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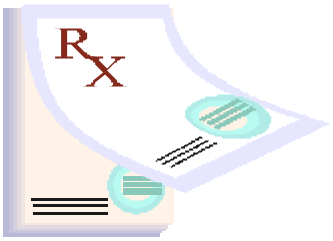
CHANGES TO APPROVED NON-PROPRIETARY NAMES OF MEDICINES



BACKGROUND

Each medicine has a non-proprietary name, which describes its active substance. This is often referred to as the "generic" name. Currently in Ireland and the UK, two different systems of non-proprietary names exist - namely the British Approved Name (BAN) and the recommended International Nonproprietary Name (rINN). These differences are historical in that medicines in the UK and Ireland originally adhered to the pharmaceutical standards laid down in the British Pharmacopoiea, which referred to BANs, while the rINN is the internationally used system, overseen by the World Health Organisation.

In most cases the rINN and BAN are the same for a given medicinal substance. In those cases where there is a difference it was decided at EU level that, in the interest of patient safety, there should be a move to the use of one approved name only (rINN) for each medicinal substance.

IMPLEMENTATION OF THE NAME CHANGES

The UK introduced the changeover during 2004. The Irish Medicines Board (IMB), which is responsible for the implementation of the changeover in Ireland, has continued to accept the use of BANs to facilitate joint packaging for the UK and Ireland; however, it will now oversee the changeover in the Irish market during 2005. Pharmaceutical companies have already been notified of the need to apply for packaging changes by March 2005 and it is hoped that the process will be completed by the end of 2005. Since many of the pharmaceutical products used in Ireland share joint packaging with the UK products it is possible that prescribers may have already noticed some changes to the non-proprietary names on medicinal products currently being dispensed. In fact the NMIC has already been notified by some Irish pharmaceutical companies that such changes have been implemented.

EXCEPTIONS TO THE RULE

Many of the changes involve minor spelling changes (e.g. change from oestradiol to *estradiol*; frusemide to *furosemide)* but there are two medicines for whom the change might adversely affect patient care. **Adrenaline** (rINN epinephrine) and **noradrenaline** (rINN norepinephrine) are critical medicines in emergency medicine and are widely known in Ireland under the original BANs. In order to prevent medication errors occurring with these two medicines, the familiar BANs (adrenaline and noradrenaline) will continue to be used on labels and packaging and the rINNs (epinephrine and norepinephrine respectively) will follow in parenthesis.

AREAS OF POTENTIAL CONFUSION.

The changes, outlined in the table, may be considered significant enough to warrant particular notification. **Please note that this is not an exhaustive list.** A full list is available at **www.bnf.org** (you can download a **free poster outlining all the changes to substances in common use** for which the former BAN has been modified to bring it into line with the existing rINN). Further information for prescribers and dispensers is available at: **www.imb.ie**; http://medicines.mhra.gov.uk/inforesources/productinfo/banrinn.htm ; **www.medicines.ie** (changes to SPCs of medicines).

Table: Existing Name (BAN)	***rINN***
Bendrofluazide	**Bendroflumethiazide**
Chlorpheniramine	**Chlorphenamine**
Dicyclomine	**Dicycloverine**
Dothiepin	**Dosulepin**
Hydroxyurea	**Hydroxycarbamide**
Methotrimeprazine	**Levomepromazine**
Thyroxine sodium	**Levothyroxine sodium**
Trimeprazine	**Alimemazine**

New year, new problems for COX-2 inhibitors

Following the withdrawal of rofecoxib (Vioxx®) from the market, new safety concerns have been raised with some of the other currently available COX-2 inhibitors. A summary of the new information now follows which may be of help to prescribers when deciding which type of NSAID to use.

Celecoxib (Celebrex®) is authorised for the treatment of osteoarthritis and rheumatoid arthritis at a recommended dosage of 200-400mg daily. New data relating to cardiovascular (CVS) safety with long-term use of celecoxib became available in December 2004. **The APC trial**, conducted by the US National Cancer Institute, was designed to evaluate the efficacy of celecoxib in adenoma prevention. The trial (n=2,400 patients, average duration of 33 months' treatment) compared celecoxib 400mg / 800mg daily with placebo. The independent monitoring board stopped the trial in December because of an apparent increase in major fatal and non-fatal CVS events, including acute myocardial infarction and stroke. The risk of CVS events was 2.5 times higher with 400mg and 3.4 times higher with 800mg compared with placebo. Over the 3-year study period this translated into a serious CVS event rate of 3% (20/671) with 800mg celecoxib; 2.2% (15/685) with 400mg; 0.9% (6/679) placebo. The increased rate was evident after 10-12 months' treatment. A second study, conducted by Pfizer (**PreSAP trial**, n=1,560), evaluated celecoxib in the prevention of adenomatous polyps and showed different results. Preliminary results showed a serious CVS event rate of 1.8% (11/628) for placebo vs. 1.7% (16/933) for celecoxib 400mg/ day for 3 years (800mg dose was not used in this study). The apparent inconsistency between these results will be fully evaluated by the EU Committee for Human Medicinal Products (CHMP) in January and a further update on the risk/benefit assessment of celecoxib will be issued.

The IMB and CHMP have advised prescribers to follow the existing warnings / precautions listed in the SPC for celecoxib. These were discussed in a previous Therapeutics Today (2004;8) and include **recommending caution with use of celecoxib in patients with ischaemic heart disease and cardiac failure; a recommendation to use the lowest dose possible; careful monitoring of patients with compromised CVS function and when increasing dosage.** Regulatory agencies in the UK and Germany have further recommended that celecoxib should not be used in patients with established CVS disease unless there is no alternative treatment available.

Valdecoxib (Bextra®) is an orally active COX-2 inhibitor, used for the treatment of osteoarthritis, rheumatoid arthritis and primary dysmenorrhoea. **Parecoxib sodium (Dynastat®)** is authorised for the management of post-operative pain and is administered parenterally (I/M; I/V). Parecoxib is a prodrug of valdecoxib. The CHMP has received post-marketing reports of **serious skin reactions**, some fatal, in patients receiving valdecoxib. These included erythema multiforme, exfoliative dermatitis, Stevens-Johnson syndrome and Toxic Epidermal Necrolysis. Erythema multiforme has been reported with use of parecoxib sodium. The reported rate of skin reactions with valdecoxib appears to be higher than that reported with other COX-2 inhibitors. Patients appear to be at highest risk early in treatment; onset was within the first 2 weeks in the majority of reports to date. **CHMP has recommended that therapy with valdecoxib or parecoxib sodium should be discontinued at the first appearance of skin rash, mucosal lesions or any other sign of hypersensitivity.**

Readers are reminded that the warnings on CVS safety as outlined for celecoxib also apply to valdecoxib and parecoxib sodium. In addition, because of a higher rate of serious CVS events compared with placebo reported from clinical trials in coronary artery bypass graft (CABG) patients, both valdecoxib and parecoxib sodium have been **contraindicated for use following CABG surgery**

Full background information on each of these safety issues is available from the sources outlined below. You are advised that these medicines are currently undergoing review at national and international level; therefore recommendations for use may change, depending on the results of these reviews. ***Therapeutics Today*** *will keep its readers updated on a regular basis, but you are also advised to monitor the sites listed below.* ***(www.emea.eu.int; www.imb.ie; http://www.mhra.gov.uk; JAMA 2005; 293: 366-7; DTB 2005; 43:1-6)***

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