the Curve, AUC_{0-24}) to the active metabolite of clopidogrel, respectively (Table 1).

The second crossover study was identical in design except that clopidogrel and omeprazole were given 12 hours apart. Findings were similar to those in the first study indicating that administering clopidogrel and omeprazole at different times does not prevent this interaction (Table 1).

Table 1: Pharmacokinetic results

	Ratio estimate clopidogrel + omeprazole vs clopidogrel alone (90%CI)	
	Clopidogrel and omeprazole at the same time	Clopidogrel and omeprazole 12 hours apart
C_{max}	0.58 (0.53-0.65)	0.44 (0.40-0.49)
AUC_{0-24}	0.60 (0.56-0.65)	0.53 (0.50-0.57)

A 30% reduction in the mean inhibition of platelet aggregation was observed when omeprazole was given at the same time as clopidogrel compared to clopidogrel alone.[4] Decreases in bleeding times and increases in platelet reactivity index were also observed, consistent with a reduction in anti-clotting ability.

Healthcare professionals are advised to avoid the concomitant use of clopidogrel with omeprazole and other CYP2C19 inhibitors e.g. esomeprazole, cimetidine, fluconazole, ketoconazole, viriconazole, etravirine, fluoxetine, and fluvoxamine.

Currently Medsafe does not have sufficient information about interactions between clopidogrel and PPIs other than omeprazole and esomeprazole to be able to make specific recommendations.

There is no evidence that other medicines that reduce stomach acid such as H_2 receptor antagonists (except cimetidine) or antacids interfere with the anti-clotting activity of clopidogrel.

The New Zealand data sheets for clopidogrel will be updated to include information to avoid concomitant use with omeprazole and other CYP2C19 inhibitors.

Medsafe is continuing to monitor the evidence in relation to interactions between clopidogrel and PPIs other than omeprazole. Further advice will be communicated as more information becomes available.

References

1. Medsafe. 2009. Clopidogrel and proton pump inhibitors - possible interaction. *Prescriber Update* 30(3): 18.
2. Ho PM, Maddox TM, Wang L et al. 2009. Risk of adverse outcomes associated with concomitant use of clopidogrel and proton pump inhibitors following acute coronary syndrome *JAMA* 301(9): 937-44.
3. Juurlink DN, Gomes T, Ko DT et al. 2009. A population-based study of the drug interaction between proton pump inhibitors and clopidogrel *CMAJ* 180:713-8.
4. **http://www.accessdata.fda.gov/Scripts/cder/DrugsatFDA/** Plavix Label Information dated 12 November 2009.

Seasonal flu vaccine – summary of spontaneous reporting in New Zealand

With the advent of the pandemic flu last year, there has been considerable interest in this year's seasonal flu vaccine. The following is an overview of all the adverse events following immunisation (AEFIs) reported to CARM associated with the seasonal flu vaccine in previous years (whether or not they have been considered by CARM to be causally related).

In the last decade, CARM has received between 91 and 135 reports per year where the seasonal flu vaccine has been suspected by the reporter to have caused an adverse event. These AEFIs can be grouped into various categories to give an overview of the reporting profile.

Table 2: Profile of reported AEFI by category

Category#	Total number of events*
Alimentary	246
Application site	860
Cardiovascular	244
Endocrine/Metabolic	12
Haematological	26
Liver	5
Musculoskeletal	210
Nervous System	515
Other	432
Procedure Related	1
Psychiatric Changes	188
Resistance Mechanism Disorders	14
Respiratory	186
Skin & appendages	326
Special Senses	83
Urinary	3
Total	**3351**

 # CARM classification.

** The number of events is greater than the number of reports as one report may include one or more suspected reactions.*

The profile for seasonal flu vaccine is shown in Table 2. The table includes all 1509 reports received by CARM since the start of the adverse reactions reporting scheme in New Zealand in 1965 through to the end of September 2009.

Over the last five years the reporting for most of the categories as a proportion of total reports for that year has been similar. The exceptions are a higher proportion of reports of dizziness in the cardiovascular category in 2006 and of injection site inflammation and pain in 2005 and 2007.

Table 3: The ten most commonly reported AEFIs for seasonal flu vaccine

Adverse event	Number	Category
Injection site inflammation	456	Application site
Injection site pain	214	Application site
Headache	149	Nervous system
Dizziness	122	Cardiovascular
Fever	118	Nervous system
Myalgia	97	Musculoskeletal
Nausea	95	Alimentary
Urticaria	77	Skin and appendages
Pruritus	71	Skin and appendages
Injection site erythema	66	Application site

There have been previous concerns that immunisation with influenza vaccine may cause rare neurological or immunological effects such as Guillain-Barré syndrome, facial/Bell's palsy or convulsions. Epidemiological studies have not consistently found an association between these types of events and seasonal flu vaccines.[1,2] Since 1965 CARM has received 14 reports of Guillain-Barré syndrome, 7 reports of facial palsy, 3 reports of Bells palsy, 5 reports of transverse myelitis and 11 reports of convulsions. The reporting rate for all of these events is lower than the background rate in the general population.[3]

A review of the reported AEFI by CARM and Medsafe has not altered the benefit risk balance for these vaccines which continues to be favourable.

Healthcare professionals are encouraged to continue to report suspected adverse reactions to all vaccines and medicines to CARM.

References

1. Haber P, Sejvar j, Mikaeloff et al. 2009. Vaccine and Guillain-Barré Syndrome *Drug Safety* 32: 309-323.
2. Stowe J, Andrews N, Wise L et al. 2006. Bell's palsy and parenteral inactivated influenza vaccine. *Hum Vaccin* 2: 110-2
3. Black S, Eskola J, Siegrist CA et al. 2009. Importance of background rates of disease in assessment of vaccine safety during mass immunisation with pandemic H1N1 influenza vaccines. *Lancet* 374: 2115-22

Finasteride – association with male breast cancer cannot be excluded

Prescribers are advised that case reports of breast cancer have been reported in male patients following the use of finasteride.

Finasteride is a specific inhibitor of type II 5a-reductase, an intracellular enzyme that metabolises testosterone into the more potent androgen dihydrotestosterone (DHT).[1]

Finasteride is approved in New Zealand for the treatment of benign prostatic hyperplasia (BPH) and androgenetic alopecia (male pattern hair loss). The recommended dose for treatment of BPH is 5mg daily; the recommended dose for male pattern hair loss is 1mg daily.[1,2]

The United Kingdom Medicines and Healthcare products Regulatory Agency (MHRA) has recently published a report on the possible association between the use of finasteride and breast cancer in males. The MHRA has concluded that an association can not be excluded.[3]

Up to November 2009, fifty cases of male breast cancer have been reported worldwide with 5mg finasteride and three cases with the 1mg dose. However, clinical trials found that the incidence of male breast cancer for the 5mg dose of finasteride was not significantly increased when compared to those not exposed to finasteride.[3]

A possible mechanism for this association relates to the pharmacodynamics of finasteride. Finasteride use leads to decreases in DHT levels that are accompanied by increases in testosterone and oestradiol levels. The increase in sex steroids has the potential to increase the risk of breast cancer.

Prescribers are reminded to advise patients to report any changes in breast tissue such as lumps, pain or nipple discharge, to their doctor.

Medsafe is currently working with the New Zealand sponsors of finasteride containing products to update the data sheets, which are available at: **http://www.medsafe.govt.nz/profs/Datasheet/dsform.asp**

References

1. Douglas Pharmaceuticals Limited. August 2009. Fintral (finasteride data sheet) **www.medsafe.govt.nz/profs/Datasheet/dsform.asp**
2. Merck Sharp and Dohme (New Zealand) Limited. February 2005. Propecia (finasteride datasheet) **www.medsafe.govt.nz/profs/Datasheet/dsform.asp**
3. The United Kingdom Medicines and Healthcare products Regulatory Agency. 2009. Finasteride: potential risk of male breast cancer. *Drug Safety Update* 3(5):3.

Antipsychotics and cardiac safety

Prescribers are reminded that antipsychotics are associated with QT interval prolongation. The QT interval is the measure of time between the onset of ventricular depolarisation and completion of ventricular repolarisation. A prolonged QT interval is a risk factor for sudden cardiac death. A corrected QT interval (QTc) greater than 450ms in men and greater than 470ms in women is considered to be prolonged.

A European review classified these medicines into three categories according to the level of information on cardiotoxic risk.[1]

Insufficient information

Pipotiazine, Prochlorperazine

Intermediate information

Amisulpride, Chlorpromazine, Clozapine, Fluphenazine, Flupenthixol, Levomepromazine, Olanzapine, Quetiapine, Risperidone, Trifluoperazine, Zuclopenthixol

Good information

Haloperidol, Droperidol, Pimozide, Sertindole, Ziprasidone

The data sheets for these medicines are being updated to include more information on the risk of QT interval prolongation. For medicines with good evidence of QT prolongation, it is recommended that they are not used in patients with:

- Clinically significant cardiac disorders.
- QTc interval prolongation.
- A history of ventricular arrhythmia or torsades de pointes.
- Uncorrected hypokalaemia.
- Current treatment that includes other QT prolonging medicines.

Caution should also be used in patients with cardiovascular disease or a family history of QT prolongation. The need for ECG monitoring should be assessed on an individual patient basis.

References

1. Medicines and Healthcare products Regulatory Agency. 2009. Antipsychotic Drugs. **www.mhra.gov.uk/Safetyinformation/Generalsafetyinformationandadvice/Product-specificinformationandadvice/Antipsychoticdrugs/index.htm**

Medicine classification update

Healthcare professionals are advised of a number of medicine classification changes recommended at the 42nd meeting of the Medicines Classification Committee (MCC) in November 2009.

The MCC has recommended that medicines containing **codeine** should be reclassified to **pharmacist-only** medicines when:

- Each dose unit contains not more than 15mg of codeine base.
- The maximum daily dose is limited to 100mg of codeine base.
- The pack size is not more than five days supply.

The MCC has also recommended all codeine containing medicines contain warnings on the labels, including that codeine is an addictive substance and should not be used for more than three days.

The MCC recommendations follow concerns about increasing rates of addiction to codeine in New Zealand and are similar to the controls recently introduced in the United Kingdom and Australia.

Medsafe is currently considering the MCC's recommendations and any submissions made by the sector in response to the Committee's decision. Medsafe is also reviewing whether implementation of the MCC's recommendations needs to be delayed so manufacturers can repack products into smaller packs. In the meantime, Medsafe supports the advice of the Pharmaceutical Society of New Zealand and the Pharmacy Guild to encourage all pharmacists to move these medicines behind the counter so they are not available for self selection.

Famciclovir has been reclassified from a prescription medicine to a **pharmacist-only** medicine, when supplied in packs specifically labelled for pharmacist-only sale. The MCC has recommended that a warning be included on the label that treatment should not be repeated within seven days.

Zolmitriptan nasal spray (Zomig) is a prefilled nasal spray containing 5mg of zolmitriptan per dose and is now a **pharmacist-only** medicine. Zomig nasal spray can only be supplied as a pharmacist-only medicine for the acute relief of migraine attacks in patients who have a well established pattern of symptoms.

Fexofenadine has been reclassified to a **general sales** medicine, but only for capsules containing 60mg or less, or tablets containing 120mg or less. Fexofenadine can only be sold as a general sales medicine for short term treatment (maximum five days) of seasonal allergic rhinitis in adults and children over 12 years of age.

Lansoprazole tablets and capsules containing 15mg or less are now **pharmacist-only** medicines when supplied in packs specifically labelled for pharmacist-only sale. This change follows the reclassification of other proton pump inhibitors to pharmacist-only, such as omeprazole in 2009.

Further information on the classification process and the minutes of the Medicines Classification Committee meetings are available at: **www.medsafe.govt.nz/profs/class/clascon.asp**

Cough and cold medicines clarification – antihistamines

Healthcare professionals will recall that in 2009 the Cough and Cold Review Group (CCRG) recommended that oral cough and cold medicines, with the exception of those containing only bromhexine, be contraindicated in children under six years of age.[1]

Since publishing the CCRG's recommendations Medsafe has received several queries about the use of antihistamines in children. To clear up any confusion, healthcare professionals are advised the following:

- The CCRG concluded that there was no evidence to support the efficacy of antihistamines in treating the symptoms of the **common cold** in children. As the risk-benefit balance is unfavourable, medicines containing antihistamines should not be used in children under six years of age for this indication.
- The use of antihistamines in children for the treatment of **allergic conditions** was not considered by the CCRG and is therefore not affected by the recommendations of the CCRG.

The CCRG also recommended that the classification of cough and cold medicines be reviewed. A submission has been prepared for the Medicines Classification Committee (MCC) meeting in April 2010. A consultation period prior to this meeting provides an opportunity for interested parties to comment on the submissions. The agenda and submissions for this meeting are expected to be published on the Medsafe website in February 2010; comments should be directed to the MCC Secretary.

Further information on the medicines classification process is available at:
www.medsafe.govt.nz/profs/class/classificationprocess.asp#process

A list of the cough and cold medicines that are affected by the recommendations of the CCRG is available at:
www.medsafe.govt.nz/hot/alerts/CoughandCold/AffectedMedicinesOct2009.asp

References

1. Medsafe. 2009. Cough and cold medicines – further contraindication recommended. *Prescriber Update*. 30(4): 26.

Graseby MS-Series Syringe Drivers – deadline extended

Healthcare professionals are advised that Medsafe has extended its target date for the removal of Graseby MS-Series Syringe Drivers from clinical use to **30 June 2010**.

Safety concerns over the use of Graseby MS-Series Syringe Drivers were first raised by Medsafe in 2007 and prompted the manufacturer, Smiths Medical, to discontinue further supply later that year.

Most of the DHBs and hospices have already changed over to the replacement device recommended by DHBNZ (Alaris AD syringe driver), but some organisations still need to make the change.

Medsafe has extended the target date for the removal of the Graseby devices to ensure that there are sufficient syringe drivers available during the transition phase. The six month extension of the deadline is expected to provide enough time for the remaining organisations to make the change.

Medsafe will continue to monitor the progress of the transition program and will provide further information to healthcare professionals as required.

Further information can be found on the Medsafe website at:
www.medsafe.govt.nz/profs/device-issues.asp

Serotonergic agents and discontinuation syndrome – reminder

CARM continues to receive reports of "withdrawal symptoms" in patients following discontinuation of serotonergic medicines such as selective serotonin reuptake inhibitors (SSRIs).

While discontinuation syndrome is a recognised reaction that can occur following the abrupt cessation of serotonergic agents, prescribers are reminded that dose tapering may reduce the likelihood of symptoms occurring.[1,2]

Paroxetine and venlafaxine have been associated with discontinuation syndrome more often than the other serotonergic antidepressants; in the case of paroxetine this may be due, in part, to its shorter half life.[3]

Common symptoms associated with discontinuation syndrome include dizziness, paraesthesia, headache, anxiety, agitation, tremor, sweating, confusion and nausea. Symptoms can occur within a few days of discontinuation or may be delayed, particularly in the case of fluoxetine, due to its longer half-life. The majority of symptoms experienced on discontinuation are self-limiting, but can be distressing for patients.

To reduce the likelihood of discontinuation syndrome the dose of serotonergic agents should be reduced gradually over a period of several weeks or months. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the dose may continue to be decreased, but at a more gradual rate.

Further information is provided in the relevant product data sheets, available on the Medsafe website.

References

1. Mylan New Zealand Limited. 2 Feb 09. Loxamine (paroxetine) data sheet **www.medsafe.govt.nz/profs/Datasheet/dsform.asp**
2. Antidepressants. In Sweetman SC (ed) 2009. *Martindale* (36th Ed). Great Britain: Pharmaceutical Press. p. 372-430.
3. Weller IVD. *Report of the CSM Expert Working Group on the safety of selective serotonin reuptake inhibitor antidepressants*. 2005. London: The Stationery Office.

Suicidality – a rare adverse effect

Prescribers are reminded of the rare adverse effect of suicidality that is associated with a number of medicines used in New Zealand.

The Oxford Textbook of Psychiatry identifies suicidality as suicidal behaviour ranging from suicidal ideation to suicide attempt and completed suicide.[1] It may not always be clear whether suicidality is related to the use of a medicine or the underlying condition.

CARM has received a number of reports of suicidality in New Zealand associated with the use of specific medicines. The most common classes of medicines mentioned in the reports include, but are not limited to, antidepressants, antiepileptics, antipsychotics, anxiolytics, interferons and retinoids.

Healthcare professionals are encouraged to refer to medicine data sheets where possible to determine whether a patient may be at risk of suicidality. All patients who are taking or starting a medicine that has been associated with suicidality should be monitored for changes in behaviour that could indicate the emergence or worsening of depression, suicidal thoughts and/or suicidal behaviour.

Healthcare professionals are reminded to inform patients, and with the patient's consent, their families and caregivers of an increased risk of suicidality with some medicines. Patients should be advised to seek medical advice immediately if they experience changes in mood or behaviour that may be suggestive of suicidality.

References

1. Gelder M et al. 2000. *New Oxford Textbook of Psychiatry* (1st Ed). Great Britain: Oxford University Press.

Summer reminder – photosensitivity reactions

Now that summer is here healthcare professionals are reminded of the risk of photosensitivity reactions with a number of topical and systemic medicines.

CARM adverse reaction data shows that the ten most commonly reported medicines associated with photosensitivity reactions in New Zealand are:

1. Doxycycline
2. Hydrochlorothiazide
3. Amiodarone
4. Piroxicam
5. Chlorpromazine
6. Trimethoprim/sulfamethoxazole (Co-trimoxazole)
7. Captopril
8. Enalapril
9. Bendroflumethiazide
10. Carbamazepine

Photosensitivity reactions typically appear as unexpected sunburn or a dry or blistering rash on sun-exposed skin, which may or may not be itchy. The most commonly affected areas are the face, neck, arms, backs of hands, and often lower legs and feet. The reaction may occur immediately or as long as 72 hours after exposure to ultraviolet (UV) light.

The New Zealand Dermatological Society recommends that patients take the following precautions when using a medicine which has been associated with photosensitivity reactions:

- Cover up with closely-woven clothing.
- Wear a broad-brimmed hat.
- Avoid direct sunlight whenever possible. Ultraviolet rays, sunlamps, and sunbeds should also be avoided. Try to keep in the shade or carry an umbrella.
- Apply a good broad-spectrum sunscreen liberally to all uncovered skin before exposure. Sunscreen should be applied at least 30 minutes before sun exposure and re-applied every two hours, as well as after swimming or exercise.
- Insect repellents reduce the sunscreen's sun protection factor (SPF) so when using together, use a sunscreen with a higher SPF and re-apply more often.

If patients experience a photosensitivity reaction, the main goal in the treatment is to identify the photosensitising agent and withdraw it if possible. In cases where the medicine cannot be withdrawn patients should be advised to follow the sun protection strategies listed above.

Further information can be found on the New Zealand Dermatological Society website: **http://dermnetnz.org/reactions/drug-photosensitivity.html**

A new look for medicine information on the Medsafe website

Medicine information, in the form of data sheets and consumer medicine information (CMI), is freely available for healthcare professionals and consumers on the Medsafe website.

Although Medsafe checks that the medicine information published on the website reflects the information provided with the medicine application, all data sheets and CMI are prepared and maintained by the company who manufacturers the medicine. Data sheets and CMI are regularly updated with new information as it arises.

Data sheets are required for all prescription and pharmacist-only medicines approved and marketed in New Zealand. Medsafe also encourages pharmaceutical companies to provide data sheets for pharmacy-only and general sales medicines; however these are not mandatory. CMI are also not mandatory in New Zealand.

To improve the timely access to medicine information, Medsafe will now be publishing data sheets and CMI in PDF format. The software needed to read PDF documents is freely available on the internet.

Medsafe expects that all data sheets and CMI will be published in PDF format by 31 August 2010.

Healtcare professionals can access medicine information on the Medsafe website at: **www.medsafe.govt.nz/profs/Datasheet/dsform.asp** or

www.medsafe.govt.nz/Consumers/cmi/CMIForm.asp

VACANCIES

Appointments to Statutory Bodies

Applications are being sought for appointments to Ministerial Advisory Committees established under the Medicines Act 1981

Medsafe is seeking applications from people who have the desire to contribute to the enhancement of medicines safety in New Zealand and have the required skills and experience needed for the following committees.

Medicines Assessment Advisory Committee

The Medicines Assessment Advisory Committee is a technical advisory committee established under section 8 of the Act to advise the Minister of Health on the risk-benefit of new medicines.

Applications are being sought from:

- Candidates with substantial clinical experience in one or more of the following: clinical pharmacology, general practice, infectious diseases, oncology, paediatrics, dermatology, geriatrics, neurology, psychiatry and internal medicine.
- Candidates with a tertiary qualification and extensive experience in biostatistics, or pharmaceutical chemistry and the manufacture of pharmaceuticals.
- Laypersons who can represent consumer interests.

For further information about this committee, including its Terms of Reference, go to the Medsafe website at: **www.medsafe.govt.nz/regulatory/MAAC.asp** or contact the committee Secretary, Andrea Kerridge, Medsafe, ph 04 819 6896.

Medicines Adverse Reactions Committee

The Medicines Adverse Reactions Committee is a technical advisory committee established under section 8 of the Act to advise the Minister of Health and Medsafe on the safety of approved medicines.

Applications are being sought from:

- Candidates with substantial clinical experience in one or more of the following: clinical pharmacology, geriatrics, general practice, and internal medicine.
- Laypersons who can represent consumer interests.

Applications are also being sought for the position of Chair of this committee. Applicants for this position should preferably also have previous experience in chairing an expert advisory committee.

For further information about this committee, including its Terms of Reference, go to the Medsafe website at: **www.medsafe.govt.nz/profs/adverse/MARC.asp** or contact Jan McNee, Medsafe, ph 04 819-6829

Medicines Review Committee

The Medicines Review Committee is established under section 10 of the Act and its functions and powers are specified under section 13 of the Act.

The functions of the Committee are to:

- Inquire into any objection to a recommendation by the appropriate committee in relation to applications to distribute a new medicine in New Zealand.
- Hear appeals against decisions made by the Director-General of Health relating to clinical trials, the sale of medical devices, or licences to manufacture, pack, label, sell by wholesale or retail, or hawk medicines, or operate a pharmacy.

Applications are being sought from candidates with extensive experience in:

- The pharmaceutical manufacturing industry.
- The practice of natural therapy (as required).
- The practice of pharmacy and medicine.

A qualification in law or experience in participating in formal legal processes is also desirable.

For further information about this Committee please contact Catherine Marnane, Medsafe, ph 04 819 6879.

Further information about appointments to statutory bodies can be found on the Ministry of Health website at **http://www.moh.govt.nz/statutorybodies**

Appointments to these committees are generally for a three-year term.

All candidates who wish to be considered for appointment to one or more of the committees must complete an application form and provide a current *curriculum vitae* by **26 February 2010**. Applications should be forwarded to:

Ministerial Advisory Committees, Medsafe
PO Box 5013, Wellington 6145

Or email to: medicinesact_committees@moh.govt.nz

A copy of the application form is available at: **http://www.medsafe.govt.nz/other/StatutoryBodiesApplicationForm.doc**

Decisions on the appointment of committee members will be made by the Minister of Health. Applicants will be notified of the outcome following the short-listing and consideration process. This process is likely to take up to twelve weeks following the closing date.

ADVERSE REACTIONS OF CURRENT CONCERN

MARC Rx ADVICE

The Medicines Adverse Reactions Committee (MARC) initiated the list *of adverse reactions of current concern* to bring particular medicine adverse reactions to the attention of prescribers. The intention is to encourage prescribers to report these reactions to the Centre for Adverse Reactions Monitoring (CARM) so that more information can be gathered, and further action taken if necessary. The reports provide a New Zealand perspective on emerging medicine safety issues.

As with any adverse reactions monitoring scheme, analysis can only be based on reports that are received. Prescribers are therefore encouraged to continue reporting adverse reactions to CARM so that the MARC can make the best possible recommendations based on information reflecting the New Zealand situation.

Regular amendments to the list of reactions are made either in response to adverse events reported in New Zealand or international pharmacovigilance issues.

Please report **all cases** of the following adverse reactions to: CARM, NZ Pharmacovigilance Centre, PO Box 913, Dunedin 9054. Use the reporting form provided with each edition of *MIMS New Ethicals*, or download the form from the CARM or Medsafe web sites: **http://carm.otago.ac.nz/reporting.asp** or **www.medsafe.govt.nz/Profs/adverse.asp**

Medicine/s	Adverse reactions of current concern	*Prescriber Update* references
Complementary and alternative medicines*	all adverse reactions	Vol.30(3), August 2009, Vol.30(2), May 2009 & Vol.30(1), February 2009 & Vol.28(1), November 2007
Leflunomide	all adverse reactions	Vol.29(1), June 2008 & Vol.27(1), June 2006 & Vol.26(2), December 2005 & Vol.25(1), May 2004
Pioglitazone and Rosiglitazone	all adverse reactions	Vol.29(1), June 2008 & Vol.28(1), November 2007 & Vol.27(1), June 2006

* includes herbal medicines, bee products, homoeopathic products, dietary supplements, minerals, and any other medicines containing animal or plant extracts.

INTENSIVE MEDICINES MONITORING PROGRAMME

IMMP INTENSIVE MEDICINES MONITORING PROGRAMME

Which medicines are currently being monitored?

Varenicline (Champix)

What to report

Please report **all clinical events** in patients taking **Varenicline**, including:

- any suspected adverse reaction
- deaths (including cause if known)
- any new clinical events, even if minor or common
- accidents
- change in a pre-existing condition
- abnormal changes in laboratory test results
- possible interactions.

Where to report

Please report all adverse events occurring with IMMP medicines to: IMMP, NZ Pharmacovigilance Centre, PO Box 913, Dunedin 9054. Use the reporting form provided with each edition of *MIMS New Ethicals* or download it from either the NZ Pharmacovigilance Centre or Medsafe websites: **http://carm.otago.ac.nz/reporting.asp** or **www.medsafe.govt.nz/Profs/adverse.asp**

Further information on IMMP is available at: **http://carm.otago.ac.nz/index.asp?link=immp**

Prescriber Update is published and distributed by Medsafe in the interests of safer, more effective use of medicines, medical devices and methods of diagnosis and treatment.

Medsafe: New Zealand Medicines and Medical Devices Safety Authority
A business unit of the Ministry of Health.

Editor: Chris James
Medsafe, PO Box 5013, Wellington 6145, New Zealand
Ph: (04) 819 6800 Fax: (04) 819 6806
E-mail: chris_james@moh.govt.nz

An electronic version of Prescriber Update is available at
www.medsafe.govt.nz/profs/PUarticles.asp

To receive Prescriber Update electronically, please register at
www.medsafe.govt.nz/profs/profs.asp

Data sheets, consumer medicine information, media releases, medicine classification issues, and adverse reaction forms can be found at
www.medsafe.govt.nz

Published with the permission of the Director-General of Health

New Zealand Government