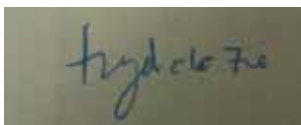
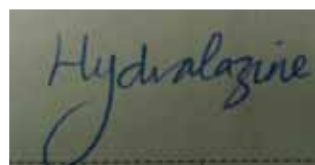


# Physicians' Handwriting

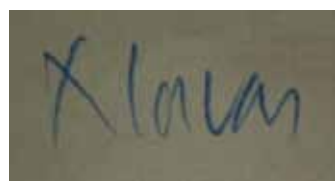
Working in an inpatient-pharmacy is very challenging. Reading medication administration records (MARs) which sent to pharmacy by fax or by hand in NCR papers from Physicians almost fills up all the working time for a day. Why is such work challenging? Besides acting as a pharmacist, sometimes we act as a detective or an inspector. Some questions will be listed here to test your skills.



This is a drug commonly used for hypertension. This drug belongs to the group of sound-alike-look-alike drugs (SALAD) or look-alike-sound-alike drugs (LASA drugs). The answer is hydralazine.

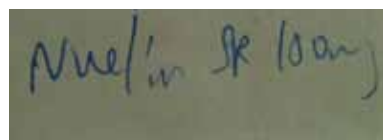


For comparison, the drug name written is very clear in the second diagram.

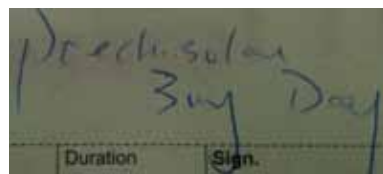


What is the drug name in the diagram? Is it a brand name started with "Xla..."? You can find MIMS and see Xalatan/Xalacom but without other findings. Is it a brand name used in foreign countries?

This is a difficult question as the spelling of drug name is a little bit wrong by physician. The answer is Norvasc. It is incredibly unbelievable.



This is obvious that physician orders Nuclin SR but how about the dose? 100mg or 150mg? After clarifying with nurse, physician prescribes as 150mg. Ridiculous!



Here comes another one that contains prednisolone daily to be taken. Low dose 3mg daily is for a lot of clinical states as immunosuppressant while 30mg daily is for acute exacerbation of asthma. The zero is really small and easily to be neglected.

During the drug distribution process, there are a lot of traps and tricky steps. More legible handwriting should be the ultimate solution to the problem and someone would propose IPMOE to solve the situation. During the interim period before IT system can streamline the process, when facing such MAR, our practice is to check Corporate Dispensing Drug History (CDDH) or have a phone call to nurse to clarify the drug name. A single dose will be given for used before the correction from physicians if urgent request is needed. Finally, it is reminded to be more alert on illegible handwriting so that medication incidents can be prevented.

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