Angiotensin Converting Enzyme Inhibitors (ACEI) and Angiotension II Receptor Blocker (ARB)

Supportive care for hypotension is the mainstay of management in cases of ACEI or ARB poisoning

Toxicity / Risk Assessment

Usually benign when ingested in isolation

Co-ingestion with a calcium channel blocker (CCB) or beta blocker (BB) can produce profound shock

Patients with renal failure, congestive heart failure, dehydration are at ↑ risk of toxicity

Single tablet accidental exposures in children are usually benign

Clinical features:

- Usually asymptomatic (lone ingestion)
- Hypotension may occur within 2 hours of exposure
- Secondary hyperkalaemia may be observed in large overdoses

Management

Decontamination

Offer activated charcoal 50g (1g/kg in children) up to 2 hours post ingestion if severe toxicity is expected based on reported ingestion / co-morbidities, or if co-ingestion with CCB or BB

Hypotension

Fluid: initially load with 10-20 mL/kg IV crystalloid

Hypotension resistant to IV fluid may require management with a vasopressor (noradrenaline initially)

Co-ingestion of a CCB producing profound hypotension:

- An echocardiogram will help characterise the degree of vasoplegia vs. negative inotropy
- Other vasoconstrictors (vasopressin, methylene blue) or positive inotropes (adrenaline, HIET) may be beneficial (discuss with clinical toxicologist)

Disposition:

- Discharge pending mental health assessment if clinically well and asymptomatic at 6 hours post ingestion
- Admit patients with hypotension for ongoing supportive care until symptoms resolve