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Obtaining the correct drug history

Sir

Obtaining an accurate drug history from a patient admitted to hospital requires reliable information sources. These sources include the general practitioner's referral letter, the patient and their medicine bottles, relatives, or carers, and records held by general practitioners or community pharmacists. The accuracy and availability of any of these information sources has been shown to be variable.¹

An accurate drug history is important to assess any drug-related problems, plan future therapeutic management and avoid potential medicine misadventures.² The ideal situation would be that there are no unintentional differences between the medication prescribed by the general practitioners and that prescribed for the patient on admission to hospital. In view of this we undertook a study to examine the accuracy of drug histories obtained on admission and the type and number of any unintentional differences that occurred.

Eighty consecutive patients who were admitted to three study wards (two care of the elderly and one respiratory medicine) during a three-week period in December 1995 were included. Their mean age was 74 years (range 18-99) and 61 were 65 years or over. A drug history was compiled by the ward pharmacist within 24 hours of admission, using all available information sources and a semi-structured patient interview. This drug history included only the medicines prescribed to be taken regularly. This pharmacist-acquired drug history was compared with the in-patient prescription chart. Data was collected regarding the number of medicines each patient was receiving, and the differences between the pharmacist-acquired drug history and the in-patient prescription chart. The differences were classified as intentional or unintentional. Intention was identified through the medical notes or in discussion with the prescriber. The number and type of unintentional differences were recorded.

The 80 patients in our study were taking 353 medicines (mean 4.4, range 1-12). This appears low for the age group, but only medication to be taken regularly was included, ie, that to be taken when required or purchased over-the-counter was not included. There were 40 unintentional differences identified in 32 patients. Most of the unintentional differences, 21 (53%) were due to the drug being omitted completely. In six cases (15%) the wrong drug was prescribed. The wrong dose was prescribed in eight (20%) and the wrong frequency in five (12%) cases.

Previous work has shown that information sources available to an admitting doctor may be inaccurate, potentially resulting in incomplete drug histories.^{3,4} The pharmacist-ac-

quired drug history is taken later and has been shown to be more complete, due possibly to increased product knowledge and availability of information sources.⁵ In our study, 40% of patients had at least one unintentional difference between the drugs prescribed for them in hospital and those prescribed by their general practitioner. Such inaccuracies can compromise patient care by hindering the identification of drug-related problems and further therapeutic management. Methods to improve drug history taking should involve improving information flow between primary and secondary care, and improving the skills of doctors or pharmacists taking the drug history. The clinical significance of the unintentional differences deserves further study.

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Incarceration of the penis by a metallic ring

Sir,

Incarceration or strangulation of the penis by an encircling object is an uncommon clinical event. This paper describes a case of long-standing penile incarceration by a metallic ring and its management.

A 35-year-old man presented in a distressed and embarrassed state with a heavy metal ring (outer diameter 3.2 cm, inner diameter 1.4 cm), encircling the penis at its root. The ring had been in place for a month, during which the patient had tried several manoeuvres to remove it, without success, although he was habituated to using a ring in this way. The patient had no urinary complaints. Movement of the ring was not possible and the penis distal to the ring was swollen, ulcerated and harbouring maggots (figure). Attempts to remove the ring using lubricants and by multiple punctures and aspiration of blood from the engorged penis



Figure Photograph showing penile incarceration by a metallic ring

failed. Division of the ring was not easy. Under spinal anaesthesia, the distal penis was degloved to the level of cavernous tissue and the iron ring was removed. Subsequent split-thickness skin grafting from the medial side of the right thigh on the denuded penis (5 x 3 cm) yielded good results.

A variety of constrictive bands ('cock-rings', rubber bands, etc) have been used to increase sexual gratification and prolong erections.¹ Patients usually present at a late stage when the penis is grossly swollen and attempts to remove the objects have already failed. When these constrictive bands are left in place for too long, the penile skin and shaft becomes oedematous, blood flow is compromised, and rupture of the urethra with extravasation may ensue. Browning *et al*² described the use of string to compress the distal penis, making it elongated and narrow. However, other authors have reported 'degloving' the distal penis to the level of cavernous tissue before the foreign object could be removed.^{3,4} Sinha⁵ suggested that multiple punctures and aspiration of blood from the engorged penis is a simple and safe method and potentially dangerous and mutilating methods of removal of the constricting object should only be used if this treatment fails.

In the present case, penile degloving and subsequent skin grafting did not affect erectile power and the cosmetic appearance was excellent. Even after long-standing penile incarceration, the patient did not have urethral stricture.

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