

Several Antidepressants Receive Revised Labeling

The FDA, GlaxoSmithKline, and Bristol-Myers Squibb have notified healthcare professionals of changes to the package labeling of several drugs used to treat depression.

The labeling of GlaxoSmithKline's paroxetine (Paxil CR, Paxil) and bupropion (Wellbutrin, Wellbutrin SR, and Wellbutrin XL) now carries a warning recommending that adult and pediatric patients with major depressive disorder be observed (by healthcare providers and family members) for signs of worsening de-

pression and thoughts of suicide, especially when treatment begins and when dosages are changed.

The revised labeling of Bristol-Myers Squibb's nefazodone (Serzone) carries a similar warning and encourages healthcare providers to consider the risk of hepatic failure associated with nefazodone treatment when choosing a medication to treat depression.

U.S. Food and Drug Administration. "CDER human drugs." 2004. www.fda.gov/cder/index.html (24 June 2004).

Hormone Therapy Impairs Cognitive Function In Elderly

Estrogen alone or in combination with progesterone adversely affects cognition in women who are 65 and older, according to the results of the Women's Health Initiative Memory Study (WHIMS). The effect was more pronounced in women with lower cognitive function at the beginning of the study.



WHIMS is an ancillary study to the Women's Health Initiative (WHI), which includes one randomized trial of estrogen-alone therapy and another of combination estrogen therapy. The estrogen-alone trial of

Error Watch

Confusing Abbreviations Can Lead To Drug Errors

Abbreviations, used to denote a drug name, dosage, frequency, or route of administration, simplify documentation. They also contribute to medication errors, according to data submitted to the USP's MEDMARX error reporting program from January 2000 to August 2004. A review of that data reveals that nearly 19,000 error reports from 498 facilities were linked to abbreviations. Fortunately, a very small percentage—less than 1%—was categorized as harmful and none were fatal.

Physicians were involved in 67% of abbreviation-related errors, compared to nurses, who were involved in 17% of the cases. In one case, an order for magnesium sulfate was written as "MgSO4 2 Gm IV" for a patient who came to the emergency room with respiratory failure. A nurse misinterpreted the order and incorrectly gave the patient 2 mg of morphine sulfate. The patient became somnolent and

required the narcotic reversal agent naloxone (Narcan). The patient made a full recovery.

To reduce the likelihood of errors associated with abbreviations, the USP recommends that facilities review their incident/error reporting program and develop a "do not use" list of abbreviations in compliance with JCAHO National Patient Safety Goals. For help in compiling the list, clinicians can consult USP's list of nearly 200 potentially dangerous abbreviations at www.usp.org/patientSafety/briefsArticles/Reports/qualityReview/qv802004-07-01.html.

THE AUTHORS

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