

## Hydralazine, Hydroxyzine Confused Again



A young man recently went to the local emergency department with a headache, numbness in his extremities, and shortness of breath that developed two hours after taking a new prescription for anxiety/insomnia. The patient brought the prescription bottle with him, which was filled for hydrALAZINE 25 mg with instruction to take 1-3 tablets every six hours. Given that hydrALAZINE is indicated for the treatment of hypertension and not anxiety, staff in the ED questioned if a prescribing or dispensing error had occurred, especially as hydrALAZINE is well known as a look- and sound-alike medication with hydrOXYzine, a medication with an indication for anxiety.

The patient's community pharmacy was called and it was determined that an error had in fact occurred. The pharmacy received a printed prescription for hydrOXYzine from an urgent care center and mistakenly entered it into the pharmacy computer system as hydrALAZINE. The patient's initial blood pressure upon admission to the ED, roughly three hours after taking 50 mg of hydrALAZINE, was 105/57 mmHg. Pharmacists should encourage prescribers to include the purpose on the prescription. However, this does not excuse pharmacists from discussing new therapies with patients to verify that the medication is appropriate to treat the patient's condition and that the patient understands the new regimen. For more than a decade the Institute for Safe Medication Practices has reported

on confusion between these two medications leading to dispensing errors.

### **SAME NAME, DIFFERENT DRUG OUTSIDE U.S.**

A hospital pharmacist located in a U.S. resort city received an order for "Cartia 100 mg" along with instructions stating that the patient would bring in his own medication. The pharmacist assumed that the patient would be taking **CARTIA XT** (diltiazem), although it is available in 120 mg, 180 mg, 240 mg, and 300 mg strengths only. The prescriber insisted that the 100 mg was correct, so the pharmacist followed up when the patient brought the medication into the hospital. It turned out that the medication was actually aspirin, or acetylsalicylic acid, which is available under the brand name Cartia in Israel, the patient's home country.

We have had similar problems in the past. It is not that unusual for a foreign drug containing a certain ingredient to share a brand name with a U.S. drug that has a totally different ingredient. In 2005, we wrote about a U.S. patient on **DILACOR XR** (diltiazem extended release, brand now discontinued) 120 mg daily for hypertension. The patient ran out of medication while traveling in Serbia, and a Serbian pharmacist dispensed digoxin 0.25 mg because, in Serbia, Dilacor is a brand name for digoxin. The patient

didn't notice the change in strength, so he continued to take the medication for three days upon return to the U.S., even taking extra doses because he didn't feel well. He developed digoxin toxicity and eventually wound up in a hospital emergency department for monitoring and treatment with **DIGIFAB** (digoxin immune FAB).

The latest incident serves as a great example of the importance of confirming any medications brought from home, especially by known travelers. Patients everywhere should be reminded when they travel to carry an adequate supply of medications and a medication list that includes both the generic and brand names. Those needing a temporary supply while overseas should confirm that the correct drug has been dispensed since brand name products may contain different active ingredients in different countries. ■

**This article is from the Institute for Safe Medication Practices (ISMP). The reports described were received through the USP-ISMP Medication Errors Reporting Program. Errors, near misses, or hazardous conditions may be reported at [www.ismp.org](http://www.ismp.org). ISMP can be reached at 215-947-7797 or [isminfo@ismp.org](mailto:isminfo@ismp.org).**