Dear Member of the Media:

Here is information that you may want to take into consideration for your 2004 coverage…a recent report of a fatal error involving **improper intrathecal injection of ionic contrast media** highlights the possible harm that can come from neglecting to take safety precautions with this class of medications. The Institute for Safe Medication Practices (ISMP) is spreading the word that many health care organizations are missing opportunities to reduce the risks associated with medication administration in clinical diagnostic departments such as radiology.

Recent Error Report: A 31-year-old man was mistakenly injected intrathecally with ionic contrast media during an outpatient myelogram (spinal radiography). Myelography is safely performed using nonionic water-soluble radiographic contrast media, which is intended for this route of administration. Administration of ionic contrast media intrathecally can result in potentially fatal muscle spasms, seizures, and cerebral hemorrhage. Despite treatment, the patient in this case died.

ISMP Safe Practice Recommendations:
The Food and Drug Administration issued a drug warning about this problem in 1994 and requires boxed warnings and package inserts to be included with iodinated contrast products not intended for intrathecal use. However, errors are still occurring. To reduce the risk of errors, ISMP suggests that health care delivery sites:

- Conduct a thorough analysis of the use of contrast media, including their distribution. If radiology requisitions these products, a pharmacist, rather than a technician or the purchasing department, should check them before they are dispensed.
- Consider placing prominent auxiliary labels on ionic media that should not be used for myelography and posting charts in areas where contrast media is used to provide information about product differences.
- Pay close attention to how and where contrast media is stored-each type should be stored separately according to use, to reduce the chance of mix-ups.
- Make an independent double check of contrast media any time it is used by clinical staff part of standard operating procedure.
- Prepare clinical staff to deal with the effects of errors in contrast administration; prompt recognition and treatment may prevent a fatal outcome.

Attached is a copy of a recent issue of ISMP's newsletter for acute care settings, *Medication Safety Alert!*, which contains a front-page article on use of ionic contrast media and more tips

on how to prevent tragedies of this kind from occurring. For additional resources on medication safety, visit ISMP's web site, www.ismp.org.

Please contact ISMP media relations at 704-321-3343 or rbrehio@ismp.org to arrange interviews on this issue or to receive a complimentary subscription to ISMP's newsletters.

Sincerely,

Renée Brehio
Media Relations
Institute for Safe Medication Practices (ISMP)

ISMP is a nonprofit organization that works closely with health care practitioners, consumers, hospitals, regulatory agencies and professional organizations to provide education about preventing medication errors. ISMP is recognized as the premier international resource in all matters pertaining to safe medication practices in health care organizations.