



Health Product InfoWatch

June 2017

HEALTH PRODUCTS MENTIONED IN THIS ISSUE

Pharmaceuticals and Biologics

- Aranesp (darbepoetin alfa)
- Clozapine
- Erwinase (Erwinia L-asparaginase)
- Mifegymiso (mifepristone and misoprostol tablets)
- Sodium chloride injection 0.9%, USP
- Sustiva (efavirenz)
- Tramacet (tramadol and acetaminophen)
- Xalkori (crizotinib)

Medical Devices

- Infrared thermometers
- SynchroMed II - Programmable Pump

Other

- Foreign health products
- Unauthorized health products

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REPORTING ADVERSE REACTIONS

Canada Vigilance Program
 Online: [Adverse Reaction and Medical Device Problem Reporting](#)
 Telephone: 1-866-234-2345
 Fax or mail: Form available online

SUBSCRIBE

To receive the Health Product InfoWatch and notifications of health product advisories electronically, subscribe to [MedEffect™ e-Notice](#) or to [MedEffect™ Canada RSS feeds](#).

ANNOUNCEMENT

Mandatory reporting of serious adverse drug reactions and medical device incidents by health care institutions

On June 28, 2017, Health Canada released a [consultation paper](#) on mandatory reporting of serious adverse drug reactions and medical device incidents by health care institutions.

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This monthly publication is intended primarily for healthcare professionals and includes information on pharmaceuticals, biologics, medical devices and natural health products. It provides a summary of key health product safety information published in the previous month by Health Canada, as well as a selection of new health product safety information meant to raise awareness. New information contained in this issue is not comprehensive but rather represents a selection of clinically relevant items warranting enhanced dissemination.



MONTHLY RECAP OF HEALTH PRODUCT SAFETY INFORMATION

The following is a list of *health product advisories*, *type I recalls* as well as *summaries of completed safety reviews* published in May 2017 by Health Canada.

Aranesp (darbepoetin alfa) Health Product Risk Communication	Severe and life-threatening skin reactions including Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) have been reported in patients treated with Aranesp. Healthcare professionals are advised to discontinue Aranesp therapy immediately if a severe skin reaction occurs or SJS/TEN is suspected and to permanently discontinue Aranesp if SJS/TEN is confirmed. Health Canada is currently working with the manufacturer to include this safety information in the Canadian product monograph.
Erwinase (Erwinia L-asparaginase) Health Product Risk Communication	To help manage the impact of the ongoing shortage of Erwinase, Health Canada has facilitated the temporary importation of UK-labelled product from Batch CAMR-181G for use with a 5 micron filter. Products with visible particulate matter anywhere other than on the underside of the stopper (e.g., on or in the product) before or after reconstitution, should not be administered. If there is no visible particulate matter in the product after reconstitution, a standard 5 micron filter should be used as an additional precaution.
Foreign health products Foreign Product Alert	These foreign health products have been found by regulators in other countries to contain undeclared drug ingredients. The products are not authorized for sale in Canada and have not been found in the Canadian marketplace but it is possible they may have been brought into the country by travellers or purchased over the Internet.
Infrared thermometers Summary Safety Review	This safety review evaluated the risk of inaccurate temperature readings in children under 2 years old associated with the use of infrared thermometers (IR). Health Canada's review concluded that there is new information to show that ear and forehead contact IR thermometers are appropriate for use in children under 2 years old. Not enough information was available for non-contact IR thermometers, therefore this type is not recommended for use in children under 2 years old.
Mifegymiso (mifepristone and misoprostol tablets) Health Product Risk Communication	Celopharma, in collaboration with Health Canada, communicated to healthcare professionals to clarify the different requirements and steps to follow to prescribe, order, stock and/or dispense Mifegymiso, as outlined in the Distribution and Administration Program for Mifegymiso.

<p>Sodium chloride injection 0.9%, USP</p> <p>Health Product Risk Communication Drug Recall</p>	<p>Three lots of 0.9% sodium chloride injection USP, 1000 mL were recalled by Fresenius Medical Care Canada due to the potential for leakage of the interior solution bag (lot numbers 16EU05011, 16EU05012, 16EU05013). The affected lots should not be used. Home hemodialysis programs should notify patients in their program about this recall without delay.</p>
<p>SynchroMed II - Programmable Pump</p> <p>Medical Device Recall</p>	<p>This type I recall was an update to information previously communicated to healthcare professionals regarding the failure rate for reduced battery performance in Medtronic Model 8637 SynchroMed II pumps manufactured through June 2011. These affected products have a potential for sudden loss of therapy due to reduced battery performance from the formation of a resistive film. Performance monitoring of the affected pump population has found a higher-than-predicted failure rate in a subset of pumps manufactured between January 2011 and June 2011. This notification does not apply to SynchroMed II devices currently being marketed or implanted, or to any previously implanted devices manufactured after June 2011.</p>
<p>Unauthorized health products</p> <p>Advisories:</p> <ul style="list-style-type: none"> Black Mamba 2 Premium and ExtenZe Dust Extreme High By Nature L-tryptophan and lithium orotate products Poppers and sexual enhancement products Super Panther 7K and Triple Green Update – Poppers and sexual enhancement products Update – Sexual enhancement products 	<p>Health Canada advised Canadians about various unauthorized health products being sold at retail locations across Canada or online.</p>
<p>Xalkori (crizotinib)</p> <p>Summary Safety Review</p>	<p>This safety review evaluated the risk of gastrointestinal perforation associated with Xalkori (crizotinib). Health Canada’s review did not establish a link. Health Canada will continue to monitor the situation.</p>

ANNOUNCEMENT

Continued from page 1

A Webinar will be held on July 18, 2017 at 12:30 pm to share information on the proposed approach for the regulations. To participate, please send your name and email address by Wednesday, July 12 to: MHPD-stakeholders_intervenants-DPSC@hc-sc.gc.ca . Questions may be sent in advance to be answered by Health Canada during the session.

Health Canada is seeking feedback on the consultation paper by August 11, 2017.

NEW HEALTH PRODUCT SAFETY INFORMATION

The following topics have been selected to raise awareness and, in some cases, to stimulate reporting of similar adverse reactions.

REVIEW ARTICLE

Clozapine and life-threatening gastrointestinal hypomotility – Update

Key points

- Healthcare professionals are reminded that clozapine may be associated with life-threatening gastrointestinal hypomotility.
- Additional deaths involving intestinal obstruction in patients taking clozapine have been reported since the last Health Canada communication.
- Health Canada will continue to monitor this safety issue.

Clozapine is an atypical antipsychotic agent indicated in the management of treatment-resistant schizophrenia.¹ Clozapine use is limited to patients who have not responded to, or are intolerant of, conventional antipsychotic medications.

The anticholinergic activity of clozapine is associated with varying degrees of impairment of intestinal peristalsis, ranging from constipation to intestinal obstruction, fecal impaction and paralytic ileus.¹ On rare occasions, these cases have been fatal. Health Canada previously communicated to healthcare professionals in January 2011 on the risk of life-threatening gastrointestinal hypomotility with clozapine.² Since this communication, additional deaths related to intestinal obstruction with the use of clozapine have been reported to Health Canada.

Healthcare professionals are reminded of the potential for life-threatening gastrointestinal hypomotility suspected of being associated with the use of clozapine. Particular care is necessary in patients who are receiving concomitant medications known to cause constipation (especially those with anticholinergic properties such as some antipsychotics, antidepressants and antiparkinsonian treatments), have a history of colonic disease or a history of lower abdominal surgery as these may exacerbate the situation.¹ It is vital that constipation is recognized and actively treated.¹ Health Canada will continue to monitor this safety issue.

References

1. *Clozaril (clozapine)* [product monograph]. Etobicoke (ON): HLS Therapeutics Inc.; 2016.
2. Smith E, Brûlé-Brown D. [Clozapine and life-threatening gastrointestinal hypomotility](#). *Can Advers Reaction News* 2011;21(1):1.

Article citation: Health Canada. Clozapine and life-threatening gastrointestinal hypomotility – Update. *Health Product InfoWatch* June 2017.

PRODUCT MONOGRAPH UPDATES

The following safety labelling updates, which were recently made to the Canadian product monograph, have been selected for your awareness. A complete list of safety labelling updates for brand name pharmaceutical drugs is available on [Health Canada's Web site](#).

Sustiva (efavirenz)

The risk of **QT interval prolongation** has been included in the *Warnings and Precautions*, *Drug Interactions*, and *Action and Clinical Pharmacology* sections of the Canadian product monograph for Sustiva.

Key messages for healthcare professionals:¹

- QT interval prolongation has been observed with the use of efavirenz.
- Healthcare professionals should consider alternatives to efavirenz when coadministered with a drug with a known risk of torsade de pointes or when administered to patients at higher risk of torsade de pointes.

Reference

1. *Sustiva (efavirenz)* [product monograph]. Montreal (QC): Bristol-Myers Squibb Canada; 2017.

Tramacet (tramadol and acetaminophen)

The risk of **QT interval prolongation** has been included in the *Warnings and Precautions*, *Adverse Reactions*, *Drug Interactions*, *Overdosage* and *Action and Clinical Pharmacology* sections of the Canadian product monograph for Tramacet.

Key messages for healthcare professionals:²

- Post-marketing experience with the use of tramadol-containing products included rare reports of QT prolongation reported with an overdose.
- Particular care should be exercised when administering Tramacet to patients who are suspected to be at an increased risk of experiencing torsade de pointes during treatment with a QT-prolonging drug.
- The concomitant use of Tramacet with QT interval-prolonging drugs should be avoided.

Reference

2. *Tramacet (tramadol and acetaminophen)* [product monograph]. Toronto (ON): Janssen Inc.; 2017.

HELPFUL LINKS

- [MedEffect™ Canada](#)
- [Recalls and Safety Alerts Database](#)
- [Summary Safety Reviews](#)
- [New Safety Reviews](#)
- [Canada Vigilance Adverse Reaction Online Database](#)
- [Drug Product Database](#)
- [Medical Devices Active Licence Listing](#)
- [Licensed Natural Health Products Database](#)
- [The Drug and Health Product Register](#)
- [Drug Shortages Canada](#)

Suggestions?

Your comments are important to us. Let us know what you think by reaching us at InfoWatch_InfoVigilance@hc-sc.gc.ca

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Adverse reactions (ARs) to health products are considered to be suspicions, as a definite causal association often cannot be determined. Spontaneous reports of ARs cannot be used to estimate the incidence of ARs because ARs remain underreported and patient exposure is unknown.

Due to time constraints relating to the production of this publication, information published may not reflect the most current information.

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