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Worst Pills, Best Pills News

Your expert, independent second opinion for prescription drug information

ROBERT STEINBROOK, M.D., EDITOR

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Beware of All Kratom-Related Products

In 2018 and 2019 we alerted our readers to the emerging risk of kratom (mitragynine) products, which are derived from the leaves of a tropical tree native to Malaysia, Thailand and other Southeast Asian countries. Historically, farmers and laborers seeking relief from the effects of physical work in these countries chewed on fresh kratom leaves or brewed them into teas.

Regular use of kratom products (which are often available online in the United States in crushed dry leaf, powder, resin extract, capsule or tablet formulations) is associated with serious adverse effects. These adverse effects include dependence (needing to use increasingly higher doses), addiction, physical withdrawal reactions (such as diarrhea, frequent yawning, lethargy, irritability, muscle or joint pain, and runny nose) and psychological withdrawal symptoms (including aggression, delusion, hallucination, nervousness, sadness, restlessness and tension), as well as liver injury and seizures.

By 2024 an estimated 5 million Americans aged 12 or older reported using kratom at least once during their lifetime, according to data from the Substance Abuse and Mental Health Services Administration's national survey on drug use and health.

Since approximately 2024, synthetic derivatives of kratom — mainly 7-hydroxymitragynine, commonly known as 7-OH —

have been available in candy-like formulations (including gummies and pills that can be chewed or placed under the tongue) at U.S. retail stores and online. These products have much higher potency than leaf kratom products.

Kratom reports to poison centers

Kratom-related reports to U.S. poison centers have hit record levels, according to a March 2026 analysis in *Morbidity and Mortality Weekly Report* published by the Centers for Disease Control and Prevention. Approximately 14,450 kratom-related reports were documented in the last 11 years. Of those, 3,434 reports were received in 2025, about a 1,200% increase from 258 reports in 2015. The collected information did not include details regarding whether kratom use involved leaf or synthetic kratom products.

Most reports involved males and young adults aged 20 to 39 years. However, by 2025 reports involving adults aged 40 to 59 years increased substantially, reaching rates close to those for young adults.

Overall, 62% of the reports pertained to individuals who reported consuming kratom by itself. The remaining reports pertained to those who combined it with certain drugs or other psychoactive substances, including alcohol, antidepressants, benzodiazepines (such as alprazolam [XANAX and generics] and diazepam [VALIUM and generics]), opioids, cannabis or cannabinoids.

Reported hospitalizations due to kratom exposure alone rose from 43 in 2015 to 538 in 2025. For kratom exposure in combination with drugs or other substances, hospitalizations rose from 40 in 2015 to 549 in 2025.

There were 233 kratom-related deaths during the study period. Of those, 79% involved consumption of other drugs or substances as well.

U.S. attempts to regulate kratom

The Drug Enforcement Administration (DEA) has considered

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FROM THE EDITOR Robert Steinbrook, M.D.

Kidney Problems From Orlistat (ALLI), an Over-the-Counter Diet Drug

Orlistat (ALLI) is the only over-the-counter weight-loss drug approved by the Food and Drug Administration (FDA). In June 2026 the FDA approved labeling changes to warn of the risk of kidney stones and kidney injury.

The agency's action calls attention to the work of Public Citizen's Health Research Group, which in 2006 and again in 2011 unsuccessfully petitioned the FDA to remove all orlistat products from the market. For many years, we have classified orlistat as **Do Not Use**.

Orlistat works by binding to enzymes known as gastrointestinal lipases that break down fats. People taking orlistat absorb less dietary fat from the digestive tract.

Approved in 2007 for nonprescription use by overweight adults in conjunction with a reduced-calorie and low-fat diet, orlistat is sold over the counter in 60-mg capsules. The retail cost for 90 capsules is about $100. A higher-strength orlistat product (XENICAL), approved in 1999, is available by prescription in 120-mg capsules. A dose of the drug is taken with each main meal containing fat up to three times a day.

When Public Citizen petitioned the FDA to ban orlistat in 2011, we argued that both the prescription and over-the-counter versions of the drug "expose patients to serious risks that greatly outweigh their minimal clinical benefits." The serious risks cited in the petition were severe liver injury, acute pancreatitis and "acute renal failure secondary to acute oxalate nephropathy, and calcium oxalate nephrolithiasis (kidney stones)." For efficacy, the petition cited clinical trial data for the higher-dose (120-mg) orlistat product showing that "the average weight loss (beyond placebo) for interval from 20 weeks to two years of treatment was only 6.5 lbs out of a starting weight of 212 lbs."

In 2013 the FDA denied the second petition, concluding that the criteria for market withdrawal for orlistat had not been met. The agency maintained that "orlistat's benefits outweigh its risks for its approved indications" and the labeling "adequately addressed" the risks.

The recent FDA drug safety communication followed an agency review of 12 cases of kidney complications associated with the nonprescription product and aligns the labeling for over-the-counter orlistat with the labeling for prescription orlistat products. Consumers are now advised to consult with a clinician before using the over-the-counter product if they have ever had kidney disease or kidney stones and to stop using the product "if they develop symptoms of kidney injury or kidney stones, such as back or groin pain, painful urination, blood in the urine, feet and leg swelling, or less frequent urination."

The labeling changes for over-the-counter orlistat are welcome but beg the question of why the FDA allows orlistat products to remain on the market at all. We recommend that you **Do Not Use** orlistat, and we call on the agency to reconsider its continuing approval of a minimally effective drug with serious risks and safety concerns. ✦

Dextromethorphan and Bupropion (AUVELITY): A Bad Choice for Agitation Due to Alzheimer's Disease Dementia

In 2022 the Food and Drug Administration (FDA) approved dextromethorphan-buproprion (AUVELITY), an oral combination drug, for major depressive disorder in adults. In April 2026 the FDA extended the approval to include agitation associated with dementia due to Alzheimer's disease. Dextromethorphan-bupropion is the second drug approved for this indication — in 2023 the FDA extended the approval of the antipsychotic brexpiprazole (REXULTI and generic) to include agitation from Alzheimer's disease dementia.

Dextromethorphan-bupropion has serious risks and only marginal benefits for agitation associated with dementia due to Alzheimer's disease. Public Citizen's Health Research Group has designated it as a **Do Not Use** drug. Importantly, dextromethorphan-bupropion is not approved for "as-needed" (often referred to as pro re nata or "PRN") use. A month's supply of dextromethorphan-bupropion costs about $1,250.

Dextromethorphan (DELSYM and generic) is an over-the-counter cough suppressant that we previously designated as **Do Not Use** because studies show that it is no more effective than placebo in suppressing nighttime cough in children. Dextromethorphan is also approved in combination with quinidine (NUEDEXTA and generic) for the treatment of pseudobulbar affect (a neurological condition that causes sudden and uncontrollable outbursts of laughing or crying). Of note, the mechanism by which dextromethorphan contributes to the treatment of agitation associated with Alzheimer's disease dementia is not known.

In 1985 the FDA approved bupropion (APLENZIN, FORFIVO, WELLBUTRIN and generics), an antidepressant, for the treatment of major depressive disorder. Bupropion has a boxed warning — the agency's most prominent warning — because it increases the risk of suicidal thoughts and behavior in children, adolescents and young adults. At a lower dose, bupropion (generic only) is approved as a smoking cessation aid, as well as for weight management in combination with the opioid disorder drug naltrexone (CONTRAVE). We previously designated bupropion as **Limited Use** for either depression or smoking cessation and as **Do Not Use** for weight management.

Antipsychotics are frequently prescribed to manage agitation associated with dementia due to Alzheimer's disease, including antipsychotics not specifically approved for this indication (off-label use). However, antipsychotics are associated with serious risks, including an increased risk of death among elderly patients with dementia-related psychosis. Because the limited benefits of antipsychotics do not outweigh the serious harms, we designated brexpiprazole as **Do Not Use** for agitation associated with dementia due to Alzheimer's disease.

Agitation due to Alzheimer's disease dementia

In addition to the decline in thinking, memory and the ability to perform daily activities associated with Alzheimer's disease, more than 90% of patients develop behavioral and psychological symptoms, such as irritability, sleep disturbances, hallucinations, depression, apathy and agitation. Symptoms of agitation such as hitting, pacing, complaining, being verbally aggressive and restlessness are distressing for patients and their caregivers. Agitation symptoms become more prevalent in the later stages of the disease. Nonpharmacological approaches (such as exercise or music therapy) are recommended as initial treatments.

Effectiveness of dextromethorphan-bupropion

Dextromethorphan-bupropion was assessed in two randomized controlled trials in adults who were diagnosed with probable Alzheimer's disease and associated agitation. Only limited data about the results of the trials are available; as of July 2026, the trial results had not been published in a peer-reviewed journal.

According to dextromethorphan-bupropion's label, one study was a double-blind, placebo-controlled study in which 357 participants were randomized to receive the approved dose twice daily, 105 mg of bupropion alone, or placebo. Due to limited effectiveness, treatment for the 49 participants in the bupropion-only group was stopped early.

After five weeks, the participants in the dextromethorphan-bupropion group showed some improvements on two measurement tools. The primary endpoint was improvement on a clinician-rated questionnaire called the Cohen Mansfield Agitation Inventory, which measures

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Tradipitant (NEREUS) to Prevent Vomiting From Motion Sickness in Adults

In December 2025 the Food and Drug Administration (FDA) approved tradipitant (NEREUS) to prevent vomiting related to motion sickness in adults. Although tradipitant is a new treatment, the pivotal trials supporting approval were short in duration, did not show a reduction in nausea symptoms from motion sickness, and did not compare the new drug to other treatments, some of which are inexpensive and available over the counter. In July 2026 the retail price of 30 85-mg tradipitant capsules was $7,550 or higher.

Motion sickness

Symptoms of motion sickness include nausea that may progress to vomiting, dizziness, excessive warmth, excessive sweating, rapid breathing, feeling faint or fainting when sitting or standing, and malaise. Although not fully understood, acute motion sickness may be triggered by excessive real or virtual motion and is likely mediated by the autonomic nervous system, the part of the peripheral nervous system that regulates involuntary bodily functions.

Studies of people traveling in watercraft, buses or planes indicate that 8% to 13% experience nausea and 1% to 7% vomit or feel "quite ill" or worse. Children under 2 years do not typically experience motion sickness. If motion sickness develops in childhood, it typically peaks around age nine and declines thereafter. Gene-wide association studies show that at least 35 genetic variations influence susceptibility to motion sickness, including several that increase susceptibility in women more than men.

Acute treatment of motion sickness is often ineffective. People with a history of motion sickness can consider preventive treatment in anticipation of travel. Treatments include over-the-counter medications and prescription topical patches. A meta-analysis of small clinical trials of the prescription anticholinergic drug patch scopolamine (TRANSDERM SCOP and generics) showed that it reduced the occurrence of motion sickness by about 50% compared with placebo. Oral over-the-counter first-generation antihistamines (for example, dimenhydrinate and meclizine) are similarly effective.

Clinical trials of tradipitant

Tradipitant should be taken on an "empty stomach, at least 1 hour prior to or 2 hours after a full meal," and about 60 minutes before an event that is expected to cause motion-induced vomiting, according to the prescribing information. A single oral dose is 85 or 170 mg, which are also the maximum doses in a 24-hour period. Tradipitant is approved to prevent vomiting, not nausea, which is a more common symptom of motion sickness.

Tradipitant inhibits the activity of substance P/neurokinin-1 receptors in the central and peripheral nervous systems, inhibition that animal studies show can prevent drug-induced emesis (vomiting).

FDA approval was primarily based on two single-dose, randomized, placebo-controlled clinical trials, one with 365 participants and the other with 316 participants. Participants had a mean age of 48 years; the range was 18 to 75 years. Participants in both trials were randomized equally into three groups: 85 mg of tradipitant, 170 mg of tradipitant, and placebo.

Tradipitant or placebo dosing occurred approximately 60 minutes before boat trips lasting two to four hours with peak wave heights of 0.3 to 2.5 meters. Participants completed a self-assessment every 30 minutes during the trip. The primary endpoint across both trials was incidence of vomiting, which occurred in 10% to 18% of the participants receiving tradipitant and 38% to 44% of those receiving placebo.

Neither study found a meaningful difference between the groups on a 5-point nausea scale (where 0 equals "no nausea" and 4 equals "very severe nausea"). The average nausea scale scores ranged from 2.2 to 2.4, with no significant differences between the three arms of either study.

Adverse effects were assessed across three trials: the two trials discussed above and a 12-month open-label safety trial. The open-label trial involved 382 participants with a history of motion sickness who were randomized to either 85-mg or 170-mg doses of tradipitant. Overall, three common adverse reactions were identified, all with an incidence of more than 5%: somnolence (drowsiness), headache and fatigue. Across the three studies, these adverse effects were more frequent with the 170-mg dose of tradipitant (for example, a somnolence rate of 12% with 170 mg of tradipitant and 6% with placebo, and fatigue rates of 8% and 2%, respectively). Drowsiness is a common adverse effect of many other drugs used to prevent motion sickness, such as first-generation antihistamines.

The 12-month open-label safety trial limited tradipitant use to up to 90 daily as-needed doses for each participant. The median number of doses used was 18, with the majority (69%) of participants using fewer than 30 doses.

The FDA review noted that the

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The 2026-2027 Influenza (Flu) and COVID-19 Vaccines

Following scientific review and advice from external experts, the Food and Drug Administration (FDA) has recommended strains for the 2026-2027 influenza (flu) and COVID-19 vaccines. Federal health officials will continue to monitor the safety and effectiveness of COVID-19 vaccination.

From 2023 to 2026, uptake of the influenza vaccine was between 49% and 54% for children, 35% and 38% for adults aged 18-49 years, 45% and 49% for adults aged 50-64 years, and 69% and 70% for people 65 years or older, according to the Centers for Disease Control and Prevention (CDC). COVID-19 vaccination rates have been substantially lower —in the 10%-14% range for children, the 11%-14% range for adults aged 18-49 years, the 17%-24% range for adults aged 50-64 years, and 34%-43% for people 65 years or older.

The influenza virus and the SARS-CoV-2 virus, which causes COVID-19, can mutate and circulate rapidly; each year, vaccine strains must be selected and updated. Strain selection identifies the key amino acid sequences that match each vaccine's composition to predicted viral threats. The updates consider (1) surveillance data about population and clinical trends, including assessments of viral variant "fitness," an indicator of which strains will become the greatest threat in the next year; (2) serology studies using human and other animal blood samples that identify the amino acid sequences, frequency and geographic distribution of virus strains; and (3) vaccine effectiveness studies and information on previous viral variants, including the availability of "candidate" viruses that may serve as vaccine templates. The World Health Organization leads most of these international data collection and analytic efforts, coordinating laboratory and other public health resources across 135 countries.

Influenza

As of February 2026, the 2025-2026 influenza season ranked as the third-worst season for hospitalizations since 2010-2011. There were 90 pediatric deaths; approximately 85% of those children were not fully vaccinated.

The 2025-2026 influenza vaccination reduced the risk of outpatient visits and hospitalizations across 16 states sampled for a national evaluation, although the vaccine's effectiveness was lower than in previous seasons. Three recent studies in adults showed vaccine effectiveness ranging from 22% to 34%.

In March 2026 the FDA's Vaccine and Related Biological Products Advisory Committee (VRBPAC) met to make recommendations on the strain composition of the 2026-2027 influenza vaccine. Most laboratory-confirmed influenza cases in the United States from mid-November 2025 through February 2026 were the alpha (A) strain, according to FDA, CDC and other analyses discussed at the meeting. The A/H3 subvariant was dominant. During the first two months of 2026, the beta (B) strain (principally the Victoria subvariant or unspecified) became more prevalent.

The VRBPAC voted unanimously to recommend an updated trivalent (two A and one B strains) influenza vaccine formulation for the 2026-2027 season.

COVID-19

From October 2025 to May 2026, there were approximately 25 COVID-19 hospitalizations per 100,000 people in the United States. These rates were markedly lower than in prior years. Hospitalization rates at the extremes of age were higher (96 per 100,000 for infants and about 71 per 100,000 for adults 64 years of age or older). Adults with one or more underlying conditions had two to five times the risk of hospitalization compared with age-matched adults without comorbidities. Three-quarters of infants who were hospitalized had no underlying medical conditions.

In May 2026 the VRBPAC met to make recommendations about the composition of the 2026-2027 COVID-19 vaccine. In the four weeks ending on June 7, 2025, the COVID-19 JN.1/LP.8.1 variant represented about 50% of all cases in the United States, according to information discussed at the meeting. By Sept. 27, 2025, the new JN.1/XFG variant accounted for over 70% of cases, almost completely replacing the LP.8.1 variant. As of April 11, 2026, XFG variants were approximately 60% of all circulating COVID-19 viruses.

Four COVID-19 vaccines are approved in the United States; three are mRNA vaccines (COMIRNATY, MNEXSPIKE, SPIKEVAX) and one is a protein vaccine (NUVAXOVID). Vaccine effectiveness was confirmed by several studies during the L.P. 8.1 strain phase of the 2025-2026 season, including one study showing 54% effectiveness in preventing outpatient visits and 57% effectiveness in preventing urgent-care or emergency-department visits.

The VRBPAC voted 9 to 0 with one abstention to recommend the monovalent, JN.1/XFG COVID-19 vaccine for 2026-2027. The committee member who abstained said that although targeting the XFG variant was acceptable, it might have been better to add one or two other viral variants to broaden the vaccine's scope.

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safety of more tradipitant use remains uncertain because of the limitations of the clinical trials. Tradipitant has a half-life in the body of at least 28 hours. Other than studies in rodents, all animal toxicology testing (including for carcinogenesis) lasted six months or less. The FDA is requiring the drug manufacturer to conduct a clinical pharmacology study to evaluate whether tradipitant and its byproducts cause liver impairment.

Tradipitant is only approved for adults; a clinical trial in children and adolescents is anticipated.

What You Can Do

If you are an adult with a history of motion sickness from car, boat or other trips, established over-the-counter or prescription drugs may prevent or reduce the frequency and intensity of some symptoms. Nondrug methods that may help include focusing on stationary objects or the horizon, sitting or lying where there is less motion or fewer confusing visual stimuli (for example, the center of a cruise ship or the driving position or front seat of a car), minimizing reading and screen time, and using relaxation or distraction techniques such as mindful breathing or listening to music.

Tradipitant does not prevent nausea. Clinical trials have not compared this drug with existing drug treatments for motion sickness. Its long-term safety and effectiveness are not known. For these reasons, Public Citizen's Health Research Group has classified tradipitant as **Do Not Use for Seven Years**. ✦

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how frequently patients show agitated behavior on a scale from 29 to 203 points (with lower scores indicating fewer agitation symptoms).

On average, participants who had received the drug combination had a reduction of 15 points on this scale, whereas those in the placebo group had a reduction of 12 points. This three-point difference between the groups was statistically significant, but it is unlikely to be clinically meaningful to patients and caregivers. Moreover, a significantly greater proportion of participants in the combination-drug group were rated to have "minimally improved" scores on a secondary measurement tool (called the Clinical Global Impression of Change) than those in the placebo group.

The second trial was a long-term withdrawal study of 456 adults. All participants first received the approved dose of dextromethorphan-bupropion twice daily for up to 52 weeks (open-label phase). The 456 participants who responded then continued with a double-blind withdrawal phase of up to 24 weeks, in which they were randomized to either continue the drug or switch to placebo. Compared with the placebo group, participants who continued with drug treatment had significantly longer periods free of agitation symptoms before relapsing. After 24 weeks, agitation symptoms relapsed in about 10% of the 54 participants who continued drug treatment, compared with a relapse rate of about 30% in the 39 participants switched to placebo.

Safety

Like bupropion alone, dextromethorphan-bupropion has a boxed warning regarding the increased risk of suicidal thoughts and behaviors in children and youths. The combination drug is associated with additional serious adverse events, including an increased risk of seizures, hypertension (high blood pressure), the precipitation of manic episodes, psychosis or other neuropsychiatric reactions, and serotonin syndrome (which can be life-threatening and cause symptoms such as hallucinations, loss of coordination, fast heartbeat, diarrhea, coma, nausea and vomiting).

Older patients are at an increased risk of hyponatremia (low blood sodium), which can cause symptoms such as confusion, weakness, memory impairment and headaches. Dextromethorphan-bupropion should not be taken during pregnancy, because it may harm the fetus.

Based on the results of the first of the two trials discussed above, participants treated with the combination drug for agitation were more likely than those who received a placebo to experience dizziness (9% vs. 3%), somnolence (8% vs. 4%), dyspepsia (indigestion; 6% vs. 1%), fatigue (6% vs. 3%) and nausea (5% vs. 3%).

Importantly, for both drug components, life-threatening overdoses, misuse and abuse have been reported.

What You Can Do

Agitation associated with dementia due to Alzheimer's disease is a frequent and challenging clinical problem for which better treatments are needed. However, we have classified dextromethorphan-bupropion as **Do Not Use** because it is associated with serious adverse events that outweigh its marginal benefits.

Discuss the best approach to address agitation due to Alzheimer's disease dementia with the patient's clinician. Other possible causes for agitation (including other prescription drugs or medical conditions) should be considered, and nonpharmacological approaches tried. If the patient is already taking dextromethorphan-bupropion, do not discontinue the drug without discussing it with the clinician first. ✦

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kratom a "drug and chemical of concern." In August 2016 the agency endeavored to temporarily classify kratom and its 7-OH derivative as Schedule I controlled substances — a classification for substances with no valid medical uses but a high potential for abuse — for two years. This classification could have criminalized the sale and use of these products. Two months later, however, the agency withdrew its decision due to pressure from kratom supporters, spearheaded by the American Kratom Association. In contrast, several countries (including Australia, France, Malaysia, Sweden and the United Kingdom) have banned kratom, and others (including Finland and Portugal) have classified it as a controlled substance.

The Food and Drug Administration (FDA) has not approved kratom for any therapeutic uses, and FDA scientists showed that multiple kratom compounds bind strongly to opioid receptors. In 2017 the agency issued a public health advisory highlighting kratom risks and noted taking steps to prevent its importation.

In July 2025 the FDA issued seven warning letters to companies that were illegally marketing 7-OH products. In an opinion article in the *New York Post*, Dr. Martin Makary, then the FDA commissioner, stated that the agency is not targeting plant-leaf kratom, claiming that it contains "trace amounts of 7-OH and has been consumed for centuries." In June 2026 the *New York Times* reported that the Trump administration is likely to take a permissive stance on plant-based kratom.

Although Makary was correct that the potency of 7-OH products greatly increases their risks, he and the Trump administration miss the mark on the risks of plant-leaf kratom. Many sources agree that the traditional Southeast Asian uses of kratom — which have been limited to chewing the fresh, bitter-tasting leaves or boiling them in water — do not form 7-OH in measurable amounts. In contrast, contemporary preparations — which come from processed dry kratom leaves — produce high 7-OH levels during drying and processing.

A March 2026 letter from a group of senators led by Sens. Pete Ricketts and Richard Blumenthal urged the FDA to recommend that the DEA schedule the whole kratom leaf, not just 7-OH products. The letter highlighted that young Americans have reported increasing addiction to various kratom products, consuming as many as a dozen a day and experiencing severe withdrawal symptoms when they try to quit.

On July 1, 2026, the DEA issued two notices of intent to temporarily place products that contain more than a specified amount of 7-OH, as well as those containing three related substances (known as mitragynine pseudoindoxyl, MGM-15 and MGM-16), into Schedule I of the Controlled Substances Act.

Some U.S. cities, counties and states have either banned kratom or raised the minimum legal age for its purchase to 18 or 21 years. An April 2026 study in *Addiction* showed that states with some local restrictions on kratom use had similarly high rates of exposure, health care utilization or severe outcomes as states with no local restrictions. In contrast, states that have banned kratom had lower rates of the above outcomes.

Therefore, federal action to ban *all* kratom-related products is urgently warranted to ensure public protection from what could become a new, preventable opioid crisis. Scheduling only 7-OH above a certain threshold and other synthetic substances would leave many other potentially addictive kratom products on shelves, incorrectly implying that they are safe.

What You Can Do

Do not use kratom, 7-OH or related products. When buying candy and dietary supplements, carefully review their listed content to ensure that they do not include these risky products.

If you are struggling with addiction, anxiety, depression or pain, seek medical care from a licensed clinician, and never self-medicate with kratom-related or other unapproved products.

If you suspect that someone has consumed a kratom-related product or other opioids and is not responsive or is unable to breathe, call 911 immediately. You should also give the person naloxone (KLOXXADO, NARCAN, REXTOVY, RIVIVE and generics), if available, to reverse the slowed or stopped breathing effects of kratom. If you have questions or concerns related to kratom exposure or use, call the Poison Help line (800-222-1222). ✦

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What You Can Do

Absent limited medical exceptions such as documented severe allergic reactions, Public Citizen's Health Research Group recommends that all eligible children and adults receive and stay up to date on influenza and COVID-19 vaccination, including people who are pregnant. The 2026-2027 influenza and COVID-19 vaccines should be widely available in pharmacies, health centers and doctors' offices. Both vaccines can be administered at the same visit. The best time for annual influenza vaccination is September or October. ✦

In the Next Issue

Read about Public Citizen's petition to ban direct-to-consumer advertisements for prescription drugs.

News Brief

FDA Approves Bemotrizinol, a New Sunscreen Active Ingredient

Unlike many European countries, the United States regulates sunscreens as over-the-counter drugs rather than cosmetics, which means they go through much more testing before they can be sold to consumers.

In June 2026 the Food and Drug Administration (FDA) added bemotrizinol, an ultraviolet (UV) filter, to the list of permitted active ingredients in sunscreen. It is the first new sunscreen filter the agency has approved in over two decades. Bemotrizinol products have been sold in Europe and Asia for many years. There are considerable data about their safety and efficacy.

There are two general types of sunscreen filters: chemical (such as avobenzene and oxybenzone) and physical (such as zinc and titanium oxide; also known as mineral filters). Both types of filters work by absorbing UV rays; physical filters also reflect the sun's rays away from the skin.

Bemotrizinol is a chemical filter. Like other chemical filters, it protects against both UVA rays (the type that cause premature aging and wrinkles) and UVB rays (the type that cause sunburn), both of which can cause skin cancer. However, bemotrizinol is significantly better at protecting against UVA rays than other available filters.

Studies have shown that bemotrizinol is unlikely to cause reproductive harm or irritate skin, and it is also less readily absorbed into the bloodstream than other sunscreen filters. The FDA says that bemotrizinol is considered to be generally safe and effective, meaning it is safe for adults and children older than 6 months to use.

Sunscreens containing bemotrizinol as an active ingredient will likely become available for purchase in the United States later in 2026, offering consumers another choice.

Any sunscreen you choose should have a sun protection factor (SPF) of at least 30 and be labeled as broad spectrum (protecting against both UVA and UVB rays). Be sure to apply it every time you go out in the sun and reapply at least every two hours (or more often if you are swimming or sweating).

DRUG INDEX

Drug names in **bold** indicate the drug is the primary subject of an article. Drug names in ALL CAPS are brand names. Numbers refer to the page containing the first reference to the drug or supplement in each article.

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