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Medication safety in seconds

A MONTHLY PUBLICATION FROM VA MEDSAFE:
VA'S COMPREHENSIVE PHARMACOVIGILANCE CENTER

Helping to achieve safe medication use

IMPORTANT CHANGE TO HEPARIN CONTAINER LABELS

Manufacturers of Heparin Lock Flush Solution, USP and Heparin Sodium Injection, USP will change the way the strength is expressed on the container and carton labels. The revised product labeling, scheduled to go into effect on **May 1, 2013**, will clearly state the total strength of the entire container of the medication followed by how much of the medication exists in 1 milliliter (mL), in order to comply with the USP standards for injectable medications (Figure1). The new format will help to reduce miscalculations occurring in products containing more than 1 mL and related medication errors. However, both the current heparin container labels and the revised heparin container labels may be available during the transition period before and after the implementation date in May. To avoid confusion between the different representations, health care professionals should consider:

- Educating staff of new heparin labeling format;
- Storing supplies of "current" and "revised" labeled heparin in separate areas in the pharmacy;
- Creating a warning system for staff to differentiate "current" and "revised" labeled heparin;

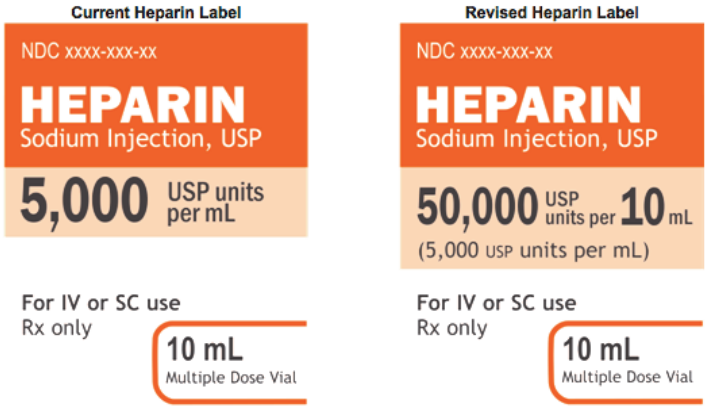

FIGURE 1. Current heparin label versus revised heparin label.

- Consuming inventory stock of the "current" heparin before using "revised" label products;
- Verifying the label on heparin vials being dispensed; and
- Counseling the patient or caregiver on how to administer the correct dose.

REFERENCES

FDA Drug Safety Communication: Important change to heparin container labels to clearly state the total drug strength. http://www.fda.gov/Drugs/DrugSafety/ucm330695.htm . (Accessed 12/14/2012).

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NEWS YOU CAN USE

FROM THE VA NATIONAL PBM: BULLETINS, COMMUNICATIONS, & RECALLS

- Dabigatran (Pradaxa®) and Packaging Error - Recall Due to Possible Compromise in Product Quality – 11-09-2012 – National PBM Communication
- Ameridose Recall of All Unexpired Product Line – 11-01-2012 - National PBM Communication

NEWS YOU CAN USE

FROM THE FOOD AND DRUG ADMINISTRATION (FDA)

SMOKING CESSATION

Safety review update of Chantix (varenicline) and risk of cardiovascular adverse events

12/12/2012 *****UPDATE FROM 07/22/2011*****

FDA first alerted the public of a possible increase in cardiovascular (CV) adverse effects associated with varenicline (Chantix®) in June 2011, and required the manufacturer to further investigate the CV safety of varenicline (Chantix®) via a meta-analysis, which included data from 7,002 patients (4,190 varenicline [Chantix®] and 2,812 placebo) enrolled in 15 Pfizer-sponsored, randomized, double-blind, placebo-controlled clinical trials of ≥12 weeks treatment duration. CV outcomes evaluated include major adverse CV events such as CV-related death, nonfatal myocardial infarction, and nonfatal stroke. Results showed:

- a low incidence of major adverse CV events occurring within 30 days of treatment discontinuation (varenicline [Chantix®] 0.31% [13/4190] vs. placebo 0.21% [6/2812]);
- exposure to varenicline (Chantix®) yielding an adjusted hazard ratio of major adverse CV events of 1.95 (95% confidence interval: 0.79, 4.82), based on at least one major adverse CV event reported per trial;
- an estimated increase of 6.3 major adverse CV events per 1,000 patient-years of exposure (95% confidence interval: -2.40, 15.10); and
- a lower (but not statistically significant) incidence of cardiovascular mortality (varenicline [Chantix®] 0.05% [2/4190] vs. placebo 0.07% [2/2812]) and all-cause mortality (varenicline [Chantix®] 0.14% [6/4190] vs. placebo 0.25% [7/2812]) in the varenicline (Chantix®) group compared to the placebo group.

Revised product labeling now includes these findings in the *Warnings and Precautions* section. Healthcare professionals should continue to weigh the potential benefits of varenicline (Chantix®) against its potential risks when contemplating use in patients with CV disease.

CARDIOLOGY

Update on the risk for serious bleeding events with the anticoagulant Pradaxa

11/02/2012

Due to numerous post-marketing reports of bleeding associated with dabigatran (Pradaxa®) submitted to FDA's Adverse Events Reporting System (AERS) database, FDA assessed the actual rates of gastrointestinal and intracranial hemorrhage using health insurance claims and administrative data to compare certain bleeding events in patients receiving dabigatran (Pradaxa®) or warfarin for the first time. Results showed that the incidence rates of intracranial and gastrointestinal hemorrhage for new users of dabigatran (Pradaxa®) do not appear higher than the rates for the same types of bleeding for new users of warfarin. As such, FDA's recommendations regarding dabigatran (Pradaxa®) remain the same. Healthcare professionals who prescribe dabigatran (Pradaxa®) should continue to carefully follow the dosing recommendations in the drug label to minimize the risk of bleeding, especially for patients with renal impairment, since dabigatran (Pradaxa®) undergoes elimination via the kidneys. As part of its ongoing safety review of dabigatran (Pradaxa®), FDA continues to monitor and assess post-market reports for evidence of inappropriate dosing, use of interacting drugs, and other clinical factors that might lead to a bleeding event. VA also continues to monitor for any side effects reported to the VA Adverse Drug Event Reporting System (VA ADERS) associated with dabigatran (Pradaxa®) use across the system.

OVER-THE-COUNTER PRODUCTS

Serious adverse events from accidental ingestion by children of over-the-counter eye drops and nasal sprays

10/25/2012

Cases of accidental ingestion of over-the-counter redness-relief eye drops or nasal decongestant sprays containing tetrahydrozoline, oxymetazoline, or naphazoline in young children have resulted in serious adverse events. Out of 96 cases of accidental ingestion of these products by young children (ranging in age from 1 month to 5 years) reported to the FDA between 1985 and October 2012, 53 resulted in hospitalization due to symptoms including nausea, vomiting, lethargy, tachycardia, decreased respiration, bradycardia, hypotension, hypertension, sedation, somnolence, mydriasis, stupor, hypothermia, drooling, and coma. No deaths were reported. This has prompted the U.S. Consumer Product Safety Commission (CPSC) to propose a ruling that requires child-resistant packaging for redness-relief eye drops and nasal decongestant sprays.

Getting the most from our safety surveillance

UPDATE: FUNGAL MENINGITIS OUTBREAK—ADDITIONAL CONTAMINATION IDENTIFIED IN MEDICAL PRODUCTS FROM NEW ENGLAND COMPOUNDING CENTER AND RECALL OF ALL AMERIDOSE PRODUCTS

An outbreak of fungal meningitis originating from 3 recalled lots of preservative-free methylprednisolone acetate (PF) 80mg/ml produced by the New England Compounding Center (NECC) led to an expanded recall of all products in circulation from NECC, as well as affiliate company Ameridose (due to linked management), in addition to further investigations by the Food and Drug Administration (FDA) and Centers for Disease Control (CDC). Ongoing laboratory testing by FDA and CDC on medical products from NECC has identified additional microbial contamination in unopened vials of betamethasone, cardioplegia, and triamcinolone solutions distributed and recalled from NECC (Table 1). To date, CDC and public health officials have not received reports of laboratory-confirmed meningitis (bacterial or fungal) or infections (spinal or paraspinal) associated with these solutions, although other illnesses including meningeal inflammation have occurred. All available data do not indicate an outbreak of infection related to non-methylprednisolone NECC products at this time. With respect to Ameridose and its product recall, questions of sterility assurance have come about from ongoing investigations even though FDA and Ameridose have neither identified any impurities in the Ameridose product line nor received any reports of any adverse events related to affected products.

As of October 2012, Department of Veterans Affairs (VA) facilities ceased use and immediately removed from their pharmacy inventory ANY product produced by the NECC, followed by all Ameridose products in November 2012. To date, a detailed review of data from the VA Adverse Drug Event Reporting System (VA ADERS) from May 21, 2012 until December 17, 2012, shows no infections associated with the use of betamethasone, triamcinolone, and carioplegia solutions within the VA healthcare system.

REFERENCES

HAN ALERT. Update: Additional Contamination Identified in Medical Products from New England Compounding Center. Center for Disease Control and Prevention: November 20, 2012; CDC HAN-00335-2012-11-20-ADV-N. Available at: http://www.bt.cdc.gov/HAN/han00337.asp .

TABLE 1. Laboratory-Confirmed Organisms Associated with NECC Recalled Lots of Betamethasone, Cardioplegia, and Triamcinolone Solutions

NECC PRODUCT	LOT NUMBER	MICROBIAL CONTAMINANTS
Betamethasone 6 mg/mL injectable –5 mL per vial	08202012@141	*Paenibacillus pabuli/amolyticus, Bacillus idriensis, Bacillus flexus, Bacillus simplex, Lysinibacillus* sp., *Bacillus niacini, Kocuria rosea, Bacillus lentus*
Betamethasone 6 mg/mL injectable –5 mL per vial	07032012@22	*Bacillus niabensis, Bacillus circulans*
Betamethasone 12 mg/mL injectable – 5 mL per vial	07302012@52	*Bacillus lentus, Bacillus circulans, Bacillus niabensis, Paenibacillus barengoltzii/timonensis*
Betamethasone 6mg/mL injectable – 5 mL per vial	08202012@44	*Bacillus lentus, Bacillus firmus, Bacillus pumilus*
Betamethasone 6 mg/mL injectable – 5 mL per vial	08152012@84	*Penicillium* sp., *Cladosporium* sp.
Triamcinolone* 40mg/mL injectable – 1 mL per vial	06062012@6	*Bacillus lentus, Bacillus circulans*
Triamcinolone 40 mg/mL injectable – 2 mL per vial	08172012@60	*Aspergillus tubingensis, Penicillium* sp.
Triamcinolone 40mg/mL injectable – 10 mL per vial	08242012@2	*Aspergillus fumigatus*
Cardioplegia solution 265.5 mL per bag	09242012@55	*Bacillus halmapalus/horikoshii, Brevibacillus choshinensis*

*Identification of other bacteria for this product is pending.