

# Beware of look-alike and sound-alike drugs



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There have been a number of reports of medication errors involving the sound-alike and look-alike drugs Amaryl (glimepiride) and Reminyl (galantamine). These reports include instances in which the oral sulfonylurea Amaryl, indicated for the treatment of type 2 diabetes, has been mistakenly dispensed to patients who have been prescribed Reminyl, an acetylcholinesterase inhibitor approved for the treatment of mild to moderate Alzheimer's dementia. The resulting adverse events included severe hypoglycemia and fatalities.<sup>1</sup>

Though these reports originated in the United States, Canadian practitioners must be aware of the potential for error and should take steps to prevent patient harm.

## Cases<sup>2</sup>

A 78-year-old woman with a history of Alzheimer's disease was admitted to the hospital with hypoglycemia. A review of the medications she was taking at home revealed that her pharmacist had dispensed Amaryl 4 mg, which she took twice daily, instead of Reminyl 4 mg twice daily. In another case, an 89-year-old female received Amaryl instead of Reminyl for three days, eventually requiring hospitalization for treatment of severe hypoglycemia. Fortunately, both patients recovered with treatment.

## Contributing factors

- Amaryl and Reminyl can sound alike when spoken and look alike when poorly written.
- Both drugs have the same dosage form (tablets), route of administration (oral), and share a common strength (4 mg).

## Recommendations

- When dispensing Amaryl or Reminyl, confirm the indication for use or purpose of the medication.
- Check the dosage and dosing interval for appropriateness. The usual starting dose of Amaryl is 1 mg once a day, whereas Reminyl has a recommended starting dose of 4 mg twice a day.
- Verify all verbal prescriptions for Amaryl or Reminyl by spelling the drug name and/or confirming the indication for use.

- Suggest to your software vendor that "alert flags" be added to these drug files (e.g., flashing screen) to alert staff to the potential for error. As an interim step, a note may be added to the drug file.
- Place cautionary labels or stickers on these and other sound-alike and look-alike drugs to alert the pharmacy staff of the potential for error.



## Sample sticker

- The manufacturers of Amaryl and Reminyl have also developed a "shelf talker" that can be used to highlight the potential for error.
- Ensure that each patient is appropriately counselled before any new prescription is given out. Provide a patient information leaflet, and highlight key information including indication for use. If the patient indicated that he has taken the medication previously, consider opening the vial in his presence to confirm that there has not been a change in the look of the medication. ■

## REFERENCES

1. Health Canada website. Medication errors involving reminyl and amaryl, December 17, 2004. Available: [www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/reminy/amaryl\\_hpc\\_e.html](http://www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/reminy/amaryl_hpc_e.html) (accessed February 2, 2005).
2. Diabetes or Alzheimers? *ISMP Medication Safety Alert* 2004;9(18).

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