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A Study on Similar Look like and Sound like Brand

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ABSTRACT

The objective of the study was to identify the improper dispensing due to look like and sound like brand names. A prospective treatment chart review was carried for out-patients who were receiving medication from hospital pharmacy for the study period of six months. All informations were collected in pre-designed structured data collection form to ensure comprehensive and accurate data extraction. A total of 1630 patients were included out of which 6 (0.37%) cases of improper dispensing due to look like and sound like brand names; and 79(4.85%) cases of substitution. The study was concluded with highlighting the importance of hospital formulary and effective Pharmacy and Therapeutical Committee to reduce the jeopardy in dispensing.

Key words: reading, writing, error, oversight.

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INTRODUCTION

A group of medicines that have similar actions often have similar sounding brand names. The generic medicine is one that contains identical amounts of the same active ingredient, in the same strength and in the same dosage form. When doctor writes a prescription they will nominate the medicine to be used –usually the originate brand name for the drug required. The pharmacist will usually offer the generic equivalent to the medicine that has been prescribed, when taken the prescription to the pharmacy, if the doctor has indicated that no substitution is to take place [1]. Certain drugs have names that may appear similar when carelessly written; others liable to confusion for other reasons. Problems are likely if the strengths and doses of the two preparations are similar. Doubts should be resolved by checking with the prescriber. Most cases, mistakes have occurred, because the item was dispensed without a second thought. A large number of them have similar sounding or similar looking names, which is a reason for major concern among the prescribing physicians [1]. All these factors should clearly be borne in mind by the drugs controller while a brand name is approved. Therefore no two drugs should differ by an alphabet, syllable, suffix or prefix. There should be absolute clarity and differentiation of any two drugs whether the name are spoken or written.[2] The purpose of this study was to identify the problems of dispensing in a hospital having more than 3000 brand and educate the pharmacist to avoid the prescription errors.

MATERIALS AND METHOD

A prospective study was conducted on similar/confusing brand drugs in clinical practice.

Study Site

The study was conducted in the Pariyaram Medical College, Kannur. It is a 1500-bed multispeciality tertiary care hospital. It provides health care facilities to the people in and around Kannur District.

Study Criteria

Inclusion: Out-Patient (OP) comes in hospital pharmacy

Exclusion: In-Patient (IP), Causality and Operation Theatre (OT) patients comes in hospital pharmacy

Study Duration

The study was conducted for a period of six month from 1st Aug 2008 to 30th Jan 2009.

Study Population

1630 patients were included in prospective treatment chart review.

Study Design

Prospective treatment chart review was carried out for out patients who receiving medication from hospital pharmacy. Data's were collected from those patients who meet the study criteria. A suitable data collection form was designed for the collection of data. The patients demographic data such as name, age and gender, therapeutic data including dose, duration, frequency and route of administration, laboratory datas, body weight and past medical history were collected and entered in the data collection form. All informations were collected in pre-designed structured data collection form to ensure comprehensive and accurate data extraction.

RESULTS

Table -I : Patient Demographic Chart based on sex

Sex	Frequency
Male	811
Female	819

Table -II: Patient Demographic Chart based on age

Age Group	Frequency
Neonates	0
Infants	28
Children	148
Adult	1454

Table -III: Classification of disease on the basis on department:

Disease	Frequency(%)
Orthopedics	144(8.83)
Cardiology	450(27.61)
Respiratory disorders	31(1.91)
Psychiatry	201(12.33)
Dermatology	85(5.21)
Infection	303(18.59)
Nephrology	49(3.01)
Gastro intestinal disorders	235(14.42)
Others	132(8.09)

Table IV: Cases of improper dispensing

Sl	Prescribed Drug	Dispensed Drug
1	Melcovit	Melovent
2	Clopilet	Ciprolet A
3	Meconerve 500	Meconerve OD 1500
4	Tibitol	Tobitil
5	Pronil	Pronim
6	Eltocin	Eltrocin

Table V : Cases of substitution

SI	Prescribed Drug	Substituted Drug	Frequency (%)
1	Alworm	Zental	1 (1.26)
2	Dolowin plus	Aroff plus	3 (3.79)
3	Microcef	Cefoprox	3 (3.79)
4	Glyree	Glyme	6 (7.59)
5	Piorest	Piomed	3 (3.79)
6	Aciloc	Rantac	22 (27.84)
7	Cimadol	Kamadol	13 (16.45)
8	Taxim	Cefotaxim	28 (35.44)

DISCUSSION

A Total of 1630 prescriptions were collected during the study period, of which 6(0.37%) cases of improper dispensing was identified due to confusing brand names. In the first case the doctor prescribed Tab.Melcovit; a nutritional supplement, the drug that was dispensed from the pharmacy was Tab.Melovent; an antiasthmatic drug (Salbutamol). Second case Tab.Clopilet, an anticoagulant drug (Clopidogrel) was prescribed by the doctor but the drug dispensed from the counter was Ciprolet A, an antibacterial drug (Ciprofloxacin). In another case the doctor prescribed Meconerve-500 (Methylcobalamine 500U), but the drug dispensed was Meconerve OD 1500 (Methylcobalamine 1500U); a vitamin supplement, but the dispensed drug was a higher dose than the prescribed. Other cases the doctor prescribed Tibitol (Ethambutol, Anti TB drug), Pronil (Fluoxetine, Antipsychotic drug) and Eltocin (Erythromycin, Antibiotic) but the dispensed drugs were Tobitil (Tenoxicam, Painkiller), Pronim   (Nimesulide, Analgesic) and Eltroxin (Levothyroxin Sodium, Hyperthyroid drug) respectively.

The main reasons for improper dispensing of confusing brand names, may be due to negligence or due to lack of knowledge of registered pharmacist or due to less number of pharmacist during rush hours. When brand names of two or more drugs are similar, faulty dispensing would result from one of the following situation:

- Illegible handwriting of the prescribing physician (reading &/or writing error).
- Incorrect dispensing by the pharmacist due to over sight (similar looking name).
- Incorrect reading of the brands name by the patient while ordering the medicine by phone, which is a common practice in some cities in this country (similar sounding name)

In the above mentioned cases first two cases were due to the illegible handwriting of the prescribing physician and the remaining cases were due to incorrect reading of the brands named by the pharmacist. It would be shocking for the patient to know that these pairs of drugs are for diametrically different illnesses. Some recently noted examples for look –alike brands are: Chlorpropamide / Chlorpromazine, Disopyramide / Dipyridamole, Lasix / Losec and Metatone / Methadone [4].

During the study period 79 (4.85%) cases of substitution were identified. One case the doctor prescribed Alworm suspension, the drug was substituted by Albendazole suspension (Zentel) at the time of dispensing; both of which were antihelmintics. Another

case the doctor prescribed Tab.Microcef; an antibiotic, which was substituted with Tab.Cefoprox. The maximum substitution were identified with cefotaxim antibiotic both oral and parental form. Out of 79 substitutions, 28 (35.44%) substitutions were identified for Taxim.

The substitution of drugs may be due to following reasons such as i) Differences in price-when pharmacy benefit manager (PBM) is both a plan, administrator and pharmacy owner ii) Unavailability of drug in the market iii) Shortage of stock (no stock) iv) Substitution of banned drugs and v) Increase in lead time. By the proper inventory management of hospital pharmacy the pharmacist can avoid the unwanted substitution of drugs. It is a duty of the pharmacist to take substitution as a last option before dispensing, he must advice the patient to consult the nearby pharmacies to obtain the correct drug, and any substitutes can be dispensed after consultation with the doctor who prescribed the drug or an RMP. The pharmacist should also explain to the patient that the prescribed medicine is not available in the pharmacy and the medicine being given in place of the prescribed drug was a proper substitute belonging to the same pharmacological group [3-6].

It is also the duty of the doctor that no negligence occurs when dealing with the patient. At the same time, the drugs prescribed by the doctor must be legible and clear to the chemist. Majority of the doctors are even now writing brand names because: to avoid the duplication of effective drugs by pharmacist. The additives used in each brand name differ according to manufacturer that makes the difference in bioavalability in each formulation.

CONCLUSION

Today, there are more than 8000 brands of drugs available in the country. A very large number of them have similar sounding/similar looking names, which create jeopardy during dispensing; which is a reason for major concern among the prescribing physicians.[1] In view of the facts in country like India, where multinational drugs companies operate together with the indigenous industries whose tendency, by and large, is to produce their own formulations of the same basic drugs under the propritetory names and/or under generic names. Under these conditions large hospitals should organize their own formulary systems in order to avoid unnecessarily large inventory of pharmaceutical. Of course, it would be necessary for the hospitals to provide for a fair and reasonable number of formulations so as provide a normal conditions of prescribing for the majority of the attending patients. At the same time drugs controller should own up responsibility for their faux pas and as a first-step towards remedial action, take a close look at all recently launched brands and insist on the manufacturer to register a fresh the confusing brands. There is also a definite need for a procedure to be put in place where a physician or a medical association can recommend alteration of a branch name if there is genuine similarity. The study was concluded with importance of hospital formulary and effective pharmacy and therapeutical committee can reduce the jeopardy in dispensing.

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