Isotretinoin incident

REPORT

- A patient of childbearing potential attended a routine medication review and on questioning, it appeared that she had been issued a 4 month prescription of isotretinoin instead of the intended 4 weeks.
- The issuing pharmacy were contacted who confirmed that the patient had been given 112 days of medication at the initially prescribed dose of 30mg.

LEARN

- The original prescription was not available at the pharmacy although on examination it was noted that the quantity prescribed could easily have been 4/12 or 4/52.
- Best practice is to not prescribe isotretinoin for more than a month at a time as the patient needs blood tests and must be on a Pregnancy Prevention Programme (PPP).

SHARE

- The dispensing pharmacy and the consultant who issued the ambiguous prescription were notified of the incident.
- The Medication Safety Officers on the Community Pharmacy Patient Safety Group were made aware of the incident to share with colleagues and pharmacy teams working across the community pharmacy network.

ACT

- In the future, the consultant who issued the ambiguous prescription will write 4 weeks instead of 4/52.
- The team will check all prescriptions for isotretinoin are for an appropriate time period and that the patient is aware of the PPP and associated risks and is having regular blood tests.

REVIEW

- The team will review whether there have been any further incidents and will alert the prescriber.

Think about the patient behind the prescription and consider any unusual circumstances which might require a conversation with the prescriber e.g. student away from home, levy Rx
Update your knowledge about isotretinoin using the following links. Record this as CPD.

- MHRA guidance on isotretinoin for severe acne
- RPS quick reference guide to dispensing oral isotretinoin and pregnancy prevent

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