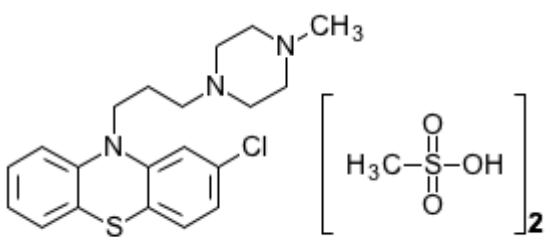
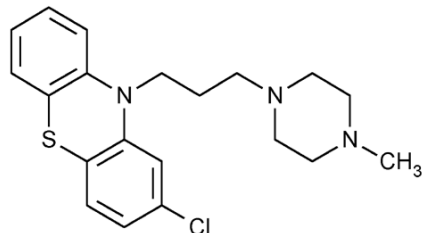


## DATA SHEET STEMETIL®

### 1 PRODUCT NAME

#### Non-proprietary Name

Injection		prochlorperazine mesilate Molecular formula: $C_{20}H_{24}ClN_3S \cdot 2CH_3SO_3H$ CAS number: 5132-55-8
Suppositories*		prochlorperazine base Molecular Formula: $C_{20}H_{24}ClN_3S$ CAS number: 58-38-8

### 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Prochlorperazine is 2-chloro-10-(3-(4-methylpiperazinyl)-propyl)phenothiazine. Prochlorperazine mesilate contains 66% of the active base.

The mesilate is an odourless, nonhygroscopic, almost white, crystalline solid which becomes coloured on exposure to light. It is very soluble in water (more than 2 g/mL) but is only slightly soluble in ethanol or chloroform and is insoluble in ether or benzene. The pH of a 2% aqueous solution is between 2 and 3.

For the full list of excipients, see section 6.1.

### **3 PHARMACEUTICAL FORM**

Stemetil suppositories\* contain prochlorperazine base equivalent to 25 mg\* prochlorperazine maleate. Stemetil suppositories are cream, smooth, torpedo-shaped suppositories.

Stemetil 12.5 mg/mL solution for injection is clean, bright and not more than very pale yellow. Each ampoule contains 1 mL.

\* Presentation currently not available in New Zealand

### **4 CLINICAL PARTICULARS**

#### **4.1 THERAPEUTIC INDICATIONS**

Prochlorperazine is used for nausea and vomiting from whatever cause. It may also be used for migraine, schizophrenia (particularly in the chronic stage) and acute mania.

#### **4.2 DOSE AND METHOD OF ADMINISTRATION**

##### **Nausea and Vomiting**

Adults

##### *Intramuscular*

##### *Treatment of nausea and vomiting*

12.5 mg by deep intramuscular injection, followed by oral prochlorperazine six hours later, if necessary.

##### *Rectal\**

25 mg followed by oral medication six hours later, if necessary.

##### **Schizophrenia and other psychotic disorders**

Adults

##### *Intramuscular*

12.5 mg to 25 mg two or three times a day by deep intramuscular injection until oral treatment becomes possible.

##### *Rectal\**

25 mg two or three times a day until oral treatment is possible.

## Children

Intramuscular or rectal prochlorperazine should not be given to children.

## Elderly

Prochlorperazine should be used cautiously in this group in psychotic disorders. Elderly patients susceptible to centrally-acting medicines hence lower initial dosage is recommended. There is an increased risk of drug-induced Parkinsonism in the elderly, particularly after prolonged use. Correct initial diagnosis of the disorder is important. Care should also be taken not to confuse adverse effects of prochlorperazine, e.g. orthostatic hypotension with effects due to the primary disorder.

\* Presentation currently not available in New Zealand

### **4.3 CONTRAINDICATION**

Circulatory collapse, central nervous system depression (coma or drug intoxication), previous history of a hypersensitivity reaction (e.g. jaundice or blood dyscrasia) to phenothiazines especially to prochlorperazine, bone marrow depression.

Known hypersensitivity to prochlorperazine or to any of the other ingredients.

Applies to solution for injection:

The use of prochlorperazine is contraindicated in children as it has been associated with dystonic reactions after the cumulative dose of 0.5 mg/kg.

Applies to suppository:

The use of suppository formulation is contraindicated in patients up to 16 years of age.

### **4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE**

Prochlorperazine should be avoided in patients with liver or renal dysfunction, Parkinson's disease, hypothyroidism, cardiac failure, pheochromocytoma, myasthenia gravis and prostate hypertrophy. It should be avoided in patients with a history of narrow angle glaucoma or agranulocytosis.

As agranulocytosis has been reported, regular monitoring of the complete blood count is recommended. The occurrence of unexplained infections or fever may be evidence of blood dyscrasia (see Section 4.8), and requires immediate haematological investigation.

Acute withdrawal symptoms, including nausea, vomiting and insomnia, have very rarely been reported following the abrupt cessation of high doses of neuroleptics. Relapse may also occur, and the emergence of extrapyramidal reactions has been reported. Therefore, gradual withdrawal is advisable.

As with all antipsychotic drugs, Stemetil should not be used alone where depression is predominant. However, it may be combined with antidepressant therapy to treat those conditions in which depression and psychosis coexist.

Because of the risk of photosensitisation, patients should be advised to avoid exposure to direct sunlight.

To prevent skin sensitisation in those frequently handling preparations of phenothiazines, the greatest care must be taken to avoid contact of the drug with the skin (see Section 4.8).

In schizophrenia, the response to neuroleptic treatment may be delayed. If treatment is withdrawn, the recurrence of symptoms may not become apparent for some time. Avoid concomitant treatment with other neuroleptics.

### **Hypotension**

The autonomic side effects of the piperazine derivatives are less troublesome than those of other phenothiazines, however care should be taken if prochlorperazine is used in the elderly or in patients undergoing surgery with spinal anaesthesia.

Postural hypotension with tachycardia as well as local pain or nodule formation may occur after intramuscular administration.

### **Epileptics**

Close monitoring is required in patients with epilepsy or a history of seizures, as phenothiazines may lower the seizure threshold. The occurrence of convulsive seizures necessitates the discontinuation of the treatment.

Piperazine derivatives are also less epileptogenic than other phenothiazines, but care should still be exercised in epileptic patients.

### **Anticholinergic effects**

Prochlorperazine can cause problems due to anticholinergic effects, especially in the elderly (urinary difficulties, constipation and precipitation of acute narrow angle glaucoma), but to a lesser extent than with other phenothiazines.

### **Hypocalcaemia**

It appears from a study of 5 hypocalcaemic patients with hypoparathyroidism that such patients are prone to acute dystonic reactions with prochlorperazine.

### **Sedative effect**

Prochlorperazine may impair mental and physical activity especially during the first few days of therapy. Patients should be warned about activities requiring alertness.

### **Antiemetic effects**

The antiemetic effects of prochlorperazine may mask signs of overdosage of toxic drugs or obscure the diagnosis of conditions such as intestinal obstruction, brain tumour.

### **Reye's Syndrome**

The extrapyramidal symptoms which can occur secondary to prochlorperazine 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 prochlorperazine and other potential hepatotoxins should be avoided in children and adolescents whose signs and symptoms suggest Reye's Syndrome.

### **Hypothermia**

Severe hypothermia may occur during swimming in cold water or in patients receiving antipyretic therapy.

### **Liver disease**

Caution should be used in patients with existing liver disease due to the extensive hepatic metabolism of prochlorperazine. A past history of jaundice resulting from phenothiazine therapy indicates a hypersensitivity reaction and there is a likelihood of cross sensitivity to other 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. Antiparkinsonian agents usually do not alleviate symptoms. It is suggested that antipsychotic 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 antipsychotic 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.

It is imperative that treatment be discontinued in the event of unexplained fever, as this may be a sign of neuroleptic malignant syndrome (pallor, hyperthermia, autonomic dysfunction, altered consciousness, muscle rigidity).

Signs of autonomic dysfunction, such as sweating and arterial instability, may precede the onset of hyperthermia and serve as early warning signs. Although neuroleptic malignant syndrome may be idiosyncratic in origin, dehydration and organic brain disease are predisposing factors (see Section 4.8).

### **QT Interval**

Very rare cases of QT interval prolongation have been reported with prochlorperazine. 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 **Section 4.8**).

### **Cerebrovascular Events**

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

### **Stroke**

In randomised clinical trials versus placebo performed in a population with 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 the other antipsychotic drugs or other populations of patients cannot be excluded. Stemetil should be used with caution with stroke risk factors.

### **Thromboembolism**

Cases of venous thromboembolism (VTE), sometimes fatal, have been reported with antipsychotic drugs. Since patients treated with antipsychotics often present with acquired risk factors for VTE, all possible risk factors for VTE should be identified before and during treatment with Stemetil and preventative measures undertaken. Therefore, prochlorperazine should be used with caution in patients with risk factors for thromboembolism (see Section 4.8).

### **Use in the elderly**

It should be used with caution in the elderly, particularly during very hot or very cold weather (risk of hyper-, hypothermia).

The elderly are particularly susceptible to postural hypotension, sedation and extrapyramidal side effects.

Stemetil should be used cautiously in the elderly owing to their susceptibility to drugs acting on the central nervous system and a lower initial dosage is recommended. There is an increased risk of drug-induced Parkinsonism in the elderly particularly after prolonged use. Care should also be taken not to confuse the adverse effects of Stemetil, e.g. orthostatic hypotension, with the effects due to the underlying disorder.

### **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.

Prolonged administration of any phenothiazine may result in persistent or tardive dyskinesias, particularly in the elderly and in children.

Stemetil is not licensed for the treatment of dementia-related behavioural disturbances.

### **Hyperglycaemia**

Hyperglycaemia or intolerance to glucose has been reported in patients treated with antipsychotic phenothiazines. Patients with an established diagnosis of diabetes mellitus or with risk factors for the development of diabetes who are started on prochlorperazine, should get appropriate glycaemic monitoring during treatment (see Section 4.8).

### **Depression**

As with all antipsychotic drugs, Stemetil should not be used alone where depression is predominant. However, it may be combined with antidepressant therapy to treat those conditions in which depression and psychosis coexist.

## **Injection**

Do not use a darkened solution for injection (more than pale yellow).

## **Use in Children**

Prochlorperazine should not be given to children by the rectal or intramuscular route.

## **4.5 INTERACTION WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTION**

Adrenaline must not be used in patients overdosed with Stemetil.

Caution is required with the use of the following medicines due to the risk of QT prolongation (see Section 4.4):

- 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.

Prochlorperazine may enhance the CNS depressant effects of alcohol and other depressant drugs, and potentiate the anticholinergic effects of atropinic agents and tricyclic antidepressants. Respiratory depression may occur. Impaired vigilance may make it dangerous to drive or use machines. Avoid consumption of alcoholic beverages and medications containing alcohol.

Anticholinergic agents may reduce the antipsychotic effect of neuroleptics. The mild anticholinergic effect of neuroleptics may be enhanced by other anticholinergic drugs, possibly leading to dry mouth, constipation, heat stroke, urinary retention and other adverse effects.

Some drugs interfere with absorption of neuroleptic agents:

- anti-Parkinson drugs
- lithium
- Topical gastro-intestinal agents (magnesium, aluminium and calcium salts, oxides and hydroxides): Reduced gastro-intestinal absorption of phenothiazine neuroleptics. Antacids should not be taken at the same time as phenothiazine neuroleptics (at least 2 hours apart, if possible).

High doses of neuroleptics reduce the response to hypoglycaemic agents, the dosage of which might have to be raised.



The hypotensive effect of most antihypertensive drugs especially alpha adrenoceptor blocking agents may be exaggerated by neuroleptics.

The action of some drugs may be opposed by phenothiazine neuroleptics; these include amphetamine, levodopa, clonidine, guanethidine, 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.

There is an increased risk of arrhythmias when antipsychotics are used with concomitant QT prolonging drugs (including certain antiarrhythmics, antidepressants and other antipsychotics) and drugs causing electrolyte imbalance.

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.

In patients treated concurrently with neuroleptics and lithium, there have been rare reports of neurotoxicity.

Phenothiazines are potent inhibitors of CYP2D6. Co-administration of phenothiazines with amitriptyline, a CYP2D6 substrate, may lead to an increase in the plasma levels of amitriptyline. Monitor patients for dose-dependent adverse reactions associated with amitriptyline.

Simultaneous administration of desferrioxamine and prochlorperazine has been observed to induce a transient metabolic encephalopathy characterised by loss of consciousness for 48-72 hours.

Procarbazine has been reported to potentiate the extrapyramidal side effects encountered with the use of prochlorperazine. Phenothiazines have been reported both to impair and increase metabolism of phenytoin, with uncertain clinical significance. Patients on levodopa should not be given phenothiazines because the two drugs are physiologically antagonistic.

Where treatment for neuroleptic-induced extrapyramidal symptoms is required, anticholinergic antiparkinsonian agents should be used in preference to levodopa, since neuroleptics antagonise the antiparkinsonian action of dopaminergics.

Thiazide diuretics may accentuate the orthostatic hypotension that may occur with phenothiazines.

Antihypertensive effects of guanethidine and related compounds may be counteracted when phenothiazines are used concomitantly.

Phenothiazines can diminish the effect of oral anticoagulants. Concomitant administration of propranolol with phenothiazines results in increased plasma levels of both drugs. Phenothiazines may lower the convulsive threshold; dosage adjustments of anticonvulsants may be necessary.

#### **4.6 FERTILITY, PREGNANCY AND LACTATION**

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

Data from epidemiological studies do not suggest a risk of congenital malformations in children exposed *in utero* to Stemetil. Nevertheless, as a precautionary measure, prochlorperazine should be avoided during pregnancy unless the potential benefits outweigh the potential risks.

When given in high doses during late pregnancy, phenothiazines have caused jaundice, hyperreflexia, hyporeflexia or prolonged extrapyramidal disturbances in the child. There is evidence of harmful effects in animals.

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 prochlorperazine is recommended.

Like other drugs it should be avoided in pregnancy unless the physician considers it essential. Neuroleptics may occasionally prolong labour and at such a time should be withheld until the cervix is dilated 3-4 cm. Possible adverse effects on the foetus include lethargy or paradoxical hyperexcitability, tremor and a low Apgar score.

### **Use in lactation**

Trace amounts of another phenothiazine, chlorpromazine, have been detected in breast milk, but there is no information available for prochlorperazine. Consequently, it is not known whether it is excreted in breast milk nor whether it has a harmful effect on the newborn. Therefore, prochlorperazine is not recommended for nursing mothers unless the expected benefits outweigh any potential risk.

### **Use in Fertility**

No fertility data available

## **4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES**

Patients should be warned about drowsiness during the early days of treatment and advised not to drive or operate machinery if affected.

## 4.8 UNDESIRABLE EFFECTS

The following reactions have been reported for prochlorperazine or phenothiazines in general.

### More common reactions

#### Gastrointestinal

Constipation, dry mouth.

#### Nervous System

Drowsiness, akathisia, parkinsonism, (with dyskinesia, tremor and rigidity).

#### Ocular

Blurred vision.

#### Vascular

Hypotension, usually postural.

### Less common reactions

#### Biochemical abnormalities

Elevated serum levels of bilirubin and hepatic enzymes may occur if the patient develops cholestatic jaundice.

#### Cardiovascular

Peripheral oedema, cardiac arrhythmias, ECG changes, QT interval prolongation, ST depression, U-Wave and T-Wave changes. Cardiac arrhythmias, including ventricular arrhythmias and atrial arrhythmias, a-v block, ventricular tachycardia, which may result in ventricular fibrillation or cardiac arrest have been reported during neuroleptic phenothiazine therapy, possibly related to dosage.

Pre-existing cardiac disease, old age, hypokalaemia and concurrent tricyclic antidepressants may predispose. There have been isolated reports of sudden death, with possible causes of cardiac origin (see Section 4.4), 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 Section 4.4).

#### Dermatological

Dermatitis or contact dermatitis, maculopapular eruptions, erythema multiforme, urticaria, photosensitivity, abnormal pigmentation.

### Endocrine

Endocrine disturbances including elevated prolactin levels, hyperglycaemia, intolerance to glucose, hypoglycaemia, menstrual irregularities, galactorrhoea, gynaecomastia, amenorrhoea, impotence.

### Gastrointestinal

Paralytic ileus.

### Genitourinary

Urinary retention, priapism, inhibition of ejaculation.

### Haematological

Agranulocytosis, atypical lymphocytes, thrombocytopenia, leucopenia, aplastic anaemia.

### Hepatic

Jaundice, liver damage.

### Nervous System

Acute dystonia or dyskinesias including oculogyric crisis, usually transitory are more common in children and young adults, and usually occur within the first 4 days of treatment or after dosage increases.

Akathisia characteristically occurs after large initial doses.

Parkinsonism. It usually develops after weeks or months of treatment. One or more of the following may be seen: tremor, rigidity, akinesia or other features of Parkinsonism.

Tardive dyskinesia: If this occurs it is usually, but not necessarily, after prolonged or high dosage. It can even occur after treatment has been stopped. Dosage should therefore be kept low whenever possible.

Torticollis and opisthotonus and trismus, seizures, EEG changes, headache, insomnia, catatonia, hyperpyrexia, agitation, dizziness.

Cases of convulsions have been reported.

### Ocular

Pigmentary retinopathy.

Brownish deposits in the anterior segment of the eye, due to accumulation of the product, generally without effects on vision.

#### Psychiatric

Activation of psychotic symptoms.

#### Respiratory

Respiratory depression.

#### Metabolic and Nutrition Disorders

Hyponatraemia and inappropriate antidiuretic hormone secretion have also been reported.

In post-marketing surveillance cases of hyperglycaemia or intolerance to glucose have been reported with antipsychotic phenothiazines (see Section 4.4).

#### Immune system disorders

Hypersensitivity reactions such as angioedema and urticaria have been reported.

#### General disorders and administration site conditions

Neuroleptic malignant syndrome (hyperthermia, rigidity, autonomic dysfunction and altered consciousness).

#### Pregnancy, puerperium and perinatal conditions

Drug withdrawal syndrome neonatal (see Section 4.6 Fertility, pregnancy and lactation, Use in pregnancy).

### **Serious or Life Threatening Reactions**

Prochlorperazine can cause very serious acute dystonic reactions in children leading to cyanosis from laryngospasm, apnoea requiring artificial ventilation, life-threatening tetanus like syndromes, coma and even death. These reactions can occur with a single therapeutic dose. For treatment, see Overdose. Also, long-term phenothiazine therapy has been associated with ECG changes and life threatening cardiac arrhythmias.

### **Reporting of suspected adverse reactions**

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions <https://nzphvc.otago.ac.nz/reporting/>.

## 4.9 OVERDOSE

### Symptoms

Overdosage with phenothiazines may cause 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, restlessness, tremor, muscle twitching, spasm or rigidity, convulsions, muscular hypotonia, difficulty in swallowing or breathing, cyanosis, and respiratory and/or vasomotor collapse, possibly with sudden apnoea. There is no information available regarding lethal dose in man.

High doses cause depression of the central nervous system, presenting as lethargy, dysarthria, ataxia, stupor, reduction in consciousness into coma, convulsions; mydriasis; cardiovascular symptoms (related to risk of QT interval prolongation), such as hypotension, ventricular tachycardia and arrhythmia; respiratory depression; hypothermia. These effects may be potentiated by other medicines or by alcohol. Anticholinergic syndrome is of importance. Extremely serious parkinsonian syndrome may occur.

### Treatment

1. Acute dystonic reactions  
Intramuscular benztropine (or another antiparkinsonian agent) should be given immediately.
2. Overdosage  
Emesis should not be induced, not only because the antiemetic action of prochlorperazine prevents the effect of the emetic agent, but also because the sedative and extra-pyramidal side effects increase the risk of pulmonary aspiration should vomiting occur. Management is generally supportive with particular attention to the possibility of obstructed ventilation, severe hypotension, hypothermia, cardiac arrhythmias, convulsions and prolonged deep sedation. Acute dystonic reactions usually occur early (if at all); treatment is with anticholinergic agents, as above.

Adrenaline must not be used as it may cause a paradoxical further lowering of blood pressure

For advice on the management of overdose please contact the National Poisons Centre on 0800 POISON (0800 764766).

## 5 PHARMACOLOGICAL PROPERTIES

Prochlorperazine is a phenothiazine with a piperazine moiety in the side chain. It possesses strong antiemetic and antipsychotic activity with less sedative action than chlorpromazine.

## 5.1 PHARMACODYNAMIC PROPERTIES

As with other phenothiazines, prochlorperazine has actions on several neurotransmitter systems:

1. Antidopamine action, which probably contributes to both the therapeutic effect and unwanted effects including extrapyramidal disorders and endocrine disturbances.
2.  $\alpha$ -Adrenoreceptor antagonism, which contributes to cardiovascular side effects such as orthostatic hypotension and reflex tachycardia.
3. Potentiation of noradrenaline by blocking its reuptake into nerve terminals.
4. Weak anticholinergic action.
5. Weak antihistamine action.
6. Weak serotonin antagonism.

Prochlorperazine also has an effect on temperature control and blocks conditioned avoidance responses.

## 5.2 PHARMACOKINETIC PROPERTIES

There are few published data on prochlorperazine pharmacokinetics in the human. Most studies have been done in rats and dose levels do not correspond to those used clinically and metabolic pathways may differ. Similar overall pharmacokinetic patterns however would occur in the human.

Prochlorperazine is well absorbed from the GI tract in rats but absorption is slowed in repeatedly treated animals. The drug is widely distributed to tissues including the brain, fat, kidney, heart and skin and is stored in reticuloendothelial tissues. Phenothiazines are metabolised primarily in the liver and are subject to enterohepatic circulation. Excretion is mainly in the faeces. Only a very small amount (approx. 0.1%) of prochlorperazine and its metabolites are excreted in the first 24 hours in the urine and the drug may continue to be excreted in the urine for up to 3 weeks after cessation of long term therapy. The elimination half-life is approximately 24 hours, presumably due to its enterohepatic circulation.

## 5.3 PRECLINICAL SAFETY DATA

No further relevant information other than that which is included in the other sections of the Data Sheet.

## **6 PHARMACEUTICAL PARTICULARS**

### **6.1 LIST OF EXCIPIENTS**

Stemetil 12.5mg/mL solution contains the following excipients:

Olamine

Sodium chloride

Sodium metabisulfite

Sodium sulfite

Water for injection

Stemetil 25mg suppositories\* contains the following excipients:

Suppository base E75 355mg

Suppository base W35 1,340mg

### **6.2 INCOMPATIBILITIES**

Not applicable

### **6.3 SHELF LIFE**

Stemetil 12.5mg/mL solution for injection has a shelf life of 60 months from date of manufacture.

Stemetil 25mg suppositories\* have a shelf life of 48 months from date of manufacture.

### **6.4 SPECIAL PRECAUTIONS FOR STORAGE**

Stemetil 12.5 mg/mL solution for injection store below 25°C. Protect from Light. Keep ampoules and trays in the carton until time of use.

Stemetil 25mg suppositories\* store below 25°C. Protect from Light.

### **6.5 NATURE AND CONTENTS OF CONTAINER**

Stemetil injection ampoules are available in cartons of 10 ampoules.

Stemetil suppositories\* are white opaque, torpedo shaped and come in a blister pack made from PVC/PVDC.

\* Presentation currently not available in New Zealand



## **6.6 SPECIAL PRECAUTIONS FOR DISPOSAL AND OTHER HANDLING**

No special requirements

## **7 MEDICINE SCHEDULE**

Prescription Medicine

## **8 SPONSOR**

sanofi-aventis new zealand limited

Level 8, 56 Cawley Street, Ellerslie

Auckland New Zealand

Toll Free Number (medical information): 0800 283 684

Email: [medinfo.australia@sanofi.com](mailto:medinfo.australia@sanofi.com)

## **9 DATE OF FIRST APPROVAL**

31 December 1969

## **10 DATE OF REVISION OF THE TEXT**

21 September 2018

### **SUMMARY TABLE OF CHANGES**

<b>Section changed</b>	<b>Summary of new information</b>
4.3, 4.4, 4.5, 4.6, 4.8, 4.9	Safety related changes
3, 4.1, 6.5, 8	Editorial changes