**Similar Drug Names A Growing Cause of Errors**

**U.S. Pharmacopeia seeks to add ‘indication of use’ on prescriptions, citing over 3,000 soundalike drug pairs.**

BY BRUCE K. DIXON

Chicago Bureau

The soaring numbers of commonly confused drugs with soundalike and look-alike names have prompted the U.S. Pharmacopeia to ask physicians and pharmacists to include an “indication of use” on prescriptions.

This and other recommendations are contained in U.S. Pharmacopeia’s 8th annual MEDMARX report, which is based on a review of more than 26,000 records submitted to the MEDMARX database from 2003 to 2006.

The records implicate nearly 1,500 drugs in medication errors due to brand or generic name confusion or be confused with other products that have been confused at your facility, Ms. Cousins emphasized. "All that is needed are simple inclusions, such as ‘for sinus,’ ‘for heart,’ or, ‘for cough,’" she said. Ms. Cousins also would help patients avoid confusion if they forget which vial is for which condition.

The recommendation that physicians include indications for use in their prescriptions is not an attempt by USP to impose on privacy, Ms. Cousins emphasized. "All that is needed are simple inclusions, such as ‘for sinus,’ ‘for heart,’ or, ‘for cough,’" she said. Ms. Cousins also would help patients avoid confusion if they forget which vial is for which condition.

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**Financial Assistance Available for High-Cost Cancer Therapies**

**BY MIRIAM E. TUCKER**

Senior Writer

WASHINGTON — Financial assistance is available to patients struggling with costs of the new— and extremely expensive— targeted therapies for renal cell carcinoma as well as other advanced cancers, Mr. James Goetz said at the annual Community Oncology Conference.

As far as the patient is concerned, the approved agents sunitinib (Sutent), sorafenib (Nexavar), and temsirolimus (Torisel) are all high cost. ballparks, with each resulting in a bill of about $135,000 for a 6-month regimen at St. Luke’s Hospital and Health Network in Bethlehem, Pa., where Mr. Goetz is the network administrator of the Oncology Service Line.

“We’re seeing more and more patients prescribed and used in hospitals, and virtually every time, all of the top 10 appeared within the USP similar names list,” Ms. Cousins said in an interview.

An important finding of this year’s report is the role of pharmacy staff in LASA-related errors, she said. “Although pharmacy personnel, who are generally technicians, made the majority of errors, pharmacists as a group identified, prevented, and reported more than any other staff.”

The report also identifies an emerging trend of look-alike drug names in computerized direct order entry systems as a source of confusion. “This trend will likely continue as these systems become a standard of practice,” she said, adding that the LASA-related error problem is further compounded by the indiscriminate use of suffixes, as well as look-alike packaging and labeling.

Over the 3-year period, the drug most commonly confused with others was ceftazolin, a first-generation cephalosporin antibiotic. “We found it to be confused with 15 other drugs, primarily antimicrobials, which might be explained by the fact that this is the most frequently used class of medications,” said Ms. Cousins.

Among other major paired LASAs were cardiovascular medications, such as losinopril and enalapril, and central nervous system agents, such as trazodone and chlorpromazine.

Drug mix-ups led to seven reported fatalities, including two deaths attributed to confusion over the Alzheimer’s drug Reminyl (galantamine) and the antidiabetic drug Amaryl (glimepiride).

In 2005, recognizing the high risk of confusion and subsequent fatal hypoglycemia, Ortho-McNeil Neurologics Inc. announced that the name Reminyl had been changed to Razadyne to avoid confusion with Amaryl.

In another case, an autistic pediatric patient was given the wrong product when disodium EDTA (a hypercalcemia treatment) was administered instead of the chelation therapy calcium disodium EDTA, which is approved by the Food and Drug Administration for the treatment of lead poisoning and was prescribed in an attempt to help treat the patient’s autism.

In another case, an emergency department physician was preparing to intubate a patient and calculated the dose for rocuronium (Zemuron), a preintubation agent used to assist with the procedure. The physician gave orders for the nurse to obtain the medication and indicated the volume to administer to the patient. The nurse obtained and administered the neuromuscular blocking agent vecuronium (Norcuron) instead. The patient received a large amount of the wrong agent, which led to a fatal heart attack.

The remaining three reported deaths involved mix-ups for the anticonvulsant primidone and phenytoin; the antiepileptic drug phenytoin sodium and the barbiturate phenobarbital; and Norcuron and the heart failure treatment Natrecor (nesiritide recombinant).

Errors occur with over-the-counter medications, Ms. Cousins described the aural confusion when an order for Ferrous 500 mg—an iron replacement—was transcribed as Serrosequel 500 mg and the order was misread as Serquel 500 mg—an antipsychotic.

The rate of mix-ups involving brand name versus generic drugs was about even split, 57% and 43%, respectively, Ms. Cousins said, adding that while most errors were made in pharmacies, many, such as the primidone-phenytoin incident, are due to confusion over the prescribing physician’s handwriting, which leads the pharmacist to issue the wrong drug.

“Errors also are due to physicians using short codes for medications, such as ‘clon,’ for clonazapem or clonapine,” she said, adding that electronically written prescriptions using a computer or label machine would eliminate many errors. “Anything that is taking pain out of the equation is a help.”

It would also be helpful if the FDA were given more authority to force name changes during the drug-approval process, as has been suggested by the Institute of Medicine. “It’s much more difficult to correct a name confusion issue once the products are on the market.”

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