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Contents

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MINISTRY OF HEALTH
MANATŪ HAUORA

Adverse effects from inappropriate use of topical corticosteroids

Key messages

- From 23 March 2028, all topical corticosteroid products used for inflammatory skin conditions will include potency information on their packaging.
- Serious adverse effects from topical corticosteroids are rare when prescribed and used appropriately.
- Local and systemic adverse effects are more likely to occur with inappropriate use of topical corticosteroids.
- Prescribe the lowest effective potency needed to control the patient's symptoms.
- Clearly explain to patients the potency of the product, when and where to apply it, how often to use it, and how long treatment should continue.
- If multiple topical corticosteroid products are prescribed, explain the different potencies, and where and when each product should be used.

Topical corticosteroids are commonly used to manage inflammatory skin conditions, such as eczema. Their benefits are well-established and serious adverse effects are seen rarely when prescribed and used appropriately.[1,2]

This article highlights the potential serious adverse effects of inappropriate topical corticosteroid use and outlines ways to minimise these risks.

Inappropriate use of topical corticosteroids includes using an incorrect potency for a body area or using them more frequently or for longer than advised.

Serious adverse effects from inappropriate use of topical corticosteroids

The risk of serious adverse effects is increased with use of higher potency corticosteroids, prolonged or frequent application, application to areas of thin skin, occlusion of the application site and concomitant use of other corticosteroids by other routes (eg, oral and high-dose inhaled corticosteroids).[3]

Significant local adverse effects

Significant local adverse effects include skin atrophy (thinning), striae (stretch marks), telangiectasia (spider veins), acne and worsening of acne or rosacea. Some effects, such as skin atrophy, may gradually improve after stopping treatment, while striae and telangiectasia are permanent.[3]

Systemic adverse effects

Adrenal suppression from systemic absorption can occur from long-term and excessive use of potent or very potent topical corticosteroids. Adrenal suppression can lead to reversible hypothalamic-pituitary adrenal (HPA) axis suppression, Cushing's syndrome and adrenal insufficiency.[3]

Topical steroid withdrawal syndrome

Topical steroid withdrawal (TSW) syndrome is a rare rebound reaction reported by patients who discontinue topical corticosteroids, particularly after prolonged, inappropriate and frequent use of higher potency topical corticosteroids.[4,5]

Features of TSW include an acute skin eruption, burning pain, severe itch and red oozing skin that may extend to untreated areas. TSW can be difficult to distinguish from a flare-up of the patient's underlying skin condition and other skin conditions that share similar features.[4,5]

Minimising adverse effects

- Prescribe the lowest effective potency needed to control the patient's symptoms.[2] Diluting topical corticosteroids does not result in a less potent medicine.[3]
- Consider seeking specialist advice for patients needing continuous daily treatment with potent or very potent topical corticosteroids for more than 4 weeks. Additional treatments may be needed to manage the skin condition.
- Provide clear patient education, explaining when and where to apply the topical corticosteroid, how often to use it, and how long treatment should continue.
- The fingertip unit measurement can be helpful to determine the amount to prescribe. This unit can also be used to explain to patients the amount of topical corticosteroid to use, ensuring enough topical corticosteroid is used while avoiding excessive exposure.[3]
- If multiple topical corticosteroid products are prescribed, explain the different potencies, and where and when each product should be used.

Clearer labelling of topical corticosteroids

From 23 March 2028, all topical corticosteroid products used for inflammatory skin conditions will include potency information on their packaging (as shown in Table 1). This change will help patients identify the correct product to use and reduce the risk of accidental use of more potent (stronger) corticosteroids on more delicate areas of the body.

Note that this requirement does not apply to pharmacy dispensing labels. However, we encourage pharmacists to include potency information on the label when appropriate.

Table 1: Potency labelling of topical corticosteroids from 23 March 2028

Potency	Examples	Product labelling
Mild	Hydrocortisone	Mild steroid
Moderate	Clobetasone Hydrocortisone butyrate Triamcinolone acetonide	Moderate steroid
Potent	Betamethasone valerate Betamethasone dipropionate Mometasone furoate Methylprednisolone aceponate	Strong steroid
Very potent	Clobetasol propionate Betamethasone dipropionate (in an optimised vehicle)	Very strong steroid

More information

For consumers

- Healthify: Steroid creams, lotions and ointments

For healthcare professionals

- bpac^{nz}: Topical corticosteroids for childhood eczema: clearing up the confusion
- Paediatric Society of New Zealand: Topical steroid withdrawal syndrome (PDF, 3 pages, 265 KB)
- Refer to local Community HealthPathways for clinical information on topical corticosteroids.

References

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MARC's remarks: March 2026 meeting

The Medicines Adverse Reactions Committee (MARC) convened for their 205th meeting on 12 March 2026.

The Committee discussed the safety profile for **melatonin** in adults. They considered that potential safety signals, such as serotonin syndrome and suicidality, are likely to be confounded by the person's underlying sleep-related conditions and concomitant medicines. The Committee noted the extensive long-term international use of melatonin, including at higher doses, provides a reasonable level of confidence in its overall safety profile and no regulatory action was recommended.

The Committee discussed the safety of **vitamin B6 (pyridoxine)** and noted that peripheral neuropathy was the main safety concern. The Committee discussed the limitations of the current regulatory framework, noting that some products that are marketed as dietary supplements fall outside the Medicines Act 1981, yet may contain doses of vitamin B6 that exceed those usually prescribed for therapeutic indications. The Committee considered setting a limit/maximum daily dose of vitamin B6 in dietary supplements, requiring label statements about peripheral neuropathy, and changing the classification to reduce the amount of vitamin B6 permitted in general sale medicines and dietary supplements would be beneficial. The Committee acknowledged that these considerations are outside of their remit and so will communicate them to relevant organisations.

The Committee reviewed the updated medical literature on **menopausal hormone therapy** (MHT) and the risk of breast cancer, cardiovascular disease and cognitive impairment. They noted that the recent published literature did not change the existing understanding of these risks, and no regulatory action was recommended. The Committee commented that MHT provides substantial benefit in reducing vasomotor symptoms for many women. MHT has additional risks and/or benefits that are relevant for some women but contributes small absolute risk differences in most cases.

See the Medsafe website for the MARC meeting minutes and the reports presented to the MARC.

Beyond pain relief: Undesirable effects of opioids

Key messages

- Opioids are a class of medicines indicated for moderate to severe pain.
- Undesirable opioid effects now include endocrine, hepatobiliary and gastrointestinal side effects.
- Consider opioids as a possible cause of signs/symptoms of hormonal disturbances and/or adrenal insufficiency in patients on high doses and long-term treatment.

Opioids, such as morphine, tramadol, oxycodone and fentanyl, are a class of medicines indicated for management of short-term moderate or severe acute pain or for chronic pain related to malignancy.

Undesirable opioid effects now include endocrine, hepatobiliary and gastrointestinal side effects, and data sheets are being updated to include them. This article provides an overview of these undesirable effects.

Endocrine effects: Suppression of the hypothalamic-pituitary axes

Long term opioid use (more than 1 month) has the potential to disrupt the secretion of certain hormones from the pituitary gland due to stimulation of opioid receptors in the hypothalamus.[1,2]

Hypothalamic-pituitary-gonadal (HPG) axis

Opioids can inhibit the release of hypothalamic gonadotrophin releasing hormone (GnRH), reducing secretion of luteinising hormone (LH) and follicle stimulating hormone (FSH) and suppressing gonadal sex steroid production (hypogonadism).[2]

These effects on the HPG axis may lead to low testosterone and oestrogen levels. Clinical symptoms such as reduced libido (both sexes), erectile dysfunction and menstrual irregularities can then occur.[2,3]

Hypothalamic-pituitary-adrenal (HPA) axis

Opioids regulate the hypothalamus-pituitary-adrenal axis via opioid receptors in the hypothalamus, pituitary and adrenal glands. They mainly act centrally to inhibit adrenocorticotropic hormone (ACTH) secretion. Reduced ACTH release has a downstream effect on cortisol production in the adrenal glands.[2]

Reversible adrenal insufficiency may occasionally occur, requiring monitoring and glucocorticoid replacement therapy. Symptoms include fatigue, dizziness, nausea, vomiting and low blood pressure.[3]

Hyperprolactinemia

Opioids can cause hyperprolactinemia in males and females, likely by inhibition of the tuberoinfundibular dopaminergic system.[2]

Prescribing considerations[1,2,4]

In general, higher opioid exposure leads to a greater potential for suppression of the above endocrine pathways. Higher doses, longer durations of treatment and use of long-acting formulations can increase the risk.

Partial agonists, such as buprenorphine, may cause less suppression of the HPG and HPA axes compared to full agonist opioids, such as morphine and oxycodone.

Symptoms of opioid-induced endocrinopathies may by subtle and have a gradual onset. They can overlap with other opioid side effects or medical conditions (including chronic pain) making recognition challenging.

Encourage patients who may be at risk of opioid-induced endocrinopathies to report potential associated signs and symptoms and investigate accordingly.

Hepatobiliary effects: Sphincter of Oddi spasm[3,5,6]

Opioids, particularly morphine, cause contraction and spasms of the Sphincter of Oddi, a muscular valve controlling bile and pancreatic juice flow into the intestine.

Sphincter of Oddi spasm can cause increased biliary pressure, increasing the risk of biliary tract symptoms and pancreatitis.

Administer opioids with caution and with appropriate monitoring in patients with pancreatitis and diseases of the biliary tract.

GI effects: Oesophageal dysfunction[3,7]

Opioid-induced oesophageal dysfunction is defined by oesophageal symptoms along with abnormal oesophageal motility following long-term opioid use.

Dysphagia is the most frequently reported symptom. Other symptoms include heartburn, regurgitation and non-cardiac chest pain.

Consider discontinuation or weaning of opioids in patients presenting with symptoms suggestive of opioid-induced oesophageal dysfunction.

More information

- See the opioid data sheets and consumer medicine information (CMI): Search for a data sheet or CMI.

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Recent approvals: New active ingredients or new indications

New active ingredients

Table 1 shows recent approval of medicines with new active ingredients gazetted during the period 23 January to 23 April 2026.

Table 1: Recent approvals of medicines with new active ingredients

Medicine	New active ingredient	Dose form: Strength(s)	Therapeutic area
Andembry	Garadacimab	Solution for injection: 200mg	Prevention of hereditary angioedema
Blenrep	Belantamab mafodotin	Powder for injection: 70mg, 100mg	Multiple myeloma

New indications

Table 2 shows approved medicines with new indications for additional therapeutic areas gazetted during the period 23 January to 23 April 2026.

Table 2: Approved medicines with new indications for additional therapeutic areas

Medicine (active ingredient)	Dose form: Strength(s)	New therapeutic area
Yervoy (ipilimumab)	Concentrate for injection: 50mg/10mL, 200mg/40mL	Colorectal cancer Hepatocellular carcinoma
Winglore (ipilimumab)	Concentrate for injection: 50mg/10mL, 200mg/40mL	Colorectal cancer Hepatocellular carcinoma[a]
Opdivo (nivolumab)	Concentrate for infusion: 40mg/4mL, 100mg/10mL	Colorectal cancer
Ozempic (semaglutide)	Solution for injection: 2mg/1.5mL, 4mg/3mL	Chronic kidney disease[a]
Tezspire (tezepelumab)	Prefilled syringe for injection: 210mg Prefilled pen for injection: 210mg	Chronic rhinosinusitis with nasal polyps
Tevimbra (tislelizumab)	Concentrate for injection: 100mg/10mL	Gastric or gastro-oesophageal junction adenocarcinoma

a. In adults with type 2 diabetes.

More information

See the Medsafe website for:

- more information about these medicines
- data sheets of currently marketed medicines
- Gazette notices for approved medicine applications.

Insulin autoimmune syndrome

Key messages

- Insulin autoimmune syndrome (IAS) is characterised by recurrent hypoglycaemic episodes, increased serum insulin and the presence of insulin autoantibodies. It usually occurs without exogenous insulin treatment.
- Medicines are a primary trigger of IAS. Other triggers include viral infections and haematological conditions.
- IAS is a self-limiting condition that typically resolves within a few months.

Medsafe recently reviewed the risk of insulin autoimmune syndrome with captopril and requested the sponsor to update their data sheet with information about the syndrome. This article briefly describes insulin autoimmune syndrome and medicines associated with it.

What is insulin autoimmune syndrome (IAS)?

IAS is a rare condition characterised by recurrent hypoglycaemic episodes, elevated serum insulin and positive insulin autoantibodies. Unlike other forms of hypoglycaemia, classical IAS occurs in the absence of exogenous insulin administration.[1]

The triggers associated with developing IAS include medicines, viruses (eg, measles, mumps, rubella, varicella zoster) and haematological conditions (eg, multiple myeloma).[2]

Under normal physiological conditions, insulin is secreted from the pancreas in response to increased blood glucose after eating. Insulin promotes uptake of glucose by cells resulting in a normalisation of blood glucose levels.

In IAS, the presence of insulin autoantibodies disrupts this process by binding to insulin. The autoantibodies have a high binding capacity for insulin which means each autoantibody can bind several insulin molecules, forming large complexes. When insulin is bound it is unable to exert its normal glucose-lowering effect.[1,2]

However, while the autoantibodies have a high binding capacity, they also have a low affinity for insulin. This means that insulin is not tightly bound to the autoantibody and can dissociate (detach) from the complex unpredictably. This increases the free insulin in the circulation, leading to recurrent episodes of hypoglycaemia.[1,2]

There appears to be a genetic predisposition to IAS associated with variation in the human leukocyte antigen (HLA) system, particularly the DRB1*0406 allele.[2] The DRB1*0406 genotype is more common in East Asian populations, which may partly explain why IAS occurs more frequently in East Asians than Caucasians.[1]

Medicines associated with IAS

Medicines are a common trigger of IAS, with about half of cases thought to be medicine-induced.[1,3]

Medicines and active metabolites that contain a sulfhydryl group (-SH) or thiol group (R-SH) have been associated with IAS. Examples include carbimazole, clopidogrel and captopril.[1,2]

It is thought these medicines bind and cleave the sulfhydryl bonds between insulin chains making endogenous insulin more immunogenic. This ultimately results in the formation of insulin autoantibodies.[1,2]

IAS has also been reported with other medicines, but the mechanism is unclear.

Treatment and prognosis

IAS, although serious, is a self-limiting condition with insulin autoantibodies generally resolving on their own within a few months.[1] Management may include stopping the causative medicine and supportive treatment, such as dietary modifications (eg, small frequent meals with low carbohydrate content) to reduce the risk of hypoglycaemia.[1,2]

References

1. Lin M, Chen Y and Ning J. 2023. Insulin autoimmune syndrome: A systematic review. *International Journal of Endocrinology* 2023(Feb 15): 1225676. DOI: 10.1155/2023/1225676 (accessed 2 April 2026).
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Quarterly summary of recent safety communications

The table below is a summary of recent safety communications for healthcare professionals and consumers. Click on a specific topic to go to the communication.

Date	Communication	Topic
21/05/2026	Alert	Consumer advisory: Unapproved peptide products health warning
11/05/2026	Dear Healthcare Professional Letter	Noflam (naproxen) 250 mg Tablets – New Zealand carton containing either the Norwegian or Dutch blisters (PDF, 1 page, 130 KB)
11/05/2026	Dear Healthcare Professional Letter	Zyprexa Relprevv (olanzapine): Temporary shortage of 405 mg powder for injection (PDF, 2 pages, 265 KB)
30/04/2026	Dear Healthcare Professional Letter	Utrogestan (progesterone) 100mg capsules – Temporary supply of overseas product (PDF, 2 pages, 439 KB)
24/04/2026	Monitoring	Further Update – Estradot (estradiol) transdermal patches: reports of quality and efficacy
03/04/2026	Dear Healthcare Professional Letter	Candesartan Viatris 4mg, 8mg, 16mg and 32mg Tablets – Supply of French Carton, Foils and Leaflet (PDF, 4 pages, 677 KB)
05/03/2026	Dear Healthcare Professional Letter	Zypine ODT (olanzapine) Orodispersible Tablets – Alternative Registered Foils (PDF, 2 pages, 488 KB)

Note that sponsors write Dear Healthcare Professional Letters and distribute them to relevant healthcare professionals. Medsafe publishes copies of these letters on the Medsafe website.

Reported adverse reactions to ashwagandha

Key messages

- Ashwagandha-containing products have been reported to the New Zealand Pharmacovigilance Database in association with severe gastrointestinal symptoms and liver-related adverse reactions.
- Patients who experience adverse reactions to an ashwagandha-containing product should stop taking it.

Medsafe has received a number of reports of adverse reactions associated with ashwagandha-containing natural health products.

Ashwagandha, also known as *Withania somnifera*, is a herbal ingredient in some natural health products.

Since 2010, there have been 24 reports to the New Zealand Pharmacovigilance Database that included an ashwagandha-containing product. Of the 24 reports, 11 described gastrointestinal symptoms including nausea, vomiting and diarrhoea, which in some cases were severe or resulted in hospitalisation. There were 4 reports of liver-related adverse events. Liver toxicity attributed to ashwagandha has also been reported in the literature.[1]

Consider natural health products as a cause of undesirable effects in patients. Report any suspected reactions to the New Zealand Pharmacovigilance Database. Reporting is easiest online.

Educate patients about the risks of buying natural health products or medicines via social media or unverified websites. These may be falsified products that contain harmful ingredients or impurities not listed on the label or promote misleading health claims that are not supported by clinical evidence. There is no regulatory assessment of the quality, safety or health claims of natural health products in New Zealand.

Reference

1. Koturbash I, Yeager RP, Mitchell CA, et al. 2024. Botanical-induced toxicity: Liver injury and botanical-drug interactions. A report on a society of Toxicology Annual Meeting symposium. *Regulatory Toxicology and Pharmacology* 153: 105708. DOI: 10.1016/j.yrtph.2024.105708 (accessed 10 April 2025).

Gathering knowledge from adverse reaction reports: June 2026

Adverse drug reaction (ADR) reporting is an important component of medicine safety monitoring. Case reports can highlight significant safety issues with medicines and how they are used.

The table below presents a selection of recent informative cases reported to the New Zealand Pharmacovigilance Database.

Case details[a,b]	Reaction description and data sheet information[b,c]
Report ID: 165060 **Age:** 85 years **Gender:** Female **Medicine(s):** Cefepime **Reaction(s):** Myoclonic jerks, dysphagia, Glasgow coma scale (GCS) abnormal, toxic metabolic encephalopathy, acute kidney injury	A patient taking cefepime developed myoclonic jerks/non-convulsive epileptic activity, dysphagia, reduced GCS and acute kidney injury. Toxic metabolic encephalopathy was suspected.
	The Cefepime AFT data sheet states that there have been reports of neurotoxicity. Symptoms of neurotoxicity include encephalopathy, seizures and/or myoclonus. Risk factors for developing neurotoxicity with cephalosporin treatment include being elderly, renal impairment, and central nervous system disorders. See also the Risk of neurotoxicity with cephalosporins article in the March 2023 edition of *Prescriber Update*.
Report ID: 165857 **Age:** 73 years **Gender:** Female **Medicine(s):** Sodium polystyrene sulfonate **Reaction(s):** Bowel necrosis, small bowel obstruction, bowel perforation, peritonitis	A patient intermittently using sodium polystyrene sulfonate experienced a small bowel obstruction followed by bowel necrosis and perforation.
	The Resonium A data sheet states that gastrointestinal ischemia, ischemic colitis, gastrointestinal tract ulceration or necrosis which could lead to intestinal perforation have been reported.
Report ID: 166489 **Age:** 52 years **Gender:** Female **Medicine(s):** Triamcinolone **Reaction(s):** Acid reflux (oesophageal), diarrhoea, vomiting, fever, postmenopausal bleeding	After intra-articular administration of triamcinolone, the patient experienced reflux, diarrhoea, vomiting, menstrual bleeding and a fever.
	The Kenacort-A 10 data sheet warns that menstrual irregularities may occur, and this possibility should be mentioned to female patients past menarche. Gastrointestinal adverse effects can occur with corticosteroids.
Report ID: 166501 **Age:** 37 years **Gender:** Male **Medicine(s):** Cabergoline **Reaction(s):** Impulse control disorder	A few months after starting cabergoline, the patient developed severe impulse control issues.
	The Dostinex data sheet recommends regularly monitoring patients for the development of impulse control disorders. Advise patients and carers of symptoms including pathological gambling, increased libido, hypersexuality, compulsive spending or buying, binge eating and compulsive eating.

Continues

Case details[a,b]	Reaction description and data sheet information[b,c]
Report ID: 166927 **Age:** 25 years **Gender:** Female **Medicine(s):** Topiramate **Reaction(s):** Renal tubular acidosis, kidney stones	A patient on long-term topiramate experienced renal tubular acidosis and kidney stones. Renal tubular acidosis is listed as a very rare ADR in the Topamax data sheet. There is a warning for nephrolithiasis (kidney stones).

Notes:

a. Only the medicines suspected to have caused the reaction are listed in the table.

b. The reactions listed in the 'Case details' column are coded according to the Medical Dictionary for Regulatory Activities (MedDRA), an internationally used set of standardised terms relating to medical conditions, medicines and medical devices. The reactions listed in the 'Reaction description' column are based on what was reported, and do not always match the MedDRA term exactly.

c. If the suspect medicine's brand name is not described in the ADR report, only the data sheet for the funded medicine is included in the table.

Information about reported suspected adverse reactions is available on the Medsafe website using the Suspected Medicines Adverse Reaction Search (SMARS).

By selecting the ingredient of a medicine or vaccine, you can find out:

- the number of reports and suspected adverse reactions for that ingredient. The suspected reactions are grouped by body system or organs (Summary report)
- single case reports, listing the medicines and/or vaccines involved that contain the ingredient and the suspected adverse reactions (Detail report).

For help with searching, see the How to Search SMARS page.

Recent data sheet updates: Important new safety information

Table 1 below provides a list of data sheets recently updated with important new safety information. Note that this is not a comprehensive list of all recently updated data sheets, nor does it describe all changes to a particular data sheet.

To find out if sponsors have made any changes to their data sheets, refer to:

- section 10 'Date of revision of the text' (at the end of each data sheet). Search for a data sheet
- the New/updates to data sheets and CMIs page on the Medsafe website.

Table 1: Recently updated data sheets (by active ingredient): important new safety information

Click on the specific medicine to open the data sheet.

Active ingredient(s): Medicine(s)	Data sheet updates Section*	Summary of new safety information
Apalutamide Erlyand	4.5	Laboratory test interference – Falsely elevated digoxin plasma level results with the chemiluminescent microparticle immunoassay (CMIA) have been identified in patients treated with apalutamide, independently of being treated with digoxin.
Carbamazepine Tegretol	4.2, 4.4	Maximum daily dose of the oral syrup is limited to 1,200 mg. At total daily doses over 1,200 mg, there is the possibility of exceeding internationally accepted daily exposure limits for trace substances in the sorbitol excipient.
	4.8	Fixed drug eruption; Generalised bullous fixed drug eruption
Colchicine Colgout	4.4, 4.5	Co-administration with P-gp inhibitors and/or moderate or strong CYP3A4 inhibitors will increase the exposure to colchicine, which may lead to colchicine induced toxicity including fatalities. In patients with normal renal and hepatic function (contraindicated in patients with renal or hepatic impairment), reduce the colchicine dose and monitor for adverse effects, or interrupt colchicine treatment.
Cytarabine Cytarabine DBL Cytarabine	4.8	Toxic erythema of chemotherapy, including hidradenitis, palmar-plantar erythrodysaesthesia syndrome, red ear syndrome
Dexamfetamine Dexamfetamine (Noumed)	4.5, 4.9	Serotonin syndrome can occur with concurrent use of serotonergic medicines, and in overdose.
	4.8	Constipation; Raynaud's phenomenon
Disulfiram Antabuse	4.8	Depression; Libido decreased; Psychotic reaction; Optic neuritis; Encephalopathy; Nausea; Vomiting; Dermatitis allergic; Fatigue
Doxorubicin Caelyx	4.8	Renal-limited thrombotic microangiopathy has been reported in patients with high cumulative exposure to pegylated liposomal doxorubicin.
IncobotulinumtoxinA Xeomin	4.4, 4.8, 4.9	Toxin spread – Cases of iatrogenic botulism have been reported following injection of botulinum toxin products. Advise patients and caregivers to seek immediate medical care if they experience signs or symptoms consistent with spread of botulinum toxin effect.
Infliximab Remicade	4.4	Contains Polysorbate 80 which may cause allergic reactions.
	4.8	Rheumatoid arthritis and inflammatory bowel disease as additional examples of new onset paradoxical drug-induced immune disorders.

Continues

Active ingredient(s): Medicine(s)	Data sheet updates Section*	Summary of new safety information
Leflunomide Arava	4.4	Musculoskeletal disorders – Myopathy and/or muscle injury has been reported. Monitor patients for signs and symptoms.
Lisdexamfetamine Vyvanse	4.8	Obsessive compulsive disorder (including trichotillomania and dermatillomania
	4.8, 4.9	Takotsubo cardiomyopathy (stress cardiomyopathy)
Metronidazole Rozex Cream Rozex Gel	4.3	Contraindicated in patients with Cockayne syndrome.
Paracetamol + Codeine + Doxylamine Mersyndol	4.4	QT interval prolongation – Doxylamine may potentiate QT interval prolongation.
Prednisone Prednisone (Clinect)	4.4	Thyrotoxic periodic paralysis (TPP) can occur in patients with hyperthyroidism and with prednisone-induced hypokalaemia. Suspect TPP if patients present with muscle weakness; monitor blood potassium and ensure it returns to normal levels.
Rocuronium Rocuronium bromide (Medsurge)	4.4	Hypertensive crisis in patients with phaeochromocytoma. Use rocuronium with caution in these patients.
	4.8	Anaphylaxis – hypersensitivity
Tolvaptan Jinarc	4.8	Blood creatinine phosphokinase increased
Upadacitinib Rinvoq	4.8	Semen discolouration (blue or green) has been reported in patients with ulcerative colitis or Crohn's disease taking the 45mg Rinvoq induction dose. There were no clinically meaningful adverse events reported with the semen discolouration.
Vortioxetine Brintellix	4.2	Treatment discontinuation – Gradually reduce the dose to avoid discontinuation symptoms.
	4.8	Discontinuation symptoms/discontinuation syndrome – May occur within the first week of vortioxetine discontinuation. Symptoms include dizziness, headache, sensory disturbances, sleep disturbances, nausea and/or vomiting, anxiety, irritability, agitation, fatigue and tremor.

* Data sheet sections listed in the table are: 4.2: Dose and method of administration; 4.3: Contraindications; 4.4: Special warnings and precautions for use; 4.5: Interaction with other medicines and other forms of interaction; 4.8: Undesirable effects; 4.9: Overdose

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