Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/ Adverse Event Information

Medical Safety Information

No.68, July 2012

Drug mix-up (1st Follow-up Report)

Information regarding drug mix-up was released as Medical Safety Information No.4 (March 2007). After that, twenty similar cases have been reported, so the information is provided here again (information collection period: from January 1, 2007 to May 31, 2012).

Cases of drug mix-up due to similar drug names have been reported again.

Drugs which should have been administered (Main efficacy)	Drugs mixed-up (Main efficacy)	Number of cases
Almarl (antiarrhythmic agent)	Amaryl (antidiabetic agent)	3
Norvasc tablets (vasodilator)	Nolvadex tablets (antineoplastic agent)	3
Thiuragyl tablets (anti-thyroid hormone drug)	Thyradin S tablets (thyroid hormone preparation)	2

- Almarl tablets have received approval for manufacture and sale under the name Arotinolol Hydrochloride (January 2012).
- Of the twenty reported cases, this table shows the names of those drugs that were reported as being involved in such cases on multiple occasions.

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Case

The physician read the referral letter from another medical institution and opened the ordering screen to prescribe the male patient 10mg of Norvasc. When the physician input "*Noruba*" (the Japanese pronunciation of the first six letters of Norvasc), Nolvadex (pronounced *Norubadekkusu* in Japanese) appeared next on the screen after Norvasc. The physician was trying to prescribe 10mg, so s/he mistakenly selected Nolvadex, which had "10" written next to it, and prescribed that. Subsequently, the pharmacist at the external pharmacy thought it was strange, but did not submit an inquiry about the prescription to the hospital and dispensed three months' supply, which the patient took. The drug error was discovered when the patient sought a consultation at another hospital to obtain his prescription.

The Ministry of Health, Labour and Welfare has issued a notice (warning) concerning the strengthening and thorough implementation of measures to prevent medical adverse events resulting from the similarity of pharmaceutical brand names.

○Health Policy Notice No.1204001 Pharmaceutical and Food Notice No.1204001 dated December 4, 2008
http://www.mhlw.go.jp/topics/bukyoku/isei/i-anzen/hourei/dl/081204-1.pdf

Preventive measures taken at the medical institutions in which the events occurred.

- **Add an alert function to the prescription screen for high-risk drugs, etc.**
- **Strengthen the system of communication between physicians and pharmacists.**

* As part of the Project to Collect Medical Near-Miss/Adverse Event Information (a Ministry of Health, Labour and Welfare grant project), this medical safety information was prepared based on the cases collected in the Project as well as on opinions of the "Comprehensive Evaluation Panel" to prevent the occurrence and recurrence of medical adverse events. See quarterly reports and annual reports posted on the Japan Council for Quality Health Care website for details of the Project. http://www.med-safe.jp/

* Accuracy of information was ensured at the time of preparation but cannot be guaranteed in the future.

* This information is intended neither to limit the discretion of healthcare providers nor to impose certain obligations or responsibilities on them.

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