



International Journal of Health care and Biological Sciences

Content available at www.saap.org.in

Online ISSN: 2582-7499



Open Access

LOOK ALIKE SOUND ALIKE DRUGS IN ADULTS

Muchu Prathyusha*. Danaboina Srinivas, Chembeti Vijayalakshmi and Chandu Babu Rao.

Priyadarshini Institute of Pharmaceutical Education and Research, 5th Mile, Pulladigunta, Guntur-522017.Andhra Pradesh, India.

Article History

Received on: 25-01-2024
 Revised on: 18-02-2024
 Accepted on: 22-03-2024



Abstract

One of the main causes of patient injury worldwide is medication errors. Due to their orthographic (look-alike) and phonetic (sound-alike) characteristics, medications labeled as LASAs are a well-known source of drug errors that can be confused. When it comes to packaging, form, color, and/or size, look-alike and sound-alike medications are identical physically, but their names, dosages, and/or strengths sound similar. Brand-to-brand, brand-to-generic, and generic-to-generic name confusion can happen. prescribing, dispense, administer, monitor, transcribing or documenting. Errors in prescribing can be attributed to a variety of factors, including handwritten prescriptions that are difficult to read, verbal instructions, the use of dangerous acronyms, and choosing a LASA medication when using computerized prescriber order entry (CPOE). Over- or under-dose of intended or unexpected drugs, as well as incorrect dosing, are possible consequences of LASA mistakes. More data would enable evidence-based methods that could lower errors brought on by Lasa medications, particularly from real-world contexts.

Keywords: Lasa errors, Medications, prescribing, Packaging.

This article is licensed under a Creative Commons Attribution-Non-commercial 4.0 International License. Copyright © 2024 Author(s) retains the copyright of this article.



*Corresponding Author

Muchu Prathyusha

DOI: <https://doi.org/10.46795/ijhcb.v5i1.609>

Introduction

Look alike and sound alike drugs with similar looking and similar sounding names. Look alike Sound alike medicines are well recognized cause of medication errors that are due to orthographic. Look alike and phonetic sound alike similarities between medicines. Look alike/sound alike (LASA) drugs errors can take place in hospital wards, and they can place patients at risk for adverse events and death. This study was aimed to realize a risk assessment model for preventing LASA drugs distribution errors by the 'S. Giovanni di Dio e Rig d'Aragona' hospital pharmacy, in Salerno, Italy (1). Medication errors are common causes of patient morbidity and mortality, and adds financial burden to the institution as well.

LASA medication errors occur when a patient receives an incorrect medication because its name is spelled or sounds like another medication. The first alert was launched 40 years ago in literature. In 1973, Teplitzky published a list

of LASA medicines to highlight the importance of considering the interpretation of the doctor's writing in the prescription of the drugs, which can lead to errors by the pharmacist. A system approaches and a blame-free environment, aimed at better organizational performances, lead to much better results than focusing on individuals, which can be blamed for forgetfulness, carelessness or moral weakness.

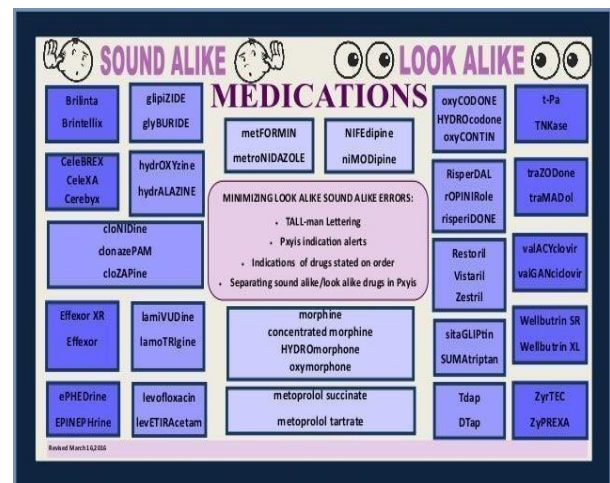


Fig1: Look alike Sound alike medications

Countries

1. WHO: The World Health Organization's International non-proprietary names expert group works to develop international non-proprietary names for pharmaceutical medicinal substances for acceptance worldwide. However, the drug brand names are fixed by pharmaceutical companies, which differ from country to country (2).

2. CANADA: The Health Canada is the federal department responsible for helping Canadians to maintain and improve their health. The health Canada has issued a revised draft on review of drug names for look-alike/sound-alike drugs attributes for the pharmaceutical industry. The policy objective of review of drug names for look-alike/sound-alike drugs is to provide market authorization holders more detailed direction on the process to be followed and information to be submitted to the health Canada (3).

3. UNITED STATES OF AMERICA: The National Coordinating Council for Medication Errors Reporting and Prevention was formed by the United States Pharmacopeia Convention to actively promote the reporting, understanding, and prevention of medication. In USA, the pharmaceutical manufacturers get pre-approval for proposed names from various organizations like US Pharmacopeia (USP) and US Food and Drug Administration (USFDA) (4).

4. AUSTRALIA: The proposed regulatory changes according to the Therapeutic Goods and Administration (TGA) Australia, state that companies or sponsors of new medicines will be required to submit evidence of risk assessment of the proposed labelling and packaging. Further, TGA is looking for methods to electronically screen proposed brand names against already existing brand names to identify potential look-alike and sound-alike names.

5. MALAYSIA: The Pharmaceutical Services Division, Ministry of Health, Malaysia has issued guidance on handling of look-alike/sound-alike medications (5). The guidelines consist of strategies to avoid errors with look-alike and sound-alike medications.

6. SINGAPORE: The Ministry of Health, Singapore has issued a guidance note on medication safety. Practice guidelines and tools mention about medication safety pointing towards medication errors. These guidelines and tools may help healthcare professionals to ensure that the medication use process is safe (6).

7. UNITED KINGDOM: The Medicines and Healthcare Products Regulatory Agency regulates medicines and medical devices in the UK. The agency plays leading role in protecting and improving public health. Through drug safety updates the agency gives information about particular care to be taken when prescribing or dispensing look-alike/sound-alike medicines. Recent examples of medication errors are listed in drug safety updates (7).

8. JAPAN: To find out similar names of drugs, an on-line searching system (Japanese Similar Names Searching

System) was implemented in Japan in 2008. In addition, the Japan Council for Quality Healthcare has developed a system in order to avoid medication errors (8).

9. INDIA: The Pharmacovigilance Programmed of India was launched to improve patient safety and welfare in the Indian population by monitoring drug safety and thereby reducing risk associated with the use of medicines. This programmed mainly emphasizes on adverse drug events.

10. Look Alike Drugs List

Look alike drugs are drugs which is visually same and the drugs which are different in dosages like milligrams. Look alike is someone who looks almost exactly like another person and some look alike are related and like identical twins or cousins who resemble each other. Look alike drug are appearance that is very similar to each other (9).

Sound Alike Drugs List:

A person or thing that closely resembles another in sound, especially someone whose voice or style of speaking or singing is very similar to that of a famous person. The different meaning and different spelling are the words to, two, and too, they sound the exact same when spoken but have very different meanings and spelling. Look Alike Sound Alike Medications.

Example of SOUND ALIKE	
Folinic Acid	Folic Acid
Amidaron	Amlor
Zinnat	Zantac
Flumazenil	Flamazine
Parlodel	Panadol
Tazocin	Prazocin
Ferrosac	Ferriprox
Kafocid	Keflex
Lasix	Losec
Aldactone	Aldomet
Ranitidine	Loratidine
voltarin	ventolin

Fig.2. sound alike drugs list

Errors Occur in Look Alike Sound Alike Drugs (10).

Medication errors are a leading cause of patient harm globally. Look-alike, sound-alike (LASA) medicines are a well-recognized cause of medication errors that are due to orthographic (look-alike) and phonetic (sound-alike) similarities between medicines that can thus be confused. Look-alike medicines appear visually the same with respect to packaging, shape, color and/or size, while sound-alike medicines are similar in the phonetics of their names, doses and/or strengths. Confusions can occur between brand-brand, brand-generic or generic-generic names (11).

Similar appearance of medicines and their packaging, not color coding of different strengths, and storage of LASA medicine pairs close to one another can result in LASA errors during dispensing. Unclear instructions for administration, failure to double-check the order and failure to monitor the patient after administration can lead to administration and monitoring errors. Failure to engage patients in their treatment at each stage of the medication

use process results in LASA errors reaching the patients (12).

Clinical Impact of Lasa Errors and Vulnerable Patients

The impact on the patient will depend on the medicine administered and the condition of the patient. LASA errors can result in toxicity due to overdosing of a medicine, adverse effects of an unintended medicine, and exacerbation of the disease for which the intended medicine was not given. 18 Some errors are detected before the medicine is administered to a patient, while others are not found until much later LASA errors are considered below under the four domains of the WHO third global patient safety challenge: Medication without harm (13)

- ⊙ Medicines: medicines as products;
- ⊙ Patients and the public: role of patients and family members in preventing LASA errors;
- ⊙ Health care professionals: role of health and care workers in preventing LASA errors; Systems and practices of medication: health care systems and practices to be addressed (15).

Clear Labelling Segregating Storage and Color Coding

Generic name	Brand name	Indications (class of drugs)
Aminophylline	Aminophylline,	Antiasthma tic and chronic obstructive pulmonary disease preparations
Amitriptyline	Amine	Antidepressants
Amoxicillin	Actimox, anoxic	Penicillin
Ampicillin	Ampilin, eskaycillin	Penicillin
Azithromycin	Elzithro, Formycin	Macrolides
Erythromycin	Althorn, Eltocin	Acne treatment preparations, macrolides
Atenolol	Tenolol, catenol	Anti-anginal drugs, beta-blockers
Timolol	Glucomol, nyolol	Antiglaucoma preparations
Beclometasone	Beclate, becoride	Topical corticosteroids, antiasthma tic and chronic obstructive pulmonary disease decongestants, other nasal preparations

Betamethasone	Betnelan, betnesol	Eye corticosteroids, ear corticosteroids, antiasthma tic and chronic
Bisacodyl	Bidlax-5	Laxatives, purgatives
Bisoprolol	Bisbeta, bisveda	Beta-blockers
Carbamazepine	Carbadac, mezapin	Anticonvulsants
Carbimazole	Thyrozole	Antithyroid agents
Clonazepam	Clonopam, ozepam	Anxiolytics, anticonvulsants
Lorazepam	L-Zepam	Anxiolytics, anticonvulsants
Clofazimine	Clofaz	Antileprotics
Clomipramine	Clomifril	Antidepressants
Carboplatin	Carboplan, carbotin	Cytotoxic chemotherapy
Cisplatin	Cisplan, cytoplatin	Cytotoxic chemotherapy
Cefotaxime	Cefotim, sifotaxim	Cephalosporins
Cefuroxime	Cefoprim, cefurin	Cephalosporins
Cimetidine	Cimetiget	Antacids, antire flux agents
Clonidine	Clodict	Antihypertensive drug
Daunorubicin	Daunotec	Cytotoxic chemotherapy
Doxorubicin	Doxobin	Cytotoxic chemotherapy
Digoxin	Digox	Cardiac drugs
Doxepin	Doxesom	Antidepressants drugs
Dopamine	Dopacard	Cardiac drugs
Dobutamine	Dobucard	Cardiac drugs

Ergotamine	Vasograin	Antimigraine preparations
Ethionamide	Ethide	Anti-TB agents, antileprotics
Folic acid	Foliday	Vitamins and minerals
Fusidic acid	Fucidin	Topical antibiotics
Gatifloxacin	Gatiquin DPS	Eye anti-infectives, antiseptics
Gemifloxacin	Gemibid	Quinolones
Gliclazide	Glazed	Antidiabetic agents
Glipizide	Dibizide	Antidiabetic agents
Ibuprofen	Brufen	Nonsteroidal anti-inflammatory drugs
Ketoprofen	Ketopatch	Nonsteroidal anti-inflammatory drugs
Rabeprazole	R.P. Zole, rabezil	Antacids, antireflux agents, antiulcerants
Ketoconazole	Ketofast	Topical antifungals
Methyldopa	Alphadopa	Other antihypertensive drugs
Levodopa	Levopa	Antiparkinsonian drugs
Mebendazole	Mebazole	Anthelmintics
Metronidazole	Metron	Preparations for vaginal conditions, topical antibiotics, antiamoebics
Nifedipine	Depin, nifedine	Anti-anginal drugs, calcium antagonists
Nimodipine	Modipin, Nimodip	Peripheral vasodilators, cerebral activators
Olanzapine	Olzap, lezapin-MD	Antipsychotics
Olapatadine	Olodin, opat	Ophthalmic decongestants,
Pheniramine	Pheniramin, retard	Antihistamines, antiallergics
Phenylephrine	Drosyn	Mydriatic drugs, anorectal preparations, cough and cold preparations
Quinidine	Natcardine	Cardiac drugs, antimalarials

Quinine sulphate	Sacquine	Antimalarials
Roxatidine	Rotane	Antacids, antireflux agents, antiulcerants
Rupatadine	Rupanex, rup-AL	Antihistamines, antiallergics
Spiramycin	Rovamycin Forte	Macrolides
Streptomycin	Streptomac	Aminoglycosides
Simvastatin	Simvotin	Dyslipidaemic agents
Somatostatin	Somatosan	Haemostatics
Tramadol	Trama, tramazac	Analgesics (opioid)
Trazodone	Traze	Anxiolytics, antidepressants
Vinblastine	Cytoblastin	Carcino-chemotherapeutic drugs
Vincristine	Cytocristin, B-kristina	Carcino-chemotherapeutic drugs
Generic name	Brand name	Indications (class of drugs)
Amoxicillin + cloxacillin	Alclox	Penicillin
Cloxacillin + ampicillin	Ampoxin	Penicillin
Fluconazole + tinidazole	Fluzon-T	Antifungals
Levodopa + carbidopa	Pardopa	Antiparkinsonian drugs
Tramadol + paracetamol	Trammel-DT	Analgesics

Procedure and Guide Lines:

Due to differing medication management processes at each Health System site and the implementation of various technology solutions, the exact procedure for managing LASA designated medications shall be determined by local P&T Committees. Recommended strategies may include, but are not limited to (16)

- Computerized Physician Order Entry – require/include indication in the medication order for pairs that are in different therapeutic classes (17)
- Pharmacy Storage – do not store LASA medications alphabetically by name but rather store them out of /order, or in a different location; place label stating “Look-Alike / Sound-Alike” on medication bins of LASA agents (18)
- Automated Dispensing Cabinets – a “Look-Alike /

Sound-Alike” alert should appear when loading and removing LASA medications from the cabinet (19)

- Formulary Management – consider LASA names and similar labeling of generic products when determining the Formulary determination of products
- Pharmacist Order Entry/Validation – include “Look-Alike/Sound-Alike” warnings into Pharmacists’ entering and/or validating LASA medication orders [20, 21, 22].

Tall Man Lettering	
Table 1. FDA-Approved List of Generic Drug Names with Tall Man Letters	
Drug Name with Tall Man Letters	Confused with
acetoZOLAMIDE	acetoHEXAMIDE
acetoHEXAMIDE	acetoZOLAMIDE
buPROPion	busPIRone
busPIRone	buPROPion
chlorprMAZINE	chlorprPAMIDE
chlorprPAMIDE	chlorprMAZINE
clomIPHENE	clomPRAMINE
clomPRAMINE	clomIPHENE
cycloSERINE	cycloSPORINE
cycloSPORINE	cycloSERINE
DAUNOrubicin	DOXOrubicin
dimenhydRINATE	diphenhydRAMINE
diphenhydRAMINE	dimenhydRINATE
DOBUTamine	DOPamine
DOPamine	DOBUTamine

FIG:3: Tall man letters

Summary and Conclusion

One common system failure is confusing medicine names. As a matter of fact, a lot of drug names have similar names to other drugs, which could result in patients taking the wrong medication and suffering grave repercussions (20). Through a risk assessment model based on the Italian Ministry of Health's (2010) recommendation and the FMEA process, this study has proactively evaluated all potential negative events that could arise during the drugs LASA distribution process carried out by our hospital pharmacy. The ensuing corrective actions were then identified. In other hospitals from developed nations, our model may help determine the most effective corrective measures to lower LASA medication errors during the distribution process. Solutions for information technology have a lot of potential. But it also needs to be implemented consistently with these automated technologies.

Author contributions

All authors are contributed equally.

Financial support

None

Declaration of Competing Interest

The authors have no conflicts of interest to declare.

Acknowledgements

None

Reference

1. Ciociano N, Grisi L, Bagnasco L, Elberti MG, Mazzarella M. Risk assessment of look-alike, sound-alike (LASA) medication errors in an Italian hospital pharmacy: A model based on the 'Failure Mode and Effect Analysis'. *J Health Soc Sci*. 2017;2(1):47-64.

https://journalhss.com/wpcontent/uploads/JHHS21_4_7-64.pdf

2. Sattiraju V, Ligade VS, Muragundi P, Pandey R, Janodia MD. National and higher education institutions (HEIs) IP policies: comparison of Indian HEIs' IP policies from a global perspective. *Journal of the Knowledge Economy*. 2023 Jun;14(2):1979-2006. <https://www.currentscience.ac.in/Volumes/109/07/1230.pdf>
3. Arun K, Babu CJ, Lakshmaiah P, Rao CB, Ravi B, Harshavardhan P. Techniques to improve the absorption of poorly soluble drugs. *International journal of research in pharmacy and chemistry*. 2012;2(2).
4. Shore DA, editor. Forces of change: New strategies for the evolving health care marketplace. John Wiley & Sons; 2012 Jun 20. <https://www.google.com/search?q=north+shore->
5. Roussel P, Moll MC, Lassale B, Ragni J. Analyse d'un incident de la chaîne transfusionnelle et gestion du retour d'expérience. *Transfusion clinique et biologique*. 2009 Sep 1;16(4):407-22. https://cdn.who.int/media/docs/default-source/patient-safety/patient-safety-solutions/ps-solution1-look-alike-sound-alike-medication-names.pdf?sfvrsn=d4fb860b_8
6. Roberta AS, Monica C, Susanna C, Laura F, Andrea M, Paola M, Gaia M, Ettore N, Carlo P, Piera P, Felice R. Sicurezza dei pazienti e gestione del rischio clinico: la qualità dell'assistenza farmaceutica.
7. Rani TT, Brahmaiah B, Revathi B, Nama S, Baburao C. TARGETING OF ANTI CANCER DRUGS THROUGH NANOPARTICLES. https://www.academia.edu/75895370/Targeting_of_Anti_Cancer_Drugs_Through_Nanoparticles
8. Gomes AT, Salvador PT, Rodrigues CC, Silva MD, Ferreira LD, Santos VE. Patient safety in nursing paths in Brazil. *Revista Brasileira de Enfermagem*. 2017 Jan;70:146-54.
9. Berman A. Reducing medication errors through naming, labeling, and packaging. *Journal of medical systems*. 2004 Feb;28:9-29.
10. Agrawal A. Medication errors: prevention using information technology systems. *British journal of clinical pharmacology*. 2009 Jun;67(6):681. <https://www.google.com/search?q=.+Agrawal+A.+M.edication+errors%3A+prevention+using+in>
11. Schulmeister L. Look-alike, sound-alike oncology medications. *Clinical journal of oncology nursing*. 2006 Feb 1;10(1):35. [https://www.google.com/search?q=13.+Schulmeister+L.+Look-alike%2C+sound-alike+oncology+medications.2006%3B10\(1\)%3A35%E2%88%9241&rlz=1C1RXQR_enIN10761](https://www.google.com/search?q=13.+Schulmeister+L.+Look-alike%2C+sound-alike+oncology+medications.2006%3B10(1)%3A35%E2%88%9241&rlz=1C1RXQR_enIN10761)
12. Ravilla S, Chandu BR, Nama S. Erythrocytes as carrier for drugs, enzymes and peptides. *Journal of applied pharmaceutical science*. 2012 Apr 30(Issue):166-76.

13. Poon EG, Cina JL, Churchill W, Patel N, Featherstone E, Rothschild JM, Keohane CA, Whittemore AD, Bates DW, Gandhi TK. Medication dispensing errors and potential adverse drug events before and after implementing bar code technology in the pharmacy. *Annals of internal medicine*. 2006 Sep 19;145(6):426-34.
14. Extemporaneous Formulation MO. Pharmaceutical Services Division, Ministry of Health Malaysia. <http://www.pharmacy.gov.my/v2/sites/default/files/document-upload/guide-handling-lasa.pdf>
15. Morriss Jr FH, Abramowitz PW, Nelson SP, Milavetz G, Michael SL, Gordon SN, Pendergast JF, Cook EF. Effectiveness of a barcode medication administration system in reducing preventable adverse drug events in a neonatal intensive care unit: a prospective cohort study. *The Journal of pediatrics*. 2009 Mar 1;154(3):363-8.
16. Ravella S, Angel M, Subramanian H, Thangavel N, Namballa M, Lokesh D, Mishra AK, Nagaraju GV. Navigating the Future of Cancer Diagnosis: A Comprehensive Review of Novel Approaches for Community-Based Treatment. *future.*;1:6.
17. Ash JS, Berg M, Coiera E. Some unintended consequences of information technology in health care: the nature of patient care information system-related errors. *Journal of the American Medical Informatics Association*. 2004 Mar 1;11(2):104-12.
18. Askari R, Shafii M, Rafiei S, Abolhassani MS, Salarikhah E. Failure mode and effect analysis: improving intensive care unit risk management processes. *International journal of health care quality assurance*. 2017 Apr 18;30(3):208-15.
19. Roy R, Ma J. Impact of a policy change on pharmacists' reporting of adverse drug reactions. *The Canadian Journal of Hospital Pharmacy*. 2018 Jul;71(4):227.
20. Al Tehewy M, El Hosseini M, Habil I, Abdel Maaboud M, Abdel Rahman S. A proactive risk management using failure mode and effects analysis for infusion therapy in a tertiary hospital intensive care unit in Egypt. *Acta Medica Mediterranea*. 2015 Jan 1;31:195-200.
21. Rodriguez-Gonzalez CG, Martin-Barbero ML, Herranz-Alonso A, Durango-Limarquez MI, Hernandez-Sampelayo P, Sanjurjo-Saez M, iPharma. Use of failure mode, effect and criticality analysis to improve safety in the medication administration process. *Journal of Evaluation in Clinical Practice*. 2015 Aug;21(4):549-59.
22. McNally KM, Page MA, Sunderland VB. Failure-mode and effects analysis in improving a drug distribution system. *American Journal of Health-System Pharmacy*. 1997 Jan 15;54(2):171-7.