AAP RECOMMENDS USING ONLY METRIC DOSING DEVICES FOR CHILDREN’S MEDICATIONS – NOT KITCHEN SPOONS

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CHICAGO - The American Academy of Pediatrics (AAP) wants parents to keep the spoons for their cereal – not their child’s medication.

The AAP urges parents, physicians and pharmacists to use only metric measurements on prescriptions, medication labels and dosing cups to help ensure kids receive the correct dose of medication. Medication should not be measured in teaspoons or tablespoons, especially not spoons taken from a kitchen drawer.

“Spoons come in many different sizes and are not precise enough to measure a child’s medication,” said pediatrician Ian Paul, MD, FAAP, lead author of the policy statement, “Metric Units and the Preferred Dosing of Orally Administered Liquid Medications,” in the April 2015 Pediatrics (published online March 30). “For infants and toddlers, a small error – especially if repeated for multiple doses – can quickly become toxic.”

Each year more than 70,000 children visit emergency departments as a result of unintentional medication overdoses. Sometimes a caregiver will misinterpret milliliters for teaspoons. Another common mistake is using the wrong kind of measuring device, resulting in a child receiving two or three times the recommended dose.

“One tablespoon generally equals three teaspoons. If a parent uses the wrong size spoon repeatedly, this could easily lead to toxic doses,” said Dr. Paul.

Research has demonstrated that common over-the-counter liquid medications for children often have metric dosing on the label, but include a measuring device marked in teaspoons, or vice versa, causing confusion among caregivers. One recent study demonstrated that medication errors are significantly less common among parents using only mL-based dosing rather than teaspoons or tablespoons.

Accuracy in dosing has long been a concern of the Academy’s. The AAP has previously testified before the Food and Drug Administration urging metric-only labeling and dosing. The updated 2015 policy statement recommends:
- Standard language should be adopted, including mL as the only appropriate abbreviation for milliliters. Liquid medications should be dosed to the nearest 0.1, 0.5, or 1 mL.
- How often a dose is needed should be clearly stated on the label. Common language like “daily” should be used rather than medical abbreviations like ‘qd’, which could be misinterpreted as ‘qid’ (which in the past has been a common way for doctors to describe dosing four times daily).
- Pediatricians should review mL-based doses with families when they are prescribed.
- Dosing devices should not have extra markings that can be confusing, and should not be significantly larger than the dose described on the label, to avoid two-fold dosing errors.
- Manufacturers should eliminate labeling, instructions and dosing devices that contain units other than metric units.

“We are calling for a simple, universally recognized standard that will influence how doctors write prescriptions, how pharmacists dispense liquid medications and dosing cups, and how manufacturers print labels on their products,” Dr. Paul said.
The American Academy of Pediatrics is an organization of 62,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults. For more information, visit www.aap.org or follow us on Twitter @AmerAcadPeds.