Correspondence

Drug errors

To the Editor:

I was disappointed to read the recent clinical report by Orser and Oxorn.¹ This report would seem to prove that history is indeed condemned to repeat itself.

As a senior resident in Saskatchewan in 1984, I had the misfortune of a similar adverse event. In fact, I made the same error, the same way, with the same two drugs and ampoules while attempting to reverse residual neuromuscular blockade in a healthy woman. The accidental injection 1 mg epinephrine was followed by ventricular tachycardia and subsequent cardiac arrest. Like Orser and Oxorn, the patient was successfully resuscitated and made a full and complete recovery. Immediately after this adverse event, the ampoules used for neuromuscular reversal were examined. We were shocked to realize that one of the ampoules originally thought to be glycopyrrolate was indeed epinephrine. Various agencies were notified including the manufacturers of these two ampoules, and we were told that the matter would be addressed. Sadly, it appears, no real change has occurred over the past ten years. Orser and Oxorn rightfully point out that in Canada there is no federal or provincial agency that deals with these problems in drug packaging. Davies and Webb, in their accompanying editorial, remark that reporting such a problem is the first step in preventing a similar recurrence.² However, after identifying the problem, action must be taken. It appears that we are reporting the problem, we are just not acting on it. Maybe it is time that provincial and federal agencies in Canada take an interest in such labeling conflicts and similarities. Obviously the error in reading the labels on the ampoules was ours, but it is harder to put on a pair of mismatched shoes if they are a different color, shape and size!

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REFERENCES

- 1 Orser BA, Oxorn DC. An anaesthetic drug error: minimizing the risk. *Can J Anaesth* 1994; 41: 120-4.
- 2 Davies JM, Webb RK. Adverse events in anaesthesia: the wrong drug. *Can J Anaesth* 1994; 41: 83-6.

REPLY (1)

Since reporting the case of epinephrine overdose due to a drug substitution error,¹ we have received correspondence from two other anaesthetists involved in similar cases. Dr. Yemen's comments regarding the need to do more than simply report these errors are well-founded. Recently, we met with the Labeling Committee of the Canadian Society of Hospital Pharmacists to discuss anaesthetic drug error associated with "look-alike" packaging. The development of an effective packaging system which enhances the recognition of anaesthetic drugs is not a simple task. Pharmaceutical companies are interested in measures that ensure the safe administration of their products. They require, however, convincing evidence that the need for such a system exists as well as clear guidelines as to its implementation (e.g., which drugs to include, which labeling features to modify). In order to obtain this information, a survey is being developed which will be distributed to Canadian anaesthetists.

As stated in the case report, there is no substitution for reading the label. Anaesthetists with immediate concerns about drugs with similar packaging should discuss the matter with their hospital pharmacist and consider alternative suppliers.

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REFERENCE

- 1 Orser BA, Oxorn DC. An anaesthetic drug error: minimizing the risks. *Can J Anaesth* 1994; 41: 120-4.

REPLY (2)

Yemen states that the same adverse event as detailed by Orser and Oxorn¹ occurred to a patient under his care. His comment, that "provincial and federal agencies in Canada take an interest in such labeling conflicts and similarities" is appropriate.² Some companies have made changes. For example, the packaging colours of Novolin ge Human Insulin and the beef-pork counterparts available in Canada have been changed by Connaught Novo Nordisk Inc. to be consistent with the company's international colours. (There is no world-wide standard for insulin packaging colours).

Unfortunately, in Canada there is "no federal programme for reporting drug packaging problems."¹ Absence of such a programme may reflect a low reported rate of problems or the small economic impact of such problems (i.e., both patients survived). These two factors may be the key to making changes. We would suggest that anaesthetists in Canada report not only every instance of a packaging-related drug error but also the cost of the complications suffered by the patients (i.e., ICU stay, etc.).

When they realize the incidence and magnitude of the problem the Canadian Society of Hospital Pharmacists, the Pharmaceutical Manufacturers' Association and the Canadian Drug Manufacturers' Association may understand why standard col-