Olanzapine

Overdose causes sedation with associated anticholinergic effects and intermittent periods of agitation

Toxicity / Risk Assessment

Expect toxicity in any ingestion > 5x patients' usual dose

Ingestions > 400 mg: expect severe toxicity including coma

Children and olanzapine naïve patients are more susceptible

Clinical features:

- Predominant anticholinergic toxidrome
- Onset usually within 1 – 2 hours (up to 4 hours)
- CNS: sedation, fluctuating agitation, miosis, ataxia
- CVS: tachycardia, postural hypotension
- Other: urinary retention
- Rarely: ↑ QT, seizures, extrapyramidal effects (can be delayed), rhabdomyolysis
- **Post-injection delirium/sedation syndrome (PDSS)**
  - Onset within an hour (up to 4 hours) post IM injection
  - Clinical features include somnolence, confusion, dysarthria, sedation, dizziness, agitation/delirium
  - May last up to 72 hours

Management

Monitor and protect airway. Intubate as required.

Decontamination:

Activated charcoal (AC) 50g (Paediatric 1g/kg) within 2 hours of ingestion

All intubated patients should be administered AC via NG tube, regardless of time since exposure

Agitation

Check for urinary retention and signs of anticholinergic delirium.

Anticholinergic delirium

Supportive care +/- titrated doses of diazepam (5-10 mg oral q30 minutely or IV q10-15 minutely)

Consider physostigmine (discuss with clinical toxicologist – see separate guideline)

Droperidol may be required in severe behavioral disturbance resistant to benzodiazepines

Hypotension (Graduated approach)

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

Norepinephrine infusion: if hypotension resistant to fluid load up to 20 mL/kg

Seizures (usually self-limiting)

Benzodiazepines: Diazepam 5 mg IV every 5 minutes as necessary

Dystonia (extrapyramidal side effects): Benztropine 1-2 mg IV

Disposition:

- Mental health assessment if no sedation + ambulating + voiding four hours post exposure
- Advise patient not to drive for at least 72 hours post exposure