

Individual Safety Report



3557717-0-00-01

M. RES. INST. USA
 or use by user-facilities,
 ors and manufacturers for
 NDATORY reporting

Approved by FDA on 09/25/95

Mfr report # PRIUSA2000006668
LTR/Mfr report #
FDA Use Only

THE FDA MEDICAL PRODUCTS REPORTING PROGRAM

Page 1 of 3

A. Patient information			
1. Patient Identifier ? - ?	2. Age at time of event: 30 yr Date of birth: ??/??/??	3. Sex <input checked="" type="checkbox"/> female <input type="checkbox"/> male	4. Weight UNK lbs or UNK kgs
B. Adverse event or product problem			
1. <input checked="" type="checkbox"/> Adverse event and/or <input type="checkbox"/> Product problem (e.g., defects/malfunctions)			
2. Outcomes attributed to adverse event (check all that apply)			
<input checked="" type="checkbox"/> death 22/22/99 (month/year)		<input type="checkbox"/> disability	
<input type="checkbox"/> life-threatening		<input type="checkbox"/> congenital anomaly	
<input type="checkbox"/> hospitalization - initial or prolonged		<input type="checkbox"/> required intervention to prevent permanent impairment/damage	
<input type="checkbox"/> other: _____			
3. Date of event (month/year) ??/??/99	4. Date of this report (month/year) 08/17/00		
5. Describe event or problem			
Report published in 1999 Annual Report of the American Association of Poison Control Centers Toxic Exposure Surveillance System (case 263) of a 30 year old (gender not stated) who intentionally misused acetaminophen/caffeine, acetaminophen/oxycodone, and acetaminophen/propoxyphene and died. No further information available at this time.			
Additional information received 14-Aug-00: A 30-year-old woman was brought to the emergency department by her husband after being sick for a week. The patient had been taking acetaminophen/aspirin/caffeine Percocet (acetaminophen/oxycodone) (not Tylox as previously reported) and acetaminophen/propoxyphene for pain. The patient was seen by her private physician who attributed her jaundice to hepatitis. The patient was encephalopathic, vomiting blood and jaundiced in the emergency department. Her blood pressure was 151/83 mmHg and pulse 117 beats per minute. She was intubated and placed on a ventilator and her temperature was normal. Laboratory studies found blood glucose of 30 mg/dL. (Cont.)			
6. Relevant test/laboratory data, including dates			
ethanol and salicylates negative (Lab data cont.)			
AUG 24 2000 (Cont.)			
7. Other relevant history, including preexisting medical conditions (e.g., allergies, race, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.)			
hepatitis DSS AUG 25 2000			

C. Suspect medication(s)			
1. Name (give labeled strength & mfr/labeler, if known)			
#1 TYLOX (capsule) (OXYCODONE/ACETAMINOPHEN)			
#2 EXCEDRIN EXTRA STRENGTH (EXCEDRIN)			
2. Dose, frequency & route used		3. Therapy dates (if unknown, give duration) (month/year or best estimate)	
#1 oral		#1 ??/??/?? - ??/??/99	
#2 oral		#2 ??/??/?? - ??/??/99	
4. Diagnosis for use (indication)		5. Event abated after use stepped or dose reduced	
#1 PAIN		#1 <input type="checkbox"/> yes <input type="checkbox"/> no <input checked="" type="checkbox"/> doesn't apply	
#2 PAIN		#2 <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> doesn't apply	
6. Lot # (if known)		7. Exp. date (if known)	
#1		#1	
#2		#2	
8. Event reappeared after reintroduction			
#1 <input type="checkbox"/> yes <input type="checkbox"/> no <input checked="" type="checkbox"/> doesn't apply			
#2 <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> doesn't apply			
9. NDC # - for product problems only (if known)			
10. Concomitant medical products and therapy dates (exclude treatment of event)			
No Concomitant Products Reported			
G. All manufacturers			
1. Contact office - name/address (& mfring site for devices)		2. Phone number	
R.W. JOHNSON PHARM. RES. INST. USA DIV. OF ORTHO PHARMACEUTICAL CORP. 920 U.S. Route 202 P.O. Box 300 Raritan NJ 08869 USA (Informing Unit)		908-704-4504	
4. Date received by manufacturer (month/year)		5. (ANDA #	
08/14/00		88-790	
6. If IND, protocol #		IND # _____ PLA # _____	
7. Type of report (check all that apply)		pre-1938 <input type="checkbox"/> yes OTC product <input type="checkbox"/> yes	
<input type="checkbox"/> 5-day <input checked="" type="checkbox"/> 15-day		8. Adverse event term(s)	
<input type="checkbox"/> 10-day <input type="checkbox"/> periodic		1) DRUG ABUSE	
<input type="checkbox"/> Initial <input checked="" type="checkbox"/> Follow-up		2) HEPATIC FAILURE	
		3) GI HAEMORRHAGE	
		4) PULMONARY OEDEMA	
9. Mfr. report number PRIUSA2000006668			
E. Initial reporter			
1. Name, address & phone #			
Dr. Toby Litovitz American Assoc of Poison Control Centers 3201 New Mexico Avenue, Suite 310 Washington, DC 20016 USA Phone #: 202-362-7493			
2. Health professional?		3. Occupation	4. Initial reporter also sent report to FDA
<input checked="" type="checkbox"/> yes <input type="checkbox"/> no		Physician	<input type="checkbox"/> yes <input type="checkbox"/> no <input checked="" type="checkbox"/> unk

Submission of a report does not constitute an admission that medical personnel, user facility, distributor, manufacturer or product caused or contributed to the event.

Individual Safety Report



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Mfr report # PRIUSA2000006668
U7/Date report #
FDA Use Only

THE FDA MEDICAL PRODUCTS REPORTING PROGRAM

Page 2 of 3

A. Patient information			
1. Patient identifier	2. Age at time of event: or _____ Date of birth: _____	3. Sex <input type="checkbox"/> female <input type="checkbox"/> male	4. Weight _____ lbs or _____ kgs
In confidence			
B. Adverse event or product problem			
1. <input type="checkbox"/> Adverse event and/or <input type="checkbox"/> Product problem (e.g., defects/malfunctions)			
2. Outcomes attributed to adverse event (check all that apply)			
<input type="checkbox"/> death (month/year)	<input type="checkbox"/> disability	<input type="checkbox"/> congenital anomaly	
<input type="checkbox"/> life-threatening	<input type="checkbox"/> required intervention to prevent permanent impairment/damage		
<input type="checkbox"/> hospitalization - initial or prolonged	<input type="checkbox"/> other: _____		
3. Date of event (month/year)	4. Date of this report (month/year)		
5. Describe event or problem			
6. Relevant tests/laboratory data, including dates			
7. Other relevant history, including preexisting medical conditions (e.g., allergies, race, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.)			

DSS

AUG 25 2000

AUG 24 2000

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3500A Facsimile

C. Suspect medication(s)			
1. Name (give labeled strength & mfr/labeler, if known) #3 DARVOCET-N 50 (DI-GESIC) #4 _____			
2. Dose, frequency & route used #3 oral #4 _____		3. Therapy dates (if unknown, give duration) (month/year) (or best estimate) #3 ??/??/?? - ??/??/99 #4 _____	
4. Diagnosis for use (indication) #3 PAIN #4 _____		5. Event abated after use stopped or dose reduced #3 <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> doesn't apply #4 <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> doesn't apply	
6. Lot # (if known) #3 _____ #4 _____		7. Exp. date (if known) #3 _____ #4 _____	
9. NDC # - for product problems only (if known) #3 _____ #4 _____			
10. Concomitant medical products and therapy dates (exclude treatment of event)			
G. All manufacturers			
1. Contact office - name/address (& mailing site for devices)		2. Phone number	
4. Date received by manufacturer (month/year)		3. Report source (check all that apply)	
6. If IND, protocol #		<input type="checkbox"/> foreign <input type="checkbox"/> study <input type="checkbox"/> literature <input type="checkbox"/> consumer <input type="checkbox"/> health professional <input type="checkbox"/> user facility <input type="checkbox"/> company representative <input type="checkbox"/> distributor <input type="checkbox"/> other: _____	
7. Type of report (check all that apply) <input type="checkbox"/> 5-day <input type="checkbox"/> 15-day <input type="checkbox"/> 10-day <input type="checkbox"/> periodic <input type="checkbox"/> Initial <input type="checkbox"/> follow-up # _____		5. (A)NDA # _____ IND # _____ PLA # _____ pre-1938 <input type="checkbox"/> yes OTC <input type="checkbox"/> yes product	
9. Mfr. report number		8. Adverse event term(s)	
E. Initial reporter			
1. Name, address & phone #			
2. Health professional? <input type="checkbox"/> yes <input type="checkbox"/> no		3. Occupation	
4. Initial reporter also sent report to FDA <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unk			

Individual Safety Report



3557717-0-00-03

USA

Continuation Sheet for FDA-3500A Form

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M . report #: PRIUSA2000006668

Date of this report : 08/17/00

B. Adverse event or product problem

B.5 Describe event or problem (Cont...)

total bilirubin, 9.5 mg/dL; AST, 8,200 U/L; ALT, 7,400 U/L; acetaminophen level, 13 mcg/mL; and ethanol and salicylates were both negative. An arterial blood gas was pH, 7.27; pCO₂, 30 mmHg; PO₂, 133 mmHg; HCO₃, 14 mEq/L; and O₂ saturation, 97%. The patient had been given dextrose to correct the hypoglycemia and now had a blood glucose of 300 mg/dL. The poison center recommended baseline coagulation studies, administration of fresh frozen plasma and vitamin K, administration of intravenous N-acetylcysteine because of active gastrointestinal bleeding and transport of the patient for evaluation of a liver transplant. Six hours after transport, the patient had a massive gastrointestinal bleed, developed pulmonary edema, could not be ventilated and expired. An autopsy was performed and the medical examiner listed the cause of death as hepatic failure secondary to acetaminophen toxicity. The patient had a massive gastrointestinal bleed and pulmonary edema secondary to the hepatic failure.

B.6 Relevant tests/laboratory data, including dates (Cont...)

Lab Result :

Sl.No.	Test date	Test name	Test result	Normal value
1	??/??/??	ALANINE AMINOTRANSFERASE	7,400 IU/L (international unit/liter)	
		ASPARTATE AMINOTRANSFERASE	8,200 IU/L (international unit/liter)	
		BILIRUBIN, TOTAL	9.5 mg/dL (milligram/deciliter)	
		BLOOD GAS	30 mmHg (millimeter mercury)	
		pCO ₂ BLOOD GAS	133 mmHg (millimeter mercury)	
		pO ₂ BLOOD GAS	14 mEq/L (milliequivalent/-liter)	
		HCO ₃ BLOOD GAS	97 % (percent)	
		O ₂ saturation BLOOD PRESSURE	151/83 mmHg	
		DRUG LEVEL	acetaminophen 13 mcg/mL (microgram/milliliter)	
		GLUCOSE	300 mg/dL (milligram/deciliter)	
		HEART RATE	112 /min (per minute)	
		PH	7.27	

Source of report (Literature):

Seq No. : 1
 Author : Toby Litovitz
 Journal title : American Journal of Emergency Medicine
 (pre-publication)
 Year : 00
 Article title : 1999 Annual Report of the American Association of
 Poison Control Centers Toxic Exposure Surveillance
 System

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AUG 25 2000

AUG 24 2000