Ethanol is present in more than 700 pharmaceutical liquid preparations, ostensibly as an "inert" solvent or diluent. Despite recent voluntary efforts by several pharmaceutical companies to replace alcohol or reduce its content, there remain on the market an excessive number of liquid medications containing alcohol in concentrations ranging from 0.3% to 68%, e.g., teething preparations, decongestants, and cough medicines. The presence of ethanol in children's medication is of major toxicologic interest with respect to both acute ingestion and passive exposure that occurs during therapy with ethanol-containing products. This commentary focuses upon the toxicology of ethanol in children and the determination of acceptable alcohol concentrations in children's medication.

INTERACTION WITH OTHER DRUGS

When taken in conjunction with other drugs, medicines containing alcohol may produce undesirable interactions. Acute ethanol administration may alter drug absorption or impair the degradation of other drugs. When taken with sedating drugs, it may result in enhanced psychomotor impairment. Chronic ethanol administration, which induces drug-metabolizing enzymes (such as P-450), may be of clinical importance by altering the clearance of several drugs (phenobarbital, phenytoin, meprobamate, and warfarin). Disulfiram (Antabuse) reactions, symptoms of which include flushing, tachycardia, nausea, vomiting, and, in severe forms, cardiac arrhythmias, cardiovascular collapse, respiratory depression, and convulsions, may also be induced by alcohol-containing medicines. Of more direct importance to pediatricians are recent reports of disulfiram-like reactions that occur in some individuals after the simultaneous use of antibacterial drugs such as moxalactam, metronidazole, sulfonamides, chloramphenicol or cefamandole, and alcoholic beverages or medicinal elixirs.

ESTABLISHING CRITERIA FOR ALCOHOL CONTENT IN CHILDREN'S MEDICATION

Toxicokinetics of Alcohol

The effects of acute and chronic alcohol ingestion in adult populations have been described previously. However, except in cases of acute poisoning, little information is available on the effects of ethanol in the pediatric age group. Furthermore, interpretation of the data is also made difficult by the conflicting information on ethanol kinetics in children. For example, despite reports that alcohol dehydrogenase activity does not reach adult levels until 5 years of age, pharmacologic studies in acutely intoxicated children show that clearance of ethanol is more rapid than that reported in adults. In addition, the precise blood ethanol concentrations that produce CNS symptomatology or death in children remain controversial. Although the reported lethal dose of ethanol is 5 to 8 g/kg in adults and 3 g/kg in children, morbidity and mortality may occur with lower amounts secondary to induced hypoglycemia or interaction with other drugs.

The major acute toxic effect of ethanol is neuronal dysfunction. CNS effects, including decreased reaction time, muscular incoordination, behavioral changes, etc are usually present with blood ethanol concentrations of approximately 100 mg/100 mL, but have been reported with concentrations as low as mg/100 mL. Based upon these data, we have arbitrarily established 25 mg/100 mL as a blood ethanol concentration not to be exceeded following a single dose of alcohol-containing medication. The blood ethanol concentration (BEC) in children following ingestion can be projected using available
For our calculations (Table 1) we have utilized the pharmacokinetic formula:

\[ \text{Plasma concentration} (C_p) = \frac{\text{Dose} (D)}{\text{Volume distribution} (V_d)} \]

to estimate the dose of ethanol that would be necessary to produce a maximum blood ethanol concentration of 25 mg/100 mL. In reality, the measured blood ethanol concentration would be predicted to be lower than our projected values because these are based on the assumption that the entire dose is completely and instantaneously absorbed, the volume of distribution is constant, and no degradation has taken place.

Additionally, in the pediatric population, it is unclear whether the BEC is affected by chronic alcohol ingestion. Based upon computer simulation studies for children between 6 and 12 years of age, the ingestion of alcohol every four hours in concentrations of 10% or less would not result in accumulation of blood ethanol (W. Schary, personal communication, 1982). Hence, in the sample problem in Table 1, the 6-year-old child would need to ingest 40 mL of 10% ethanol every four hours in order to maintain a BEC of 25 mg/100 mL.

### Volume Permissible in Ethanol-Containing Products

The total amount of ethanol present in each container is also of concern, since possible toxic or lethal blood ethanol concentrations might be produced in small children after accidental ingestion of the entire contents. Utilizing the lethal Poisindex value of 3 g/kg, the ingestion volume necessary to produce the potential lethal blood level in children can be calculated (Table 2). These extrapolated levels do not, however, take into consideration problems induced by hypoglycemia or drug interactions.

### Packaging Recommendations

It is desirable that no ethanol be included in medicinal products intended for use in children. However, if ethanol is required to solubilize the active ingredients, the Committee on Drugs has made the following specific recommendations to the FDA: (1) Over-the-counter (OTC) liquid preparations should be limited to a maximum of 5% v/v ethanol. (2) Physician supervision is suggested for children less than age 6 years using OTC preparations containing alcohol. (3) The amount of ethanol contained in any medicinal preparation should not be able to produce a blood concentration greater than 25 mg/100 mL after a single recommended dose. (4) Appropriate intervals between medication doses should be prescribed to prevent the accumulation of blood alcohol. (5) The packaged volume of ethanol-containing products should be kept to a reasonable minimum to prevent potential lethal ingestions. (6) Safety closures should be recommended for medications with greater than a 5% ethanol content.

### CONCLUSIONS

Pediatricians and other health care providers should be aware of the widespread presence of
alcohol in liquid medications and its potential toxicity. Alcohol-containing medicines may affect the disposition of other drugs, cause undesirable drug interactions, or induce disulfiram (Antabuse)-like reactions. Since CNS toxicity occurs when the concentration of ethanol in the blood is 25 mg/100 mL, a single dose of alcohol-containing medication must not be able to produce this level of ethanol. Although fatal blood ethanol concentrations are widely quoted, including those in Table 2, such information does not take into consideration the effects of chronic administration, effects of simultaneous treatment with other medications, possible development of hypoglycemia, and reported fatalities with lower blood concentrations. Finally, continued efforts should be made to have alcohol removed from liquid preparations for children. In those instances in which alcohol is a necessary solvent, preparations should be packaged in small volumes with safety closures.

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REFERENCES

19. Poisindex® Inc. Rocky Mountain Poison Center, Denver, 1982
the separation of psychological trauma from medical trauma (as long as they are both attended to) can be in the best interest of the patient and physician alike.

8. The pediatrician may have a fear of opening Pandora’s box. Often, simple problems become more complex as a counselor learns more about the family. Most families have secrets. The physician as counselor must be able to hear unspeakable things without surprise or a judgmental attitude. A counselor must acknowledge that sometimes things will get worse before they can get better. Persistence and acknowledgment of the difficulty in talking about “forbidden” subjects is necessary for the family to take the remedial measures necessary to correct symptomatology.

At present, the pediatrician is seeking to expand his/her role into the area of counseling. In order to achieve the standard of competence expected in other areas of practice, the pediatrician must have a clear understanding of his/her own feelings as they affect the therapeutic relationship with patients. For the mental health professional, this understanding is the result of supervision. A similarly effective opportunity must be a part of the training of the pediatrician as well.

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REFERENCES
5. Chess S: Mothers are always the problem—or are they? Old wine in new bottles. Pediatrics 1983;71:974–976

ERRATUM

In the article “Ethanol in Liquid Preparations Intended for Children” by the Committee on Drugs of the American Academy of Pediatrics (Pediatrics 1984;73:405–407), there is an error under “Toxicokinetics of Alcohol.” In the second paragraph, the second sentence should read: CNS effects, including decreased reaction time, muscular incoordination, behavioral changes, etc. are usually present with blood ethanol concentrations of approximately 100 mg/100 mL, but have been reported with concentrations as low as 20 mg/100 mL.
Ethanol in Liquid Preparations Intended for Children

*Pediatrics* 1984;73;405

The online version of this article, along with updated information and services, is located on the World Wide Web at:

http://pediatrics.aappublications.org/content/73/3/405

An erratum has been published regarding this article. Please see the attached page for:

http://pediatrics.aappublications.org/content/73/5/732.full.pdf