

Sir,

'Hyperacute' unilateral anterior uveitis and secondary glaucoma following streptokinase infusion

I read with interest Ah Kiné and Adams'¹ report of marked anterior uveitis following streptokinase infusion. I have been involved with a similar case recently that was bilateral. The onset was also within 12 h of the streptokinase infusion, and the patient had bilateral hypopyons. I agree that the rapidity of the immune response suggests previous exposure to streptococcal antigen.

When I presented this case at our regional postgraduate meeting, it transpired that two other cases were known within the region in the preceding 12 months. It seems likely that anterior uveitis secondary to streptokinase infusion is more common than is generally recognised.

References

- 1 Ah Kiné D, Adams W. 'Hyperacute' unilateral anterior uveitis and secondary glaucoma following streptokinase infusion. *Eye* 2001; **15**: 804–805.

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Sir,

What do your authors do?

It is the custom in *Eye* to state where the authors work but not what they do. Their qualifications are not mentioned at all. I refer as an example to:

Habib NE, Balmer HG, Hocking G. Efficacy and safety of sedation with propofol in peribulbar anaesthesia. *Eye* 2002; **16**: 60–62.

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and we are told that he is a consultant ophthalmic surgeon, but we are told nothing more about Mr/Dr Balmer and Mr/Dr Hocking. The importance of this is buried in the paper where it states that 'Sedation and anaesthesia were administered by ... a single... anaesthetist.

There is so much to read nowadays that some readers, including me, go through a journal only reading the title, author, and then the abstract or even just the summary. Then they read more of the few papers of interest to them, as I have done with this one.

In this paper, an abstract-only reader would miss the extremely important fact that sedation should only be administered by someone trained in managing the airway of an unconscious patient. Patients are individuals and I have rendered such a patient totally unconscious with an obstructed airway with just 1 mg of midazolam—an amount so small that I anticipated almost no effect. If it was obvious at the start of the paper that either Dr Balmer or Dr Hocking was an anaesthetist, this message would be more likely to get through.

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Sir,

Re: Confusion between similarly named eye drops

Over the last week I have come across two patients who were using the wrong medications. One had been prescribed Predsol but was using Predsol-N, the other had been on Cosopt for some time, but had recently received Trusopt from his pharmacist.

It is clear that there is considerable room for confusion by general practitioners when renewing long-term prescriptions and by pharmacists at the point of sale when similarly named drops are concerned. The wrong medication may have significant consequences for the course of a patient's ocular condition, especially if a steroid is unnecessarily added or if a component in a combination glaucoma preparation is dropped.

Confusion is likely between:

Betagan and Betoptic,
Betnesol and Betnesol-N,
Ilube and Lacrilube,
Neomycin, Neosporin, and Neocortef,
Polyfax and Polytrim,
Predsol, Predforte, and Predsol-N,
Maxidex and Maxitrol,
Teoptic and Timoptol,
Tobramycin and Tobradex,
Trusopt and Cosopt,
Xalatan, Xalacom and Zaditen.

Errors in dispensing can be reduced if ophthalmologists limit the range of drops in a hospital formulary, by using generic names when possible, by writing prescriptions clearly and by educating local general practitioners, pharmacists, and junior doctors as to the similarities and differences between similarly named preparations.

When patients are seen in clinic, it is important to determine exactly what drops they are using and how often, even when you think you know what they are using. This not only gives opportunity to check a patient's level of compliance but may also reveal dispensing errors, such as those mentioned above, which may have bearing on a patient's apparent response to medication.

I can still vividly remember a patient nearly 20 years ago who was prescribed Timolol, 1 drop twice a day. His pharmacist prescribed Timolol, 2 drops three times a day which precipitated a severe asthma attack.

Checking which medications a patient is using is part of every patient consultation, even for patients reviewed with chronic conditions.

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Sir,

Reply

Thank you for sending this to me for comments.

General comments:

I share the concerns raised. Pharmacists are only too well aware of the dangers of transcription and/or reading errors leading to patients receiving incorrect medicines.

Use of generic terms is now routine practice by pharmacy computer systems but combination agents of eye drops where there is only one product will be identified by the proprietary name. Manufacturer's should take some responsibility when naming their agents. Cosopt[®], for example, establishes from the start that it is a combination agent, while Xalacom[®] emphasises the similarity to Xalatan[®].

With generic terminology of combinations of oral forms it is an established practice to use the prefix co- (as with co-trimoxazole and co-proxamol). While in general practice computer-generated prescriptions are standard, hospitals in the main still rely on the handwritten prescription followed up by a typed letter to the GP. The problems of both transcription and reading errors will be considerably reduced come the day of shared electronic medication records!

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