

## Latest advice for medicines users

The monthly newsletter from the Medicines and Healthcare products Regulatory Agency and its independent advisor the Commission on Human Medicines

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The Medicines and Healthcare products Regulatory Agency (MHRA) is the government agency responsible for ensuring that medicines and medical devices work and are acceptably safe.

The Commission on Human Medicines gives independent advice to ministers about the safety, quality, and efficacy of medicines. The Commission is supported in its work by Expert Advisory Groups that cover various therapeutic areas of medicine.



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First, we inform healthcare professionals that chloramphenicol eye drops can be safely administered to children younger than 2 years when indicated after concerns were raised about exposure to boron (page 2). Following a review of the available toxicological data and a calculation of daily exposure to boron from a typical dosing regimen, we have concluded that the balance between the benefits and risks of chloramphenicol eye drops containing borax or boric acid remains positive for children, including those aged 0 to 2 years.

Next, we remind healthcare professionals to ask patients whether they are taking any herbal or homeopathic medicines if an adverse drug reaction is suspected, and to report any suspicions about these products to the Yellow Card scheme. We also ask healthcare professionals to remind patients to check that a herbal or homeopathic medicine is licensed and to follow the advice included in the patient information.

On page 8 we link to recent MHRA guidance for specialists on monitoring arrangements for oral retinoid medicines while remote appointments continue.

On page 10 we summarise recent advice relating to COVID-19 vaccines that has been published since the June 2021 issue of Drug Safety Update, including revisions made to the information for healthcare professionals and information for UK vaccine recipients for the COVID-19 Vaccine Moderna and Pfizer/BioNTech COVID-19 vaccine following a thorough review of extremely rare reports of myocarditis and pericarditis after COVID-19 vaccination.

And on page 13 we include recent letters, recalls and notifications sent to healthcare professionals about medicines and medical devices.

## **Chloramphenicol eye drops containing borax or boric acid buffers: use in children younger than 2 years**

Following a review of the available toxicological data and a calculation of daily exposure to boron from a typical dosing regimen, we have concluded that the balance between the benefits and risks of chloramphenicol eye drops containing borax or boric acid remains positive for children aged 0 to 2 years. Chloramphenicol eye drops can be safely administered to children aged 0 to 2 years where antibiotic eye drop treatment is indicated.

### **Advice for healthcare professionals:**

- some licences for chloramphenicol eye drop products containing borax or boric acid buffers were recently updated to restrict use in children younger than 2 years of age to reflect warnings on maximum daily limits for boron exposure
- we have reviewed the available evidence and sought independent expert advice to understand whether there is a risk for children aged 0 to 2 years when using these products within the licensed indication, for what is likely to be a short period of time
- our review has concluded that the benefits of chloramphenicol eye drops containing borax or boric acid outweigh the potential risks for children, including those aged 0 to 2 years
- a typical regimen of one drop, applied typically 3 to 4 times a day, to both eyes, would result in a daily exposure well below the safety limit for children aged 0 to 2 years (see notes on dosing schedule in section on Findings of review)
- advise parents and caregivers that chloramphenicol eye drops remain an important medicine for children when antibiotic eye treatment is indicated and that they have been used safely for many years – see Advice to provide to parents and carers
- report the product information for affected chloramphenicol products is being updated to reflect the revised advice and remove restrictions for use in infants – in the meantime we ask healthcare professionals to reassure parents and carers that these products can be safely given to children aged 0 to 2 years as prescribed

### **Advice for healthcare professionals to provide to parents and carers:**

- eye infections (conjunctivitis) are very common in babies and infants and it is important they are treated properly
- chloramphenicol eye drops are an important medicine for treating bacterial eye infections in children and have been used safely for many years
- some eye drops contain borax or boric acid, which are sources of boron – these ingredients are included as buffers to make sure the medicine is not too acidic or alkaline and is comfortable when administered to the eye
- although concerns have been raised about boron and a possible effect on future fertility, these products can be safely given to children younger than 2 years as advised by a doctor or other prescriber
- experts have advised that the amount of liquid that can be absorbed through the eyes of young children and the way these products are prescribed mean that the daily exposure to children would be well below the calculated safety limits

# Review of the interpretation of EU guidance on boric acid and borates as excipients

## **Excipient guidance**

In October 2017, warnings for boric acid (and borates) were introduced into the European Commission guideline for excipients in the labelling and package leaflet of medicines containing boron.<sup>1,2</sup> Marketing authorisation holders were asked to update their product information (Summary of Product Characteristics and Patient information Leaflet) in line with the 2017 guidance over a period of time; and this occurred in the UK last year.

1 [EMA](#). SANTE-2017\_11668. Published 9 October 2017; updated November 2019.

2 [EMA](#). Boric acid and borate used as excipients. Published 9 October 2017.

The European guidance requires the addition of strong warnings not to give children aged 0 to 2 years products if an exposure greater than 1 milligram (mg) of boron a day is exceeded due to concerns around impaired fertility.

## **MHRA review**

With restrictions introduced on the use of some products in children younger than 2 years, concerns were raised by the Royal College of Ophthalmologists and other professional organisations regarding the applicability of these warnings and restrictions for very young children and the lack of suitable alternatives to chloramphenicol eye drops.

We therefore undertook a review of the interpretation of the EU guidance on boric acid and borates as relates to children aged 0 to 2 years. The MHRA reviewed the available quality, clinical and toxicological evidence and sought independent expert advice from the [Paediatric Medicines Expert Advisory Group](#) of the Commission on Human Medicines to understand the risk for infants when these products are used within the licensed indication for what is likely to be a short period of time.

## **Findings of the review**

The European guidance threshold for boron is based on a pregnancy-related effect (reduced fetal weights). Furthermore, the uncertainty factors used in the derivation of the permitted daily exposure (PDE) are based on toxicokinetic and bodyweight data from pregnant rats and humans. Therefore, our review concluded that the current PDE is not relevant to children aged 0 to 2 years.

Based on studies conducted in animals, the most sensitive toxicological effect potentially relevant to infants is reproductive toxicity (adverse effects on fertility). This data was generated in adult animals, not juvenile animals, therefore the relevance to the developing reproductive tract and long-term effects on fertility are unknown. There are no data indicating clinical relevance to adults and children at present, therefore the assumption of potential risk to future fertility of infants is hypothetical. In terms of the exposures associated with the use of chloramphenicol eye drops, there are adequate safety margins in place for adverse effects on fertility and for exposures associated with reduced fetal weights, an endpoint not considered relevant to infants.

Levels of boron in chloramphenicol eye drops vary by product, but around 0.12mg of boron per drop might be present (based on a boron concentration of around 3mg/ml and a drop size of about 40 microlitres ( $\mu\text{L}$ )). Boron exposure calculated using the full amount per drop appears to be an overestimate. Administering eye drops in young children is difficult due to lack of co-operation and potential crying during administration. Because of this, some liquid will be blinked out. Based on expert opinion, the maximum volume that can be accommodated in the conjunctival sac of a child younger than 2 years is between 10 $\mu\text{L}$  and 20 $\mu\text{L}$ .

Expert advice on current clinical practice suggests a typical regimen of one drop administered, applied typically 3 to 4 times a day to both eyes, which would result in a daily exposure well below 1mg per day, even if 100% absorption is assumed.

<sup>3</sup> [BNF for Children \(BNF-C\)](#). Accessed June 2021.

For severe eye infections, the [BNF-C](#) states a dose of one drop, every 2 hours (with frequency reduced as the infection is controlled).<sup>3</sup> This would result in a daily exposure over the limit of 1mg per day threshold for infants younger than 2 years assuming the maximum dose (24 drops) is administered and 100% absorption occurs. Expert opinion is that it is unlikely that the maximum dose will be achieved as the drops will likely be only administered during waking hours and the high dose is for a short duration of a few days.

### **Conclusion of the review**

Given the toxicological data and the calculation of daily exposure from a typical dosing regimen, it has been concluded that the benefit-risk balance of chloramphenicol eye drops containing boron or boric acid remains positive for children aged 0 to 2 years.

The product information for affected chloramphenicol products will be updated shortly to reflect the revised advice that these products can be safely administered to children aged 0 to 2 years.

We have requested the removal of restrictions and associated warnings about boron exposure in children aged 0 to 2 years from the product information (Summary of Product Characteristics and Patient Information Leaflets) for UK chloramphenicol eye drop products.

To ensure continuity of supply, we will not be recalling products that are accompanied by Patient Information Leaflets with previous warnings. As such, for a short time, we ask healthcare professionals to reassure concerned parents and caregivers that chloramphenicol eye drops can be used safely when prescribed for use in their children as long as the instructions for use are followed.

### **Report suspected reactions on a Yellow Card**

Report suspected adverse drug reactions or adverse incidents involving chloramphenicol eye drops to the [Yellow Card Scheme](#).

Healthcare professionals, patients, and caregivers are asked to submit reports using the Yellow Card scheme electronically using:

- the [Yellow Card website](#)
- the Yellow Card app; download from the [Apple App Store](#) or [Google Play Store](#)
- some clinical IT systems for healthcare professionals (EMIS, SystemOne, Vision, MiDatabank, and Ulysses)

When reporting please provide as much information as possible, including information about batch numbers, medical history, any concomitant medication, onset timing, treatment dates, and product brand name.

*Article citation: Drug Safety Update volume 14, issue 12: July 2021: 1.*

## Herbal and homeopathic medicines: reminder to be vigilant for suspected adverse reactions and to report them to the Yellow Card scheme

If an adverse drug reaction is suspected, ask patients if they are taking any herbal or homeopathic medicines and report any suspicions to the Yellow Card scheme. Remind patients to check that a herbal or homeopathic medicine is licensed and to follow the advice included in the patient information.

### Advice for healthcare professionals:

- be vigilant for suspected adverse reactions associated with the use of herbal and homeopathic medicines and interactions with other medicines and report suspicions to the MHRA's [Yellow Card scheme](#) (see section on page 6 for what to include in reports)
- if an adverse reaction is suspected, ask patients whether they are taking any herbal or homeopathic medicines and include a full list of medicines in the Yellow Card report
- enquire if patients are taking herbal or homeopathic medicines during routine medicine reviews and remind them to check they are using licensed products (see advice to provide to patients below)
- remind patients to read the safety information provided in the patient information for herbal and homeopathic medicines, including when to seek medical advice

### Advice for healthcare professionals to provide to patients:

- to ensure a product has been licensed by the MHRA and meets the required standards of quality, safety, and patient information:
  - check for the [Traditional Herbal Registration \(THR\) Certification Mark](#) and THR number on the label of traditional herbal medicines (some herbal medicines have a product licence, shown by a product licence (PL) number)
  - check for the Simplified Homeopathic Registration (HR) or National Rules Authorisation (NR) number on the label of homeopathic medicines
- always read the patient information provided with a herbal or homeopathic medicine to ensure that it is suitable for you and that you know how to use it safely
- if you suspect you have had an adverse reaction to a herbal or homeopathic medicine, you can report this to your doctor or pharmacist, or directly to the [MHRA's Yellow Card Scheme](#)

## Yellow Card reporting for herbal and homeopathic medicines

The [Yellow Card scheme](#) is vital in helping the MHRA to monitor the safety of all medicines in the UK, including herbal and homeopathic medicines.

Herbal and homeopathic medicines are available from outlets such as pharmacies, retail stores, online shops or supplied by herbal or homeopathic practitioners and only some of these are licensed by the MHRA. Here we provide several examples of why it is important that we monitor both licensed and unlicensed herbal and homeopathic medicines in order to protect patient safety.

Yellow Card reporting has identified many important safety issues for herbal medicines, for example, interactions between St John's wort and [hormonal contraceptives](#) and [antiepileptic medicines](#), which were unknown before being reported.

In addition, our vigilance of herbal products has led to warnings regarding the use of Butterbur (*Petasites hybridus*) products. Butterbur contains pyrrolizidine alkaloids, which can cause serious adverse effects such as liver damage and organ failure. The MHRA has previously published [a safety alert](#) advising consumers not to take unlicensed Butterbur herbal remedies. This advice remains unchanged.

Although homeopathic medicines are sometimes diluted to contain only a few molecules of active ingredient, a recent study highlighted a manufacturing error for a homeopathic medicine that resulted in an accidental atropine overdose and hospitalisation in a patient in Germany.<sup>1</sup> Although this occurred outside of the UK, it is an example of the need to consider these medicines in patients who have an adverse reaction.

<sup>1</sup> [Schmoll S, Romanek K, and others. Clinical Toxicology. 2021. 1–3.](#)

### **Who advises the MHRA on herbal and homeopathic medicines?**

The independent [Herbal Medicines Advisory Committee](#) (HMAC) and [Advisory Board on the Registration of Homeopathic products](#) (ABRHP) advise the MHRA and Ministers on the safety, quality and patient information for traditional herbal and homeopathic medicines.

HMAC and ABRHP review safety issues identified for traditional herbal and homeopathic products via the reporting of Yellow Card reactions and advise on changes to the safety information for UK licensed products when required.

### **Knowing whether a herbal or homeopathic medicine is licensed in the UK**

For herbal medicines, patients should check for:

- [Traditional Herbal Registration Certification Mark](#)
- Traditional Herbal Registration (THR) number
- Or a Product Licence (PL) number

For homeopathic medicines, patients should check for a:

- A Simplified Homeopathic Registration (HR) number
- Or a National Rules Authorisation (NR) number

Choosing a product that is licensed means that it meets the required standards of quality, safety, and patient information

## Report suspected adverse reactions to herbal or homeopathic medicines

A recent study of a cohort of people in Wales showed that fewer than 1 in 3 participants knew that they could report an adverse reaction to a herbal medicine or homeopathic medicine to the Yellow Card scheme.<sup>2</sup>

Healthcare professionals and patients are encouraged to report all suspected side effects or adverse reactions to any herbal or homeopathic medicine using the [Yellow Card scheme](#).

When reporting a Yellow Card, it is good practice to routinely ask patients which other medicines, including herbal medicines, supplements, and homeopathic medicines they are taking, in addition to those they have bought themselves, and listing these in the report. You can also inform patients they can self-report any side effects directly using the Yellow Card app or website.

## What to include when submitting a Yellow Card for herbal and homeopathic medicines

Use the [Yellow Card website](#) or Yellow Card app (download from the [Apple App Store](#) or [Google Play Store](#)) to report suspected reactions to herbal and homeopathic medicines.

When submitting a Yellow Card for herbal and homeopathic medicines, it is important to provide some extra details to help us with our assessment and to identify the exact herbal or homeopathic product, such as:

- the brand name (if it has one)
- the list of ingredients
- details of the manufacturer or supplier and THR/PL/HR/NR number (if it has one)
- the condition it was being used for
- any other medicines taken in the previous 3 months
- if the product was supplied by a herbal or homeopathic practitioner, their name and address
- a photograph of package labelling (emailed to [yellowcard@mhra.gov.uk](mailto:yellowcard@mhra.gov.uk))

If you do not have all the above information, please still complete a [Yellow Card](#).

If the reaction is severe, you can also retain a sample of the product, in case further investigations are required. Please note that you can also report suspected reactions that arise as a result of error, misuse, abuse, or off-label use. If in doubt about whether to report a suspected reaction, please complete a Yellow Card.

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## **Oral retinoid medicines (isotretinoin ▼, alitretinoin ▼, and acitretin ▼): temporary monitoring advice during coronavirus (COVID-19) pandemic**

We have published guidance about the use of remote consultations for pregnancy prevention in women of childbearing potential and monitoring for signs of psychiatric reactions (especially depression) and other safety risks in all patients taking oral retinoid medicines during the COVID-19 pandemic.

### **Guidance for specialists**

Oral forms of the retinoid medicines isotretinoin, alitretinoin and acitretin are used in the treatment of severe dermatological diseases that are resistant or unresponsive to standard therapies.

We have recently issued [Guidance for specialists](#) to support the safety of patients on oral retinoids.

The requirements for monitoring of these safety issues reflect established safety measures for oral retinoid medicines. Prescribing of these medicines is understood to be increasing to more normal levels following reduced use earlier in the pandemic.

The [Guidance](#) is to remind specialists of the need to implement the Pregnancy Prevention Programme (PPP) and monitor all patients taking oral retinoids and to support them in protecting the safety of patients while remote appointments continue. The guidance also includes advice that can be provided to patients to help them understand the monitoring requirements.

Psychiatric adverse events have been reported in patients taking oral retinoids for skin disorders, and with respect to isotretinoin; these are [currently under review](#). Prescribers are reminded to inform patients of the risk of psychiatric side effects. Patients should also be encouraged to inform friends and family that they are taking an oral retinoid so that they can be alert for any changes in mood.

Remote consultations should occur with at least the same frequency as the usual clinic consultations, to allow adequate monitoring of mental health and other potential adverse events.

We will publish updated information once these temporary recommendations are no longer considered necessary. These requirements are not applicable to topically applied retinoids and the product information should be consulted for recommendations about these products.



## Report suspected reactions on a Yellow Card

Isotretinoin, alitretinoin and acitretin are black triangle medicines and all suspected adverse reactions should be reported via the [Yellow Card scheme](#).

Reports can be made of suspected reactions experienced at any time, including historic adverse experiences with medicines. Please include in the report as much detail as possible, particularly if a side effect continued or started after treatment was stopped.

Report to the Yellow Card scheme electronically using:

- the [Yellow Card website](#)
- the Yellow Card app; download now from the [Apple App Store](#) or [Google Play Store](#)
- some clinical IT systems (EMIS/SystemOne/Vision/MiDatabank)

When reporting please provide as much information as possible, including information about batch numbers, medical history, any concomitant medication, onset timing, treatment dates, and product brand name.

Report suspected side effects to medicines, vaccines or medical device and diagnostic adverse incidents used in coronavirus (COVID-19) using the [dedicated Coronavirus Yellow Card reporting site](#) or the Yellow Card app. See the MHRA website for the [latest information on medicines and vaccines for COVID-19](#).

*Article citation: Drug Safety Update volume 14, issue 12: July 2021: 3.*

## COVID-19 vaccines: updates for July 2021

Revisions have been made to the information for healthcare professionals and information for UK vaccine recipients for the COVID-19 Vaccine Moderna and Pfizer/BioNTech COVID-19 vaccine following a thorough review of extremely rare reports of myocarditis and pericarditis after COVID-19 vaccination.

These events are extremely rare and tend to be mild when they do occur. Our advice remains that the benefits of getting vaccinated outweigh the risks in the majority of people.

### Review of extremely rare reports of myocarditis and pericarditis

The MHRA and the Government's independent expert advisory body, the [Commission on Human Medicines](#) (CHM), has conducted a thorough review of suspected adverse reaction reports of myocarditis and pericarditis following COVID-19 vaccination.

The CHM has carefully considered the available data and has advised that healthcare professionals should be alert to the signs and symptoms of myocarditis and pericarditis. Vaccinated individuals should be advised to seek immediate medical attention should they experience new onset of chest pain, shortness of breath or symptoms of arrhythmia.

On Friday 25 June, revisions were made to the product information for [COVID-19 Vaccine Moderna](#) and [Pfizer/BioNTech COVID-19 vaccine](#), and the MHRA sent a notification to NHS contacts and healthcare stakeholders.

### Advice for healthcare professionals:

- there have been extremely rare reports of myocarditis and pericarditis occurring after vaccination with COVID-19 Vaccine Moderna and Pfizer/BioNTech COVID-19 vaccine
- cases occurred most frequently in younger men and shortly after the second dose of the vaccine
- these are typically mild cases and individuals tend to recover within a short time following standard treatment and rest
- healthcare professionals should be alert to the signs and symptoms of myocarditis and pericarditis
- vaccinated individuals should also seek immediate medical attention should they experience new onset of chest pain, shortness of breath, palpitations or arrhythmias
- all suspected adverse reactions associated with COVID-19 vaccines should be reported to the MHRA through the [MHRA's Coronavirus Yellow Card reporting site](#)

## **Further information on reports of myocarditis and pericarditis**

As of 23 June 2021, the MHRA has received 60 Yellow Card reports of myocarditis and 42 reports of pericarditis following use of the Pfizer/BioNTech vaccine, as well as one report each of viral pericarditis and Streptococcal endocarditis. There have been 5 reports of myocarditis and 2 reports of pericarditis following use of COVID-19 Vaccine Moderna up to the same date. As of 23 June 2021, an estimated 18 million first doses and around 11 million doses of the Pfizer/BioNTech vaccine had been administered. An approximate 0.88 million first doses of the COVID-19 Vaccine Moderna have also now been administered.

There has also been reporting of similar cases internationally following receipt of the Pfizer/BioNTech and Moderna vaccines. These have occurred most frequently in younger men aged 40 years and younger and within 10 days after the second dose. Most of these cases were mild and individuals typically recovered within a short time and with symptomatic treatment and rest. While reports of myocarditis and pericarditis after vaccination with COVID-19 vaccine AstraZeneca have also been received, there is insufficient evidence to recommend similar warnings for this vaccine.

Healthcare professionals should be alert to the signs and symptoms of myocarditis and pericarditis. Confirmation of diagnosis of these conditions typically requires targeted diagnostic procedures, such as electrocardiograms, cardiac imaging, and biomarker analysis, and it is also important to exclude other potential causes for the symptoms. Treatment of more symptomatic patients will occasionally require relevant expert follow up that might need detailed cardiac imaging to determine the nature of the condition.

### **Advice for the public**

Vaccinated individuals should be advised to seek immediate medical attention should they experience new onset of chest pain, shortness of breath, or symptoms of disturbance of cardiac rhythm.

The COVID-19 vaccines remain highly effective in protecting people from COVID-19 and have already saved thousands of lives. These events are extremely rare and tend to be mild when they do occur. Our advice remains that the benefits of getting vaccinated outweigh the risks in the majority of people. It is still vitally important that people come forward for their first and second vaccination when invited to do so, unless advised otherwise.

### **Summaries of Yellow Card reporting and other recent MHRA publications**

We continue to publish the summaries of the [Yellow Card reporting for the COVID-19 vaccines](#) being used in the UK.

The report summarises information received via the Yellow Card scheme and will be published regularly to include other safety investigations carried out by the MHRA under the [COVID-19 Vaccine Surveillance Strategy](#).

We have also recently:

- published the [Public Assessment Report](#) (PAR) and updated the [Decision page](#) on our website to provide more details about the COVID-19 Vaccine Janssen
- issued [a conditional marketing authorisation for the COVID-19 Vaccine AstraZeneca](#), with corresponding Summary of Product Characteristics, Patient Information Leaflet, Conditions of Authorisation, Information for healthcare professionals and for UK recipients documents

We have previously provided summaries of the latest COVID-19 information, including in the [April 2021](#), [May 2021](#) and [June 2021](#) issues of Drug Safety Update. See [guidance on COVID-19 for all our latest information](#), including after publication of this article.

### **Reporting Yellow Cards**

Suspected adverse reactions associated with COVID-19 vaccines should be reported to the MHRA through the MHRA's [Coronavirus Yellow Card reporting site](#) or via the Yellow Card app.

As these products are under additional monitoring this includes all suspected ADRs associated with these vaccines. This will allow quick identification of new safety information.

When reporting please provide as much information as possible, including information about medical history, any concomitant medications, onset, treatment dates, and vaccine product brand name and batch number.

You may be contacted following submission of a Yellow Card report so that we can gather additional relevant information for the assessment of the report. These contributions form an important part of our understanding of suspected adverse events.

*Article citation: Drug Safety Update volume 14, issue 12: July 2021: 4.*

# Letters and medicine recalls sent to healthcare professionals in July 2021

## Letters

In June 2021, the following letters were sent or provided to relevant healthcare professionals:

- [Venetoclax ▼ \(Venclyxto\): updated recommendations on tumour lysis syndrome \(TLS\) in CLL patients](#)
- [Iloprost 100 micrograms/ml concentrate for solution for infusion – medication error: risk of underdosing due to ampoule labelling](#)
- [Inrebic ▼ \(fedratinib\) 100 mg hard capsules: Potential interaction with grapefruit or grapefruit juice](#)
- [Venlafaxine hydrochloride \(ViePax XL 150 mg prolonged-release tablets\): change of tablet appearance and formulation](#)
- [Xaluprine 20mg/ml oral suspension \(mercaptopurine monohydrate\): interim supply of Ireland stock to mitigate supply disruption](#)
- [Clenil Modulite \(beclometasone\): release of additional batches for all strengths using the standard colours of the inhaler actuators with no dose indicator](#)
- [Evorel Sequi \(estradiol, norethisterone acetate\): discrepancy in marketing authorisation number on the Evorel 50 pouch \(PL 49105/0006\) within the Evoral Sequi carton \(PL 49105/0010\) for a limited number of batches](#)

## Medicine Recalls and Notifications

In June 2021, recalls and notifications for medicines were issued on:

[Company led medicines recall: Noidecs T20/C4 \(THC 20%; CBD <4%\) Indica Cannabis Flower \(unlicensed medicine\) and Noidecs T20/C4 \(THC 20%; CBD <4%\) Sativa Cannabis Flower \(unlicensed medicine\)](#). Issued 09 June 2021. A batch of Noidecs T20/C4 Indica Cannabis Flower, and a batch of sativa cannabis flower are being recalled due to potential contamination with mould. The affected batches of these unlicensed medicines are being recalled as a precautionary measure. Stop supplying the batches immediately, quarantine all remaining stock and return to supplier.

[National Patient Safety Alert: Class 1 Medicines Recall Notification: Recall of Co-codamol 30/500 Effervescent Tablets, Batch 1K10121, Zentiva Pharma UK Ltd, due to precautionary risk of causing overdose, NatPSA/2021/004/MHRA](#). Issued 16 June 2021. A batch of Co-codamol 30/500 Effervescent Tablets is being recalled due to varying levels of active ingredients present in the tablets. An investigation has identified tablets with lower levels of the active ingredients codeine and paracetamol than displayed on the label, and there is also a potential risk for some tablets to contain higher levels of these active ingredients. Stop supplying the batch immediately, quarantine all remaining stock and return to supplier. Healthcare professionals should contact all patients dispensed the affected batch and request them to urgently return the tablets for a replacement, and also advise patients to report any side effects to the MHRA Yellow Card scheme.

[Class 2 Medicines Recall: Bristol Laboratories Limited, Brown & Burk UK Ltd, Teva UK Ltd, Irbesartan-containing and Losartan-containing products, EL \(21\)A/14](#). Issued 17 June 2021. Batches of the following medicines are being recalled by multiple manufacturers: irbesartan 75mg, 150mg and 300mg film coated tablets; losartan potassium 50mg and 100mg film coated tablets; irbesartan/hydrochlorothiazide 150mg/12.5mg, 300mg/12.5mg and 300mg/25mg film coated tablets. This is a precautionary recall as batches have been identified to be contaminated with an impurity of mutagenic potential. Stop supplying the batch immediately, quarantine all remaining stock and return to supplier. The MHRA will provide further updates as our investigation progresses. Healthcare professionals should advise patients not to stop taking their medicine without consulting their doctor or pharmacist.

## **Medical Device Safety Information**

A recent MHRA National Patient Safety Alert has been published on:

- [National Patient Safety Alert: Philips ventilator, CPAP and BiPAP devices: Potential for patient harm due to inhalation of particles and volatile organic compounds \(NatPSA/2021/005/MHRA\)](#)

There was also a recent MHRA Device Safety Information page published on:

- [Medical devices sterilised by Steril Milano – potential for incomplete sterilisation \(DSI/2021/008\)](#)

For all of the latest safety notices from the MHRA on drugs and medical devices, see [Alerts and recalls for drugs and medical devices](#).

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