National Shortage of Bumetanide 1mg tablets

- Please switch patient's medication before they run out of tablets.
- If suitable, consider a switch to furosemide first line (dose equivalents below).
- Renal function and electrolytes (including magnesium) need monitoring, initially after one week and then as needed.

A National Patient Safety Alert (NatPSA)[1] has been issued by NHS England and Department of Health and Social Care (DHSC) regarding a shortage of Bumetanide 1mg tablets - Bumetanide 1mg tablets are **out of stock until late July 2025**. 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. The NatPSA alert is for action by all organisations involved in prescribing, dispensing and administering bumetanide 1mg tablets. Further information can also be found on SPS [2].

This cohort of patients are at high-risk of decompensation and unintentional fluid retention (and potentially hospital admission) if they stop taking their bumetanide 1mg tablets when not prescribed suitable diuretics, therefore a switch should be made before patients run out of tablets to avoid a break in therapy. Healthcare professionals in primary and secondary care should not initiate any new patients on bumetanide 1mg tablets until the supply issue has resolved.

NPSA alert actions to be completed (please see NPSA alert for full details):

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.

An EMIS search has been provided to support you with identifying patients prescribed Bumetanide 1mg tablets at your practice:

Bumetanide 1mg tablets.xml

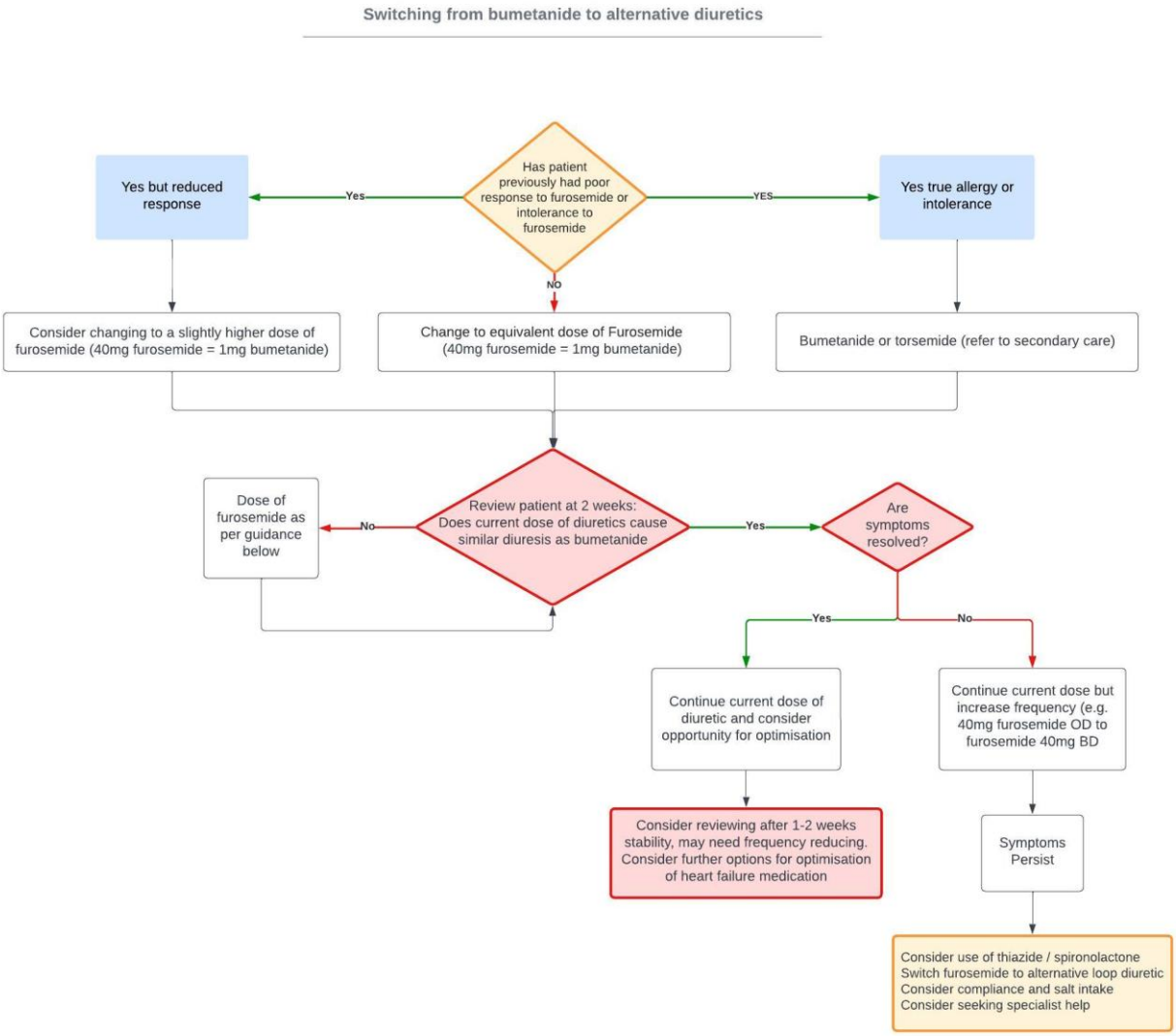
3. Patients with insufficient supplies should be considered for furosemide tablets ensuring that the patient is not intolerant to any of the excipients, is counselled on the appropriate dose to take, additional weight monitoring requirements and to report any side effects and loss of treatment response.

4. Patients who fit the criteria should be prioritised for remaining supplies of bumetanide 1mg tablets. 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. **Contact information below.**

Furosemide and thiazides (bendroflumethiazide or metolazone) remain available and are first choice for use.

Recommendations



Flow chart above adapted with permission from Leeds Heart Failure Service[3].

Loop diuretic quick conversion chart/equivalent doses (when kidney function is normal)			
	Bumetanide	**Furosemide**	**Torsemide** (for use in patients allergic to furosemide, recommendation for use by Specialist only)
Oral	1mg	40mg	10-20mg
IV	-	20mg	-

The bioavailability of oral furosemide is 50% therefore a switch may require dose adjustment to maintain diuresis. Torsemide has a longer half-life than furosemide (3.5hrs vs 1-2 hrs respectively) and increased bioavailability (>80%).

Dose adjustment of furosemide should be considered as a total daily dose. If patients are on a low dose, then consider doubling, either the single dose or increasing frequency to twice daily dosing, considering how this fits with patient lifestyle. Patients should be advised to take medication at a time that is convenient and does not cause issues with nocturnal diuresis. For patients on a higher dose of furosemide (>120mg), the dose should be increased by 40-80mg steps, depending on volume of oedema and kidney function. The largest single dose should be 120mg, greater than this should be given as twice daily dosing.

The majority of patients can be switched to furosemide, however for patients with a true furosemide allergy or severe diuretic resistance please send an Advice and Guidance for Specialist advice from the relevant secondary or community care Heart Failure Team.

***Additional diuretics*.** In patients who require increased diuresis but cannot be maintained easily on furosemide alone due to renal impairment, hypotension or electrolyte disturbance, thiazides or metolazone should be considered.

Seek advice and guidance from Heart Failure Specialist team or Renal team if additional diuretics are to be started. Please note that there is very limited capacity for outpatient referrals just for diuretic management and this will be prioritised for patients with complex co-morbidities.

The table below outlines how to add additional diuretics to furosemide to enhance diuresis.

Renal Function	1st line	Titration
<30ml/min	Metolazone 2.5mg od	Up or down to alternate days or 5mg od depending on diuresis
>30ml/min	Bendroflumethiazide 2.5mg od	Titrated to 5mg od if needed

Troubleshooting

- If potassium drops, consider adding spironolactone / eplerenone (if eGFR >30ml/min)
- Some changes in urea and creatinine often occurs with effective diuresis. If change is small, then persist with diuretics if they are providing symptomatic benefit.
- Hyponatraemia in the presence of fluid overload is usually dilutional and is not necessarily a contraindication to the use of loop diuretics.
- If there is marked oedema consider addition of thiazide diuretic – often initially as a single dose and review response.

Monitoring

The risk of electrolyte disturbance is high, and patients should be monitored closely during the period of the switch. All patients should have renal function and electrolytes (including magnesium) checked after one week and those demonstrating hypokalaemia should have weekly monitoring until stable. Sando-K supplements can be used until patients are stable. Patients on high dose furosemide (>200mg) should have their renal function checked every 4-6 weeks.

Please avoid referring patients to emergency care for hypokalaemia, instead seek advice and guidance from the relevant secondary care heart failure or renal team who will be able to take over management where necessary.

Some patients may experience hyponatraemia if they become overloaded – consider volume status carefully before stopping/reducing loop or thiazide diuretics.

Contact information

NBT	HeartfailureService@NBT.nhs.uk
UHBW	Heart Failure Nurse Specialist line 0117 34 26602 (Mon-Fri 9-5pm) HeartFailureTeam@uhbw.nhs.uk
Sirona	sirona.heartfailureservice@nhs.net 0117 9617153

References:

1. NHSE, DHSC, July 2025. Shortage of bumetanide 1mg tablets [Online]. Available from: https://www.cas.mhra.gov.uk/ViewAndAcknowledgment/viewAlert.aspx?AlertID=103264 [Accessed 4 July 2025]
2. Specialist Pharmacy Services, 3 July 2025. Shortage of Bumetanide 1mg tablets [Online]. Available from: https://www.sps.nhs.uk/shortages/shortage-of-bumetanide-1mg-tablets/ [Accessed 4 July 2025]
3. Leeds Heart Failure Service, December 2020. *The Leeds Integrated Heart Failure Pathways, Leeds Heart Failure Service*. Permission requested in 2024 to adapt for use in BNSSG.
4. British National Formulary, 2023. London: Pharmaceutical Press. Available from: https://bnf.nice.org.uk/
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