Antipsychotics (Typical): Phenothiazines

Phenothiazines: Chlorpromazine, Periciazine, Prochlorperazine

Toxicity / Risk Assessment

- *Toxicity is dose dependent*
- *One tablet in a child may produce significant toxicity*
- *With ↑ dose: ↑HR, ↓BP (alpha-receptor blockade), anticholinergic effects, sedation, agitated delirium*
- *Onset of effects occurs within 4 hours*
- *Large exposures may lead to coma lasting > 24 hours*

Clinical features:

Central Nervous System: drowsiness, agitated delirium, coma (may be prolonged), seizures, miosis may occur in large exposures (alpha receptor effect), extrapyramidal effects (rare, often delayed)

Cardiovascular: tachycardia, hypotension, QRS prolongation (usually not clinically significant)

Anticholinergic effects: ↑HR, agitated delirium, mydriasis urinary retention, warm dry skin, seizures

Other: neuroleptic malignant syndrome (usually associated with therapeutic dosing, rather than overdose), respiratory depression

Management

- Maintain airway. Intubation may be required in large overdoses

Decontamination

- Consider activated charcoal 50g within 2 hours of ingestion in patients at risk of significant toxicity
- Patients with severe toxicity should receive activated charcoal 50g via NGT post intubation

Hypotension

- **Fluid**: initially load with 10-20 mL/kg IV crystalloid
- Hypotension resistant to IV fluid should initially be treated with norepinephrine

Anticholinergic delirium

- Exclude urinary retention
- Supportive care +/- titrated doses of diazepam (5-10 mg oral 30 minutely or IV 10-15 minutely PRN)
- Consider physostigmine (discuss with clinical toxicologist – see separate guideline)
- Droperidol may be required in severe behavioral disturbance resistant to benzodiazepines

Extrapyramidal Side Effects (EPSE)

- May be delayed up to 72 hours. Benztropine 1-2 mg IV (paediatric dose: 0.02 mg/kg up to 1mg).
- Dose may be repeated in 20 mins.

Disposition

- Discharge pending mental health assessment if asymptomatic 6 hours post exposure

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