



Shortage of bumetanide 1mg tablets

Date of issue:

3-Jul-25

Reference no:

NatPSA/2025/003/DHSC

This alert is for action by: All organisations involved in prescribing, dispensing and administering bumetanide 1mg tablets

This is a safety critical and complex National Patient Safety Alert. Implementation should be co-ordinated by an executive lead (or equivalent role in organisations without executive boards) and supported by clinical leaders in pharmacy, community pharmacy, GP practices, care home settings, clinical leaders in cardiovascular disease and renal medicine and those working in the Health and Justice sector.

Explanation of identified safety issue:

Bumetanide 1mg tablets are out of stock until mid-August 2025.

The supply disruption is caused by a combination of manufacturing issues and a resulting increase in demand to other suppliers.

Bumetanide 1mg/5ml oral solution and bumetanide 5mg tablets remain available, however cannot support any increase in demand.

Furosemide 20mg and 40mg tablets remain available and can support increased demand.

There is a risk of decompensation and unintentional fluid retention if patients stop taking their bumetanide 1mg tablets. Patients will require a switch to an alternative loop diuretic.

Actions required



Actions to be completed by 11/07/2025 and to remain in place only until the supply issues have resolved (see [Medicine Supply Tool](#) for up to date resolution dates):

1. Do not initiate new patients on bumetanide 1mg tablets until the supply issue has resolved.
2. Identify all patients currently prescribed bumetanide 1mg tablets; review to determine if this is still the most suitable therapy and if patients have sufficient stock to last until the resupply date.
3. Patients with insufficient supplies should be considered for furosemide tablets ensuring that the patient is not intolerant to any of the excipients, is counselled on the appropriate dose to take, additional weight monitoring requirements and to report any side effects and loss of treatment response (see Note A, B).
4. Patients who fit the criteria should be prioritised for remaining supplies of bumetanide 1mg tablets (see Note C). Check locally to ensure stock is available before prescribing.
5. Prescribers should immediately refer patients to a specialist for advice on alternative treatments if above options are not suitable.

Additional information:

Clinical Information

Bumetanide is a loop diuretic licensed for the treatment of oedema associated with e.g., congestive heart failure, renal dysfunction including nephrotic syndrome and cirrhosis of the liver in adults.

Furosemide, another loop diuretic, is licensed for use in all indications where a prompt and effective diuresis is required. It is similar in activity to bumetanide; both act within 1 hour of oral administration and diuresis is complete within 6 hours. The diuresis associated with these drugs is dose related.

Note A: Furosemide produces a similar diuretic to bumetanide if given at equipotent doses. When kidney function is normal, a 40mg dose of furosemide is approximately equal to 1mg of bumetanide. Selecting an equivalent dose is determined on a case-by-case basis as effects will differ based on clinical status and stability of patient, fluid status, and renal function. Patients switched from a stable dose of bumetanide to furosemide may require follow up to assess response, with dose titration if required, to ensure fluid balance remains stable, particularly if on higher doses of bumetanide. A switch from bumetanide to furosemide should be made before patients run out of tablets to avoid a break in therapy that could increase the risk of decompensation and unintentional fluid retention.

Note B: Patients should take daily weights and contact their GP / heart failure team if their weight increases by ≥ 1 kg per day or ≥ 2 -3 kg over 3-5 days.

Note C: Remaining supplies of bumetanide should be reserved for patients who are either allergic to furosemide, have severe left ventricular systolic dysfunction or who have not been adequately managed on furosemide previously including those who had hospital admissions despite maximum doses of furosemide.

References:

1. [SmPC Bumetanide 1mg tablets \(Teva UK\)](#)
2. [SmPC Bumetanide 1mg tablets \(Niche Generics Ltd\)](#)
3. [SmPCs Furosemide 20mg and 40mg tablets](#)
4. [BNF: Loop diuretics](#)
5. [CKS: Chronic heart failure - managing diuretics](#)

Stakeholder engagement

The following stakeholders have been engaged in the management and consulted in the drafting of this alert: NHS Specialist Pharmacy Service Medicine Advice; Medicine Shortage Response Group; NHS England; national clinical experts in heart disease, cardiovascular disease prevention, renal medicine and national patient safety team; Medicine and Healthcare products Regulatory Agency and the Devolved Governments

Advice for Central Alerting System (CAS) officers and risk managers

This is a safety critical and complex National Patient Safety Alert. In response to [CHT/2019/001](#) your organisation should have developed new processes to ensure appropriate oversight and co-ordination of all National Patient Safety Alerts. CAS officers should send this Alert to the executive lead nominated in their new process to coordinate implementation of safety critical and complex National Patient Safety Alerts, copying in the leads identified on page 1.