

## Tylenol = acetaminophen: Don't take too much!

While waiting at a train station, a pharmacist from the Institute for Safe Medication Practices noticed a large wall banner advertising Tylenol Rapid Release Gels for fast pain relief (see below). But there was no mention on the banner that Tylenol is acetaminophen. Similar ads appear on TV and on billboards across the US. Even the Tylenol website does not clearly state that acetaminophen is the generic name for Tylenol ([www.tylenol.com](http://www.tylenol.com)). The generic name doesn't appear until you pick a specific Tylenol product, look for the active ingredients in that medicine, and click on that screen.

Acetaminophen is well known to consumers as a generic over-the-counter (OTC) pain reliever and fever reducer. It has also received much public attention as a cause of liver damage when taking more than the recommended amount. To be safe, consumers need to look at the active ingredients in any medicine they are taking. Sadly, the Food and Drug Administration (FDA) reports that there have been many

cases of harm, even death in some cases, from liver damage caused by accidental acetaminophen overdoses. The FDA identified four reasons ([www.fda.gov/cder/drug/analgesics/SciencePaper.htm](http://www.fda.gov/cder/drug/analgesics/SciencePaper.htm)) that adults have accidentally taken too much acetaminophen:

- 1 There is a large selection of both prescription and non-prescription medicines that contain acetaminophen, particularly medicines in which one of several active ingredients is acetaminophen. For example, many cold medicines contain acetaminophen for fever and pain, a decongestant to treat nasal stuffiness, and a cough medicine.
- 2 Consumers did not see that acetaminophen was one of the active ingredients in OTC medicines, and/or they did not understand the possible harm that can happen when taking more than the suggested dose.
- 3 Consumers were not aware of possible serious side effects from taking two or more products together that contain acetaminophen.
- 4 The labels on prescription pain relievers did not list acetaminophen as one of the ingredients. There is little space on a pharmacy label to include all the ingredients in a pain reliever. So, a common abbreviation for acetaminophen—APAP—is often listed instead. (APAP stands for N-acetyl-p-aminophenol, a chemical name for acetaminophen.) For example, the pain reliever Percocet contains oxycodone (a narcotic) and acetaminophen. A prescription for Percocet that is filled using a generic

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Tylenol banner never mentions that Tylenol is acetaminophen.

## 60-second safety tip

■ **Lovaza name mix-up.** In 2007, the drug company that makes Omacor (omega-3-acid ethyl esters) changed the name of the medicine to Lovaza to prevent confusion with another medicine, Amicar (amino-caproic acid). Lovaza lowers triglycerides, and Amicar treats bleeding caused by problems with the blood clotting system. One problem with changing the name of a well-known medicine like Omacor is that it takes time before everyone gets used to the new name. The unfamiliar new name could be misread as a more familiar medicine name during this "learning phase." That's exactly what happened in the following case. After picking up a prescription from the pharmacy, a consumer read the information leaflet that was attached to pharmacy bag and discovered that a mistake had been made. He was supposed to get 1 gram tablets of Lovaza but instead received 1 mg tablets of lorazepam, a medicine used to treat anxiety. He went back to the pharmacy and was given the right medicine. Check any prescription medicine when you pick it up from the pharmacy, and be sure to read the drug information leaflet. In this case, the man had received a leaflet for lorazepam, not Lovaza. Reading the leaflet prevented him from taking the wrong medicine.

■ **Talk to your pharmacist.** While speaking with a consumer about a new prescription, a pharmacist

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drug often has a label on the bottle that says "**oxycodone** and **APAP**."

Consumers need to know when **acetaminophen** is an ingredient in their medicines. The FDA makes sure that labels on OTC medicines list all the active ingredients. Unfortunately, the same does not apply to advertisements. So make it a habit to read the active ingredients on the label before taking medicine. Be cautious when

taking both prescription and OTC medicines, particularly pain relievers and cough/cold medicines. When you pick up a prescription for a pain reliever, ask your pharmacist if it contains **acetaminophen** (**Tylenol**). (Some pain relievers contain **aspirin** instead of **acetaminophen**.) Also look for the abbreviation **APAP** on the label. As ads for **Tylenol** note, "Stop" and "Think" before taking medicine. Too much of anything—including **acetaminophen**—can be dangerous.



**NATURALLY SPEAKING...** Be cautious with **ginkgo biloba**

The "memory enhancer" herb **ginkgo biloba** has been linked to bleeding problems. One of the components in this herb slows blood clotting. Consumers who take ginkgo with other medicines that prevent blood clots, such as **Coumadin** (**warfarin**) or **aspirin**, may increase their risk of bleeding. In one reported case, a young man experienced spontaneous bleeding from his right eye after taking **ginkgo** for just one week. He was also taking a low dose of **aspirin** (80 mg) every morning to help prevent a heart attack. When he stopped taking **ginkgo**, the bleeding stopped and did not happen again. There have also been reports of bleeding in consumers who were not taking other medicines to prevent blood clots. One report involved a young woman who experienced serious bleeding in her brain after she had been using **ginkgo** for a long time. **Ginkgo** can also reduce the effectiveness of a brain and liver enzyme (monoamine oxidase - MAO) that helps keep your blood pressure under control. So, over-the-counter medicines that could increase your blood pressure, like the decongestant phenylephrine found in many flu and cold products, should be used with caution or avoided if you are taking **ginkgo**.

**National Patient Safety Awareness Week Coming in March**

The first week in March (2-8) is Patient Safety Awareness Week. This is a national awareness-building program to help improve patient safety at the local level. It is sponsored by the National Patient Safety Foundation. Hospitals and healthcare organizations across the country are encouraged to plan activities during this week to support patient safety within their own organizations. Most often, these activities are designed to help

promote consumer involvement in their own healthcare and safety. For example, your hospital might hold an open house for patients and families on a particular safety topic such as medication safety. The hospital also might hand out wallet cards that can be used to keep track of all the medications you take. Call your local hospital to see what activities have been scheduled for this week, and plan to attend to learn more about patient safety.



**60-second safety tip**

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noticed that a mistake had been made when interpreting the doctor's directions for taking the medicine. The patient's doctor had written a new prescription for **Vicodin** (**hydrocodone and acetaminophen**) to treat pain. The prescription had been filled by another pharmacist earlier in the day. The doctor's original prescription was kept with the medicine until it was picked up from the pharmacy. When the consumer came in to pick up his prescription, another pharmacist spoke with him about how to take the medicine. While talking to the consumer, the pharmacist noticed that the medicine label said to take the drug just once a day. The pharmacist became concerned because **Vicodin** is not usually taken only once daily. When she compared the label to the prescription, she realized that the doctor had actually ordered **Vicodin** to be taken every 6 hours. The doctor's penmanship was poor, and the pharmacist on duty earlier in the day had misread the doctor's instructions. Be sure to talk with your pharmacist when you pick up any prescription. This allows an additional opportunity to uncover a mistake that may have occurred when filling your prescription. It also allows you an opportunity to ask questions about your medicine and to make sure you understand the directions for taking it. Your pharmacist is a helpful source of information and can give valuable advice about prescriptions, herbals, and over-the-counter medicines.

Contact Information



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▶ Brand name medicines appear in **green**; generic medicines appear in **red**.