National Agency for Food and Drug Administration and Control (NAFDAC)

SUMMARY OF PRODUCT CHARACTERISTICS
(As Per NAFDAC Template)

(Chlorpromazine Tablets BP 100mg)

Manufactured by: **Swiss Pharma Pvt. Ltd.** 3709, G.I.D.C, Phase IV, Vatva, Ahmedabad- 382445 Ph.: +91-079-25842852 Email: info@swisspharma.in	Marketed by: **Embassy Pharmaceutical & Chemocals Ltd** LAGOS, NIGERIA.

1.3.1 Summary of Product Characteristics (SmPC)

1. Name of Medicinal Product

CHLORPROMAZINE TABLETS BP 100 MG

2. Qualitative and Quantitative Composition

2.1. Qualitative declaration:

Composition of the Drug product:

Each film coated tablets

Chlorpromazine Hydrochloride BP 100mg

Excipients Q.S.

Colour: Titanium Dioxide

Qualitative & Quantitative Composition Formula:

Batch Size: 1,00,000 Tablets

Sr. No.	Name of raw material	Specification	Label Qty/tab (mg)	Overages	Qty. per Tab (mg)	Qty. Per Batch (Kg)	Function
1.	Chlorpromazine Hydrochloride	BP	100.00	---	100.00	10.00	Active
2.	Starch	BP	20.00	---	20.00	2.00	Diluent
3.	Lactose	BP	12.00	---	12.00	1.20	Diluent
4.	Povidone K30	BP	5.00	---	5.00	0.50	Disintegrant
5.	Iso Propyl Alcohol	BP	Q.S.	---	Q.S.	Q.S.	Solvent
6.	Magnesium Stearate	BP	4.00	---	4.00	0.40	Lubricant
7.	Purified Talc	BP	3.00	---	3.00	0.30	Glidant
8.	Fumed silica	BP	1.00	---	1.00	0.10	Absorbent
9.	Cross carmellose sodium	BP	5.00	---	5.00	0.50	Disintegrant
10.	Hydroxy Propyl Methyl Cellulose	BP	2.50	---	2.50	0.25	Film Forming Agent

11.	Titanium Dioxide	BP	0.70	---	0.70	0.07	Coating agent
12.	Polyethylene Glycol	BP	0.80	---	0.80	0.08	Film Coating Agent
13.	Purified Talc	BP	0.50	---	0.50	0.5	Glidant
14.	Methylene Chloride	BP	Q.S.	---	Q.S.	Q.S.	Solvent
15.	Iso Propyl Alcohol	BP	Q.S.	---	Q.S.	Q.S.	Solvent
Total Weight of tablets					154.50 mg	15.40 kg	

BP: British Pharmacopoeia

***Does not present in finished product, evaporated during drying.**

3. Pharmaceutical form

Film coated Tablets

Round, white film coated tablet, plain on both the sides.

4. Clinical particulars

4.1 Therapeutic indications

Schizophrenia and other psychoses (especially paranoia), mania and hypomania. In anxiety, psychomotor agitation, excitement, violent or dangerously impulsive behaviour. Is used as an adjunct in the short-term management of these conditions.

Intractable hiccup.

Nausea and vomiting in terminal illness (where other drugs have failed or are not available).

Induction of hypothermia is facilitated by Chlorpromazine Tablets which prevents shivering and causes vasodilatation.

Childhood schizophrenia and autism.

4.2 Posology and method of administration

Posology

Dosages should be low to begin with and gradually increased under close supervision until the optimum dosage for the individual is reached. Individuals vary considerably and the optimum dose may be affected by the formulation used.

Dosage of chlorpromazine in schizophrenia, other psychoses, anxiety and agitation etc.

Adult:

Initially 25 mg t.d.s. 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 the risk-benefit ratio has

been assessed.

Children 1-5 years:

0.5 mg/kg body weight every 4-6 hours to a maximum recommended dose of 40 mg daily.

Children 6-12 years:

$^1/_3$-½ adult dose to a maximum recommended dose of 75 mg daily.

Elderly or debilitated patients:

Start with $^1/_3$-½ usual adult dose with a more gradual increase in dosage.

Hiccups

Adult:

25-50 mg t.d.s. or q.d.s.

Children under 1 year:

No information available.

Children 1-5 years:

No information available.

Children 6-12 years:

No information available.

Elderly or debilitated patients:

As for adults.

Nausea and vomiting of terminal illness:

Adults:

10-25 mg every 4-6 hours.

Children under 1 year:

Do not use unless the risk-benefit ratio has

been assessed.

Children 1-5 years:

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

Children 6-12 years:

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

Elderly or debilitated patients:

Initially $^{1}/_{3}$-½ adult dose. The physician should then use his clinical judgment to obtain control.

Method of administration: Oral

4.3 Contraindications

- Hypothyroidism
- Cardiac failure
- Phaeochromocytoma
- Myasthenia gravis
- Hypersensitivity to chlorpromazine, phenothiazines or one of the other constituents.
- Risk of angle-closure glaucoma.
- Risk of urinary retention related to urethroprostatic disorders.
- History of agranulocytosis.
- Dopaminergic antiparkinsonism agents (see Section 4.5).
- Nursing mothers (see Section 4.6).
- Gluten allergy or intolerance (see Section 4.4).
- Citalopram, escitalopram.

Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine.

4.4 Special warnings and precautions for use

Blood Dyscrasias: Agranulocytosis has been reported rarely, most commonly in the first three months of treatment, but occasionally later. Other blood dyscrasias including thrombocytopenia and haemolytic anaemia have occurred very rarely. All patients must be advised that, if they experience fever, sore throat or any other infection, they should inform their physician immediately and undergo a complete blood count. Treatment will be discontinued if any marked changes (hyperleucocytosis, granulocytopenia) are observed in the latter.

Neuroleptic malignant syndrome: treatment must be interrupted in the event of unexplained hyperpyrexia since this can be one of the signs of neuroleptic malignant syndrome (pallor, hyperthermia, disorders of autonomic function). Signs of autonomic instability, such as hyperhydrosis and irregular blood pressure, can precede the onset of hyperthermia and as such constitute premonitory signs of the syndrome. While this neuroleptic-related effect can be of idiosyncratic origin, certain risk factors such as dehydration and brain damage would seem to indicate a predisposition.

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, hypokalaemia, 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 Section 4.8).

Where clinically possible, the absence of any factors favouring the onset of ventricular arrhythmias should be ensured before administration:

• bradycardia less than 55 beats per minute;

• hypokalaemia;

• congenital long QT interval;

• ongoing treatment with any drug which could induce marked bradycardia (<55 beats per minute), hypokalaemia, intracardiac conduction depression or QT prolongation (see Section 4.5).

With the exception of emergencies, it is recommended that the initial work up of patients receiving a neuroleptic should include an ECG.

Except under exceptional circumstances, this drug must not be administered to patients with Parkinson's disease.

The concomitant use of chlorpromazine with lithium, other QT prolongation agents, and dopaminergic antiparkinsonism agents is not recommended (see Section 4.5). Anti-Parkinson agents should not be prescribed routinely, because of the possible risks of aggravating anticholinergic side effects of chlorpromazine, of precipitating toxic-confusional states or of impairing its therapeutic efficacy. They should only be given as required.

Cases of venous thromboembolism (VTE) sometimes fatal, have been reported with antipsychotic drugs. Therefore Chlorpromazine Tablets should be used with caution in patients with risk factors for thromboembolism (see Section 4.8).

Stroke: In randomised clinical trials versus placebo performed in a population of elderly patients with dementia and treated with certain atypical antipsychotic drugs, a 3-fold increase of the risk of cerebrovascular events has been observed. The mechanism of such risk increase is not known. An increase in the risk with other antipsychotic drugs or other populations of patient cannot be excluded. Chlorpromazine should be used with caution in patients with stroke risk factors.

Elderly Patients with Dementia: Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5% compared to a rate of about 2.65 in the placebo group. Although the cause 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 patient is not clear.

Chlorpromazine commonly causes increased susceptibility to sunburn and patients should be warned to avoid excessive exposure. Phototoxic or photoallergic reactions may occur. Various skin rashes and reactions, including exfoliative dermatitis and erythema multiforme have been reported. Contact skin sensitivity may be produced by contact with chlorpromazine. The occurrence of antinuclear antibodies has been reported. SLE has very rarely occurred.

Chlorpromazine impairs body temperature regulation and cases of severe hypothermia or hyperpyrexia have been reported, usually in association with moderate or high dosage. The elderly or hypothyroid patient may be particularly susceptible to hypothermia. The hazard of hyperthermia may be increased by especially hot or humid weather or by drugs, such as anti- Parkinson agents, which impair sweating. It has also been reported after intramuscular injections of chlorpromazine.

Hyperglycaemia or intolerance to glucose has been reported in patients treated with

Chlorpromazine Tablets. Patients with an established diagnosis of diabetes mellitus or with

factors for the development of diabetes who are started on Chlorpromazine Tablets should get appropriate glycaemic monitoring during treatment (see Section 4.8).

• The following populations must be closely monitored after administration of chlorpromazine.

o epileptics, since chlorpromazine may lower the seizure threshold. Treatment must be discontinued if seizures occur.

o elderly patients presenting with heightened susceptibility to orthostatic hypotension, sedation and extrapyramidal effects; chronic constipation (risk of paralytic ileus), and potentially prostatic hypertrophy.

o patients presenting with certain forms of cardiovascular disease, since this class of drug has quinidine-like effects and can induce tachycardia and hypotension.

o patients with severe liver and/or renal failure because of the risk of accumulation.

• Patients on long-term treatment should receive regular ophthalmological and haematological examinations.

• Treatment should be discontinued immediately and another anti-psychotic drug should be considered as an alternative in the following situation:

Severe liver toxicity

• Severe liver toxicity, resulting sometimes in death, has been reported with chlorpromazine use. Patients or caregivers should immediately report signs and symptoms such as asthenia, anorexia, nausea, vomiting, abdominal pain or icterus to a physician. Investigations including clinical examination and biological assessment of liver function should be undertaken immediately (see section 4.8).

• **Eosinophilia**

• The presence of eosinophilia may indicate an allergic reaction to chlorpromazine. A thorough clinical examination and a repeat complete blood count (CBC) with differential count to confirm the presence of eosinophilia should be performed (see section 4.8).

• **Drug reaction with eosinophilia and systemic symptoms**

• Drug reaction with eosinophilia and systemic symptoms (DRESS) which can be life

threatening or fatal, have been reported in association with chlorpromazine treatment.

• At the time of prescription patients should be advised of the signs and symptoms and monitored closely for skin reactions. If signs and symptoms suggestive of these reactions appear, chlorpromazine should be withdrawn immediately and not be restarted.

• Chlorpromazine tablets contain lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine.

• **Sodium content**

• This medicine contains less than 1 mmol sodium (23 mg) per tablet, that is to say essentially, 'sodium free'

• **Paediatric population**

• Since there is a potential to impact on cognitive function, children should undergo a yearly clinical examination to evaluate learning capacity. The dosage should be adjusted regularly as a function of the clinical status of the child.

4.5 Interaction with other medicinal products and other forms of interaction

Adrenaline must not be used in patients overdosed with Chlorpromazine.

Antichlolinergic drugs may reduce the antipsychotic effect of Chlorpromazine and the mild anticholinergic effect of Chlorpromazine may be enhanced by other anticholinergic drugs possibly leading to constipation, heat stroke etc.

The action of some drugs may be opposed by Chlorpromazine; these include amphetamine, levodopa, clonidine, guanethidine and adrenaline.

Increases or decreases in the plasma concentrations of a number of drugs e.g. propranolol Phenobarbital have been observed but were not of clinical significance.

Simultaneous administration of deferoxamine and prochlorperazine has been observed to induce a transient metabolic encephalopathy characterised by loss of consciousness for 48-72 hours. It is possible this may occur with Chlorpromazine since it shares many of the pharmacological properties of prochlorperazine.

There is an increased risk of agranulocytosis when neuroleptics are used concurrently with drugs

with myelosuppressive potential, such as carbamazepine or certain antibiotics and cytotoxics.

Combinations contraindicated

Dopaminergics (quinagolide, cabergoline), not including dopaminergic antiparkinsonism agents, are contraindicated (see Section 4.3): reciprocal antagonism of the dopaminergic agent and neuroleptic. Citalopram and escitalopram are contraindicated.

Combinations not recommended

Dopaminergic antiparkinsonism agents (amantadine, bromocriptine, cabergoline, levodopa, lisuride, pergolide, piribedil, ropinirole) are not recommended: reciprocal antagonism of the antiparkinsonism agent and neuroleptic (see Section 4.4). Neuroleptic-induced extrapyramidal syndrome should be treated with an anticholinergic rather than a dopaminergic antiparkinsonism agent (dopaminergic receptors blocked by neuroleptics).

Levodopa: reciprocal antagonism of levodopa and the neuroleptic. In Parkinson's patients, it is recommended to use the minimal doses of each drug.

QT prolonging drugs: there is an increased risk of arrhythmias when chlorpromazine is used with concomitant QT prolonging drugs (including certain antiarrhythmics and other antipsychotics including sultopride) and drugs causing electrolyte imbalance (see Section 4.4).

Alcohol: alcohol potentiates the sedative effect of neuroleptics. Changes in alertness can make it dangerous to drive or operate machinery. Alcoholic beverages and medication containing alcohol should be avoided (see Section 4.4).

Lithium (high doses of neuroleptics): concomitant use can cause confusional syndrome, hypertonia and hyperreflexivity, occasionally with a rapid increase in serum concentrations of lithium (see Section 4.4). There have been rare cases of neurotoxicity Lithium can interfere with the absorption of neuroleptic agents.

Combinations requiring precautions

Antidiabetic agents: concomitant administration of high chlorpromazine doses (100 mg/day), and antidiabetic agents can lead to an increase in blood sugar levels (decreased insulin release). Forewarn the patient and advise increased self-monitoring of blood and urine levels. If necessary, adjust the antidiabetic dosage during and after discontinuing neuroleptic treatment.

Topical gastrointestinal agents (magnesium, aluminium and calcium salts, oxides and

hydroxides): decreased GI absorption of phenothiazine neuroleptics. Do not administer phenothiazine neuroleptics simultaneously with topical GI agents (administer more than 2 hours apart if possible).

CYP1A2 inhibitors

Administration of chlorpromazine with CYP1A2 inhibitors, in particular strong or moderate inhibitors may lead to an increase of chlorpromazine plasma concentrations. Therefore, patients may experience a chlorpromazine dose-dependent adverse drug reaction.

There is a possible pharmacokinetic interaction between inhibitors of CYP2D6, such as phenothiazines and CYP2D6 substrates.

Combinations to be taken into consideration

Antihypertensive agents: potentiation of the antihypertensive effect and risk of orthostatic hypotension (additive effects). Guanethidine has adverse clinically significant interactions documented.

Atropine and other atropine derivatives: imipramine antidepressants, histamine H1-receptor antagonists, anticholinergic, antiparkinsonism agents, atropinic antispasmodics, disopyramide: build up of atropine-associated adverse effects such as urinary retention, constipation dry mouth and heat stroke etc.

Other CNS depressants: morphine derivatives (analgesics, antitussives and substitution treatments), barbiturates, benzodiazepines, anxiolytics other than benzodiazepines, hypnotics, sedative anti-depressants, histamine H1 receptor antagonists, central antihypertensive agents increased central depression. Changes in alertness can make it dangerous to drive or operate machinery.

4.6 Fertility, pregnancy and lactation

Pregnancy

There is inadequate evidence of the safety of chlorpromazine in human pregnancy. There is evidence of harmful effects in animals, so like other drugs, it should be avoided in pregnancy unless the physician considers it essential. It may occasionally prolong labour and at such a time should be withheld until the cervix is dilated 3-4cm. Possible adverse effects on the foetus include lethargy or paradoxical hyperexcitability, tremor and low Apgar score.

A large amount of exposure to chlorpromazine during pregnancy did not reveal any teratogenic effect.

It is advised to keep an adequate maternal psychic balance during pregnancy in order to avoid decompensation. If a treatment is necessary to ensure this balance, the treatment should be started or continued at effective dose all through the pregnancy.

Neonates exposed to antipsychotics (including chlorpromazine) during the third trimester of pregnancy are at risk of adverse reactions including extrapyramidal and/or withdrawal symptoms that may vary in severity and duration following delivery. There have been reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress, bradycardia, tachycardia, feeding disorder, meconium ileus, delayed meconium passage, abdominal bloating. Consequently, newborns should be monitored carefully in order to plan appropriate treatment.

Breast-feeding

Chlorpromazine being excreted in milk, breast-feeding is not recommended during treatment.

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 (see Section 4.8). In men, data on consequences of hyperprolactinaemia are insufficient with regard to fertility.

4.7 Effects on ability to drive and use machines

The attention of patients, particularly drivers and machine operators, should be drawn to the risk of drowsiness with this medication especially at the start of treatment.

4.8 Undesirable effects

The following undesired events, listed by body system, have been reported with the following frequencies: very common (≥ 1/10), common (≥ 1/100 to <1/10), uncommon (≥ 1/1000 to <1/100), rare (≥ 1/10,000 to <1/1,000), very rare (<1/10,000), not known (cannot be estimated from the available data).

System organ class	**Very common (≥1/10)**	**Common (≥1/100 to <1/10)**	**Not known (cannot be estimated from available data)**
Blood and lymphatic system disorders			Agranulocytosis Leukopenia
Immune system disorders			Systemic lupus erythematosus Antinuclear antibody positive[1]
Endocrine disorders		Hyperprolactinaemia Amenorrhoea	Galactorrhoea Gynaecomastia Erectile dysfunction Female sexual arousal disorder
Metabolism and nutrition disorders	Weight increased	Glucose tolerance impaired (see Section 4.4)	Hyperglycaemia (see Section 4.4) Hypertriglyceridaemia Hyponatraemia Inappropriate antidiuretic hormone secretion
Psychiatric disorders		Anxiety	Lethargy Mood altered

Nervous system disorders	Sedation[2] Somnolence[2] Dyskinesia Tardive dyskinesia[3] Extrapyramidal disorder (in the form of acute dystonias, parkinsonian rigidity, tremor or akinesia, akathisia and oculogyric crises may occur, and are common on moderate to high dosage) Akathisia	Hypertonia Convulsion	Torticollis Oculogyric crisis Trismus Akinesia Hyperkinesia Neuroleptic malignant syndrome (see Section 4.4.)
Eye disorders			Accommodation disorder Deposit eye[4]

Cardiac disorders		Electrocardiogram QT prolonged (see Section 4.4)	Ventricular arrhythmia Ventricular fibrillation Ventricular tachycardia Torsade de pointes Cardiac arrest Sudden death/Sudden cardiac death (with possible causes of cardiac origin as well as cases of unexplained sudden death, in patients receiving neuroleptic phenothiazines) (see Section 4.4)
Vascular disorders	Orthostatic hypotension		Embolism venous Pulmonary embolism (sometimes fatal) Deep vein thrombosis (see Section 4.4) Dose related postural hypotension may occur, particularly in the elderly and

			after intramuscular injections
Respiratory, thoracic and mediastinal disorders			Nasal stuffiness
Gastrointestinal disorders	Dry mouth Constipation (see Section 4.4)		Colitis ischaemic Ileus paralytic (see Section 4.4) Intestinal perforation (sometimes fatal) Gastrointestinal necrosis (sometimes fatal) Necrotising colitis (sometimes fatal) Intestinal obstruction
Hepatobiliary disorders			Jaundice cholestatic Liver injury Cholestatic liver injury Mixed liver injury
Skin and subcutaneous tissue disorders			Dermatitis allergic Angioedema Urticaria Photosensitivity reaction
Renal and urinary disorders			Urinary retention (linked to anticholinergic effects)
Pregnancy, puerperium and perinatal conditions			Drug withdrawal syndrome neonatal (see Section 4.6)
Reproductive system and breast disorders			Priapism

General disorders and administration site conditions			Temperature regulation disorder

[1] may be seen without evidence of clinical disease

[2] particularly at the start of treatment

[3] particularly during long term treatment; may occur after the neuroleptic is withdrawn and resolve after reintroduction of treatment or if the dose is increased

[4] in the anterior segment of the eye caused by accumulation of the drug but generally without any impact on sight

[5] in the anterior segment of the eye caused by accumulation of the drug but generally without any impact on sight.

[6] A premonitory sign may be a sudden onset of fever after one to three weeks of treatment followed by the development of jaundice. Chlorpromazine jaundice has the biochemical and other characteristics of obstructive (cholestatic) jaundice and is associated with obstructions of the canaliculi by bile thrombi; the frequent presence of an accompanying eosinophilia indicates the allergic nature of this phenomenon. Liver injury, sometimes fatal, has been reported rarely in patients treated with chlorpromazine. Treatment should be withheld on the development of jaundice (see section 4.4). Cases of hepatocellular, cholestatic and mixed Liver injury, sometimes fatal, has been reported rarely in patients treated with chlorpromazine.

[7] The development of a metallic greyish-mauve coloration of exposed skin has been noted in some individuals, mainly females, who have received chlorpromazine continuously for long periods (four to eight years).

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the Yellow Card Scheme at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

4.9 Overdose

Toxicity and treatment of overdosage: Symptoms of chlorpromazine overdosage include drowsiness or loss of consciousness, hypotension, tachycardia, E.C.G. changes, ventricular

arrhythmias and hypothermia, Parkinsonism, convulsions and coma. Severe extra-pyramidal dyskinesias may occur.

Treatment should be symptomatic with continuous respiratory and cardiac monitoring (risk of prolonged QT interval) until the patient's condition resolves.

If the patient is seen sufficiently soon (up to 6 hours) after ingestion of a toxic dose, gastric lavage may be attempted. Pharmacological induction of emesis is unlikely to be of any use. Activated charcoal should be given. There is no specific antidote. Treatment is supportive.

Generalised vasodilatation may result in circulatory collapse; raising the patient's legs may be sufficient in mild hypotension but, in severe cases, volume expansion by intravenous fluids may be needed; infusion fluids should be warmed before administration in order not to aggravate hypothermia.

Positive inotropic agents such as dopamine may be tried if fluid replacement is insufficient to correct the circulatory collapse. Peripheral vasoconstriction agents are not generally recommended; avoid use of adrenaline.

Ventricular or supraventricular tachy-arrhythmias usually respond to restoration of normal body temperature and correction of circulatory or metabolic disturbances. If persistent or life threatening, appropriate antiarrhythmic therapy may be considered. Avoid lidocaine and, as far as possible, long acting antiarrhythmic drugs.

Pronounced central nervous system depression requires airway maintenance or, in extreme circumstances, assisted respiration. Severe dystonic reactions usually respond to procyclidine (5-10 mg) or orphenedrine (20-40 mg) administered intramuscularly or intravenously. Convulsions should be treated with intravenous diazepam.

Neuroleptic malignant syndrome should be treated with cooling. Dantrolene sodium may be tried.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic Group: Antipsychotics, ATC Code: N05AA01. Chlorpromazine is a phenothiazine neuroleptic.

Chlorpromazine has depressant actions on the Central Nervous System, with alpha-adrenergic blocking and anticholinergic activities. It inhibits Dopamine and Prolactin release-inhibitory factor, thus stimulating the release of Prolactin. It increases the turnover of Dopamine in the brain. It has anti-emetic, anti-puritic, serotonin-blocking and weak anti-histamine properties and slight ganglion blocking activity. It inhibits the heat regulating centre in the brain, and is analgesic and can relax skeletal muscle.

Due to its action on the autonomic system it produces vasodilatation, hypotension and tachycardia.

Salivary and gastric secretions are reduced

5.2 Pharmacokinetic properties

Chlorpromazine is rapidly absorbed and widely distributed in the body. It is metabolised in the liver and excreted in the urine and bile. Whilst plasma concentration of chlorpromazine itself rapidly declines excretion of chlorpromazine metabolites is very slow. The drug is highly bound to plasma protein. It readily diffuses across the placenta. Small quantities have been detected in milk from treated women. Children require smaller dosages per kg than adults.

5.3 Preclinical safety data

No additional data of relevance to prescriber

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Sr. No.	Ingredients Name	Specification
1.	Starch	BP
2.	Lactose	BP
3.	Povidone K30	BP
4.	Iso Propyl Alcohol	BP
5.	Magnesium Stearate	BP
6.	Purified Talc	BP
7.	Fumed silica	BP
8.	Cross carmellose sodium	BP
9.	Hydroxy Propyl Methyl Cellulose	BP
10.	Titanium Dioxide	BP
11.	Polyethylene Glycol	BP
12.	Purified Talc	BP
13.	Methylene Chloride	BP
14.	Iso Propyl Alcohol	BP

6.2 Incompatibilities:

Chlorpromazine can increase the central nervous system depression produced by other CNS-depressant drugs including alcohol, hypnotics, sedatives or strong analgesics.

It antagonises the action of adrenaline and other sympathomimetic agents and reverses the blood pressure lowering effects of adrenergic blocking agents such as guanethidine and clonidine. It may impair the metabolism of tricyclic antidepressants, the anti-Parkinson effects of levodopa and the effects of anticonvulsants; it may possibly affect the control of diabetes, or the action of anticoagulants. Antacids can impair absorption. Tea and coffee may prevent absorption by causing insoluble precipitates.

Undesirable anticholinergic effects can be enhanced by anti-Parkinson or other anticholinergic drugs. It may enhance the cardiac-depressant effects of quinidine, the absorption of corticosteroids and digoxin, the effect of diazoxide and of neuromuscular

blocking agents. Interactions with propanolol have been reported. The possibility of interaction with lithium should be bone in mind.

Further information: Chlorpromazine is a phenothiazine with an aliphatic side-chain. Its pharmacological profile of activity includes pronounced sedative and hypotensive properties, with fairly marked anticholinergic and anti-emetic activity and a moderate tendency to cause extrapyramidal reactions.

6.3 Shelf-life: 36 Months

6.4 Special precautions for storage:

Store in a dark, dry place, Not exceeding 30°C temp.

Keep all medicines out of reach of children.

6.5 Nature and contents of container:

1000 tablets are packed in a jar with silica gel pocket and leaflets

6.6 Special precautions for disposal and other handling

No special instructions for use/handling

7- Marketing Authorization Holder:

EMBASSY PHARMACEUTICAL & CHEMICALS LTD.

41, ADEMOLA STREET, SOUTH WEST IKOYI, LAGOS-NIGERIA.

mc

8- Marketing Authorization Number (s):

Product license / registration Number (s)

9- Manufacturer Name:

SWISS PHARMA PVT.LTD.

3709, G.I.D.C. Phase IV, Vatva,

Ahmedabad –382445,

Gujarat, India.

10- Date of first authorization/renewal of the authorization:

11- Date of revision of the text:

SWISS PHARMA PVT. LTD.
3709, G.I.D.C., Phase IV, Vatva, Ahmedabad-382 445, GUJARAT, INDIA