



2010 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 (2010: issues 315 to 326).

Packaging Awards



NOT ATTRIBUTED IN 2010

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 (see in a coming issue of *Prescrire International*).

Detailed analysis. Every aspect of the 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.

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 by *Prescrire* Packaging Working Group, in total independence and with no input from drug or packaging manufacturers. The rules are available on our website, at www.english.prescrire.org.

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Yellow cards (in alphabetical order)



• **Exforge HCT° tablets** Novartis (**amlodipine 5 mg or 10 mg + valsartan 160 mg + hydrochlorothiazide 12.5 mg or 25 mg**)

For the similar labeling of the boxes and blister packs of different dose strengths, representing a source of confusion (Rev *Prescrire* n° 325).

• **Resikali° powder for oral or rectal suspension** Fresenius Medical Care (**calcium sulfonate polystyrene**)

This product is not contained in a box, meaning that the information leaflet may be lost; in addition, the dosing spoon is buried within the powder and is sometimes difficult to find (Rev *Prescrire* n° 319).

• **Sifrol° LP sustained-release tablets** Boehringer Ingelheim (**pramipexole**)

For the ambiguous labeling of the blister packs (straddling two blisters), creating a risk of intake of two tablets instead of one (Rev *Prescrire* n° 323).

• **Temeritduo° tablets** Menarini (**nebivolol 5 mg + hydrochlorothiazide 12.5 mg or 25 mg**)

For the near-identical labelling of the boxes, representing a source of confusion between the dose strengths (Rev *Prescrire* n° 316 and 320).

Red cards



• **Codotussyl toux sèche enfants° and Codotussyl toux sèche adultes° (pholcodine) syrups** Génévrier

For the fanciful labelling of the boxes and bottles, overshadowing the international nonproprietary name (INN) and representing a source of confusion with other members of this over-the-counter umbrella range; also for the lack of safety cap, creating a risk of overdose in children (*pholcodine* has neurological adverse effects) (Rev *Prescrire* n° 317).

• **Coveram° tablets** Servier (**amlodipine 5 mg or 10 mg + perindopril 5 mg or 10 mg**)

For the bulk bottles that create a risk of overdose; and for the similar labelling of the different dose strengths, exposing patients to a risk of hypotension and malaise (Rev *Prescrire* n° 316).

• **Dolirhume aux huiles essentielles° solution for inhalation by fumigation** Sanofi Aventis (**Peru balm + eucalyptus and styrax tinctures + thyme and lavender essential oils + levomenthol**)

For the failure to mention the ingredients on the bottle, creating a source of medication errors; and for the lack of a safety cap, representing a risk of overdose in children (terpene derivatives can cause hallucinations, drowsiness and confusion) (Rev *Prescrire* n° 318).

• **Ebixa° oral solution** Lundbeck (**memantine**)

For the measuring device based on a primed pump, creating a risk of confusion and overdose and exposing patients to the adverse effects of this psychotropic drug (Rev *Prescrire* n° 323) (a).

• **Instanyl° nasal solution 50 µg, 100 µg or 200 µg per puff** Nycomed (**fentanyl**)

For the unsafe packaging and the lack of a built-in mechanism ensuring a sufficient pause between puffs, thus creating a risk of overdose with this opiate (Rev *Prescrire* Int n° 110).

• **Keppra° oral solution 100 mg/ml** UCB (**levetiracetam**)

For the oral syringe graduated in milliliters of solution, requiring the user to convert the dose (in mg) to a volume (in ml), and representing a source of overdose with this antiepileptic drug used to treat children (Rev *Prescrire* n° 321 and 327).

• **Nurofenem° 400-mg tablets** Reckitt Benckiser (**ibuprofen**)

For the failure of the information leaflet to underline the risk of miscarriage linked to the use of nonsteroidal anti-inflammatory drugs (NSAIDs) during the first trimester of pregnancy. This exposes pregnant women to an unjustifiable risk with this widely used over-the-counter drug (Rev *Prescrire* n° 320).

• **Sodium valproate Winthrop 20 pour cent° oral solution (200 mg/ml)** Sanofi Aventis (**valproic acid**)

For the differences, relative to the reference product, in the graduation of the oral syringe, and the way in which the concentration is expressed on the box and bottle (b), creating a source of confusion and overdose, and exposing patients to an increased risk of adverse effects with this antiepileptic drug (Rev *Prescrire* n° 315).

• **VoltarenPlast° medicated plasters 140 mg** Novartis Santé Familiale (**diclofenac**)

For the failure of the labeling and leaflet to underline cardiac and renal risks for the unborn child linked to the use of NSAIDs during the second trimester of pregnancy (Rev *Prescrire* n° 320).

a- After the review in Rev *Prescrire* n° 323, oral Ebixa° was modified.

b- Particularly as Depakine°, the reference product, is also marketed by Sanofi Aventis.