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.

PW Sellar

Department of Ophthalmology, West Cumberland Hospital, Whitehaven CA28 8JG, UK

Correspondence: PW Sellar
Tel: +44 190 082 8644,
E-mail: william@sellarpw.freeserve.co.uk

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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!

V Haylor

Clinical Pharmacist (Opthalmology)
Royal Hallamshire Hospital
Sheffield S10 2JF, UK

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