Drug experts tackle trouble with medication names

BY DELTHIA RICKS Newsday.com

Even though a new report on medication errors has found that thousands of people receive the wrong drug because too many have confusing look-alike or sound-alike names, experts say there are ways to prevent the mix-ups, which in some instances have proven deadly.

The United States Pharmacopeia, which sets standards for the purity and potency of medications, examined 26,000 instances of patients receiving the wrong medication in 870 hospitals nationwide. About 1.4 percent of those mistakes resulted in harm, including seven that may have caused or contributed to patients' deaths, the nonprofit group said in a report last week.

But experts say it's not necessarily sloppiness by health care professionals that's causing the errors. Too many pharmaceutical companies christen their medications with names similar to those of other companies. The drugs rarely, if ever, are for the same condition.

"The most common reason for this error is not negligence, but simply misreading the prescription," said Jason Zvokel, pharmacy manager at Walgreens in Centereach who has published pamphlets to help fellow pharmacists - and consumers - recognize subtleties that can lead to mistakes.

"With more look-alike and sound-alike medications on the market than ever before, it's becoming all too easy to misread doctors' handwriting," he said.

USP found 3,170 pairs of names that look or sound alike, nearly double the 1,750 pairs it identified in its 2004 analysis.

Zvokel said consumers should always discuss their prescriptions with a pharmacist so that each is aware of the reason the prescription was written. New York State requires pharmacists to counsel patients on medication use, Zvokel said.

Electronic prescribing is helping to clear some of the confusion, but human error - entering the wrong drug name - leads to the same problem as bad handwriting.

Sometimes prescriptions are called into pharmacies, and the sound-alike names can result in a mistake: Zantac, an ulcer medication, sounds confusingly similar to Xanax, a tranquilizer. Other examples: Zoloft, Zofran, Zocor, Zyrtec, Zantac, Ziac, Zetia, Zerit, Zestril and Zyprexa, to name a few.

Pharmaceutical companies are trying to alleviate some of the problems. The cholesterol reducer Lovaza, made by GlaxoSmithKline, was once known as Omacor, but it was frequently confused with the drug Amicar.

The name switch can help alleviate drug mix-ups, Zvokel said.

Mistakes can be serious when patients receive the wrong medication. In its report, the USP found in one instance a patient inappropriately received Lamictal, a bipolar drug, instead of the blood-pressure lowering medication Labetalol. Within days the patient was hospitalized with elevated blood pressure.

Dr. Darrell Abernethy, chief science officer at USP, said doctors should always explain on the prescription what the drug is for as a way of preventing pharmacy errors. "By recording and communicating not only the name of the drug, but also what it is being used for, prescribers, pharmacists and consumers can work together to dramatically reduce these types of medication errors," he said.

Zvokel said generics, because of their longer scientific names derived from their chemical structures, pose another level of difficulty.

The potential for error, Zvokel added, does not end with name similarity. "Problems can also occur because of doses. Both ... [hydralazine and hydroxyzine] come in 10 milligrams and 25 milligrams. And on most pharmacy shelves, they'll be very close to each other."

The USP emphasizes what it calls "tall-man" lettering: Uppercasing "ZOL" in the glaucoma drug acetaZOLamide to prevent confusion with acetoHEXamide, a diabetes medication.