

From the Deputy Chief Medical Officer, Prof Lourda Geoghegan



Reference: HSC (SQSD) 10/25

Date of Issue: 23 January 2026

For Action:

Chief Executives HSC Trusts
Chief Operating Officer, SPPG
Chief Executive, PHA
Chief Executive, RQIA
Chief Executive, NIMDTA

Related documents

None

Implementation: Immediate

For Information:

Distribution as listed at the end of this Alert Letter.

**URGENT ACTION REQUIRED - NATIONAL PATIENT SAFETY ALERT:
HARM FROM DELAYED ADMINISTRATION OF RASBURICASE FOR TUMOUR
LYSIS SYNDROME (TLS)**

SUMMARY

The NHS England Patient Safety Team issued a National Patient Safety Alert (NaPSA) on 9 September 2025 ([NatPSA/2025/005/NHSPS](#)) regarding harm from delayed administration of rasburicase for tumour lysis syndrome (TLS). This instructs all organisations providing an Emergency Department and/or cancer services to review and update local clinical procedures or equivalent documents.

ACTIONS TO BE COMPLETED BY 09 MARCH 2026

To align with the updated British Society for Haematology (BSH) guidelines,¹ review and update local clinical procedures (or equivalent documents) to ensure:

- a) Prior to initiation of new treatment, every patient with a haematological malignancy has a documented, personalised risk assessment for TLS and, depending on the assessed risk, has appropriate prophylaxis prescribed.³

NOTE B

- b) Indication, appropriate dose and monitoring requirements for rasburicase are clearly documented to avoid the need for further validation outside of the immediate specialist clinical team. ^{NOTE C}
- c) **Routine** use of rasburicase is limited to clinical areas where clinical staff have the competency to initiate treatment, understand the time critical nature of administration, the risk of delays in treatment and when to escalate concerns. ^{4, NOTE D}
- d) If **by exception** rasburicase needs to be initiated in, or a patient receiving treatment needs to be transferred to, any clinical area where it is not routinely used, specialist clinical staff ensure:
- rasburicase is prescribed on the medication chart/electronic prescribing system used in the receiving setting.
 - sufficient stock of rasburicase is available to ensure completion of the treatment course.
 - relevant, documented clinical information is available in the clinical area.
- ^{NOTE D}
- e) Both strengths of rasburicase (1.5mg/ml and 7.5mg/ml) are available and accessible in sufficient quantities in the fridge in all relevant clinical settings for administration of prophylactic or treatment doses within 1 hour of prescribing. ^{NOTE E}

(Please refer to the Additional Information section of the [NaPSA](#) for NOTES A-E and References)

Chief Executives of HSC Trusts are asked to:

1. Disseminate this circular to relevant staff within your organisation.
2. Appoint an executive member of staff, supported by clinical leaders and heads of departments in pharmacy, emergency care and haematology/oncology to oversee the implementation of the actions outlined above.
3. Trusts are requested to confirm that actions above have been completed by returning a 3rd Line of Assurance Template to the Performance, Safety and Service Improvement Directorate (PSSID), Strategic Planning and Performance Group (SPPG) at Alerts.SPPG@hscni.net by 9 March 2026.

Chief Operating Officer of Strategic Performance and Planning Group should:

1. Disseminate this circular to all relevant staff.
2. Assess the level of assurance provided by the Trust's 3rd Line of Assurance Template and address any concerns.
3. Notify the Quality, Safety and Improvement Directorate of the Department (qualityandsafety@health-ni.gov.uk) of any ongoing concerns.

Chief Executive PHA should:

1. Disseminate this circular to all relevant PHA staff.
2. Ensure relevant professionals work with colleagues in SPPG to assess the level of assurance provided by the Trust's 3rd Line of Assurance Template to address any concerns.

Chief Executive RQIA should:

1. Disseminate this circular to all relevant Independent Providers.
2. Implement relevant actions from this circular and through the usual RQIA monitoring processes assure implementation of advised approach/ best practice guidance.

Chief Executive NIMDTA should:

1. Disseminate this circular to doctors in training in all relevant specialties.

SUMMARY OF IDENTIFIED ISSUE

Tumour lysis syndrome (TLS) is a life-threatening complication of cancer or its treatment. It is caused by the large-scale destruction of malignant cells, either spontaneously in malignancies with a high proliferation rate (eg Burkitt's lymphoma) or, more commonly, after the administration of systemic anti-cancer therapy (SACT). The release of intracellular contents and electrolytes into the bloodstream overwhelms the normal physiological mechanisms of clearance. ^{1, NOTE A}

Rasburicase is indicated for the treatment and prophylaxis of acute hyperuricaemia in adults, children and adolescents (aged 0 to 17 years) with haematological malignancy, a high tumour burden and at risk of a rapid tumour lysis or shrinkage at initiation of chemotherapy. ² It is recommended as prophylaxis for patients at high

risk of TLS, those at intermediate risk who cannot take alternative therapy, and those who need immediate therapy and pre-existing urate levels are high.¹

A review of the National Reporting and Learning System in 2021 in England identified 82 incidents associated with delays and omissions in treatment with rasburicase. A subsequent review in 2024 identified a further 41 incidents including a report of a patient with lymphoma and deteriorating renal function, who was not prescribed rasburicase for potential TLS on admission to hospital and had a cardiac arrest and sadly died the following day. In total, of the 123 reported incidents of omitted or delayed doses of rasburicase:

- five patients with suspected TLS, or at high risk of developing TLS, died,
- six patients at risk of TLS, went on to develop TLS, two of whom required transfer to ITU
- three patients at risk of TLS deteriorated significantly, one of whom required transfer to ITU.

ENQUIRIES

Any enquiries about the content of this circular should be addressed to:

Safety Strategy Unit
Department of Health
Room D1.4
Castle Buildings
BELFAST
BT4 3SQ
E: qualityandsafety@health-ni.gov.uk

DoH Safety and Quality Circulars including Patient Safety Alerts can be accessed [here](#).

Thank you for your attention to this important matter.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Prof L Geoghegan', is centered within a light gray rectangular box.

Professor Lourda Geoghegan
Deputy Chief Medical Officer

Distributed for Information to:

Medical Directors, HSC Trusts
Nursing Directors, HSC Trusts
Governance Leads, HSC Trusts
Assurance Contacts, HSC Trusts
Executive Medical Director/Director of Public Health, PHA
Director of Nursing and Allied Health Professions, PHA
Safety Lead, PHA
Director of Performance, Safety and Service Improvement, SPPG
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