# NATIONAL PBM BULLETIN

**JULY 2, 2009**

**VETERANS HEALTH ADMINISTRATION PHARMACY BENEFITS MANAGEMENT SERVICES (PBM), MEDICAL ADVISORY PANEL (MAP), & CENTER FOR MEDICATION SAFETY (VA MEDSAFE)**

## OXYBUTYNIN AND OXYCODONE: LOOK-ALIKE/SOUND-ALIKE (LA/SA) CONFUSION

### I. ISSUE [1]

One local facility noted an instance of a look-alike/sound-alike (LA/SA) inpatient computer medication ordering error where oxybutynin was ordered instead of oxycodone.

### II. BACKGROUND [1-4]

Oxybutynin is a urinary antispasmodic used for the treatment of overactive bladder muscle dysfunction and neurogenic bladder. Oxycodone is an opioid analgesic used for the treatment of moderate to severe chronic pain. These agents are known look-alike sound-alike pairs reported to the United States Pharmacopeia **(**USP**),** and previous anecdotal mix-ups have been reported within VA as well. Patients who mistakenly receive oxybutynin instead of oxycodone will not receive adequate pain relief. Patients who inadvertently receive oxycodone instead of oxybutynin will continue to have suboptimal detursor control and also be at risk of exposure to a controlled substance with use/abuse potential.

A provider at one site ordered oxybutynin instead of oxycodone (dosage on orders unknown) during inpatient computer medication order entry. Pharmacy intervened at the time of verifying/processing the inpatient order and the patient did not receive the incorrectly entered drug. No adverse events or harm occurred. After discovering this close call, pharmacy made changes to the viewable orderable item in Computerized Patient Record System (CPRS):

- Addition of the brand name "Ditropan" to the oxybutynin orderable item; and
- Inclusion of a drug text warning: *"Look-alike/sound-alike medication - This is Ditropan for overactive bladder"*.

Additionally, this incidence was reported to the Institute for Safe Medication Practices (ISMP).

### III. FACILITY/PROVIDER RECOMMENDATIONS

1. Facilities may use the VistA "Orderable Item DRUG TEXT" functionality to provide additional distinguishing information for oxybutynin and/or oxycodone which can be viewed by providers in CPRS at the time of medication order entry.
2. Staff must be informed of potential look-alike/sound-alike confusion between oxybutynin and oxycodone when ordering these medications via the computer order entry system, due to the proximity of the drugs in the alphabetic medication list in CPRS.
3. Providers and pharmacists should carefully check the name, dosage, and indication when either oxybutynin or oxycodone is ordered.

### IV. REFERENCES


1. Field Information Report.
2. USP Center for the Advancement of Patient Safety. *USP Quality Review: Use Caution Avoid Confusion*. Rockville, MD; 2004 April.
3. Ditropan® package insert. Macquarie Park NSW, Australia: sanofi-aventis pty ltd; 2008 Sept.
4. OxyContin® package insert. Stamford, CT: Purdue Pharma, L.P.; 2007 Nov.


***ACTIONS:***

- ***Facility COS and Chief Nurse Executives:*** *Forward this document to all appropriate providers who prescribe/use/handle this agent (e.g.,* ***primary care providers, urologists, pain specialists, oncologists, and palliative care specialists,*** *including contract providers, etc.). In addition, forward to the Associate Chief of Staff (ACOS) for Research and Development (R&D). Forward to other VA employees as deemed appropriate.*
- ***ACOS for R&D:*** *Forward this document to Principal Investigators (PIs) who have authority to practice at the facility and to your respective Institutional Review Board (IRB).*