■Medical Safety Information
Pharmaceuticals and Medical Devices Agency
https://www.pmda.go.jp/english/safety/info-services/safety-information/0001.html
No. 37 Revised September, 2016
No. 37 April, 2013

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No. 37 Revised September 2016

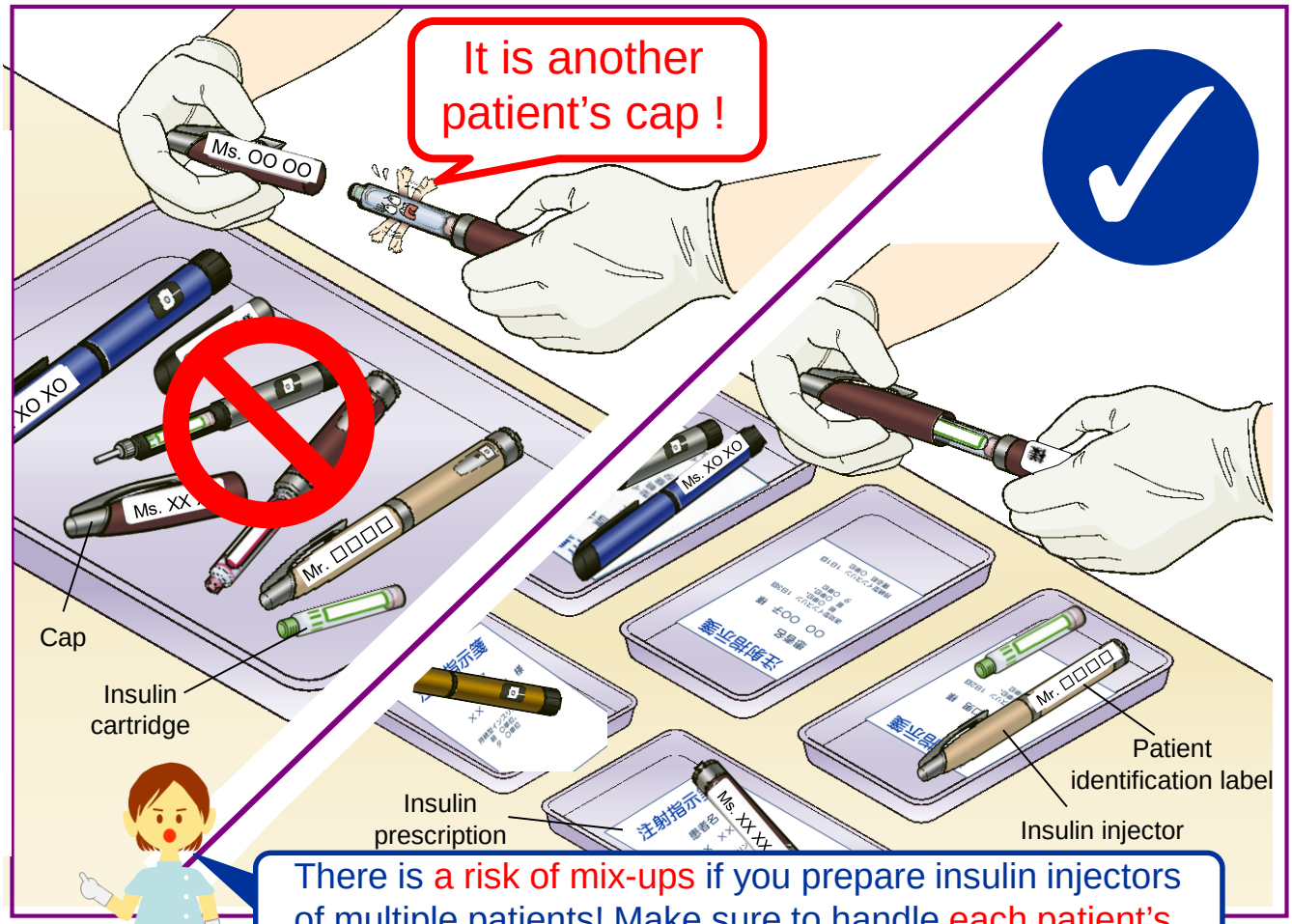
Precautions in Handling of Insulin Injectors

POINT Key points for safe use

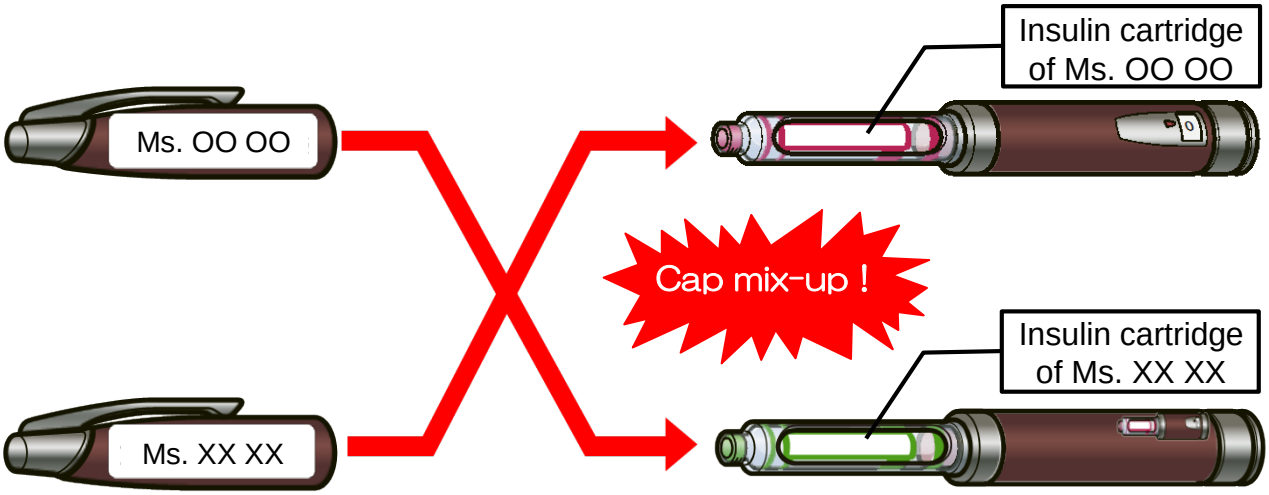
(Case 1) When preparing multiple insulin injectors at the same time, a cap was accidentally put on another patient's injector. A mix-up occurred.

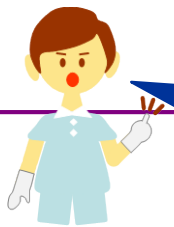
1 Cases of insulin injector mix-up

- **Make sure to check each patient's injector one by one when preparing insulin injectors (including setting up of insulin cartridges).**



Cause of mix-ups

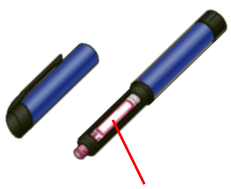
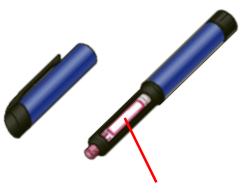
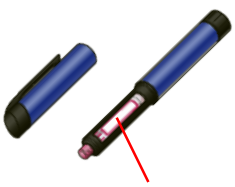


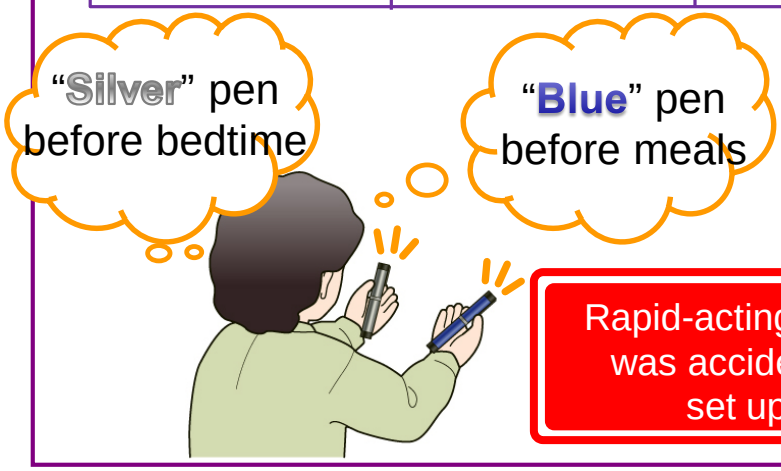


Dosing errors can be prevented via placing a patient identification label on the injector itself rather than the cap.

(Case 2) A patient, who had been receiving rapid-acting insulin 3 times a day before meals and long-acting insulin once before bedtime, went into a hypoglycaemic coma after accidentally setting up a rapid-acting insulin cartridge and using it before bedtime instead of a long-acting one.

2 Cases of insulin cartridge mix-up

Before breakfast	Before lunch	Before dinner	Before bedtime
 Rapid-acting insulin	 Rapid-acting insulin	 Rapid-acting insulin	 Long-acting insulin



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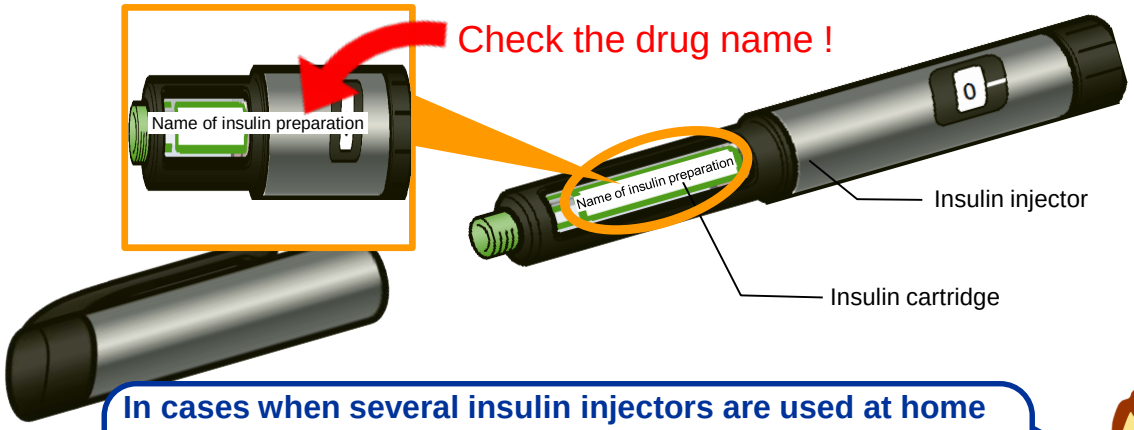
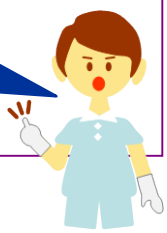
Precautions when using insulin injectors



In cases when several insulin injectors are used at home or in a ward, there is a risk that a cartridge will be set up in the wrong injector, which leads to dosing errors if injectors are distinguished just by color. Make sure to check the drug name on the cartridge before administration!



Sanofi K.K.

Apidra Inj. Cart

Lantus Inj. Cart

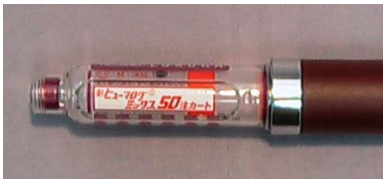
Novo Nordisk Pharma Ltd.

NovoRapid Penfill

Levemir Penfill

Eli Lilly Japan K.K.

HUMALOG Cartridge for Injection



HUMALOG MIX50 Cartridge for Injection

About this information

* PMDA Medical Safety Information is issued by the Pharmaceuticals and Medical Devices Agency for the purpose of providing healthcare providers with clearer information from the perspective of promoting the safe use of pharmaceuticals and medical devices. The information presented here has been compiled, with the assistance of expert advice, from cases collected as Medical Accident Information Reports by the Japan Council for Quality Health Care, and collected as Adverse Drug Reaction and Malfunction Reports in accordance with the Pharmaceutical Affairs Law.

* We have tried to ensure the accuracy of this information at the time of its compilation but do not guarantee its accuracy in the future.

* This information is not intended to impose constraints on the discretion of healthcare professionals or to impose obligations and responsibility on them, but is provided as a support to promote the safe use of pharmaceuticals and medical devices by healthcare professionals.

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