Confusing tablets

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An 82-year-old woman with type 2 diabetes was admitted with acute renal failure. She presented her dose administration aid; an unlabelled plastic box containing seven different tablets. We contacted the hospital pharmacist who identified tablets of lisinopril 20 mg and captopril 25 mg in the patient's pill box. We suspected a dispensing error and contacted the pharmacist that filled the pill box, who claimed to have dispensed gliclazide 80 mg tablets rather than captopril 25 mg tablets. We then found that both products have an identical shape and markings although they are made by different generic manufacturers and contain different drugs (figure). The regional toxicology centre confirmed that the tablets were indeed gliclazide.

We look after many elderly patients. To help patients take the correct doses at the right times, pharmacies commonly use pill boxes, and remove external packaging, to make handling easier. The presentation and appearance of different medications should be specific, to avoid such errors in identification.[1,2] Meanwhile, clinicians and pharmacists need to be aware that identical tablets can contain different active ingredients and tablet identification systems are not infallible.

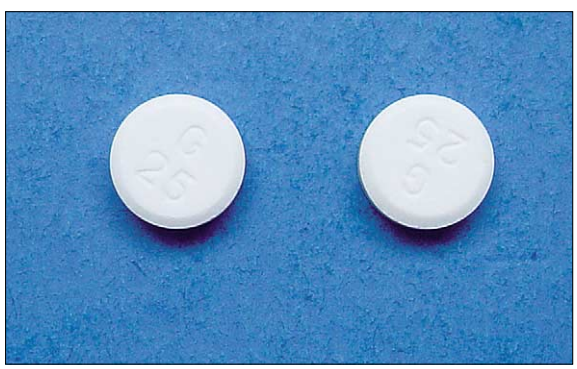

Figure: **Milpharm 80 mg gliclazide tablet (left) and Goldshield 25 mg captopril tablet (right)**

References:

1 Pathak A, Senard MJ, Bujaud T, et al. Medication error caused by confusing drug blisters. *Lancet* 2004; **363:** 2142.

2 Ferner RE. Reducing medication errors. *JAMA* 2001; **286:** 2091.