PHARMACOVIGILANCE - FDIC NEWS

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Adverse drug reactions (ADRs) attributable to antiretroviral medicines constitute 17% of Individual Case Safety Reports (ICSR) received by the Nigerian National Pharmacovigilance Centre, through spontaneous reporting system across the country as at September 2009. Consequently, this issue discuses the reported ADRs attributable to antiretroviral medicines and examines their specific toxicities. Other features of this Christmas edition include; compilation of adverse reaction reports of interest as reported in "Reaction Weekly" and alert notices. Your comments and acknowledgement of receipt of this issue through our email would be most appreciated.

PHARMACOVIGILANCE OF ANTIRETROVIRAL MEDICINES

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Introduction: Considerable progress has been made in providing global access to antiretroviral therapy (ART), with three million people currently on antiretroviral (ARVs) medicines around the world[1]. However, the effectiveness of treatment programmes, particularly in low and middle income countries like Nigeria can be compromised by problems related to toxicity, intolerance and drug-drug interactions. These adverse events (AEs) are relatively common phenomena affecting patients on ARVs in both private and public health programmes. Unfortunately, these AEs are only intermittently identified and under reported. The severity of adverse reactions associated with the use of ARVs may erode confidence in the safety of these medicines and alter patient adherence to antiretroviral therapy. This will not only reduce the treatment efficacy with increased morbidity and mortality, but also reduce the effectiveness of treatment programme and increase the risk for emergence of secondary drug resistance. New adverse events and toxicities are identified as people live longer on ART. The availability of numerous new drugs and drug combinations make it critical to monitor more systematically adverse events linked to ARVs. For these reasons, there is an urgent need to strengthen the science and practice of Pharmacovigilance (PVG) for antiretroviral drugs.

The WHO Departments of HIV and Medicines Policy and Standards (experts committee in Pharmacovigilance) in February 2008 emphasized the need to promote PVG of ART as a prerequisite for

improving patient safety and the effectiveness of treatment programmes, for guiding national policies and for stimulating research. The ultimate goal is to develop a thesaurus of definitions of these adverse events of ARVs and contribute to improving global pharmacovigilance for ARVs, with particular focus on resource-limited settings, children and special populations.

With the support of a network of experts, WHO is committed to further developing a mechanism to harmonize the reporting, assessment and analysis of antiretroviral drug-related adverse events, with a view to informing global and country specific treatment programmes and improving the science of pharmacovigilance for antiretroviral drugs. In Nigeria, the National Pharmacovigilance Centre {NPC} is collaborating with public health programmes to enhance the detection and reporting of ADRs associated with ART.

Burden

It has been observed and documented from clinical practice that ***antiretrovirals*** can substantially extend lives of those living with HIV/AIDS. However, ensuring rational use of these medicines can be very challenging in HIV management, as it may not always be possible to tailor medicines to individual patient's needs such as co-morbid conditions, nutritional status or special groups {pregnant mothers, paediatrics, and the elderly}.

There is a high prevalence of co-morbidity amongst HIV/AIDS patients. Many HIV/AIDS patients suffer from other chronic diseases like diabetes, asthma, hypertension, in addition to the common problems of opportunistic infections like TB, Pneumonias, Hepatitis B and C, etc. There is also widespread use of generics and multisource antiretroviral drugs in resource limited settings, more off-label use and concurrent use of alternative medicines by HIV/AIDS patients. All these combined could contribute to increase in the incidence of ADRs.

In the overview of current knowledge of ARV-related AEs presented at the WHO/Forum for Collaborative HIV Research Joint Meeting in February 28, 2008, Nyasha reviewed 40 publications on ARV-related AEs from 1999-2007. She identified anaemia, rash, neuropathy, lipodystrophy, and hepatitis as the top 5 AEs that led to treatment switches in South America and South East Asia. In an Italian Cohort, toxicity was reported as the major reason (58%) for discontinuation of 1^{st} line HAART[2]. In an observational analysis, Reisler and colleagues found that the most common grade 4 events were

liver-related[3]. Other grade 4 events included neutropenia, anemia, cardiovascular disease, pancreatitis, psychiatric, and renal-related events. There were 272 deaths, of which 153 experienced a grade 4 event prior to death. Grade 4 events associated with the highest risk of death were cardiovascular, renal-related, liver-related, and pancreatitis.[3]

These data illustrate the need to carefully assess co-morbid conditions, recreational drug and alcohol use, and concomitant medications at baseline and throughout follow-up.

In Africa, neuropathy, neutropenia, and lipodystrophy were the predominant AEs that limited treatment or resulted in treatment switches. Some studies have documented ART treatment modification due to AEs in Africa.

After 4 years of the Medicine-Sans-Frontier (MSF) ART programme in Khayelitsha, a poor township with about 500 000 residents in Cape Town, it was established that 14% of patients changed ARV due to AE or contraindication[4]. In Botswana, the preliminary result of the Tshepo adult ART and resistance study to assess the emergence of drug resistance and the tolerability of different Protease Inhibitors {PIs} sparing ART regimens showed that about 18% of patients experienced AE that required treatment modification.

In a study on adverse events in HIV-Infected persons receiving ARVs in large urban slum in Nairobi from 2003-2005, it was established that 65% of 283 patients experienced AEs, out of which 6% had severe toxicity (Kim et., al[5]). At 18months, only about 17% of patients had a probability of not experiencing any AE. This study highlights the importance of monitoring AE on patients on ART in Kenya.

If access to medicines is a human right, then preventing avoidable harm from medicines is a professional and moral obligation[6]. Over 70% of the ADRs are either possibly or definitely avoidable[7]

REPORT OF ADVERSE DRUG REACTIONS (ADRs) ATTRIBUTABLE TO ANTI RETROVIRAL MEDICINES, PRESCRIBED BY MEDICAL PRACTITIONERS IN NIGERIAN HOSPITALS

176 (17%) ICSRs were attributable to antiretroviral medicines, with a total of 321 reported ADRs. The most frequently reported ADRs were: **skin rash** (mild to generalized skin rash, often associated with

itching) – 60(19%); **body weakness** – 40 (12.5%); **Steven Johnson syndrome** 21(6.5%); **anaemia** -17 (5.3%); **vomiting** 16(5.0%) & **peripheral neuropathy** – 15 (4.7%).

Most of the reactions started within 4 weeks of commencing therapy and worsened, necessitating discontinuation or admission within 6 – 8months. In terms of outcome, 1 case of death was reported, while 16 cases required hospitalization. 4 of the hospitalized cases were life threatening. 32 recoveries were reported with one or more forms of disability (e.g. scar, depigmentation, blindness and contractures).The categorization and frequency of reported ADRs attributed to ART is shown below:

TABLE: 1

SUSPECTED ART-INDUCED ADVERSE DRUG REACTIONS REPORTED TO THE NATIONAL PHARMACOVIGILANCE CENTRE, NAFDAC, ABUJA.

ADR	FREQUENCY	ADR	FREQUENCY
• Rash	- 60	• Internal Heat	- 3
• General Body Weakness	- 40	• Fever	- 3
• Steven Johnson Syndrome	- 21	• Gait Disturbance	- 2
• Anaemia	- 17	• Stooling (Diarrhoea)	- 3
• Vomiting	- 16	• Sleep Disturbance (Insomnia)	- 2
• Peripheral Neuropathy	- 15	• Psychosis	- 2
• Itching	- 13	• Hallucination/Nightmares	- 2
• Abdominal Pain/Discomfort	- 13	• Dyspepsia/Epigastria Pain	- 2
• Joint/Muscular Pain	- 12	• Tinnitus	- 2
• Nausea	- 11	• Yellowness of Eyes	- 2
• Headache	- 10	• High Blood Pressure	- 2
• Lipodystrophy	- 8	• Loss of Appetite	- 2
• Dizziness	- 8	• Poor Vision	- 1
• Dermatitis	- 7	• Hepatomegally	- 1
• Body/ Leg Swelling	- 6	• Anorexia	- 1
• Protrusion of the belly	- 6	• Gynaecomastia	- 1
• Fatigue	- 5	• Menorrhagia	- 1
• Hyper pigmentation of Hand/Sole & Feet	- 5	• Somnolence	- 1
• Difficulty/Hearing loss	- 4	• Sweating	- 1
• Constipation	- 4	• Dryness of Skin	- 1
• Cough	- 4	• Perspiration	- 1

Table 2.0: ARV DRUG SPECIFIC TOXICITIES[14, 15, 16, 17,18,]

DRUGS	TOXICITY	FEATURES
Nevirapine (NVP)	Liver toxicity occurs more commonly with Nevirapine than with other antiretroviral drugs. Life-threatening skin rash (Stevens-Johnson syndrome) which occurs in less than 5% of patients and usually within 8 weeks of treatment, DRESS syndrome (drug rash, eosinophilia and systemic symptoms) manifesting as fever, athralgia, etc	Clinically asymptomatic and symptomatic liver toxicity, including rapidly occurring fatal liver failure have been observed
Efavirenz (EFV)	Mobiliform rash may appear but usually not life-threatening. CNS side effects occur in about 50% of patients (usually self-limiting), Teratogenic effect and false cannabinoids test, hepatotoxicity	Hallucinations, Insomnia, Abnormal dreams, Nightmares, Somnolence, Amnesia, Abnormal thinking, Confusion & Euphoria. For these reasons, EFV is contra-indicated in patients who already have psychiatric manifestations.
Abacavir (ABC)	Abacavir causes a hypersensitivity reaction (HSR), which may be life-threatening if not recognized in time. It occurs in approximately 5-8 % of patients	The HSR occurs after a median of 8 days, and Lactic acidosis within the first 6 weeks in 93 % of cases. The rash associated with the ABC hypersensitivity reaction is often discrete, in contrast to the skin reactions caused by nevirapine and efavirenz; 80 % of patients have fever.
Zidovudine (ZDV)	Haematological (Anaemia, Neutropenia, thrombocytopenia), myopathy, GI intolerance: Hypersalivation Nausea and abdominal discomfort	Blue to black discoloration of nails, nausea and headache
Lamivudine (3TC)	Well tolerated, but occasionally Pancreatitis, Liver toxicity Mild peripheral neuropathy,	Skin rash, headache
Stavudine (D4T)	Peripheral neuropathy, Lactic acidosis with hepatic steatosis (This is worse when d4T is used in combination with ddI).Peripheral fat atrophy (lipoatrophy)	Insomnia, anxiety, panic attacks painful and peripheral sensations in the lower more than in the upper limb. Ascending motor weakness resembling Guillain-Barre syndrome may occur
Emtricitabine (FTC)	Similar to lamivudine. FTC-Associated hyper pigmentation	Occasional hyper pigmentation observed primarily on palm and soles. Occurred in 3% of patients.
Tenofovir (TDF)	Nephrotoxicity (Acute renal failure and proximal tubulopathy) with Fanconi's syndrome and nephrogenic diabetes insipid have been reported.	

	Bone demineralization & Occasional GI intolerance have also been reported	
Didanosine (ddI)	Dose-related pancreatitis. Effect is worse when combined with hydroxyurea. Painful peripheral neuropathy. Effect is worse if combined with d4T. Lactic acidosis (a class adverse effect) may occur.	Abdominal cramps, diarrhoea
Lopinavir/Ritonavir	Diarrhoea, nausea, vomiting and skin rash	Headache, weakness
Nelfinavir (NFV)	Diarrhoea (seen in 10-30% of patients). Should be managed with agents as Loperamide Fat accumulation Hyperlipidemia and other class effects	
Indinavir (IDV)	Renal problems. Approximately 10-28% of patients develop nephrolithiasis, which is not visible on X-ray, accompanied by renal colic. Nephrolithiasis is primarily caused by high indinavir levels in relation to a low body mass index. Alopecia in hair-bearing areas	Symptoms of acute colic include back pain and flank pain as well as lower abdominal pain, which may radiate to the groin or testes. Hematuria may also occur. Evaluations should include a physical examination, urine and renal function tests. Ultrasound evaluation can exclude urinary obstruction but does not detect small indinavir stones. rash, retinoid-like effects, alopecia,
Saquinavir	Class adverse effects	GI Intolerance, headache, increased transaminases
Amprenavir	GIT intolerance (oral paresthesia in 28% of patients), Lactic acidosis Renal failure, Haemolysis	Oral solution contains propylene glycol which may precipitate:Seizures, Stupor, Tachycardia Hyperosmolality
Tipranavir	increased transaminases, (grade3), Class adverse reactions	GI Intolerance, nausea vomiting and diarrhoea,
Darunavir		GI Intolerance
Ritonavir	Class side effects Perversion of taste Circum-oral and peripheral paraesthesia Hepatotoxicity Asthenia	
Fosamprenavir	Class adverse effects	GI Intolerance, Skin rash 19%, increased transaminases

Conclusion

Antiretroviral therapy has dramatically improved patients' treatment outcomes, but it is not without toxicity. It is therefore important to differentiate ART toxicity from other potential causes of adverse events. The selection of medicines during initiation of patient on ART should be informed by existing data on ADRs and toxicities related to the candidate ARVs. The understanding of the severity and frequency of ADRs and potential local susceptibility to these ADRs helps in projecting the utility of ARVs and their cost-effectiveness in managing HIV/AIDS.

Because of the dynamism of ART, pharmacovilance data generated from spontaneous reporting can inform the revision of treatment guideline(s). When data is generated on a new safety concerns, programmes like the ART programme can use these data to warn providers accordingly. It is not enough to monitor adverse effects of ARV and make treatment adjustment as deemed appropriate by different ART programmes. It is essential that all the observed ADRs are appropriately documented and forwarded to the NPC, NAFDAC-Abuja for assessment and global characterization of the ADRs.

All data related to safety of medicines use in Nigeria should be available to NPC...

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ACKNOWLEDGEMENT:

In addition to the cited references, teaching and presentation materials from the under listed persons have been quoted with thanks.

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ADVERSE DRUG REACTION CASE REPORTS FROM THE REACTIONS WEEKLY (the Uppsala Monitoring Centre) AND PHARMACOVIGILANCE NEWS INVOLVING COMMONLY USED DRUGS

Insulin detemir

Hypoglycaemia: case report

A 34 year-old woman developed preoperative hypoglycaemia after receiving insulin detemir (Levemir). The woman, who had type 2 diabetes mellitus, was recently changed from twice-daily insulin aspart/insulin protamine aspart to SC insulin detemir 55 units in the morning plus insulin glulisine 5 units three times daily before food. Three weeks after the change, she was seen in a preoperative medical optimization clinic, where her serum glucose level was 220mg/dL. Her preoperative instructions included taking no food or water, except what was needed for medication, after midnight before surgery, and to take her usual dose of basal insulin detemir on the morning of the surgery, but not the insulin glulisine. Seven days later at the surgical suite, on the morning surgery, her blood glucose level was 68mg/dL. She reported taking only insulin detemir 45 units that morning.

The woman was started on 5% dextrose solution with an initial improvement in her glucose level, but it fell to 47mg/dL , 3 hours later while she was still receiving the dextrose. She was then administered dextrose 50%, with limited effect, and an hour later, her glucose level was 46mg/dL and the surgery was cancelled. She received further dextrose and her glucose level reached 168mg/dL. She was admitted over night for IV insulin therapy, and had no further hypoglycaemia. Her serum glucose the next morning was 99mg/dL and she under went surgery later that day, with no problems.

Author Comment: *"The basal insulin should not have exceeded 35 U daily. This excess basal insulin led to fasting hypoglycaemia, and because of the long duration of insulin detemir, it is not surprising that the hypoglycaemia was prolonged over several hours, necessitating the cancellation of her surgical procedure"*

Aspirin Overdose

Fatal salicylate poisoning: case report

A 28-year-old man experienced salicylate poisoning with arrhythmias, respiratory insufficiency and altered mental state, after ingesting an aspirin overdose in a suicide attempt; he subsequently died.

The man was hospitalized with tinnitus and dyspnoea, and reported that he had ingested a 'whole bottle' of aspirin 4 hours earlier (dosage not stated). He was mildly agitated on presentation, with BP of 128/70mm Hg, tachycardia of 110/min, a respiratory rate of 24/min and slightly labored breathing; his oxygen saturation was 98% and he had an oral temperature of 37.0°C. Urinalysis revealed a pH of 6.1, and the presence of ketones (+); serum toxicology identified salicylates with a concentration of 35mg/100mL. Other findings included an anion gap of 22 mEq/L and a pCO_2 of 20mm Hg.

The man received activated charcoal and hypertonic sodium biocarbonate. He became diaphoretic, more agitated and tachypnoeic 2 hours later, and reported respiratory distress. At that time, he had a BP of 140/70mm Hg, a HR of 120/min and a respiratory rate of 32/min; his oxygen saturation had decreased to 92%, and his body temperature was 37.9°C. He was sedated with diazepam, and his respiratory distress worsened. He was successfully intubated on the third attempt, ventilated and transferred to an ICU. Repeat blood gas analysis showed a pH of 7.22, a pCO_2 of 48mm Hg and a pO_2 of 140mm Hg; his plasma salicylate concentration was 85mg/100mL. One hour after transfer, an ECG revealed pulseless electrical activity and he died despite resuscitation attempts.

Codeine overdose

Coma and death in children with extensive metabolism: 2 case reports

Inadvertent codeine overdoses led to coma and death, respectively, in 3.25-year-old twin boys with respiratory infections. Both children had been given codeine once daily for the past 6 days. The accidental overdoses were considered to be due to dosing by drops rather than by using a dosing spoon (the mother had administered ten drops each, instead of the recommended 0.5mL); according to the prescription information, 10 drops weigh 500mg and contain12.5mg of codeine. The boys had last received codeine 5hours before the first twin was found. The children had also received paracetamol (acetaminophen), ibuprofen and an ivy extract. CYP2D6 genotyping later showed both boys to be extensive metabolizers.

The first boy was found apnoeic and lying in vomit at 2:40am, and emergency services were called; his mother immediately resuscitated him. On admission, he had a Glasgow Coma Scale score of 3, a systolic BP of 80mm Hg, a respiratory rate of 120/min, and required ventilation. Chest x-rays disclosed alveolar infiltrates in his upper left lung, and laboratory investigations showed ALT and AST levels of 205 IU/L and 182 IU/L, and an elevated WBC count; his CRP level peaked at 39mg/dL on day 2. A tracheal swap revealed Moraxella catarrhalis and Human metapneumovirus. He received antibiotics for aspiration pneumonia, and was ventilated for 3 days; he also required catecholamines for 3 days, to treat sever hypotension. Toxicological analysis revealed the following drug concentrations about 7.5 hours after codeine administration: free codeine 179 ng/mL (serum), and 3400 ng/mL (urine), total codeine 489 ng/mL (serum), and free morphine 33 ng/mL (serum) and 1230 ng/mL (urine). He was transiently confused and extubation, but eventually made full recovery.

The second boy was found dead and lying in vomit 2.5 hours after emergency services were called for his brother. Resuscitation attempts were unsuccessful. A post mortem examination revealed massive aspiration of gastric contents and diffuse cerebral oedema. Toxicological analysis showed the following drug concentrations in heart, femoral vein and urine, respectively: free codeine 547 ng/mL, 587 ng/mL and 16224 ng/mL; total codeine and morphine concentrations were 645 ng/mL and 426 ng/mL, respectively, in his heart serum.

Author comment: "*Our experiments to determine the weight of drops showed that dosing by drops could inadvertently lead to high codeine doses; the mean doses were 14.9, 17.0 or 20.7 mg, depending on the dropping angle. These doses were at least 49% higher than the recommended 10mg dose of codeine. The highest possible dose applied by the mother of the twins was 23.5mg.*"

Quinine

Lichen planus: case report

A 19-year-old woman received a quinine infusion (dosage and therapeutic indication not stated) and developed a pruritic lesion 6 days later. The lesion began at the infusion site and spread after scratching; several days later, the eruption showed a linear distribution and was involving her dorsal left first and second fingers, her left forearm and elbow. Examination revealed linearly arranged small dark purple papules with a flat top and pigmented central depression. Histology disclosed a dense subepidermal infiltrate of lymphocytes and histiocytes. She received topical corticosteroids, and her skin eruption gradually healed.

Author comment: *The process of linear distribution of the lesion may have been either due to a chemical mechanism related to the spread of the antimalarial or due to a mechanical mechanism with development of new lesions corresponding to Koebner's phenomenon.*

Gathse A, Oba A, Peko F, Obengui. Linear lichen planus triggered the site of an infusion: One case. Nouvelles Dermatologiques 28: 210-211, No. 4, Part 1, Apr 2009 [French summarized from a translation.] – Congo 801146492

INSULIN GLARGINE {LANTUS^{R}} AND CANCER RISK

The attention of the NPC has been drawn to a report of a meta-analysis of studies that possibly indicated that Lantus use is associated with cancer.

Insulin glargine marketed as Lantus by Sanofi Aventis is a long lasting insulin analogue. It is used to treat both type I and II diabetes mellitus. Lantus insulin is ***not registered by NAFDAC*** and therefore not approved for sale or use in Nigeria. However, for the purpose of keeping our patrons informed on current research on drug safety issues, we wish to refer you to the site below: http://www.diabetologia-journal.org/cancer.html

ALERT NOTICES:

TOXIC SUBSTANCE IN RHINATHIOL 2% COUGH SYRUP – SUGAR FREE

The Agency's attention has been drawn to the recall of ***RHINATHIOL 2% COUGH SYRUP – SUGAR FREE*** from circulation by Sanofi-Aventis {manufacturer of the product} due to the presence of toxic substance.

The company, Sanofi-Aventis markets four variants of ***RHINATHIOL*** cough syrup namely:

- **RHINATHIOL 2% COUGH SYRUP**
- **RHINATHIOL 2% COUGH SYRUP – SUGAR FREE**
- **RHINATHIOL EXPECTORANT 5% COUGH SYRUP**
- **RHINATHIOL EXPECTORANT 5% COUGH SYRUP - SUGAR FREE**

The two variants that are ***currently marketed*** in Nigeria do not contain toxic substance and are therefore ***not affected*** by the recall. These are: **RHINATHIOL 2% COUGH SYRUP** & **RHINATHIOL EXPECTORANT 5% COUGH SYRUP.**

However, NAFDAC staffs are vigilantly monitoring the drug distribution outlets and the ports of entry for this affected product. Parents, caregivers and operatives of pharmaceutical outlets and medicine stores who may be in possession of **RHINATHIOL 2% COUGH SYRUP – SUGAR FREE** are advised to return them to the nearest NAFDAC office.

RE-CALL OF CONTAMINATED APOTEX PRODUCTS

The attention of the National Agency for Food and Drug Administration and Control (NAFDAC) has been drawn to the recall from circulation the under listed batches of drug products by Apotex Incorporated, Toronto due to contamination of one of the ingredients.

S/N	Name of product	Lot Nos. of product	Expiry dates
1	Apo-Amilzide	JD5858, JF0078 & JD5863, JD5864 JD5070	March, 2012 May, 2012 December, 2009
2	Apo-Meloxicam	JD4927 & JD4928,	March, 2011

	(7.5mg)		
3	Apo-Meloxicam (15mg)	JD4930 & JD4931	March,2011
4	Apo-Ranitidine	HM5503 & HM5505 HL7557 & HL7558 HM5509	October, 2011 October, 2009 April, 2009

In view of the precautionary steps taken by the company to re-call the affected batches in the interest of public safety, NAFDAC hereby advises pharmaceutical outlets, medicine stores and users of these products to stop the sale and use of these contaminated batches.

The Agency wishes to alert the public that No APOTEX brand of pharmaceutical products is currently registered by NAFDAC.

The staff of the Agency have been put on alert to mop up all unregistered, counterfeit and unwholesome products from circulation in Nigeria.

ALERT NO. 123: DEXTROPROPOXYPHENE - CONTAINING MEDICINES TO BE WITHDRAWN FROM EUROPEAN MARKET

In June 2009 the European Medical Agency (EMEA) recommended the withdrawal of dextropropoxyphene-containing medicines from the European market (1).The Agency based its decision on the advice of its Committee for Medical Products for Human Use (CHMP) that the risk from these products, particularly the risk of potentially fatal overdose, exceed their benefits.

Dextropropoxyphene is a painkiller used to treat acute and chronic pain. It has been in use for over forty years, either on its own or in combination with other medicines such as paracetamol, in the form of tablets, suppositories and solutions for injection.

There have been some concerns about intentional and accidental fatal overdose with dextropropoxyphene - containing substances. Safety reviews of these products carried out in the past have led to different conclusion, with some European Member States withdrawing these products from their markets (2). The CHMP carried out a full review of the safety and efficacy of these medicines in order to assist the European Commission in providing a more harmonized level of protection across the European Union from the risks of these medicines.

The CHMP carried out a full assessment of the benefits and risks of medicines containing dextropropoxyphene alone and of medicines containing dextropropoxyphene in combination with paracetamol, to determine whether the marketing authorizations for these medicines should be maintained, varied, suspended or withdrawn. The committee concluded that the available data do

not provide evidence that these medicines are more effective that other alternative painkillers; that forensic data and national mortality statistics show a significant number of deaths associated with over dose of dextropropoxyphene-containing medicines. Because no adequate measures could be identified to minimize these risks sufficiently, the CHMP recommended that these medicines should be withdrawn from the European market.

This Alert is being issued for wider dissemination of the EMEA recommendation to withdraw dexotropropoxyphene-containing medicines from the European market.

Reference:

1. European Medicines Agency recommends withdrawal of dextropropoxyphene-containing medicines. EMEA Press office, 25 June 2009 (www.emea.europa.eu).
2. WHO Pharmaceuticals Newsletter No. 1, 2005 http://www.who.int/medicines/publications/newsletter/en/index.html).

The National Agency for Food and Drug Administration and Control {NAFDAC} Nigeria wishes to state that Dextropropoxyphene containing medicines are currently not licensed for sale/use in Nigeria. *

Dear Readers,

On Behalf of the staff of the National Pharmacovigilance Centre, NAFDAC Nigeria, we are thanking you for your readership in the outgoing year. We wish you Merry Christmas & a prosperous 2010 filled with happiness and all round success.

PHARMACOVIGILANCE/FDIC NEWS : A QUARTERLY NEWSLETTER OF NATIONAL PHARMACOVIGILANCE CENTRE {NPC}, NATIONAL AGENCY FOR FOOD AND DRUG ADMINISTRATION AND CONTROL {NAFDAC}

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