A case of mistaken identity

To the Editor—I read with interest the article on "Drug-induced hypoglycaemia—new insight into an old problem" in the October issue of the *Hong Kong Medical Journal*.[1] It reminded me of a case I saw a year ago. A 62-year-old diabetic woman came to see me complaining of loss of consciousness after breakfast every day for a week. She was admitted to hospital for further investigation. She did indeed lose consciousness after breakfast and woke up before lunch. During the time when she was unconscious her blood sugars were in excess of 10 mmol/L on each occasion. A computed tomographic brain scan and an electroencephalogram were normal. The other blood parameters were normal.

She had been taking gliclazide (Diamicron MR; Servier, Gidy, France) 30 mg twice a day. Her tablets were taken out for inspection. It transpired that instead of taking Diamicron MR she had been taking zolpidem (Stilnox; Sanofi-Synthelabo, Tours, France) instead. This is a sleeping tablet that she requested when she had difficulty sleeping 1 month earlier. As you can see from the Figure the two tablets are similar. It is easy to mistakenly substitute one for the other. This is a reversal of the situation highlighted in the article on hypoglycaemia. However general practitioners may like to note that for elderly patients with diabetes it is preferable not to prescribe Diamicron MR at the same time as prescribing Stilnox because of the similarity of the two tablets.

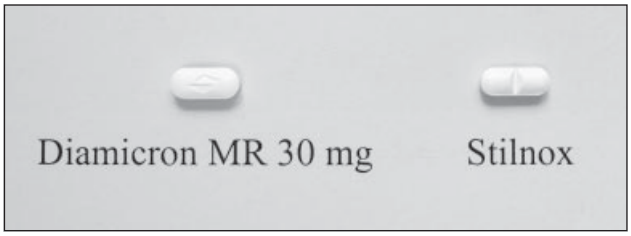

Fig. The two pills are very similar in appearance

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Reference

1. Ching CK, Lai CK, Poon WT, et al. Drug-induced hypoglycaemia—new insight into an old problem. Hong Kong Med J 2006;12:334-8.