Amoxapine overdose
Acute renal failure: case report

Beta lactams
Bleeding diathesis and platelet dysfunction: 11 case reports

Carbamazepine
Toxic postulodermatoma: case report
A facial maculopapular rash, which rapidly became generalised, developed 3 weeks after carbamazepine 200mg tid was added to the multidrug regimen of a 55-year-old woman with bipolar affective disorder. Fever and cervical lymphadenopathy were also noted. Initially, all medications were continued and paracetamol [acetaminophen] was administered. Symptomatic improvement for several days was followed by rapid deterioration, and mild hepatosplenomegaly, pruritic erythroderma and generalised cutaneous oedema were observed. Micropustules appeared, first on the face and scalp followed by gradual progression, caudally. All medications were withdrawn and prednisolone, terfenadine, ampicillin and fluocoxacin were administered with the patient recovering over the following 4 days. Nine months later, all previous medications except carbamazepine were reintroduced without incident.

Carbamazepine interaction
Reduced plasma concentrations with concomitant felbamate: clinical study
Carbamazepine plasma concentrations were significantly reduced when felbamate, a novel anticonvulsant, was added to carbamazepine monotherapy in 22 patients. The effect on carbamazepine concentration was evident within 1 week of combined therapy, plateauing after 2-4 weeks. The average reduction was 25% (range 10-42%) of baseline. This effect persisted throughout felbamate therapy (up to 8 weeks), with carbamazepine concentrations returning to baseline 2-3 weeks after felbamate withdrawal.

The reduction of CBZ [carbamazepine] concentrations during FBM [felbamate] cotherapy may have clinical implications. This effect is predictable and of a relatively constant magnitude in patients receiving carbamazepine monotherapy.

Chlorothiazide/hydrochlorothiazide + amiloride
Hyponatraemia and atiroventricular block: 2 case reports
Second-degree or complete atrioventricular (AV) block occurring during or shortly after an episode of diuretic-induced hyponatraemia prompted the admission of 2 patients with existing heart failure.

Case 1: A 60-year-old man, known to have first-degree AV block, was admitted with progressive weakness 1 month after starting chlorothiazide. An ECG showed Mobitz type 2 second-degree AV block. The patient was hyponatraemic and hyperglycaemic. Diuretic therapy was withdrawn and fluid intake was restricted to 1 L/day. Over the next 2 weeks, serum sodium levels ranged from 115 to 128 mmol/L, and Mobitz type 2 second-degree AV block was noted to alternate with Wenkebach type or first-degree AV block. Second-degree AV block was not recorded when serum sodium levels were 125-133 mmol/L.

Anasthetics
Delirium: case report

Anticoagulants
Adverse effects: review

Antipsychotics
Neuroleptic malignant syndrome: 2 case reports
Neuroleptic malignant syndrome was diagnosed in a 12-year-old girl and in a 14-year-old boy with primary bipolar affective disorder, following antipsychotic therapy for associated psychotic symptoms. Medication included oral and IM haloperidol, thioridazine, and trifluoperazine. Both patients presented with rigidity, fever, hypertension, tachycardia and elevated serum creatine phosphokinase levels. Following haloperidol dosage reduction in the girl, and withdrawal of lithium and all antipsychotic medication in the boy, both patients were treated with bromocriptine. The boy was also treated with dantrolene. Extrapyramidal symptoms gradually resolved and elevated serum creatine phosphokinase levels and vital signs normalised over the next 10-20 days.

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