A case series of duplication errors due to brand name confusion – experience from a Sri Lankan teaching hospital

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Introduction and objectives: Confusion with drug names has been identified as a leading cause of medication errors. The majority of these errors result from look-alike or sound-alike drugs. This case series aims to provide examples of duplication errors due to brand confusion where there are no similarities in names.

Method: Information for this case series was extracted from a database prospectively collected from Colombo North Teaching Hospital as part of a study conducted to evaluate the impact of the addition of a clinical pharmacist to the standard inpatient care.

Results: Of 800 patients reviewed during the study period of 7 months, clinical pharmacist identified 8 cases of duplication errors due to prescribing generic and brand names of the same drug, but with no similarities in name. Cases identified include duplication of frusemide caused by the lack of awareness that “Amifru” (a combination of frusemide and amiloride) contains frusemide. Similarly, a patient was prescribed ‘H Pylori Kit’ plus the three individual drugs included in the ‘Kit’ prescribed using their generic name. A patient was found to be taking 2 different brands of carbidopa and levodopa not knowing the two contained the same drugs.

Conclusion: Brand confusion does not necessarily arise from look-alike or sound-alike drug names. It can be due to various brands of generic ingredients and lack of awareness of drug names among the patients. Employing trained clinical pharmacists in the wards, educating patients on discharge drugs, and appropriate labelling of medicines may prevent these errors.
A CASE SERIES OF DUPLICATION ERRORS DUE TO BRAND NAME CONFUSION - EXPERIENCE FROM A SRI LANKAN TEACHING HOSPITAL

INTRODUCTION
Confusion with drug names has been identified as a leading cause of medication errors. The majority of these errors result from look-alike or sound-alike drug names. However, brand confusion may occur without similarities in names.

OBJECTIVES
This case series aims to provide examples of duplication errors due to brand confusion where there are no similarities in the names.

METHOD
Information was extracted from data prospectively collected from Colombo North teaching hospital as part of a study conducted to evaluate the impact of the addition of a clinical pharmacist to the standard inpatient care.

RESULTS
Of 600 patients reviewed during the study period of 7 months, clinical pharmacists identified 8 cases of duplication errors due to drug name confusion, but with no similarities in names.

CASE 1
52 year old male (alcoholic cirrhosis) patient with painful breast enlargement on spironolactone 100mg bid & frusamide 40mg bid. Gynaecomastia, a well known adverse drug reaction to spironolactone was suspected.
A senior doctor on the ward ceased spironolactone and frusamide
Commenced 'Amiflu' (a combination of 40mg frusamide and 3mg amiodone).
The discharge prescription included frusamide 40mg twice daily, spironolactone 100mg twice daily plus 'Amiflu'
1 tablet twice daily.

Duplicating dosages can result in patient harm from over-dosage. Continuing spironolactone could have resulted in worsening gynaecomastia and/or hyperkalaemia in the context of decompensation.

This patient, being in the intervention arm, received clinical pharmacy services. Thus, this issue was identified and communicated to the prescriber before discharge by the clinical pharmacist.

CASE 2
71 year old male patient, admitted for esophage-gastro-duodenoscopy (EGD) showed evidence of gastric ulcers.
The gastroenterologist recommended H. Pylori kit twice daily for two weeks followed by omeprazole 20mg twice daily.
The patient was given a prescription for this 'Kit' prior to discharge. The kit included amoxicillin, metronidazole and omeprazole.
The discharge prescription also included the three drugs in the 'Kit' prescribed generically.
During the follow up phone call conducted six days after discharge, as part of the clinical pharmacy study, it was found that the patient was taking the H. Pylori Kit contents plus the three individual drugs concurrently.

This could potentially result in worsened side effects, particularly gastrointestinal effects and is also an unnecessary cost to the patient.

No pharmaceutical intervention was made at discharge as this patient was in the control arm and therefore was not reviewed by the clinical pharmacist as an in-patient.

CASE 3
An 86 year old male patient with a history of Parkinson's disease, admitted with decreased level of consciousness and impaired speech.
Whilst obtaining the medication history from the carer, the clinical pharmacist identified that the patient had been taking two brands of levodopa 250mg/ carbidopa 25mg (Tidmotol' and 'Syndopa').
The carer was not aware that the two drugs were equivalent.

This mistake resulted in a doubling of the prescribed dose and the potential for increased side effects.

CONCLUSION
Brand confusion does not necessarily arise from look-alike or sound-alike drug names. It can be due to numerous brands of generic ingredients and lack of awareness of drug names among the patients.

EMPLOYING TRAINED CLINICAL PHARMACISTS IN THE WARDS

EDUCATING PATIENTS ON DISCHARGE DRUGS

APPROPRIATE LABELING OF MEDICINES

may help preventing these errors.

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REFERENCES