Institute for Safe Medication Practices

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Different Drugs with Same Brand Name in Different Countries Can Cause Patient Harm

HUNTINGDON VALLEY, Pa.— Many healthcare consumers and health professionals do not realize that the same brand name may be used for different drugs in different countries, a practice that as a recent mix-up shows can cause serious harm. This overlooked issue has major safety implications, especially in light of the growing interest in drug reimportation to help U.S. consumers save money.

In the recent error, a patient traveling to Serbia ran out of Dilacor XR (diltiazem extended release), a drug to treat angina and high blood pressure that is marketed by Watson Labs in the U.S. A Serbian pharmacist filled the prescription with digoxin 0.25 mg. In Serbia, Dilacor, marketed by a local company, is the brand name for digoxin, which is used to treat congestive heart failure or irregular heartbeat. The patient took the digoxin without realizing the mistake and was hospitalized after returning to the U.S. with life-threatening digitalis toxicity.

Mix-ups such as this one occur because there is no worldwide oversight of brand names for drugs, as there is for generic drug names. The same brand name may be used simultaneously in several countries for drugs with different active ingredients. For example, Dilacor is a brand name for diltiazem in the U.S., digoxin in Serbia, barnidipine in Argentina, and verapamil in Brazil.

To prevent errors, The Institute for Safe Medication Practices (ISMP) recommends that patients who are traveling abroad carry an adequate supply of their medications along with a list of the drugs they are taking by both generic and brand name, so that they will be able to confirm that the correct drug has been dispensed if they require a prescription refill.

The increasing practice of drug reimportation has heightened the need for action on this issue. Several U.S. states are actively referring citizens to Canadian pharmacies to receive prescriptions for U.S.-manufactured drugs at a lower cost, and some also are exploring importing medications from Europe. As with the patient who took the wrong kind of Dilacor, the opportunity for medication errors is substantial unless good naming practices endorsed by global health authorities are adopted that minimize or prevent the use of the same brand name for different products. ISMP also recommends that a thorough analysis for medication error potential be undertaken to identify other possible safety problems with drug reimportation.

The attached ISMP newsletter provides more information, including a sample list of brand names for U.S. drugs that represent different active ingredients in Europe. Please contact ISMP media relations at 704-321-3343 or rbrehio@ismp.org to arrange interviews.

About ISMP: The Institute for Safe Medication Practices (ISMP) is a 501c(3) nonprofit organization that works closely with healthcare practitioners and institutions, regulatory agencies, consumers, and professional organizations to provide education about medication errors and their prevention. ISMP represents nearly 30 years of experience in helping healthcare practitioners keep patients safe, and continues to lead efforts to improve the medication use process. In 2004, the Institute is celebrating the 10th anniversary of is official incorporation as a nonprofit organization. For more information on ISMP, or its medication safety alert newsletters for healthcare professionals and consumers, visit www.ismp.org

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