Selective Serotonin Reuptake Inhibitors (SSRIs)

Lone SSRI overdose is usually benign. Citalopram and escitalopram are associated with dose-dependent QT prolongation & risk of torsades des pointes (TdP)

Toxicity / Risk Assessment

Paroxetine, fluoxetine, fluvoxamine, and sertraline

- Clinical toxicity is usually mild when ingested in isolation
- There is no well-defined toxic dose

Citalopram, and escitalopram

-Dose dependent QT-interval prolongation occurs with ingestion > 600 mg citalopram or > 300 mg escitalopram

Clinical features:

All SSRIs

- Nausea, vomiting, tremor, tachycardia, diaphoresis, flushing
- CNS depression is uncommon, seizures are rare
- Coma is NOT expected with isolated SSRI ingestion

Citalopram, and escitalopram

In addition to the clinical features described, citalopram and escitalopram cause bradycardia and dose dependent QT interval prolongation

Serotonin Toxicity (see separate *Serotonin Toxicity* guideline)

– Rare following isolated SSRI ingestion

- Co-ingestion of other serotonergic agents (e.g., tramadol, MAOIs, SNRIs, MDMA) increases the risk

Management

Good supportive care is the mainstay of management

Decontamination:

Activated charcoal 50 g (Paediatric: 1g / kg):

- Offer to co-operative patients presenting within 2 hours of ingestion
- Offer to co-operative patients presenting within 4 hours of ingestion of >600 mg of citalopram OR >300 mg of escitalopram

Management of ↑ QT interval

See separate ***Prolonged QT interval / TdP*** guideline

Serotonin Toxicity

See separate ***Serotonin Toxicity*** guideline

Disposition

- All patients require a minimum of 6 hours observation post ingestion
- Ingestion > 600 mg citalopram or > 300 mg escitalopram: minimum of 12 hours cardiac monitoring
- Discharge pending mental health assessment post observation period once any ECG abnormalities have normalized AND the patient is asymptomatic