Helping to achieve safe medication use

**VACCINE ABBREVIATIONS AND ACRONYMS MAY LEAD TO ERRORS**

Long and complex generic names for vaccines have prompted the use of abbreviations and acronyms to specify the type of vaccine and distinguish among vaccines used for the same disease. The Center for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP) provides a list of standardized abbreviations or acronyms for FDA-approved vaccines in order to promote accuracy and consistency while reducing medical errors (available at: www.ismp.org/sc?id=2866). These abbreviations are encouraged for scientific publications but not specifically required for use in the clinical setting. The CDC site also catalogs abbreviations often used on immunization records, including abbreviations for vaccine-targeted diseases and non-standard abbreviations (available at: www.ismp.org/sc?id=2867).

A recent alert from the Institute for Safe Medication Practices (ISMP) discusses vaccine errors due to similar abbreviations or acronyms. A search of the ISMP Vaccine Errors Reporting Program (VERP) from September 2012 to February 2017 tallied the most frequent abbreviations or acronyms involved in reported mix-ups (see Table 1, page 3). Errors with vaccines can result in an inadvertent vulnerability that renders patients unprotected against serious diseases such as hepatitis A, hepatitis B, diphtheria, tetanus, measles, pneumonia, and many others.

Within the VA, a recent Patient Safety Alert issued by VHA Central Office describes two similar pneumococcal immunizations incorrectly documented in the Veterans Health Information Systems and Technology Architecture/Computerized Patient Record System (VistA/CPRS) as given to patients on the same day, when only one immunization was actually given on that day. These errors

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**NEWSWORTHY...**

- Direct-Acting Antiviral Safety Issues - 03/14/2017 – National PBM Bulletin
- ADDENDUM: Mirtazapine Tablets, USP 45mg – Ongoing Recall Due to Commingled Tablets - 03/08/2017 – National PBM Patient Level Recall Communication
- Mirtazapine Tablets, USP 45mg – Recall Due to Potential of Commingled Tablets – 03/07/2017– National PBM Patient Level Recall Communication
- Alprostadil for Injection (Edex®) – Recall Due to Potential Lack of Sterility Assurance – 03/06/2017– National PBM Patient Level Recall Communication

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**GASTROENTEROLOGY**

**FDA warns about increased risk of serious pancreatitis with irritable bowel drug Viberzi (eluxadoline) in patients without a gallbladder**

3/15/2017

Hospitalizations and deaths due to pancreatitis have been reported with eluxadoline (Viberzi) use in patients who do not have a gallbladder. Eluxadoline (Viberzi) is a mu-opioid receptor agonist, indicated in adults for the treatment of irritable bowel syndrome with diarrhea (IBS-D). FDA received reports of 120 serious cases of pancreatitis or death associated with eluxadoline (Viberzi) use in the FDA Adverse Event Reporting System (FAERS) database from May 2015 (date of FDA approval) through February 2017. Out of the 120 reports:

- 76 cases resulted in hospitalization,
  - 2/76 deaths
  - Both deaths occurred in patients who did not have a gallbladder.
  - One patient exhibited pancreatitis symptoms such as acute, severe abdominal pain, nausea, and vomiting within 60 minutes of taking a single dose of eluxadoline [Viberzi]; death ensued within 3 days of the initial dose.
  - The other death involved a patient who experienced sphincter of Oddi spasm with severe abdominal pain and vomiting occurring shortly after taking the first dose.
- 6 reported sphincter of Oddi spasm
- 16 reported abdominal pain
- 84 cases reported a time to onset of the adverse event:
  - 48/84 serious cases of pancreatitis or death occurred after one or two doses.
  - 36/84 experienced pancreatitis with prolonged use.
- 68 cases reported gallbladder status:
  - 56/68 cases of pancreatitis or death occurred in patients without a gallbladder.
    - 44/56 received the currently recommended dosage of eluxadoline [Viberzi] (75 mg) for patients who do not have a gallbladder.
    - 21/56 did not abuse alcohol and
    - 35/56 did not report alcohol use status.

FDA recommends that health care professionals should:

- Be aware that symptoms of pancreatitis have occurred with just one or two doses of eluxadoline (Viberzi) at the recommended dosage for patients who do not have a gallbladder (75 mg) and who do not consume alcohol.
- Consider alternative treatment options before using eluxadoline (Viberzi). **Do not prescribe eluxadoline (Viberzi) in patients who do not have a gallbladder.**
- Avoid use of eluxadoline (Viberzi) in the following patients with:
  - No gallbladder
  - Current or prior blockage of the gallbladder or a sphincter of Oddi problem
  - Pancreatitis or other pancreas problems, including a blockage of the pancreas
  - History of serious liver problems
  - History of chronic or severe constipation
  - Current or prior intestinal obstruction
  - History of alcohol abuse, alcohol addiction, or drinks more than three alcoholic beverages a day
- Educate patients on diet and lifestyle changes as well as stress management to help control symptoms of IBS-D.
- Instruct patients to talk with a health care professional before taking any anti-diarrhea medicine, including over-the-counter medicines.
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resulted from an erroneous link between immunization entries (IMM) and Current Procedural Terminology (CPT) codes found in Patient Care Encounter (PCE) code mapping, leading to documentation in VistA/CPRS that the patient received two vaccines when only one has been given. Incorrect entries affect clinical reminders and may prevent a patient from getting a pneumococcal immunization. The pneumococcal vaccines involved were PCV13 [Prevnar 13® Pneumococcal 13-valent Conjugate Vaccine (Diphtheria CRM197 Protein)] and PPSV23 [PNEUMOVAX®23 (Pneumococcal Vaccine Polyvalent)]. Of note, this pair has also been identified among ISMP’s most frequently reported mix-ups due to vaccine abbreviations and acronyms. This issue has prompted a national review and assessment of facility processes for adult vaccination and immunization within VA.

ISMP offers recommendations to reduce the risk of errors ensuing from vaccine abbreviation/acronym confusion, some of which include:

- Allow use of only current, CDC-approved abbreviations and acronyms for vaccines where permitted instead of non-standard names.
- Where CDC-approved abbreviations and acronyms for vaccines are permitted, list both the full nonproprietary name (and brand, if needed) along with the approved abbreviation or acronym on all order sets to reinforce their correct use.
- Establish regular review (at least annually) of all standard order sets for vaccines, and update as needed (e.g., change in vaccine brands).

REFERENCES:
2. VHA Central Office. Pneumococcal immunizations can be incorrectly documented as given within VistA/CPRS. Veterans Health Administration Patient Safety Alert. March 27, 2017; AL17-02: 1-23. Available at: http://www.ncps.med.va.gov/Guidelines/alerts/Docs/AL17-02.pdf (internal VA access only)