Benzodiazepine overdose produces CNS depression. Lone benzodiazepine exposures usually only need supportive care.

### Toxicity / Risk Assessment

Lone benzodiazepine exposures in otherwise well patients are normally well tolerated + only require supportive care. A ceiling CNS effect is reached, even with increasing doses. More significant toxicity is likely with CNS depressant co-ingestants, co-existing cardio-respiratory illness.

*Greater CNS depression and need for intubation, however, is observed following alprazolam OD.*

### Clinical features:
- CNS depression: drowsiness, ataxia, slurred speech, coma
- Systemic effects in large OD: ↓Temp, ↓HR, ↓BP
- Lone OD – significant coma unlikely
- Paradoxical excitation possible in children

### Management

Supportive care is mainstay of management

Protect airway. Intubation may be required. *(More likely with alprazolam or co-ingestion of other CNS depressants)*

**Decontamination:** Activated charcoal is not indicated because possible early CNS depression

**Flumazenil** is an effective benzodiazepine antagonist, but is **NOT** routinely indicated because of adverse effects such as precipitation of withdrawal, seizure or unmasking of arrhythmias

Possible indications: *(see Flumazenil guideline)*
- Non-benzodiazepine dependent patients with lone benzodiazepine OD with airway compromise
- Paediatric population with airway compromise and no co-ingestion
- Iatrogenic/post procedural sedation where over-sedation produces respiratory compromise
- Elderly / nursing home patient with airway compromise where intubation is deemed inappropriate

### Disposition

- Severe clinical effects normally resolve in 12-24 hours
- If significant ataxia or drowsiness occur, observe in hospital until improvement occurs
- Discharge pending mental health assessment if normal conscious state and able to ambulate safely at 4 hours post ingestion
- Advise patient not to drive for at least 72 hours post exposure

AUSTIN CLINICAL TOXICOLOGY SERVICE GUIDELINE

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