

2009 Prescrire Packaging Awards

The Packaging Awards focus on the quality of packaging for drugs evaluated during the previous year in the New Products section of our French edition (2009: issues 303 to 314).

Packaging awards

NOT AWARDED IN 2009

Throughout the year, the editorial staff systematically examines the packaging of several hundred pharmaceutical products. This provides us with an opportunity to identify high-quality packaging and to detect dangerous packaging that is a potential source of confusion and errors, in order to inform our readers.

Detailed analysis. Every aspect of packaging is examined: the outer packaging (the box), the primary internal packaging (blister pack, bottle, syringe, sachet, etc.); devices provided for preparing and/or administering the doses; and of course, the legibility and quality of information provided in the package leaflet.

Specialised editors within the Prescrire Packaging Working Group further review packaging items and grant the annual Packaging Awards.

Annual Awards in total independence. At the end of each year, the Packaging Awards are granted following a review of the year's standardised forms, in total independence and with no input from drug or packaging manufacturers. The rules are available on our website, at www.english.prescrire.org.

No Awards granted in 2009. In 2009, as in previous years, the packaging of several products stood out from the rest for one reason or another (see the June 2010 issue). This year, however, none of them met all of the quality and safety criteria required to merit a Packaging Award.

Particularly poor packaging is awarded a yellow or red card, depending on the degree of risk it creates. Unfortunately, the list for 2009 is rather long (see right).

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Yellow cards

• **Coversyl° tablets**, Servier ***(perindopril)***

• **Bipreterax° and Preterax° tablets**, Servier (***perindopril*** + ***indapamide***)

For the change in the way the *perindopril* dose is worded on the label, leading to a 20% increase in dosing specifications, even though the *perindopril* dose per tablet has barely changed. This represents a potential source of confusion and dosing errors. And for the switch from blister packs to bulk bottles without a childproof safety cap, creating a risk of overdose, especially in children (*Rev Prescrire* 313).

• **Vicks Expectorant adultes° syrup**, Procter & Gamble Pharmaceuticals ***(guaifenesin)***
For the poor legibility of the labelling information on the box; for example, the lack of contrast (white print on a metallic background) for useful information such as indications, making it difficult for patients to read the label and obtain the information they need for use of this over-the-counter medication (*Rev Prescrire* 306).

• **Tiorfanor° tablets**, Bioprojet ***(racecadotril)***
For the misleading promotional nature of the patient leaflet, which states that *racecadotril* is (our translation) "a very effective drug", while it provides no more than a limited reduction in stool frequency. This misleading claim may make patients neglect the need for rehydration (*Rev Prescrire* 307).

• **Betaine citrate Cristers° granules**, Cristers ***(betaine citrate)***
For minimising and scattering inadequate information printed on and inside the box (there is no proper patient leaflet), and the total lack of labelling on the sachets containing the granules, other than the lot number and expiry date (*Rev Prescrire* 311).

Red cards

• **Zarontin° syrup**, Pfizer (***ethosuximide***)
For the lack of dosing device in the box containing the bottle of this antiepileptic drug. The use of an ordinary spoon, as recommended in the patient leaflet, is a source of imprecise dosing, especially under-dosing, with a risk of seizure relapse (*Rev Prescrire* 309).

• **Nplate° powder for injectable solution**, Amgen (***romiplostim***)
For the ambiguous labelling of the "250 µg" dose strength (the bottle actually contains 375 µg of *romiplostim*), and the lack of a precise and appropriate dosing device. Together, these flaws represent a potential source of error during dose preparation. This is particularly problematic for an injectable drug that increases the platelet count (*Rev Prescrire* 311).

• **Prialt° 100 µg/1 ml and 500 µg/5 ml solution for intraspinal infusion**, Eisai (***ziconotide***)
For the inadequate information provided on the labelling: the total amount of *ziconotide* is not shown on the main face of the box, the INN is not mentioned on the bottle labels, and the words "solution for infusion" and "intraspinal route" are printed separately on the boxes. These represent sources of confusion that could lead to errors during dose preparation or in the choice of the route of administration (*Rev Prescrire* 312).

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