



Practice sting 2022-05

Practice sting Nortriptyline overdose due to inadequate first dispensing

Good explanation when dispensing medicines is important. This is necessary when the patient collects the medicine from the pharmacy and when the medicine is delivered to the patient's home, as shown by the notification that VMI received from a patient.

Notification

A man who uses smoking cessation medication receives two packages of 25 mg nortriptyline tablets of different brands from an internet pharmacy. Both packages differ in three respects. Firstly, the dosage on the pharmacy label is different, but the start date of both packages is the same. Second, the boxes have a different appearance. And thirdly, there is a big difference in the number of tablets per box. The total quantity supplied is enough for a use of more than three months. The patient received no oral or written explanation.

In the box with the smallest quantity, 90 tablets, the build-up schedule is printed on the label. The maintenance dose is stated on the other box with 200 tablets: 3 tablets once a day. The patient does not know how to use the medication. The package with the text that is most understandable to the patient reads '3 tablets once a day'. He takes 3 tablets from both boxes, a total of 6 tablets of nortriptyline, and takes them all at once. The patient becomes unwell and calls 112 (general alert number). He makes a full recovery after hospitalization.

Analysis

The use of nortriptyline in smoking cessation requires a fixed schedule: start with 25 mg once a day for 3 days, then 50 mg once a day for 3 days, and then 75 mg once a day for 6 to 12 weeks.

Where it went wrong with the patient is:

- The build-up schedule box and the maintenance dose box have the same start date. The recipe for the build-up schedule was probably prepared at the same time as that for the maintenance dose. Both boxes were delivered at once.
- The patient did not receive any oral or written first-dispensing guidance from the pharmacy. Only the text on the boxes was available for the patient.
- The patient did not realize that both boxes contained the same medicine and did not understand the build-up scheme.

Recommendations

For pharmacists and pharmacy assistants

- Provide good oral and written guidance for the first-dispensing of a medicine. There are specific build-up schedules for smoking cessation. Be alert.
- In principle, never deliver the same medicine in multiple packages where the use differs per package.
- Do not deliver different brands of the same medicine at once. Only do this if there are no other options due to availability issues. Tell the patient that the medicine supplied in two packages of different brands still contains the same medicine and verify that the patient understands this.