

## Data Sheet

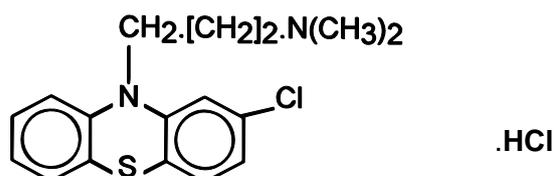
### Largactil

#### NAME OF THE MEDICINE

Tablets, Injection - chlorpromazine hydrochloride

#### DESCRIPTION

Chemical structure of chlorpromazine hydrochloride:



Chlorpromazine is 10-(3-dimethyl-aminopropyl)-2-chlorophenothiazine, a dimethylamine derivative of phenothiazine. Chlorpromazine 100 mg is approximately equivalent to 111 mg of chlorpromazine hydrochloride. MW = 355.3

Chlorpromazine hydrochloride is an odourless white powder, which decomposes and changes colour on exposure to light. Chlorpromazine hydrochloride is soluble in water, alcohol and chloroform but practically insoluble in ether. The pH of a 10% aqueous solution of the hydrochloride is 4 to 5.

#### Excipients

##### Tablets

Lactose, maize starch, colloidal silicon dioxide, magnesium stearate, hypromellose, polyethylene glycol 200, titanium dioxide.

##### Ampoules

Sodium sulfite anhydrous, sodium metabisulfite, sodium chloride, sodium citrate, water for injections.

#### PHARMACOLOGY

Chlorpromazine is a major tranquilliser. It is a phenothiazine, which has antipsychotic actions, the exact basis for which are not fully understood.

Its clinical properties include alleviating anxiety, tension and agitation, potentiating CNS depressants including analgesics, narcotics and sedatives; an antiemetic action.

Chlorpromazine is a dopamine inhibitor. It inhibits prolactin-release-inhibitory factor, considered to be dopamine, thereby stimulating 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.

## **Absorption**

Chlorpromazine is readily absorbed from the gastrointestinal tract but is subject to considerable first-pass metabolism in the gut and the liver. Following oral administration, peak plasma levels are reached in 1-4 hours; following intramuscular injection, peak plasma levels usually occur in 15 - 30 minutes. Oral absorption is erratic and incomplete with 10 - 80% of the oral dose reaching the systemic circulation. There is wide inter-subject variation.

## **Distribution**

Chlorpromazine is widely distributed to the body tissue. It crosses the blood-brain barrier and achieves higher concentrations in the brain than in the plasma. The average volume of distribution of chlorpromazine is quite large, ranging from 10 - 35 L/Kg (mean 22 L/Kg). It is highly protein-bound (90 - 99%). Chlorpromazine has been detected in urine for up to one year after discontinuation of chronic administration.

## **Metabolism**

Chlorpromazine metabolism is complex. There is extensive first pass metabolism after oral administration, accounting for a low oral bioavailability of unchanged drug, especially at low oral doses. Over 150 metabolites have been postulated of which about half have been detected in blood and urine. 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. Chlorpromazine is almost completely metabolised with less than 1% excreted in the urine as unchanged drug. Serum levels of unchanged drug and clinical effect do not correlate well. A therapeutic serum level is usually between 100-300ng/mL and toxic effects appear by 750ng/mL but routine serum level monitoring is not necessary. Serum levels in chronic dosing may be lower than those reached after acute dosing.

## **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**

Chlorpromazine is indicated in the following conditions:

- Schizophrenia and other psychoses (especially paranoid), mania and hypomania.
- In anxiety psychomotor agitation excitement, violent or dangerously impulsive behaviour. Chlorpromazine is used as an adjunct in the short-term management of these conditions.
- Intractable hiccup.
- Nausea and vomiting of terminal illness (where other medicines have failed or are not available).
- Childhood schizophrenia and autism.

## **CONTRAINDICATIONS**

Chlorpromazine should never be used in the following circumstances:

Circulatory collapse.

CNS depression, e.g. coma or drug intoxication.

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 tablets or injection.

Bone marrow depression.

Phaeochromocytoma.

Hepatic failure or active hepatic disease.

LARGACTIL Injection contains sodium metabisulfite and sodium sulfite and may cause allergic-type reactions including anaphylactic symptoms and asthmatic episodes in susceptible people.

## **PRECAUTIONS**

Chlorpromazine generally should not be used in epilepsy, Parkinson's disease, hypoparathyroidism, myasthenia gravis and prostatic hypertrophy.

### **Epilepsy**

Chlorpromazine should be avoided in patients with epilepsy as treatment with neuroleptics can result in a lowered seizure threshold. Chlorpromazine may be used in conjunction with anticonvulsant drugs.

### **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**

Use of chlorpromazine should be avoided in hypoparathyroidism as a severe dystonic reaction has been reported in patients with untreated hypoparathyroidism.

### **Myasthenia Gravis**

As 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.

### **Antiemetic Effects**

The antiemetic effects of chlorpromazine may mask signs of overdose of toxic drugs or obscure the diagnosis of conditions such as intestinal obstruction and brain tumour.

### **Temperature Regulation**

Phenothiazines depress the mechanism for regulation of temperature. Severe hypothermia may occur during swimming in cold water or in patients receiving antipyretic therapy, and heat stroke may occur in hot weather. Patients who develop pyrexia, along with clouding of Largactil

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 major tranquillisers (see **ADVERSE EFFECTS**).

### **Prolonged Usage**

As with all phenothiazines, long term usage of chlorpromazine can cause the development of tardive dyskinesia, which may be irreversible (see **ADVERSE EFFECTS**).

### **Alertness**

Chlorpromazine may impair mental and/or physical abilities, especially during the first few days of therapy. Therefore, caution patients about activities requiring alertness (e.g. operating machinery or vehicles).

### **Agranulocytosis**

Agranulocytosis has been reported at an incidence of between 1:1,300 and 1:500,000. Most reported cases have occurred between the fourth and tenth week of treatment.

Warn patients to report the sudden appearance of sore throat, fever or other signs of infection. 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.

### **Retinopathy**

Periodic ophthalmological examinations should be performed during prolonged therapy.

### **Respiratory Disease**

Chlorpromazine should be used with caution in patients with chronic respiratory disorders. 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 system signs of an undiagnosed primary disease responsible for the 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.

### **Renal disease**

Chlorpromazine should be given cautiously to patients with renal disease.

### **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 include autonomic dysfunction, care should be taken when giving chlorpromazine to patients with a history of neuroleptic malignant syndrome and glaucoma. Patients should be monitored for symptoms and signs of neuroleptic malignant syndrome (see **ADVERSE EFFECTS**).

## **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.

## **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. Avoid adrenaline in the treatment of phenothiazine induced hypotension, as the action of adrenaline may be reversed causing a further fall in blood pressure.

## **QT Intervals**

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

Neuroleptic phenothiazines may potentiate QT interval prolongation which increases the risk of onset of serious ventricular arrhythmias of the torsade de pointes type, which is potentially fatal (sudden death). QT prolongation is exacerbated, in particular, in the presence of bradycardia, hypokalemia, and congenital or acquired (i.e., drug induced) QT prolongation. If the clinical situation permits, medical and laboratory evaluations should be performed to rule out possible risk factors before initiating treatment with a neuroleptic agent and as deemed necessary during treatment (see **ADVERSE EFFECTS**).

## **Cerebrovascular Events**

An increased risk of cerebrovascular events has been reported in elderly patients with dementia treated with atypical antipsychotic drugs. An increase in the risk of cerebrovascular events with other antipsychotic drugs or other populations of patients cannot be excluded. Chlorpromazine should therefore be used with caution in patients with stroke risk factors.

## **Venous Thromboembolism**

Cases of venous thromboembolism, sometimes fatal, have been reported with antipsychotic drugs. Therefore, chlorpromazine should be used with caution in patients with risk factors for thromboembolism (see **ADVERSE EFFECTS**).

## **Elderly**

The elderly are relatively more susceptible to the adverse effects of chlorpromazine. The starting dose should be about half the usual adult dose and dosage increments should be gradual and reviewed regularly.

## **Elderly Patients with Dementia**

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Although the causes of death in clinical trials with atypical antipsychotics were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g. pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear.

## **Hyperglycaemia**

Hyperglycaemia or intolerance to glucose has been reported in patients treated with chlorpromazine. Patients with an established diagnosis of diabetes mellitus or with risk factors for the development of diabetes who are started on chlorpromazine, should get appropriate glycaemic monitoring during treatment (see **ADVERSE EFFECTS**).

## **Effects on Fertility**

A decrease in fertility was observed in female animals treated with chlorpromazine. In male animals data are insufficient to assess fertility.

In humans, because of the interaction with dopamine receptors, chlorpromazine may cause hyperprolactinaemia which can be associated with impaired fertility in women. In men, data on consequences of hyperprolactinaemia are insufficient with regard to fertility.

## **Suicide**

The possibility of a suicide attempt is inherent in schizophrenia and bipolar disorder, and close supervision of high-risk patients should accompany therapy.

## **Use in Pregnancy (Category C)**

Studies in animals by oral route have shown reproductive toxicity (dose related embryo foetotoxicity: increased resorptions and dead foetuses). Increased incidence of malformations was observed in mice but only at doses inducing maternal mortality. There is inadequate animal data regarding reproductive toxicity with chlorpromazine by parenteral route. In humans, the teratogenic risk of chlorpromazine has not been evaluated. Different prospective epidemiological studies conducted with other phenothiazines have yielded contradictory results regarding teratogenic risk.

When given in high doses during late pregnancy, phenothiazines have caused prolonged extrapyramidal disturbances in the child.

The following effects have been reported (in postmarketing surveillance) in neonates exposed to phenothiazines during the third trimester of pregnancy:

- various degrees of respiratory disorders ranging from tachypnoea to respiratory distress, bradycardia and hypotonia, most often when other drugs such as psychotropic or antimuscarinic drugs were coadministered.
- signs related to the atropinic properties of phenothiazines such as meconium ileus, delayed meconium passage, initial feeding difficulties, abdominal bloating, tachycardia;
- neurological disorders such as extrapyramidal symptoms including tremor and hypertonia, somnolence, agitation.

Appropriate monitoring and treatment of neonate born to mothers receiving chlorpromazine is recommended.

Chlorpromazine should not be used in pregnant women, or those likely to become pregnant, unless the expected benefit outweighs any potential risk.

## **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.

## **ADVERSE EFFECTS**

The following adverse effects have been reported for chlorpromazine or phenothiazines in general.

## **More Common Adverse Effects**

### Cardiovascular

Postural hypotension, ECG Changes.

### Dermatological

Contact dermatitis, photosensitivity, urticarial, maculopapular, petechial or oedematous reactions.

### Endocrine

Elevated prolactin levels, impaired thermoregulation, hyperglycaemia, other hypothalamic effects.

### Gastrointestinal

Dry mouth, constipation.

### Immunological

Raised ANA titre, positive SLE cells.

### Genitourinary

Urinary retention.

### Haematological

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

### Nervous System

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

*Central:* extrapyramidal reactions (parkinsonism, akathisia) tardive dyskinesia, nonextrapyramidal effects including lowering of seizure threshold and paradoxical effects, e.g. agitation, excitement and aggravation of schizophrenic symptoms; drowsiness, dystonias, motor restlessness.

### Ocular

Blurred vision, photophobia, miosis, mydriasis, corneal deposits.

### Respiratory

Stuffy nose, respiratory depression.

### Local Reactions (injection)

Pain at injection site, injection abscess.

### General

Weight gain.

## **Less Common Adverse Effects**

### Cardiovascular

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

There have been isolated reports of sudden death, with possible causes of cardiac origin (see **PRECAUTIONS**), as well as cases of unexplained sudden death, in patients receiving neuroleptic phenothiazines.

Cases of venous thromboembolism, including cases of pulmonary embolism, sometimes fatal, and cases of deep vein thrombosis have been reported with antipsychotic drugs (see **PRECAUTIONS**).

### 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, glycosuria.

### Gastrointestinal

Paralytic ileus.

### General

Rarely, systemic lupus erythematosus has been reported in patients treated with chlorpromazine. In some cases, positive anti-nuclear antibodies may be seen without evidence of clinical disease.

Allergic reactions.

### Genitourinary

Inappropriate ADH secretion, water retention, oedema, incontinence.

### Haematological

Coagulation defects.

### Hepatic

Cholestatic jaundice and liver injury, mainly of cholestatic or mixed type, are rarely reported in patients treated with chlorpromazine (see **PRECAUTIONS**).

### Musculoskeletal

Neuroleptic malignant syndrome, myasthenia gravis.

### Nervous System

Fits, cerebral oedema, nightmares, abnormality of cerebrospinal fluid proteins.

### 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.

### 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

Phenothiazine produced sudden death has been reported and is possibly due to cardiac effects (ventricular fibrillation), asphyxia, convulsions or hyperpyrexia. Fortunately, occurrences are rare. There are also reports of unexplained sudden death in patients receiving neuroleptic phenothiazines.

### 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, puffing the cheeks, puckering of the mouth, 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.

Both the risk of developing the syndrome and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of the drug increases. 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 become clinically recognisable either during treatment, upon dosage reduction, 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

A potentially fatal syndrome called neuroleptic malignant syndrome 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).

The management of neuroleptic malignant syndrome should include immediate discontinuation of anti-psychotic drugs, intensive monitoring and treatment of symptoms, and treatment of any associated medical problems.

## **Other adverse effects**

In post-marketing surveillance cases of intolerance to glucose and hyperglycaemia have been reported (see **PRECAUTIONS**).

### Metabolism and nutrition disorders

Hypertriglyceridaemia, hyponatraemia.

### Gastrointestinal disorders

Colitis ischaemic, gastrointestinal necrosis, necrotising colitis (sometimes fatal), intestinal perforation (sometimes fatal).

### Skin and subcutaneous tissue disorders

Angioedema, urticaria.

## **INTERACTIONS**

### **Interactions with Other Drugs**

#### Interactions resulting in decreased chlorpromazine levels

Food, alcohol and benzotropine can reduce the absorption of chlorpromazine. Antacids can slow the absorption of chlorpromazine. Lithium and chronic administration of barbiturates can lead to increased clearance of chlorpromazine.

#### Interactions resulting in increased chlorpromazine levels

Tricyclic antidepressants decrease the clearance of chlorpromazine and may lead to increased serum levels.

Administration of chlorpromazine with CYP1A2 inhibitors, in particular strong (such as ciprofloxacin and fluvoxamine) or moderate (such as oral contraceptives and vemurafenib) inhibitors leads to an increase in chlorpromazine plasma concentrations. Therefore, patients may experience any chlorpromazine dose-dependent adverse drug reaction.

#### Interactions in which other drugs are affected by chlorpromazine

Chlorpromazine can increase the depressant action of central nervous system depressants such as benzodiazepines, anaesthetic drugs, opioids, barbiturates and lithium. Chlorpromazine may reduce serum phenytoin levels, may reduce propranolol clearance and may antagonise antidiabetic agents and levodopa, increase valproic acid levels, antagonise the effects of amphetamines, diminish the effect of oral anticoagulants and interact with anticholinergic drugs such as orphenadrine to produce hypoglycaemia.

Chlorpromazine can oppose the effects of adrenaline to produce a paradoxical fall in blood pressure (see **OVERDOSAGE**). It can also oppose the effects of guanethidine and clonidine.

Thiazide diuretics may accentuate the orthostatic hypotension that may occur with phenothiazines. Interaction with quinidine may lead to additive myocardial depression. Interaction with MAOIs may lead to additive hypotensive effects. Interactions with suxamethonium, organophosphorus insecticides and atrophine or related drugs are also a possibility.

Chlorpromazine may lower the convulsive threshold; dosage adjustments of anticonvulsants may be necessary (see **PRECAUTIONS**).

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

#### Interactions with drugs that may risk QT Prolongation

Caution is required with the use of the following medicines due to the risk of QT prolongation (see **PRECAUTIONS**):

- Class Ia antiarrhythmic agents such as quinidine and disopyramide.
- Class III antiarrhythmic agents such as amiodarone and sotalol.

- Other medications such as bepridil, cisapride, sultopride, thioridazine, methadone, intravenous erythromycin, intravenous vincamine, halofantrine, pentamidine, sparfloxacin.
- Medicines which induce bradycardia, such as bradycardia-inducing calcium channel blockers (diltiazem, verapamil), beta-blockers, clonidine, guanfacine, digitalis.
- Medicines which can cause hypokalaemia, such as diuretics, stimulant laxatives, intravenous amphotericin B, glucocorticoids, tetracosactides.
- Other antipsychotics .

### **Effects on Laboratory Tests**

The presence of phenothiazines may produce false positive phenylketonuria (PKU) test results.

### **DOSAGE AND ADMINISTRATION**

Oral administration should be used whenever possible. Dosages should be low to begin with and gradually increase under close supervision until the optimum dosage within the recommended range for the individual is reached. Individuals vary considerably and the optimum dose may be affected by the formulation used. LARGACTIL Tablets should not be crushed and solutions should be handled with care because of the risk of contact dermatitis.

The parenteral formulation may be used in emergencies. It may only be administered by deep intramuscular injection. LARGACTIL is too irritant to give subcutaneously. Repeated injections should be avoided if possible. LARGACTIL injection solution has a pH of 5.0 - 6.0 and is incompatible with benzyl-penicillin potassium, pentobarbitone sodium and phenobarbitone sodium. LARGACTIL injection solution, on exposure to light, rapidly develops a pink or yellow colouration; any such solution should be discarded.

### **Schizophrenia, Psychoses, Anxiety and Agitation**

#### Oral

##### *Adult*

Initially 25 mg three times daily or 75 mg at bedtime increasing by daily amounts of 25 mg to an effective maintenance dose. This is usually in the range 75 to 300 mg daily, but some patients may require up to 1 g daily.

##### *Children*

Under 1 Year: Do not use unless need is life saving.

1-5 Years: 0.5 mg/kg bodyweight every 4 - 6 hours to a maximum recommended dose of 40 mg daily.

6 -12 Years: A third to half the adult dose, to a maximum recommended dose of 75 mg daily.

##### *Elderly*

Start with a third to a half the usual adult dose with a more gradual increase in dosage.

#### Intramuscular

##### *Adult*

For acute relief of symptoms 25 - 50 mg every 6 - 8hours.

### *Children*

Under 1 Year: Do not use unless need is life saving.

1-5 Years: 0.5 mg/kg bodyweight every 6 - 8 hours. Dosage is not advised to exceed 40 mg daily.

6-12 Years: 0.5 mg/kg bodyweight every 6 - 8 hours. Not to exceed 75 mg daily.

### *Elderly*

Doses in the lower range for adults should be sufficient to control symptoms, i.e. 25 mg, 8 hourly.

## **Intractable Hiccup**

### Oral

#### *Adult*

25 - 50 mg three or four times daily.

#### *Children*

No information available.

#### *Elderly*

No information available.

### Intramuscular

#### *Adult*

25 - 50 mg every 6-8 hours.

#### *Children*

No information available.

#### *Elderly*

No information available

### Intravenous Infusion

#### *Adult*

If other routes of administration are inappropriate, give 25-50 mg in 500-1000 ml sodium chloride by slow intravenous infusion every 6-8 hours.

#### *Children*

No information available.

#### *Elderly*

No information available.

## **Nausea and Vomiting of Terminal Illness**

### Oral

#### *Adults*

10 - 25 mg every 4 - 6 hours.

#### *Children*

Under 1 Year: Do not use unless need is life saving.

1-5 Years: 0.5 mg/kg every 4 - 6 hours. Maximum daily dosage should not exceed 40 mg.

6 - 12 Years: 0.5 mg/kg every 4 - 6 hours. Maximum daily dosage should not exceed 75 mg.

#### *Elderly*

Initially a third to half the adult dose. The physician should then use their clinical judgement to obtain control.

### Intramuscular

#### *Adults*

25 mg initially, then 25 - 50 mg every 3 - 4 hours until vomiting stops, then drug to be taken orally.

#### *Children*

Under 1 Year: Do not use unless need is life saving.

1 - 5 Years: 0.5 mg/kg 6 - 8 hourly. It is advised that maximum daily dosage should not exceed 40 mg.

6-12 Years: 0.5 mg/kg every 6 - 8 hours. It is advised that maximum daily dosage should not exceed 75 mg.

#### *Elderly*

For oral use only.

## **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**

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, 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 followed ingestion of 350 to 800 mg of chlorpromazine. Acute toxicity has been determined in animals. LD<sub>50</sub> values range from 15 mg/kg (intra-venous, rabbit) to 75 mg/kg (oral, mouse).

## **Treatment**

Symptomatic and supportive treatment should be administered as appropriate. Removal of the drug by inactivation by administering activated charcoal should be considered. Emetics should not be used, not only because the antiemetic action of chlorpromazine prevents the

effect of the emetic agent, but also because the sedative and extrapyramidal side effects increase the risk of pulmonary aspiration should vomiting occur.

To counter acute hypotension the patient should be placed in the head down position and noradrenaline or phenylephrine administered intravenously. Adrenaline is contraindicated as it may produce a further fall in blood pressure (see **PRECAUTIONS**).

The central nervous depression should generally be allowed to recover naturally, however, artificial respiration may be required. Appropriate antibiotic therapy should be instituted for any respiratory infections.

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 (intramuscular dose in adults: 1 to 2mg, children 0.2 to 0.25mg initially with increments if necessary).

## **PRESENTATION AND STORAGE CONDITIONS**

### **Tablets**

10 mg (white, film coated): 100s

25 mg (white, film coated): 100s

100 mg (white, film coated): 100s

Store below 30°C

### **Ampoules**

25mg/mL, 2mL: 10s

Store below 25°C, Protect from light.

## **MEDICINES CLASSIFICATION**

Prescription Medicine

## **NAME AND ADDRESS OF THE SPONSOR**

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## **DATE OF PREPARATION**

4 February 2013