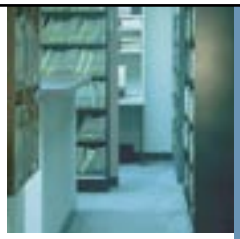
An unusual case of diarrhoea



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Case histories are based on actual medical negligence claims, however certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.

Medication errors in general practice are relatively common. This article describes a medication error that led to a patient complaint and claim.

Case history

Dr Fraser saw Mrs Leonard, aged 67 years, as a 'fit in' patient at the end of a busy day's consultations. Mrs Leonard said that she was visiting from interstate and staying with a friend. She told Dr Fraser that she had inadvertently left all of her medications at home. She requested prescriptions for Colgout and Celebrex. The patient said that she had used these medications in the past for the management of her gout. She said that she felt she had a flare up of this condition and wanted to get on top of it before it got any worse.

Dr Fraser briefly examined the patient's foot. She noted that the first metatarsophalangeal joint was slightly inflamed, consistent with the diagnosis of gout. Dr Fraser duly wrote a prescription for the requested medications.

A few weeks later, Dr Fraser received an angry letter from Mrs Leonard. The patient wrote that she had returned to her friend's home and taken both of the medications prescribed by Dr Fraser. Some time later, she had felt drowsy and went to bed. She woke several hours later and was horrified to discover that her clothing and the bed were smeared with faeces. She was particularly distressed because the diarrhoea had soiled the bed linen and mattress. Mrs Leonard had subsequently checked her medications. She found that she had been given a sedative, oxazepam, instead of her anti-inflammatory medication, Celebrex. She concluded her letter by stating that she did not think she would be asked back to visit her friend again. She listed the costs of her clothes, the double bed mattress and bed linen in her letter. The letter concluded by stating: 'Would you kindly give me your opinion of this incident because I am very embarrassed and upset about the financial loss and inconvenience for my lifelong friend'.

Medicolegal issues

On receipt of Mrs Leonard's letter, the general practitioner reviewed her medical records. She noted that she had written prescriptions for Celebrex and Colgout. Dr Fraser contacted the patient to express her concern and to discuss the matter further. It transpired that the patient had taken the prescription to the local chemist who had offered her cheaper generic brands of the drugs, which she had gratefully accepted. When the names of the drugs and the tablets did not look like her usual medications, the patient had assumed that it was because they were the generic brands. The patient had commenced both medications on her return to her friend's home. The colchicine had promptly caused diarrhoea. It appeared that she had then become drowsy as a result of the oxazepam and she was unable to get out of bed to use the toilet, causing the soiling of her clothes and the bed. Dr Fraser advised the patient that her medical records noted that she had written prescriptions for Celebrex and Colgout. She suggested that there may have been a dispensing error and

the medication Celebrex may have been confused for the sedative drug Serepax. Dr Fraser offered to contact the pharmacy to see if she could identify the cause of the problem.

Discussion and risk management strategies

Similar sounding drug names with totally different therapeutic indications and side effects can be easily confused, resulting in a medication error. More than 1000 name pairs confused on prescriptions have been identified.[1] This case involved confusion between Serepax and Celebrex. Other similar brand names include Lamictal/Lamisil, Xanax/Zantac, Microlax/Murelax, and Lasix/Luvox/Losec.

Medication errors in general practice are relatively common. An analysis of 790 settled GP claims revealed that the largest proportion of these claims, 25% (196/790), were directly related to errors in prescribing, monitoring or administering medications.[2] The medications most commonly involved in the claims were steroids, NSAIDs, anticoagulants, antibiotics and opiates. An Australian study that examined incidents of potential or actual harm to general practice patients revealed that pharmacological events were the most frequent, accounting for 51% of the incidents reported (407/805).[3] The types of pharmacological incidents included:

- inappropriate drug
- prescribing error
- administering error
- inappropriate dose
- side effect
- allergic reaction
- dispensing error.

In the study, 79% of the pharmacological incidents were largely considered to be preventable. The authors concluded that pharmacological incidents could be prevented through clearer prescription writing, double checking of doses and potential interactions, and improved patient understanding.

Strategies for minimising medication errors include:

- write legibly on prescriptions and take care with abbreviations
- clearly note any drug allergies in the medical records and ask the patient about any known allergies before prescribing
- review the patient's past medical history and current medications before prescribing any new medication
- take care when prescribing medications with similar names
- do not prescribe unfamiliar medications without first reviewing the relevant prescribing information, and
- educate patients about their medications and encourage them to ask if something is different or doesn't seem right when they are taking their medications.

Summary of important points

- Medication errors are a common cause of complaints and claims in general practice.
- Strategies to minimise the possibility of a medication error include legible handwriting, care when prescribing medications with similar names, and patient education.

Conflict of interest: none.

References

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