

## Product Information

# Chlorpromazine Mixture & Chlorpromazine Mixture Forte

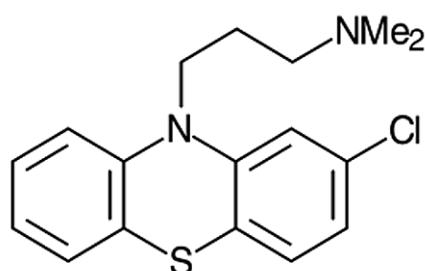
### Name of the drug:

Chlorpromazine hydrochloride.

### Description:

Chlorpromazine is 10-(3-dimethylaminopropyl)-2-chlorophenothiazine, a dimethylamine derivative of phenothiazine.

Chemical structure of chlorpromazine hydrochloride:



,HCl

$C_{17}H_{19}ClN_2S \cdot HCl$ . MW = 355.3  
CAS Number = 69-09-0

Chlorpromazine 100 mg is approximately equivalent to 111 mg of chlorpromazine hydrochloride.

Chlorpromazine hydrochloride is a white crystalline powder which decomposes and changes colour on exposure to air and light. Chlorpromazine hydrochloride is soluble 1 in 1 of water, 1 in 1.5 of alcohol and 1 in 1.5 of chloroform. It is practically insoluble in ether. A freshly prepared 10% aqueous solution has a pH of 3.5 to 4.5.

### **Excipients:**

#### Chlorpromazine Mixture (25mg/5mL):

Saccharin sodium, chloroform, ethanol, glycerol, sorbitol, citric acid-anhydrous, ascorbic acid, water-purified, natural peppermint flavour 07-7686.

#### Chlorpromazine Mixture Forte (10mg/mL):

Saccharin sodium, methyl hydroxybenzoate, ethanol, glycerol, citric acid-anhydrous, ascorbic acid, water-purified, sorbitol solution (70 per cent) (non-crystallising), natural peppermint flavour 07-7686.

### Pharmacology:

Chlorpromazine is a major tranquilliser. It is a phenothiazine which has antipsychotic actions the exact basis for which are not fully understood. It possesses a number of clinical properties including alleviating anxiety and agitation; potentiating CNS depressants including analgesics, narcotics and sedatives; an antiemetic action.

Chlorpromazine is a dopamine inhibitor and stimulates the release of prolactin. The turnover of dopamine in the brain is also increased. The antagonism of central dopaminergic function may be related to the therapeutic effect in psychotic conditions.

Chlorpromazine can produce alpha-adrenergic blockade which may produce hypotension.

Chlorpromazine also has a tendency to produce elevated serum glucose and cholesterol levels. It also exerts sedative properties and has antiemetic activity

**Pharmacokinetics:**

*Absorption:* Chlorpromazine is readily but erratically absorbed from the gastrointestinal tract with peak plasma levels being reached in 1-4 hours after oral administration. Chlorpromazine is subject to extensive first pass metabolism in the gut wall and in the liver, accounting for a low oral bioavailability of unchanged drug, especially at low doses. There is very wide inter-subject variation in plasma chlorpromazine concentrations.

Serum levels of unchanged drug and clinical effect do not correlate well.

*Distribution:* Chlorpromazine is highly protein-bound (more than 90%) and is widely distributed to the body tissue. It crosses the blood-brain barrier and achieves higher concentrations in the brain than in the plasma. Chlorpromazine and its metabolites also cross the placental barrier and are distributed into breast milk.

*Metabolism:* Chlorpromazine is almost completely metabolized, with less than 1% excreted in the urine as unchanged drug. Serum levels in chronic dosing may be lower than those reached after acute dosing. Major metabolic pathways are hepatic and include demethylation, N-oxidation, sulphoxidation, deamination and conjugation. The metabolites of clinical importance appear to be 7-hydroxychlorpromazine, 3-hydroxychlorpromazine, desmethylchlorpromazine and chlorpromazine N-oxide, all of which are biologically active; and chlorpromazine sulphoxide, which is not biologically active.

*Excretion:* Chlorpromazine and its metabolites are removed from the body significantly in the urine, in small amounts in faeces and in lesser amounts in sweat and hair. Average urinary excretion in 24 hours ranges from 43 - 65% of the daily dose. There is a wide variation in the elimination half lives proposed by various groups, and also wide inter-patient variation. There may be several elimination phases consisting of an early phase of 2 - 3 hours, an intermediate phase of 15 hours and a late phase of up to 60 days.

**Indications:**

Treatment of acute functional psychosis (eg schizophrenia, mania or psychotic depression).

Long term treatment of schizophrenia.

Short term treatment of agitation and/or behavioural disturbance in patients with delirium or dementia.

Short term treatment of agitation and severe depression.

Severe behavioural disturbances, as can be found in children with mental retardation or autism, including the treatment of self injurious and aggressive behaviour or overactivity. Use of chlorpromazine should be in conjunction with an appropriate non pharmacological management program and long-term use should only be carried out under the supervision of a physician experienced in the management of psychiatric disorders in children.

In the management of terminal illness to enhance the effect of analgesics and to control nausea and vomiting.

Control of intractable hiccough.

**Contra-indications:**

Chlorpromazine is contraindicated in patients with:

- CNS depression or coma
- Bone marrow suppression
- Pheochromocytoma
- Prolactin-dependent tumours
- Previous history of a hypersensitivity reaction (e.g. jaundice or blood dyscrasia) to phenothiazines, especially chlorpromazine itself, or to any of the excipients contained in the mixture
- Hepatic failure or active hepatic disease

- Severe cardiovascular disease, especially clinically relevant arrhythmias, eg torsades de pointes
- Circulatory collapse

### **Precautions:**

Chlorpromazine generally should not be used in epilepsy, Parkinson's disease, hypoparathyroidism, myasthenia gravis and prostatic hypertrophy, or in patients with a history of blood dyscrasia.

*Epilepsy:* Phenothiazines may lower the seizure threshold. Chlorpromazine should be avoided in patients with epilepsy or a history of seizures.

*Parkinson's Disease:* Chlorpromazine should be avoided in parkinsonism as phenothiazines may block post synaptic dopamine receptors in the striatum. There is also a possible antagonistic effect of chlorpromazine with dopaminergic agonists used in the treatment of parkinsonism.

*Hypoparathyroidism:* Severe dystonic reactions associated with the use of phenothiazines have been reported in patients with untreated hypoparathyroidism. Chlorpromazine should be avoided in hypoparathyroidism.

*Hypocalcaemia:* Chlorpromazine should be administered with caution to patients with hypocalcaemia since these patients seem to be more susceptible to dystonic reactions.

*Myasthenia Gravis:* The underlying defect in myasthenia gravis is a decrease in the number of available acetylcholine receptors at neuromuscular junctions, chlorpromazine should be avoided in myasthenia gravis due to its strong antimuscarinic effects.

*Prostate Hypertrophy:* Chlorpromazine should be avoided in patients with prostate hypertrophy due to the anticholinergic effects of phenothiazines and hence increased risk of urinary retention.

*Antiemetic Effects:* The antiemetic effects of chlorpromazine may mask signs of overdose of other drugs or obscure the diagnosis of conditions such as intestinal obstruction, brain tumour or Reye's syndrome.

*Temperature Regulation:* Phenothiazines impair body temperature regulation. This may result in hypo- or hyperthermia depending on the environment. Severe hypothermia may occur during swimming in cold water or in patients receiving antipyretic therapy. Heat stroke may occur in hot weather.

Patients who develop hyperthermia, altered levels of consciousness and rigidity should cease medication and undergo immediate investigation, as these are the early symptoms of the neuroleptic malignant syndrome, a potentially lethal adverse effect of antipsychotics (See below and **Adverse Reactions**).

*Neuroleptic Malignant Syndrome:* A potentially fatal symptom complex sometimes referred to as neuroleptic malignant syndrome (NMS) has been reported in association with antipsychotic drugs. The syndrome is characterized by muscular rigidity, fever, hyperthermia, altered consciousness and autonomic instability (See **Adverse Reactions**).

*Tardive Dyskinesia:* As with all phenothiazines, long term usage of chlorpromazine can cause the development of tardive dyskinesia, a syndrome consisting of involuntary dyskinesic movements, which may be irreversible (See **Adverse Reactions**).

*Abrupt withdrawal:* Like other phenothiazines, chlorpromazine is not known to cause psychological dependence. There may be, however, following abrupt withdrawal of high dose therapy, some symptoms such as abdominal pain, nausea, vomiting, dizziness and tremulousness. These symptoms can usually be avoided or reduced by gradual reduction of the dosage or by continuing concomitant anti-parkinsonism agents for several weeks after chlorpromazine is withdrawn.

Elderly or debilitated patients: Elderly patients or debilitated are more susceptible to the adverse effects of chlorpromazine. If chlorpromazine is to be used in the elderly, the starting dose should be about one half the usual adult dose and dosage increments should be gradual and reviewed regularly.

Alertness: Chlorpromazine may impair mental and/or physical abilities, especially during the first few days of therapy. Patients should therefore be cautioned about performing activities requiring mental alertness or physical coordination (e.g. operating machinery or driving).

Hypotension: Chlorpromazine should be used with extreme caution in patients with cardiovascular disease, phaeochromocytoma, or other conditions in which a sudden drop in blood pressure would be undesirable. If it is used in conjunction with other drugs likely to cause postural hypotension, an adjustment of dosage may be necessary.

The use of adrenaline in the treatment of chlorpromazine induced hypotension should be avoided, as the action of adrenaline may be reversed causing a further lowering of blood pressure.

QT Intervals: Very rare cases of QT interval prolongation have been reported with chlorpromazine.

Agranulocytosis: Agranulocytosis has been reported with chlorpromazine. Most reported cases have occurred between the fourth and tenth week of treatment.

Patients should be warned to contact their doctor if signs or symptoms of agranulocytosis, such as sore throat, fever or other signs of infection occur. Blood counts are advised if the patient develops an unexplained fever. If white blood cell and differential counts indicate cellular depression, stop treatment and start antibiotic and other suitable therapy, subject to the expert guidance of a haematologist.

Liver Dysfunction: If bilirubinaemia, bilirubinuria or icterus occur, the drug should be discontinued and liver function tests performed. Routine tests are advisable during prolonged therapy. Due to the extensive hepatic metabolism and clearance of chlorpromazine, caution should be taken when treating patients with hepatic impairment. Dose reduction may be necessary in such patients.

Renal disease: Chlorpromazine should be given cautiously to patients with renal disease.

Retinopathy: Chlorpromazine may induce a pigmentary retinopathy which is dependent on both the dose and duration of treatment. Regular ophthalmological examinations should be performed during prolonged therapy.

Respiratory Disease: Chlorpromazine should be used with caution in patients with chronic respiratory disorders such as asthma or emphysema, and acute respiratory tract infections, since the central nervous system depression caused by chlorpromazine may exacerbate these conditions. Chlorpromazine can suppress the cough reflex hence aspiration of vomitus is possible.

Reye's Syndrome: The extrapyramidal symptoms which can occur secondary to chlorpromazine may be confused with the central nervous systems signs of an undiagnosed primary disease responsible for vomiting, e.g. Reye's syndrome or other encephalopathy. The use of chlorpromazine and other hepatotoxins should be avoided in children and adolescents whose signs and symptoms suggest Reye's syndrome.

Glaucoma: As with all drugs which exert an anticholinergic effect, and/or cause mydriasis, chlorpromazine should be used with caution in patients with glaucoma. As the clinical features of neuroleptic malignant syndrome (NMS) include autonomic dysfunction, care should be taken when giving chlorpromazine to patients with a history of NMS and glaucoma. Patients should be monitored for symptoms of NMS (see above and **Adverse reactions**).

Photosensitivity: Patients on high doses should be warned that they may develop photosensitivity in sunny weather and should avoid exposure in strong sunlight, e.g. at the beach or snow. If

exposure is unavoidable, patients should be encouraged to wear suitable clothing including a hat and to apply a SPF 15+ sunscreen. The tendency to this adverse effect may be increased with chronic dosing. Periodic examinations for lens opacities and abnormal pigmentation are required.

**Carcinogenicity, mutagenicity, impairment of fertility:**

Phenothiazines increase prolactin levels which may affect human breast cancers, one third of which are prolactin dependent *in vitro*. Although clinical studies have not shown a clear association between chronic administration of antipsychotic drugs and an increase in the incidence of breast cancers, it may be a factor of importance when prescribing chlorpromazine for patients in which breast cancer was previously detected.

Studies in rodents showed aberrations in spermatocytes and sperm. *In vitro* cell cultures showed an increased frequency of chromosomal breaks but only at higher drug concentrations. An increased frequency of breaks has also been reported in one study of humans treated clinically with chlorpromazine but could not be replicated in follow-up studies.

**Use in Pregnancy: Category C**

Non-teratogenic class effect: Neonates exposed to antipsychotic drugs (including Chlorpromazine) during the third trimester of pregnancy are at risk of experiencing extrapyramidal neurological disturbances and/or withdrawal symptoms following delivery. There have been post-market reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress, and feeding disorder in these neonates. These complications have varied in severity; while in some cases symptoms have been self-limited, in other cases neonates have required additional medical treatment or monitoring.

Chlorpromazine should be used during pregnancy only if the anticipated benefit outweighs the risk and the administered dose and duration of treatment should be as low and as short as possible.

**Use in Lactation:**

Chlorpromazine has been found to be excreted in breast milk in variable amounts; therefore it is not recommended for nursing mothers unless the expected benefits outweigh any potential risk.

**Interactions with Other Drugs:**

Additive pharmacological effects: The most common interactions are those resulting from concomitant administration of phenothiazines with other drugs which possess similar pharmacological actions.

The symptoms of CNS depression may be enhanced if chlorpromazine is given concomitantly with other drugs that possess CNS depressant properties including alcohol, benzodiazepines, anaesthetic drugs, opioids, barbiturates and lithium.

Caution should be used when administering chlorpromazine with other drugs that produce orthostatic hypotension (eg anaesthetics, thiazide diuretics, calcium channel blockers and other anti-hypertensives and trazodone); dosage adjustments may be required. Severe orthostatic hypotension occurs when chlorpromazine is administered concomitantly with ACE inhibitors. However, higher dosages of chlorpromazine antagonize the hypotensive effect of adrenergic neurone blockers such as guanethidine and clonidine.

Care should also be taken with drugs which prolong the QT interval (eg quinidine, sotalol, astemizole, terfenadine and pimozide), and with phenylpropanolamine, as there is an increased risk of arrhythmias when antipsychotics are used with such agents.

The combined use of chlorpromazine and MAOIs may lead to additive hypotensive effects and increase extrapyramidal effects.

Use of chlorpromazine with drugs producing extrapyramidal effects, such as haloperidol, metoclopramide, methyl dopa, tetrabenazine, and lithium may increase the risk of extrapyramidal effects.

The risk of neurotoxicity with lithium may be enhanced by phenothiazines in general although combined use with chlorpromazine may lower the serum concentrations of both drugs (see below). An encephalopathic syndrome (characterised by weakness, lethargy, fever, tremulousness and confusion, extrapyramidal symptoms, leucocytosis, elevated serum levels, BUN and FPS) has occurred in a few patients treated with lithium plus an antipsychotic. In some instances the syndrome has resulted in irreversible brain damage. Because of the possible causal relationship between these events and the concomitant administration of lithium and antipsychotics, patients receiving such combined therapy should be monitored closely for early evidence of neurological toxicity and treatment discontinued promptly if such signs appear. This encephalopathic syndrome may be similar to or the same as neuroleptic malignant syndrome (see Adverse Reactions). Early signs of lithium toxicity may be masked by the antiemetic effects of chlorpromazine.

Anti-cholinergic drugs such as antihistamines, atropine, antiparkinson drugs, tricyclic antidepressants and MAO inhibitors, may enhance the anti-cholinergic side effects of phenothiazines. Interactions with suxamethonium and organophosphorous insecticides are also a possibility.

Chlorpromazine should not be used with radiopaque contrast media metrizamide or iohexol, as the seizure threshold may be lowered. Chlorpromazine should be discontinued at least 48 hours before myelography, and should not be resumed for at least 24 hours post procedure.

Cimetidine has been reported to both increase and decrease the effects of chlorpromazine.

Simultaneous administration of desferrioximine and prochlorpromazine can induce a transient metabolic encephalopathy. Interaction of desferrioxamine and chlorpromazine is a possibility.

Concomitant use of chlorpromazine and antithyroid agents (eg propylthiouracil, carbimazole) may increase the risk of agranulocytosis (see **Precautions**).

Interactions resulting in decreased chlorpromazine levels: Chlorpromazine absorption can be decreased by antacids, food and anticholinergic agents such as benztrapine. Lithium can increase clearance of chlorpromazine, and chronic administration of barbiturates can induce metabolism of chlorpromazine; both leading to a reduction of chlorpromazine levels

Interactions resulting in increased chlorpromazine levels: Tricyclic antidepressants decrease the clearance of chlorpromazine and may lead to increased serum levels. Propranolol and anti-malarial drugs have also been reported to increase plasma chlorpromazine levels.

Interactions in which other drugs are affected by chlorpromazine: Chlorpromazine may increase serum levels of phenytoin, valproic acid tricyclic antidepressants and propranolol.

Chlorpromazine may antagonise the effects of antidiabetic agents, as well as the anti-parkinson effects of levodopa, bromocriptine and pergolide. It may also antagonise the effects of amphetamines, diminish the effect of oral anticoagulants and interact with anticholinergic drugs such as orphenadrine to produce hypoglycaemia.

Due to its alpha-blocking effects, chlorpromazine can oppose the effects of adrenaline to produce a paradoxical fall in blood pressure (see **Overdosage**). At high dosages it can also oppose the effects of adrenergic neurone blockers such as guanethidine and clonidine.

*Effects on Laboratory Tests:* The presence of phenothiazines may produce false positive phenylketonuria (PKU) test results.

### **Adverse Reactions:**

Chlorpromazine generally produces a moderate incidence of anticholinergic and extrapyramidal effects, and a high incidence of sedation and cardiovascular events. The following reactions have been reported for chlorpromazine or phenothiazines in general.

### **Common**

**Autonomic Reactions:** Dry mouth, orthostatic hypotension, mental confusion, nasal congestion, nausea, obstipation, constipation, adynamic ileus, urinary retention, priapism, miosis and mydriasis, atonic colon, ejaculatory disorders/impotence.

**Cardiovascular:** Orthostatic hypotension, ECG Changes.

**Central Nervous System:** Extrapyrarnidal reactions including parkinsonism, akathisia, dystonias, motor restlessness and tardive dyskinesia. Nonextrapyramidal effects including drowsiness, convulsive seizures and paradoxical effects, e.g. agitation, excitement and aggravation of schizophrenic symptoms.

**Dermatological:** Contact dermatitis, photosensitivity, urticarial, maculopapular, petechial or oedematous reactions.

**Endocrine:** Elevated prolactin levels, impaired thermoregulation, hyperglycaemia, other hypothalamic effects.

**Gastrointestinal:** Constipation, dry mouth.

**Immunological:** Raised ANA titre, positive SLE cells.

**General:** Weight gain.

**Genitourinary:** Urinary retention.

**Haematological:** Leucopenia, agranulocytosis, eosinophilia, hemolytic anaemia, aplastic anaemia, thrombocytopenic purpura and pancytopenia have been reported.

**Ocular:** Blurred vision, photophobia, miosis, mydriasis, corneal deposits.

**Respiratory:** Respiratory depression, stuffy nose.

### **Less Common**

**Cardiovascular:** Arrhythmias, hypertensive crisis (following abrupt withdrawal), A-V block, ventricular tachycardia, QT interval prolongation and fibrillation.

**Central Nervous System:** Abnormality of cerebrospinal fluid, cerebral oedema, nightmares

**Dermatological:** Skin pigmentation and rarely purpura, exfoliative dermatitis and toxic epidermal necrolysis.

**Endocrine:** Hyperthermia, hypothermia, lactation and moderate breast engorgement in females on large doses, false-positive pregnancy tests, amenorrhoea, gynecomastia, hypoglycaemia, hyperglycaemia and glycosuria.

**Gastrointestinal:** Paralytic ileus.

**General:** Rarely, lupus erythematosus, severe allergic reactions and contact sensitisation.

**Genitourinary:** Inappropriate ADH secretion, water retention, oedema, incontinence.

**Haematological:** Coagulation defects.

**Hepatic:** Cholestatic jaundice.

**Musculoskeletal:** Neuroleptic malignant syndrome, myasthenia gravis.

Ocular: Precipitation/aggravation of narrow angle glaucoma, optic atrophy, pigmentary retinopathy, lens opacities.

Psychiatric: Dysphoria, catatonic excitement.

Serious or Life Threatening Reactions: Of the above the following are potentially life threatening: profound hypotension, cardiac arrhythmia, agranulocytosis, progressive hepatic fibrosis, malignant hyperpyrexia (see **Precautions**).

Temperature Regulation: Hypothermia or hyperthermia may be life threatening (see **Precautions**). In hot climates, patients are particularly at risk if they are overweight, physically active, and taking high doses of neuroleptics and anti-parkinsonian agents. Physically debilitated, aged, alcoholic and organic brain syndrome patients may also be at risk.

Sudden Death: Sudden death has been reported in patients receiving phenothiazines. This is possibly due to cardiac effects (ventricular fibrillation), asphyxia, convulsions or hyperpyrexia. Fortunately, occurrences are rare.

Tardive Dyskinesia: Tardive dyskinesia may develop in patients on antipsychotic drugs. The disorder consists of repetitive involuntary movements of the tongue, face, mouth, or jaw (e.g. protrusion of the tongue, pouting of the lips and cheeks, chewing movements). The trunk and limbs are less frequently involved. It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome.

The risk of developing the syndrome and the likelihood that it will become irreversible may increase with the duration of treatment and the total cumulative dose administered. Less commonly, the syndrome can develop after relatively brief treatment periods at low doses. The risk seems to be greater in elderly patients, especially females.

The syndrome may occur during long-term treatment or upon withdrawal of treatment. The dosage of antipsychotic drug should be reduced periodically (if clinically possible) and the patient observed for signs of the disorder, since the syndrome may be masked by a higher dose. In patients requiring long-term treatment, the smallest dose and the shortest duration of treatment producing a satisfactory clinical response should be sought.

There is no known effective treatment for tardive dyskinesia. Anti-parkinsonian agents usually do not alleviate symptoms. It is suggested that anti-psychotic agents be discontinued if symptoms of tardive dyskinesia appear.

Neuroleptic Malignant Syndrome (NMS): Although relatively uncommon, NMS is a potentially fatal syndrome that has been reported in association with anti-psychotic drugs. The syndrome is characterised by muscular rigidity, fever, hyperthermia, altered consciousness and autonomic instability (e.g. tachycardia, labile blood pressure, profuse sweating, dyspnoea). Additional signs may include elevated creatine phosphokinase, leucocytosis, myoglobinuria (rhabdomyolysis) and acute renal failure.

The diagnosis of NMS may be difficult. It must be differentiated from other conditions such as systemic infections, untreated or inadequately treated extrapyramidal symptoms, central anticholinergic toxicity, heat stroke, drug fever and primary central nervous system pathology.

The management of NMS (and patients with unexplained high fever without additional clinical manifestations of NMS) should include immediate discontinuation of anti-psychotic drugs, intensive monitoring and treatment of symptoms, and treatment of any associated medical problems.

## Dosage and Administration:

Dosage varies both with the individual and the purpose for which the drug is used. Therefore, only general guidance can be given on the dosage likely to be effective and well tolerated. Initial dosage should be low, with dosage increases occurring gradually until the desired response has been obtained.

### Adults:

Initial dose of 25 mg three times daily is suitable for most ambulant patients. This can be increased, if necessary, by 25 mg two or three times daily up to an effective maintenance dose. Maintenance doses usually range from 25 to 100 mg three times daily, although higher doses may sometimes be required in bed patients or in psychotic cases.

The maximum daily dose should not exceed a total of 600 - 800 mg.

### Children:

Over 5 years of age, one third to one half of the appropriate adult dosage may be given. The dose in children aged 1 – 5 yrs may be calculated on the basis of 0.5 mg/kg bodyweight. Doses may be repeated three or four times a day as necessary. The maximum recommended daily dose is 40mg in children 1-5 years of age, and 75mg in children 6-12 years of age. Children need to be monitored for hypothermia and hypotension.

### Hepatic or Renal Impairment:

The dosage in these patients may need to be reduced (see **Precautions**).

### Elderly or Debilitated:

The dosage in these patients may need to be reduced (see **Precautions**).

## Overdosage:

*Symptoms:* The symptoms of overdosage with chlorpromazine include CNS depression progressing from drowsiness to coma with areflexia; patients with early or mild intoxication may experience restlessness, disorientation, confusion and excitement. Other symptoms include hypotension, tachycardia, hypothermia, pupillary constriction, tremor, muscle twitching, spasm or rigidity, convulsions, muscular hypotonia, difficulty in swallowing and breathing, cyanosis and respiratory and/or vasomotor collapse, possibly with sudden apnoea. Polyuria has also been noted, which may result in dehydration.

Deaths in young children have been reported following ingestion of 350 to 800 mg of chlorpromazine.

*Treatment:* Symptomatic and supportive treatment should be administered as appropriate. The use of activated charcoal should be considered if the phenothiazine has been taken within 1 hour.

***Induction of emesis should not be attempted because the sedative and extrapyramidal side effects of chlorpromazine increase the risk of pulmonary aspiration of vomitus during emesis.***

Patients with acute hypotension should be placed in the head down position and the patient's legs should be raised. Noradrenaline or phenylephrine can be administered intravenously if a vasopressor is required. Adrenaline is contraindicated as it may produce a further fall in blood pressure (see **Precautions**). If treatment with a vasopressor is required the patient should be carefully monitored, particularly for cardiac function.

Attention should be paid to symptoms of metabolic acidosis and delayed cardiac effects.

The central nervous depression should generally be allowed to recover naturally, however, artificial respiration may be required.

Hypothermia should be allowed to recover naturally unless the temperature approaches levels at which cardiac arrhythmias may be feared (e.g. 29.4°C). Shivering is a sign of the waning effects of the drug.

Severe extrapyramidal reactions should be treated with benztropine or another antiparkinsonian agent. See the product information for these products.

Chlorpromazine is not dialysable.

### **Presentation:**

AUST R 11347: Orion Chlorpromazine Mixture is an almost clear liquid containing 25 mg/5mL of chlorpromazine (as chlorpromazine hydrochloride), in bottles of 500mL.

AUST R 21145: Orion Chlorpromazine Mixture Forte is a colourless hazy liquid containing 10mg/mL of chlorpromazine (as chlorpromazine hydrochloride), in bottles of 500mL.

### **Storage:**

Store below 25°C  
Protect from light.

### **Schedule:**

All States and A.C.T.- S.4 (Prescription Only Medicine)

### **Sponsor:**

ORION Laboratories Pty Ltd  
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BALCATTWA WA 6021

#### *Revision Information*

Date	Document	Superseded Document	Revision Information
30 September 2003	CHL01376_01_PI	N/A	New document. TGA approved 30 September 2009
14 June 2006	CHL01376_02_PI	CHL01376_01_PI	General Review
12 April 2011	CHL01376_03_PI	CHL01376_02_PI	Changes to <i>Use in Pregnancy</i> section