Speaking for Myself

The topsy turvy world of drug brand names

T. SUDHAKAR BHAT

A few years ago, I prescribed Depsert (sertraline) to a woman and she telephoned me after two or three days to say that she is unable to tolerate the dryness of mouth. I said: 'Impossible; don't read the internet too much and imagine side-effects.' She said she never searched the internet because she did not know how to and offered to spell the drug she had. She did so slowly—D-E-P-S-O-L, a brand of imipramine. I warned the chemist who had filled up the prescription and left it at that. A few months later, when a child to whom I had prescribed 'Attentrol' got 'atenolol' instead, I was really alarmed. Although the mistake was detected, albeit accidentally, within a day or two, I realized how narrow was the escape I and the child had. It was then that I went through the alphabetical index of the latest edition of the *Current Index of Medical Specialties* (CIMS) to find out whether there are more instances of brand names that may cause similar confusion. It opened a whole new world of brand names that I had never thought existed.

There are several brand names which are so old that we almost take them to be generic names—'Serenace', 'Depsonil', 'Valium', to name a few. Then there are some brand names, for which the generic names are easy to guess—'Aten' (atenolol), 'Flucort' (fluticasone), 'Telma' (telmisartan) and so on. A little more complicated, yet not so difficult to understand are those which combine the generic name and the manufacturers' name—'Relinase', 'Lithosun' and 'Amlokind'. At the next higher level of complexity are those which hint at the indications for use—'Vomikind' (ondansetron), 'Stopvomit' (domperidone), 'Dolocare' (piroxicam) and 'Chericof' (cough syrup).

Then come some of the brand names that leave us completely clueless as to their origin. 'Aloo' is aceclonac and so is 'LetGo'. 'Algebra', 'Reward', 'Roll', 'Rodeo', 'Staycool' and 'Value' are all rabeprazole. 'Alfabel', 'Match', 'ABC-9' are arteether. 'Day' and 'Fine' are paracetamol. 'Hema' is neither haemoglobin/iron nor the name of the popular actress of yesteryears, it is progesterone. 'Palmy' and 'Buffet' are pantaprozole. 'Volvo' is voglibose. I felt a little giddy when I learnt that 'Zoom' was omeprazole.

Some brand names are similar but actually belong to different classes of drugs. 'Kind' is levoceterezine but 'Kind-MD' is nimesulide. '2-Her' is iron and folic acid but '2-Hngry' is cyproheptadine. 'ABC-9' is arteether but 'A to Z' is a multivitamin–minerals combination. 'A2L' is also a multivitamin combination, probably because the content list ends with lycopene. 'Fullform' is formoterol and beclamethasone, 'Full 24' is ginkobiloba, ginseng and garlic but 'Full 365' is cholecalciferol, vitamin D and minerals. Some brand names are funny but are equally mysterious in origin. 'Funnie' is fluconazole and 'Fury' is cefuroxime. 'Aladin' is alpha-lipoic acid, 'Car-Race' is ramipril, 'Clouds' is clopidogrel and aspirin, 'Congo' is a laxative (sodium picasulfate), 'Flush' is a herbal urinary antiseptic, 'Flute' fluticasone, 'HAA' is chlorhexidine mouth wash, 'ECT' is ericoxib, and 'Real One' is aripiprazole.

It is when naming the drugs affecting sexual functioning that the creative imagination of brand managers soars high. Consider some of the brand names of Sildenafil—'1-2-3', 'Adam's Delite', 'Bison', 'Man Force', 'Rocky', 'Romento', 'Uplift', 'Viraha' and 'Zerect'. 'Kutub' is dapxetine, another drug for erectile dysfunction and perhaps is meant to evoke the image of the historical monument as a suggestive image. Similarly, 'Abortum', 'MTP', 'Undo', 'Unwanted' are some of the brands of mifeprestone, the postcoital contraceptive. But my vote for the best goes to 'PopUp' for tadalafil and 'Oh God!' for mifeprestone.

More seriously, apart from the confusions already mentioned, I often face difficulty in knowing what other doctors have prescribed when I see a prescription. The most widely used compilation, CIMS does not include all brand names and the names appear, disappear and reappear in successive editions at random.

I fully sympathize with the drug industry. It is a crowded market and it is difficult to 'stand out' and get noticed. It is even more difficult to be remembered. Just to show how crowded the market is: there are nearly 60 preparations of paracetamol, 120 of ceftriaxone and more than 250 of iron with different vitamins and minerals listed in the latest edition of CIMS I consulted! (Does it show the priorities of the drug industry as compared to that of our planners?) But the confusions in the minds of those who prescribe and those who dispense may lead to serious consequences. I have tried some ways out but none appear to be fully satisfactory. Prescribing by the generic name only is one way. But the prices of different brands of the same drug vary—sometimes as much as five times. Thus, the cheapest brand of Atorvastatin 10 mg is about ₹30 per 10 tablets while the costliest is ₹105. Prescribing by generic name gives the chemists the liberty to dispense the costliest brand, an unnecessary burden on the patient. Often chemists are so ignorant of the generic names that my patients came back saying the drugs were not available with any local chemists. Although there is a rule that every pharmacy should have a qualified pharmacist, the rule is observed only in name with the pharmacists lending the name without actually being present in the drug store. Writing both the brand name and the generic name too gives the leeway to drug stores to say that the same brand is not available but some other is. The patient, faced with the prospect of going to a different town in search of the drug is forced to buy what is available. Often the chemists do it surreptitiously, when they know that I have not asked the patient to come back and show the drugs she has purchased.

Another way is to have an understanding with one drug store to stock the brands I prescribe and asking the patients to buy only from the particular store. But the different drugs manufactured by a company may not uniformly be the cheapest. The chemists, who get the drugs from wholesalers/distributors may not be able to

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keep stock of different drugs from different companies. Further, such an understanding often comes with a rider, a request for pushing something in which the chemist is interested; a general tonic, for example.

What I do now is to write the brand name in capital letters and as far as possible ask the patient to come back to show the drugs purchased. It involves additional time spent both for me and for the patient, and additional auto fare for the patient, but I do not see any other option at present.

The 'middle path' and the perils of moderation in medicine

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INTRODUCTION

The 'middle path' has been touted as a virtue in life and in medical practice, much more so in India, perhaps because of the cultural influence of the *Gita* (*akarma*, inaction) and the teachings of the *Budhha* (*madhyamâ-pratipada*, the middle way). While being moderate is in general a good trait in a medical practitioner, it can sometimes lead to inappropriate clinical decisions if these are guided solely by considerations of moderation. The chances of such an occurrence are high, given that medicine is an inexact science and often we do not have convincing evidence for or against a particular treatment or practice, and the doctor's personality and personal convictions play a major role in determining the course of action. Even though practitioners exhibit the entire behavioural spectrum from therapeutic nihilism to cowboyish aggression, the large majority of doctors can be described as being moderate. Therefore, potentially more (albeit unintended) damage may be caused by this large group of well-meaning practitioners if they uncritically adopt a middle path for apparently no reason other than the fallacious assumption that moderation is always good.

MODERATION MAY MISLEAD

The middle path in medical practice is treacherous for at least two reasons. First, as illustrated by the *Golden Mean Fallacy*, a compromise between two extreme options may not represent the optimal course of action in a given clinical situation. Second, even if one assumes that the middle path is the optimal one, clinical decision-making requires the balancing of numerous risk–benefit trade-offs simultaneously. Therefore, in a given situation, there may not be one single middle course that addresses all the risk–benefit considerations. Further examination of these reasons in the context of commonly encountered clinical scenarios may help clarify why adopting a middle path solely for the sake of moderation can lead the clinician astray.

The middle path may not be the optimal path

The foundation for unconditional faith in moderation is perhaps the belief that 'too much' of anything is bad. This belief is reinforced by the fact that in life, the middle course is often the correct one. But the problem with the middle path in medicine is that it cannot be determined independently and is necessarily defined by the extreme options. The range of options may change with accumulating knowledge and the middle ground may shift with it, without having any legitimacy of its own. As an example, early in the evolution of the treatment of non-valvular atrial fibrillation (AF), after the introduction of adjusted-dose warfarin, the use of antiplatelet drugs alone represented a middle path, between giving warfarin and not doing anything, to balance the risk of bleeding and stroke. As was shown in due course, the uncritical acceptance of this middle path resulted in substantial harm.[1] Subsequently, the use of a combination of aspirin and warfarin adjusted to a lower international normalized ratio (INR) (1.2–1.5) came to represent the middle ground between the 'extreme' options of aspirin alone or warfarin (adjusted to an INR of 2–3). Once again, this 'moderate' approach failed to show any benefit.[2] The shifting of the low density lipoprotein (LDL) cholesterol target to progressively lower levels (with the middle ground shifting along with it) provides another example of the failure of an approach adopted simply because it represents the middle path.

There are several plausible explanations for the failure of moderate approaches in general. The effects of interventions are often non-linear, making it nearly impossible to determine the middle ground. In addition, the relationship of an intervention with harms and benefits may be qualitatively and quantitatively different and the middle paths for harms and benefits may not coincide. These illustrations do not predicate that the middle path must not be chosen because it is always wrong; they simply make the case that the middle path may not be the optimal option merely because it represents moderation. In fact, the middle path may occasionally turn out to be the best choice as in the case of long-standing diabetes where a more 'moderate' HbA1c target results in the optimal risk–benefit balance.[3]

There may be no meaningful middle path

A middle path is theoretically not possible when the choice is between carrying out or not carrying out an intervention, e.g. angioplasty. In such cases, the intuitive search for a middle path results in a course of action which fallaciously appears to represent a moderate path (e.g. do angioplasty later rather than now). The case of invasive treatment for acute coronary syndromes (ACS) amply illustrates the pitfalls involved in such choices. A few decades ago, the dilemma was whether or not to perform early intervention (or surgery) in these patients. The middle path was a 'conservative strategy' of non-invasive testing before contem-

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