

Be careful when giving cough and cold medicines to young children

A recent medical report* noted the accidental death of three infants between the ages of 1 and 6 months who were given cough and cold medicines. The report should not panic parents but should make all aware of the danger with giving cough and cold medicines to infants or young children. The infants who died were given too much **pseudoephedrine**, a drug found in some cough and cold medicines to help lessen nasal congestion. One infant received a prescription AND non-prescription (over-the-counter) cough and cold medicine at the same time. Both medicines contained the medicine, **pseudoephedrine**. The other infants received a single medicine with **pseudoephedrine**; one a prescription medicine and the other a non-prescription medicine.

Since March 2006, medicines with **pseudoephedrine** are now located behind the pharmacy counter and are no longer on store shelves. You can still purchase small amounts of these medicines without a prescription by

asking a pharmacist, who will be available to answer questions. Cough and cold medicines without **pseudoephedrine** are also available, but none are recommended for children less than 2 years of age. In fact, the overall safety of non-prescription cough and cold medicines for children less than 2 years has not been studied. Directions on medicines for children this young tell consumers to check with the child's doctor before giving these medicines.

There are other things you can do for infants and young children who have a cough and cold. For

example, you can clear nasal congestion with a rubber suction bulb (available in pharmacies). Secretions in the nose can first be softened with saline nasal drops (available in pharmacies) and a cool-mist humidifier. But be sure to talk with your doctor before giving any cough and cold medicines to infants and children less than 2.

*Report was published in the January 12, 2007, issue of *Morbidity and Mortality Weekly Report*.

The safety of cold medicines for children less than 2 has not been studied.



Caution with Internet purchases

The Food and Drug Administration (FDA) issued a news release about the dangers of buying prescription medicines over the Internet. Some individuals who ordered **Ambien (zolpidem tartrate)** for sleep, **Xanax (alprazolam)** or **Ativan (lorazepam)** for anxiety, and **Lexapro (escitalopram)** for depression, actually received medicines that contained **haloperidol**. This powerful drug is used to treat serious mental health conditions. Some people developed breathing problems and muscle spasms, and had to seek treatment in the emergency department. If you buy your medicines over the Internet, visit the FDA Web site at www.fda.gov/buyonline for more information. This Web site has consumer tips for buying medicines safely over the Internet.

60-second safety tip

■ **Dose counter may not work.** A man brought his **ASMANEX TWISTHALER (mometasone furoate)** to the pharmacy to find out why the dosage counter showed that 182 puffs remained. His prior inhaler had lasted only 1 month, but he had been using two puffs daily from his current inhaler for several months. This asthma medicine is taken daily to help breathing, although it does not treat sudden episodes of wheezing. The inhaler is designed to automatically keep track of the remaining doses (see photo). To prepare a dose, the white cap is twisted in a counter-clockwise direction and removed. When the cap is removed, the dosage counter decreases by one and a single dose is ready to be inhaled. After the cap is replaced, the inhaler is ready for the next dose. When the dosage counter reaches "00," the Twisthaler should lock shut to prevent people from using an empty device. But if you apply enough force while turning the cap, the counter could reset to its highest possible number, 199. Until this problem is fixed, be sure to discard the inhaler 45 days after starting it, or when the dosage counter nears "00," whichever comes first. For more about using this inhaler, visit www.asmanex.com.



Ask questions if your medicine is a powder

A child's father went to the pharmacy to pick up a prescription for liquid **amoxicillin**, an antibiotic used to fight infections. The liquid form of this medicine starts as a powder that needs to be mixed with a specific amount of water by the pharmacist before use. By mistake, the pharmacist gave the child's father the bottle of medicine with just the powder. The directions on the pharmacy label said to give 9 mL (about 2 teaspoons) of medicine for each dose. These were the correct directions for the medicine if it was mixed with the right amount of water. The child's father had a small plastic cup for measuring each dose. He filled the cup with enough concentrated powder to reach the 9 mL line and gave it to his child to take with a little water. The child actually got **twenty times more** medicine than the doctor ordered because the powder was not diluted. Nine mL of the powder would make twenty doses once it is mixed with the proper amount of water. After giving his child the first dose, the father thought something was wrong and called the pharmacy. The mistake was discovered and the medicine was mixed correctly and returned to the child's father. Fortunately, the child was not harmed.

How could the pharmacist forget to add the water to this powder medicine? Actually, it's quite easy to make this mistake and it happens from time to time. The pharmacist knows it is best to mix some medicines—including this one—with

water right before it is picked up by the parent or caregiver. So, the usual process in most pharmacies is to put a label with the patient's name and directions for taking the medicine on a bottle that contains the correct amount of powder medicine. The medicine is then placed in a bag with a note on it to let the store clerk know that the medicine requires mixing by a pharmacist before it is given to the customer. Sometimes this message can be overlooked, especially if the pharmacy clerk is new, as in this case.



Always double check with your pharmacist before taking or giving a medicine if:

- ✓ The medicine is a powder that you were told to take by mouth (swallow), but there are no directions on the label about adding water or another liquid
- ✓ The medicine is a powder with directions to measure the dose in teaspoons, tablespoons, or mL (milliliters); these measures are used for liquid medicines
- ✓ You expected a liquid medicine and you receive a powder medicine.

These conditions suggest there could be an error. You will need to take the medicine back to the pharmacy. Do not try to add water to the powder yourself. The amount of water used must be carefully measured to be sure that each teaspoon has the correct amount of medicine in it. Opening the bottle and checking the medicine before you leave the pharmacy might help spot a mistake right away.

In The News!

Questions are the Answer. A government agency that funds patient safety projects (Agency for Healthcare Research and Quality) just kicked off a national campaign to urge consumers to become more involved in their healthcare by asking questions. The **Questions are the Answer** campaign directs individuals to an Internet Web site (www.ahrq.gov/questionsaretheanswer) that provides important information on:

- Reducing medical mistakes
- Talking with your clinician
- Planning for your surgery
- Getting a prescription
- Patient safety resources.

One of the highlights of the campaign is a short video that can be seen on the Internet. The Web site also has a unique feature that allows you to "Build your own List of Questions." You simply choose the topics that are important to you, and a list of possible questions will appear for each group. Check off the questions that you feel are important. Then you can print your list of questions, with space for the answers, to take with you when you visit your doctors, nurses, and pharmacists. If you are not comfortable using the Internet, you can call 1 (800) 931-2477 for more information.

Source: Adapted from **Questions are the Answer**, accessed on the Agency for Healthcare Research and Quality Web site at: www.ahrq.gov/questionsaretheanswer.

Poison Control



To promote **National Poison Prevention Week** (March 18-24),

safety tips for using over-the-counter medicines are available at: www.poisonprevention.org/materials.htm.

Contact Information



Safe Medicine (ISSN 1550-6282) ©2007 Institute for Safe Medication Practices (ISMP). Reproduction is prohibited without written permission from ISMP. Editors: Judy Smetzer, RN, BSN; Charlotte Huber, RN, MSN; Michael R. Cohen, RPh, MS, ScD, Russell Jenkins, MD. ISMP, 1800 Byberry Road, Suite 810, Huntingdon Valley, PA 19006. Email: consumer@ismpp.org. To subscribe, visit: <https://www.ismp.org/orderForms/safeMedicineSubscription.asp>.