catheter with a local anaesthetic. When it was determined that there was no sensory block or when a "spotty" or unilateral block was seen, the catheter was replaced (in which case the patient was included in the study), or the catheter was abandoned and PCA was started (in which case the patient was not included in the study). With this approach we chose to compare only patients with appropriately functioning epidural catheters with PCA patients.

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Drug labelling

To the Editor:

With the ever-increasing number of drugs available in the anaesthesia armamentarium, the need for clear, easy to identify drug labelling has been recently reinforced.¹⁻³

In their report Drs. Orser and Oxorn outline a potentially fatal medication error, the treatment and their subsequent investigation and follow-up. One of their recommendations suggest "Whenever possible, each drug available on the anaesthetic cart should have distinct and unique markings." I could not agree more. There is presently a Canadian standard; Canadian Standards Association (CSA) #Z327-M91 *Standard for User Applied Drug Labels in Anaesthesia and Critical Care*⁴ for anaesthesia drug syringe labels which is similar to the standard of the American Standards for Testing and Materials (ASTM) D4774-93.⁵ This standard specifies design requirements for size, colour, pattern, shape and typeface used on labels applied to unlabelled syringes filled by users to identify their contents. The original intention of the standard was not to include manufacturer applied labels to drug vials. However, it may potentially be used as a framework for future manufacturer-applied drug labels.

Another ASTM Standard, D4267-89,⁵ which I believe has not been implemented in Canada, requires drug names on glass ampoules to be printed in such a way that the drug's name and dosage is clearly visible at arm's length and has a contrasting colour background.

These standards were established to try to reduce the risk of accidental administration of a wrong drug and

improve patient safety. Hopefully implementation of a standard for manufacturer-applied drug labels may provide some consistency in drug labelling so that future disasters may be averted.

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- 3 Dain SL. Safety hazard - Abbott drug labels (Letter). *Can J Anaesth* (in press).
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- 5 Annual Book of ASTM Standards, American Society of Testing and Materials, 1916 Race Street, Philadelphia PA 19103.

Anaesthetic drug error

To the Editor:

We read with interest the clinical report "An anaesthetic drug error: minimizing the risk" by Beverley A. Orser *et al.*¹ and are in agreement with the recommendations of the Risk Management Team.

However, instead of each country having its own programme for reporting of drug packaging problems, we suggest a single global organization. A drug manufactured in one country may not be used only in that country. For example in our institute we use Dopaplus® (dopamine) manufactured by Chemil Farmaceutics, Milano, Italy and Nitrocure® (nitroglycerin) manufactured by Pharma Hamein GmbH Hamein Wesser in West Germany. Both the drugs are in 5 ml glass vials and are of the same size, shape and brown colour. They look and even feel very similar.

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