Medicines Safety Alert

No. 12

Health and Social Care Board

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To: All Prescribers and Community Pharmacists for onward cascade to relevant staff

Dear Colleague

Caution: Patient Harm following Pregabalin Overdose

The Board has been made aware of a number of incidents where patients have been admitted to hospital following an inadvertent overdose of pregabalin. The cause of these incidents was a mix-up between pregabalin and gabapentin by the prescriber and/or the pharmacist.

I am writing to highlight the risks associated with pregabalin overdose and to ask prescribers and community pharmacists to put additional measures in place to reduce the risk of overdose and confusion between these products.

Symptoms of pregabalin overdose can vary between individuals but the most commonly reported adverse reactions when pregabalin was taken in overdose included drowsiness, confusion, agitation and restlessness.

Following investigation into the reported incidents, the main contributory factors identified were:

- Confusion between pregabalin and gabapentin which are in the same therapeutic class of drug and have similar sounding names
- Lack of awareness of the maximum recommended dose of pregabalin (ie 600mg daily).

Action required by Prescribers and Community Pharmacists:

1. Steps should be put in place to ensure pregabalin and gabapentin are not mixed up and that staff are aware of the maximum daily dose.

   Although pregabalin and gabapentin are used to treat similar indications they have markedly different dosing regimens, for example:

Generic Name	Brand Name		Neuropathic Pain Maximum Adult Daily Dose (BNF64)
Pregabalin	Lyrica®		600mg
Gabapentin	Neurontin®		3600mg

- **Prescribers** should take extra care when prescribing generically due to the similarity in names.

- **Community Pharmacists** should take extra care when dispensing pregabalin e.g, use of shelf alert stickers with maximum daily dose; computer warning.

2. When prescribing or dispensing pregabalin, the dose should always be checked to ensure that it does not exceed the maximum adult daily dose of 600mg. It is recommended that GP practices carry out a search for patients receiving pregabalin to ensure that the doses prescribed are appropriate.

   Where doses of pregabalin exceed 600mg daily:

   - **Prescribers** should review and amend the dose as appropriate.
   - **Community pharmacists** should query the dose with the prescriber. The patient should be referred to their GP if required.

   Where doses of pregabalin have been queried, a note of the query together with the outcome should be made in the patient's record.

3. As part of regular medication reviews **prescribers** should review patients on pregabalin to ensure both the prescribed dose and continued treatment are appropriate.

4. Compliance with pregabalin should be checked before repeat prescriptions are issued and dispensed. Early ordering on a regular basis may be a marker of dose misunderstanding by the patient; this should be clarified with the patient and/or prescriber.

5. The actions outlined in this safety alert should be discussed with all relevant staff and an action plan agreed to minimise the risk of pregabalin overdose by patients in your practice/pharmacy.

If you have any further queries please contact your Medicines Management Adviser.

Yours sincerely

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Pharmacy & Medicines Management