To the Editor,
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Respected Sir,

There has been unfortunate reports of cases where Sepgard (feracrylum) 100 ml, was given as intravenous infusion, mistaking it as a bottle of SUMOL (Fig. 1) (paracetamol) 100 ml, which leads to serious complications including the death of the patient. This is because feracrylum is a water-soluble biodegradable polymer which acts as a hemostatic agent by forming gel-like complexes when it comes into contact with blood. On intravenous (IV) administration, it leads to stagnation of blood flow and thrombus formation in veins which can lead to widespread infarction and multiorgan failure leading to even death of the patient.

A recent incidence occurred in our hospital also where a nursing staff was asked to bring a bottle of 1 gm IV PCM and just when she was about to start the infusion, a resident noticed that the bottle was of Sepgard instead. A serious mishap was prevented by the vigilant resident but this might not be the case everytime. And, all this confusion is because of the similar looking bottles of both the commonly used drugs.

Can we please request you to kindly consider notifying such incidences to the manufacturers of both the drugs in order to change shape or color of either of the bottles. This change could prevent the possibility of any such fatal outcomes in the future.

REFERENCES