Drug packaging plays an important role in protecting and providing information to patients. The packaging examined by Prescrire in 2012, on the whole, still fails to perform all of these functions effectively.

Two issues are especially worrisome. First, packaging too often poses a danger to children. In addition, too many patient leaflets provide incomplete information about adverse effects, thus failing to properly protect the most vulnerable patients.

Yet, the method Prescrire used to analyse drug packaging shows that it is not difficult to detect and anticipate risks. It is up to healthcare professionals to take advantage of the method, to protect patients from, and report, dangerous packaging.

In 2012, children appear to be the population group most overlooked in the marketing authorisation process, in terms of packaging.

Think about children first

Are drug regulatory agencies and pharmaceutical companies concerned about children accidentally or erroneously exposed to drugs intended for adults? The situation is common, since medicines are present in almost every household.

No child-proof cap: poisonings, accidents. The risk of accidental ingestion of caustic household products, such as hydrochloric acid or sodium hydroxide, by children is well known. But the need to protect children from drug toxicity seems to have escaped the attention of health authorities, given the quantity of drug bottles on the market that lack a child-proof cap.

Some examples of bottles without a child-proof cap in 2012: Preterval (perindopril + indapamide), Predyl (povidone-iodine), and Codotussyl toux sèche (pentoxysverine).

Paracetamol overdose provokes serious or even fatal hepatic disorders. A retrospective study has shown that the orodispersible form of paracetamol tablets in particular exposes children to a risk of overdose (Prescrire Int n° 132). Yet in 2012, bulk tubes containing a total of 8 g of orodispersible paracetamol were available for self-medication in France without a child-proof cap (Elferalanodis®). These pleasantly tart, fruit-flavoured, effervescent tablets resemble mint candies. This product represents a danger to children and should be withdrawn from pharmacies.

Beware of alcohol. The use of alcohol-based hand sanitisers is now widespread. Accidental ingestion of these products by children has resulted in acute poisoning, with inebriation, agitation, drowsiness and impaired consciousness (Prescrire Int n° 129). Although they are not drugs, cases of this type show that more thought must be given to the risks to which children are exposed due to the presence of alcohol and to excipients used in drug formulations.

Abstract

Drug packaging plays an important role in protecting and providing information to patients. The packaging examined by Prescrire in 2012, on the whole, still fails to perform all of these functions effectively.

Two issues are especially worrisome. First, packaging too often poses a danger to children. In addition, too many patient leaflets provide incomplete information about adverse effects, thus failing to properly protect the most vulnerable patients.

Yet, the method Prescrire used to analyse drug packaging shows that it is not difficult to detect and anticipate risks. It is up to healthcare professionals to take advantage of the method, to protect patients from, and report, dangerous packaging.
Children are particularly vulnerable to errors. In 2012, French poison control centres published a study that identified, over a 2-month period, 169 reports of administration errors involving single-dose containers: 79% of the victims were children under 5 years of age. In 151 cases, the confusion was linked to the packaging. Two children suffered serious adverse effects (Rev Prescrire n° 345).

The consequences of accidental injection of adrenaline via autoinjectors have sometimes been serious, including finger amputation and death (Prescrire Int n° 131). Several reports concerned children.

The recommended dosage for Flixovate® (fluticasone cream and ointment) is one cutaneous application per day (Rev Prescrire n° 341). Yet the dosing schedule on the packaging shows 2 boxes, labelled “morning” and “evening”, implying that it should be applied twice daily, thus exposing infants aged between 3 months and 1 year to the adverse effects of an overdose of a high-potency topical corticosteroid.

European Paediatric Regulation: mainly benefiting the drug industry. In 2012, five years after the European Paediatric Regulation came into effect, the European Commission opened a public debate on its impact (b), giving Prescrire the opportunity to share its conclusions that the results have been disappointing. This Regulation benefits pharmaceutical companies, while children have gained little (2,4).

In March 2011, we evaluated Cozaar® (losartan oral suspension), an expensive product with dangerous packaging, for which the pharmaceutical company did not request reimbursement (Rev Prescrire n° 329). And yet this earned the company, MSD, a 6-month extension for its market monopoly on the drug, including the formulations intended for adults.

Another notable example in 2012: the European marketing authorisation (MA) for Revatio® (sildenafil) was extended in May 2011 to include children aged 1 year or older with pulmonary arterial hypertension (Prescrire Int n° 129). In France, however, the paediatric form was not marketed until 17 months later (5). In the meantime, pharmacists had to prepare formulations that require tablets to be divided, which can then be lifted in order to peel off the safety film. Child-resistant blister packs are covered with a strong film detached from the strip, freeing an unattached corner of film that is difficult to break without a sharp object. To remove the tablet, the pre-cut blister pocket must first be removed by child-proof caps have been added to the bottles of Uvestérol® D and Uvestérol® ADEC vitamin solutions, but the announced change to the formulation of these solutions has yet to...
Prescribe, dispense and refer to drugs by their INN. A drug’s real name, its international nonproprietary name (INN), makes it possible to identify the same active ingredient in various products. This is the name that should be emphasised, especially in order to prevent overdoses and manage the risk of drug-drug interactions.

The INN was given due prominence on some of the packaging analysed in 2012: nomegestrol and estradiol were displayed in bold type on the box and blister pack of Zoely®; the brand name Bétabistine Bouchara-Recordati® includes the INN; and the INN and dose strength are clearly displayed on the single-unit blisters of Pentasa® (mesalazine 1 g), Pradaxa® (dabigatran 150 mg), and Zelboraf® ( vemurafenib).

But as in previous years, most packaging examined emphasised the brand name, using large, bold type, while the INNs were displayed in small, light-face type without sufficient background contrast. They are sometimes so stylised as to be barely legible, for example on the box for Aldalix® (spironolactone + furosemide) (c). Again in 2012, some drugs were authorised for sale despite the absence of the INN on packaging items such as the single-dose containers of Saflutan® (taffufrost) and the blister packs of Gelutrophyl® (thenoic acid).

Resemblances between dose strengths, umbrella brands: danger! In 2012, the packaging of too many different dose strengths from the same product line looked so similar that it could be a source of confusion for users: for example, Xeroquel® extended-release 300 mg and 400 mg (quetiapine), Xarelto® 15 mg and 20 mg (rivaroxaban), and Sycrest® 5 mg and 10 mg (asenapine).

Even more troubling, the French health products agency (ANSM) took no steps in 2012 to ban or strongly recommend the use of umbrella brands. This practice has become widespread in the self-medication sector: different drugs with different indications and adverse effect profiles are sold under similar brand names, in packaging that often looks very similar (for example, under the umbrella brand Advil®: RhinAdvil® (ibuprofen + pseudoephedrine) (Rev Prescrire n° 345) (7).

Dosing devices: bad habits persist. In 2012, the oral delivery syringe supplied with Oxynorm® 10 mg/ml (oxycodone oral solution) combines the major known flaws of dosing devices: it is graduated in millilitres instead of milligrams, creating a risk of confusion between the two units of measurement; there is no graduation for the 2.5 mg dose indicated in the summary of product characteristics (SPC) for patients with renal impairment; and its capacity is too large for the preparation of low doses (1 mg or 2 mg).

Incomplete patient leaflets: dangerous for patients

More patient leaflets examined this year provided incomplete information about adverse effects (d).

Reports of QT interval prolongation triggering cardiac arrhythmia, including sometimes fatal torsades de pointes, have been attributed to oral domperidone. Yet the patient leaflet for Bépérïdysfois® (domperidone), which was introduced in France in October 2011, does not mention the risk of cardiovascular adverse effects or dangerous interactions with other drugs that can prolong the QT interval (Rev Prescrire n° 340) (8).

Beware of paracetamol. The patient leaflets for products containing paracetamol are inconsistent, particularly the warnings provided about interaction with alcohol. The leaflets for Paratabs® are clear (our translation): “if you regularly drink large quantities of alcohol, you may need to take lower doses of [paracetamol] and limit your alcohol intake for a short period of time, otherwise it could damage your liver” and “avoid taking (...) with large quantities of alcohol” (9).

These explanations contrast with those in the patient leaflet for Efferalgan® tab, which simply mentions that the maximum daily dose in case of chronic alcohol abuse is 3 g and advises to (our translation) “take special care (...) in case of alcohol abuse” (10). When will patient leaflets for useful drugs finally be harmonised up to the highest standard?

Important information missing. The patient leaflet we examined for Mycohydralin® cream ( clotrimazole) intended for vulvar application does not mention whether it can be used with latex condoms (11). However, the patient leaflet for the vaginal tablets (Rev Prescrire n° 342) advises against using them with latex condoms due to the risk of condom breakage (11). We contacted the company and were told that an application to improve the patient leaflet for the cream is planned, with the addition of this information, but it had not yet been submitted as of 30 October 2012.

The European patient leaflet and SPC for Diflis® ( fidaxomycin) make no mention of the risk of serious gastrointestinal haemorrhage (12). Yet the risk is significant and is mentioned in the US prescribing information (13).

Labelling also includes useful information. In 2012, the box for Ostram Vitamin D3® (tricalcium phosphate + colecalciferol) no longer mentions that the drug is contraindicated in patients with renal impairment, and the word phosphate is not printed on the front of the box. This is a regrettable step backwards because healthcare professionals could easily forget that Ostram® contains a calcium phosphate salt, while equivalent products containing calcium carbonate salts are not contraindicated in these patients.

NSAIDs: patient leaflets should clearly deter their use throughout pregnancy. The patient leaflet for AleveTabs® (naproxen) states that (our translation) “during the first 5 months of your pregnancy, your doctor may prescribe this medication, if necessary” (14).

Some information provided in the leaflet for patient leaflets for RhinAdvil® and Rhinureflex® (ibuprofen + pseudoephedrine), although not incorrect, is convoluted and ambiguous, and leaves the door open to the use of NSAIDs during pregnancy depending on “the opinion of your doctor or pharmacist” (our translation) (15, 16).

Exposure to NSAIDs in early pregnancy carries a documented risk of spontaneous abortion. A risk of fetal malformations cannot be ruled out (Rev Prescrire n° 341). There is solid evidence that prenatal exposure to NSAIDs during the second and third trimesters of pregnancy poses a risk of premature closure of the ductus arteriosus, pulmonary arterial hypertension and renal failure. In addition, low-level evidence concerning pseudoephedrine is consistent and points to an increased risk of teratogenesis (Rev Prescrire n° 248).

NSAIDs should never be used during pregnancy: patient leaflets for NSAIDs that do not state this clearly pose a risk to the unborn child, and the risk increases when the NSAID is combined with pseudoephedrine.

In summary, Healthcare professionals can play a role in improving drug packaging by reporting any identified errors, suspected risks and observed flaws: poorly legible INNs, unsuitable dosing devices,
etc. (e). They should choose medicines with the best packaging, advise patients on their use (helping them to identify the INN on labelling, explaining the use of dosing devices), and inform patients about adverse effects that have been omitted from the packaging.

With innovation in new drugs or new indications at a standstill, we could at least expect improvements in the packaging of existing drugs. The pharmaceutical industry and drug regulatory agencies have a duty to embark upon a major packaging safety programme to improve existing packaging, paying particular attention to children and other vulnerable patients. This includes improving the quality of paediatric packaging, banning bottles without a child-proof cap, testing the various models of child-proof caps, requiring child-resistant blister packs for particularly dangerous drugs, improving information about overdose in SPCs and encouraging studies by poison control centres on unintentional poisoning.

It is equally urgent that drug regulatory agencies and especially agency rapporteurs responsible for evaluating marketing authorisation applications should anticipate the inherent risks of the proposed packaging and the risk of medication errors before marketing authorisations are granted.

How many years, accidents and deaths will it take before health authorities recognise the importance of drug packaging and take appropriate action? ©Prescrire

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c- The INNs on the Aldalix° box are tiny, resembling little more than a line drawn underneath the brand name. The boxes for Aldactone° (spironolactone alone) and Aldactazide° (spironolactone + altizide) have the same flaw. These boxes all look alike and have similar brand names. The withdrawal of Aldalix° from the French market is a welcome development.
d- Although not actually dangerous, some information about adverse effects provided in patient leaflets is disgusting, to say the least. For example, in the European patient leaflet for Victrelis° (boceprevir), the following adverse effects were classified under “mental illness”: memory loss, anger, and trouble concentrating (ref 17).
e- In France, any packaging flaws should be reported to the medication errors office of the French health products agency (ANSM): erreurs.medicamenteuses@ansm.sante.fr or fax +33 (0)1 53 87 13 10. They can also be reported to Prescrire’s Preventing the Preventable programme: http://evitable.prescrire.org/fr.

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Selected references from Prescrire’s literature search.
3- Comité de Coopération de Toxicovigilance “Ingestion of substances irritants or corrosives: étude descriptive des cas avec atteinte endoscopique enregistrés par les centres antipoison et de toxicovigilance d’avril 2009 à mars 2010” February 2012: 37 pages.
4- Prescrire Editorial Staff “Who benefits from the European Paediatric Regulation?” 28 November 2012: 6 pages. english.prescrire.org
5- ANSM “Revatio poudre pour suspension buvable” 26 October 2012: 1 page.
6- FDA “FDA recommends against use of Revatio in children with pulmonary hypertension” 30 August 2012: 2 pages.
9- ANSM “Notice-Paratabs” 28 October 2010: 7 pages.
16- ANSM “Notice-Rhinureflex” 18 December 2008: 2 pages.

Medicines in Europe
See also Prescrire’s response to an EMA consultation on potential medication errors: “Safety and usability of packaging and labelling: assessment is required prior to marketing authorisation for all medicinal products, not just for copies of existing drugs (November 2012)”.

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