Department of Veterans Affairs
Veterans Health Administration
Pharmacy Benefits Management Strategic Health Group
PO Box 126
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Dear VA Provider,

We are writing to alert you to Look-Alike (LA) Sound-Alike (SA) errors that have been reported with sulfasalazine and sulfadiazine at one VAMC. One case was identified during medication reconciliation by a clinical pharmacist, which provided the impetus for a facility-wide, as well as VISN-wide, review of all patients with an active prescription for sulfadiazine. This identified a total of 16 patients (six medical facilities). Of the 16 patients receiving sulfadiazine, 4 (25%) and 1 (6%) carried a diagnosis of ulcerative colitis and rheumatoid arthritis, respectively. In all cases, the provider chose sulfadiazine (in error) instead of sulfasalazine. No adverse outcomes have been reported.

USP recognizes sulfasalazine and sulfadiazine as possible confusing LA/SA name pairs. Sulfasalazine is a non-aspirin salicylate used for the treatment of ulcerative colitis and rheumatoid arthritis. Sulfadiazine is a sulfonamide antibiotic used to treat a variety of infections, such as acute otitis media; chancroid; congenital toxoplasmosis; Haemophilus influenza meningitis; inclusion conjunctivitis; malaria; meningococcal meningitis; nocardiosis; recurrent rheumatic fever; toxoplasma encephalitis; trachoma; and urinary tract infections. Not receiving sulfasalazine for ulcerative colitis or rheumatoid arthritis could cause disease flares or progression. Furthermore, receiving an antibiotic like sulfadiazine in error for a long period of time could contribute to the problem of antimicrobial resistance. In addition to their orthographic and phonetic similarities, both agents are available as 500 milligram tablets, increasing the potential for LA/SA confusion.

In light of these case reports, VAMedSAFE and the Pharmacy Benefits Management/Strategic Healthcare Group (PBM) recommend the following:

1. Staff should be informed of potential LA/SA confusion between sulfasalazine and sulfadiazine.
2. Pharmacy should create a warning system for staff to notify of potential LA/SA confusion between sulfasalazine and sulfadiazine (i.e., computer alerts during the ordering/verifying process and/or warning stickers on packaging).
3. Providers should include an indication on prescriptions for sulfasalazine and sulfadiazine.
4. Pharmacy should store sulfasalazine and sulfadiazine in separate areas in the pharmacy.
5. Report all adverse drug events to VHA's Adverse Drug Event Reporting Program as well as FDA's MedWATCH program.

Please inform pharmacy staff of this LA/SA error and report any instances of close calls or actual errors involving LA/SA confusion between sulfasalazine and sulfadiazine to the Pharmacy Benefits Management/Strategic Healthcare Group and the VA Center for Medication Safety (VAMedSAFE), in addition to the VHA's Adverse Drug Event Reporting System and FDA's MedWATCH program.

Thank you for your prompt attention in addressing this LA/SA safety issue.

Source: VISN 8 Safety Report