PATIENTS PEOPLE POPULATION

NHS
Sandwell and West Birmingham
NHS Trust

DRUG SAFETY NOTICE

Supply Shortage

DRUG NAME/STRENGTH/FORM:

Desmopressin (DDAVP) 4 micrograms/1ml solution for injection ampoules

PROBLEM

Desmopressin (DDAVP®) 4 micrograms/1ml solution for injection ampoules are out of stock from early August until w/c 16th September 2024.

ADVICE AND ALTERNATIVE

- Pharmacy will review current stockholding to identify if there is sufficient stock to cover the out of stock period.
- Unlicensed imports of desmopressin 4 micrograms/1ml solution for injection ampoules may be available.
- If the above option is not considered appropriate or cannot be sourced in time, advice should be sought from specialists on alternative management options.

SUPPORTING INFORMATION

Clinical Information:

Desmopressin (DDAVP®) 4 micrograms/1ml injection is licensed for:

- The diagnosis and treatment of cranial diabetes insipidus (adult treatment dose 1 to 4 micrograms once daily; children and infant doses from 0.4 micrograms, by SC, IM or IV injection);
- Increasing Factor VIII:C and Factor VIII:Ag in patients with mild to moderate haemophilia or von Willebrand's disease undergoing surgery or following trauma (0.4 micrograms per kg by IV infusion)
- It also has a licence for establishing renal concentration capacity, treating headache resulting from a lumbar puncture, and testing fibrinolytic response.

National Patient Safety Alert on risk to patients with cranial diabetes insipidus when desmopressin is omitted or delayed

Desmopressin is considered a life sustaining medication when used to treat cranial diabetes insipidus. It is most commonly administered as a nasal spray or oral tablets, but may also be given as an injection, which is useful in the treatment of acutely unwell or fasting patients. The dose of desmopressin is different depending on the indication for use and formulation. An Alert issued in 2016 highlighted reports to the National Reporting and Learning System (NRLS) of dosing errors with resulting patient harm, and several incidents where omission of desmopressin resulted in severe dehydration and death. The main themes from reported incidents of desmopressin omission, included: a lack of awareness of the critical nature of desmopressin amongst medical, pharmacy and nursing staff; and poor availability of desmopressin within inpatient clinical areas where it was often not kept as a stock item.

Key resources

- **BNF: Desmopressin**
- **SmPC DDAVP/ Desmopressin injection**
- **Society for Endocrinology Clinical Guidance: Inpatient Management of cranial diabetes insipidus**
- **WFH guidelines for the management of haemophilia**
- **NHSE Patient Safety Alert (2016): Risk of severe harm or death when desmopressin is omitted or delayed inpatients with cranial diabetes insipidus**

FOR FURTHER INFORMATION CONTACT YOUR WARD BASED PHARMACY TEAM
OR
THE PHARMACY DEPARTMENT (CITY ext.5263; SANDWELL ext.3783).

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