EDITED PUBLIC SUBMISSIONS RECEIVED ON, OR BEFORE, THE CLOSING DATE MENTIONED IN THE NOTICE INVITING PUBLIC SUBMISSIONS FOR THE:

Joint Meeting of the Advisory Committees on Medicines & Chemicals Scheduling – 8 December 2010 (ACCS-ACMS#1); and
Meeting of the Advisory Committee on Medicines Scheduling – 9 December 2010 (ACMS #1)

Regulation 42ZCZL, Therapeutic Goods Regulations 1990

The delegate of the Secretary of the Department of Health and Ageing publishes herein all public submissions received on or before the closing date mentioned in the notice inviting public comments for ACCS-ACMS#1 and ACMS#1 (accessible at www.tga.gov.au/docs/html/pc-acms.htm).

In accordance with the requirements of the Therapeutic Goods Regulations 1990 these submissions have been edited to remove information that the delegate considers to be confidential.

As advised in the notice inviting public comments, it was up to the person making the submission to highlight any information which they wish to be considered as confidential. Material claimed to be commercial-in-confidence has been considered against the guidelines for the use and release of confidential information set out in Chapter 6 of the Scheduling Policy Framework (SPF), issued by the National Coordinating Committee on Therapeutic Goods. The SPF is accessible at www.tga.gov.au/regulation/scheduling-policy-framework.htm.

Discrete submissions have been grouped by item. However, a number of applicants provided submissions that related to multiple items. These submissions on multiple items have been separately grouped.

LIST OF SUBMISSIONS

1. DECEMBER 2010 JOINT MEETING OF THE ADVISORY COMMITTEE ON CHEMICALS SCHEDULING (ACCS) AND THE ADVISORY COMMITTEE ON MEDICINES SCHEDULING (ACMS) – ACCS-ACMS#1

Item	Number of public submissions
1.1 5-Aminolevulinic acid	1
1.2 Triclosan	5 (and in both submissions under item 1.5)
1.3 Laureth carboxylic acid	In both submissions under item 1.5.
1.4 Sodium lauryl sulfate	1 (and in 1 submission under item 1.5 – 1 of 2)
1.5 Submissions on multiple matters	2

2. DECEMBER 2010 MEETING OF THE ADVISORY COMMITTEE ON MEDICINES SCHEDULING (ACMS) – ACMS#1

Item	Number of public submissions
2.1.1 Cough and cold	8
2.1.2 Diclofenac	1
2.1.3 Mercury / mercurochrome	1
2.2.1 Pseudoephedrine	3

XXXXX

XXXXX

The Secretary
Scheduling Secretariat
GPO Box 9848
Canberra ACT 2601

28 October 2010

Dear Scheduling Secretariat,

Re: 5-aminolevulinic acid (5-ALA scheduling proposal

XXXXX welcomes the opportunity to provide comment on the proposal to schedule 5-aminolevulinic acid (5-ALA) in Australia for the joint meeting of the Advisory Committees on Medicines and Chemicals Scheduling.

XXXXX is endeavouring to establish standards in this evolving area of medicine and feels the need to highlight the possible dangers that surround the use of 5-ALA by non-medical personnel and courses promoting photodynamic therapy (PDT) for beauty therapists.

XXXXX requests that the TGA schedule 5-ALA and any of its derivatives and related compounds which are used as photosensitising agents during photodynamic therapy. PDT is generally conducted by doctors to treat precancerous and some forms of cancerous skin lesions.(1,2,3)

Statistically, Australia has the highest rate of skin cancer in the world, with one in two people who spend their life in Australia developing some form of skin cancer.(1,2) PDT is suitable for the treatment of biopsy-confirmed nodular and superficial basal cell carcinomas (BCC) (which are approximately 70% of non-melanoma skin cancers (NMSC) diagnosed).(1,3,4,5,6) According to the New South Wales Cancer Council statistics, over 370,000 new cases of BCC and squamous cell carcinoma (SCC) are diagnosed in Australia every year, resulting in 400 deaths.(3)

There are a number of BCC subtypes, however, that are not suitable for PDT therapy.(3,4) These include those lesions histopathologically defined as morpheaform, infiltrating, micronodular, fibrosing or sclerosing BCCs, all which may demonstrate aggressive behaviour and high recurrence rates (even with traditional surgical therapy). (4,5,6,7,8,9,10,11,12,13,14)) Furthermore, some 20-33% of patients will develop a new BCC within a year after treatment for an initial BCC, and by the 5th year, 45% of patients will develop an additional BCC. (16,17,18,19) It is also estimated that 20% of individuals with Fitzpatrick Type I or II skin, which is very common is Australia, who incur excessive sun exposure will develop subsequent BCC. (16,17,18,20,21,22,23,24)

PDT is also suitable for some precancerous lesions such as actinic keratoses (which have the ability to progress to squamous cell carcinoma (SCC) (approximately 30% of NMSC diagnosed).(2,6,7,8,9,15) Doctors prescribing PDT for cancerous or precancerous lesions use a stabilized 20% solution of 5-ALA or a TGA-approved S4 medication, Metvix® after examination, diagnosis and ensuring the lesions are suitable for treatment with these substances. With 5-ALA being unscheduled, it allows beauty therapists to access this substance at lower concentrations or at “medical strength”. This 5-ALA may also be a non-stabilised form which can lead to a variability of concentration and penetration with consequent unpredictability of results and potential side effects.

An example of a beauty therapy training course for PDT can be found at the AKISS College website: http://www.professionalbeauty.com.au/2009/11/04/article/AKISS-College-Brisbane-introduces-Photo-Dynamic-Therapy-training/PCFNNKWHCF. Our investigations found the AKISS college claimed to use 5-ALA at a cosmetic strength of about 3%; however the college was not forthcoming as to who supplied their formulation.

XXXXX main concerns regarding the delivery of medical treatments by non-medically trained individuals include:

- Beauty therapy training does not provide the individual with the ability to correctly examine, diagnose or treat advanced sun-damaged skin; and that the ability to biopsy for histopathological diagnosis of suspicious lesions before the appropriate treatment is prescribed is not within the beauty therapy skill base;[8,9,16,17,18,19,20,24]
- Beauty therapists do not have professional indemnity insurance cover commensurate with that of a medical practitioner to safeguard potential clients;
- PDT is being promoted for treatment of sun-damaged skin within the beauty therapy profession without the relevant medical and clinical guidelines. In Australia there is a distinct possibility of pre-cancerous and cancerous lesions being present.[1,2,4,16,17,18,21,22] Of particular concern is the central face region where lesion malignancy is a known high risk [3,4,5,12,17,21];
- PDT is not a comfortable experience at therapeutic levels. The CPSA is duly concerned about aftercare, follow up and pain management for those individuals who undergo this treatment in this environment;
- The application of PDT-type procedures may not be appropriate for the "skin condition" being treated due to inaccurate diagnosis;
- Treatment in a beauty therapy environment may lead the patient to believe they are adequately treated for their sun-damage, which in turn may lead to a false sense of security and delayed presentation to a medical practitioner. Correct diagnosis and treatment may then require a more involved medical +/- surgical intervention perhaps with now-necessary mutilation and increased overall health care costs. For example, if patients have consulted www.treatskincancer.com.au they may expect they are receiving the same standard of treatment due to the terminology used to promote this treatment in a beauty therapy environment;
- There are currently no advertising restrictions applying to beauty therapists which are equivalent to those imposed on the medical profession. This may lead to a series of false or exaggerated treatment claims, further enticing and confusing the individual considering such treatments.

XXXXX strongly recommends that 5-ALA, its derivates and related compounds, become scheduled, prescription-only medications, in order to increase public safety through increased likelihood of correct diagnosis and appropriate treatment and management of skin conditions. XXXXX also recommends against any long implementation periods should the committees propose to schedule 5-ALA as any lengthy implementation periods will leave potential clients of non-medically trained individuals open to harm by incorrect diagnosis and treatments of sun-damage.
Regards

XXXXX

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1.2 Triclosan - Submission 1/5

29 October 2010

The Secretary
Scheduling Secretariat
GPO Box 9848 CANBERRA ACT 2601
e-mail: SMP@health.gov.au

Dear Sir/Madam,

ACMS/ACCS Joint Meeting Notice: Item 2.4 Triclosan

XXXXX appreciates the opportunity to provide comment in relation to the proposal before the new committee, to include a parent entry for Triclosan in Schedule 6 with an exemption for:

- non-therapeutic human use (e.g. cosmetic use) containing 0.2 per cent or less; and
- all other preparations (e.g. therapeutic use and non-human use) containing 1 per cent or less of triclosan.

XXXXX made comment to Meeting 59 of the National Drug and Poisons Schedule Committee (NDPSC) in June. In our comments to the new joint committees we would like to addressed relevant items under section 52E (1) of the *Therapeutic Goods Act*: (b) the purposes for which a substance is to be used and the extent of use of a substance;(c) the toxicity of a substance;(d) the dosage, formulation, labelling, packaging and presentation of a substance.

Extent and purpose of use

As identified by NICNAS, triclosan is an ingredient on the Australian Register of Therapeutic Goods for use as:

- an Active Ingredient for Export only, Over the Counter and Prescription medicines; and
- an Excipient for Export Only, Over the Counter, Prescription Medicines, Devices, Listed Medicines, Solely for Export.

It has a long history (in some medicinal products over 30 years) of safe use in therapeutic goods utilizing the substance's antimicrobial properties either in the role of active or preservative.
Our members have experience of use of triclosan as an active ingredient in registered and listed therapeutic goods and as a preservative in excluded goods (cosmetics/personal care products).

Dosage, formulation labelling, packaging and presentation of a substance

When used as an active in therapeutic goods, triclosan is typically used in skin wash/hand sanitizers (pre-operative use in hospitals and commercial/domestic use), topical treatments such as antiseptic creams and acne treatment products and in oral hygiene products such as mouth washes and toothpastes. XXXXXdvise that when used as an active ingredient

- in wash-off preparations or bath wash preparations (where the product is diluted in a bath for use), its maximum concentration in the product is 1%.
- in a leave-on topical product, its maximum concentration is 0.3%.
- in oral hygiene products, its maximum concentration of 0.3%.

As indicated in our previous comment, this list of typical uses and concentrations is true of XXXXX ' products but cannot be considered an exhaustive list of uses in therapeutic goods in Australia. So while XXXXX agrees with the proposed exemption limit for therapeutic useXXXXX would like to express concern that the Record of Reasons of Meeting 59 of the NDPSC was not

clear whether there has been consideration of the appropriateness of this limit for all currently marketed products on the ARTG. XXXXX do not make comment with respect to the exemption limit for non human use. XXXXX feels the concerns we raised to the 59th Meeting of the NDPSC with regard the implications of the Schedule 6 signal heading when applied to medicines has been appropriately addressed by the proposal.

In the absence of limits for use of triclosan in Australia, XXXXX advise that when formulating cosmetic and personal care products with triclosan as the preservative, the limit specified in the EC Cosmetic Directive 76/768/EEC has determined the maximum level of use at 0.3%. This has been necessary as our major export markets like New Zealand, much of Asia and the Middle East, base their regulatory requirements on European requirements. Therefore the European limit for triclosan has in effect been used as a harmonised limit.

Toxicity of the substance

The NICNAS Priority Existing Chemical Assessment (PEC) report made the following conclusions with regard to public health and safety:

- "triclosan is rapidly and completely absorbed by the gastrointestinal tract, while a lower rate of absorption occurs dermally. It is rapidly removed from the blood, and extensive first pass metabolism occurs following oral administration. Major metabolic pathways in humans and animals involve glucuronide and sulphate conjugations, this has also been observed in the skin. Excretion is relatively rapid; the major route of excretion being the urine."
- "Human oral and dermal data provide no evidence of bioaccumulation."
- "There is no evidence of an in vivo genotoxic potential," "no evidence of a carcinogenic potential" and "no evidence of teratogenicity".
- "Main route of exposure is likely to be dermal", "oral exposure may occur via accidental or incidental ingestion of lip balm, toothpaste or mouthwash formulations."
- "Risk to the public of inhalation toxicity, skin, eye or respiratory irritation is low because of the low concentrations of triclosan in cosmetic and personal care products, and in textiles and plastic products."
- "Under normal conditions of consumer use, the risk of adults and children being exposed to levels of triclosan that would lead to chronic health effects is low."
- "Although there is potential for breast feeding babies to be exposed to triclosan via breast milk, this assessment indicates it is likely to be the lowest source of exposure to babies, and therefore the risk of an adverse health effect during lactation is very low."
- "There is no evidence that the use of triclosan is leading to an increase in triclosan-resistant bacterial populations or that there is any increased risk to humans regarding antibiotic resistance."
- "Potentially, the greatest source of exposure to consumers (adults, young children and babies), and thus the risk of an adverse health effect, is from the use of cosmetic and personal care products containing triclosan. Although the chronic health risk from such products is generally considered to be low, there are exposure data from volunteer studies that suggest that repeated use of a range of triclosan-containing products could increase the exposure levels and therefore the exposure risk."

This final potential aggregate use of triclosan is the risk that is proposed for mitigation by a schedule entry. The nature of the potential chronic health risk however is not clear.

It was noted that the NICNAS Submission to NDPSC provided calculations "based on a realistic worst case scenario where exposure is assumed from multiple cosmetic and personal care products containing triclosan by all exposure routes" and an MOE based on a limit of 0.3% triclosan was in the range 112-125. This MOE is greater than 100 and MOE's above this level are usually accepted as 'low risk'. That is, the worst case aggregate usage would result in a low risk of experiencing health effects.

While the EC's Scientific Committee on Consumer Products (SCCP) Opinion on Triclosan (21 January 2009) http://ec.europa.eu/health/ph_risk/committees/04_sccp/docs/sccp_o_166.pdf concluded that the current EU limit of 0.3% or less as a preservative in all cosmetics is not safe due to concerns of aggregate use, it did not propose a blanket reduction in the limit of use of

triclosan. It concluded “[triclosan] use at a maximum concentration of 0.3% in toothpastes, hand soaps, body soaps/shower gels and deodorant sticks ("common-use products" as defined by the applicant) is considered safe. Any additional use of triclosan in face powders and blemish concealers at this concentration is also considered safe but the use of triclosan in other leave-on products (e.g. body lotions) and in mouthwashes is not considered safe for the consumer due to the resulting high exposures.” Further information from industry has lead the SCCP to re-review their opinion. The final opinion is expected in the first half of 2011.

The US Cosmetic Ingredient Review (CIR) have also been reviewing ‘Triclosan as used in Cosmetics’ and have published a Tentative Report on 13 September 2010 for public comment http://www.cir-safety.org/staff_files/triclo092010tentx.pdf . The final report is expected in Spring 2011. The tentative report concludes the CIR Expert Panel “found that the available safety data across a wide variety of studies addressing purity, stability, general toxicity, carcinogenesis, endocrine disruption, and antimicrobial resistance, support a conclusion that triclosan may be used safely in a wide variety of products in the present practices of use and concentration, even were all product types to contain triclosan were used concurrently, on a daily basis.”

In a summation of the points made under the relevant sections of 52E (1), XXXXX question that the risk case warrants such urgent action that Australia needs to progress with a schedule entry which will result in a unique requirement for the Australian market for the use of triclosan in cosmetics and personal care products. As acknowledged by NICNAS, the majority of these products on the Australian market already conform to the EC limit of 0.3% or less, which when used in a worst case aggregate use would still pose a low risk to health. We therefore request the committee and the delegate defer a final decision on this item to allow consideration of the EC and US CIR review final outcomes both anticipated in the first half of 2011.

While XXXXX agree with the proposed limit for exemption from Schedule 6 for therapeutic goods, we ask for confirmation that this proposal has considered the appropriateness of the limit for all currently marketed products on the ARTG.

Should the committee decide to proceed with the proposed schedule entry, XXXXX request that an appropriate transition period be considered taking into account the requirement to reformulate these products with an effective preservative system that is stable, along with the necessary leadtimes for manufacture and importation and allow for minimisation of write off costs of existing labelling and packaging.

Yours sincerely

XXXXX

[redacted]

[redacted]

To whom it may concern

October 27, 2010

[redacted]

Public comment submission under Regulation 42ZCZK of the Therapeutic Goods Regulation 1990 – joint ACMS/ACCS meeting 29th October 2010

Information prepared by [redacted] to support the continued use of Triclosan at an internationally harmonised level of up to 0.3% in cosmetics.

Dear Sir/Madam,

We refer to the request from the Australian Government, Department of Health and Ageing Therapeutic Goods Administration, for public submissions under regulation 42ZCZK of the Therapeutic Goods Regulation to the proposed scheduling of Triclosan in non-therapeutic use and all other uses.

We would like it to be known that we are not in agreement with the current proposal for a reduced usage rate of Triclosan in cosmetics and we submit the following information to present our case and justifications. In appendix I, more detailed argumentation can be found to the relevant points. In summary the main reasons for our concern are as follows:

- The PEC 30 report published in January 2009 reported no concerns about the safety and usage of Triclosan and a proposed usage rate of 0.3% for cosmetics was given. The same data was used in the assessment for the recent NICNAS submission to the NDPSC and an alternative proposal of a usage rate of 0.2% is given. The interpretation of the data is not transparent and it is not clear why a 0.3% usage rate with an MOE of >100 (an internationally recognised standard) is no longer acceptable and why the recommendation is in conflict to the PEC 30 report.

- Approving a use level of 0.3% of Triclosan in cosmetics would be in line with the globally harmonised allowable use concentration. A recent meeting of the CIR expert panel, USA, recently re confirmed that Triclosan is, for use in cosmetics, safe as used. Europe is reassessing the use of Triclosan in various cosmetic products at 0.3% and is expected to publish its findings early next year. It is our request that the scheduling of Triclosan in Australia is postponed until the final decision is taken in Europe.

- It is unlikely that once an approval limit of 0.3% is set for Triclosan that all product formulations will be increased to include this amount, in particular as Australia currently does not have a maximum limit in place. The summary of cosmetic and medical products found in the

[redacted]

market and highlighted in table 15.1 of the PEC 30 report, show a range of application rates and none of them have taken advantage of the lack of maximum concentration limit for Triclosan so it is unclear why this would now be the case once a limit is set.

- Triclosan is only supported and recommended by [redacted] for use in personal care and medical care applications. The use of Triclosan in household markets and industrial applications is no longer supported by [redacted]. The human safety exposure aspect is further supported by [redacted] because all [redacted] Triclosan currently placed on the market consistently fulfills the high quality standard defined by the USP specification. Establishing a quality standard would also be a route to regulate the quality of Triclosan entering the Australian market.

We feel these points listed above are not suitably addressed in the NICNAS submission on Triclosan to the June 2010 meeting of the NDPSC. We request that the ACMS and ACCS take into account the points raised above in making decisions for scheduling of triclosan.

Yours sincerely,

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

October 28, 2010

The Secretary
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Department of Health & Ageing
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Public Submission to the Joint Meeting of the Advisory Committees on Medicines & Chemicals Scheduling

Item 2.4 Triclosan

[redacted] refers to the scheduling notice inviting public submissions, with respect to certain substances, addressing a matter raised in S.52E of the *Therapeutic Goods Act 1989.*

[redacted] wishes to provide comment for consideration for agenda item 2.4 for the consideration of a proposal to include Triclosan in Schedule 6. Our brief submissions on both these items are attached.

[redacted] has a significant interest in this substance as it is an ingredient in oral hygiene products, including toothpaste, manufactured by [redacted]

[redacted] would appreciate being advised of the outcomes of the discussions on this agenda item, and have the opportunity to provide further submissions if appropriate.

Yours sincerely,

[redacted]

Joint Meeting of the Advisory Committees on Medicines and Chemical Scheduling (ACMS and ACCS)

Agenda Item 2.4 - Triclosan

[redacted] seeks to make comment on the proposed scheduling for Triclosan in Schedule 6 with cutoffs for cosmetic use and all other preparations.

[redacted] proposes that there are key considerations that the Scheduling Committees should review before considering a scheduling proposal for Triclosan.

Harmonization

It is noted that the cosmetic use cutoff of 0.2% proposed in the NICNAS submission made to the NDPSC June 2010 meeting, which is foreshadowed, is not consistent with the limits for Triclosan being considered by other international regulatory agencies. The NICNAS June 2010 report proposed tighter limits for Triclosan compared to the NICNAS PEC issued in 2009, and also compared to the major trading markets including the US, Canada & EU. Given the "global village" of international regulation of chemicals, and communications between international medicines regulatory agencies, [redacted] is conscious that any scheduling decision for Triclosan made in Australia will have international implications.

Now that [redacted] has reviewed the NICNAS June 2010 report, it is difficult to understand the scientific justification for proposing these tighter limits, compared to the 0.3% limit for cosmetic products contained in the 2009 NICNAS PEC and implemented by other international regulatory agencies.

The European position allows the use of Triclosan up to 0.3% in cosmetic products. The SCCP January 2009 opinion confirmed the safety of Triclosan at the current 0.3% concentration in toothpastes, hand soaps, body soaps/shower gels and deodorant sticks (common–use products). Additional use of Triclosan in face powders and blemish concealers at this 0.3% concentration was also considered safe, however the significant contribution to exposure of Triclosan in leave-on products (e.g. body lotions) and in mouthwashes was deemed unacceptable. It was confirmed by Industry that Triclosan was no longer used in leave on products, and used at lower levels in mouthwash, and consequently the SCCS has been requested to revisit its original assessment in order to take into account this information, and provide a realistic exposure scenario for these cosmetic product categories. This revised assessment is due to be released Q1 2011.This demonstrates how market information is important to be included in any exposure assessment.

In addition, the recently published draft Cosmetic Ingredient Review (CIR) "Triclosan as used in Cosmetics" (published September 2010), reports that Triclosan is used in cosmetics at concentrations ranging from 0.01 to 0.3%. This is consistent with the current European position that allows Triclosan in concentrations up to and including 0.3% in

cosmetic products. The CIR Expert Panel assessed Triclosan reviews from various governmental sources, including the 2009 NICNAS PEC report. The CIR Expert Panel concluded that Triclosan "is safe for use in cosmetics in the present practices of use and concentrations."

The final CIR report will be issued shortly, and in the interests of international harmonization, Australia should consider the final US report in its scheduling consideration for Triclosan.

It is [redacted] view that given the absence of public safety concerns, and the desirability of international harmonization in ingredient assessment, it is appropriate to defer making a decision on the scheduling proposal for Triclosan in Australia until the SCCS opinion and final CIR reports are available for review (Q12011). This information needs to be considered in order to allow the NICNAS recommendation to be assessed objectively.

Exposure & Margin of Safety

The June 2010 NICNAS report misconstrues the EU opinion presented in the SCCP January 2009 assessment, by stating that "the most current opinion of the SCCP considered a maximum of 0.3% concentration of Triclosan in all cosmetic products as unsafe because of the magnitude of potential aggregate exposure." The SCCP opinion was that Triclosan was considered safe for use in most product categories, with the exception of leave-on body lotions and mouthwashes that use high concentrations of Triclosan. Of relevance is that the SCCP opinion is based on a NOAEL that is 4 times more conservative than the standard. [redacted] notes both NICNAS PEC report (40mg/kg/day) and CIR (48mg/kg/day) use a more realistic NOAEL than the SCCS. Consequently, NICNAS should reassess its interpretation of the EU assessment, given the more conservative NOAEL used by the SCCS.

In the June 2010 report, NICNAS calculates that at a concentration cut-off of 0.3% based on use of multiple products containing Triclosan, the MoE is "as low as 112." It would be helpful for [redacted] and the Committee, to understand the method of calculation of exposure employed by NICNAS, given the MoE is significantly lower than obtained from other studies.

NICNAS state that this MoE raises a concern that health effects may be likely in individuals through combined use of multiple products. The NICNAS submission (section "Areas of concern") refers to volunteer studies in humans showing high levels of exposure, and has used this as the basis for applying more conservative exposure values to justify a recommendation to limit the cutoff for use of Triclosan to 0.2%.

These volunteer study results contradict recent biomonitoring studies conducted in the US by the EPA in 2008, which demonstrates that "the population based biomonitoring data are believed to be more accurate predictor of aggregate exposure. Not only are the

data Triclosan specific, they are also based on actual consumer use of various Triclosan products." The outcome of this study demonstrated that biomonitoring data combined with a very conservative NOAEL provides an acceptable margin of safety.

The recently published CIR Expert Panel findings have extensively drawn on the recent review of Triclosan by Rodricks et al on the development of margins of safety for consumer products. This review considered the impact of the use of multiple cosmetic products on a daily basis, were each of them to contain Triclosan. A MoS, at the low end of the range, of 128 was determined for the daily use of all the products combined, using the appropriate NOAEL and the most conservative exposure values with the MoS extending up to 1000 for adult males, 732 for adults females, and 634 for children exposed to all product types daily. Were fewer products used that contained Triclosan, the exposure estimates would be lower and MoS higher. Rodricks et al concluded that exposure to Triclosan in consumer products is not expected to results in adverse health effects in children or adults who use the products as intended.

The CIR Expert Panel concluded that Triclosan "is safe for use in cosmetics in the present practices of use and concentrations."

Conversely, the June 2010 report by NICNAS expresses reservations about the acceptability of a MoS of 100. [redacted] understands that 100 is internationally recognized as the gold standard for assessment of acceptable margins of safety. See Appendix 1 for a detailed review of the international acceptance of the 100-fold margin of safety.

Contrary to the NICNAS June 2010 report's concern about a MoS of 100, the NICNAS guideline on risk assessment in Non hazardous chemicals states that a margin of Exposure greater than or equal to 100 are considered acceptable to account for inter and intra species differences. Furthermore, the NICNAS guideline states that the risk of systemic effects from the chemical following prolonged use of personal care products containing the chemical is low.

It is worth noting that the CIR report refers to the extent of use of Triclosan in cosmetics, based on information provided by Industry to the FDA's Voluntary Cosmetic Registration Program, and Triclosan use concentration, based on a survey conducted by the Personal Care Products Council (PCPC). These US market survey demonstrated the reducing frequency on which Triclosan is found in many categories of personal care products, particularly leave-on products. Given that this category of products is the largest contributor to exposure, it is critical to understand whether in Australia, like the US & COLIPA European surveys indicate, these products are no longer being formulated with Triclosan.

[redacted] considers it appropriate that a current survey of the usage of Triclosan in personal care products in Australia is undertaken, to enable a relevant quantification of exposure to be made before the scheduling committee makes any determination of

scheduling Triclosan. Regrettably, the NICNAS PEC includes a usage survey that appears to be unrepresentative of the current environment.

[redacted] has discussed the concept of a local market survey with [redacted] and understands that [redacted] plans to conduct a market survey capturing similar data to the COLIPA European survey and the PCPC US study.

Scheduling Proposal for Triclosan in all other preparations (e.g. therapeutic use and non-human use)

From a process perspective, [redacted] notes that the NICNAS risk assessment of Triclosan is limited in its scope to cosmetic products; however the proposed schedule entry captures a broader range of preparations containing Triclosan.

[redacted] is not aware that TGA or other regulatory agencies have sought scheduling consideration for Triclosan in these preparations. [redacted] understands that as part of the product evaluation process required for Triclosan containing medicines, TGA undertakes its own risk management process.

[redacted] is not aware internationally of medicines containing Triclosan being subject to restriction, such as scheduling. Consequently, [redacted] queries the appropriateness of the NICNAS risk assessment of Triclosan in cosmetics to be extrapolated to a proposed schedule entry for other preparations, such as medicines.

Conclusions

Given the absence of any demonstrated public health or safety concern with Triclosan use, [redacted] recommends to the Scheduling Committee that the consideration of Triclosan for scheduling be deferred until the local survey is completed, and the final CIR report and SCCS opinions are available for review.

The European experience has shown that for exposure modeling to be accurate, the usage of Triclosan in different product categories, and their relative contribution to exposure, must be considered. As discussed above, in Europe, two product categories, leave-on products and mouthwash, were included by the SCCP initial calculations as major contributors to Triclosan exposure, however it was confirmed by Industry that Triclosan was no longer used in the former, and used at lower levels in the latter product type. The SCCS is currently revisiting its original assessment in order to take this information into account, and provide a realistic exposure assessment.

[redacted] reiterates its previously stated view that any proposal to schedule Triclosan should consider international harmonization, particularly the European Cosmetics Directive, and that Australia does not create a unique set of limits. To do so would be inconsistent with the NICNAS stated position of support for international harmonization, as stated in the Triclosan PEC Report 2009.

In our submission to the June 2010 NDPSC meeting, [redacted] stated that if NICNAS proposed a different set of limits to those outlined in the NICNAS 2009 PEC review, a justification of the limits proposed should be provided.

In this submission, [redacted] has shown that the NICNAS 0.2% proposal is not consistent with international assessments on the safety of Triclosan. Moreover, in its argument to justify the lower 0.2% cut-off, NICNAS has argued that the internationally accepted standard for risk assessment (MoS of 100) is in this situation not appropriate. [redacted] respectfully disagrees.

As previously expressed in a submission to the NDPSC, [redacted] proposes that the Scheduling Committee acts consistently with international precedent and scientific consensus, when considering scheduling Triclosan.

References:

1. SCCP Scientific Opinion January 2009 (SCCP/1192/08)
2. SCCS Updated request for scientific opinion: Triclosan, 2009
3. Cosmetic Ingredient Review (CIR) Triclosan as Used in Cosmetics September 13, 2010
4. Rodricks JV, Swenberg JA, Borzelleca JF, Maronpot RR and Shipp AM. Triclosan: A critical review of the experimental data and development of margins of safety for consumer products. Early online. *Crit Rev Toxicol. 2010,*
5. NICNAS Submission to NDPSC June 2010
6. NICNAS PEC Report PEC/30 2009

[redacted] submission to the Joint Meeting of the Advisory Committees on Medicines and Chemical Scheduling (ACMS and ACCS)

Appendix 1

International Acceptance of the 100-Fold Margin of Safety

Summary
Historically, the derivation of the safe level of an ingredient has been based on a 100-fold safety factor, which is the default safety factor recognized by the majority of health organizations and regulatory bodies worldwide. Regulatory agencies have traditionally used the safety factor of 100 because it has been supported by experimental data and has been shown to be a conservative approach to risk assessment. Therefore, a decision to not accept an MOS slightly above 100 is unnecessarily cautious.

Detail
In order to predict the safety of ingredients that are assumed to cause threshold toxicity (non-cancer toxicity), the dose-response relationship from animal data is employed to derive a safe level of exposure. The derivation of safe levels relies on dividing the No Observed Adverse Effect Level (NOAEL) by a 100-fold safety factor. The Margin of Safety (MOS) of a substance can be calculated by dividing its appropriate NOAEL by its possible systemic exposure dosage. A MOS of 100 is accepted when using a NOAEL from a chronic animal study and in the absence of data-derived uncertainty factors or chemical specific adjustment factors (CSAFs).

Safety factors were originally defined by Lehman and Fitzhugh (1954) and employed by the United States Food and Drug Administration (US FDA) in the 1950's to define guidelines for food additives and environmental contaminants. Today, health organizations and regulatory bodies throughout the world utilize this 100-fold safety factor and it is generally accepted that the MOS should be at least 100 to declare a substance safe for use. In an Internal Programme on Chemical Safety (IPCS) risk assessment guidance, it was noted that historically a safety factor of 100 has been properly used to convert a NOAEL derived from a study in experimental animals into a health-based guidance value for human exposure (IPCS 2009). This safety factor is used to calculate acceptable daily intake (ADI), tolerable daily intake (TDI), minimal risk level (MR), reference dose (RfD), and reference concentration (RfC) by agencies such as the United States Environmental Protection Agency (US EPA), the United States Agency for Toxic Substances and Disease Registry (US ATSDR), the US FDA, the Research for Man and Environment (RIVM) in the Netherlands, Health Canada, the European Union Scientific Committee on Consumer Products (SCCP), the European Food Safety Authority (EFSA), the Joint FAO/WHO Expert Committee on Food Additives (JECFA), and IPCS (consisting of the International Labour Organization (ILO), the United Nations Environment Programme (UNEP), and the World Health Organization (WHO)) (for review see Dourson et al., 1996). Specifically, the U.S. EPA outlines in their risk assessment guidance for deriving an RfD (1993) that the use of the 100-fold safety factor

should be utilized. In addition, JECFA and Health Canada use this same 100-fold safety factor to establish ADIs. Furthermore, the European Union SCCP specifically states in its guidance for the safety evaluation of cosmetic ingredients, "It is generally accepted that the MOS should be at least 100 to declare a substance safe for use"(SCCP 2006).

The default 100-fold safety factor comprises two separate 10-fold safety factors that account for interspecies differences and human variability. These safety factors can be further subdivided to represent toxicokinetic and toxicodynamic differences. For interspecies variations, the IPCS (2009) and SCCP (2006) risk assessment guidances have recommended default subfactors of 4.0 and 2.5 for toxicokinetic and toxicodynamic variations, respectively, while recommending equal values of 3.16 for each for human variability (see also Renwick 1993). Although CSAFs can be used to derive a more accurate measure of safety, in the absence of CSAFs the default subfactors still collapse to equal a 10-fold safety factor, which results in the MOS of 100.

The use of the 100-fold safety factors has been supported experimentally and studies have indicated that they tend to result in a conservative estimate that is protective to the human population (Dourson et al., 1996). Using the 10-fold safety factor for interspecies differences assumes that humans are more sensitive to toxicity than animals. However, in a study that examined human sensitivity to teratogenic chemicals, the increase in sensitivity was less than an order of magnitude (Brown and Fabro 1983; Dourson et al., 1996). In addition, Dourson and Stara (1983) noted that using an interspecies adjustment factor supports the use of a 10-fold safety factor to account for interspecies differences. For human variability, the 10-fold safety factor assumes that there is variability in the toxicity response in humans and that there may be especially sensitive populations such as young children and the elderly. However, although Renwick and Lazarus (1998) found that the kinetic default factor of 3.16 did not cover human variability for a particular polymorphism, the analysis still indicated that the composite 10-fold factor covered more than 99.9% of the population. In addition, there have been multiple studies finding that a large percentage of the population, including children, is protected using the 10-fold safety factor (Dourson et al., 2002). For example, Burin and Saunders (1999) analyzed pharmacokinetic and pharmacodynamic data from pharmaceutical clinical trials and reported that a 10-fold safety factor was protective for at least 99% of the human population.

The 100-fold safety factor is based on very conservative assumptions supported by the available data mentioned above and it is widely accepted and used by regulatory agencies worldwide. Therefore, not accepting a MOS that is slightly above 100 is going against the standard set forth in the risk assessment guidelines put forth by various regulatory agencies.

References (Available upon request)

Brown, N.A., and Fabro, S. (1983). The value of animal teratogenicity testing for predicting human risk. *Clin. Obst Gynecol.* 26, 467-477.

Dourson, M.L., Charnley, G., Scheuplein, R. (2002). Differential sensitivity of children and adults to chemical toxicity. *Regulatory Toxicology and Pharmacology* 35, 448-467.

Dourson, M.L., Felter, S.P., Robinson, D. (1996). Evolution of science-based uncertainty factors in noncancer risk assessment. *Regulatory Toxicology and Pharmacology* 24, 108-120.

Dourson, M.L. and Stara, J.F. (1983). Regulatory history of experimental support of uncertainty (safety) factors. *Regulatory Toxicology and Pharmacology* 3, 224-238.

Internal Programme on Chemical Safety (2009). Principle and methods for the risk assessment of chemicals in food. Chapter 5. Dose-response assessment and derivation of health-based guidance values.

Renwick, A.G. (1993). Data-derived safety factors for the evaluation of food additives and environmental contaminants. *Food Addit. Contam.* 10, 275-305.

Renwick, A.G., and Lazarus, N.R. (1998). Human variability and noncancer risk assessment-an analysis of the default uncertainty factor. *Regulatory Toxicology and Pharmacology* 27, 3-20.

Scientific Committee on Consumer Products (2006). The SCCP's notes of guidance for the testing of cosmetic ingredients and their safety evaluation. 6th Revision.

1.2 Triclosan - submission 4/5

27 October 2010

The Secretary
Scheduling Secretariat
GPO Box 9848
Canberra ACT 2601

Dear Sir/Madam,

Re: Proposed Scheduling of Triclosan

We refer to the notice for Invitation for Public Comment – ACMS and Joint ACMS/ACCS meetings, specifically to point 2.4:

2.4 Triclosan - proposal to include in Schedule 6 with an exemption for:

- *non-therapeutic human use (e.g. cosmetic use) containing 0.2 per cent or less; and*
- *all other preparations (e.g. therapeutic use and non-human use) containing 1 per cent or less of triclosan.*

Our pre-June 2010 NDPSC Meeting submission was considered at the last NDPSC meeting in June 2010 and we believe we addressed Sections 52E (d) and (e) of the Act. We have attached a copy of that pre-June 2010 Meeting submission. Our position on the scheduling threshold for triclosan has not changed and the need for harmonization with potential export markets (eg New Zealand).

If the delegate decides to accept the proposal above then a reasonable implementation period will have to be established. From XXXXX perspective, the implementation date will need to consider:

- reformulation, stability & performance testing of current products
- exhaustion of finished products in the supply chain
- exhaustion of stocks of packaging components in the warehouse and currently on order

To ensure an orderly, cost effective change we would require an implementation date no sooner than 1 January 2012.

Yours faithfully,

XXXXX

07 May 2010

The Secretary
National Drugs & Poisons Schedule Committee
GPO Box 9848
Canberra ACT 2601

Dear Sir,

Re: Pre-June 2010 Scheduling Meeting Notice

We refer to the published pre-June 2010 Scheduling Meeting Notice and specifically to point 3.3:

> *3.3 Triclosan – consideration of scheduling, including a proposal from a NICNAS public report (available at www.nicnas.gov.au/Publications/CAR/PEC/PEC30.asp) that triclosan be scheduled, with a concentration cut-off when used as a preservative in cosmetic preparations. Consideration may also include triclosan uses beyond those addressed in the NICNAS report, such as use in agricultural, veterinary or therapeutic preparations.*

In line with the requirements for making a pre-meeting submission we believe we have addressed Sections 52E (d) and (e) of the Act.

XXXXX a wide range of products including XXXXX
.
. The table below lists the product types and maximum concentration of triclosan in XXXXX.

Product Type	Max. Concentration (% w/w)
XXXXX medicine	0.1
Cosmetic – XXXXX	0.3
Cosmetic – XXXXX	0.3
Cosmetic – XXXXX	0.3

NICNAS has produced a detailed and comprehensive report (Priority Existing Chemical Assessment Report No. 30) on triclosan. Recommendation 4 on page xxi of the Report notes that the major source of exposure of the public to triclosan comes from cosmetics and personal care products, although the Report does note a potential exposure from cleaning products. Recommendation 4 goes on to quote the EU maximum allowable concentration of triclosan (as a preservative) at 0.3% in all cosmetic products.

We also note that the New Zealand Cosmetic Product Group Standard lists the maximum allowable concentration for triclosan (as a preservative) at 0.3%.

Based on NICNAS's Recommendation 4 and the benefits of harmonization with both the EU and New Zealand, we believe that a scheduling threshold of 0.3% maximum concentration is appropriate in cosmetics.

In line with this pre-meeting submission and Regulation 42ZCY of the Therapeutic Goods Regulation 1990, we reserve the right to submit a post-meeting comment should the Committee decide to adopt a scheduling threshold that is less than 0.3%.

Yours faithfully,

XXXXX

1.2 Triclosan - submission 5/5

[redacted]

28 October 2010

The Secretary
Scheduling Secretariat
GPO Box 9848
CANBERRA ACT 2601
Email: SMP@health.gov.au

Fax: 02-6289 2500

Dear Sir/Madam

Re: Items for discussion at the ACMS and Joint ACMS/ACCS meeting

[redacted] appreciates the opportunity to make a submission regarding matters to be considered at the forthcoming joint meeting of the Advisory Committees on Medicines and Chemicals Scheduling, in accordance with Section 52E of the Therapeutic Goods Act.

ITEM 2.4 TRICLOSAN

[redacted] supports the proposal to exempt all other preparations (e.g. therapeutic use and non-human use) containing 1% or less of triclosan given their long history of safe and widespread use.

[redacted] submits that the proposal to limit the exemption for non-therapeutic human preparations (e.g. cosmetics) to preparations containing 0.2% or less of triclosan is particularly conservative.

The NICNAS PEC report's initial recommended for re-consideration of triclosan scheduling with a cutoff of 0.3% in cosmetic preparations when used as a preservative. However, there appeared to be no basis for the suggested 0.3% cutoff from either human or animal data contained in the report. Furthermore the human health risk characterization indicates low risk for chronic effects.

[redacted]

The concentration at which triclosan is used in various imported cosmetic and personal care products is given as 0.00125% to 0.87%, and it is likely that similar concentrations are used in locally manufactured products. The report does not provide any evidence that there are safety issues with the current levels at which triclosan is used nor that there should be restrictions on the levels of triclosan currently used in products. Instead the PEC assessment has found that "the risk to the public of inhalation toxicity, skin, eye or respiratory irritation is low because of the low concentrations of triclosan in cosmetic and personal care products, and in textiles and plastic products. Under normal conditions of consumer use, the risk of adults and children being exposed to levels of triclosan that would lead to chronic health effects is low."

We therefore submit that the exemption limit from scheduling should be much higher than the suggested 0.2%. RB supports the proposal to exempt all other preparations (e.g. therapeutic use and non-human use) containing 1% or less of triclosan given their long history of safe and widespread use.

Should you require any additional information, please contact the undersigned.

Yours sincerely

[redacted]

[redacted]

[redacted]

1.4 Sodium lauryl sulfate - submission 1/1

29 October 2010

The Secretary
Scheduling Secretariat
GPO Box 9848 CANBERRA ACT 2601
e-mail: SMP@health.gov.au

Dear Sir/Madam,

ACMS/ACCS Joint Meeting Notice: Item 2.3 Sodium lauryl sulfate

XXXXX appreciates the opportunity to provide comment in relation to the proposal before the new committee and the delegate, to include SLS in Appendix E with appropriate labelling statements for preparations containing more than 5% SLS.

Should the committee decide to proceed with the labelling requirements for products exempt from Schedule 6 containing more than 5% SLS, XXXXX request that an appropriate transition period taking into account the NDPSC's recognition that the substance has had a long safe history of use. We would suggest that a suitable transition period be considered, one that allows XXXXX to make a soft change over and allows for run out of current stock and current printed packaging materials. This would minimise the burden on industry given no safety signal occurred to warrant the requirement.

Yours sincerely

XXXXX

1.5 Multiple matters - Submission 1/2

29 October 2010

The Secretary
Scheduling Secretariat
GPO Box 9848
CANBERRA ACT 2601

Email: SMP@health.gov.au

Dear Sir/Madam

Public Comment Submission to Inaugural Joint Meeting of the Advisory Committee on Medicines (ACMS) and Advisory Committee on Chemicals (ACCS)

We refer to the scheduling meeting notice published on 29 September 2010 inviting public submissions, with respect to certain substances, addressing a matter raised in s.52E of the *Therapeutic Goods Act 1989.*

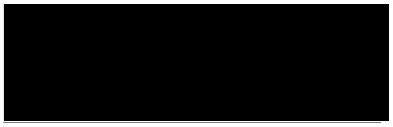
XXXXX

XXXXX wishes to provide information on **laureth carboxylic acid, sodium lauryl sulphate (SLS) and triclosan** for consideration at the joint meeting of the ACMS and ACCS. Please see attached submissions.

XXXXX is an interested party and stakeholder with regard to the nominated substance and would appreciate being advised of the Committee's considerations, with the opportunity for further submission, if appropriate.

We look forward to further advice from the ACMS and ACCS. Should the Committees require any additional information from XXXXX at this stage please do not hesitate to contact me on XXXXX .

Yours faithfully



XXXXX

National Drugs and Poisons Schedule Committee

Meeting: 22-23 June 2010

Agenda Item 2.2

Laureth Carboxylic Acid (LCA)

XXXXX understands that at the June 2010 meeting the National Drugs and Poisons Schedule Committee (NDPSC) made the decision to exempt from scheduling leave-on preparations containing 1.5 per cent or less of LCA and all other preparations including wash-off preparations containing 30 per cent or less of LCA based on the long history of safe use of the substance and also the similarity between LCA and sodium lauryl sulphate (SLS).

Given that there was an acknowledgement by the NDPSC at the June 2010 meeting that currently LCA is used safely without mandatory warning statements, other than where they are now scheduled, mandatory labelling should only be applied to scheduled products containing LCA at greater than 5%.

If ACMS and ACCS decide to apply mandatory labelling statements to un-scheduled products containing LCA, we urge ACMS and ACCS to allow enough time for industry to transition to the new labelling requirements.

National Drugs and Poisons Schedule Committee

Meeting: 22-23 June 2010

Agenda Item 2.3

Sodium lauryl sulphate (SLS)

XXXXX understands that at the June 2010 meeting the National Drugs and Poisons Schedule Committee (NDPSC) made the decision to exempt from scheduling based on the long history of safe use of the substance;

- wash-off preparations containing 30 per cent or less of SLS,
- leave-on preparations containing 1.5 per cent or less of SLS,
- toothpaste and oral hygiene preparations containing 5 per cent or less of SLS,
- other preparations for animal use containing 2 per cent or less of SLS, and
- other preparations containing 30 per cent or less of SLS.

Given that there was an acknowledgement by the NDPSC at the June 2010 meeting that currently SLS is used safely without mandatory first aid statements, other than where they are now scheduled, mandatory labelling should only be applied to scheduled products containing SLS at greater than 5%.

If ACMS and ACCS decide to apply mandatory labelling statements to un-scheduled products containing SLS, we urge ACMS and ACCS to allow enough time for industry to transition to the new labelling requirements.

National Drugs and Poisons Schedule Committee

Meeting: 22-23 June 2010

Agenda Item 3.3

Triclosan

XXXXX has a keen interest in the scheduling decisions for triclosan.

Triclosan is used in a number of cosmetic and personal care products such as hand soap, body soap, shower gel and toothpastes as a preservative. Triclosan is also used as an active ingredient in therapeutic products such as antibacterial soaps, toothpaste and anti-acne face wash.

In our submission to the June 2010 NDPSC meeting XXXXX noted that:

- NICNAS had put forward a recommendation in its Priority Existing Chemicals (PEC) Report completed in January 2010 to limit triclosan in cosmetics to maximum of 0.3% partly to promote international harmonisation,
- NICNAS flagged in an XXXXX before the end of the June 2010 NDPSC pre-meeting comment period that NICNAS will be putting forward a recommendation that differs from its own PEC Report (maximum level of 0.2% triclosan in cosmetics),
- Industry was not informed of any basis for NICNAS recommending setting the maximum concentration level of triclosan in cosmetics at 0.2%,
- XXXXX did not believe that the NICNAS PEC on triclosan contained clear scientific reasons for recommending scheduling of triclosan, however, as XXXXX have indicated that currently their products contain less than or equal to 0.3% of triclosan in their cosmetic formulations, we could tentatively support scheduling of triclosan for cosmetic use only, with exemption for products containing 0.3% or less of triclosan.
- The European Scientific Committee is currently progressing additional review of human safety of triclosan (expected finalization by first quarter of 2011) – currently the EU cut-off for triclosan use in cosmetics is 0.3%,
- US FDA is re-reviewing triclosan use in consumer products (expect finalization in 2011, http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm205999.htm)

Since making the pre-June 2010 NDPSC meeting submission, XXXXX has reviewed NICNAS submission to the NDPSC June 2010 meeting (which has been made available through the ACMS/ACCS Secretariat for the inaugural ACMS/ACCS joint meeting) and the *Tentative Report on Triclosan as used in Cosmetics* by Cosmetic Ingredient Review (CIR) published in September 2010 (http://www.cir-safety.org/).

The Cosmetic Ingredient Review (CIR) was established in 1976 by the industry trade association (then the Cosmetic, Toiletry, and Fragrance Association, now the Personal Care Products Council), with the support of the U.S. Food and Drug Administration and the Consumer Federation of America. Although funded by the Council, CIR and the review process are independent from the Council and the cosmetics industry. CIR operates under a set of procedures outline in its website (http://www.cir-safety.org/).

Having reviewed extra information available, XXXXX is still firmly of the view that there is no scientific basis for scheduling of triclosan.

NICNAS submission to the June NDPSC meeting argues that "at a concentration of 0.3% (of triclosan in cosmetic and personal care products), the MOE (margin of exposure) is as **low as 112**". This is where the calculation of MOE is "based on a realistic **worst case scenario** where exposure is assumed from multiple cosmetic and personal care products containing triclosan by all exposure routes".

That is, according to NICNAS' calculations, in a worst case scenario where multiple products containing 0.3% of triclosan are used concurrently, the MOE is still >100. It is our understanding that an MOE of 100 or greater are considered acceptable internationally to account for inter and intra species differences in toxicology.

The reason NICNAS puts forward for recommending 0.2% scheduling cut-off for triclosan in cosmetics is that "the **MOE for a combined exposure scenario** assuming use of multiple cosmetic and personal care products is estimated to be **187-168 and is considered representative of an acceptable risk**."

We cannot understand the scientific basis for NICNAS assertion that a MOE of 125-112 is considered "low" while a MOE of 187-168 is considered "acceptable".

Further, in calculating the MOE, NICNAS assumed that if a maximum allowable level of triclosan is set at 0.3%, then all products containing triclosan will be reformulated to the maximum level of triclosan. This is a naïve if not a spurious claim. Currently in Australia there is no limit on the concentration level of triclosan in cosmetics and there is a range of different concentrations of triclosan in cosmetics up to 0.3%. Product formulators will use the amount of chemical needed in a formulation, not the maximum concentration allowed.

XXXXX has been in communications with XXXXX, a major international manufacturer and supplier of triclosan. XXXXX has been manufacturing and supplying triclosan for close to XXXX years, and have performed and analysed numerous toxicological studies on triclosan over that time. XXXXX.

The toxicologists at XXXXX are of the view that the NICNAS MOE calculations are more conservative than they should be. Firstly, the NOAEL value used in the calculation is for rats (from chronic studies) rather for hamsters (40 mg/kg bw/d vs 75 mg/kg bw/d). Although the NOAEL values are of the same order of magnitude, the hamster is considered to be the most relevant species for human risk assessment for several reasons that are highlighted by XXXXX in its submission. More importantly, XXXXX also indicates that while the NOAEL value for hamsters was 75 mg/kg bw/d (based on decreased body weight gain), the benchmark-dose based on renal nephropathy was calculated to be 150 mg/kg bw/d (LOAEL value of 250 mg/kg bw/d).

Using this consideration, XXXXX calculated that daily use of all cosmetic products containing triclosan would yield MOE of 630.

The CIR Tentative Report on Triclosan as used in Cosmetics includes information on the frequency of use and use concentrations of triclosan in cosmetics available in the US market (Table 5 of the CIR Tentative Report). The table summarises not only the maximum concentration of triclosan in different types of products, but how many products available on the US market contain triclosan. The table below summarises product types and the number of triclosan containing products on the market (please refer to the original table for full information including percentage of triclosan in each product type and foot notes on the figures derived).

Product Category (Column 1)	Total number of products i n each product category (Column 2)	Number of products containing triclosan in each product category (Column 3)	Percentage of triclosan containing products available on the market (column 3 / column 2) x 100
Baby products	336	4	1.2%
Bath products	721	1	0.1%
Eye makeup	3359	28	0.8%
Fragrance products	2842	42	1.5%
Non-colouring hair care products	5248 3		0.1%
Hair colouring products	2839 None	reported	-
Make up	4345	10	0.2%
Nail care	617	1	0.2%
Oral hyg iene products	219 None	reported	-
Personal hygiene products	3070 226		7.4%
Shaving products	661	11	1.7%
Skin care products	9731	162	1.7%
Suntan products	409	3	0.7%

Given the small market share of triclosan containing products shown in the above ta ble, the worst case scenar io where an individual uses all per sonal care products co ntaining triclosan daily is highly unlikely.

While we note that the above market share percentages of triclosan containing products ar e based on cosmetics available on the US market, we ha ve no basis to believe that the Australian market will be signifi cantly different. However, if the Committees beli eve that there is value in reviewing Australian sp ecific information XXXXX can organize a survey of XXXXX for future consideration by ACMS and ACCS.

This information coupled with the co nsideration of high MOE value, the risk posed by triclosan in current use is extremely low.

The CIR Tentative Report on Triclosan as used in Cosmetics draws the following conclusion:

> *"The CIR Expert Panel concluded th at triclosan is safe for use in co smetics in the pre sent practices of use and concentration."*

The last paragraph of the summary also states:

> *"Overall, the CIR Expert Panel found that the available safety data across a wide variety of studies addressing purity, stability, general toxicity, carcinogenesis, en docrine disr uption, and antimicrobial resistance, support a conclusion that* ***triclosan may be used safely in a wide variety of products in the present practices of use and co ncentration, even were all product types to contain triclosan were use d concurre ntly, on a dail y basis****."*

XXXXX is strongly supportive of the conclusion drawn by the CIR Expert Panel.

It is also int eresting to n ote that the CIR Tentative Report q uestions the scientific va lidity of some of the toxicological end point derived by NICNAS in its PEC Report:

"NICNAS reported a developmental and maternal toxicity NOAEL of 50 mg/kg/day for no specific species, but the basis for that NOAEL was unclear."

"NICNAS considered triclosan at most a very weak sensitizer in guinea pigs, although a review of the studies considered in the NICNAS report each concluded that there was no sensitization."

CONCLUSION

XXXXX requests that the ACMS and ACCS consider maintaining status quo for triclosan (i.e. unscheduled).

While XXXXX can tentatively support scheduling of triclosan only for cosmetic products with the exemption for products containing 0.3% or less of triclosan for purposes of international harmonisation, we do not believe that there is scientific basis for such consideration.

Also, NICNAS PEC did not review triclosan in therapeutic goods. The PEC was confined to industrial, domestic and cosmetic uses.

Considering that NICNAS has not conducted studies into risks and benefits of triclosan used in therapeutic settings, we do not believe that therapeutic goods containing triclosan should be scheduled. Given that all therapeutic goods are subject to rigorous consideration by the Therapeutic Goods Administration (TGA), we do not believe that there should be a blanket scheduling requirement without consideration of the risks and benefits of triclosan in therapeutic uses.

If this is unacceptable to the Committees, then as the European and the US FDA reviews of triclosan are pending, we request that the ACMS and ACCS defer its decision making on scheduling of triclosan until the European Union and the US FDA review of triclosan are finalised in 2011.

1.5 Multiple matters - submission 2/2.

The Secretary
Scheduling Secretariat
GPO Box 9848 CANBERRA ACT 2601
e-mail: SMP@health.gov.au
Facsimile: 02 6289 2500

26 October 2010

Dear Sir,

Re: Submissions on items 2.2 Laureth Carboxylic acid and 2.4 Triclosan of the proposed scheduling proposals for the ACMS/ACCS meeting under section 52E of the Therapeutic Goods Act 1989

XXXXX
submits the following:

Proposal 2.2

"2.2 Laureth carboxylic acids (LCA) - proposal to include LCA in Appendix E with appropriate labelling statements. Specifically, it is proposed that for preparations containing more than 5 per cent LCA:

- standard statement E1 "if in eyes wash out immediately with water" apply; and
- standard statement S1 "if skin or hair contact occurs, remove contaminated clothing and flush skin and hair with running water" apply to preparations which are not leave-on or wash-off.

The Delegate additionally proposes labelling requirements for products to qualify for the current exemptions from the Schedule 6 LCA entry. Specifically, it is proposed:

- wash-off preparations, greater than 5 per cent up to 30 per cent or less are to be exempt only when labelled with "if in eyes wash out immediately with water";
- leave-on (1.5 per cent or less), no additional labelling required; and
- all other preparations, greater than 5 per cent up to 30 per cent or less are to be exempt only when labelled with "if in eyes wash out immediately with water" and "if skin or hair contact occurs, remove contaminated clothing and flush skin and hair with running water".

XXXXX understands that this proposal excludes salts and derivatives of LCA and requests the right to comment if in discussion the proposal changes in any way or differs from our understanding.

Proposal 2.4

"2.4 Triclosan - proposal to include in Schedule 6 with an exemption for:

a. non-therapeutic human use (e.g. cosmetic use) containing 0.2 per cent or less; and
b. all other preparations (e.g. therapeutic use and non-human use) containing 1 per cent or less of triclosan."

(a) Non-therapeutic human use (e.g. cosmetic use) containing 0.2 per cent or less

Triclosan is used most commonly in cosmetic formulations as a cosmetic biocide, deodorant agent, or preservative at concentrations ranging from 0.01 to 0.3% and has a long history of use. XXXXX is opposed to this proposal for the following reasons:

1. XXXXX submits that the proposal is not consistent with the definition of a Schedule 6 poison and is not justifiable based on the evidence put forward on human safety for triclosan as described in the Record of Reasons of the 59th meeting of the NDPSC 22-23 June 2010.

The proposal is not consistent with the definition of a Schedule 6 Poison

The definition of a Schedule 6 Poison [SUSDP] is as follows: **"**Substances with a moderate potential for causing harm, the extent of which can be reduced through the use of distinctive packaging with strong warnings and safety directions on the label."

Reviews of the available data do NOT conclude that triclosan in its current use in cosmetics has a moderate potential for harm. The latest US FDA CIR report 13 September 2010-10-20 that incorporates all reputable reviews to date concluded: *"The available data relevant to the safety of the chlorinated aromatic compound, triclosan, were reviewed by the Cosmetic Ingredient Review Expert Panel. A wide variety of studies addressing purity, stability, general toxicity, carcinogenesis, endocrine disruption, and antimicrobial resistance, support a conclusion that triclosan may be used safely in a wide variety of products in the present practices of use and concentration, even*

were all products types to contain triclosan and used concurrently, on a daily basis." This recommendation was primarily in relation to cosmetic and personal care products with concentrations of triclosan up to 0.3%.

Evidence described in the Record of Reasons is not supportive of the proposal

The calculations of Margin of Exposure (MOE) presented by NICNAS (as described in the record of reasons) do not support the conclusion that health effects may be likely at triclosan exposures of 0.3%. The established cut-off for "low risk" is 100. MOE's greater than 100 are considered low risk regardless of how much greater than 100 the MOE is. The calculated MOE provided by NICNAS was 112. Thus the MOE data supports the contention that a cut-off of 0.3% is appropriate for cosmetics and personal care products, more especially as the calculations were based on a worst case scenario providing a margin of safety in the conclusion. This is also supported by the statement in the NICNAS report that "The lowest MOE seen was 179 in males following the repeated use of a single hand wash product containing 1 per cent triclosan." , i.e. > 3 times the previously proposed limit of 0.3%.

2. ***Acceptance of proposal (a) above will result in the mandatory addition to labels of cosmetic products containing > 0.2% triclosan the following statements:***

   POISON (on first line of main label)
   KEEP OUT OF REACH OF CHILDREN (second line of main label)
   Approved name of poison
   Quantity/strength of poison
   Possible SAFETY DIRECTIONS (Appendix F)
   Possible Warnings (appendix F)
   Possible FIRST AID instructions (appendix E)

In addition the labels will require the name and address of the manufacturer or distributor (as for all scheduled products). This is not currently mandatory for cosmetic product imported fully finished.

These changes will result in Australian unique requirements that are detrimental to Australian business without a clear public benefit. Implementation of such labelling to currently existing cosmetic products with triclosan concentrations of >2% will cause unnecessary alarm to consumers regarding their previous and future use (products with same ingredients but with heading "POISON" on the label). This heading requirement of "POISON" is clearly inappropriate for cosmetic products.

XXXXX with a triclosan
concentration of XXXXX intended to be used to XXXXX. The impact
of adding the labelling requirements of Schedule 6 to these products will:

- deter purchase of these products
- force unnecessary reformulation work in order to meet the reduced cut-off without any clear safety benefit to the consumer.
- discontinuation of products
- increase the cost of supplying these products in Australia

XXXXX believes that the previous proposed limit of 0.3% is more consistent with other major markets and should be adopted in the interests of international harmonisation.

Should the proposed limit of 0.2% be accepted consideration should be given to a reasonable transition period that would allow for product reformulation development and production, and the minimisation of write-off costs of existing labelling and packaging.

(b) All other preparations (e.g. therapeutic use and non-human use) containing 1 per cent or less of triclosan.

Similar to above it would appear that the evidence provided by NICNAS "The lowest MOE seen was 179 in males following the repeated use of a single hand wash product containing 1 per cent triclosan." may not support the proposed cut-off and perhaps a higher cut-off should be considered. As XXXXX proposal as stated we have no further
comment, however should the proposal change we request the opportunity to comment further.

Yours Faithfully

XXXXX

xxxxx

22 October 2010

The Secretary
Scheduling Secretariat
GPO Box 9848
CANBERRA ACT 2601
Email: SMP@health.gov.au
Facsimile: 02 6289 2500

XXXXX submission on ACMS and joint ACMS / ACCS meetings
Due 29 October 2010

XXXXX appreciates the opportunity to comment on the scheduling changes proposed for Cough and Cold Medicines.

XXXXX proposes 2 minor changes to the recommendation for 1.1 Cough & Cold Medicines.

Grouping of ages of children

In the cited section, the Advisory Committee on Medicine Scheduling (ACMS) specifies the ~~age ranges affected by the p~~roposal.

> *1.1 Cough and Cold Medicines – proposal to reschedule 19 substances used in over–the-counter and cold medicines to:*
>
> - *Schedule 4 for use in children less than 2 years of age.*
> - *Schedule 3 for use in children aged from 2 to 6 years of age.*
> - *Schedule 2 for use in children and adults above 6 years of age.*

XXXXX accepts revision of the expression in turn affecting cough and cold preparations for children. However, XXXXX propose that these actions should be aligned with the regulatory actions in similar jurisdictions, such as the UK and New Zealand.

The ACMS proposes slightly different grouping of ages for children. In particular, the cut-off at the age of 6 years differs slightly from the other countries.

The changes in scheduling and labelling in New Zealand are specified for children from 2 years and under 6 years, and also from 6 years and above. In the UK the changes for labels and leaflets are for 6 to 12 years, again 6 years and above.

However, the ACMS proposes age groups from 2 years to 6 years, and then from above 6 years, that is from 7 years and above. Children at 6 years are grouped differently in Australia.

XXXXX propose that the grouping should be:

- Schedule 4 for use in children less than 2 years of age.
- Schedule 3 for use in children aged from 2 to under 6 years of age.
- Schedule 2 for use in adults and children 6 years of age and above.

Oxymetazoline administration

In the cited section, the Advisory Committee on Medicine Scheduling (ACMS) specifies the dosage forms affected by the proposal.

> *1.1 Cough and Cold Medicines – proposal to reschedule 19 substances used in over–the-counter and cold medicines to:*
>
> - *Oxymetazoline (excluding for nasal spray use)*

"for nasal spray use" specifies the dose form and excludes nasal drops.

XXXXX propose that the route of administration "for nasal use" be used.

Confidentiality

I request that my specific details for direct contact by the TGA given underneath be kept confidential to the TGA.

XXXXX
.

Yours sincerely

XXXXX

29 October 2010

The Secretary
Scheduling Secretariat
GPO Box 9848
CANBERRA ACT 2601

Email: SMP@health.gov.au

Invitation for public comment – ACMS and joint ACMS/ACCS meetings (date to be advised)
1.1 Cough and cold medicines:

Brompheniramine
Carbetapentane
Chlorpheniramine
Codeine
Dexchlorpheniramine
Dextromethorphan
Dihydrocodeine
Diphenhydramine
Doxylamine
Ipecacuanha
Oxymetazoline (excluding for nasal spray use)
Pheniramine
Phenylephrine
Pholcodine
Promethazine
Pseudoephedrine
Senega
Triprolidine
Xylometazoline (excluding for nasal spray use)

XXXXX appreciates the opportunity to provide comment in relation to this issue. We wish to address relevant matters under section 52E of the Therapeutic Goods Act 1989 as these apply to the substances mentioned above: (a) risks and benefits; (b) purposes for use and extent of use; (c) toxicity; (d) labelling; (e) potential for abuse.

1. OVERVIEW

1.1 The current scheduling of most cough and cold medicines as Schedule 2 medicines ensures that advice is available from the pharmacist, if necessary.

1.2 In November 2009 the TGA sought comment on proposed restrictions for cough and cold medicines for children following its consideration of a report (the External Report) by two TGA-appointed experts based on extensive published data and information provided by sponsors; data on suspected adverse drug reactions in Australia over a 28 year period, and the decisions taken by other regulatory agencies.

1.3 XXXXX accepts the proposal that the substances listed above be rescheduled to Schedule 4 for use in children less than 2 years of age

1.4 XXXXX accepts the proposal that the substances listed above be rescheduled to Schedule 3 for use in children aged from 2 to 6 years of age

1.5 XXXXX does not support the proposal that the substances listed above be rescheduled to Schedule 2 for use in children and adults above 6 years of age. XXXXX contends that this proposal is outside the scope of the review which prompted the proposal, is not justified on the basis of evidence available and will have unintended effects on the scheduling of products labelled for use in adults. XXXXX suggests that this proposal be revised so as to only apply to children aged from 6 to 12 years of age (as discussed below).

1.6 XXXXX contends that some of the proposed changes are excessive and not justified on the basis of the evidence available. XXXXX has made alternative suggestions, which we believe would introduce more appropriate measures for the benefit of Australian consumers and be consistent with the principle of minimum effective regulation.

2. INTRODUCTION

2.1 XXXXX appreciates the opportunity to respond to the TGA's
proposed changes to the availability, labelling, packaging and scheduling of registered OTC cough and cold medicines for use in children aged 2-12 years.

2.2 XXXXX acknowledges the TGA's extensive investigation and consideration of published data, information provided by sponsors, reports of adverse drug reactions over a 28 year period, and the decisions taken by other regulatory agencies.

2.3 XXXXX commits to working with the TGA and other stakeholders to assist in the development and delivery of appropriate educational messages about the use of cough and cold medicines in children to ensure the quality use of medicines.

2.4 XXXXX notes that cough and cold products have a long history of safe use in Australia in both adults and children. Many products on the market today have been available and used safely for more than 30 years

2.5 XXXXX agrees that the proposed restrictions on the use in children should be reviewed if and when robust efficacy data becomes available.

3. BACKGROUND

3.1 Regulatory authorities in the USA, Canada, the United Kingdom, New Zealand and Australia have reviewed the safety and efficacy of OTC cough and cold medicines for children under 2 years of age and concluded that these medicines should not be used for children in that age group. Regulatory and voluntary actions were taken and labelling changes were made to enforce these conclusions.

3.2 Subsequently, the focus of review has extended to the use of cough and cold medicines for the treatment of children aged 2-12 years.

3.3 The TGA is now proposing significant changes to the availability, labelling, packaging and scheduling of registered OTC cough and cold medicines for use in children.

3.4 The medicines reviewed and potentially affected by the regulatory actions being considered contain one or more of 19 substances in the categories Antihistamines, Antitussives, Expectorants/Mucolytics and Decongestants. As indicated in the Record of Reasons from the NDPSC meeting of June 2010, this rescheduling proposal affects approximately 645 cough and cold medicines registered in Australia.

3.5 As part of the review process in Australia, the TGA engaged two experts to conduct an external review of the available safety and efficacy data for registered OTC cough and cold medicines for children marketed in Australia, as published in the medical literature and supplemented with additional information provided by sponsors of cough and cold medicines. The resulting report (External Report) was considered by a TGA internal panel, together with additional safety data from TGA records, and by the Medicines Evaluation Committee (MEC).

3.6 According to the External Report, MIMS identifies over 130 products in the category expectorants, antitussives, mucolytics and decongestants which are available in Australia. Doses for children aged less than 12 years are supplied on the labels of more than 70 of these medicines, which are mostly scheduled as S2 (pharmacy medicines). After recent changes, all sedating antihistamines are now S4 drugs when used in children aged less than two years.

3.7 Problems in the US with the use of cough and cold medicines in children related to misuse, medication error, accidental overdose, accidental exposure and concurrent use of multiple products, rather than consequences from usage in accordance with the directions.

3.8 The External Report points out that the presentation and availability of cough and cold medicines overseas is very different from the situation in Australia. The US has a far greater range of products, with a greater range of “actives” and a greater range of combination products. In the US, cough and cold medicines are generally available without any requirement for “pharmacy only” sale or “pharmacist advice”, which is an intrinsic feature of Australian drug regulation and is widely considered to be a valuable feature.

3.9 As noted in the External Report, records of death with possible attribution to poisoning have been kept in the US for more than 50 years, long before the advent of child resistant-packaging both for liquid and solid forms of drugs. Information based on former decades is now being used to suggest excess mortality from cough and cold medicines, and this information may not altogether reflect the current situation in the US, and even less the situation in Australia.

4. SAFETY

4.1 Cough and cold products have a very long history of safe use in Australia in both adults and children. Many products on the market today have been available and used safely for more than 30 years. Mild, reversible side effects of cough and cold medicines are well known and well described.

4.2 The External Report considered data about poisonings in Australia and stated that "death or serious injury from children's cough and cold medicines is vanishingly rare". It noted that, although there are substantial numbers of calls to Poisons Centres in regard to these medicines, very few are considered to be serious enough to refer for assessment and treatment.

4.3 The External Report stated that it was possible to make definite conclusions about the safety of cough and cold medicines in children as follows:

- *Generally, these medicines are very unlikely to be harmful in label dosages, and in non-intentional overdose in the typical 1-2 year old age group, serious poisoning is rarely seen.*

- *A recent study in the United States demonstrated that OTC cough and cold preparations were only present in toxicology screens in 5% of life-threatening poisonings in children.*

- *This may not apply to some drugs in adult doses in solid form, but this is not going to be influenced by any changes that might be made in the nature or availability of cough and cold medicines for children.*

- *Overseas reports of serious poisoning including deaths from cough and cold medicines are generally not reflected in current Australian experience. Documentation of such deaths is often confounded by co-existing severe illness, multiple drug administration, solid drug forms, the possibility of homicide and other factors.*

4.4 As stated in the Internal Report, the risk/benefit ratio of cough and cold preparations is difficult to ascertain. As stated in the External Report, it is impossible to make a general statement about the efficacy of the 21 cough and cold medicines for children which they reviewed, and death or serious injury from children's cough and cold medicines is vanishingly rare.

4.5 XXXXX notes that 12 of the 14 suspected ADRs reported to the TGA over a 28 year period which were considered to be serious (1 probable, 3 possible and 3 unclear) were in children under 6 years of age.

5. MISUSE/ABUSE

5.1 There is no evidence in the Australian market suggesting patterns of misuse, either intentional or accidental. Those products that could potentially be abused are only available in pharmacy which provides a level of restriction on availability, along with access to advice from a health care professional. Given the absence of any evidence of abuse or misuse, it is unlikely that the proposed restrictions will have any impact on the potential for misuse.

6. POTENTIAL HAZARDS

6.1 XXXXX .

6.2 Over a period of 28 years (1981-2009) the TGA has received 99 reports of suspected adverse drug reactions (ADRs) in children under the age of 12 associated with cough and cold medicines. Fourteen ADRs were classified as serious (1 probable causality, 10 possible, 3 unclear). Twelve of the serious ADRs occurred in children under 6 years. In addition, two reports of accidental overdose and two reports of intentional overdose were received.

7. RISKS AND BENEFITS

7.1 OTC cough and cold medicines, in common with many other existing therapeutic products, were "grandfathered" when the new national regulatory system was introduced in Australia in 1991, on the basis that they met the criteria in place prior to the introduction of the new requirements. Products have only been required to retrospectively meet new requirements if there have been justifiable grounds to do so. In general, there is currently insufficient evidence for or against the effectiveness of cough and cold medicines which meets modern standards for clinical trials.

7.2 The TGA did not provide a breakdown of the pattern of the ADRs by year, and so it was not possible to determine if ADRs have decreased (or increased) in recent years.

7.3 Despite data over a 28 year period revealing only 1 ADR with a probable causal relationship with the use of cough and cold medicines in Australia, in a child under 12 years of age, and another 10 possibly-related ADRs, the TGA in its recent consultation paper referred to "the historical profile of ADRs in Australia and overseas" in making its recommendations and determining that the risks relating to the use of cough and cold medicines in children outweigh the benefits. In XXXXX view the conclusions reached by the TGA have not been justified.

7.4 Studies of 8 cough and cold substances representing about 95% of the cough and cold paediatric market are being undertaken in the US to generate data on safety and efficacy in children, and are expected to be completed in 2011. XXXXX considers that the information derived from the studies should be considered in Australia when they become available before any further restrictions are imposed.

8. TGA REVIEW OF OTC COUGH AND COLD MEDICINES FOR CHILDREN AGED 2-12 YEARS

8.1 An external review of published and confidential safety and efficacy data was carried out for the TGA by independent, medical experts. The resulting report *Review of cough and cold medicines in children* (the "External Report") together with other information was considered by a TGA internal panel and by the TGA's Medicines Evaluation Committee. Their deliberations were summarised in the *TGA Internal Panel Report on a Review of the Safety and Efficacy of Cough and Cold Medicines in the Treatment of Children aged 2-12 Years* (the "Internal Report"), *Minutes of the TGA Internal Panel's Discussions* and *Extract from Minutes of Medicines Evaluation Committee Meeting 30 July 2009*.

8.2 At the outset it is important to note that terms of reference for the External Report were as follows:

> *"… to review the safety and efficacy of cough and cold medicines currently available in Australia for children aged less than 12 years, using journal articles, documents and other data supplied by the TGA and by sponsors."* [Emphasis added]

8.3 It is also important to note that both the External Report and the Internal Report only reviewed and discussed evidence with respect to children aged between 2 and 12 years of age.

8.4 According to the External Report, the external reviewers and the TGA decided to use a broad search strategy in reviewing the literature, because of the overlap of the use of drugs for coughs and colds and other conditions, in order to obviate as far as possible missing important references. All abstracts provided by the TGA and all references from Cochrane reviews were read and relevant articles were reviewed in full text. Additional articles were read and referenced as appropriate in the final review to clarify efficacy and toxicity of the drugs. A summary for each drug and/or drug class was included in the External Report.

8.5 The external reviewers interpreted safety to include adverse effects of the medicines, either single drugs or a combination of drugs, of any severity i.e. from minor, to death, in recommended dosages, but including also in non-intentional overdose where this is common. They interpreted efficacy to relate to effectiveness of relief of cough and other symptoms of the common cold, in accord with the label claims of cough and cold medicines sold for use in children.

8.6 The TGA internal panel report (Internal Report) summarised the key findings of the External Report as follows:

> *(i) There is currently a strong demand for OTC cough and cold medicines for the treatment of children and that demand has been regarded as evidence of their effectiveness.*
>
> *(ii) The available clinical data does not support the efficacy of these medicines in children.*
>
> *(iii) The use of these medicines in children has been the cause of significant adverse reactions, including death.*

8.7 In our view, this summary did not adequately reflect the observations and conclusions reached by the external reviewers in the External Report.

8.8 In particular, in relation to safety, the external reviewers considered data about poisonings in Australia and stated that "death or serious injury from children's cough and cold medicines is vanishingly rare". They noted that, although there are substantial numbers of calls to Poisons Centres in regard to these drugs, very few are considered to be serious enough to refer for assessment and treatment.

8.9 The External Report stated that it was possible to make definite conclusions about the safety of cough and cold medicines in children as follows:

> *- Generally, these medicines are very unlikely to be harmful in label dosages, and in non-intentional overdose in the typical 1-2 year old age group, serious poisoning is rarely seen.*
>
> *- A recent study in the United States demonstrated that OTC cough and cold preparations were only present in toxicology screens in 5% of life-threatening poisonings in children.*
>
> *- This may not apply to some drugs in adult doses in solid form, but this is not going to be influenced by any changes that might be made in the nature or availability of cough and cold medicines for children.*
>
> *- Overseas reports of serious poisoning including deaths from cough and cold medicines are generally not reflected in current Australian experience. Documentation of such deaths is often confounded by co-existing severe illness, multiple drug administration, solid drug forms, the possibility of homicide and other factors.*

8.10 In relation to efficacy, the External Report concluded that it is impossible to make a general statement on the efficacy of cough and cold medicines for children. The external reviewers observed that there are relatively few high quality studies of efficacy of these medicines that include children, and extrapolation from adult studies is of limited value. They then endeavoured to "discuss probabilities and to inform decision-making, in regard to at least some of the commoner drugs and combination products".

8.11 As noted in the External Report, there has been ample time for post-marketing surveillance, and the adverse effects of drugs used in cough and cold medicines are generally well known, both in normal use and over-dosage.

8.12 Mild, reversible side effects of cough and cold medicines are well known and well described in standard references such as Martindale, as might be expected for drugs which have been in use for decades.

8.13 In addition to the External Report, the TGA has prepared an analysis of reports of suspected adverse drug reactions (ADRs) to cough and cold medicines used for the treatment of children in Australia.

8.14 XXXXX

8.15 Over a period of 28 years (1981-2009) the TGA has received 99 reports of suspected ADRs in children under the age of 12 associated with cough and cold. 14 ADRs were classified as serious (1 probable causality, 10 possible, 3 unclear). 12 of the serious ADRs occurred in children under 6 years.

8.16 In addition, two reports of accidental overdose and two reports of intentional overdose were also received.

8.17 The TGA has not provided a breakdown of the pattern of reports by year.

8.18 Despite these data revealing only 1 ADR with a probable causal relationship with the use of cough and cold medicines in Australia, in a child under 12 years of age over a 28 year period, and another 10 possibly-related ADRs, the TGA refers to "the historical profile of ADRs in Australia and overseas" in making its recommendations and determining that the risks relating to the use of cough and cold medicines in children outweigh the benefits.

8.19 In XXXXX view the conclusions reached by the TGA have not been justified.

8.20 The External Report further states:

> *"Both internationally and within Australia, there is a strong emerging viewpoint that drugs should not be used in children without study of efficacy, safety and pharmacokinetics done specifically in children of the age-groups likely to receive those drugs. Applied broadly, this would deprive children of many useful drugs currently used for children, as well as new drugs as they become available. In the current context, the lack of studies done in children is a constantly-recurring feature."*

8.21 The external reviewers considered three Cochrane reviews that are relevant to the current deliberations. Two of these are currently described on the Cochrane website as being "withdrawn" (28 October 2010). The most recent Cochrane review - Smith SM, Schroeder K, Fahey T. Over-the-counter medications for acute cough in children and adults in ambulatory settings. Cochrane.Database.Syst.Rev. 2008; CD001831 – is readily available and contains several very pertinent observations. This Cochrane review considered randomised controlled trials comparing oral OTC cough preparations with placebo in children and adults suffering from acute cough in ambulatory settings, and noted all cough outcomes and adverse effects. The results in children were summarised as follows:

> *"Antitussives (two studies), antihistamines (two studies), antihistamine decongestants (two studies) and antitussive/bronchodilator combinations (one study) were no more effective than placebo. No studies using expectorants met our inclusion criteria. The results of one trial favoured active treatment with mucolytics over placebo. One trial tested two paediatric cough syrups and both preparations showed a 'satisfactory response' in 46% and 56% of children compared to 21% of children in the placebo group."*

8.22 The Cochrane reviewers concluded:

> *"There is no good evidence for or against the effectiveness of OTC medicines in acute cough. The results of this review have to be interpreted with caution due to differences in study characteristics and quality. Studies often showed conflicting results with uncertainty regarding clinical relevance. Higher quality evidence is needed to determine the effectiveness of self-care treatments for acute cough."* [Emphasis added]

8.23 Thus, the Cochrane reviewers did not conclude that cough and cold medicines were ineffective. They concluded that there is insufficient evidence for or against their effectiveness which meets the standards and criteria applied by the Cochrane review.

8.24 Similarly, in the External Report, the external reviewers note that:

> *"There is an undoubted strong demand for cough and cold medicines for children, interpreted by some as evidence of efficacy. The reviewers do not agree with this interpretation, but there is no evidence to refute or support the idea."* [Emphasis added].

8.25 This, we feel, is the nub of the problem facing sponsors of cough and cold medicines in Australia, as well as the TGA. OTC cough and cold medicines, in common with many other existing therapeutic products, were "grandfathered" when the new national regulatory system was introduced in Australia in 1991, on the basis that they met the criteria in place prior to the introduction of the new requirements. Products have only been required to retrospectively meet new requirements if there have been justifiable grounds to do so.

8.26 In XXXXX view, the TGA has not produced clear evidence that there is a significant problem in Australia caused by the use of cough and cold medicines in children which provides sufficient grounds to justify the proposed new requirements.

9. PROPOSED SCHEDULE 2 ENTRIES AND ADULTS

9.1 The TGA proposal in relation to Schedule 2 is:

> *"Schedule 2 for use in children and adults above 6 years of age"*

9.2 XXXXX suggests that this should be revised to:

> *"Schedule 2 for use in children aged from 6 to 12 years of age"*

9.3 This revision would keep the proposal within the scope of the review which prompted the proposal and would be more consistent with the available evidence.

9.4 As indicated above the discussion to date surrounding the scheduling of the 19 cough and cold substances has been entirely focussed on their use in children between the ages of 2 and 12 years.

9.5 The External Report and the Internal Report only reviewed and discussed evidence in relation to children between the ages of 2 and 12 years.

9.7 The External Report demonstrates that the risks to children decrease with increasing age and recognition of this trend is implicit in the proposed scheduling arrangements.

9.6 The examination of this topic (by the TGA and the NDPSC) has therefore involved a balance between the different risks for the different age groups and the sufficiency of efficacy evidence.

9.7 This balance was acknowledged in the Record of Reasons from the NDPSC meeting of June 2010, where it was noted that:

> *"While a number of Members contended that there appeared to be insufficient data for considering tighter access restrictions for these medicines, the Committee generally agreed that the regulator (and the Committee) could only make a decision based on the available evidence and that this evidence indicated that while the risk signal may not be strong, this was being balanced against no, or little, evidence of efficacy."* [Emphasis added]

9.8 XXXXX therefore contends that the proposal in relation to Schedule 2 must be restricted to children between the ages of 6 and 12 years so as to more correctly represent the data review as well as the assessment of the risks and benefits in the different age groups.

10. PROPOPSED SCHEDULE 2 ENTIRES AND PHENLYLEPHRINE

10.1 The TGA proposal in relation to Schedule 2 is:

> *"Schedule 2 for use in children and adults above 6 years of age"*

10.2 XXXXX suggest that this should be revised to:

> *"Schedule 2 for use in children aged from 6 to 12 years of age"*

10.3 This revision would prevent any unintended effects on existing products labelled for use in adults which are unscheduled.

10.4 By way of example we draw the Committee's attention to the scheduling of products containing paracetamol combined with phenylephrine and/or guaiphenesin (PPGC products). These products were considered by the NDPSC at its February 2010 meeting.

10.5 At the February meeting, the NDPSC agreed that such combinations ought to be unscheduled if (among other things) they were not labelled for the treatment of children under 12 years of age. This decision became effective in September 2010 and was made acknowledging the TGA's review of cough and cold products.

10.6 The Record of Reasons from the NDPSC meeting of February 2010 indicates that:

> *"Members then examined the potential benefits of allowing PPGC to be unscheduled, with an initial discussion about the efficacy of PPGC. A Member suggested that perhaps the Committee should be cautious, noting that the TGA was currently reviewing the evidence of efficacy for a number of OTC preparations for the short-term symptomatic relief of colds, chills and influenza including chesty coughs. Other Members noted that this was an ongoing review by the TGA and had yet to be finalised. The Committee generally agreed that, at this time, it had before it at least some evidence suggesting efficacy for PPGC, and that any further questions on efficacy for a particular product would be a matter for the regulator to consider."*

10.7 XXXXX understands that a number of products are available on the Australian market which contain paracetamol combined with phenylephrine and/or guaiphenesin and which are unscheduled because they are not labelled for the treatment of children under 12 years of age.

10.8 XXXXX therefore contends that the proposal in relation to Schedule 2 must be restricted to children between the ages of 6 and 12 years so as to preserve the scheduling of existing products and to appropriately recognise the decision of the February 2010 NDPSC which specifically looked at the combination in the context of the TGA's review of cough and cold products.

11. PUBLIC AWARENESS

11.1 XXXXX supports the quality use of medicines. It is XXXXX position that revised labelling, combined with the communication of clear, consistent messages to consumers and health care professionals, will ensure appropriate use. As has been stated in previous education campaigns, cough and cold medicines are intended for short-term use only and for symptomatic relief of self-limiting conditions.

11.2 XXXXX agrees that any changes would need to be widely promoted and explained to medical practitioners, pharmacists, parents and caregivers. In particular, XXXXX considers that it would be very important to emphasise the long history of safe use of cough and cold medicines in Australia, both in adults and in children and to avoid causing undue concern or alarm by citing data relating to overseas use in circumstances where presentation and availability have been very different from the practice in Australia.

11.3 XXXXX would be pleased to work with the TGA and other stakeholders to assist in the development and delivery of appropriate educational messages about the use of cough and cold medicines in children.

12. TIMING

12.1 XXXXX considers that the changes proposed must be implemented in a reasonable fashion, especially given that there is no evidence of patterns of misuse, either intentional or accidental, or serious injury to children in Australia caused by current use of cough and cold medicines.

12.2 XXXXX notes that the rescheduling proposals affect approximately 645 cough and cold medicines registered in Australia and that labelling changes to seasonal products such as these are especially complex.

12.3 XXXXX notes that timings for implementation were not covered in the Record of Reasons from the NDPSC meeting of June 2010 and suggests that the implementation of any labelling or scheduling changes be finalised in consultation with all stakeholders, having due regard to the number of affected products and the complexities involved.

13. CONCLUSION

13.1 The current scheduling of most cough and cold medicines as Schedule 2 medicines ensures that advice is available from the pharmacist, if necessary.

13.2 XXXXX accepts the proposal that the substances listed above be rescheduled to Schedule 4 for use in children less than 2 years of age

13.3 XXXXX accepts the proposal that the substances listed above be rescheduled to Schedule 3 for use in children aged from 2 to 6 years of age

13.4 XXXXX does not support the proposal that the substances listed above be rescheduled to Schedule 2 for use in children and adults above 6 years of age. XXXXX contends that this proposal is outside the scope of the review which prompted the proposal, is not justified on the basis of evidence available and will have unintended effects on the scheduling of products labelled for use in adults. XXXXX suggests that this proposal be revised so as to only apply to children aged from 6 to 12 years of age.

13.5 XXXXX contends that some of the proposed changes are excessive and not justified on the basis of the evidence available. XXXXX has made alternative suggestions, which we believe would introduce more appropriate measures for the benefit of Australian consumers and be consistent with the principle of minimum effective regulation.

XXXXX remains committed to working with the TGA to implement evidence-based measures to ensure the continued safe use of these products by Australian consumers.

XXXXX contends that it is important that the scheduling of OTC cough and cold medicines in Australia continues to be aligned with the requirements in New Zealand.

XXXXX would be happy to provide further information if required.

Yours faithfully,

XXXXX

XXXXX

The Secretary
Scheduling Secretariat
GPO Box 9848
CANBERRA ACT 2601

By **email to SMP@health.gov.au**

Dear Secretary

XXXXX provides the following comments on items for discussion at the upcoming meeting of the Advisory Committee on Medicines Scheduling (the Committee).

Cough and cold medicines (Item 1.1)

XXXXX accepts that the recommendations made by the National Drugs and Poisons Schedule Committee (NDPSC) at its final meeting in June probably represent the best compromise between accessibility and safety that can be achieved for the substances considered, and accordingly is willing to accept those recommendations.

XXXXX agrees that the supply of these medicines for the treatment of children aged 2 to 6 years should be accompanied by the advice of a pharmacist, and that when supplied for the treatment of older children and adults, pharmacist advice should at least be available to the purchaser.

XXXXX thanks the NDPSC for reconsidering its position in relation to ammonia, bromhexine and guaiphenesin, and oxymetazoline and xylometazoline when used in nasal sprays.

Yours Sincerely
XXXXX
15 October 2010

XXXXX

26th October 2010

Invitation for Public Comment under Regulation 42ZCZK of the Therapeutic Goods Regulations – Advisory Committee for Medicines Scheduling

Item 1.1 – Cough and Cold Medicines

XXXXX wish to provide comment on the proposed amendment to the SUSMP, to reschedule 19 substances used in OTC cough and cold medicines. (See Invitation for public comment, Item 1.1, issued 29 September 2010).

The proposed amendment is to reschedule the list of 19 substances as follows:

- Schedule 4 – for use in children less than 2 years
- Schedule 3 – for use in children aged 2 to 6 years
- Schedule 2 – for use in children and adults over 6 years.

XXXXX supports the proposal to reschedule the list of substances to Schedule 4 for use in children less than 2 years, and Schedule 3 for use in children aged 2 to 6 years.

XXXXX also supports the proposal to reschedule the list of actives to schedule 2 (only where it will not result in less restrictive scheduling) **except for phenylephrine**.

The proposal to reschedule the list of substances to Schedule 2 for use in children and adults over 6 years requires further consideration particularly with respect to phenylephrine. At present, phenylephrine is allowed to be unscheduled under the following circumstances:

- In oral preparations containing 50mg or less of phenylephrine per recommended daily dose in packs containing 250mg or less of phenylephrine

- In powders, capsules, tablets, sachets, granules, together with paracetamol and/or guaiphenesin, when enclosed in specified small pack sizes, compliant with the requirements of the Required Advisory Statements for Medicine Labelling and when not labelled for children under 12 years. This is allowed as an exception to the paracetamol schedule. This particular entry in the SUSMP was only recently considered and came into effect in September 2010.

Considering the way that the scheduling proposal to be considered by the Delegate is written, it is unclear whether phenylephrine will continue to allowed as an unscheduled

medicine under the above provisions. The proposal of *"Schedule 2 – for use in children **and adults** over 6 years"* is absolute and makes no mention of the current exclusions continuing to be allowed.

XXXXX therefore does not support the proposal for phenylephrine as currently written.

XXXXX are the sponsors of a number of products that contain phenylephrine. Some of these are allowable currently as unscheduled medicines. These are XXXXX, that contain phenylephrine as a single ingredient and XXXXX that contains phenylephrine combined with paracetamol.

We believe that phenylephrine, either as a single active ingredient or in combination with paracetamol and/or guaiphenesin, should continue to be available as an unscheduled medicine in limited pack sizes for adults and children over 12.

The consultation process that eventually led to the consideration of the 19 actives by the NDPSC (now ACMS) has been centred on the use and safety of these actives in children 2-12 years. In May 2009, the TGA published the internal panel report on the safety, efficacy and use of cough and cold medicines in the treatment of children aged 2-12 years[1]. In July 2009, the Medicines Evaluation Committee reviewed the use of cough and cold medicines in the treatment of children aged 2-12 years[2]. This was followed in October 2009 by the TGA's summary of actions taken by TGA and other regulatory agencies regarding cough and cold medicines in the treatment of children[3] and the TGA consultation document/review – "Labelling and packaging of cough and cold medicines – proposed changes to requirements – TGA review of OTC cough and cold medicines for children aged 2-12"[4]. This clearly shows that all of the review and analysis done by the TGA is within the framework of use in children aged 2-12 years.

We believe that rescheduling of phenylephrine to remove the existing use as an unscheduled medicine in adults and children over 12 is not justified. The NDPSC considered scheduling on the basis of evidence provided by the TGA as well as other submissions. The TGA's evidence did not support tightening the schedule of phenylephrine in children over 12 years and adults, and the safety of these products in adults and over 12s has not been questioned.

The consultation documents that were provided to stakeholders did not indicate that children over 12 years and adults would be considered as part of the NDPSC decision-making process.

We believe that the wording of the Schedule 2 phenylephrine schedule should remain as it is currently, with the addition of "when not labelled for use in children under 12 years" to the exclusion, i.e.

Pharmacy Medicine S2

PHENYLEPHRINE **except**:

a) When included in Schedule 3 and 4
b) In oral preparations containing 50mg or less of phenylephrine per recommended daily dose in packs containing 250mg or less of phenylephrine, *when not labelled for use in children under 12 years*
c) In topical eye or nasal preparations containing 1% or less phenylephrine.

The exclusion for unscheduled PE + paracetamol and/or guaiphenesin combinations as currently shown in the Schedule 2 entry for paracetamol should also be retained as currently written.

The decision on the scheduling of the PE + paracetamol and/or guaiphenesin combination was made very recently and came into effect in September 2010. The NDPSC were aware of the work being done by regulatory authorities in Australia and overseas on safety of cough and cold medicines in children aged 2-12. It can therefore be assumed that the NDPSC considered that the issue of safety of cough and cold medicines in children aged 2-12 years had no impact on the proposal to allow PE + paracetamol and/or guaiphenesin combinations to be unscheduled as of 1st September 2010. Removal of this provision to allow unscheduled PE + paracetamol and/or guaiphenesin products will be in direct contradiction to the decision made by the NDPSC earlier this year, at the same time as the review was being conducted.

Implementation of scheduling changes

The timings for implementation have not been covered in the Record of Reasons from the June 2010 meeting, nor was there discussion of any additional labelling warnings.

XXXXX a number of cough and cold products which could be affected by scheduling changes and would like to request that consideration be given to allow sponsors to run out existing product that has already been manufactured, as well as allow adequate time for implementation of any new labelling warnings. A time of 12-18 months should be considered. Any possible new labelling warnings should be considered separately as part of the RASML requirements and should allow for flexibility in wording as well as consultation with industry.

Advisory Committee on Medicines Scheduling (ACMS)

Comments on proposed amendments referred by the delegate for scheduling advice

1.1 Cough and cold medicines – proposal to reschedule 19 substances (see Attachment A) used in over-the-counter cough and cold medicines to:

- Schedule 4 for use in children less than 2 years of age.
- Schedule 3 for use in children aged from 2 to 6 years of age.
- Schedule 2 for use in children and adults above 6 years of age.

88888 ***position***

XXXXX supports the proposed schedule change for cough and cold medicines.

.

Contact person:
XXXXX

27 October 2010

XXXXX

Background

A large number of cough and cold medicines are available in Australia for adults and children over two years of age. Many of these products have been available for many years for indications that were accepted with much lower levels of evidence than now required. These products have not previously been required to demonstrate their efficacy for registration on the Australian Register of Therapeutic Goods (ARTG) due to their grandfathering onto the register.

Cough and cold products are available in a variety of formulations such as dispersible sachets, tablets or capsules, oral liquids (mixtures or syrups), topical nasal preparations (sprays or drops) or topical throat preparations (lozenges, gargles or sprays). Some products are registered solely for use in adults and children over 12 years of age, and some, such as paediatric topical nasal products, are registered for children of specific age groups. Other products, particularly cough and cold mixtures, are registered for use for adults and children over two years of age.

Australia has one of the most effective scheduling systems for medicines in the world, having two over-the-counter (OTC) schedules that either requires consultation with a pharmacist (Pharmacist Only Medicine/Schedule 3 or S3) or the opportunity to consult a pharmacist (Pharmacy Medicine/Schedule 2 or S2). The majority of cough and cold medicines for adults and children over two years of age are either S2 or S3, whilst all products for children under two years of age in Australia are Prescription Only Medicines (Schedule 4 or S4) requiring prescribing by a doctor. There are also a number of cough and cold medicines that are exempt from scheduling and available from general retail outlets without any opportunity for health professional intervention.

Currently, individual OTC products are not listed in separate medicine schedules according to the intended patient age but rather according to the presence and/or strength of particular active ingredients and/or pack size. Rather, products are licensed for use with particular age restrictions (e.g. indicated for adults and children over 12 years of age) and listed on the Australian Register of Therapeutic Goods (ARTG).

Cough and cold medicines may include a single active ingredient or multiple active ingredients. Typically, children's doses for cough and cold medicines are based on age with the majority of products having two dose increments: from 2 to 6 years of age and from 6 to 12 years of age.

Over the past couple of years, reviews have been conducted by the Therapeutic Goods Administration (TGA) with consideration of safety and efficacy of cough and cold medicines for children and what is the most appropriate schedule category for these products. At its meeting of June 2010, the National Drugs and Poisons Scheduling Committee (NDPSC) considered a proposal (Original Proposal) for cough and cold medicines to be:

- S4 for children under 6 years of age
- S3 for children of 6 to 11 years of age and
- S2 for children aged 11 to 12.

The NDPSC had also advised that it would concurrently consider the scheduling of cough and cold products for adults and children over 12.

Comments

XXXXX has previously responded to TGA reviews and the Original Proposal to change the scheduling of cough and cold medicines for children and adults that include ingredients from that listed in Attachment A.

Although there is significant demand for these products for all age groups, paediatric preparations are particularly popular because of parents' natural concern for their children and a desire to provide treatment when available. The conditions are usually self-limiting and not serious in nature and capable of self-management for adults, or management by a parent or guardian for children, particularly with access to health professional support such as from a community pharmacist.

Public Safety

Currently, the majority of cough and cold medicines for adults and children over 2 years of age are listed as Pharmacy Medicines (S2).XXXXX was opposed to the Original Proposal to reschedule cough and cold medicines for children aged 2 to 6 years to S4 as we have been concerned that rather than improving the safety profile of these medicines, such a move may increase the risk of misadventure in this vulnerable paediatric group.

Our concerns included:

- An increased risk that parents may provide misleading information about their child in order to obtain the medicine they want without having to see a doctor. Pharmacists would be unable to provide instructions without a prescription, leading to parents guessing doses for younger children and potentially resulting in childhood overdoses or adverse events.
- A risk that parents may resort to requesting inappropriate products as an alternative (e.g. promethazine syrup).
- A risk that parents may resort to herbal or homeopathic remedies with questionable efficacy and/or safety issues as the only readily available alternative. When these products are obtained from health food or general retail outlets, the opportunity for health professional intervention is removed. With the low level of consumer health literacy in Australia, relying solely on fact sheets or information on packaging is not a suitable alternative to health professional advice.

When products are listed as either S2 or S3, consumers have access to counselling and posology advice from a highly trained health professional. This is particularly important for the parents or carers of young children. Acknowledging that the risk is greater in children under 6 years of age, the decision for listing cough and cold medicines for children aged 2 to 6 years as S3 medicines is both practical and sensible, addressing the concerns expressed above.

Cost-effective Public Access

The Original Proposal to reschedule cough and cold medicines to S4 for children aged 2 to 6 years would have significantly affected public access. Not only would parents have had to have their child see a doctor, but there was the additional financial burden of doctor's fees and increased costs for S4 medicines.

The current proposed schedule change not only addresses public safety issues, but it does so in a manner that maintains and promotes responsible public access to these medicines, particularly for children aged 2 to 6 years. There is an additional benefit of not having the medical system clogged by patients with minor ailments that can be effectively and appropriately dealt with by pharmacists.

~~Pharmacy Practice~~

XXXXX had a number of concerns with the Original Proposal regarding the effect on community pharmacy, in particular:

- Confusion on the schedule status of the medicines affecting labelling, supply and storage requirements – having identical therapeutic agents in different schedules based on age is a largely unknown concept in Australia and the Original Proposal could have seen the same product as S2, S3 or S4 according to the indicated aged group.
- Capacity of community pharmacy to professionally manage the significant increase in S3 medicines. It is important that arrangements are in place to ensure pharmacists are supported and prepared for changes which may impact significantly on the pharmacy workflow. Recent amendments to the scheduling of combination analgesics containing codeine have had a significant impact on pharmacy workflow.

Although the current proposed schedule change will have some impact on labelling, supply and storage requirements as well as pharmacy capacity, it is much more manageable for both pharmacy and industry.

~~Medical Practice~~

XXXXX also had a number of concerns with the Original Proposal regarding the effect on medical practice, in particular the following matters relating to the listing of cough and cold medicines for children as Schedule 4:

- Doctors are much less familiar with cough and cold medicines than pharmacists. There is a greater risk of incorrect dosing, particularly if this information is not as readily available and doctors are not supported or sufficiently informed. Industry is more familiar with detailing pharmacists about cough and cold products and may not have the capacity to additionally detail doctors.

- The onus on doctors is to prescribe efficacious medicines – Medical Boards hold doctors accountable for what they prescribe and doctors would (and should) expect that registered medicines restricted to prescription only have supporting evidence for quality, safety and efficacy. The Original Proposal to restrict medicines with questionable efficacy to S4 was placing doctors in an insidious position.

- Parents presenting to their doctor with a child expect an outcome – usually a prescription. It is unlikely they will be content with advice for bed rest, fluids and honey and lemon. There will be significant pressure on doctors to provide a prescription – this may result in inappropriate prescribing of antibiotics or bronchodilators.
- In addition to this, the following impacts had to also be considered:

- The capacity of general practice to treat children under six in a timely manner – particularly in rural and remote areas.
- Potential delays in the treatment of children because of long waiting lists to see a doctor.
- The significant impost on the Medical Benefits Schedule (MBS) as parents of children under six will need to see a doctor.
- The increased need for parents to take carer's leave so that they can take their child to the doctor.
- Potential delays of treating patients with more serious health complaints and chronic conditions as waiting lists grow due to demand for treating minor cough and cold ailments in children.
- Delays and costs associated with additional pathology tests for URTIs.

The current proposal for cough and cold products for adults and children over two years of age to be listed as either S2 or S3 medicines addresses the above concerns whilst facilitating access to pharmacist intervention. Pharmacists are well placed and experienced in assessing cough and cold symptoms, referring patients that require or would benefit from medical intervention.

~~Efficacy~~

XXXXX agrees that product efficacy is imperative to justify supply within Australia and has been of the view that efficacy is a registration/licensing issue and not a scheduling issue.

There has been little effective evaluation done on the efficacy of cough and cold medicines and many of the trials have not been well designed or have been too small in nature to be of use. Although the general consensus is that the evidence to date is not sufficiently compelling to demonstrate the safety or efficacy of cough and cold medicines for any age group, **a lack of evidence does not equate to evidence of lack of efficacy.**

XXXXX is aware that pharmacokinetic studies are being conducted in the United States of America with completion expected in 2011[1,2]. The current proposed change is sensible in maintaining supply and access to cough and cold medicines whilst these medicines can continue to be assessed and evaluated.

Additional Matters

- In responding to the Original Proposal, XXXXX had concerns that such significant changes were being considered for such a wide range of substances that some mucolytic/expectorants such as ammonium chloride, bromhexine and guaiphenesin may have been unintentionally 'caught in the crossfire'. However, with the current proposal, we believe that it may be appropriate to also include these substances in the schedule change as it would reduce confusion within the pharmacy setting regarding the storage and supply requirements for different products, improve the safety aspect by facilitating access to health professional intervention and have little or no impact of public access. It would also be reasonable to expect this to be more manageable for industry.

- We note that the current proposed schedule change excludes oxymetazoline and xylometazoline for 'nasal spray use'. We support the intent of this exclusion,

having argued for this position in our response to the Original Consultation. However, for greater flexibility it would be more appropriate to list the exclusion in more general terms, such as 'for topical nasal use'. This would ensure that other topical preparations (e.g. nasal drops) containing these substances are also covered by the exclusion.

- We would also like to see cough and cold mixtures that are licensed for use for adults and children from two years of age but which are packaged and marketed as S2 products for adults and children over 6 years of age to include directions with the intent that 'use in children under six years of age should only be on the advice of a health professional.' This would prompt parents to seek accurate dosing advice from their pharmacist or doctor.

- Although not specifically scheduling matters, we would also like to see as part of the product registration/licensing requirements, that metric measures are mandated for inclusion in all oral liquid preparations, and that paediatric dose instructions are listed by weight.

Conclusion

The proposed schedule change for cough and cold medicines addresses safety concerns whilst maintaining responsible public access. XXXXX supports the proposal to list cough and cold medicines as:

- S4 for use in children less than 2 years of age.
- S3 for use in children aged from 2 to 6 years of age.
- S2 for adults and children above 6 years of age.

In addition to this change being applied to the substances listed in Attachment A, XXXXX suggests that it may also be appropriate to extend the list to include ammonium chloride, bromhexine and guaiphenesin.

We would also like to see appropriate labelling on medicine packaging to facilitate consultation with a health professional.

XXXXX is happy to work with industry and other stakeholders to ensure community pharmacy is prepared for this change and is adequately resourced and supported to ensure it can continue providing the professional service for which it is respected.

Reference Sources:

[1] Overview – Risk: Benefit of OTC Cough and Cold medicines in children; www.mhra.gov.uk
[2] Medsafe: Minutes of the 2nd Cough and Cold Review Group Meeting; 18 August 2009; www.medsafe.govt.nz

Attachment A:

List of cough and cold substances proposed for rescheduling by the Delegate (only where it will not result in less restrictive scheduling)

ANTIHISTAMINES:
Brompheniramine
Chlorpheniramine
Dexchlorpheniramine
Diphenhydramine
Doxylamine
Pheniramine
Promethazine
Triprolidine

ANTITUSSIVES:
Codeine
Carbetapentane
Dihydrocodeine
Dextromethorphan
Pholcodine

MUCOLYTICS/EXPECTORANTS:
Ipecacuanha
Senega

DECONGESTANTS:
Phenylephrine
Pseudoephedrine
Oxymetazoline (excluding for nasal spray use)
Xylometazoline (excluding for nasal spray use)

29 October 2010

The Secretary
National Drugs and Poisons Schedule Committee
GPO Box 9848
CANBERRA ACT 2601

Email: NDPSC@health.gov.au
Facsimile: 02-6289 2500

RE: ITEMS FOR DISCUSSION AT THE ACMS AND JOINT ACMS/ACCS MEETING

XXXXX appreciates the opportunity to make a submission regarding matters to be considered at the forthcoming joint meeting of the Advisory Committees on Medicines and Chemicals Scheduling, in accordance with Section 52E of the Therapeutic Goods Act.

Item 1.1 of the pre-meeting gazette notice states

Cough cold mdeicines – proposal to re-schedule 19 substances used in over the counter cough cold medicines to:

Schedule 4 for use in children less than 2 years of age.

Schedule 3 for use in children aged from 2 to 6 years of age.

Schedule 2 for use in children and adults above 6 years of age.

- That this rescheduling apply to brompheniramine, carbetapentane, chlorpheniramine, codeine, dexchlorpheniramine, dextromethorphan, dihydrocodeine, diphenhydramine, doxylamine, ipecacuanha, pheniramine, phenylephrine, pholcodine, promethazine, pseudoephedrine, senega and triprolidine.

- That the rescheduling should apply only where it will not result in less restrictive scheduling.
- That the rescheduling not apply to oxymetazoline and xylometazoline when for nasal spray use for treating cough and cold, but would apply for any other preparation for treating cough and cold.

- That use of ammonia, bromhexine, and guaiphenesin in preparations for treating cough and cold did not need to be rescheduled.

XXXXX agrees with the proposal that the use of certain substances in preparations for treating cough and cold be rescheduled to Schedule 4 for use in children less than 2 years of age and Schedule 3 for use in children aged from 2 to 6 years of age.

XXXXX does not agree with the proposed change to "Schedule 2 (S2) for use in children and adults above 6 years of age". RB requests that there should be an upper limit of 12 years of age set on the S2 schedule for the 22 substances when used in over-the-counter cough and cold medicines.

XXXXXsuggests that a more appropriate wording of the Schedule 2 would be ***" for use in children from 6 to 12 years of age".***

The reasons for requesting a change in the proposed S2 scheduling are as follows:

1) Schedule change for adults not warranted
The re-scheduling for adults is outside the scope of the "TGA internal panel report on the safety, efficicay and use of cough and cold medicines in the treatment of children 2-12 years, May 2009" (Internal Report). This report focused on the balance of safety and efficacy in children. It did not address the benefit/risk profile in adults. The re-scheduling should therefore only apply to the age group assessed in the TGA Internal Report, namely 6 to 12 years.

2) Schedule change is not in line with previous phenylephrine scheduling decisions
The proposed S2 scheduling is not in line with phenylephrine scheduling decisions made earlier in 2010. Any proposed S2 change should ensure that the schedule only applies for children up to 12 years of age, rather than the open-ended "above 6 years of age" as proposed.

3) Benefit/risk balance
The TGA Internal Report shows that many of the actives under consideration for scheduling changes have few if any ADR's.

The table below is taken from the Internal Report and shows all ADR's reported from 1981 to 2009 for children under 12 years.

Drug available in Australia	**No. ADR (Total)**	**No. ADR (Serious)**	**Comment**
ANTIHISTAMINES:			
Brompheniramine maleate	0	0	No ADR's
Chlorpheniramine maleate	1	1 (1)	
Dexchlorpheniramine maleate	13	3	
Diphenhydramine hydrochloride	(1)	0	1 combination ADR, None serious
Doxylamine succinate	0	0	No ADR's
Pheniramine maleate	0	1	

Promethazine hydrochloride	3 (5)	0	
Triprolidine hydrochloride	0	0	No ADR's
ANTITUSSIVES:			
Codeine phosphate	(1)	0	1 combination ADR, None serious
Dextromethorphan hydrobromide	10 (2)	2	
Dihydrocodeine tartrate	0 (1)	0	1 combination ADR, None serious
Pentoxyverine citrate	0	0	No ADR's
Pholcodine	15	1	
MUCOLYTICS/EXPECTORANTS:			
Ammonium chloride	0	0	No ADR's
Bromhexine hydrochloride	10 (2)	1	
Guaifenesin (guaiphenesin)	3	0	3 ADR's, None serious
Ipecacuanha	3	1	
Senega & ammonia (as bicarbonate)	0	0	No ADR's
DECONGESTANTS:			
Oxymetazoline hydrochloride	9	2	
Phenylephrine hydrochloride	(1)	(1)	ADR's only occurred in combination
Pseudoephedrine hydrochloride	18 (4)	2	
Xylometazoline hydrochloride	1	0	1 ADR, None serious
TOTAL	**86 (17)**	**13 (2)**	

Phenylephrine hydrochloride reports ADR's only in combination with other actives. From the above table it can be seen that in a 28 year period only 2 serious ADR's occurred in children 6-12 years. We ackowledge the TGA's concerns that there is a lack of robust efficacy data for some these actives, however the Australian evidence does not support that there is a risk from them. We contend that there is no clear evidence of a risk outweighing a benefit for the following actives:

- Brompheniramine maleate
- Doxylamine succinate
- Triprolidine hydrochloride
- Pentoxyverine citrate
- Ammonium chloride.
- Diphenhydramine hydrochloride
- Codeine phosphate
- Dihydrocodeine tartrate
- Guaifenesin.
- Senega & ammonia
- Xylometazoline hydrochloride

- Phenylephrine Hydrochloride

In summary, XXXXX agrees with the proposal that the use of certain substances in preparations for treating cough and cold be rescheduled to Schedule 4 for use in children less than 2 years of age and Schedule 3 for use in children aged from 2 to 6 years of age. However XXXXX opposes the proposed change to "Schedule 2 (S2) for use in children and adults above 6 years of age", and requests that there should be an upper limit of 12 years of age set on the S2 schedule over-the-counter cough and cold medicines.

The reasons for opposing the new proposed S2 scheduling are:
1) that the schedule change for adults is not warranted,
2) the schedule change is not in line with previous phenylephrine scheduling decisions, and
3) the benefit/risk balance of phenylephrine hydrochloride does not warrant more restrictive scheduling in those over 12 years of age.

Should you require any additional information, please contact the undersigned.

Yours sincerely

XXXXX

The Secretary
Scheduling Secretariat
GPO Box 9848
CANBERRA ACT 2601
e-mail: SMP@health.gov.au
Facsimile: 02-6289 2500

XXXXX

Re: Public submission under Regulation 42ZCZK of the Therapeutic Goods Regulations 1990

Proposed amendments referred by the delegate for scheduling advice.

Cough and cold medicines - proposal to reschedule 19 substances used in over-the-counter cough and cold medicines to:

- Schedule 4 for use in children less than 2 years of age.
- Schedule 3 for use in children aged from 2 to 6 years of age.
- Schedule 2 for use in children and adults above 6 years of age.

XXXXX wishes to address relevant matters under section 52E of the Therapeutic Goods Act 1989 (a) risks and benefits; (b) purposes for use and extent of use; (c) toxicity; (d) labelling; (e) potential for abuse.

XXXXX believes that the above
proposed amendments to the Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP) are not in line with the current National Medicines Policy regarding the Access of Medicines and does not adequately consider the risk benefit of all products.

The proposed amendment for the 19 substances to be Schedule 2 for use in children and adults above 6 years of age restricts the access of the substances to a retail pharmacy setting only, greatly reducing overall access for symptomatic relief of cough and colds and increasing the burden on pharmacies.
XXXXX agrees that in some cases the substances included do require healthcare practitioner intervention for children however a ‘catch all’ amendment as above reduces access for the adult population also. The risk benefit ratio for many of these products would not appear to warrant any scheduling change for adults.

The proposed Schedule 2 change for these ingredients also does not address the changing attitude of consumers that increasingly rely on the convenience of non–pharmacy retail when choosing symptomatic relief for self limiting conditions. These changes may cause switching in-store to the use of complementary medicines which have lower levels of evidence requirements and unknown safety profiles; this is not inline with the intent of the original review.

It is also noted that previous reviews by the Therapeutic Goods Administration did not address efficacy in adults and children 12 years and over. As such the risk benefit assessment for this age group is not represented adequately in the NDPSC review.

XXXXX would propose the following ingredient be exempted from the proposed amendment 'Schedule 2 for use in children and adults above 6 years of age' or that proposed amendment is changed to read 'Schedule 2 for use in children aged from 6 to 12 years of age' as originally proposed.

Pentoxyverine (Carbetapentaine) Citrate

XXXXX unscheduled Pentoxyverine
has a long history of use. Electronic records beginning January 2004 show XXXXX adverse events XXXXX

Table 1. – AE Classification – XXXXX Pentoxyverine XXXXX

The adverse events are all non-serious and predominantly relate to non-efficacy and demonstrate an excellent safety profile XXXXX.

From the data above the restriction of Pentoxyverine XXXXX to the Pharmacy only setting for the 6 years and above is not warranted. Any risk to children less than 6 years can more than adequately be addressed by an age restriction on labeling without impeding access to those above 6 years of age for which no safety risk has been demonstrated.

Lack of efficacy data has been brought into question for this ingredient however the historical use pattern and lack of any known serious safety risk to adults would indicate upscheduling to be unnecessary.

XXXXX would propose the following ingredient be exempted from the proposed amendment 'Schedule 2 for use in children and adults above 6 years of age.

or that proposed amendment is changed to read:

'Schedule 2 for use in children aged from 2 to 6 years of age except:

In topical eye or nasal preparations containing 1 percent or less of Phenylephrine'.

Phenylephrine Hydrochloride

XXXXX unscheduled Phenylephrine XXXXX has a long history of use. Electronic records from January 2004 show XXXXX adverse events XXXXX

Table 2. – AE Classification – XXXXX Phenylephrine XXXXX

This product is not indicated for use in children and does not require healthcare professional intervention prior to use for adults 12 years and over. The adverse event profile predominantly refers to non-efficacy and while this could be due to

rebound affect the product label does currently have a warning to avoid prolonged use. There is no indication from this data that the product in its current format poses a known safety risk to adults and its efficacy has not been evaluated in the TGA review which focused on children under 12 years of age. The products safety profile is further enhanced by little to no risk of overdose if inadvertently taken by children due to the small container size XXXXX applicator, and low level of active XXXXX.
Any rescheduling of this product would be unwarranted based on the evidence currently available.
XXXXX
are of the opinion that the proposed 'Schedule 2 for use in children and adults above 6 years of age' is excessive and unjustified from the available evidence and further believe that the proposal is not inline with the intent of the original review.

XXXXX appreciates the opportunity to provide a response to the NDPSC proposals and believes that the XXXXX recommendations above are in line with the National Medicines Policy on Access to Medicines and are of a balanced nature.

XXXXX are happy to provide more information should it be warranted.

Best Regards

XXXXX

XXXXX

Monday, October 25th 2010

The Secretary
Scheduling Secretariat
GPO Box 9848
CANBERRA
ACT 2601

e-mail: SMP@health.gov.au

Dear Sir/Madam

Re: Public comment relating to Item 1.1 Cough and cold medicines proposal to reschedule 19 substances used in over-the-counter cough and cold medicines to:

- **Schedule 4 for use in children less than 2 years of age.**
- **Schedule 3 for use in children aged from 2 to 6 years of age.**
- **Schedule 2 for use in children and adults above 6 years of age.**

for use in cough and cold products (only where it will not result in less restrictive scheduling) for:

- Brompheniramine
- Carbetapentane
- Chlorpheniramine
- Codeine
- Dexchlorpheniramine
- Dextromethorphan
- Dihydrocodeine
- Diphenhydramine
- Doxylamine
- Ipecacuanha
- Oxymetazoline (excluding for nasal spray use)
- Pheniramine
- Phenylephrine
- Pholcodine
- Promethazine
- Pseudoephedrine
- Senega
- Triprolidine
- Xylometazoline (excluding for nasal spray use)

XXXXX appreciates the opportunity to provide comment on item 1.1 in relation to the rescheduling of the 19 substances listed above.

For the 19 ingredients listed above, XXXX X supports the following NDPSCs scheduling recommendations

- **Schedule 4 for use in children less than 2 years of age.**
- **Schedule 3 for use in children aged from 2 to 6 years of age.**

In supporting these recommendations, XXXXX takes the position that a more restrictive scheduling of cough & cold products for children aged 2-6 is likely to result in an increase the level accidental overdose in this age group and inappropriate off-label use of these products. Having a pharmacist involved in the dispensing of these medicines for children within the specified age groups listed above is likely to ensure safe and proper use and dosage of these medicines.

For the following recommendation made by the NDPSC

- **Schedule 2 for use in children and adults above 6 years of age.**

We believe that the wording of this recommendation inadvertently captures solid dose phenylephrine/phenylephrine combination products that were reviewed by the NDPSC in the previous sittings of the committee. It is therefore requested that the committee consider the following wording for this recommendation for phenylephrine and phenylephrine combination products

- **Schedule 2 for use in children aged 6 to 12 years of age.**

Thank-you for your consideration on these matters. In the interest of privacy, I would like to request that my name, and contact details are redacted from the correspondence/information that is to become a publically available.

Yours sincerely,

XXXXX

XXXXX

The Secretary
Scheduling Secretariat
GPO Box 9848
CANBERRA ACT 2601

By **email to SMP@health.gov.au**

Dear Secretary

XXXXX provides the following comments on items for discussion at the upcoming meeting of the Advisory Committee on Medicines Scheduling (the Committee).

Diclofenac (Item 1.2)

XXXXX agrees that products for the treatment of solar (or actinic) keratoses should be prescription-only medicines by virtue of the medical condition they are used to treat. XXXXX is also of the opinion the current entry for diclofenac in Schedule 4 is inadequate in this regard.

XXXXX considered the entry for Solaraze® gel in the Australian Register of Therapeutic Goods (ARTG entry 116785) and noted that this product is described as containing 3% w/w of diclofenac sodium.

Accordingly XXXXX requests that the committee reconsider whether the proposal to include preparations containing 3% or more of diclofenac for the treatment of solar keratoses in Schedule 4 will achieve the anticipated outcome. Perhaps a more suitable alternative would be to amend the current exemption (b) in the Schedule 4 entry to read “in preparations for dermal use containing 1 per cent or less of diclofenac”.

Yours Sincerely
XXXXX
15 October 2010

XXXXX

The Secretary
Scheduling Secretariat
GPO Box 9848
CANBERRA ACT 2601

By **email to SMP@health.gov.au**

Dear Secretary

XXXXX provides the following comments on items for discussion at the upcoming meeting of the Advisory Committee on Medicines Scheduling (the Committee).

Mercury (Item 1.3)

In its submission to the October 2009 meeting of the NDPSC XXXXX sought clarification of the scheduling of merbromin solutions, particularly whether a 2% merbromin solution (marketed as Mercurochrome) met the requirements for a Schedule 2 product.

XXXXX believes there is little if any benefit to the public in having 2% merbromin solutions available as an over-the counter medicine as more efficacious and less toxic products are widely available.

XXXXX is uncertain as to how the proposal to amend the current schedule 2 entry by changing the reference to 0.5% of mercury to 0.50% of mercury would serve to clarify this issue.

Yours Sincerely
XXXXX
15 October 2010

XXXXX

26th October 2010

Invitation for Public Comment under Regulation 42ZCZK of the Therapeutic Goods Regulations – Advisory Committee for Medicines Scheduling

Item 1.4 – Deletion of Pseudoephedrine from Appendix H

XXXXX do not object to the deletion of pseudoephedrine from Appendix H.

1.

XXXXX

The Secretary
Scheduling Secretariat
GPO Box 9848
CANBERRA ACT 2601

By **email to SMP@health.gov.au**

Dear Secretary

XXXXX provides the following comments on items for discussion at the upcoming meeting of the Advisory Committee on Medicines Scheduling (the Committee).

Pseudoephedrine (Item 1.4)

XXXXX is not opposed to the proposal to delete the Appendix H entry for pseudoephedrine.

However XXXXX is of the opinion that doing so will likely have little effect on the illicit use and diversion of pseudoephedrine for the manufacture of illegal drugs.

Yours Sincerely
XXXXX
15 October 2010

Monday, October 25th 2010
Encl.

The Secretary
Scheduling Secretariat
GPO Box 9848
CANBERRA
ACT 2601

e-mail: SMP@health.gov.au

Dear Sir/Madam

Re: Item 1.4 Pseudoephedrine - proposal to delete the existing Appendix H entry

XXXXX appreciates the opportunity to provide comment in relation to the proposal to delete the existing Appendix H entry for pseudoephedrine.

XXXXX would like to object to the proposal to delete the existing Appendix H entry for pseudoephedrine on the basis of the public health benefit in making consumers aware of their therapeutic options and the fact that no evidence has been presented to demonstrate that permitting advertising of pseudoephedrine has resulted in an increase in criminal diversion of pseudoephedrine to methamphetamine.

A full position statement has been provided overleaf. On behalf of XXXXX, I would like to request that the committee members at the first meeting of the Advisory Committee on Medicines Scheduling carefully consider the points raised in the position statement before making any decision on the status of pseudoephedrine in Appendix H of the *Standard for the Uniform Scheduling of Medicines and Poisons*.

In the interest of privacy, I would like to request that my name, and contact details are redacted from the correspondence/information that is to become a publically available.

Yours sincerely,

XXXXX

Contents

Public Health Benefit

For many different classes of medicines there are often multiple therapeutic options for patients. This includes, but is not limited to analgesics, proton pump inhibitors and anti-hypertenisves. Orally administered nasal decongestants are no different, in the sense that there are various therapeutic options available to patients. Given the genetic/metabolic diversity that exists in Australia, there is an inherit public health benefit in having multiple therapeutic options available to patients i.e. what works for one patient may not work equally well in another patient (different responders). Having multiple therapeutic options, allows different responders to use products that have optimum effect for their condition.

Pseudoephedrine is an oral sympathomimetic nasal decongestant that has been available for many years in Australia for the symptomatic treatment of rhinitis associated with colds and flu or hayfever. The efficacy and safety of pseudoephedrine as an orally dosed systemic nasal decongestant is well documented (1, 2), however, pseudoephedrine was up-scheduled due to concerns with the criminal diversion of pseudoephedrine to methamphetamine, rather than a specific safety concern with the correct/legitimate use of pseudoephedrine.

The primary result of the up-scheduling of pseudoephedrine was the introduction of safeguards that have been built into the Australian community pharmacies for products containing pseudoephedrine. These principally being:

- Pharmacist intervention prior to purchase of the product (including counseling)
- Pharmacists recording the purchase of pse udoephedrine containing products, to deter *"Pharmacy Shopping*" or *"Pseudo Running"*

With the introductions of the pharmacy safeguards, XXXXX a XXXX decline in ex-factory sales of pseudoephedrine containing products was experienced, with XXXXX. With the decline in sales, reduction in the demand and fewer products being made available to the consumer as a result, one could argue that the up-scheduling has achieved its objective in making it more difficult for criminal diversion of pseudoephedrine, by way of reduced access to starting material.

Even though the up-scheduling of pseudoephedrine was made with public health benefits in mind, the continued ability to advertise direct to the consumer has allowed for consumers to be aware of their therapeutic options when it comes to orally administered nasal decongestants.

It is therefore in the interest of public health and the continued promotion of the quality use of medicines pseudoephedrine remain in Appendix H of the SUSMP, allowing consumers to be aware of their therapeutic options for the symptomatic treatment of rhinitis associated with colds and flu or hayfever.

One less obvious and unappreciated advantages to public health is the value of advertising non-prescription medications, such as those containing pseudoephedrine, is the reduction in the burden placed on doctors in general practice treating patients with common illnesses that could have been self-managed. Relieving doctors from unnecessary involvement in patient self-care allows them to focus on other priorities – The result is a net benefit to public health, subsidised by industry (3).

Finally in support of this argument, in a position statement from the Pharmaceutical Society of Australia (relating to the advertising of S3 products) it is stated:

> *"Where it is demonstrated that brand advertising of particular Schedule 3 "pharmacist only" products will lead to improved health outcomes, the Pharmaceutical Society of Australia believes such advertising should be permitted on a case by case basis.*
> *The objectives of such advertising are to:*
> - *Inform consumers of the availability of these Schedule 3 treatments*
> - *Convey information of an educational, rather than a promotional nature*
>
> *and as part of the advertisement script:*
> - *Emphasize that such treatments may only be used on the recommendation of, or after consultation with, a pharmacist or medical practitioner*
> - *Refer consumers to their pharmacist or doctor for further information, thus promoting better communication between consumers and health professionals."*

The likelihood of advertising of the substance leading to inappropriate patterns of medication use

It was accepted by the committee members at the 44th meeting of the NDPSC held in June 2005 that "*pseudo-runners*" generally would have specific information on the product that they intend to purchase and were unlikely to be influenced by advertising. All medicines containing pseudoephedrine are listed on the Australian Register of Therapeutic Goods, a publically visible database. Additionally this information can be sourced via other online resources.

Therefore the position of the previous committee is aligned with that of industry – i.e. that advertising of pseudoephedrine contain medicines does not influence "*pseudo-runners*" on their procurement of medicines containing pseudoephedrine.

Finally, with the additional role that the pharmacist has played since the up-scheduling of pseudoephedrine (counselling patients and helping consumers select an appropriate nasal decongestant, and recording the details of the consumers that purchase pseudoephedrine containing medicines), it has added an element of difficulty for the "*pseudo-runners*" in terms of purchasing sufficient quantities of medicines containing pseudoephedrine for the criminal diversion.

Studies have demonstrated that people do not choose to buy medicines if they have no need for them. Advertising cannot force people to buy and use a medicine they do not want or need and it is generally accepted that consumer behaviour with respect to the purchase and use of medicines differs greatly from other common items of commerce (3). Research shows that advertising of nonprescription medicines does not lead to growth in consumption (3).

There has been no evidence provided to the committee to indicate that the current status i.e. the advertising of Pseudoephedrine has lead to an increase in criminal diversion. Given this, there is sufficient reason to ask: Why is there a need to remove pseudoephedrine from Appendix H ?

Advertising of an off-label indication

In Australia, Pseudoephedrine is primarily indicated for the symptomatic treatment of rhinitis associated with colds and flu or hayfever.

Off label indications for pseudoephedrine may also be used as a first-line therapy of priapism (4) and treatment for urinary incontinence (5). It is believed that the treatment of priapism and urinary incontinence are the only potential off-label indications for pseudoephedrine.

To date, there have been no instances of promotion of the off label indications stated above.

The responsibility of pharmacists to be actively involved in the supply of substance(s)

There is a need for pseudoephedrine containing medicines to be made available to consumers as a viable therapeutic option for the symptomatic relief of rhinitis associated with colds and flu or hayfever. Indeed, pharmacists have acted as *"gatekeepers"* for community health with respect to pseudoephedrine containing medicines since the being up-scheduled to S3. The pharmacist has played an important role in:

- ensuring appropriate use of products containing pseudoephedrine,
- counselling customers on potential side effects that may be experienced
- determine the impact of polypharmacy and any potential drug-drug interactions
- ensure that any other medical conditions will not be exacerbated by the appropriate use of the pseudoephedrine containing medicines and
- recording of customer details that do purchase pseudoephedrine containing products

The Department of Health and Aging have developed a national strategy for the quality use of medicines. Implementing this strategy ensures management options are selected prudently, choosing an appropriate medicine if it is deemed that a medicine is considered necessary and using medicines safely and effectively.

From this perspective it is ideal to have a pharmacist assess whether a product requested by a consumer is appropriate for their conditions. It would help to ensure that consumers do not unnecessarily purchase products that are not efficacious or suitable for their symptoms.

There is no reason to believe that the responsibility or a workload increase on the pharmacist is likely, if advertising of products containing pseudoephedrine is permitted to continue, it is envisaged that the workload and responsibility placed on the pharmacist is likely to remain unchanged.

The level of patient education necessary to ensure correct use

The level of education required for consumers is deemed relatively minimal.

The products containing pseudoephedrine all have packaging & labelling that contain adequate warning statements, dosage instructions, indications, contra indications and advice on contacted a healthcare professional if symptoms persist and will meet the requirements as stipulated by the TGA. The information provided to the consumer by way of the packaging & labelling is sufficient to ensure correct use of the product.

The pharmacist, at time of purchase, will reiterate the dosage instructions, indications, contra indications to the consumers.

What is required is patient education on the availability of other therapeutic options for this class of products.

Available consumer medicine information

As pseudoephedrine has been an S3 compound for a considerable length of time, the companies with products that contain pseudoephedrine should have a CMI for these products. This is a regulatory requirement. There is a requirement that the dispensing pharmacist offers the consumer medicine information to the customer at the time of dispensing the medication or at request of the customer.

Additionally, many companies also make their CMIs available through their website, however the TGA have, under business reform, have developed a database of PIs and CMIs for products where there is a regulatory requirement to maintain these documents.

Consequently, through the avenues mentioned above there is sufficient opportunity for consumers to obtain copies of the current consumer medicine information

The Desire of Consumers to Manage Their Own Medication

It is a well established, undisputed social trend of consumers self diagnosing and self treating various self limiting ailments (6). Consumers being aware of the various therapeutic options will help ensure the quality use of medicines.

Advertising Controls Through ASMI

There is a requirement for any advertising through main stream media to be pre-approved by the Industry body – Australian Self Medication Industry (ASMI). This pre-approval process helps to

maintain an appropriate level of control. No additional advertising control should be required. ASMI currently pre-approve all of the mainstream advertising of products containing pseudoephedrine.

References

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