European Medicines Agency
Post-authorisation Evaluation of Medicines for Human Use

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Response to Public Consultation
from the CHMP Pharmacovigilance Working Party (PhVWP)
on the EC Legislative Proposals for
Strengthening and Rationalising Pharmacovigilance
discussed in January and agreed by the PhVWP in February 2008

The Pharmacovigilance Working Party broadly welcomes the European Commission's legislative proposals to strengthen and rationalise EU Pharmacovigilance. The Working Party supports the strategic aims of the Commission, not only to address weaknesses in the current system, but to introduce a new approach where requirements are proportionate to risk, the current complexity and duplication is simplified, and best use is made of resources in the EU network.

The Working Party offers its views on the proposals from the experience and the practical perspective of those most closely involved with the day to day conduct of pharmacovigilance in the EU. In particular, we support: the clarification of tasks and responsibilities across stakeholders; establishment of Good Vigilance Practice; simplification of adverse reaction reporting requirements; rationalisation of EU Referral procedures; strengthened requirements to ensure delivery of risk management plans; provisions to ensure failure of compliance is subject to appropriate penalties; improved transparency and better information on risk: benefit for health professionals and patients.

We would wish greater clarity and further refinement of some of the proposals, in particular: around the interface between CHMP and the new Pharmacovigilance Committee; patient and public involvement including patient reports of suspected adverse reactions; the role of an intensive monitoring list, and the definitions for non-interventional studies.

The Working Party's views are set out below in the order of the consultation summary.

1. Fast, robust EU decision-making on safety issues

We support the creation of a Pharmacovigilance Committee whose decisions regarding the safety of medicines are legally binding across the EU.

A number of points regarding the Pharmacovigilance Committee require clarification and/or further discussion.

- The Committee's role in decision-making and its remit with regard to the various routes of product authorisation. (This is particularly relevant when safety issues affect a class of medicines encompassing national, decentralised/mutual recognition and centralised authorisations);
- Divergent opinions of the Pharmacovigilance Committee and CHMP (we assume that the Pharmacovigilance Committee will also consider risk: benefit);
- The role of the Committee in signal detection and analysis (of which Eudravigilance signals are only one part);
- The need to maintain a scientific focus for the new Committee alongside its increased co-ordination role;

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- The process of appointing patient and health professional representatives, and the nature of their specific contributions.

While greater public transparency is to be welcomed, the criteria for public hearings should be clarified. Regular public hearings will involve a significant use of regulatory resources, diverting them away from other safety issues and potentially impacting on public health. The added value of public hearings for every Referral should be closely explored on a case by case basis and consideration given to other approaches e.g. utilising web based technologies.

We support rationalisation of existing EU Referral procedures (replacement of Article 107 by a 'light' Referral procedure, to co-exist with Articles 31 and 36). In this context, we strongly support continuation of the Urgent Safety Restriction procedure to deal with safety issues requiring rapid action.

Further, we suggest that inclusion of advanced therapy medicinal products (and clarification regarding the inclusion or not of investigational medicinal products) within the scope of these legislative proposals is made explicit.

2. Clarify/codify roles and responsibilities and codify standards for industry and regulators

We strongly support clarification and codification of tasks and responsibilities across and between all stakeholders: Member State Competent Authorities, EMEA (including its committees), Commission and Marketing Authorisation Holders, including their Qualified Person for Pharmacovigilance. We propose that a QPPV designate be designated in each MS in order that national issues may be addressed appropriately and in a timely fashion (see also communication section).

As regards the maintenance of a public register of PV tasks delegated by one MS to another or to the Agency. While this is acceptable for reasons of accountability and transparency; we propose that the rationale for such delegation should be clearly explained as relating to work sharing; in this way, public perception of their individual NCA competences is not unfairly and inappropriately undermined.

We strongly support the establishment of the concept and scope of Good Vigilance Practice (GVP), with the aim of supporting inspections and quality management. We also strongly support the proposal that the Marketing Authorisation Holder who fails to discharge its pharmacovigilance obligations should be subject to effective, proportionate and dissuasive penalties.

The need for pharmacovigilance audit is recognised and has already been recognised through the Heads of Agencies BEMA framework which provides for a rolling 3 year model, auditing all areas of Competent Authority activities related to regulation of medicines. Any additional audit proposals should be undertaken within this framework. We support the proposed audit of the EMEA's pharmacovigilance tasks with a report to its management board on a yearly basis.

We endorse the proposed EMEA collaboration and information sharing with the WHO in matters of international pharmacovigilance. As regards harmonisation and standardisation at national & EMEA level, this is supported. However, it must be noted that implementation of safety measures may necessarily vary across EU Member States and between the EU and other territories, by merit of differing national clinical practices and cultural factors.

As regards use of collaborative approaches to maximise the use of resources available within the EU, this should include all appropriate resources, including academia e.g. ENCEPP.

3. Simplify informing authorities about the company pharmacovigilance system

We support the proposed maintenance by companies of a Pharmacovigilance System Master file, to be submitted on request by authorities or viewed during inspections, which will have a clear legal basis (including prior to grant of a marketing authorisation). In addition, we strongly advise that the term Pharmacovigilance System is used to describe a company's PV systems and organisation, whereas the term Risk Management Plan should be applied to product specific risk management.

4. Rationalise Risk Management Planning

We fully support enacting a clear legal basis for risk management plans (RMPs) and oversight of the fulfilment of the cited conditions (including agreed deadlines), together with a legal basis to enforce the conduct of post authorisation safety studies. The current definition of Risk Management System (Plan) does not capture its proactive nature which is the major contribution of the new concept, and we consider "proactively" should be added after "designed to". In case of non-fulfilment of an RMP, Article 22 establishes the possibility of revoking the marketing authorisation, but we consider other dissuasive measures could also be adopted (e.g. the prohibition of supply of the product to new patients). Article 22 should be maintained in its current wording. ("Exceptional circumstances"). The current conditional approval article should be modified instead.

We consider that the possibility to impose certain conditions in the marketing authorisation (included in the RMP) at the time of the authorisation for new products should also be extended to products already on the market (including deadlines for the fulfilment of the conditions). Moreover, it is proposed to add the following to the third condition: "including the requirement to implement additional risk minimisation measures or the evaluation of their effectiveness". It should be stated that an RMP needs to be updated and that the periodicity for this should take into account the periodicity of PSURs, unless otherwise stated by Competent Authorities.

We support the new definition for Post Authorisation Safety Studies (PASS) together with a legal basis to enforce the conduct of post-authorisation safety studies. A PASS may also have the aim of "evaluating the effectiveness of a risk minimisation measure" and this should be included in the definition.

5. Codify oversight of non-interventional safety studies

We support codifying the oversight of non-interventional safety studies conducted in more than one Member State, to ensure health rather than promotional objectives. Most PASS are concerned with non-interventional studies. The definition of "non-interventional trials" in the Directive 2001/20/EC accords quite well with retrospective observational studies. However, it creates considerable confusion amongst sponsors and researchers, since many prospective observational studies may be classified as clinical trials, which tends to dissuade performance of PASS. We therefore propose utilising this legislative initiative to modify the definition of non-interventional trials in order to accommodate all observational studies. In particular, the part of the definition which reads "No additional diagnostic or monitoring procedure shall be applied to the patients" should be deleted.

We also support the prohibition of the conduct of PASS where this promotes the use of a medicinal product. We suggest that the legal initiative to prohibit those PASS where the act of conducting them promotes the use of a medicinal product should be extended to all Post Authorisation Studies (PAS). To achieve this, Article 101h should be divided into 2 parts, the first concerning all PAS and the second only PASS. In order to optimise surveillance, oversight of PAS should be performed at national level. A general statement in the European legislation such as "Member States may impose specific obligations on the sponsors of Post Authorisation Studies in order to control the appropriate use of these studies" could be enough. A definition for PAS should be provided in the Directive.

We would suggest that the current draft Article 101h is too detailed in terms of procedures. It is preferable that the Directive contains a clear statement concerning the obligation of the MAHs to report the study protocols, leaving the detailed procedures to guidelines (Volume 9A). Additionally, a distinction should be made between those PASS that are required by the Competent Authorities and/or included in the RMP and those performed on the initiative of the MAH. Only the former should require formal approval by the Competent Authorities (or the new Pharmacovigilance Committee), in line with that is already stated in Volume 9A.

In relation to monitoring the outcome of risk minimisation measures, the current legislation mandates that the Marketing Authorisation Holders should provide usage data to regulatory authorities fully and promptly; this should also be applied to matters involving risk minimisation measures. Methodologies to measure the outcome of risk minimisation measures should be developed.

6. Simplifying and making proportional reporting of single serious adverse reaction case reports

We fully support the move towards simplification of reporting of suspected adverse reactions and best use of electronic advances to facilitate efficient capture and transfer of adverse reaction data. In line with greater simplification, we suggest that consideration should be given to the implications of requiring all reports of suspected adverse reactions from outside as well as inside the EU to be sent to Eudravigilance, either in an expedited or non-expedited fashion.

In regard to proposed web-based adverse reaction reporting by health professionals and patients into Eudravigilance, it is not clear from the current draft if these reports first come to the national Competent Authority. We believe that the national authorities' links with local health professionals and patients play a vital part in the effectiveness of national reporting schemes. We consider removal of this link by mandating direct reporting to Eudravigilance would seriously undermine national schemes which are the basis of the data collected in Eudravigilance. Therefore, a new requirement for reporting of adverse reactions for intensively monitored drugs by patients to marketing authorisation holders (and not to competent authorities) is also considered likely to be detrimental.

In addition, quality assurance of reports is performed by many NCAs. This can include causality assessment, requesting additional documentation on the case, analysing listedness etc. This quality assurance of reports performed by NCAs constitutes the basis of the final quality of the EV database.

MAHs should continue to report to the NCA where the adverse reaction occurred as well as to Eudravigilance in order that NCAs hold complete adverse reaction datasets for their own country for the purposes of country-specific signal detection.

In Article 101e the roles in relation to causality assessment are not clear, e.g.which view on causality has precedence – that of the health professional or the patient? In our view the wording should be consistent with ICH guidance.

Requirements for identification, evaluation and reporting of signals by NCAs, EMEA and MAH need to be clarified and stated explicitly. We have set up a drafting group on this topic and would envisage offering a draft proposal for your consideration.

Common approaches to handling patient reports and common procedures for conducting signal detection on patient reports need to be developed. Concerns in some Member States about the value of patient reporting and about the resource involved need to be addressed. (See Annex 1 for the PhVWP report on a recent review of direct patient reporting in some Member States).

We consider that requests for Eudravigilance data should go solely through the EMEA, and procedures for answering these requests should be underpinned by an EU-wide agreed access policy.

The general aim of the proposed intensive monitoring list is endorsed but further clarification is needed, particularly on its anticipated value. The PhVWP was concerned about a selective list and such proposal would be better applied to all new products. We are also concerned that one consequence of such a list could be that HCPs and patients hesitate to use these products. There would be a need to explain how the products have been authorised, and that robust safety monitoring procedures are in place for all products, irrespective of route of authorisation or time on the market.

We believe that a harmonised definition of medication error is required. The legal basis for receipt of medication errors will be very different for different Member States and an accumulation of all these reports in Eudravigilance may dilute the dataset and thereby compromise signal detection at an EU level.

7. Simplify and make proportional to risk periodic safety update report submission by industry (PSURs)

We strongly support the proposal to link the requirement for PSURs to the knowledge about safety of the product and even to create the possibility that PSURs are not required at all. We welcome the proposal not to require PSURs for generic products, herbals and homeopathics, unless there is a safety issue. The Working Party also agrees that this reduction in routine periodic safety reporting should be balanced by clearer obligations on Marketing Authorisation Holders to report changes in the benefits and risks of their products and to ensure that the product information remains up to date.

The Working Party welcomes the proposal for a legal basis for the existing Member State PSUR synchronisation initiative and assessment work-sharing with a clear role for the new Pharmacovigilance Committee. The Working Party also supports the proposal that the new Pharmacovigilance Committee should determine reference dates and frequency of submission for PSURs, or decision not to submit PSURs for certain products. The appointment by the new Pharmacovigilance Committee of Member States or rapporteurs in charge of preparing the assessment report for specific drugs is seen as a logical provision to substantiate the proposed work-sharing.

The proposal that PSURs should be linked to risk management plans is not supported without qualification. This is because there is no periodic procedure for RMP as is the situation for periodic safety update report. RMPs and PSURs are dealing with different issues: RMPs discuss how to gather information on known or potential risks, whereas PSUR documents consist of condensed safety data including a review of previously unknown safety signals from ADR reports that may turn into potential or identified risks. There may be situations where no known or potential risks have been identified at approval and thereby no proactive studies are required, but PSURs are still necessary to monitor the safety profile of the product. It is therefore suggested that PSURs should be used as a regular tool for pharmacovigilance, and where there is a RMP, it should be linked to PSURs as much as possible. Importantly, repetition of the same information in the two documents should be avoided.

Instead of taking into account the date of first marketing authorisation of a product containing a certain active substance, the Working Party believes that the new Pharmacovigilance Committee should take into account the date of the initial placing of the product on the market, if known. If not known the new Committee should be able to allocate any reference date. It is not clear whether the proposals include centrally authorised products.

The proposal to make public the PSUR assessment conclusions and any recommendation for the product information does not seem to be in line with the current Article 21(4) of the Directive which in fact says that the full assessment reports should be made public.

The proposal that the Marketing Authorisation Holder should take into account the recommendations from a PSUR assessment should be strengthened e.g. by using the wording in Article 23, fourth subparagraph, of the Directive: …shall ensure that the product information is kept up to date with the current scientific knowledge including assessment conclusions made public via the European medicines safety web-portal.

What is missing in the proposals is a provision by which the renewal of a marketing authorisation is linked to the regular PSUR submission scheme and to an appropriate period of marketing experience of the relevant product. The regular PSUR submission scheme is already linked to the date of initial placing of the product on the market. The renewal date could also be linked to this date by introducing the following provisions: that a marketing authorisation ceases to be valid five years after the date of first marketing; that a renewal application can be filed at least six months before the lapse of the marketing authorisation; and that the renewal application should contain a PSUR covering a period of at least four years since the date of first marketing. This would also mean that there is no further reason to make PSUR addendum reports, line listings of adverse reactions to complete a certain period or even to make an extra PSUR in certain circumstances, which is now often the case. (If it is preferred to have five years marketing experience on which a renewal should be based, the marketing authorisation should cease to be valid six years after the initial placing on the market of the product.)

8. Strengthen medicines transparency and communication

Generally, the harmonised view on transparency and communication in the EU is supported and a web-portal with information on safety issues is very welcome. However, in some situations, despite legislative changes and new guidelines, there will be situations when it is necessary for a NCA to communicate on safety issues, e.g. to respond immediately to enquiries from the public/media, to avoid public mistrust in the EU system. Furthermore, even if the communication is harmonised in the EU, the key message may need to be adapted to and tailored for different needs in different MSs.

We can see the added value of a common safety portal for the EU but would prefer that safety was put in context of efficacy and risk/benefit. A common EU portal, where all documents on efficacy and safety on CAPs, MRPs, DPs and NAPs could be found, would therefore be preferable. The establishment of national web-portals linked to the European web portal is also endorsed. Information on how to report suspected adverse reactions should be given.

It should be clarified if the safety portal would be an extension of the Eudrapharm database, which could be an advantage. The content and the goal of the EU safety web-portal needs to be further clarified and detailed, and the language difficulties should be considered. Publication of conclusions and recommendations of the PhV Assessment Reports on the safety web portal is supported but in order to strengthen transparency and to enhance the value for HCP and decision makers the rationale for the decisions should also be published.

One missing aspect is if, and if so, how, safety signals under evaluation are to be communicated to alert the health care professionals and patients to an ongoing concern, to encourage adverse reaction reporting and to make possible intermediate recommendations when needed. These are points that should be carefully considered and the PhVWP proposes that a working group is set up, preferably with representatives from patient and healthcare professional organisations, to elaborate further on this issue.

The proposal that as soon as the MAH has the intention to make a public announcement it shall notify the NCA, the Agency and the Commission is endorsed, but should be further strengthened to support co-ordination across the EU. It is essential that in the case of important safety information, such as product withdrawals and major restrictions of use of a product, the CA/EMEA/Commission is informed -as soon as the MAH considers public communication and at least 2 working days before external communications.

The role of the Agency vis a vis the Pharmacovigilance Committee in coordinating communications in case of safety announcements should be clarified. The importance of establishing and maintaining adequate expertise in communications within the committee should be highlighted.

9. Clearer safety warnings in product information to improve the safe use of medicines

The overall aim of the proposal is endorsed i.e. improvement of safety information in the SPC/PL to ensure correct use of drugs. However, there are several issues that need clarification.

Criteria for *when* key safety information will be provided should be developed as well as selection criteria for *how* to choose the most important safety issue are also of concern, e.g. choice of the most important safety issue for an oncology product. The most common safety concern may not be the most relevant one for a specific individual patient. Since it is proposed that every new drug, both systemic and topical, will have a key safety information section, there is a risk of watering down the message.

We also want to point out the need for placing the new safety information in the appropriate context i.e. against the backdrop of the positive effects of the drug. This is applicable to the SPC as well as the PL, the latter of particular importance to patients (see Article 59). Additionally, encouraging the patient to take the medicine for the full treatment period, e.g. antibiotics, could be the most valuable "safety-information" for the individual patient.

Over time SPCs have become more and more complex and PLs focus on adverse reactions to a large extent. A future revision of the SPC/PL guideline is recommended, where focus should be directed to user friendly information on how to achieve safe and effective prescription and use of drugs. This revision should be undertaken in close co-operation with health care professionals and patients.

In our opinion, suspected adverse reactions should not be reported by patients directly to the MAH, and accordingly this should not be stated on the package leaflet. It would be very confusing to the patient to have to use different channels for adverse reaction reporting. Furthermore the roles of the regulators and the MAHs could be mixed. (See 101 e, 3, second paragraph "To facilitate the reporting of suspected adverse reactions by healthcare professionals and patients, each Member State shall accept reports of adverse reactions via their websites which shall be linked to the European medicines safety web-portal referred to in Article 101 I").

We consider that there should be a requirement that MAHs, including those of CAPs, are responsible for the provision of a contact in each Member State. This contact person should be conversant in the national language, in order to ensure effective communication with consumers and HPs and provide good quality translations of educational materials and Direct Health Professional Communications.

10. Concluding comments

In conclusion, the Pharmacovigilance Working Party strongly supports the Commission's principal goals and objectives and believes that this is a vitally important opportunity to strengthen the legislation on pharmacovigilance. Some key areas where the legislation could be further developed are:

- Risk: benefit – as indicated we consider that information on risk should be provided in the context of benefit and that this should properly be within the remit of the new Pharmacovigilance Committee;

- Signal management - we suggest that this opportunity is taken to explicitly allocate responsibility for identification and analysis of signals;

- Work-Sharing – the principle of work-sharing should also be applied to activities beyond PSURs e.g. signal generation and evaluation for products authorised through MRP/DCP and national procedures.

- Information for health professionals – we believe that further consideration should be given to developing improved information specific to the needs of health professionals;

- Funding - A general statement should be made providing legal support to the public funding of independent studies on important safety issues.

We are ready to contribute to the development of the draft legislative proposals, to ensure that the fullest use is made of this unique opportunity to strengthen and rationalise pharmacovigilance in the best interest of EU citizens.

Pharmacovigilance Working Party
20 February 2008

Annex 1

European Medicines Agency
Post-authorisation Evaluation of Medicines for Human Use

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Report from the CHMP Pharmacovigilance Working Party (PhVWP)
on Direct Reporting of Adverse Reactions by Patients
agreed by the PhVWP in January 2008

BACKGROUND OF THIS REPORT

The current EU legislation does not include provisions for reporting of adverse reactions by patients themselves. However, patient behaviour has been changing given their increasing access to information and empowerment, and some Member States have taken initiatives in favour of patient reporting.

In particular in Denmark, new legislation came into force on 1 July 2003 allowing patients and their relatives to directly report adverse reactions to the Competent Authority. In the same year, also in the Netherlands the national reporting system started offering an internet-based reporting mechanism for all patients. Some other Member States initiated pilot projects to explore potential mechanisms for direct patient reporting and their value as source of safety information.

Since the beginning of these initiatives, the PhVWP has been very interested in the experiences gained. In autumn 2007, the PhVWP heard latest updates from Denmark, France, the Netherlands, Sweden and the United Kingdom, and agreed that it was timely to prepare a summary report to the EMEA Human Scientific Committee's Working Party with Patients' and Consumers' Organisations (PCWP) for presentation at their meeting in February 2008. This forms a response to one of the key recommendations issued in March 2005 by the precursor working group of the PCWP, namely the patient interest to report any suspicion over adverse reactions directly to those responsible for the safety of medicines.

Also, the European Commission issued their legislative proposals for strengthening pharmacovigilance in December 2007, which include provisions for direct patient reporting. Therefore, the PhVWP in December 2007 agreed to annex their report to the PhVWP comments on the legislative proposals and to provide the report to the members of the PCWP by the end of January 2008.

The CHMP will also be presented with the contents of this report.

SUMMARY ON EXPERIENCES IN MEMBER STATES

Experience with direct patient reporting has been gained in five Member States: In Denmark and the Netherlands the option of direct patient reporting was introduced nationwide in 2003, and data collected until mid-2007 have been analysed. Projects for piloting and studying mechanisms for and the value of direct patient reporting were launched in France, Sweden and the UK in 2005/2006 and run for 18 to 24 months.

In Denmark, around 150 reports have been received yearly by the Competent Authority since 2003, while in the Netherlands the reporting rate has reached about 820 per year. Through the programmes in France and Sweden, about 250 and 200 reports respectively were collected by the Competent Authorities. France specifically collaborated with 22 patient organisations. In the UK, 6000 reports were collected through the extended yellow card system between 2005 and 2007, translating into an average reporting rate of 200 per month (paper, telephone, internet).

In the Member States with a nationwide direct patient reporting option, a considerable percentage of all adverse reaction reports originate from patients: In Demark this percentage is 7%, and in the Netherlands it has reached 20%.

The reasons why patients report adverse reactions directly were investigated in the Netherlands. Almost half of the patients felt that their healthcare professionals do not take their concerns seriously or do not report the case as the patient had asked.

In terms of age and gender distribution, reports received directly from patients seem to have a similar pattern as those cases reported by healthcare professionals, as shown for Denmark.

The products classes for which patients mainly reported were:
- Psychotropic drugs *(Denmark: citalopram top number 2, France: psychotropic drugs top number 4, Netherlands: selective serotonin reuptake inhibitors top number 2, Sweden: antidepressants top number 1)*;
- Lipid-lowering drugs *(France and Netherlands: HMG-CoA-reductase inhibitors top number 1, Sweden: lipid-lowering drugs: top number 3)*;
- Cardiovascular drugs *(Netherlands: beta-blockers top number 3 and anticoagulants top number 4, Sweden: beta-blockers top number 2 and calcium antagonists beta-blockers top number 5, Denmark: reporting rates for cardiovascular drugs were significantly higher compared to healthcare professionals reports)*;
- Non-steroidal anti-inflammatory drugs *(Denmark: rofecoxib top number 3, Sweden: top number 4)*;
- Dermatologicals *(Denmark: isotretinoin top number 1)*;
- Quinolones (*France top number 2, while in Denmark reporting rates for anti-infectives were significantly lower compared to healthcare professionals reports)* ;
- Vaccines *(France: top number 3)*; and
- Proton-pump inhibitors *(Netherlands top number 5)*.

The top three reactions reported in Denmark were dizziness, depression and joint pain and the top five in the Netherlands nausea, diarrhoea, headache, pruritus and fatigue. Significantly increased reporting rates when compared to healthcare professionals were found in Denmark for psychiatric, nervous and reproductive system-related reactions. In Denmark, some reactions were only reported by patients and not by healthcare professionals, namely local convulsions, dysgraphia, dysphasia, myasthenia gravis, nerve compression, parosmia, thromboembolic stroke, all representing nervous system disorders.

The percentage of serious reports was similar for patients and physicians (Denmark: around 45%, Netherlands 21% and 34% respectively, UK: similar compared to all healthcare professionals, in France 60% of the patient reports were serious, mainly concerning effects on quality of life).

With regard to causality, the UK found that a similar percentage of reports concerned at least possibly causally related events when comparing patient with healthcare professional reports.

As for expectedness, the majority of reactions reported by patients in Denmark (about 67%) and France were expected, and in the UK it was shown that the pattern in this respect is similar as known for healthcare professionals.

The quality of the patient reports is often very good and was overall judged as beyond expectations. 75% of the French reports were deemed valuable for further assessment. In the Netherlands, patient provided more details than healthcare professionals on outcome including non-recovery, and there was also more information on the actual use of suspected medicinal product as well as of over-the-counter products. Likewise, UK patient reports included more information on the impact of adverse reactions on quality of life. In Sweden, patient reports were perceived as an additional source for information on over-the-counter products as well as misuse. They also saw a 100% responder rate when contacting patients for more information. In France, 11% of patient reports were submitted with medical documentation and for about a further 20% a medical confirmation was obtained through follow-up with the physician as permitted by the patient.

The assessment of patient reports may be classified as a time-intensive task, but given, at least so far, the limited number of reports, the work was considered manageable.

Indications for an added value in terms of detecting signals of unexpected adverse reactions have arisen from the Netherlands and Sweden, where review of patient reports resulted in publications of signals and regulatory action for products.

CONCLUSIONS ON OPPORTUNITIES AND RECOMMENDATIONS

The PhVWP considers patient reports as a further valuable source of safety information. The reports are often of good quality and provide details on the use of prescribed and OTC medicines as well as

outcome and impact of adverse reactions on quality of life, which healthcare professionals may not know about and in any case include less often in their reports. Further, the patients have shown to be cooperative in providing more information upon request. Indications for an added value in terms of detecting signals of unexpected adverse reactions are resulting publications of signals and regulatory action for products. Also, product information was improved in response to reviewing patient reports. But not only should direct patient reporting be seen as an information source – it offers those concerned with safety of medicines the option for dialogue with patients and the public. The PhVWP acknowledges that direct patients reporting would introduce a more patient-centred approach to and active patient participation in pharmacovigilance.

Therefore, the PhVWP agreed to consider direct patient reporting further in co-operation with the PCWP.