



Rx Update

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LOOK-ALIKE DRUG PRODUCTS

The Department of Pharmaceutical Care has employed steps to reduce mix-ups involving drug names that may look similar when read quickly or sound similar when spoken aloud. Pharmacy policy designates several drug names that have been frequently associated with errors due to similarly appearing or sounding drug names. However, look-alike errors can also occur with products that physically look similar. This may occur because of similar packaging, similar labeling, or use of caps of the same color or size (typically for injection vials).

Product packaging similarities have been associated with many documented medication errors in the U.S., including recent errors in Indiana following a mix-up between two heparin products with similar packaging manufactured by one company. [Note: the UIHC does not stock either of the products involved in these mix-ups.] A recent meeting involving officials from the FDA and drug safety experts concluded that drug container labels that look visually similar and utilize similar appearing text make it difficult for users to quickly and safely distinguish among various parenteral products. In addition, visual similarities used to promote a company's product line make differentiating among several strengths difficult.

Those who handle drug products should not rely solely upon physical cues to distinguish among various products. **Specifically, staff should not rely on: packaging materials/size/color, product labeling format/color (of the text or background), or cap color to distinguish between drug products.** Product labels must be carefully read (and, where required, bar codes appropriately scanned) to ensure proper product selection and avoidance of errors.

If you are aware of drug products, in any form, that may be confused with one another because of similarities in appearance of the manufacturer's packaging, please bring these products to the attention of your area manager/ supervisor or the Pharmacy servicing your area. Such products may need to be stored in a different manner, such as placing them in physically separate locations where the opportunity for confusion is reduced. Your assistance with this safety concern is appreciated.

WARNING: ENOXAPARIN WITH EPIDURAL CATHETERS

Low-molecular weight heparins (e.g., enoxaparin) can increase the risk of developing an epidural or spinal hematoma if they are used concomitantly with epidural/spinal anesthesia or spinal puncture. This can result in long-term or permanent paralysis. The risk of hematoma formation is increased by the use of post-operative indwelling epidural catheters for administration of analgesia or by the concomitant use of drugs affecting hemostasis such as nonsteroidal anti-inflammatory drugs (NSAIDs), platelet inhibitors, or other anticoagulants. The risk also appears to be increased by traumatic or repeated epidural or spinal puncture.

Enoxaparin must not be administered to patients who have an epidural catheter in place. Doses of enoxaparin should be delayed until at least 2 hours after epidural catheter removal. An epidural catheter should not be placed until at least 10 to 12 hours after a prophylactic-dose of enoxaparin (e.g., 40 mg daily) or 24 hours after a treatment-dose of enoxaparin (e.g., 1.5 mg/Kg/dose daily or 1 mg/Kg/dose twice daily).

Patients who are on other anticoagulants (e.g., heparin, warfarin) or antiplatelet medications (e.g., clopidogrel, ticlopidine, eptifibatide, tirofiban, abciximab) are also at risk for developing epidural or spinal hematomas when used concurrently with neuraxial blockade. **The Pain Service (pager 3832) must be consulted for guidance when an anticoagulant is ordered in a patient with an epidural or peripheral nerve catheter.**